Authorization For Release Of Protected Health Information

I hereby authorize Aetna Life Insurance Company and any of its parents, subsidiaries, and affiliates (including, but not limited to Aetna Health Management, Inc., Aetna's affiliated HMOs and Aetna Integrated Informatics) and their respective agents and subcontractors, to disclose confidential information about the member/insured identified below.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.

Please Print All Responses

If you do not fill out both sides of this form completely, Aetna may be unable to process your request. Incomplete authorization requests will be returned to you.

1. Member/Insured Information

Last Name		First Name	Middle Initial
Member I.D. Number	Social Security Number	Birthdate *(MM/DD/YYYY)*	Daytime Telephone Number *(include area code)*
Street Address		City, State and Zip Code	

2. I authorize the individual(s) or company(ies) identified below to receive confidential health information pertaining to the member/insured named above.

Individual or company authorized to receive confidential information	Daytime Telephone Number *(include area code)*
Street Address	City, State and Zip Code
Individual or company authorized to receive confidential information	Daytime Telephone Number *(include area code)*
Street Address	City, State and Zip Code
Individual or company authorized to receive confidential information	Daytime Telephone Number *(include area code)*
Street Address	City, State and Zip Code

3. Purpose(s) for this Authorization

This authorization is for Aetna:

☐ To respond to all requests for confidential information made by the individual(s) or company(ies) named in Section 2 above.

☐ To respond to requests for only the following specific information: (for example, disclosures about claims submitted by a specific provider)

_____

_____

_____

If this authorization is limited to information in effect for a specific period of time, please indicate:

_____ through _____

mm/dd/yyyy *mm/dd/yyyy*

4. Type of coverage to which this authorization applies *(check all that apply)*

☐ Disability ☐ Long Term Care ☐ Health (This includes medical, dental, pharmacy, vision, and flexible spending accounts)

5. Description of the information to be released or disclosed: (*check all that are appropriate*)

☐ Application or enrollment information.

☐ Claim records

☐ Claim status

☐ Patient management records

☐ Other: *(please specify)* _____

6. IMPORTANT: Your signature below means that you understand and agree to the following:

- The protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information. These records will be included in the information we will make available to the individual(s) or company(ies) identified in Section 2 above.
- Information disclosed under this authorization may be redisclosed by the recipient and no longer protected by federal privacy regulations.
- If we receive requests for copies of claims and encounter information from the individual or company you have authorized to receive your confidential information, we may charge a reasonable fee (except where prohibited by law) to defray our copying and mailing costs.
- Your ability to enroll in an Aetna plan, your eligibility for benefits and payment for services will not be affected if you do not sign this form. (However, without your signature, your request to release the information described above to a third party will not be honored.)
- You may receive a copy of this form if you ask for it by writing to the address listed at the bottom of this page.
- This authorization will expire one year from the date you sign this authorization. If you sign this form, you may revoke the authorization at any time by notifying Aetna in writing at the address below. Revoking this authorization will not have any effect on actions that Aetna took in reliance on the authorization before we received the notification.

7. Signature of Member/Insured or Member/Insured's Legal Representative

Signature of Member/Insured, Member/Insured's Legal Representative, or Member/Insured's Parent (if Member/Insured is an unemancipated minor child)	Date
Print Name	

If the person signing this Authorization is not the Member, describe relationship to the Member:

☐ Natural or Adoptive Parent of Unemancipated Minor Child

☐ Legal Representative (i.e., someone with legal authority to act on the Member/Insured's behalf)

If this authorization is being signed by Member/Insured's legal representative (other than a parent of an unemancipated minor child), you must furnish a copy of the health care power of attorney, or other relevant document authorizing you to act on the Member/Insured's behalf.

Return this completed form to: Aetna Legal Support Services
151 Farmington Avenue, W121
Hartford, CT 06156-9998
Fax: (860) 907-3017