Aetna International

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, Inc.) and their respective employees, agents and subcontractors, to disclose PHI concerning the Member identified below.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.

Please Print All Responses

Please submit a separate Authorization for Release of Protected Health Information for each Member for whom Aetna is being requested to disclose protected health information to a third party. If both sides of this form are not completed, as applicable, Aetna will be unable to process your request. Incomplete authorization requests will be returned.

1. Member Information

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

2. Subscriber Information

*(The Subscriber is usually the Employee who obtains coverage for his or her family. Please complete this **Section** if the Subscriber is not the member whose records are being requested.) This **Section** does not apply to Long Term Care.*

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

3. I authorize the individual(s) or company(ies) identified below to receive PHI pertaining to the Member identified in Section 1.

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

4. Purpose(s) for this Authorization

This authorization will apply to any and all requests for PHI, as well as information pertaining to disability and life insurance products, made by the individual(s) or company(ies) named in Section 3. It is not necessary to complete Section 4, unless you want to give a partial authorization. If you prefer to authorize disclosure of only selected categories of information, please indicate below which types of information may be disclosed.

☐ Any information requested ☐ Patient management records

☐ Health (medical, dental, pharmacy, vision and flexible spending account information)

Sensitive Information: (this information may include diagnosis and/or treatment information)

☐ Substance use disorder (alcohol/drug) ☐ HIV/AIDS ☐ Sexually transmitted diseases

☐ Other sensitive services (such as gender affirming care or sexual or reproductive health)

☐ Behavioral health/Mental health (but NOT psychotherapy notes). ☐ Other (please explain) ______________________

This authorization will apply to all PHI maintained by Aetna, unless you specify certain categories below.

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)* ____

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

- The PHI disclosed pursuant to this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually-transmitted diseases, 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 3**.
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy regulations.
- If we receive requests for copies of claims and encounter information from the individual(s) or company(ies) you have named in **Section 3**, 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, and 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 information to the individual(s) named in **Section 3** will not be honored.)
- You may receive a copy of this signed form if you ask for it by writing to the address listed at the bottom of this page.
- If you sign this form, you may revoke this 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.

6. Signature of Member or Member's Legal Representative

Minors* must sign this form below ***if*** (check applicable box):

1. ☐ the minor is married or emancipated
   or,
2. ☐ the information being authorized for release pertains to drug or alcohol treatment
   or,
3. ☐ the information being authorized for release pertains to mental health treatment and applicable state law allows minors to receive such treatment without parental consent.

*< age 19 (NE and AL); < age 21 (PA);
< age 18 (all other states)

Signature	Date

Print Name

All others must sign this form below as(check applicable box):

4. ☐ the member or member's legal representative
   or,
5. ☐ the parent of unemancipated minor, unless minor has signed at left *and* box 3 at left has been checked
   or,
6. ☐ the parent of unemancipated minor if the information authorized for release pertains to drug or alcohol treatment and applicable state law does NOT allow minors to receive such treatment without parental consent (Note: in this case, signature of both parent and minor are required.)

Signature	Date

Print Name

If the person signing this Authorization is not the Member, describe relationship to the Member (i.e. Parent, Legal Representative):

If this authorization is being signed by the Member's Legal Representative, you must furnish a copy of the health care power of attorney, or other relevant document authorizing you to act on the Member's behalf.

Please sign and return this completed form and relevant documentation, if required, to:

HIPAA Member Rights Team
PO Box 14079
Lexington, KY 40512-4079

Or you can fax it to: 1-859-280-1272

NOTICE TO RECIPIENT(S) OF INFORMATION (Section 3)

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For Plans Compliant with United States Federal Affordable Care Act (ACA) legislation
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779), 1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

English	**To access language services at no cost to you, call the number on your ID card.**
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Persian Farsi	**برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.**
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.