Authorization For Aetna To Request Protected Health Information

1. MEMBER INFORMATION (Information About Person For Whom This Authorization Is Requested.)

Last Name	First Name	Middle Initial
Claim Number	Year of Birth	Daytime Telephone Number *(include area code)*
Street Address	City, State and ZIP Code	

PLEASE READ THE FOLLOWING CAREFULLY BEFORE COMPLETING YOUR AUTHORIZATION. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

☐ This form requests a Member's unconditioned authorization for Aetna to ask another person or organization to disclose Member's Protected Health Information ("PHI") to Aetna for the following purpose(s).

☐ The specific PHI we are asking you to authorize Aetna to request is (This section completed by Aetna.)

2. By signing this form, you will authorize Aetna to request PHI described above from the following persons or organizations (or classes of persons or organizations).

3. Expiration of this Authorization (Select one.)

☐ On the following date: ____/____/____

☐ When the following event occurs.

Please review and complete important information on the reverse of this form.

4. Important: Your signature below means that you understand and agree to the following.

- You authorize Aetna to request from the persons or organizations named above the PHI described above for the purposes stated above.
- The information to be disclosed may be protected by law. Information disclosed under this authorization may be redisclosed and no longer protected by federal privacy regulations.
- 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.
- You may revoke the Authorization at any time by notifying Aetna in writing, but if you do that, it won't have any effect on actions that Aetna takes before we received your notice.
- You may receive a copy of this form if you request it in writing from the address listed below.
- You agree that, unless you provide a written restriction in Section 1 above, you have expressly authorized the release to Aetna of information concerning treatment of mental illness, alcohol or substance abuse, Human Immunodeficiency Virus (HIV) infection, or Acquired Immune Deficiency Syndrome (AIDS).

5. Signature of Member/Insured or Legal Representative.

Signature of Member/Insured or Legal Representative	Date
Print Name	

If not the Member, describe your relationship to the Member:

☐ Natural or Adoptive Parent of Unemancipated Minor Child

☐ Other Legal Representative

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 designating you as the representative.

NOTICE TO RECIPIENT(S) OF INFORMATION (Section 2. above):
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. *Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.*

To be filled in by Aetna:

Return this completed form to: _____
Aetna Business Area Name

_____
Aetna Street Address

_____
City, State, ZIP Code

_____
Attn: Contact Name and Mail Location

Contact Telephone Number: _____

Contact Fax Number: _____

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).