Authorization for Release of Personal Confidential Information to Third Parties

I hereby authorize Aetna and any of its parents, subsidiaries, or other affiliates (including, but not limited to, Aetna Health Management, Inc., Aetna Life Insurance Company, U.S. Quality Algorithms), and their respective agents and subcontractors, to disclose confidential information about the member/insured listed below.

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 the member.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY and that the information to be disclosed may be protected by law.

Member/Insured Name _____ Aetna I.D. or Social Security Number _____ Date of Birth _____

Name and Aetna I.D. or social security number of subscriber, if different from Member/Insured _____

Street Address _____ City, State, and Zip Code _____ ( ) Daytime Telephone Number _____

I authorize the individual or company identified below to receive confidential information pertaining to the member/insured named above.

Individual or company authorized to receive confidential information _____

Street Address _____

City, State, & Zip Code _____

( ) Daytime Telephone Number _____

Information to be disclosed to this individual or company includes application or enrollment information, eligibility information, claims records, claim status, and patient management records.

Disclosure requested will include otherwise confidential medical information. If our records include claims or other information pertaining to chronic diseases, behavioral health conditions, including 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 or company designated above.

Type of coverage to which this authorization applies (check all that apply):

☐ **MEDICAL** ☐ **DENTAL** ☐ **DISABILITY** ☐ **PHARMACY**

☐ **PENSION** ☐ **LONG TERM CARE** ☐ **LIFE** ☐ **Other (specify)** _____

Continued on other side

Authorization for Release of Confidential Information to Third Parties (continued)

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

- Requests for paper copies of claims and encounter information we receive from the individual or company you have authorized to receive your confidential information, require payment of a $10 administrative fee (except where prohibited by law) to defray our copying and mailing costs. Requests for paper copies should be accompanied by a check or money order made payable to Aetna Inc. in the amount of $10 for each member whose records are requested.
- You understand that your eligibility for benefits and payment for services covered by Aetna under your plan 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.)*
- The confidential information provided to the authorized individual or company upon their request, may include diagnosis and treatment information, including information on chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information.
- You understand that 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.
- You understand this authorization will expire one year from the date you sign this authorization. You also understand that if you 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 took before we received the notification.
- You agree to hold Aetna Inc. and its affiliates harmless from any claim or liability (including, but not limited to, any claim brought under a confidentiality or privacy law) in connection with the release at your request of the information and records described above.

_____ _____

Signature of Member/Insured or Legal Representative | Date

_____ _____

Print name of Member/Insured's Legal Representative (if applicable) | Relationship to Member/Insured

If this authorization is being requested by member/insured's legal representative, you must furnish a copy of the power of attorney, or other relevant document designating you as the representative.

(Important note: the witness below may not be the person authorized to receive the information to be disclosed.)

Witnessed by: _____ _____

Printed name of witness | Date

_____

Signature of witness

Return the completed form to:

Aetna Law Document Center
151 Farmington Avenue, W121
Hartford, CT 06156-9998

Please provide a copy of this form to your authorized representative so that they will be able to establish the validity of their request for your health information.