

4. Purpose(s) for this Authorization (continued)

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: <i>(check all that are appropriate)</i>	
<input type="checkbox"/> Application or enrollment information	<input type="checkbox"/> Claim status
<input type="checkbox"/> Claim records	<input type="checkbox"/> Patient management records
<input type="checkbox"/> Other: <i>(please specify)</i> _____	

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 above.
- 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 or company 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 above 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.
- 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.

6. Signature of Member or Member's Legal Representative.

Minors* must sign this form below <i>if</i> (check applicable box):		All others must sign this form below as (check applicable box):	
1. <input type="checkbox"/> the minor is married or emancipated or, 2. <input type="checkbox"/> the information being authorized for release pertains to drug or alcohol treatment or, 3. <input type="checkbox"/> 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)	4. <input type="checkbox"/> the member or member's legal representative or, 5. <input type="checkbox"/> the parent of unemancipated minor, unless minor has signed at left <i>and</i> box 3 at left has been checked or, 6. <input type="checkbox"/> 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	Signature	Date
Print Name		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.

Return this completed form and relevant documentation, if required, to:

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

NOTICE TO RECIPIENT(S) OF INFORMATION (Section 3. above):

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.