aetna®

Authorization to Share and Use Medical Information

Mail this completed form to:
Aetna Life Insurance Company
PO Box 14560
Lexington, KY 40512-4560
Fax: **866-667-1987**

I allow all doctors, hospitals, other health care providers, government agencies, insurers, employers, schools, training facilities, health plans, policyholders, contract holders, vendors, health and benefit plan administrators or their successors ("Records Holders") to give out and discuss my medical information as explained on this Authorization form.

This information includes, but is not limited to, any records or facts about my medical condition, treatment, supplies, employment, vocation, education, training, income, and other insurance coverage including benefits paid ("Information"). This Information may also include diagnosis, treatment and education related to drug and/or alcohol abuse, HIV/AIDS or other communicable or sexually-transmitted disease, as well as behavioral health conditions (but does not include psychotherapy notes).

I allow the Records Holders to give my Information to the following individuals or entities ("Benefit Managers"): the employer named below, Aetna Life Insurance Company, their benefit plan or claims administrator(s), their related companies, contractors, investigators, attorneys, and service consultants, authorized union representatives, health care providers treating or evaluating me or my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim. I allow the Records Holders to discuss and clarify information provided in support of a claim for short term disability benefits, long term disability benefits, salary continuation, leave under the federal Family and Medical Leave Act, local and state leave laws, workers' compensation and/or any other health benefit program, fitness for duty, other work accommodation programs, or leave benefits offered by and through my employer ("Benefits Program").

I allow the Benefit Managers to use, give out or otherwise make available the Information only to evaluate, analyze, manage and/or administer the Benefits Program. I also allow the Benefits Managers to give/make available my Information to any other person or entity if needed to find out whether I am eligible for benefits, to manage my claim, or to run the Benefits Program.

I understand that Information disclosed to Benefit Managers pertaining to certain alcohol or drug abuse treatment or HIV/AIDS or other communicable or sexually-transmitted disease is protected by federal (42 CFR Part 2) and state confidentiality rules and statutes, which prohibit any further disclosure of this information without my express written consent, or as otherwise permitted by such rules and statutes. I understand that a general authorization for the release of medical or other information is NOT sufficient for release of these types of records. Therefore:

☐ **If any of my records contain information about alcohol or drug abuse, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the Benefits Program. I understand that the federal rules restrict any use of the Information to criminally investigate or prosecute any drug or alcohol abuse patient.**

☐ **If any of my records contain information about HIV/AIDS or other communicable or sexually transmitted disease, then, by checking this box, I hereby expressly allow my Benefits Managers to use or give out such information to evaluate, analyze, manage and/or administer the Benefits Program.**

The Benefits Managers will tell those receiving Information that the Information is confidential. The Information provided to Aetna will not be used for any purpose other than its intended use stated above. I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by the Benefit Managers.

Unless revoked earlier, I understand that this permission lasts twelve (12) months after my claim is processed or twelve (12) months after the end of my coverage under the Benefits Program, whichever is longer, unless law requires a shorter period. If I change my mind about this Authorization before that time is up, I can tell my Records Holders and Benefit Managers in writing that I do not want them to share any more information. If I revoke my Authorization by telling them in writing to stop sharing information, it will not change any actions they took before I revoked my permission. If I do not sign this Authorization, it will not affect how my health care providers treat me. However, if I do not sign, the Benefits Managers may not be able to review my claim and cannot find out whether I am eligible for benefits. This may result in denial of my request for benefits.

The Information released under this Authorization can be submitted to the Benefits Managers electronically, by phone or fax, or by mail. I know I can see or copy the records given to the Benefits Managers. I agree that a copy of this Authorization may be treated as a signed original.

NOTICE TO RECIPIENT(S) OF INFORMATION:
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.*

Claimant's Name	Date of Birth	Date
Claimant's or Legal Representative's Signature	Legal Representative's Name and Relationship	
Employer's Name		