aetna®

ECHS Category – PHIA

Aetna International

Aetna
Authorization for Release of Personal Information to Third Party
(a.k.a. Third Party Authorization – Non-HIPAA)

I hereby authorize Aetna International, Inc., Aetna Life Insurance Company and any of its subsidiaries (hereinafter Aetna), their respective employees, agents and subcontractors, to disclose Personal/Sensitive Personal (Health) Information concerning the member identified below.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.

Please submit a separate Authorization for Release of Personal/Sensitive Personal (Health) Information for each member for whom Aetna is being requested to disclose personal 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 (Member or Entity)	Birth Date (MM/DD/YYYY)	Daytime Telephone Number (include area code)
Address		

2. Subscriber Information *(The Subscriber is usually the Individual who obtains coverage for his or her family. Please complete this Section if the Subscriber is not the member whose records are being requested.)*

Last Name	First Name	Middle Initial
I.D. Number	Birth Date (MM/DD/YYYY)	Daytime Telephone Number (include area code)
Address		

3. I authorize the individual(s) or company(ies) identified below to receive personal information pertaining to the member identified in Section 1 above.

Individual or company authorized to receive Personal Information	Daytime Telephone Number (include area code)
Address	
Individual or company authorized to receive Personal Information	Daytime Telephone Number (include area code)
Address	
Individual or company authorized to receive Personal Information	Daytime Telephone Number (include area code)
Address	

4. Purpose(s) for this Authorization

This authorization will apply to any and all requests for Personal/Sensitive Personal Information, as well as information pertaining to disability and life insurance products, made by the individual(s) or company(ies) named in Section 3 above. 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.

☐ Health (This includes medical, dental, pharmacy, vision information)

☐ Behavioral Health (e.g., mental health, drug and alcohol abuse treatment)

☐ Disability ☐ Life Insurance ☐ Long Term Care ☐ Other

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below.

________________________ through ________________________

mm/dd/yyyy mm/dd/yyyy

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

This authorization will apply to all Personal/Sensitive Personal Information 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 status
☐ Claim records ☐ Patient management records
☐ Other: *(please specify)* ___

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

- The Personal/Sensitive Personal (Health) Information 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 privacy laws and 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 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.
- 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 ***if*** (check applicable box):	All others must sign this form below as(check applicable box):
1. ☐ the minor is married or emancipated or, 2. ☐ the information being authorized for release pertains to drug or alcohol treatment	3. ☐ the member or member's legal representative or, 4. ☐ the parent of unemancipated minor, unless minor has signed at left 5. ☐ the parent of unemancipated minor if the information authorized for release pertains to drug or alcohol treatment. (Note: in this case, signature of both parent and minor are required.)
Birth Date (MM/DD/YYYY)	Birth Date (MM/DD/YYYY)
Signature	Signature
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 HIPAA Member Rights Team
PO Box 14079
Lexington, KY 40512-4079
USA

Facsimile: 00 1-859-280-1272 (when dialing from outside U.S)

E-mail: LSSInternationalMailbox@aetna.com

Note: Please be aware that if you elect to use e-mail to send and receive information related to your personal information, the information may not be protected from unauthorized access unless secure encryption is used.