Authorization For Aetna to Disclose Protected Health Information (PHI) for Health and Disability Benefits Coordination

This authorization allows Aetna to disclose protected health information (PHI) to Aetna Disability Services which will be used to coordinate management of health care and disability benefits.

- 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.
- PHI provided under this authorization may include application or enrollment information, claim records, claim status and patient management information, diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information.
- PHI disclosed to Aetna Disability Services pursuant to this authorization may no longer be protected by federal privacy regulations. However, Aetna policy prohibits further disclosure, except for purposes described in this authorization.
- This authorization will expire twelve months after you sign this form, unless you direct us to terminate the authorization sooner. You may revoke this authorization at any time by notifying us in writing at the address below. The cancellation will apply from the date we receive your written notification.
- You may receive a copy of this form by requesting it in writing at the address below.
- You have a right to inspect or copy the PHI described above.
- Please return completed, signed authorization to the address below.

I hereby authorize Aetna and any of its parents, subsidiaries, or other affiliates (including, but not limited to, Aetna Health Management, Inc., Aetna's affiliated HMOs and Aetna Integrated Informatics, Inc.) and their respective employees, agents and subcontractors, to disclose Protected Health Information (PHI) of the member/insured listed below to Aetna Disability Services.

1. Member Information

Last name	First Name	MI
Member I D Number or Social Security Number		Birth date (MM/DD/YYYY)
Street Address	City, State	Zip

2. Signature of Member/Insured or Legal Representative

Signature of Member/Insured or Legal Representative	Date
Print Name	

Please Check One

☐ Insured ☐ Parent/Legal Guardian ☐ Legal Representative*

*Legal Representatives must furnish a copy of the healthcare power of attorney or other relevant document designating you as the representative.

Mail Form To: Aetna Inc.
Legal Support Services, W101
151 Farmington Avenue
Hartford, CT 06156

Fax Number: 860-907-3017

Referring Aetna Office: ______________________________