aetna™

# Health information authorization



**800-264-4000**
aetnaseniorproducts.com

- Please read these statements carefully. Print clearly using blue or black ink.
- This is a HIPAA required authorization.
- Applicant / insured must submit a completed, signed copy to the home office.
- Applicant / insured should keep a copy for their records.

## Applicant / insured declarations

I authorize the use and disclosure of health information about me as described below.

**Health Information to be Used or Disclosed:** I understand this authorization applies to information about my past, present or future physical or mental health or condition and may include facts about my other insurance coverage, hazardous activities, finances, vocation, and other personal traits. This information may come from my medical records including, but not limited to, my prescription history, diagnoses and treatment for illnesses, medical conditions, mental illness, substance abuse and tobacco use, but excluding psychotherapy notes and information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

**Who May Request or Use Information:** This information may be disclosed to and used and or disclosed by: Aetna and the members of its Affiliated Covered Entity ("Aetna ACE"). An Affiliated Covered Entity is a group of Covered Entities under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The members of the Aetna ACE will share Protected Health Information ("PHI") with each other for the treatment, payment and health care operations of the Aetna ACE and as permitted by HIPAA and this authorization; Aetna ACE's insurance support organizations and reinsurers; providers, treatment facilities, insurers, pharmacies, pharmacy benefit managers and consumer reporting agencies.

**Who is Authorized to Disclose Information:** All of the following persons or entities are authorized to disclose health information or records about me: care providers or evaluators, physicians, chiropractors, physical therapists, psychologists, mental health and substance abuse counselors and other health professionals; treatment facilities including hospitals, clinics, substance abuse treatment or consultation facilities, nursing homes, mental health facilities, ambulatory care centers and other medical or medically related facilities, reinsurers, other insurance companies and consumer reporting agencies.

**Purpose:** This health information may be used or disclosed to: evaluate and underwrite my insurance application; determine premium amounts, adjudicate claims and to support the operations of Aetna's life and health insurance plans.

**Statements of Understanding:** I understand that: (1) I will receive a copy of this Authorization and that a copy of it is as valid as the original; (2) this Authorization is valid for 24 months from the date signed; (3) if I do not sign this Authorization or I revoke it by writing to Aetna at its administrative office, my application may be declined; (4) if I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization; and (5) some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Applicant / insured complete this section.

Signature of applicant / insured

**X**

Date

.

Printed name of applicant / insured

**X**

City

.

State

.

Zip

.

Policy number of insured (if known)

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