AETNA BETTER HEALTH®

Authorization to Use or Share Personal Information

1. **I authorize Aetna Better Health to use and share my health information.**

   Name: _____

   Date of Birth: _____ Phone: _____

   Address: _____

   E-mail: _____ ID Number: _____

2. **Reason for disclosure**: Aetna Better Health can use and share my health information for my treatment and my care management and coordination. Aetna Better Health can do this is by sharing my information with doctors and others who give me care through a website.

3. **Information to be disclosed:** I allow the sharing of my health-related information, such as my past medical care, the drugs I take and my care management plans.

4. **Authorized recipients:** Below is a list of providers/practices that Aetna Better Health can share my health information.

Provider Name	Clinic Name	Address	Phone

4.1 **Drug and alcohol addiction or abuse:** If my medical record has information on drug and alcohol addiction or abuse Aetna Better Health care share this information with the people in Section 4.

Aetna Better Health can disclose all my health information, including drug and alcohol addiction or abuse, to the authorized recipients in Section 4. _____Yes _____No/Not Applicable

Aetna Better Health will disclose this information from records protected by federal confidentiality rules (42 CFR Part 2). The rules do not allow the people in Section 4 to further share any of your information unless you expressly permit further disclosure by written consent or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient. Federal rules do not allow any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

5. **Expiration:** This authorization expires when I am no longer a member of Aetna Better Health.

6. I understand that:

a. I may take back my authorization at any time by writing to Aetna Better Health. If information already has been disclosed before I cancel my authorization, canceling it only stops additional disclosures.
   Aetna Better Health
   Attn: Privacy Officer
   One S. Wacker Dr., 12th Fl., F646
   Chicago, IL 60606
b. Aetna Better Health does not decide treatment, payment, enrollment or eligibility based on this authorization.
c. Information (except drug and alcohol) I share under this authorization may be re-disclosed by the individuals/organizations in Section 4 and no longer may be protected by federal confidentiality rules.
d. Aetna Better Health, its programs, services, employees, officers and contractors do not have any legal responsibility or liability for disclosure of my information to the extent indicated and authorized.
e. I may refuse to sign this authorization.

* * * * * * * * *

Check "Yes" or "No/Not Applicable" in Section 4.1 before signing.

_____ _____
Signature of Individual or Personal Representative Date

If personal representative, state relationship to individual: _____

_____ _____
Signature of Witness Date

If individual is physically unable to sign, signature of second witness is required.

_____ _____
Signature of Second Witness Date

If individual is helped by provider, please provide the additional information below:

Provider Name: _____ Clinic Name: _____

Address: _____ Phone: _____

E-mail: _____ Tax ID Number: _____

Send completed forms to:

Mail:
Aetna Better Health
Attn: Member Services
One S. Wacker Dr., 12th Fl., F646
Chicago, IL 60606

Fax: 855-802-4291

E-mail: AetnaBetterHealthIllinois@aetna.com

Questions? Please call us at **1-866-600-2139.**