



# 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., 12<sup>th</sup> 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., 12<sup>th</sup> Fl., F646  
Chicago, IL 60606

**Fax:** 855-802-4291

**E-mail:** AetnaBetterHealthIllinois@aetna.com

**Questions?** Please call us at **1-866-212-2851**.