Revocation of Authorization Previously Given to Aetna

1. Member Information (Information about person who is revoking authorization.)

Last Name		First Name	Middle Initial
Member I.D. Number	Social Security Number	Birthdate *(MM/DD/YYYY)*	Daytime Telephone Number *(include area code)*
Street Address		City, State and ZIP Code	

2. Authorization To Be Revoked *(Check the appropriate box.)*

- ☐ Authorization for Aetna to Disclose Health Information to Other Persons or Organizations
- ☐ Authorization for Aetna to Request Health Information from Other Persons or Organizations
- ☐ Authorization for Other Persons or Organizations to Disclose Health Information to Aetna

Note: If we have more than one authorization on file for a category, ALL will be revoked unless you provide a copy of the specific authorization you are revoking.

3. Important: *Your signature below means that you understand and agree to the following:*

- You revoke your authorization(s) as indicated above for Aetna to either use and/or disclose your protected health information, or to request it from others.
- You understand that revocation of your authorization will not have any effect on actions that Aetna took before we received your notification.
- You may receive a copy of this form if you request it in writing from the address listed below.

Signature of Member or Legal Representative	Date
Print Name of Member's Legal Representative *(if applicable)*	

If this request is being made or signed by the Member's Legal Representative, you must furnish a copy of the power of attorney or other relevant document designating you as the representative.

Return this completed form to:

HIPAA Member Rights Team
PO Box 14079
Lexington, KY 40512-4079

Fax: (859) 280-1272