

6. By signing below, I understand and agree:

- My PHI that I agree to share may be sensitive. It may include diagnosis and treatment information. It may cover chronic diseases, behavioral health conditions and alcohol or drug abuse. It may cover communicable diseases, sexually transmitted diseases such as HIV/AIDS, and genetic marker information.
- Whoever gets my PHI may share it with others. That means federal or state privacy laws may no longer protect my PHI.
- I can get a copy of this authorization form that I have signed by sending Aetna a signed request using the address at the bottom of this form.
- Aetna will not release my PHI to the individual(s) or company(ies) named in Section 2 unless I sign this form.
- I can cancel or change my decision any time. I can do this by writing to Aetna, using the address at the bottom of this form.
- If I do cancel my permission, it will not affect actions Aetna took before getting my request.
- My ability to enroll won't change if I do not sign this form.
- My eligibility for benefits and services won't change if I do not sign this form.

ATTENTION:

- My signature is required if any of the below apply:
- I am 18 years of age or older
 - I am a minor under the age of 18 and I am either married or I am emancipated
 - The information being disclosed pertains to drug or alcohol treatment
 - The information being disclosed pertains to one of the following conditions and my state allows me to be treated even if my parents or legal guardian do not agree with my decision:
 - Mental health
 - Sexually transmitted disease (including HIV/AIDS)
 - Reproductive health (including contraception, prenatal care and abortion)
 - General medical and dental health

7. My signature or my legal representative's signature

Signature	Date
Print name	
If a legal representative signed this form, describe the relationship: (parent, legal guardian, Power of Attorney, personal representative)	

- If this request is being signed by the member's legal representative, you must provide legal documentation authorizing you to act on the member's behalf (legal guardianship, power of attorney, personal representative).
- If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

Please sign and return this completed form to:
Rural Carrier Benefit Plan
PO Box 14079
Lexington, KY 40512-4079
Fax 859-280-1272