Authorization for Release of Protected Health Information and Testimonial/Opinion Statements

I hereby authorize Innovation Health and any and all of its parents, subsidiaries, affiliates (Aetna and Inova), contractors, subcontractors, partners, and joint venturers, and their respective officers, directors, agents, employees, attorney, and representatives (collectively, "Innovation Health"), to use my name, state of residence, still photographs, video and/or sound recordings of me, statements made by me, and confidential information and testimonial/opinion statements about me in Innovation Health marketing communications and/or advertising materials, including television and/or radio ads, related to Innovation Health health plan(s).

The information that I authorize Innovation Health to use and disclose by this Authorization includes information about my personal experiences with and/or opinions related to Innovation Health health plan(s) in which I was enrolled, including information about my experience with and/or opinions about enrollment, eligibility, or coverage under such insurance policy or benefit plan; and communications concerning such matters.

The authorized information that I authorize Innovation Health to disclose by this Authorization may also include information and documents concerning diagnosis and treatment information, information pertaining to chronic diseases, behavioral health conditions, psychological and psychiatric counseling or treatment, alcohol or substance abuse, communicable diseases, including HIV/AID, and/or genetic marker information, and any and all other information relating to my health, medical, or mental conditions, medical or mental health treatment, or health or other insurance that I would otherwise be entitled to keep confidential under state or federal laws or regulations.

I understand that Innovation Health may not condition payment, enrollment or eligibility for benefits based on this authorization.

I hereby release Innovation Health from any and all claims that I may have against Innovation Health for or relating to the use of our information for the purpose describe above.

This Authorization shall remain valid for one year from the date signed unless sooner revoked in writing sent by certified mail or FAX to:

Nannette Henderson
3190 Fairview Park Drive, Suite 900
Falls Church, VA 22042
Fax number: 703-207-7063

I agree that any such revocation will not have any effect on actions taken by Innovation Health in reliance on the Authorization before actual receipt of the revocation by the person identified above.

When I checked the box with my member story submission, I verified that I have read this Authorization and consent to and agree with its terms.