



# Authorization for Disclosure of Private Health Information

I hereby authorize CIGNA HealthCare\*, its agents or subsidiaries to disclose the Private Health Information (PHI) indicated below to the persons or entities specified on this form.

**Please Note:** This form is not required for all releases of your PHI. For example, this form may not be required to release information to:

- A spouse of a Member/Participant, when both are covered by the CIGNA HealthCare plan
- Parents of minors or other dependents
- Personal Representative on file with CIGNA HealthCare

We will disclose certain PHI about you to these persons upon their request if they successfully complete a caller verification process.

Please print your responses on this form. **All sections must be completed for this authorization to be valid.**

## VERIFICATION

### Identification of Member/Participant:

*(The following information is needed for verification.)*

Name of Member/Participant whose information will be disclosed: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Member/Participant Address: \_\_\_\_\_

Phone number where we can reach you if we need to contact you to process your request (required): \_\_\_\_\_

Social Security #: \_\_\_\_\_ Member/Participant ID card # (if applicable): \_\_\_\_\_

Group or Account # on ID card: \_\_\_\_\_

Subscriber Name (if different from Member/Participant): \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Subscriber's Relationship to Member/Participant: \_\_\_\_\_

Subscriber's Social Security # (if different from Member/Participant): \_\_\_\_\_

**If you have additional coverage with CIGNA, other than that which is described above, please provide the following information as well:**

Other Employer Name: \_\_\_\_\_

Member/Participant ID Card #: \_\_\_\_\_

Group or Account # on ID Card: \_\_\_\_\_

Does this request apply to all coverage?  Yes  No

*Please Complete Next Page* ➡

## Description of Information to be Released

Please indicate what information you wish to release by checking one or more of the boxes below. If you wish to grant limited access (i.e., specific dates of service, specific case management issues, etc.), please specify that in the space provided.

- Claims: \_\_\_\_\_
- Eligibility/Benefits: \_\_\_\_\_
- Medical Records: \_\_\_\_\_
- Case Management: \_\_\_\_\_
- Other: \_\_\_\_\_

Unless otherwise indicated, my authorization includes the release of the following: *(Please strike through those you wish to exclude, if any):*

- Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency
- Diagnosis and/or treatment of mental illness
- HIV antibody test results and/or AIDS diagnosis and treatment
- Genetic testing information

**Oklahoma Residents** – *The information authorized for release may include records concerning a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS. You may have additional protections under Section 1-502.2 of the Oklahoma Statutes if this type of information is to be released.*

## Entity or Person Authorized to Receive Information:

Name: \_\_\_\_\_ Company (if applicable): \_\_\_\_\_

Address of Individual or Company authorized to receive the information: \_\_\_\_\_

**Virginia Residents** – *A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with your original health records.*

## Purpose of this release of information:

\_\_\_\_\_  
\_\_\_\_\_

## Expiration of Authorization:

This authorization expires: \_\_\_\_\_ (date or event).

If you state an event rather than a specific date, it will be necessary for you to submit a revocation form when the event occurs.

*Note for Members/Participants in the following states: If you live in **Arizona, California, Georgia, Illinois, Massachusetts, Montana or Minnesota**, your authorization will be valid for no more than one year. Authorizations signed by **Virginia** residents will be valid for no more than two years. Members/Participants living in those states who seek to authorize disclosure of their personal information for a longer period will have to submit a new authorization at the time that this authorization expires.*

Please Complete Next Page ➡

## PLEASE NOTE

- Information disclosed based on this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.
- If the information on this form is not complete, CIGNA HealthCare will return the form to you, and this request will not be considered until CIGNA HealthCare receives complete information.
- If your Member/Participant ID or date of birth is changed, another form will need to be completed at that time.
- If either the Member/Participant or Group changes to a different type of health care benefits coverage provided by CIGNA HealthCare, another form will need to be completed at that time.
- You may change or revoke this request by sending a written request to CIGNA HealthCare, Central HIPAA Unit, at the address below. You can obtain a Change/Revoke form by calling CIGNA HealthCare Member Services at the number on your CIGNA HealthCare ID card.
- The provision of treatment, payment enrollment or eligibility for benefits does not depend on whether you sign this authorization.

**I have read and understand the above information.**

**My signature authorizes the disclosure of the information described.**

Signature of Member/Participant, Personal Representative, Parent/Guardian who is authorizing the Release:

\_\_\_\_\_ Date: \_\_\_\_\_

Relationship if the person signing is other than Member/Participant whose information is to be used and disclosed: \_\_\_\_\_

- If this request is made by a Personal Representative, we will require verification of the authority of that Personal Representative before this request will be considered complete.
- If request is made by a Parent/Guardian, please complete the following: Member/Participant is a minor, \_\_\_\_\_ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

**We recommend that you keep a copy of your completed form for your records. A copy will be retained by CIGNA HealthCare and made available upon your request.**

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## TO RETURN YOUR COMPLETED FORM

Fax or Mail to: \_\_\_\_\_

OR

Mail to: CIGNA HealthCare Central HIPAA Unit, PO Box 5400, Scranton, PA 18505