# Cigna Global Health Benefits℠ HIPAA Request for Access to Individually Identifiable Health Information

**This form will allow me, as a Cigna Global Health Benefits member/participant to request access to my Individually Identifiable Health Information that may be used to make decisions about me, including medical records and billing records, but not including psychotherapy notes.**

**Identification of member/participant requesting Access. The following information is needed for verification.**

Name of Member/Participant Requesting Access ______ Date of Birth ______ Member # ______

Subscriber Name (if different from Member) ______ Subscriber's Relationship to Member ______

Subscriber's Employer Name ______ Subscriber Member Number ______

**I hereby request a copy of my individually identifiable health information for the following dates:**

______

**I request individually identifiable health information contained in the following records:** ***(Please check all that apply)***

- ☐ Enrollment
- ☐ Premium/Contribution Payment
- ☐ Case or Medical Management
- ☐ Other: *(Please specify)* ______
- ☐ Customer Service
- ☐ Designated Record Set
- ☐ Claims, Billing and EOB information relating to the following service or claim: (specify date and/or medical condition ______

**I understand that I may access my individually identifiable health information through any of the following methods:**
***(Please check the desired method)***

- ☐ I prefer to inspect and/or copy the requested information in person and will arrange for a mutually convenient time to come to Cigna Global Health Benefits by calling 1.800.441.2668. I understand that I may be charged a per page copying fee.
- ☐ I prefer to have the requested information copied and mailed to me at the following address (I understand that I may be charged a copying and postage fee):

  ______

- ☐ I prefer to receive a written summary of the requested information instead of the complete records. I understand that I may be charged a fee for such.

I understand that any form returned to Cigna Global Health Benefits incomplete will be returned to me for completion and my access request will not be implemented until all the information is received complete and processed.

I also understand that if either I, as a member/participant or my group subscriber changes health care benefits coverage or employers that I will need to resubmit this request.

**Please forward this request to:** Privacy Office
Cigna Global Health Benefits
300 Bellevue Parkway
Wilmington, Delaware 19809

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

Date: ______ Signature of Authorizing Member/Participant: ______

If patient is unable to give consent because of physical condition or age, complete the following: Patient is a minor of ______ years of age or is unable to give consent, because: ______

Signature of Parent/Guardian/POA: ______ Relationship: ______

Signature of Personal Representative: ______ Relationship: ______

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