



NAME
 PCP
 PCP PHONE
 ID #

GROUP
 MOD #

COPAYS
 OV ER RX
 VIS
 MED REC #

**CIGNA Medical Group (CMG)
 Change/Revocation Request**

Please complete this form to request a change or revocation to a previously approved request for restriction, confidential communication, authorization or statement of disagreement. By completing and signing this form, you authorize the CMG to change or revoke a previously approved request. Your signature *must* be notarized if you are returning this request by mail. You may complete this form and have your signature verified at the check-in desk of any healthcare center.

PATIENT NAME:		DATE OF BIRTH:		MEMBER ID# (If applicable):	
ADDRESS (Street):		CITY:	STATE:	ZIP CODE:	TELEPHONE #:

Restriction Revocation: Please complete this ONLY if you have a previously approved restriction request.

I wish to revoke my previous request for restriction to deny other family members access to my protected health information.

Confidential Communications Revocation/Change: Please complete ONLY if you have a previously approved confidential communication request.

I wish to revoke my previous request for confidential communications to the following address:

I wish to change my confidential communications request to the following address:

Authorization: Please complete this ONLY if you have previously authorized release of your Protected Health Information.

I wish to revoke my authorization for the following:

Statement of Disagreement: Please complete this ONLY if you have previously submitted a statement of disagreement to a denied amendment request OR requested information disclosed related to a denied amendment request.

I wish to revoke my request to disclose this denied amendment information to those who may receive my Protected Health Information.

If you would like to re-instate any of these restrictions or authorizations, please contact any of the CIGNA Medical Group HealthCare Centers for the appropriate form.

Signature of Patient/Representative Requesting Change: _____ Relationship to Patient: _____ Date: _____

Signature of Notary/Witness: _____ Date: _____ Stamp: _____
 (If Notarized)

FOR CMG USE ONLY: