



CIGNA HealthCare of Arizona

CIGNA Medical Group

NAME  
 PCP  
 PCP PHONE  
 ID #

GROUP  
 MOD #

COPAYS  
 OV ER RX  
 VIS  
 MED REC #

**CIGNA Medical Group (CMG)**  
***Request for Restriction on the Disclosure of Protected Health Information***

Please complete this form to request a restriction on the disclosure of your protected health information. This request will be reviewed by a CMG Administrator and/or the CMG Privacy Officer. If you are returning this request form to CMG via the mail, it **must** be notarized. You may complete this form and have your signature witnessed at the check-in desk of any healthcare center. CIGNA Medical Group will consider all requests for restrictions carefully; however, we are not required to agree to a requested restriction.

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

**Please describe your request:**

- If we approve a request to deny access to your Protected Health Information to family members, your CMG records will be flagged to restrict CMG staff from communicating with anyone except you regarding matters related to your medical relationship with CMG.
- Communications containing Protected Health Information will continue to be sent to you at the current address we have on file for you.
- If you wish your employer, group health plan or anyone outside the CIGNA Medical Group to restrict their use or disclosure of your information, you must notify them separately.

Signature of Patient/Representative  
 Requesting Restriction: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

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

**FOR CMG USE ONLY:**

APPROVED BY: \_\_\_\_\_ Date: \_\_\_\_\_

DENIED BY: \_\_\_\_\_ Date: \_\_\_\_\_

Notification Letter sent on date: \_\_\_\_\_