

CIGNA International Expatriate Benefits* HIPAA Request for Access to Individually Identifiable Health Information

This form will allow me, as a CIGNA International Expatriate 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 _____ customer service
 ___ premium/contribution payment _____ designated record set
 ___ case or medical management _____ claims, billing and EOB information relating to the following service or claim: (specify date/and or medical condition)
 ___ other (please specify) _____

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 International Expatriate 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 International Expatriate 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.

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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