



CIGNA Medicare Rx[®] (PDP)

Medicare Part D Prescription Drug Plans

Authorization for Disclosure of Private Health Information

I hereby authorize CIGNA Medicare Services,* 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 required for releases of your PHI outside of treatment, payment and healthcare operations. For example, this form may be required to release information to:

- A person involved in your care
- Attorney office requesting records

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

VERIFICATION

Identification of Member

(The following information is needed for verification.)

Name of Member whose information will be disclosed: _____

Date of Birth: _____

Member Address: _____

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

Medicare ID #: _____ Member ID card # (if applicable): _____

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 drug names, specific dates of service, etc.), please specify that in the space provided.

* Claims: _____

* Eligibility/Benefits: _____

* Medical: _____

* Other: _____

Please Complete Next Page

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 and/or AIDS diagnosis and treatment
- Genetic testing information

Arizona Residents – The information authorized for release may include records concerning communicable or venereal diseases, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS. You may have additional protections under Arizona Revised Statutes 36-664 if this type of information is to be released.

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): _____

Phone Number: (_____) _____

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 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 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 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 Medicare ServicesSM will return the form to you, and this request will not be considered until CIGNA Medicare Services receives complete information.
- If your Member ID or date of birth changes, another form will need to be completed at that time.
- You may change or revoke this request by sending a written request to CIGNA Medicare Services, at the address below. You can obtain a Change/Revoke form by calling CIGNA Member Services at the number on your CIGNA Medicare Services 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, Personal Representative, Parent/Guardian who is authorizing the Release:

_____ Date: _____

Relationship if the person signing is other than Member whose information is 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 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 Medicare Services and made available upon your request.

Please Return This Completed Form To:

CIGNA Medicare Services • PO Box 269005 • Weston, FL 33326-9927

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