Cigna Global Health Benefits℠ HIPPA Request for an Accounting of Disclosures of Individually Identifiable Health Information

This form will allow me, as a Cigna Global Health Benefits member/participant, to request an accounting of disclosures of my Individually Identifiable Health Information for the purposes other than treatment, payment and/or health care operations and other exceptions under the Privacy Rule.

Effective as of April 14, 2003, Cigna Global Health Benefits will provide an accounting of a member/participant's disclosures of individually identifiable health information for up to six (6) years prior to the date of the member/participant's request.

When a request for an accounting of disclosures of individually identifiable health information is received, it will be provided within sixty (60) days. If necessary, this time frame may be extended for thirty (30) days. The member/participant requesting the accounting will be informed in writing, within sixty (60) days of the original request, of the reason(s) for the extension and the date by which action will be taken upon the request.

A member/participant may receive an accounting of disclosures once during any twelve (12) month period at no charge. If a member/participant requests more than one accounting within the same twelve (12) month period, Cigna Global Health Benefits may charge such member/participant a cost-based fee.

Identification of member/participant requesting an Accounting of Disclosures: The following information is needed for verification:

Name of Member/Participant Requesting an Accounting of Disclosures	Date of Birth	Member #

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

Subscriber's Employer Name	Subscriber's Member Number

Please return the signed and completed form to the following address:

Privacy Office
Cigna Global Health Benefits
300 Bellevue Parkway
Wilmington, Delaware 19809

I understand that any form returned to Cigna Global Health Benefits incomplete will be returned to me for completion and my request for an accounting of disclosures 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 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: _____

Clear Form