PERMISSION TO DISCUSS LIMITED HEALTH INFORMATION WITH FAMILY AND FRIENDS

Cigna HealthSpring®

Customer name

Date of birth

Customer ID number

By signing this form where indicated, I give permission to Cigna-HealthSpring to discuss limited information about my care, including payment for care, with the person(s) listed in the table below. Cigna-HealthSpring will use its professional judgment to share information that is directly relevant to the person(s) involvement with or payment related to my health care.

Name of individual and relationship to customer	Comments or instructions (may discuss appointment times, may disclose test results, etc.)

Cigna-HealthSpring staff also has my permission to (please check all boxes that apply)

☐ Leave a detailed message on my voicemail:

Home phone number ___ - ___ - ____

☐ Leave a message at my home phone number with:

Name

Relationship

☐ Leave message on my cell phone:

Cell phone number ___ - ___ - ____

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Please sign below

Signature of customer or personal representative

Date

Printed name of customer or personal representative

Relationship (if you are the personal representative)

This authorization expires:

If the expiration date is omitted from this form, your authorization will expire after one year and a new authorization will need to be submitted at that time.

Note for customers 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. Customers 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.

This form does not permit Cigna-HealthSpring to discuss substance abuse, mental illness, HIV/AIDS or genetic testing information. The provision of treatment, payment, enrollment or eligibility for benefits does not depend on whether I sign this authorization. Information disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed Authorization for Disclosure of PHI form.

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. You have the right to revoke this authorization at any time by writing to Cigna-HealthSpring at the address below. You may revoke this authorization except to the extent that action has already been taken based on this authorization.

MAIL COMPLETED FORM TO:

Cigna-HealthSpring Rx
P.O. Box 269005
Weston, FL 33326

OR FAX TO:
1-800-735-1469

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-222-6700 (TTY 711). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-222-6700. 注意：如果您使用繁體中文, 您可以免費獲得語言援助服務. 請致電 1-800-222-6700 (TTY 711). Cigna-HealthSpring complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna-HealthSpring cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. © 2018 Cigna