AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Cigna, its agents or subsidiaries to disclose the Protected Health Information (PHI) indicated below to the persons or entities specified on this form.

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

VERIFICATION – (Please print)

Identification of customer:

(The following information is needed for verification. Please complete all applicable items.)

Name of customer whose information will be disclosed: _____ Date of birth: _____

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

Address: _____

_____

Medicare ID #: _____ Customer 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.

RECORDS TO BE DISCLOSED (check all that apply):

Information requested from records maintained by Cigna.

☐ All records ☐ Claims ☐ Eligibility/benefits ☐ Billing records ☐ Medical

Other information (please describe): _____

_____

Customer must initial in the space provided if any of the boxes below are checked.

_____ ☐ Drug/alcohol diagnosis, treatment and referral

_____ ☐ HIV/AIDS information

_____ ☐ Mental health diagnosis, treatment and referral

_____ ☐ Genetic testing information

Dates of service (if applicable): _____ to _____

☐ Check if this authorization is for notes from private therapy sessions **(if this box is checked, a separate authorization form must be used for any other type of protected health 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: _____

_____

PURPOSE OF RELEASE

☐ Medical care ☐ Insurance ☐ At the request of the patient

Other (please explain): _____

_____

EXPIRATION OF AUTHORIZATION

This authorization expires: _____ (date or event)

If no expiration date or event is noted, this authorization will expire one year from the date signed.

PLEASE NOTE

- You may refuse to sign this authorization and it is strictly voluntary.
- Information disclosed based on this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy regulations.
- If the information on this form is not complete, Cigna will return the form to you, and this request will not be considered until Cigna receives complete information.
- If your customer 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, at the address below. You can obtain a Change/Revoke form by calling Cigna at the number on your Cigna ID card.
- The provision of treatment, payment enrollment or eligibility for benefits does not depend on whether you sign this authorization. However, if the information is needed to determine the payment of a claim, refusal to sign this form may result in nonpayment of the claim.

Please complete the next page.

SIGNATURE

I have read and understand the above information. Date: _____

Signature of customer, parent/guardian, other person legally authorized to act on behalf of the customer:

_____

Relationship, if signed by other than customer: _____

Note that, if not already provided, we will require verification of the authority of another person to act on behalf of the customer before this request will be considered complete.

If customer is unable to give consent because of age, complete the following:

Customer 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 of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with your original health records.

COMPLETED FORM MAILING ADDRESSES

Please send your completed form to your plan's corresponding address below:

Cigna Medicare Advantage Plan

Cigna Privacy Office
PO Box 188014
Chattanooga, TN 37422

Cigna Medicare Prescription Drug Plan

Cigna
PO Box 269005
Weston, FL 33326-9927

Please maintain a copy of this form for your records.