

Cigna Life Insurance Company of Canada 100 Consilium Place, Suite 301 Scarborough, Ontario, Canada M1H 3E3

Certain Services Provided by Cigna Healthcare, Global Health Benefits Mailing Address: P.O. Box 15050

Wilmington, DE 19850

Consent to Disclose Personal Health Information

CLEAR FORM

Customer Name:	Subscriber Number:
Date of Birth: (/)	
	, hereby authorize Cigna Life Insurance Company of Canada to
(Print your name)	
disclose my personal health information consisting of:	
(Describe the personal health information to be disclosed)	
Or the personal health information of:	
	of person for whom you are the substitute decision - maker*)
consisting of:	
(Describe the p	ersonal health information to be disclosed)
(Print name and address of person requiring the information)	
The purpose for disclosing this personal health information to the person noted above is:	
(If left blank, this consent form will be returned to you for completion) I also understand that I can refuse to sign this consent form. This consent will remain in effect for a period of not less than twelve and not more than twenty-four months, however I understand that I may revoke this authorization by sending a written request to the address as indicated above. I agree that a photocopy of this authorization shall be as valid as the original.	
My Name: Address:	
Home Tel.:	Work Tel.:
Signature:	Date:
Witness Name: Address:	
Home Tel.:	Work Tel.:
Signature:	Date:
*Please note: A substitute decision-maker is a person authorized under the appropriate Provincial Health Act to consent, on behalf of an individual, to disclose personal health information about the individual.	

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