*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:** (__ / __ / ____) **Employer Name:** _____

**I,** _____ **, 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:** _____
*(Name of person for whom you are the substitute decision - maker*)*

**consisting of:** _____
*(Describe the personal health information to be disclosed)*

**to:** _____
*(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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