Cigna Authorization to Release Information

PLEASE COMPLETE AND RETURN VIA FAX OR EMAIL TO:

Fax: 860.731.3049

Email: PreDisability@Cigna.com

To facilitate my participation in work absence prevention services made available to me under my employer's disability plan, I authorize the representative(s) of Cigna* companies to:

- Contact my health care provider to discuss the nature and extent of my illness or injury and if needed recommend:
    1. Health and wellness resources such as disease management or lifestyle management programs, or
    2. Vocational resources or accommodations necessary for my job.

I authorize any physician, hospital or other health care provider or facility and any insurer or service provider to release to any of the companies named below (collectively "Cigna") the following:

- Medical records pertinent to the present illness or injury, history or other information regarding my physical, mental or emotional condition, or any treatment including prescriptions but excluding psychotherapy notes.

I authorize Cigna to share this information with its affiliated companies and services vendor(s) as necessary to support my participation in the program. I also authorize Cigna to share this information with providers of health and wellness resources (such as disease management and lifestyle management programs) available through my employer, and authorize those providers to contact me.

I authorize Cigna to release the following information about my functional ability to my employer as necessary to help me return to or stay at work:

- Any restrictions (things I should not do) or
- Any limitations (things I cannot do)

I understand that Cigna makes no guarantee as to results, and assumes no liability, with respect to those services.

I understand that information disclosed under this authorization may no longer be protected under the HIPAA Privacy Rule, but that it may continue to be protected by other applicable privacy laws and would not be deemed to be Protected Health Information under the HIPAA privacy rules. Re-disclosure would be subject to the requirements of other privacy laws and regulations whose requirements may differ from the HIPAA privacy rules.

I am entitled to a copy of this authorization and a copy of it shall be valid as the original. I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, by writing to Cigna at the email address at the top of this form. This authorization will expire one year from the date of this signature.

I have read and understand the above information:

Signature	**Date**
Name (printed)	**Date of Birth**
Company	**Phone**
Cigna HealthCare customer ID # (if applicable)	

* "Cigna" refers to Life Insurance Company of North America, Cigna Life Insurance Company of New York, Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, or their affiliates.