**Cigna Healthcare, Global Health Benefits**

**Authorization for Disclosure of Protected Health Information**

I hereby authorize Cigna Healthcare, Global Health Benefits (GHB), its subsidiaries, affiliates and agents to disclose the Protected Health Information (PHI) indicated below to the persons or entities specified on this form. Please Note: This form is not required for all releases of your PHI such as: Parents of minors or other dependents, Personal Representatives on file, or your spouse if you are both covered by a GHB plan, if they successfully complete a caller verification process.

**Identification of Customer: The following information is needed for verification.**

Customer whose information will be disclosed _____ Date of Birth _____ Customer ID Number _____

Subscriber Name (if different from Customer) _____ Date of Birth _____ Relationship to Customer _____

Subscriber's Employer _____ Subscriber's ID Number _____

Telephone Number _____ Email Address _____

Address: _____

Name of entity or person(s) authorized to receive information: _____

Purpose of this release of Information: _____

**Description of the information to be released**:

☐ Claims ☐ Medical Records ☐ Eligibility/Benefits ☐ Case Management

☐ Other: _____

Unless otherwise indicated, my authorization includes the release of the following: (Please strike through those you wish to exclude, if any):

☐ Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency

☐ Diagnosis and/or treatment of mental illness

☐ HIV antibody test results and/or AIDS diagnosis and treatment

☐ Genetic Testing Information

***California Sensitive Services (e.g., CA)(*Check box if applicable)*:**

☐ *By checking this box and signing and dating this form below, I authorize Cigna Healthcare®, its agents and/or subsidiaries, to disclose information related to my treatment for sensitive services, which may include, but is not limited to, services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, to other members of my plan, including but not limited to the subscriber. If selecting this option, please also complete sections 1 and 6 of this form. We will not re-impose the restriction unless you instruct us to.*

***Please Complete Next Page***

***Arizona and 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 Arizona Revised Statutes 36-664 (if AZ resident) or Section 1-502.2 of the Oklahoma Statues (if an Oklahoma resident) if this type of information is released.*

***California residents*** *– In accordance with Cal. Civ. Code 56.107 and Cal. Insurance Code 791.29, as applicable, the information authorized for release may include information related to treatment for sensitive services, which may include, but are not limited to, services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence.*

***For Virginia residents*** *- A copy of this authorization and a notation concerning the persons or agencies to which disclosure was made shall be included with your original health records.*

**Are you a resident of Arizona, California, Georgia, Illinois, Massachusetts, Montana, Minnesota or Virginia?**

☐ **Yes** ☐ **No This authorization expires:** ***(date or event)***

---

*(Note: For residents of 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.)* ***California*** *residents – An authorization that allows Cigna Healthcare to disclose treatment related to sensitive services to other plan members, including the plan subscriber, will not automatically expire in one year. We will not re-impose the restriction unless you tell us to.*

**Please Note**

- Information disclosed based on this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.
- If the information on this form is not complete, GHB will return the form to you, and this request will not be
- considered until GHB receives complete information.
- If your Customer ID or date of birth is changed, another form will need to be completed at that time.
- If either the Customer or Group changes to a different type of health care benefits coverage provided by GHB, another form will need to be completed at that time.
- You may change or revoke this request by sending a written request to GHB at the address below.
- The provision of treatment, payment, enrollment or eligibility for benefits does not depend on whether you sign this authorization.
- I have read and understand the above information. My signature authorizes the disclosure of the information described.

***Please Complete Next Page***

**Signature of Authorizing Customer, Personal Representative Parent/Guardian who is authorizing the Release:** **Date:**

---

**Relationship if the person signing is other than the Customer whose information is to be used or disclosed:**

---

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.

If a request is made by a Parent/Guardian, please complete the following: Customer is 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 will be retained by GHB and made available upon your request*

Please return your completed form.

Privacy Office
Cigna Healthcare, Global Health Benefits
300 Bellevue Parkway
Wilmington, Delaware