Authorization Form for Cigna Global Health Benefits℠ to Use and Disclose Health Information

This form will allow Cigna Global Health Benefits, its subsidiaries, affiliates and agents to release the information specified to the persons, class of persons or entities specified on this form.

I understand by completing and signing this form, I authorize Cigna Global Health Benefits to release the following information to the person, class of persons or entity(s) identified below:

Description of Individually Identifiable Health Information (IIHI) to be Released

Identification of person authorizing release: The following information is needed to ensure we are releasing your information identified above.

Member/Participant Authorizing Release of Information | Date of Birth | Member #

Subscriber Name (if different from Member) | Relationship to Member

Subscriber's Employer Name | Subscriber Member Number

Identification of person, class of persons or entity who will be the recipient(s) of the information authorized:

Purpose of this release of Information

I understand that this authorization expires on: ***(date or event)***

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by this authorization. By signing this form, I hereby authorize Cigna Global Health Benefits to disclose the information according to the terms set forth above. I understand that any forms returned to Cigna Global Health Benefits incomplete will be returned to me for completion and my release of information will not occur until I complete all necessary information.

I understand that I may revoke this authorization by sending a written request to do so to the following address:

Privacy Office
Cigna Global Health Benefits
300 Bellevue Parkway
Wilmington, Delaware 19809

I have read and understand the above information:

Date: ________________ Signature of Authorizing Member/Participant: ____________________________________

Date: ________________ Signature of Witness: ____________________________________

If patient is unable to give consent because of physical condition or age, complete the following: Patient is a minor of ______ years of age or is unable to give consent, because: ____________________________________

Signature of Parent/Guardian/POA: ______________________________ Relationship: ________________

Your Rights: You may request to inspect or copy the IIHI to be released and may choose to refuse to sign the authorization. Treatment, payment and enrollment or eligibility for benefits is not conditioned on the signing of this authorization. The use or disclosure of the requested information has not resulted in direct or indirect remuneration from a third party. You will receive a signed copy of this authorization for your records.

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