HIPAA Authorization For Release of Information

Section A: I authorize the disclosure of my personal health information to the persons/entities as described in Section B below. I understand this authorization is voluntary and made to confirm my directions. I understand that once the information is disclosed, it may be re-disclosed and no longer protected by federal privacy regulations. I hereby give permission for the disclosure of my personal health information in the manner described below.

My Name: ____

Address: ____

Telephone: ______________________________ Member Number: ____

Section B: Personal Health Information to be Disclosed: I authorize the disclosure of the following personal health information: **All medical information relevant to the request for health care coverage, which is the subject of my request for external review.**

Your request will be deemed to include information related to sexually transmitted diseases, such as HIV or AIDS, alcohol or drug use treatment, or mental health/psychology/psychiatry that may be within your above request, unless you specifically state your objection here:

Person/Entity Authorized to Disclose: I authorize the person(s) and/or entity(ies) described below to disclose the personal health information described above:
All Providers with medical records relevant to my request for external review ("Providers").

Person/Entity Authorized to Receive and Use: I authorize my providers to disclose the non-public personal health information described above to the entity described below:
The Independent Review Organization (IRO) assigned by the Insurance commissioner of the State of Hawaii to conduct my external review.

Purpose of the Disclosure: The disclosure is being made for the following reason:
To conduct an external review of an adverse determination made by Cigna, pursuant to my request.

Right to Revoke: I may revoke this authorization in writing at any time. I understand my revocation will not affect any disclosures that were made by my providers before receipt of my written revocation. If I do not revoke it, this authorization will expire upon completion of the external review. To revoke this authorization, I must write to the Insurance Commissioner, Department of Commerce and Consumer Affairs, State of Hawaii, 335 Merchant St., Honolulu, HI 96813.

Signature:

I, ________________________, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction. I understand that Cigna and my providers will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization, but that I must provide this authorization to be eligible for IRO external review by the insurance commissioner. I further understand that, by signing this form, I am confirming my authorization that the providers identified above may disclose to the IRO assigned to conduct my external review the nonpublic personal health information described in this form.

Signature: ____ Date: ____

**** ALL DATA FIELDS ABOVE MUST BE COMPLETED FOR A VALID AUTHORIZATION ****

If a personal representative on behalf of the individual signs this authorization, complete the following and attach a copy of legal authority, if applicable, (e.g., medical power of attorney, legal guardianship, etc.):

Personal Representative's Name: ____

Relationship to Individual: ____

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