CIGNA HealthCare

Authorization for Use and Disclosure of Private Health Information

I HEREBY AUTHORIZE CIGNA HEALTHCARE*, ITS AGENTS OR SUBSIDIARIES TO RELEASE THE PRIVATE HEALTH INFORMATION INDICATED BELOW TO THE PERSONS OR ENTITIES SPECIFIED ON THIS FORM.

Description of Private Health Information to be released (Please Print)**:**

_____

_____

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 regarding mental health issues
- HIV antibody test results and/or AIDS diagnosis and treatment
- Genetic test results and/or related treatment

Identification of person authorizing release: (The following information is needed for verification. Please complete all applicable items.)

Name of Member/Participant: _____

Phone number where we can reach you, if we need to contact you to process your request (required): _____

Date of Birth: _____

Social Security #: _____

Address: (including Zip Code) _____

_____

Member ID card number (if applicable) _____ Group or Account Number on ID card: _____

Subscriber Name (if different from Member): _____ Subscriber's Relationship to Member: _____

Subscriber's Employer Name: _____ Subscriber's Social Security Number (if different from Member): _____

If you have additional coverage with CIGNA, other than described above, please complete the following information as well:

Subscriber's Employer Name: _____

Number on Member ID card: _____ Group or Account Number on ID card: _____

I authorize the persons or entities below to receive the information:

☐ Your or the Subscriber's Employer benefits representative (name, if applicable): _____

☐ Your Attorney (name): _____

☐ Other _____

_____

Purpose of this release of information:

_____

This authorization expires: _____ (to be completed by Member/Participant)
(date or event)

I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.

- *I understand that if information on this form is not complete, CIGNA HealthCare will return the form to me, and this request will not be considered until all information has been received by CIGNA HealthCare.*
- *I understand that I may revoke this authorization by sending a written request to the Privacy Office at the address shown below. You can obtain a form to revoke the authorization by calling CIGNA HealthCare member services at the number on your CIGNA HealthCare ID card. Any revocation will not be effective for any actions we already have taken.*

Please Complete Form On Next Page ➥

SIGNATURE

I have read and understand the above information: Date: _____

Signature of Member/Participant, Parent/Guardian, Personal Representative _____

Relationship if person signing is other than Member/Participant: _____

Note that, if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If request is made by a Parent/Guardian, complete the following: Member/Participant is a 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.

The provision of treatment, payment, enrollment or eligibility for benefits does not depend on whether you sign this authorization. You should keep a signed copy of this authorization for your records, however, a copy of this signed authorization will be provided upon your request.

**"CIGNA HealthCare" and "CIGNA" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, CIGNA Vision Care, Inc., Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.*

A copy of this form will be submitted to the CIGNA HealthCare Privacy Office.

To return your completed form, please:

Fax to: _____ **at** _____

OR

Mail to: _____

OR

Mail to: CIGNA HealthCare Privacy Office, P.O. Box 5400, Scranton PA 18505

