AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Cigna HealthCare®,* its agents or subsidiaries 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 unless separately required by state law. For example, this form typically is not required to release information to:

- A spouse of a Customer, when both are covered by the Cigna HealthCare plan
- Parents of minors or other dependents
- Personal Representative on file with Cigna HealthCare

We will disclose certain PHI about you to these persons upon their request if they successfully complete a caller verification process. Please print your responses on this form. **All sections must be completed for this authorization to be valid.**

Please note that additional requirements may apply to residents of certain states. Residents of **California, Arizona,** and **Oklahoma**: please see below for some provisions and requirements that are specific to your state.

California Sensitive Services *(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*.

1. Verification

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

Name of Customer whose information will be disclosed:

_____

Date of Birth: _____

Customer Address: _____

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

Social Security # (Optional)**:** _____

Customer ID card # (if applicable)**:** _____

Group or Account # on ID Card: _____

Subscriber Name (if different from Customer)**:**

_____

Subscriber's Employer: _____

Subscriber's Relationship to Customer: _____

Subscriber's Social Security # (if different from customer) (Optional)**:**

_____

If you have additional coverage with Cigna, other than that which is described above, please provide the following information as well:

Other Employer Name: _____

Customer ID Card #: _____

Group or Account # on ID Card: _____

Does this request apply to all coverage? ☐ **Yes** ☐ **No**

2. Description of Information to be Released

Please indicate what information you wish to release by checking one or more of the boxes below. If you wish to grant limited access (i.e., specific dates of service, specific case management issues, etc.), please specify that in the space provided.

☐ **Claims:** _____

☐ **Eligibility/Benefits:** _____

☐ **Medical Records:** _____

☐ **Case Management:** _____

☐ **All Health Records (Includes all of the above):** _____

☐ **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

Arizona 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 this type of information is to be released.

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 Section 1-502.2 of the Oklahoma Statutes if this type of information is to be 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.

3. Entity or person authorized to receive information

Name: _____

Company (if applicable)**:** _____

Address of Individual or Company authorized to receive the information:

_____

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

4. Purpose of this release of information

☐ **At the request of the individual**

☐ **Other** (please describe) _____

If the expiration date is omitted from this form, your authorization will expire after one year and a new authorization will need to be submitted at that time.

5. Expiration of Authorization

This authorization expires: _____ (date or event).

If you state an event rather than a specific date, it will be necessary for you to submit a revocation form when the event occurs.

Note for customers in 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 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, Cigna HealthCare will return the form to you, and this request will not be considered until Cigna HealthCare 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 Cigna HealthCare, another form will need to be completed at that time.
- You may change or revoke this request by sending a written request to Cigna HealthCare, Central HIPAA Unit, 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.

6. Signature of Customer, Personal Representative, Parent/ Guardian who is authorizing the release:

_____ **Date:** _____

Relationship if the person signing is other than Customer whose information is to be used and 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 request is made by a parent/guardian, please complete the following: Customer 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.

California residents – in some cases, California law prohibits Cigna from disclosing information related to treatment for certain services where the care recipient is of the legal age to consent to such services, unless the individual has authorized such disclosure. This restriction therefore may prohibit us from disclosing information to subscribers for care received by dependents. Where the law applies, this authorization form may be executed only by the care recipient, unless that person is legally incompetent for reasons other than age. In other words, subscribers or other legal representatives may not sign this form on behalf of minors to obtain information related to certain services.

We recommend that you keep a copy of your completed form for your records. A copy will be retained by Cigna HealthCare and made available upon your request.

Please return this completed form:

Fax to: 877.815.4827 or 859.410.2419

or

Mail to: Cigna HEALTHCARE CENTRAL HIPAA UNIT,
PO Box 188014,
Chattanooga, TN 37422.

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