CIGNA Behavioral Health

Authorization for Disclosure of Protected Health Information

I hereby authorize CIGNA Behavioral Health*, its agents or affiliates 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. For example, this form may not be required to release information to:

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

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.

Sections 1 through 6 must be completed for this authorization to be valid.

Incomplete forms will not be processed, and will be returned to the requestor for additional information.

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 Behavioral Health, 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

Please Complete Next Page ➥

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: _____

☐ 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.*

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) _____

5. Expiration of Authorization:

This authorization expires: _____ (date).

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.

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.

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 theirpersonal information for a longer period will have to submit a new authorization at the time that this authorization expires.*

Please Complete Next Page ➥

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 Behavioral Health will return the form to you, and this request will not be considered until CIGNA Behavioral Health 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 Behavioral Health, another form will need to be completed at that time.
- You may change or revoke this request by sending a written request to CIGNA Behavioral Health, Central HIPAA Unit, at the address below. You can obtain a Change/Revoke form by calling CIGNA Behavioral Health Customer Service at 1.800.926.2273.
- 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.

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

**"CIGNA Behavioral Health" refers to CIGNA Behavioral Health, Inc. and subsidiaries of CIGNA Behavioral Health, Inc., including CIGNA Behavioral Health of California, Inc., and CIGNA Behavioral Health of Texas.*

TO RETURN YOUR COMPLETED FORM

Fax to: **952.996.2507**

OR

Mail to: **CIGNA Behavioral Health Central HIPAA Unit, 11095 Viking Drive, Ste. 350**
Eden Prairie, MN 55344

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