Cigna Global Health Benefits℠
Authorization for Disclosure of Protected Health Information

I hereby authorize Cigna Global Health Benefits (CGHB), its subsidiaries, affiliates and agents 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 such as: Parents of minors or other dependents, Personal Representatives on file, or your spouse if you are both covered by a CGHB plan, if they successfully complete a caller verification process.

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

Customer whose information will be disclosed | Date of Birth | Customer ID Card #

Subscriber Name (if different from Customer) | Date of Birth | Relationship to Customer

Subscriber's Employer | Subscriber's ID Card #

Name of entity or person(s) authorized to receive information:

Purpose of this release of Information:

Description of the information to be released:

☐ **Claims** ☐ **Medical Records** ☐ **Other:**

☐ **Eligibility/Benefits** ☐ **Case Management**

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 and 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 Arizona Revised Statutes 36-664 (if AZ resident) or Section 1-502.2 of the Oklahoma Statues (if an Oklahoma resident) if this type of information is released.

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

Please Complete Next Page

Are you a resident of Arizona, California, Georgia, Illinois, Massachusetts, Montana, Minnesota or Virginia? ☐ **Yes** ☐ **No**

This authorization expires: ***(date or event)***

(Note: For residents of 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.)*

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, CGHB will return the form to you, and this request will not be considered until CGHB 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 CGHB, another form will need to be completed at that time.**
- **You may change or revoke this request by sending a written request to CGHB 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.

Signature of Authorizing Customer, Personal Representative Parent/Guardian who is authorizing the Release: **Date:**

Relationship if the person signing is other than the Customer whose information is to be used or 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 a request is made by a Parent/Guardian, please complete the following: Customer is 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 CGHB and made available upon your request

Please return your completed form.

Mail or fax to: **Cigna Global Health Benefits**
300 Bellevue Parkway
Wilmington, Delaware 19809
Fax: +1.302.797.3150 or 1.800.243.6998