REQUEST FOR RESTRICTION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form will allow me, as a Cigna Healthcare customer, to request a Restriction of the Use and Disclosure of my Protected Health Information (PHI). I understand Cigna Healthcare will consider all requests for restrictions carefully; however, Cigna Healthcare is not required to agree to a requested restriction.

Note: If your request is granted, it will affect only written and oral communications by Cigna Healthcare. If you also wish another group health plan, physician or anyone outside of Cigna Healthcare to make this change, you must obtain their agreement separately.

VERIFICATION – (Please print)

Identification of customer:

(The following information is needed for verification. Please complete all applicable items.)

Name of customer: _____ Date of birth: _____

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

Current address on file: _____

_____

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

Cigna Healthcare will not disclose confidential information without your authorization unless it is necessary to provide your health benefits, administer your benefit plan, to support Cigna Healthcare programs or services, or as otherwise required or permitted by law. We will not, for example, give your confidential information to a credit agency, a telemarketer or a prospective employer. We will not sell, rent or license the confidential information you provide to us. You do not need to request a restriction if you are concerned about those uses and disclosures.

REQUESTED RESTRICTIONS

Please describe your request: _____

_____

_____

_____

_____

_____

Please complete the other side.

PLEASE NOTE

- Communications, including communications containing PHI, will continue to be sent to the current address we have on file for you.
- If any information on this form is not complete, Cigna Healthcare will return the form to you, and your restriction request will not be considered until Cigna Healthcare receives complete information.
- If your date of birth is changed in our system or your Cigna Healthcare ID changes, a new form must be completed at that time.
- You may change or revoke this restriction by sending a written request to Cigna Healthcare, at the address shown below. You can obtain a Change/Revoke form by calling Cigna Healthcare at the number on your Cigna Healthcare ID card.

SIGNATURE

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

Signature of customer, parent/guardian, other person legally authorized to act on behalf of the customer:

_____

Relationship, if signed by other than customer: _____

Note that, if not already provided, we will require verification of the authority of another person to act on behalf of the customer before this request will be considered complete.

If request is made by a parent/guardian, complete the following:

Customer is a minor, _____ years of age.

If you are a parent or guardian requesting a restriction on a child that will prevent the child's other legal parent from accessing the child's Protected Health Information, you must:

1. Provide evidence that the parental rights of the other parent have been terminated, or
2. Obtain the other parent's agreement to this restriction. If you obtain the other parent's agreement to this restriction, please have the other parent sign this form and notarize it, or send a statement signed and notarized by both parents indicating that both parents have agreed to place a restriction on the child's Protected Health Information.

COMPLETED FORM MAILING ADDRESSES

Please send your completed form to your plan's corresponding address below:

Cigna Medicare Advantage Plan

Cigna Healthcare Privacy Office
PO Box 188014
Chattanooga, TN 37422

Cigna Medicare Prescription Drug Plan

Cigna Healthcare
PO Box 269005
Weston, FL 33326-9927

Please maintain a copy of this form for your records.

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