Authorization/Notification to Release Protected Health Information

CIGNA HealthCare of Arizona, Inc.
CIGNA Medical Group

CIGNA

- ***All required areas must be completed or this release will be considered invalid.***
- *Please fill out sections 1 through 4 if requesting information from your **Medical Chart/Pharmacy Profile**.*
- *Please fill out sections 1, 2, 3 and 5 if requesting **x-ray films** and/or other diagnostic images.*
- *Please fill out section 1 through 4 if requesting "**Other**" types of health information, please specify.*
- Form **must** be *completed in ink.*

FOR CIGNA USE ONLY

MRN:	CL:	NO. PAGES RELEASED;	DATE REQUEST RECEIVED:
RECORDS PREPARED AND TRANSMITTED BY (*PRINT NAME*):	SIGNATURE:		DATE:
RECIPIENT - PRINT NAME (*as listed in part 2 only*);	SIGNATURE:		DATE:

PART 1. PATIENT INFORMATION

PATIENT'S NAME:		DATE OF BIRTH:
IDENTIFICATION NUMBER:	DAYTIME PHONE:	HOME PHONE:
ADDRESS (Street, City, State, Zip Code):		

PART 2. DESTINATION OF RECORDS

I hereby authorize CIGNA HealthCare of Arizona, Inc. to release medical records Information concerning the above-named patient to:

RECIPIENT'S NAME:	RECIPIENT'S PHONE NUMBER:
ADDRESS (*Street, City, State. Zip Code*):	

PART 3. PURPOSE OF RELEASE

PLEASE NOTE: Fees are applicable If the nature of the request is for other than the patient's continuation of care. **If this section is left blank, CIGNA assumes that the request Is for personal use and fees will apply.**

Purpose of Request:

- ☐ Continuation of Care (Future Appointment) (*Provider Name/Address Required in Section 2*)
  Date of Appointment: _____
- ☐ Personal Use (*Please see current Fee Schedule*)
- ☐ Other (*Please indicate purpose of request*). _____

PART 4. TYPE OF RECORDS BEING REQUESTED

PLEASE NOTE. Requests normally take 10 business days for processing. They are then mailed to recipient (as listed in Part 2),

- ☐ Copies of records of the last (2) years of treatment
- ☐ Copies of records covering dates from _____ to _____
- ☐ Laboratory Results (*Dates*): _____
- ☐ Pharmacy Profile
- ☐ **Other (*Please specify*):** _____

PART 5. X-RAY FILMS/ DIAGNOSTIC IMAGES

- ☐ Reports Only (*A fee may apply for copies*)
- ☐ Films Only (*A fee may apply for copies*)
- ☐ Films and Reports. (*A fee may apply for copies*)
- ☐ Permanent Transfer of Mammograms (*All*)

For: X-Ray Exam; _____ Date; _____
X-Ray Exam; _____ Date: _____
X-Ray Exam: _____ Date: _____
X-Ray Exam: _____ Date: _____

I authorize the release of photocopies of the following medical records and/or diagnostic images in the possession or control of CIGNA HeathCare of Arizona, Inc., its employees and/or agents. FOR THE PURPOSE HEREOF "MEDICAL RECORDS" AND "DIAGNOSTIC IMAGES" SHALL INCLUDE ALL:

1. CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661).
2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661).
3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ).
4. CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.
5. CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. SECTION 12-2801).

I hereby release you, your physicians, and your employees from any and all lability for fulfilling the authorization request for release of medical information. I understand it is possible that the information in my medical records may be disclosed by the recipient to other parties This consent will expire ninety (90) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify CIGNA HealthCare of Arizona, Inc. in writing to that effect. I understand that any releases, which were made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Certain information concerning a minor is governed by AZ State and Federal statutes and will require the minor's signature prior to any release. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original.

PATIENT SIGNATURE:			**DATE:**
PARENT/ GUARDIAN / POWER OF ATTORNEY:	**RELATIONSHIP TO PATIENT:**	**WITNESS/NOTARY:**	**DATE:**

SP1813 Rev.4-03 White: File/Legal Yellow: Requestor

Authorized Agent:
Knox Attorney Service, Inc., Knox Services LLC.