

**AUTHORIZATION FORM FOR CIGNA INTERNATIONAL EXPATRIATE BENEFITS TO USE AND DISCLOSE HEALTH INFORMATION**

This form will allow CIGNA International Expatriate Benefits its subsidiaries, affiliates and agents to release the information specified to the persons, class of persons or entities specified on this form.

I understand by completing and signing this form, I authorize CIGNA International Expatriate Benefits to release the following information to the person, class of persons or entity(s) identified below:

**Description of Individually Identifiable Health Information (IIHI) to be Released**

\_\_\_\_\_

**Identification of person authorizing release: The following Information is needed to ensure we are releasing your information identified above.**

Member/participant authorizing release of information:

Date of Birth \_\_\_\_\_ Member # \_\_\_\_\_

Subscriber Name (if different from member) \_\_\_\_\_

Relationship to Member \_\_\_\_\_

Subscriber's Employer Name \_\_\_\_\_

Subscriber **Member** Number \_\_\_\_\_

**Identification of person, class of persons or entity who will be the recipient(s) of the information authorized:**

**Purpose of this release of Information**

I understand that this authorization expires on: \_\_\_\_\_  
(date or event –if left blank denotes 1/1/2010)

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by this authorization. By signing this form, I hereby authorize CIGNA International Expatriate Benefits to disclose the information according to the terms set forth above. I understand that any forms returned to CIGNA International Expatriate Benefits incomplete will be returned to me for completion and my release of information will not occur until I complete all necessary information.

***I understand that I may revoke this authorization by sending a written request to do so to the following address: Privacy Office CIGNA International Expatriate Benefits 590 Naamans Road, Claymont, DE 19703***

I have read and understand the above information:

Date \_\_\_\_\_ Signature of authorizing member/participant \_\_\_\_\_

Date \_\_\_\_\_ Signature of Witness \_\_\_\_\_

If patient is unable to give consent because of physical condition or age, complete the following: Patient is a minor of \_\_\_\_\_ years of age or is unable to give consent, because \_\_\_\_\_ )

Signature of Parent/Guardian/POA \_\_\_\_\_ Relationship \_\_\_\_\_

**Your Rights:** You may request to inspect or copy the IIHI to be released and may choose to refuse to sign the authorization. Treatment, payment and enrollment or eligibility for benefits is not conditioned on the signing of this authorization. The use or disclosure of the requested information has not resulted in direct or indirect remuneration from a third party. You will receive a signed copy of this authorization for your records.

\*CIGNA refers to CIGNA Corporation and/or one or more of its subsidiaries. CIGNA Corporation is a holding company and is not an insurance or an operating company. CIGNA International Expatriate Benefits ("CIEB") refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. Most employees are employed by such subsidiaries and not by CIGNA Corporation. CIGNA\* is a registered servicemark of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its subsidiaries.