CIGNA HealthCare of Arizona

CIGNA Medical Group

## *Authorization/Notification to Release Protected Health Information*

- ***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 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 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) ☐ Personal Use *(Please see current Fee Schedule)*

☐ Other *(Please indicate purpose of request)*: ____________________

Date of Appointment: ____________________

### PART 4. TYPE OF RECORDS BEING REQUESTED

**PLEASE NOTE:** Requests normally take 10 business days for processing; but, please allow 30 days from the request date for receipt at the given destination *(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)*: ____________________

☐ Co-Pay Statement

☐ Pharmacy Profile

☐ **Other** ***(Please specify)*:** ____________________

### PART 5. X-RAY FILMS / DIAGNOSTIC IMAGES

☐ Reports Only *(A fee may apply for copies)* For: X-Ray Exam: ____________________ Date: ________

☐ Films Only *(A fee may apply for copies)* X-Ray Exam: ____________________ Date: ________

☐ Films and Reports *(A fee may apply for copies)* X-Ray Exam: ____________________ Date: ________

☐ Permanent Transfer of Mammograms *(All)* 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 HealthCare of Arizona, 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 TREATMENT PROGRAM INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ).
4. CONFIDENTIAL PSYCHOTHERAPY NOTES. (AS DEFINED IN 42 CFR SECTION 164.501).
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 liability 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 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: |
|---|---|---|---|