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 Medical Group to release medical records information concerning the above-named patient to:

RECIPIENT'S NAME:	RECIPIENT'S PHONE NUMBER:
RECORDS DEPOSITION SERVICE, INC.	248-357-3330

ADDRESS *(Street, City, State, Zip Code)*:
PO BOX 5054, SOUTHFIELD, MI, 48086-5054

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)

Date of Appointment: _____

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

☑ Other *(Please indicate purpose of request)*:
PRE TRIAL DISCOVERY

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)*:**
PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

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 Medical Group, 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 Medical Group 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:

IMPORTANT INFORMATION/NOTES FOR THE RECIPIENT:

It is Cigna Medical Group's practice to release (upon authorization and/or notification) photocopies of medical records and/or x-ray films from the last two (2) years of treatment received unless otherwise requested by the patient. There may be additional records/medical information available. The patient is required to sign a specific authorization for the additional information to be released. For all continuing care requests, additional information will be provided upon request of the Physician.

Redisclosure Prohibited: The information disclosed to you is confidential and protected by law. Any further disclosure may be strictly prohibited under applicable law. For example, if you received any medical records and/or x-ray films which included genetic test or genetic testing information as defined in A.R.S. Section 12-2801, further disclosure of the test information and results is prohibited under Arizona law without the specific written consent of the person to whom it pertains or as otherwise permitted by law.

In addition, if you received any medical records and/or for x-ray films which included confidential HIV-related information or confidential communicable disease-related information as defined in A.R.S. Section 36-661, the following notice on redisclosure applies under Arizona law:

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM CONFIDENTIAL RECORDS WHICH ARE PROTECTED BY STATE LAW THAT PROHIBITS FURTHER REDISCLOSURE OF THE INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY LAW (A.R.S. SECTION 36-664 (G)). THIS DOES NOT APPLY TO THE PROTECTED PERSON OR A PROTECTED PERSON'S HEALTH CARE DECISION MAKER.

Further, if you received any medical records and/or x-ray films which included confidential alcohol or drug abuse-related information as defined in 42 CFR Section 2.1 et seq., the following notice on redisclosure applies under the federal law.

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42 CFR PART II). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART II. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. THE FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.