Cigna Global Health Benefits℠ HIPAA Request for Restriction of Use and Disclosure

This form will allow me, as a Cigna Global Health Benefits member/participant to request a restriction on disclosure of my confidential Protected Health Information for treatment, payment and health care operations.

I understand that by completing and signing this form, I request Cigna Global Health Benefits to restrict disclosure of my Individually Identifiable Health Information (IIHI) as described below. I understand Cigna Global Health Benefits will consider all requests for restrictions carefully; however, Cigna Global Health Benefits is not required to agree to a requested restriction but will accommodate reasonable requests whenever feasible.

Identification of member/participant requesting a Restriction. The following information is needed for verification.

Name of Member/Participant Requesting a Restriction ______________________ Date of Birth ____________ Member # ____________

Subscriber Name (if different from Member) ______________________ Subscriber's Relationship to Member ____________

Subscriber's Employer Name ______________________ Subscriber Member Number ____________

Requested Restriction:

☐ **I request to restrict any outreach to me for participation in any disease management programs.**

☐ **I request to restrict phone and Internet access to my Individually Identifiable Health Information (IIHI) to myself only.** ***(This would restrict the subscriber of benefits if not myself from phone/internet access to my PHI).***

☐ **Other:** ***(Please describe in detail)***

By signing this form, I hereby authorize Cigna Global Health Benefits to disclose the information according to the terms set forth herein. I understand that any form returned to Cigna Global Health Benefits incomplete will be returned to me for completion and my restriction request will not be implemented until all the information is received complete and processed.

I also understand that if either I, as a member/participant or my group subscriber changes health care benefits coverage or employers that I will need to resubmit this request.

I understand if I have previously submitted a HIPAA Privacy Personal Representative request, this current request for restriction will stay in force and information will still be forwarded to my Personal Representative unless I indicate below that I wish to rescind or revoke my request for Personal Representative.

☐ I wish to revoke my previously submitted request for a Personal Representative.

I have read and understand the above information:

Date: ____________ Signature of Authorizing Member/Participant: ______________________

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: ____________

I understand that I may revoke this authorization by sending a written request to do so to the following address:

Privacy Office
Cigna Global Health Benefits
300 Bellevue Parkway
Wilmington, Delaware 19809

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