



CIGNA HealthCare

# Request for Restriction of Use and Disclosure of Private Health Information

THIS FORM WILL ALLOW ME, AS A CIGNA HEALTHCARE\* MEMBER/PARTICIPANT, TO REQUEST A RESTRICTION ON THE USE AND DISCLOSURE OF MY PRIVATE HEALTH INFORMATION (PHI). I UNDERSTAND CIGNA HEALTHCARE WILL CONSIDER ALL REQUESTS FOR RESTRICTIONS CAREFULLY; HOWEVER CIGNA HEALTHCARE IS NOT REQUIRED TO AGREE TO A REQUESTED RESTRICTION.

**Note: If your request is granted, it will affect only written and oral communications by CIGNA HealthCare. If you also wish your employer, group health plan, physician or anyone outside of CIGNA HealthCare to make this change, you must obtain their agreement separately.**

## VERIFICATION – (Please Print)

**Identification of Member/Participant:** (The following information is needed for verification. Please complete all applicable items.)

Name of Member/Participant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone number where we can reach you if we need to contact you to process your request (required): \_\_\_\_\_

Social Security #: \_\_\_\_\_ Member/Participant ID card # (if applicable): \_\_\_\_\_

Group or Account # on ID card: \_\_\_\_\_ Subscriber Name (if different from Member/Participant): \_\_\_\_\_

Subscriber's Relationship to Member/Participant: \_\_\_\_\_ Subscriber's Employer Name: \_\_\_\_\_

Subscriber's Social Security # (if different from Member/Participant): \_\_\_\_\_

CIGNA HealthCare will not disclose confidential information without your authorization unless it is necessary to provide your health benefits, administer your benefit plan, to support CIGNA HealthCare programs or services, or as otherwise required or permitted by law. We will not, for example, give your confidential information to a credit agency, a telemarketer or a prospective employer. We will not sell, rent or license the confidential information you provide to us. You do not need to request a restriction if you are concerned about those uses and disclosures.

## VERIFICATION QUESTIONS

**The answers you provide below will be used to verify your identity if you call for your private health information. Note that we ask these questions because the answers should be easy for you to remember, but you may enter other numbers as described below.**

Last 4 digits of your favorite credit card (you may use any four digit number): \_\_\_\_\_

What is your mother's date of birth: (answer in the following 8-digit format: 11231949 for November 23, 1949) \_\_\_\_\_

You may use any date, however, it cannot be a future date, and it must be a legitimate calendar date.

For example, we cannot accept 11361949 (November 36, 1949) because there are not 36 days in November. We also cannot accept 11232010 (November 23, 2010) because 2010 is a future date.

- Please DO NOT provide anyone else with the answers to these questions.
- You should keep a copy of this form for reference.

## REQUESTED RESTRICTIONS

Please describe your request: \_\_\_\_\_

Please Complete Form On Next Page ➡

**Please Indicate Below If You Wish the Following Restriction to Apply:**

I wish to deny other family members covered under my policy access to my PHI via phone and Internet. If you make this election and you are not the Subscriber, you will not be able to access your information on the Internet. You will need to call the number on your or the Subscriber's ID card to obtain information by phone. (The Subscriber will still be able to obtain his/her own PHI via phone and Internet.)

**PLEASE NOTE**

- If you are not the Subscriber, any check payment for services you receive that is not sent to the health provider will be sent to the Subscriber. Therefore, a Subscriber may receive a check that may prompt questions to you about the services rendered.
- Communications, including communications containing PHI, will continue to be sent to the current address we have on file for you.
- If any information on this form is not complete, CIGNA HealthCare will return the form to you, and your restriction request will not be considered until CIGNA HealthCare receives complete information.
- If your Member/Participant ID or date of birth is changed, another form will need to be completed at that time.
- If either the Member/Participant or Group changes to a different type of health care benefits coverage provided by CIGNA HealthCare, another form will need to be completed at that time.
- You may change or revoke this restriction by sending a written request to the CIGNA HealthCare Privacy Office, at the address shown below. You can obtain a Change/Revoke form by calling CIGNA HealthCare Member Services at the number on your CIGNA HealthCare ID card.

**SIGNATURE**

I have read and understand the above information:	Date: _____
Signature of Member/Participant, Parent/Guardian, Personal Representative: _____	
Relationship if signed by other than Member/Participant: _____	
<b>Note: If not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.</b>	
If request is made by a Parent/Guardian, complete the following: Member/Participant is a minor ____ years of age.	
<b>If you are a parent or guardian requesting a restriction on a child that will prevent the child's other legal parent from accessing the child's private health information, you must:</b>	
1. provide evidence that the parental rights of the other parent have been terminated, or	
2. obtain the other parent's agreement to this restriction. If you obtain the other parent's agreement to this restriction, please have the other parent sign this form and notarize it, or send a statement signed and notarized by both parents indicating that both parents have agreed to place a restriction on the child's private health information.	

\*"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

**Please Return This Completed Form To:  
CIGNA HEALTHCARE • PRIVACY OFFICE • PO BOX 55270 • PHOENIX AZ 85078-5270**