AUTHORIZATION/NOTIFICATION TO RELEASE

PROTECTED HEALTH INFORMATION

I hereby authorize Cigna HealthCare of Arizona, Inc. dba Evernorth Care Group ("the group") previously known as Cigna Medical Group, its employees and/or agents to release my protected health information (PHI) described here to the persons or entities specified on this form and in the form/manner described below. I understand that this authorization is voluntary and made to confirm my directions. I understand that once the information is disclosed, it may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient to other parties. **Please print your responses in ink and complete all required fields.**

1. VERIFICATION: The following information is needed for ID verification purposes.

Patient Name: _____ **Date of Birth**: _____

Address: _____

Phone number where we can reach you: _____

2. DESTINATION OR RECORDS: Information will only be disclosed to the person/entity noted below.

Recipient's Name: _____

Address: _____

Recipient's Phone Number: _____ **Recipient's Fax Number:** _____

3. PURPOSE OF RELEASE

☐ **Continuation of Care**: Date of Future Appointment _____ ☐ **At the request of individual**

☐ **Other**: _____

4. DESCRIPTION OF INFORMATION TO BE RELEASED

☐ Copies of **all medical records for the last 2 years** of treatment

☐ Copies of all **medical records** (to include lab, XR, notes, etc.) from (dates): _____ to _____

☐ **Laboratory results** from (dates): _____ to _____

☐ **X-ray films/Diagnostic** Images from (dates): _____ to _____

☐ **Pharmacy Profile** **Billing**: ☐ Equivalent Value Statement (EVS) ☐ Co-Pay Statement

☐ **Other** (Please specify): _____

I understand that the information released may contain other sensitive information about me, such as information regarding communicable diseases (including sexually transmitted diseases and HIV/AIDS, as defined in A.R.S. Sections 36-661, 36-664), genetic testing/genetic history (as defined in A.R.S. Section 12-2801), mental/behavioral health, substance use disorders/treatment (as defined in 42 CFR section 2.1), reproductive health care (45 CFR section 160.103), and developmental disabilities. My consent includes disclosure of other sensitive health information in connection with the release of my health information unless I have provided specific instructions in the space below.

_____

5. PSYCHOTHERAPY RECORDS (Optional). Please include **Confidential Psychotherapy Notes** (as defined in 45 CFR Section 164.501), for example notes of private counseling sessions, as follows:

☐ Copies of therapy records from (dates): _____ to _____

6. FORMAT / MANNER OF RELEASE

CLINIC USE ONLY - MRN: _____

☐ **Paper** – By default **Standard Font** size will be used. **Optional Font** (check one): ☐ Large ☐ Extra Large

☐ **Patient Portal** – pdf format. *(Requires patient/proxy to have an active **MyChart** account for patient noted.)*

Electronic Format (mailed on CD/DVD unless otherwise noted): ☐ PDF file ☐ Screen Readable PDF File

☐ CCD Clinical Patient Summary (xml format) ☐ CCD Encounter Clinical Summary (xml format)

☐ **Email to:** _____ *(if within file size limit of 24 M**B** will be sent via encrypted email unless request specifies otherwise; if file too large, records will be mailed on CD/DVD)*

☐ **Other** (Please Specify):_____

PLEASE NOTE:

If the information on this form is not fully completed, the group will return the form to you and this request will not be considered until the group receives all required information. You may not be entitled to receive all of your PHI, including information such as psychotherapy notes (as defined in 45 CFR 164.501) or information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding.

I hereby release Evernorth Care Group, its physicians and employees from any and all liability for fulfilling this authorization request for the release of my medical information. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time provided that I notify the group in writing to that effect. I understand that any releases made prior to my revocation and in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Certain information concerning a minor is governed by Arizona State and Federal law and will require the minor patient's signature prior to any release. I understand that a photocopy/fax of this authorization is considered acceptable in lieu of the original.

7. EXPIRATION: This consent will expire **1 year** after the signed date below.

8. SIGNATURES:

I have read and understand the above information: **(Print Name)** _____

Signature of Patient/Guardian/Personal Representative: _____ **Date**: _____

Relationship if not signed by the Patient (or description of authority to act for Patient):

_____

If this request is made by a Parent/Guardian, complete the following:
Patient is a minor _____ years of age. If minor patient is 12 years or older, the group will require authorization from the minor prior to release of sensitive information or a valid Personal Representative form completed by the minor for parent/guardian on file; otherwise, records will be reviewed and redacted.

Minor's signature: _____ **Date**: _____

Witness (Print Name): _____ (Signature) _____ **Date:** _____

Telephonic/Verbal: Form ID verified, reviewed in full and documented per patient/representative's request. Requires sign-off by 2 Evernorth Care Group employees who witnessed the authorization.

2nd Witness (Print Name): _____ (Signature) _____**Date**: _____

Note that if not already provided, the group will require verification of the authority of a Personal Representative before this request will be considered complete including furnishing a copy of a valid healthcare power or attorney, Personal Representative Form or other relevant documents.

EVERNORTH Care Group℠