Authorization for the Release of Information

I. Information about Use or Disclosure

By signing this authorization, I authorize the use or disclosure of my protected health information ("PHI") as described below.

Patient Name:	Date of Birth: / /
Address:	Phone number (provide one): Home: Cell:

If covered under a medical plan insured or administered by Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company please provide the following information:

Member/Participant Identification Card ("ID Card") Number:	Policy, Group or Account Number on ID Card:
Subscriber Name:	Subscriber's Employer:
Subscriber's Relationship to Patient:	

I authorize Cigna Onsite Health, LLC ("COH"), Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company and their affiliates and agents (collectively referred to as "Cigna") to use and disclose my PHI for the purpose identified below.

I authorize COH, Cigna, my medical plan or its vendor(s), to receive my PHI for the purpose identified below.

Purpose of the use and disclosure:
COH, my medical plan and Cigna, an administrator of my medical plan will use and disclose PHI to provide health management or to administer an incentive program. This authorization will allow reporting of health data at the aggregate level only (de-identified data which does not include my name or other identifiable information) to my employer or health plan for the purpose of creating health program improvements, and identifiable data to my employer only for the purpose of incentive programs.

For purposes of this Authorization, PHI includes but is not limited to the following:
Pharmacy and prescription drug information, laboratory test results, disease and health management information, visit notes, results of analytical models, health advocacy program participation, eligibility benefits information, biometric data, vaccinations, genetic testing information, demographic and claims information, Point of Service information such as location information, provider name, etc., alcohol or drug abuses treatment program information, psychotherapy notes, communicable disease- related and HIV-related information.

II. Important Information About Your Rights

I understand that:

- This authorization is voluntary and I may refuse to sign it.
- I may revoke this authorization by sending a written request to Cigna Onsite Health, LLC, 25500 N. Norterra Drive, Phoenix, Arizona 85085-8200. A revocation form is available from the onsite health center staff. The revocation will not have any effect on actions that COH or Cigna took before it received the revocation notice.
- I am not required to sign this authorization as a condition to receiving treatment or payment for health care, enrolling in a health plan or eligibility for benefits.
- A copy of this authorization and notation concerning the persons or agencies to whom disclosures are made shall be included with original health records.
- This authorization expires twelve (12) months from the date of signature.

III. Signature of Patient or Patient's Representative

Signature of Patient **X**	Date: / /
Signature of Personal Representative or Parent/Guardian **X**	Date: / /
Printed Name of patient's personal representative:	
Relationship if the person signing is other than Patient whose information is to be used and disclosed:	

Please note: If the State in which services are provided permits minors to obtain care without parent/guardian's consent, please obtain the minor's signature to consent to authorize information disclosure of those services.

The information used or disclosed pursuant to the authorization may be re-disclosed by the recipient and, upon re-disclosure, no longer be protected by federal privacy laws.

We recommend that you keep a copy of your completed form for your records. Cigna and Cigna Onsite Health, LLC will retain a copy which will be made available upon your request.