



CIGNA Behavioral Health

Authorization for Use and Disclosure of Private and Confidential Health Information

THIS FORM WILL ALLOW CIGNA BEHAVIORAL HEALTH *, INC. TO RELEASE THE PRIVATE HEALTH INFORMATION SPECIFIED BELOW TO THE PERSONS OR ENTITIES SPECIFIED ON THIS FORM.

Description of Private Health Information to be released:

- 1) Attendance or Non-Attendance at EAP session(s). Information will not include diagnostic or clinical disclosure
- 2) Suggestions, if any, resulting from the EAP assessment regarding workplace/supervisory strategy that may support improved work performance. Information will not include diagnostic or clinical disclosure.
- 3) Recommendation(s), if any, resulting from the EAP assessment. Information shall be limited to identifying the **level of care**: (outpatient, partial hospitalization, inpatient or residential), **type of referral resource(s)**: (self-help, support groups, medical evaluation, etc.), the **name of the treating provider and/or facility if requested for purposes of ongoing follow-up**. Information will not include diagnostic or clinical disclosure
- 4) The estimated time frame necessary to complete the recommendation(s). Information will not include diagnostic or clinical disclosure.
- 5) The employee's demonstrated compliance or non-compliance with initial follow-through of the recommendation(s). Information will not include diagnostic or clinical disclosure

VERIFICATION

Identification of person authorizing release: (Accuracy and completeness is needed for this document to be valid.)
(Please complete all applicable items.)

Name of Participant: _____
Street Address: _____
City: _____
State: _____ Zip Code: _____
Date of Birth: _____ Participant's Social Security Number: _____
Participant's Employer Name : _____

I authorize the persons or entities below to receive the information:

Name of Contact: _____
Title and Department: _____
Street Address: _____
City: _____ State: _____ Zip code: _____
Phone number: _____

Purpose of this release of information:

To confirm the employee's compliance with the process for formal management or continuation of employment referrals to the EAP and to assist in restoring optimal job performance.

This document will expire 60 days following discharge from and/or completion of treatment or education as recommended by the EAP provider.

Participant's Social Security Number: _____

I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

- *I understand that if information on this form is not complete, CIGNA Behavioral Health will return the form to me, and this request will not be considered until CIGNA Behavioral Health has received all the required information.*
- *I understand that I may revoke this authorization by sending a written request to CIGNA Behavioral Health, EAP, 11095 Viking Drive, Suite 350 Eden Prairie, MN 55344*
- *You can obtain a form to revoke the authorization by calling CIGNA Behavioral Health customer services at: 1.800.433.5768. Any revocation will not be effective for any actions CIGNA Behavioral Health may already have taken.*

SIGNATURE

I have read and understand the above information: X _____ Date: _____

Relationship if person signing is other than Participant: _____

Note that:

If not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If this request is made by a Parent/Guardian, complete the following: Participant is a minor, ____ years of age.

If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

The provision of treatment, payment, enrollment or eligibility for benefits does not depend on whether you sign this authorization. It is recommended that you keep a signed copy of this authorization for your records, however a copy of this signed authorization can be provided upon your request.

If the information disclosed to you relates to substance abuse treatment, in addition to HIPAA Privacy regulations, these confidential records' are protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the privacy of patients' records, and may be more restrictive than applicable federal regulations.

Please Return This Completed Form To:

CIGNA Behavioral Health

Functional Area Name: Employee Assistance Program _____

Functional Area Address: 11095 Viking Drive, Suite 350, Eden Prairie, MN 55344 _____

Functional Area Facsimile: 952-956-7100

Staff Person's Name:

Staff Person's Telephone Number: 800-241-4057 x

****CIGNA Behavioral Health** refers to CIGNA Behavioral Health, Inc. and subsidiaries of CIGNA Behavioral Health, Inc., including CIGNA Behavioral Health of California, Inc.**

11/11/2005ddb