HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION UPDATE FORM

Section A: I do **NOT** authorize the disclosure of my personal health information to the persons/entities as described in Section B below. I understand this non-authorization is voluntary and made to confirm my directions. I understand that once the information is disclosed, it may be re-disclosed and no longer protected by federal privacy regulations; therefore, I do **NOT** give permission for the disclosure of my personal health information in the manner described below.

My Name: _____

Address: _____

Telephone: _____ Member Number: _____

Section B: I do NOT authorize the Life Insurance Company of North America and other entities that do business with Cigna Leave Solutions to contact my health care providers that populated my Family Medical Leave Act (FMLA) or American Disability Act (ADA) leave or accommodation forms to obtain medical information required to complete this form and/or clarify or validate medical information that is provided on the FMLA/ADA forms.

If my [employer, union, group association] sponsors any other plans, whether or not underwritten or administered by Life Insurance Company of North America or its affiliates, the information and records may not be shared with the underwriting company [insurer] or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs for purposes of administering any service, benefit or feature describe in those plans without my WRITTEN AUTHORIZATION.

This request will include information related to sexually transmitted diseases, such as HIV or AIDS, alcohol or drug use treatment, or mental health/psychology/psychiatry that may be within my FMLA/ADA requests

---

Right to Rescind: I may rescind this **non-authorization** in writing at any time. I understand my recension will not affect any disclosures that were made by my providers before receipt of this information.

Signature:

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction. I further understand that, by signing this form, I am confirming my non-authorization that the providers identified above may NOT disclose my health information to Life Insurance Company of North America and other entities that do business with Cigna Leave Solutions.

Signature: _____ Date: _____

**** ALL DATA FIELDS ABOVE MUST BE COMPLETED FOR A VALID AUTHORIZATION ****