

I, \_\_\_\_\_, Medicare Health Insurance Claim Number \_\_\_\_\_, by this written statement authorize:

Name: \_\_\_\_\_  
(please print)

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

to act on my behalf while making inquiries regarding my Medicare file(s). This authorization is effective until:

Expiration date: \_\_\_\_\_

Expiration event: \_\_\_\_\_

The designated individual has the authority to make inquiries and discuss my Medicare file(s). The Medicare representative may:

Discuss and release any and **ALL** Medicare file and claims information to the designated individual.  
OR

Discuss and release **ONLY** information about \_\_\_\_\_  
\_\_\_\_\_ to the designated individual.

The purpose of this disclosure is:

I understand refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

**NOTE:**

Your personal medical information that you authorize Medicare to disclose may be subject to re-disclosure and no longer protected by law. You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. To revoke your authorization, send a written request to the address below.

Return this completed form to:  
CIGNA HealthCare Medicare Administration  
P. O. Box 690  
Nashville, TN 37202

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Beneficiary's Telephone #