Authorization to:
Disclose Protected Health Information

In order for us to disclose your Protected Health Information to another person or entity, you must complete and sign this form and return it to us. You can send it back to us through secure message or by emailing it to help@hioscar.com. You can also snail mail the form as outlined below. You have the right to receive a copy of this form.

All members: Cigna + Oscar c/o Oscar Management Corporation, P.O. Box 52146, Phoenix, AZ 85072-2146.

Full name: _____ Date of birth: _____

Phone #: _____ Oscar ID#: _____

Address: _____

I authorize the disclosure of the following protected health information:

☐ All Records ☐ Records pertaining to: _____

Unless otherwise indicated, my authorization includes the release of the following: (Please check the box of those you wish to exclude, if any):

- ☐ Diagnosis and/or treatment for substance use disorder, including alcoholism and/or drug abuse or dependency
- ☐ Diagnosis and/or treatment of mental illness
- ☐ HIV antibody test results and/or AIDS diagnosis and treatment and/or sexually transmitted infections
- ☐ Genetic testing information

Purpose:

☐ At My Request ☐ Other: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____ Fax: _____

How long should this authorization be in effect?

This authorization should expire on : _____

If no expiration is specified, this authorization will expire 1 year from the date this form is signed. Arizona and California residents: your authorization will be valid for no more than 1 year even if you designate a different date above.

Redisclosure: I understand that once my information is disclosed pursuant to this authorization, the information may no longer be protected by federal and state privacy standards and my health information may be re-disclosed.
Revocation: I have the right to revoke (cancel) this authorization at any time by sending a written notice to the address listed at the top of this form. I understand the revocation will not be effective until received. I am aware that my revocation will have no effect on disclosures made prior to the receipt of my revocation.
Refusal: If I refuse to sign this form, my treatment, payment, enrollment or eligibility for benefits will not be affected.
Signature required: I have read and understood the terms of this form.

Signature: _____ Date: _____

Note: This form must be signed by either the member or his/her/their personal representative. If you are not the member, please sign below and indicate your relationship by checking the appropriate box.

Representative signature: _____ Date: _____

Relationship: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other*: _____

*Documentation must be provided supporting your legal authority to act on the member's behalf.

Notice of Non-Discrimination:

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services at all times to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator

P.O. Box 188016

Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card.

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación.

Chinese – 注意：我們可為您免費提供語言協助服務。
對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên.

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card.

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана.

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية.

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou.

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité.

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação.

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej.

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は　IDカード裏面の電話番号まで　お電話にてご連絡ください

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione.

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an.

Persian (Farsi) –توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید.