AUTHORIZATION FOR RELEASE OF INFORMATION

ANY USE AS AN AUTHORIZATION TO USE OR DISCLOSE PSYCHOTHERAPY NOTES MAY NOT BE COMBINED WITH ANOTHER AUTHORIZATION EXCEPT ONE TO USE OR DISCLOSE PSYCHOTHERAPY NOTES.

Beneficiary name _____ Sponsor ID Number _____

Beneficiary street, city, state, zip: _____ Beneficiary S.S. number _____

I authorize the use or disclosure of the above-name beneficiary personal health information by Humana Military Healthcare Services ("HMHS") and/or TRICARE Health Plan, as describe below: **(CHECK ONLY ONE BOX BELOW)**

☐ Any and all records in the possession of HMHS ***excluding mental health, HIV, and / or substance abuse records***

☐ Records regarding the treatment for the following condition or injury _____

On or about / / (MM/DD/YR)

☐ Records covering the period of time from / / to / / (MM/DD/YR)

☐ OTHERS: _____

NOTE: To authorize disclosure of a sensitive diagnosis such as Mental Health, Drug & Alcohol Abuse, HIV/AIDS, Pregnancy, or Abortion records, a <u>separate</u> completion <u>for</u> <u>each</u> is required using the Authorization form specific to SENSITIVE DIAGNOSIS.

This information may be disclosed to, and used by, the following individual or organization:

Name: _____

Address: _____

The information is being disclosed for the following purpose(s)::

□ Personal Use □ Continued Medical Care □ School □ Other_____

□ Insurance Claims □ Retirement/Separation □ Legal (Purpose of disclosure, as specific as possible)

By signing below, the beneficiary or the beneficiary's representative agrees to the following statements:

1. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
2. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
3. I understand that I may revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to HMHS' Privacy Office to the address below. I understand that the revocation will not apply to information that has already been released in response to the authorization.
4. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations

Must be completed for all authorizations

I understand that I may refuse to sign this authorization and that HMHS may not condition treatment or payment on whether I sign this authorization.

I understand that I may refuse to sign this authorization and that HMHS may not condition treatment or payment on whether I sign this authorization. If no expiration date is specified then this authorization will expire one year from the date of signature.

Expiration Date

____ / _____ / _____

(MM) (DD) (YR)

Printed name of the beneficiary or the beneficiary's representative _____ Representative relation to beneficiary

/ /

Signature of beneficiary or beneficiary's representative _____ Date (MM/DD/YR)

Return completed form (select best option): Humana Military Healthcare Services
HMHS Privacy Office
P.O. Box 740062
Louisville, Kentucky 40201-7462
Or fax to: 877-298-3407

HMHS will follow all Federal and state laws and regulations that are more stringent

If signed by legal representative, please provide representative documentation as required by state law, i.e. Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers. HMHS will not process invalid forms.