

Member Information: (Individual whose information will be released)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(First, Middle, Last) (Month, Day, Year)

Address: \_\_\_\_\_  
City State Zip Code

Telephone Number: (including area code) \_\_\_\_\_

Group Plan #: \_\_\_\_\_ Member ID #: \_\_\_\_\_

I authorize the use or disclosure of personal and health\* information by Humana, as described below:

- Any and all personal and health information Humana maintains (including mental health, HIV and/or substance abuse records - Cross out any item you do not authorize to be released)
- Personal and health information regarding the treatment for the following condition or injury: \_\_\_\_\_  
\_\_\_\_\_ on or about \_\_\_\_\_
- Personal and health information covering the period of time \_\_\_\_\_ to \_\_\_\_\_
- Other (Please specify and include dates): \_\_\_\_\_  
\_\_\_\_\_

Note: This consent form allows personal and health information to be shared via a telephone call with the person being authorized. It does not apply to the information stored on our web site.

This information may be disclosed to, and used by, the following individuals or organizations:

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This information is being disclosed for the following purpose(s): \_\_\_\_\_  
\_\_\_\_\_

I understand that I have the right to 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 Humana. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to Humana when the law provides it with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 365 days.

I understand that I do not have to sign this authorization and that Humana may not condition treatment or payment on whether I sign this authorization. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

Signature of Member: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Legal Representative  
only if member is unable to sign\*\*: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by Legal Representative, relationship to Member: \_\_\_\_\_

**\*\* If signed by legal representative, must provide representative documentation as required by state law, i.e. Healthcare Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers.**