FOR SENSITIVE DIAGNOSIS ONLY

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.

Veteran's Name (First Name, Middle Name, Last Name): _____ **Veteran's Full 9-Digit Social Security Number** _____

Veteran's Address Street, City _____ **State** _____ **Zip** _____

I authorize the use or disclosure of the above-named Veteran's personal health information by Humana Government Business ("HGB"), VA, and/or Sub-Contractors, as described below: **(ONLY ONE CHECK BOX BELOW IS ALLOWABLE, PER FORM)**

- ☐ Pregnancy & Birth Control Records
- ☐ Abortion Records
- ☐ AIDS & STDS Records
- ☐ Sickle Cell Anemia
- ☐ Mental Health Records
  (Nature of Information, as limited as possible: _____)
- ☐ Alcohol & Drug Abuse Records
  (Nature of Information, as limited as possible: _____)

This information may be disclosed to and used by the following individual(s) or organization(s):

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 Veteran or the Veteran'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 the HGB 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. EXCEPTION: Re-disclosure of alcohol and substance use information is expressly prohibited without the written consent of the person to whom it pertains.
5. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the Regulations.

MUST BE COMPLETED FOR ALL AUTHORIZATIONS

The Veteran or the Veteran's representative must agree to the following statements:

I understand that this authorization will expire on: _____ **(MM/DD/YR)** If no expiration date is specified, this document will expire **1 (one) year** from the date it is signed.

_____

Printed Name of Veteran or Veteran's Representative (*See below. If signed by someone other than the veteran, appropriate documentation must be provided for review i.e. Power of Attorney, Guardianship, etc.)*

_____ _____

Signature of Veteran or Veteran's Representative Todays Date (MM/DD/YR)

(State/federal law commonly state that information related to alcohol/drug treatment, abortion, venereal disease, sickle cell anemia and/or AIDS cannot be disclosed without written consent of the patient/Veteran. In some instances, information related to mental health and pregnancy/birth control may also require written consent of the patient/Veteran.)

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

Return completed form (select best option): **Mail:** HGB Privacy Office
P.O. Box 740062
Louisville, KY 40201-7462

Fax to: 877-298-3409 or **E-mail Printed / Signed Form to:** hmhsprivacyoffice@humana.com

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

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