# Authorization to release information (General)

**PRIVACY ACT STATEMENT:** In accordance with the *Privacy Act of 1974 (Public Law 93-579)*, the notice informs you of the purpose of the form and how it will be used. Please read it carefully. **AUTHORITY:** *Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.* **PRINCIPAL PURPOSE(S):** This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information. **ROUTINE USE(S):** To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons. **DISCLOSURE:** Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information. This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, 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.

The purpose of this form is to provide Humana Military (TRICARE Health Plan [THP]) with a means to request the use and/or disclosure of an individual's Protected Health Information (PHI) to an individual or organization, which in many cases, is a spouse, close relative or caregiver. This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or alcohol or drug abuse treatment programs. Completion of this form is voluntary.

**ALL FIELDS MUST BE COMPLETED. INCOMPLETE FORMS WILL NOT BE PROCESSED.**

**The completion of the form does not impact your ability to view another individual's information through beneficiary self-service at HumanaMilitary.com.**

**Section 1-5: Beneficiary/Patient data**

This section identifies the patient/individual who wishes to release their information to another individual.

Line 1: Full name of the beneficiary/patient (last, first, middle initial)
Line 2: Date of birth (mm/dd/yyyy) of the beneficiary/patient
Line 3: DEERS Benefits Number (DBN) or sponsor ID number
Line 4: Address of the beneficiary/patient
Line 5: Social Security Number (SSN) of the beneficiary/patient

**Section 6: Disclosure**

This section authorizes Humana Military (THP) permission to disclose information to the individual or organization named in this section.

Line 6: Enter the type of information you wish to disclose. Check the appropriate box and complete additional information if needed.
Line 6a: **Enter the name of the individual or organization** you wish to grant access to receive your protected medical information.
Line 6b-d: Enter the relationship of the individual to the beneficiary, **full** address, phone number of the individual or organization designated to receive the medical information.
Line 7: Place an "X" in the corresponding box. If "Other" is chosen, specify the medical information. Typically, this will be "personal use."
Line 8: A valid expiration date must be listed. "Indefinite" and "forever" are not acceptable. A date must be provided. If no date is provided, the form will expire one year from the date signed. If the form is being completed on behalf of a minor child, the expiration date cannot exceed their 18th birthday.

**Section III: Release authorization**

A signature is required. If a patient's representative signs the authorization, documentation must be submitted along with the form which outlines the representative's authority (i.e. power of attorney, guardianship, custody order, etc.)

**Please return form by fax/mail to:**

**Fax**
(877) 298-3407

**Mail**
Humana Military Privacy Office
PO Box 740062
Louisville, KY 40201-7462

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# Authorization to release information (General)

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/Patient information**

1. Name: _____
(last, first, middle initial)

2. DOB: _____ 3. DBN _____
(mm/dd/yyyy) (or sponsor ID #)

4. Address: _____

City: _____ State: _____ ZIP: _____

5. Social Security Number (SSN): _____

6. I authorize the use or disclosure of the above-named beneficiary's personal health information by Humana Military and/or THP, as described below (**check only one box below**):

☐ Any and all records in the possession of Humana Military (excluding any sensitive diagnoses)

☐ Records regarding the treatment for this condition or injury:

_____

☐ Records covering the period of time (mm/dd/yyyy):

_____ to: _____

☐ From **other**: _____

**Note:** To authorize the disclosure of a sensitive diagnosis such as behavioral health, Substance Use Disorders (SUD), HIV/AIDS/STDs, pregnancy or abortion records, a sensitive diagnosis authorization is required. This general release form cannot be used to release any sensitive information.

**Information may be disclosed to these individual(s)/organization(s):**

6a. Disclose my information to: _____

6b. Relationship: _____

6c. Address: _____

City: _____ State: _____ ZIP: _____

6d. Phone: _____

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

☐ Personal use ☐ School ☐ Retirement ☐ Legal ☐ Insurance

☐ Other: _____
(Purpose of disclosure. Be as specific as possible.)

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

- I understand that my healthcare and the payment for my healthcare will not be affected if I do not sign this form.
- I understand that I may see and copy the information described on this form if I ask for it, and that I may request a copy of this form after I sign it.
- 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 and send my written revocation to the Humana Military Privacy Office at the address below.
- I understand that the revocation will not apply to information that has already been released in response to the authorization.
- I understand that I may refuse to sign this authoriztion and Humana Military cannot condition payment or treatment on my refusal to do so.
- 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.

8. If no expiration date is specified, this authorization will expire **one year** from the date of signature.

Expiration date (mm/dd/yyyy): _____

**You must enter a date above. Forms cannot have an indefinite expiration date.**

_____
(Beneficiary/Representative name [print])

_____
(Beneficiary/Representative name [signature])

_____
(Representative's relationship to beneficiary)

_____
(Date [mm/dd/yyyy])

**Note:** Humana Military will follow all federal and state laws and regulations that are more stringent. If signed by legal a representative, provide documentation as required by state law, e.g. Power of Attorney. If you have a **Court Ordered Guardianship, send only the Guardianship** (no Release of Information is needed for Court Ordered Guardians.) **Humana Military will not process invalid or incomplete forms.**

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