

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 Full Name _____ Veteran's 9-Digit Social Security Number _____

Veteran's Street, City, State, Zip: _____

I authorize the use or disclosure of the above-named veteran's Protected Health Information by Humana Veteran's Healthcare Services ("HVHS"), VA and/or Sub-Contractors, as described below: **(CHECK ONLY ONE BOX BELOW)**

- Any and all records in the possession of HVHS (*excluding mental health, HIV/AIDS/STDs, pregnancy/birth control, abortion 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: _____

**To authorize disclosure of a sensitive diagnosis such as mental health, drug & alcohol abuse, HIV/AIDS/STDs, pregnancy or abortion records; a separate form for each individual sensitive diagnosis is required using a separate authorization form specific to SENSITIVE DIAGNOSIS titled "FOR SENSITIVE DIAGNOSIS ONLY: AUTHORIZATION FOR RELEASE OF INFORMATION."*

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

NAME: _____

ADDRESS: _____

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

1. I understand that my healthcare and the payment for my healthcare 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 HVHS' 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 HVHS may not condition treatment or payment on whether I sign this authorization.

I understand that I may refuse to sign this authorization and that HVHS 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 Veteran or the Veteran's representative *(If signed by personal representative, Power of Attorney or anyone other than the Veteran, other documentation will be required.)*

/ /

Signature of Veteran or Veteran's representative

Date (MM/DD/YR)

Return completed form to (select best option): Humana Veterans Healthcare Services
HMHS Privacy Office
P.O. Box 740062
Louisville, Kentucky 40201-7462
Or fax to: 877-298-3409

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.