MEMBER AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

*** Required Field**

Member Information (identifying the individual whose information is to be released)

** Member Name:* _____ ** Date of Birth:* _____ *(Month, Day, Year)*

** Member ID / SSN:* _____ *Group No.:* _____

Member Address: _____

Member Phone No.: _____

I authorize the use or disclosure of the above-named member's personal and health information by Humana as described below: *Check Box

- ☒ Any and all Claims Records in your possession,
  - ☒ Check this box to include mental health, HIV records, and/or substance abuse records)
- ☐ Claims records for the time period_____to_____.
- ☐ Claims records relating to_____for the time period_____to_____.
  (Insert specific injury or condition.)
- ☐ Claims submitted by_____for the timeperiod_____to_____.
  (Insert provider's name.)
- ☐ Prescription drug claims **(Include dates)**:_____.
- ☐ Other**(Be specific; Include dates.)**: _____

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

Name: CD SERVICES INC.

Address: 24027 RESEARCH DRIVE FARMINGTON HILLS 48335

* This protected health information is being used or disclosed for the following purpose(s): _____

ALL PURPOSES ALLOWABLE UNDER THE LAW

* I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to; *HUMANA - 1100 Employers Blvd Green Bay, WI 54344*

and/or CD SERVICES

I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that Humana may not condition eligibility or enrollment, and payment on whether I sign this authorization

I understand that information used or disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by state or federal law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under state or federal law. I also have the right to refuse to 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.

I release Humana from any liability associated with releasing this information to the persons and/or Organizations named above.

If this authorization is 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).

Unless otherwise specified, this authorization will expire 90 days after the date (as shown at the end of this document) of my signature.

* _____ _____

Name of Member or Personal Representative | If Personal Representative, Relationship to Member

* _____ * _____

Signature or Member or Personal Representative | Date of Signature

_____ _____

Signature of Witness | Date

I have received a copy of this form. _____

(signor's initials)