

Instructions for completion: Authorization for disclosure of medical or dental information (DD2870)

The purpose of this form is to provide Humana Military (“TRICARE Health Plan”) 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 the on line beneficiary web self-service portal at HumanaMilitary.com

Section I: Patient data

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

- Line 1: Full name (last, first, middle initial)
- Line 2: Date of birth (yyyymmdd)
- Line 3: Social Security Number of the **sponsor**
- Line 4: Identify the date range for the information to be released
- Line 5: Check one box

Section II: Disclosure

This section authorizes Humana Military (“TRICARE Health Plan”) permission to disclose information to the individual or organization named in this section.

- Line 6: “Humana Military/TRICARE Health Plan”
- 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 full address, phone number and fax (if applicable) 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: Use this space to explain, clarify, or provide specific date ranges of medical information to be released, if necessary. If you do not want to narrow the scope of records, this box must specify the information you want to release, i.e. “any and all records” or “records from Jan 1, 2018-January 1, 2019” or “claims and billing info.”
- Line 9: The effective date.
- Line 10: 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 be returned to you as incomplete. 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.)

Email, fax or mail the completed form:

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

Fax: (877) 298-3407

E-mail: humanamilitaryprivacy@humana.com



AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

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.

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)	5. TYPE OF TREATMENT (X one) <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT <input type="checkbox"/> BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE <u>Humana Military/TRICARE</u> TO RELEASE MY PATIENT INFORMATION TO:	
<i>(Name of Facility/TRICARE Health Plan)</i>	
a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS (Street, City, State and ZIP Code)
c. TELEPHONE (Include Area Code)	d. FAX (Include Area Code)
7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable)	
<input type="checkbox"/> PERSONAL USE <input type="checkbox"/> CONTINUED MEDICAL CARE <input type="checkbox"/> SCHOOL <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> INSURANCE <input type="checkbox"/> RETIREMENT/SEPARATION <input type="checkbox"/> LEGAL	
8. INFORMATION TO BE RELEASED	
9. AUTHORIZATION START DATE (YYYYMMDD)	10. AUTHORIZATION EXPIRATION <input type="checkbox"/> DATE (YYYYMMDD) <input type="checkbox"/> ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:

- a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
 - b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
 - c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
 - d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
- I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT <i>(If applicable)</i>	13. DATE (YYYYMMDD)
--	---	---------------------

SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

14. X IF APPLICABLE: <input type="checkbox"/> AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE (YYYYMMDD)
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE		SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER: