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 No.:* _____ *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 one box. *

- ☐ Any and all Claims Records in your possession, including mental health, HIV records, and/or substance abuse records. **(Cross out any item you do not authorize Humana to release.)**
- ☐ 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 time period _____. To _____.
  (Insert provider's name.)
- ☐ Other **(Be specific; include dates.)**: _____
  _____.

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

Name: RECORDS DEPOSITION SERVICE, INC.

Address: PO BOX 5054
SOUTHFIELD, MI 48086 - 5054

P: 248.357.3330
F: 248.357.3337

* This protected health information is being used or disclosed for the following purpose(s): _____
FOR DISCOVERY BEFORE TRIAL.

* I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to RECORDS DEPOSITION SERVICE, INC.
P.O. BOX 5054, SOUTHFIELD, MI 48086-5054.

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 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.

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

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).

_____	_____
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)