

Humana Benefit Plan of Illinois

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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

A. Information to be disclosed and to whom

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below in this section. I understand that this authorization is voluntary. No individual has coerced me into signing this authorization and I am providing this authorization under my own free will. I understand that once this information is received by the authorized organization or person, then it may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws. However, I understand that Illinois law prohibits redisclosure of HIV information, if any, and genetic information by the recipient except as otherwise allowed by law.

NOTE: The Individual should also sign an additional Authorization Form if the information to be used or disclosed includes: (i) mental health or developmental disability information; or (ii) alcohol or substance abuse treatment information.

1. This authorization is valid until _____ (please list expiration date).
[NOTE: The expiration date shall not be later than: (i) 30 months when an authorization is signed for the purpose of collecting information regarding an insurance policy application, a policy reinstatement, or a request for change in policy benefits; or (ii) the term of policy coverage when an authorization is signed for the purpose of collecting information regarding a claim for benefits under the policy.]
2. Individual's name: _____
3. Individual's identification number: _____
4. Name or other identification of types of persons authorized to make the requested use and/or disclosure:

5. Name or other identification of the insurance institution or agent and generic reference to representatives of the insurance institution or agent authorized to receive the information:

6. Specific description of information to be used and/or disclosed:

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The use and/or disclosure

<input type="checkbox"/> may	<input type="checkbox"/> may not
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 include individually identifiable genetic information.

7. Description of each purpose of the requested use and/or disclosure:

B. Right to Revoke.

I acknowledge that I have the right to revoke this authorization in writing except to the extent that:

- (1) A person or organization listed in Section A.4 above has taken action in reliance on this Authorization; or
- (2) If this Authorization was obtained as a condition of obtaining insurance coverage, the insurer has a right to contest a claim under the policy even if this Authorization is revoked.

If you wish to revoke this Authorization, please contact the Member Service Department of Humana Benefit Plan of Illinois at (309) 677-8222.

C. Conditions Relating to Treatment, Payment, Enrollment, or Eligibility.

I understand that the person(s) or organization(s) authorized to make the requested use and/or disclosure may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on the provision of an authorization, except:

- (1) A health care provider may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for research; and
- (2) A health plan may condition enrollment in the health plan or eligibility for benefits on provision of an authorization requested by the health plan prior to an individual's enrollment in the health plan if:
 - (i) the authorization sought is for the health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations; and
 - (ii) the authorization is not for a use or disclosure of psychotherapy notes; and
- (3) A covered entity may condition the provision of health care that is solely for the purpose of creating protected health information (PHI) for disclosure to a third party on provision of an authorization for the disclosure of the PHI to such third party.

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D. Signature

By signing below I acknowledge and affirm the statements in this Authorization form. I also understand that I have a right to receive a copy of this authorization by request.

Signature of Individual or Representative

Printed Name of Individual or Representative

Representative's Relationship to Individual

Date