Humana

Member's Name _____ D.O.B. _____

CONSENT FORM
RELEASE OF INFORMATION/PERMISSION FOR USE OF INFORMATION

I hereby authorize you to release and/or request medical records and/or other related information for the above named patient, and or disclosure of all or any part of the clinical record to any physician, hospital or other health treatment facility. I agree to the release and/or request of information to individuals acting in official capacities as the named patient's advocate, representing governmental third party payors, or other health care providers involved in the care. I consent the release of Agency records to be reviewed by authorized representatives of Medicare, Medicaid and/or my private insurance company(ies) for use in determining health benefits. They may examine my personal and medical records now held by the Agency and to make machine or photographic copies of said records. I consent the review of my Agency records by any accreditation body or for any necessary audits within the Agency.

My Plan of Care has been reviewed with me by my Care Manager and I consent to the services I will be receiving.

Member's Signature _____ Date _____

(or)

Member Representative Signature _____

Relationship to Member _____ Date _____