

REVOCATION OF AUTHORIZATION

I hereby revoke my previous authorization to the use or disclosure of my personal health information by HMHS. I understand that this revocation will not apply to information that has already been released in response to the previous authorization. I understand that this revocation will not apply to HMHS when the law provides it with the right to contest a claim under my policy.

I hereby revoke the use or disclosure of the below-named beneficiary's personal health information by HMHS, as described below:

- Entire record Problem List Medication List List of Allergies
- Immunization Record Most recent history and physical
- Most recent discharge summary
- Laboratory results from _____ (date) _____ to _____
- X-Ray and/or imaging reports from _____ (date) _____ to _____
- Consultation reports from (please supply doctors' names) _____
- Other (please describe _____)

This information was disclosed to, and used by, the following individuals or organizations:

Name: _____
Address: _____
Name: _____
Address: _____

This information was being disclosed for the following purpose(s): _____

Please print the following information

Beneficiary name: _____ Sponsor ID#: _____
Address: _____ Beneficiary S.S.# _____
Date of birth: _____ Daytime phone: _____
Evening phone: _____

Signature of beneficiary or authorized representative Date: _____

If signed by authorized representative, relationship to beneficiary:
Please return completed form to: Humana Military Healthcare Services, HMHS Privacy Office
P.O. Box 740062, Louisville, Kentucky 40201-7462
Or fax to 877-298-3407

If signed by legal representative, please provide representative documentation as required by state law, i.e. Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers.