PERMISSION TO SPEAK TO HUMANA – CARESOURCE®
ON MY BEHALF

(AUTHORIZED REPRESENTATIVE) – *For members age 18 and older*

This form lets you pick a person ("authorized representative") to speak to Humana – CareSource for you. Once the form is filled out, please send it to the Humana – CareSource Privacy Officer by mail to Humana – CareSource, PO Box 8738, Dayton, OH 45401-8738 or fax to 937-425-0907.

Member Name: _____ Member Address: _____

Member City, State, Zip Code: _____

Member Phone: _____ Member ID #: _____ Member Date of Birth: _____

I allow _____ to speak to Humana – CareSource on my behalf.
Member's Authorized Representative

This consent (check one): ☐ ends on _____.

☐ has no end date.

By signing my name, I agree:

I know that Humana – CareSource may share data about my health with my Authorized Representative. I know that my Authorized Representative may share my data with others. This data may not be protected by federal or state law.

I know that this form is not a Health Care Power of Attorney. This form does not let anyone make choices about my health care treatment, services or procedures. I do not have a Healthcare Power of Attorney or Guardianship established for someone to make these choices.

I know that I can change my mind at any time by sending something in writing. This written letter should be sent to: Privacy Officer, Humana – CareSource, PO Box 8738, Dayton, OH 45401-8738.

Email: hipaaprivacyofficer@caresource.com. Fax: 937-425-0907.

_____
Member Signature

_____
Member Printed Name

_____
Date