

# Consent for release of protected health information (PHI)

## Member information (person whose information will be released):

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First Middle Last Month Day Year  
Address: \_\_\_\_\_  
Street City State ZIP  
Member ID: \_\_\_\_\_ Group # (if applicable): \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Home  Cell\*

## I understand that this authorization will allow Humana and its affiliates to use or disclose the protected health\*\* information described below: (Please check only **one** box)

- Full Disclosure: Any protected health information Humana and its affiliates maintains, including mental health, HIV, health status or substance use or disorder records. This also includes sharing information on mail-order pharmacy, wellness products, and health programs with the person being authorized.
- Limited Disclosure: You specify what PHI to share. Ex. condition or treatment information, a specific date range, or product type. Unless you limit by product type, information will apply to all products and services. \_\_\_\_\_

If Limited Disclosure was selected please indicate which product(s) apply:

- Medical and/or Prescription coverage  Vision  Dental  Humana Pharmacy (mail delivery)  Go365

This information may be disclosed to, and used by, the following person or organization (such as nursing home, care provider, and care managers) to assist me with the Humana-owned products or services for which I am providing consent to disclose information:

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First Middle Last *Required Field* Month Day Year  
Or if organization: \_\_\_\_\_  
Name  
Address: \_\_\_\_\_  
Street City State ZIP  
Email: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Home  Cell\*  
Relationship:  Spouse  Sibling  Parent  Child  Agent/Broker  Friend  Organization

I understand:

·I am not required to fill out this consent and Humana cannot base decisions regarding treatment, payment, enrollment or eligibility for benefits on whether I submit it.

·Disclosures may include information from past, present, and/or future treating providers.

·This consent is valid until I cancel my Humana membership. For customers in the following states, CA, CT, GA, IL, MA, MD, MT, NC, NJ, NV, OH, OR, PR, VA consents will expire in compliance with applicable state laws.\*\*\* I can cancel my consent at any time through my MyHumana account, by calling customer service, or by submitting a written notice to Humana.

·If I cancel consent, it will not apply to any information previously released with this authorization. Once information is shared, Humana cannot prevent the person or organization who has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.

Member or Legal Representative signature \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Member  Legal Representative

**Please note: Legal representatives must attach copies of authorization as required by law. Examples include healthcare power of attorney, healthcare surrogate, living will or guardianship papers.**

After you complete and sign the form, please fax it to **1-800-633-8188**. OR If you prefer, mail your completed form to: **Humana Insurance Company, P.O. Box 14168, Lexington, KY 40512-4168**

\* By giving your cell phone number, you give Humana permission to make calls to your cell

\*\* Health includes Medical, Dental, Pharmacy, Behavioral Health, Vision, Long-Term Care

\*\*\* Expires in 12 months: CA, CT, GA, IL, MA, MD, NC, NJ, NV, OH, OR

Expires in 24 months: MT, VA & Puerto Rico

For Humana Use Only

GNHJ5Y5EN 1221

Humana will follow the more stringent of all federal and state laws and regulations.

**Humana**  
Healthy Horizons<sup>SM</sup>  
in Florida

**ENGLISH:** This information is available for free in other languages and formats. Please contact our Customer Service number at **800-477-6931**. If you use **TTY**, call **711**, Monday – Friday, 8 a.m. to 8 p.m.

**SPANISH:** Esta información está disponible gratuitamente en otros idiomas y formatos. Comuníquese con nuestro Servicio al Cliente llamando al **800-477-6931**. Si usa un **TTY**, marque **711**. El horario de atención es de lunes a viernes de 8 a.m. a 8 p.m.

**CREOLE:** Enfòmasyon sa a disponib gratis nan lòt lang ak fòma. Tanpri kontakte nimewo Sèvis Kliyan nou an nan **800-477-6931**. Si ou itilize **TTY**, rele **711**, Lendi - Vandredi, 8 a.m. a 8 p.m.

**FRENCH:** Ces informations sont disponibles gratuitement dans d'autres langues et formats. N'hésitez pas à contacter notre service client au **800-477-6931**. Si vous utilisez un appareil de télétype (**TTY**), appelez le **711** du lundi au vendredi, de 8h00 à 20h00.

**ITALIAN:** Queste informazioni sono disponibili gratuitamente in altre lingue e formati. La preghiamo di contattare il servizio clienti al numero **800-477-6931**. Se utilizza una telescrivente (**TTY**), chiami il numero **711** dal lunedì al venerdì tra le 8 e le 20:00.

**RUSSIAN:** Данную информацию можно получить бесплатно на других языках и в форматах. Для этого обратитесь в отдел обслуживания клиентов по номеру **800-477-6931**. Если Вы пользователь **TTY**, звоните по номеру **711** с понедельника по пятницу, с 8.00 до 20.00.

## Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **800-477-6931 (TTY: 711)**. We are available Monday through Friday, from 8 a.m. to 8 p.m. Eastern time. We can help you at no cost to you. We can explain the document in English or in your first language. We can also help you if you need help seeing or hearing. Please refer to your Member Handbook regarding your rights.

## Important!

### At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:  
**Discrimination Grievances**, P.O. Box 14618, Lexington, KY 40512-4618  
If you need help filing a grievance, call **800-477-6931** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the  
**U.S. Department of Health and Human Services, Office for Civil Rights**  
electronically through their Complaint Portal, available at  
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

### Auxiliary aids and services, free of charge, are available to you. **800-477-6931 (TTY: 711)**

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

**Humana Healthy Horizons in Florida is a Medicaid product of Humana Medical Plan, Inc.**

**English: ATTENTION:** If you do not speak English, language assistance services, free of charge, are available to you. Call **800-477-6931 (TTY: 711)**.

**Español: (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **800-477-6931 (TTY: 711)**.

**Kreyòl Ayisyen: (French Creole): ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **800-477-6931 (TTY: 711)**.

**Tiếng Việt: (Vietnamese) CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **800-477-6931 (TTY: 711)**.