Consent for Release of Protected Health Information (PHI)

☐ Medicare ☐ Medicaid ☐ Commercial

Member information (person whose information will be released):

Your 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 Access Behavioral Health and their respective affiliates to use or disclose the protected healthinformation described below:** (More than one box may apply)

☐ Any and all protected health information Humana and its affiliates maintain, including mental health, HIV, health status or substance use disorders. This also includes information on health programs, plan information and caregiver resources with the person being authorized. ***

☐ Specifically protected or privileged categories of information that I have initialed below:

- ☐ HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
- ☐ Substance Use Disorders Protected by Federal Confidentiality Rules 42 CFR Part 2
  (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2).
- ☐ Psychiatric Records or information
- ☐ Sexually Transmitted Diseases (STDS)

☐ Confidential Details of:

- ☐ Other professional services by a licensed psychologist
- ☐ Records related to diagnosis/or treatment of Hepatitis
- ☐ Domestic Violence Victim's Counseling Records
- ☐ Social Work Counseling/Therapy___Genetic Counseling/records
- ☐ Sexual Assault Evidence Collection Kit/Sexual Assault Counseling

☐ Protected health information about treatment for the following condition or injury, or other information (include dates):

____

I authorize Access Behavioral Health, ILS, the case management Clinician(s), my Behavioral Health Providers, my PCP, and Humana to disclose my protected health information to Access Behavioral Health, ILS, the case management Clinician(s), my Behavioral Health Providers, PCP, and Humana and other members of my care team for purposes of Case Management. My care team, to whom my information may be released, consists of:

PROVIDER	NAME	ADDRESS	PHONE
Primary Care Physician (PCP)			
Behavioral Health Provider			
Access Behavioral Health (Care Management Clinicians)			
ILS (Care Management Clinicians)			
Other			

This information is being disclosed to allow the person(s) named above to assist me with my Humana plan, including but not limited to participation in disease management programs or care management programs directed at my medical and/or mental health conditions.
I understand I have the right to revoke this authorization at any time by sending written revocation to Humana. I understand the revocation will not apply to information that has been released in response to this authorization. I understand the revocation will not apply to Humana when the law provides the right for Humana to contest a claim under my policy. Unless otherwise revoked or earlier date is specified, this authorization will automatically expire ***2 years*** after the date of my signature below or upon the end of my participation in the disease management program, whichever is sooner.

Expiration Date:__________/_________/___________

I understand I do not have to sign this authorization and that Humana cannot base treatment or payment decisions on whether I sign this authorization. I understand that the purpose of this disclosure is to allow for case management of my condition, including the coordination of my care with various providers listed herein. I understand that after the information is disclosed pursuant to this authorization, it can be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

Member or Legal Representative Signature:______________________Date:_____/____/_____Time:_________

Relationship to Member: ☐ Member ☐ Legal Representative

Witness' Signature:____Date:_____/____/_____Time:________________

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

After you complete and sign the form, please email it to:

abhbhreferral@bhcpns.org or fax it to 1-850-469-3661. If you prefer, mail your completed form to: Access Behavioral Health, 1221 West Lakeview Avenue, Pensacola, FL 32501

Please make a copy of this release for your records or you may request a copy be made for you.

Humana.com

* By giving your cell phone number, you give Humana permission to make calls to your cell
** Health includes Medical, Dental, Pharmacy, Behavioral Health, Vison, Long-Term Care *** Includes web access when available Humana will follow the more stringent of all federal and state laws and regulations. For Humana Use Only

GCHJXJBEN 5.17