Consent for Release of Protected Health Information (PHI)

☐ Medicare ☐ Medicaid ☐ Commercial

Member information (person whose information will be released):

You name: _____ Date of birth: ____/____/____
First Middle Last Month Day Year

Address: _____
Street City State ZIP

Member ID: _____ Group number (if applicable): _____

Phone number: _____ ☐ Home ☐ Cell*

I understand that this authorization will allow Humana and Carelon Behavioral Health and their respective affiliates to use or disclose the protected health information 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 Carelon Behavioral Health, ILS, the case management Clinician(s), my Behavioral Health Providers, my PCP, and Humana to disclose my protected health information to Carelon Behavioral Health, ILS, the case management Clinician(s), my Behavioral Health Providers, PCP, and Humana and other members of my care team for purpose of Case Management. My care team, to whom my information may be released, consists of:

Primary Care Physician (PCP)	
Name:	Phone number:
Address:	

Behavioral Health Provider	
Name:	Phone number:
Address:	

Carelon Behavioral Health (Care Management Clinicians)	
Name:	Phone number:
Address:	

ILS (Care Management Clinicians)	
Name:	Phone number:
Address:	

Other	
Name:	Phone number:
Address:	

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 l 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: _____ ☐ a.m. ☐ p.m.

Relationship to member: ☐ Member ☐ Legal representative

Witness' signature: _____

Date: ____/____/____ Time: _____ ☐ a.m. ☐ p.m.

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:

For Illinois Plan Members: **BeaconILConsultation@beaconhealthoptions.com** or fax it to **855-371-9232**, lf you prefer, mail your completed form to: **Carelon Behavioral Health**, 9250 W Flagler Street, Suite 600, Miami, FL 33174

For Florida Plan Members: **Beacon_CM@beaconhealthoptions.com** or fax it to **800-370-1116**. If you prefer, mail your completed form to: **Carelon Behavioral Health**, 9250 W Flagler Street, Suite 600, Miami, FL 33174

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

Humana Healthy Horizons®

* 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 willfollow the more stringent of all federal and state laws and regulations. For Humana Use Only.

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'autre 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 Kreyòle 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)**.