

# 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 Beacon Health Options 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 Beacon Health Options, ILS, the case management Clinician(s), my Behavioral Health Providers, my PCP, and Humana to disclose my protected health information to Beacon, 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			
Beacon Health Options (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:

*For Illinois Plan Members:* [BeaconILConsultation@beaconhealthoptions.com](mailto:BeaconILConsultation@beaconhealthoptions.com) or fax it to 1-855-371-9232, If you prefer, mail your completed form to: Beacon Health Options, 2311 22nd Street, Suite 101, Oak Brook, IL 60523

*For Virginia Plan Members:* [BeaconVAConsultation@beaconhealthoptions.com](mailto:BeaconVAConsultation@beaconhealthoptions.com) or fax it to 1-855-765-9705, If you prefer, mail your completed form to: Beacon Health Options, 10200 Sunset Drive, Miami, FL 33173

*For Florida Plan Members:* [BeaconFLConsultation@beaconhealthoptions.com](mailto:BeaconFLConsultation@beaconhealthoptions.com) or fax it to 1-800-370-1116. If you prefer, mail your completed form to: Beacon Health Options, 10200 Sunset Drive, Miami FL 33173

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



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\* 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 \*\*\* Includes web access when available Humana will follow the more stringent of all federal and state laws and regulations. For Humana Use Only

This information is available for free in other languages and formats. Please contact our Customer Service number at 1-800-477-6931. If you use TTY, call 711, Monday – Friday, 8 a.m. to 8 p.m.

Esta información está disponible gratuitamente en otros idiomas y formatos. Comuníquese con nuestro Servicio al Cliente llamando al 1-800-477-6931. Si usa un TTY, marque 711. El horario de atención es de lunes a viernes de 8 a.m. a 8 p.m.

Enfòmasyon sa a disponib gratis nan lòt lang ak fòma. Tanpri kontakte nimewo Sèvis Kliyan nou an nan 1-800-477-6931. Si ou itilize TTY, rele 711, Lendi - Vandredi, 8 a.m. a 8 p.m.

Ces informations sont disponibles gratuitement dans d'autres langues et formats. N'hésitez pas à contacter notre service client au 1-800-477-6931. Si vous utilisez un appareil de télétype (TTY), appelez le 711 du lundi au vendredi, de 8h00 à 20h00.

Queste informazioni sono disponibili gratuitamente in altre lingue e formati. La preghiamo di contattare il servizio clienti al numero 1-800-477-6931. Se utilizza una telescrivente (TTY), chiami il numero 711 dal lunedì al venerdì tra le 8 e le 20:00.

Данную информацию можно получить бесплатно на других языках и в форматах. Для этого

обратитесь в отдел обслуживания клиентов по номеру 1-800-477-6931. Если Вы пользователь ТТУ, звоните по номеру 711 с понедельника по пятницу, с 8.00 до 20.00.

## **Discrimination is Against the Law**

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 1-800-477-6931 [TTY 711].

If you believe that Humana Inc. or its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

### **Discrimination Grievances**

P.O. Box 14618  
Lexington, KY 40512 – 4618  
1-800-477-6931 or if you use a TTY, call 711.

You can file a grievance by mail or phone. If you need help filing a grievance, Customer Service is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

### **U.S. Department of Health and Human Services**

200 Independence Avenue, SW  
Room 509F, HHH Building Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)  
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

# Multi-Language Interpreter Services

**English:** ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-477-6931 (TTY : 711) .

**Español (Spanish):** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-477-6931 (TTY : 711).

**Kreyòl Ayisyen (French Creole):** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-477-6931 (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 1-800-477-6931 (TTY : 711).

**Português (Portuguese):** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-477-6931 (TTY : 711).

**繁體中文 (Chinese):** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-477-6931 (TTY : 711)。

**Français (French):** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-477-6931(ATS : 711).

**Tagalog (Tagalog – Filipino):** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-477-6931(TTY : 711).

**Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-477-6931(телетайп: 711).

**العربية (Arabic):**

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-477-6931 (رقم هاتف الصم والبك: 711).

**Italiano (Italian):** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-477-6931(TTY: 711).

**Deutsch (German):** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-477-6931(TTY: 711).

**한국어 (Korean):** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-477-6931(TTY: 711) 번으로 전화해 주십시오.

**Polski (Polish):** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-477-6931(TTY: 711).

**ગુજરાતી (Gujarati):** સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-477-6931 (TTY: 711).

**ภาษาไทย (Thai):** เรียงน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-477-6931 (TTY: 711).

**Diné Bizaad (Navajo):** Díí baa akó nínízin: Díí saad bee yánílti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-477-6931(TTY: 711).