# Consent for release of protected health information

Member infor	<b>mation</b> (person v	whose information	will be released):			
Name:				Date of birth:	/	/
	First	Middle	Last	Mor	ith 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<sup>†</sup> information (PHI) 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, e.g., 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 □ Centerwell 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:	ame:				Date of birth:				
	First	Ν	1iddle	Last		Required Fie	eld Month	Day	Year
Or if organization:									
5					Name				
Address:									
	Street		City			State		ZIP	
Email:	nail: Phone #:								
							🖵 Home	Cell*	
Relationship: 🛛	Spouse	Sibling	🛛 Parent	🛛 Child	🛛 Ager	nt/Broker	Friend	🛛 Organ	ization

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.<sup>‡</sup> 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 **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

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

## 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 877-320-1235 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.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

#### Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (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.

#### Language assistance services, free of charge, are available to you. 877-320-1235 (TTY: 711)

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística. **繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。

**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí. 한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis. **Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique. **Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer. **Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis. **Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti. **Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

(Farsi) فارسی

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

**Diné Bizaad (Navajo):** Wódahí béésh bee hani'í bee wolta'ígíí bich'íí hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé niká'adoowoł.

(Arabic) العربية

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك