Consent for release of protected health information (PHI)

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Member information (person whose information will be released):									
Name:	First	Mido		Last	Da1	te of birth:	//		/ Year
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Address:	Street			ìtv		State		7TP	
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Member 1b			<i>э</i> чр # (п чр	plicable)		FIIOHE #.	☐ Hor	ne	☐ 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	l/or Prescript	ion coverage	☐ Vision	Dental	CenterWell Ph	narmacy (ma	il delivery) 🖵	Go:	365
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:									
Or if organizat					req	juli eu i letu	MONITH	uy	rear
Or if organization:Name									
Address:									
Address:Street			City			State ZIP			
Email:				Pł	none #:				
						☐ Hon	ne 🗖 Cell*		
Relationship:	☐ Spouse	□ Sibling	☐ Parent	☐ Child	☐ Agent/Broke	r 🛭 Friend	🗖 Organi	zatio	n
I understand:									
·I am not requ or eligibility fo	ired to fill ou r benefits on	t this consent whether I sul	and Humo omit it.	ana cannot	oase decisions re	egarding trea	tment, paym	nent,	enrollment
·Disclosures m	ay include in	formation fro	m past, pre	esent, and/a	or future treating	providers.			
MD, MT, NC, N.	I, NV, OH, OR	PR, VA conse	nts will exp	oire in comp	or customers in liance with appli g customer servi	cable state la	ıws.*** I can	can	cel my
·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 Le	gal Represen	tative signatu	re				Date:		/
		ıal Represento							

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
- $\hbox{** Health includes Medical, Dental, Pharmacy, Behavioral Health, Vision, Long-Term Care}\\$
- *** Expires in 12 months: CA, CT, GA, IL, MA, MD, NC, NJ, NV, OH, OR Expires in 24 months: MT, VA & Puerto Rico

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, marital status or religion. 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 the number on your ID card 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, 1-800-368-1019,
 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: 1-800-927-HELP (4357), to file a grievance.

Auxiliary aids and services, free of charge, are available to you. Call the number on your ID card (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. Call the number on your ID card (TTY: 711)

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711)... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación (TTY: 711)... 注意:如果 您使用繁體中文,您可以免費獲得語言援助服務。請致電會員卡上的電話號碼 (TTY: 711)... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị (TTY: 711)... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 (TTY: 711)... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card (TTY: 711)... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении (телетайп: 711)... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou (TTY: 711)... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre (ATS: 711)...UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej (TTY: 711)... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação (TTY: 711)... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa (TTY: 711)... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet (TTY: 711)... 注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。 お手持ちの ID カードに記載されている電話番号までご連絡ください (TTY: 711)...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره تلفن روی کارت شناسایی تان تماس بگیرید (**TTY: 711)...**

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éi ná hóló, námboo ninaaltsoos yézhí, bee néé ho'dólzin bikáá'ígíí bee hólne' (TTY: 711)...

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك (TTY: 711)·

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