Medicaid sensitive protected health information (PHI) provider consent

This form is to allow information sharing between Humana Healthy Horizons® and your treating providers. Your personal health information will be used for care management, disease management and care coordination activities in support of your healthcare needs. The content we will share with your providers will include assessments and plans of care as required by your state Medicaid plan during your participation in Humana Healthy Horizons.

Member information (person whose information will be released)		
Name (First/Middle/Last)	Date of birth (MM/DD/YYYY)	
Address		
City	State	ZIP
Medicaid ID	Group number (if applicable)	
Phone number ☐ Home ☐ Cell*		

I understand that this authorization will allow Humana Healthy Horizons to use or disclose my protected health† information as indicated below: (Select Full or Limited Disclosure)

☐ Full Disclosure: Any protected health information Humana Healthy Horizons and its affiliates maintain, including mental health, HIV, sexually transmitted diseases, or substance use disorder records. This also includes sharing information on mail-order pharmacy, wellness products, and health program participation with the provider(s) being authorized.‡

☐ Limited Disclosure: Non-restricted health information AND the categories of items selected below will be shared. This also includes sharing information on mail-order pharmacy, wellness products, and health program participation with the provider(s) being authorized.‡

When limited disclosure is selected, please initial additional categories to be shared below:

___ Sexually transmitted diseases (STDs) including HIV status

___ Substance use disorders diagnoses and treatment

___ Information about abortion procedures

* By giving your cell phone number, you give Humana permission to make calls to your cell.
† Health includes medical, dental, pharmacy, behavioral health, vision and long-term care.
‡ This also includes web access when available. Humana Healthy Horizons will follow the most stringent of all federal and state laws and regulations.

Consent for release of PHI—continued

I authorize Humana Healthy Horizons to disclose and share my protected health information with the members of my care team listed below in compliance with federal and state law.

Provider	Name	Address	Phone
Primary medical provider (PMP)/group			
Behavioral health provider(s)/group			
Behavioral health provider(s)/group			
Other (note specialty)			
Other (note specialty)			
Other (note specialty)			

- I understand I have the right to revoke this authorization at any time by sending written revocation to Humana Healthy Horizons.
- I understand the revocation will not apply to information shared in response to this authorization.
- I understand the revocation will not apply to Humana Healthy Horizons when the law provides the right for Humana Healthy Horizons to contest a claim under my policy.
- Unless otherwise revoked, this authorization will automatically expire 12 months after the date of my signature below or upon my disenrollment from Humana Healthy Horizons.
- I understand I do not have to sign this authorization and that Humana Healthy Horizons cannot base treatment, payment, enrollment or eligibility decisions on whether I sign this authorization.
- 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 personal representative signature	
☐ Member ☐ Personal representative	Date (MM/DD/YY)

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

After you complete and sign the form, please provide this to your Humana Care Management Team to document your preferences as indicated above or mail it back to us in the enclosed envelope.