Consent for release of protected health information

This form will allow us to share certain health information about you with a family member or other trusted person. Only complete this form if you want to authorize Humana Healthy Horizons® to share your information with someone other than you.

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 and its affiliate to use or disclose the protected health† information (PHI) described below: (Please check only **one** box)

☐ Full disclosure: Any PHI Humana and its affiliate maintain, 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/or prescription coverage
☐ Vision
☐ Dental
☐ Go365®

Humana Healthy Horizons® in Indiana

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For Humana use only.

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

Consent for release of PHI—continued

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 (First/Middle/Last)		Date of birth (required) (MM/DD/YYYY)	
Name (if organization)			
Address	City	State	ZIP
Email		Phone number ☐ Home ☐ Cell*	
Relationship ☐ Spouse ☐ Sibling ☐ Parent ☐ Child ☐ Agent/broker ☐ Friend ☐ Organization			

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. 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 personal representative signature	
☐ Member ☐ Personal representative	Date (MM/DD/YYYY)
Relationship (of personal representative) to member	

Please note: If applicable, 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 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.