Consent for Release of Protected Health Information (PHI)

☐ Medicare ☐ Medicaid ☐ Commercial

Member information (person whose information will be released):

You name: _____ Date of birth: ____/____/____
First Middle Last Month Day Year

Address: _____
Street City State ZIP

Member ID: _____ Group number (if applicable): _____

Phone number: _____ ☐ Home ☐ Cell*

I understand that this authorization will allow Humana and Carelon Behavioral Health 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 Carelon Behavioral Health, ILS, the case management Clinician(s), my Behavioral Health Providers, my PCP, and Humana to disclose my protected health information to Carelon Behavioral Health, ILS, the case management Clinician(s), my Behavioral Health Providers, PCP, and Humana and other members of my care team for purpose of Case Management. My care team, to whom my information may be released, consists of:

Primary Care Physician (PCP)	
Name:	Phone number:
Address:	

Behavioral Health Provider	
Name:	Phone number:
Address:	

Carelon Behavioral Health (Care Management Clinicians)	
Name:	Phone number:
Address:	

ILS (Care Management Clinicians)	
Name:	Phone number:
Address:	

Other	
Name:	Phone number:
Address:	

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 l 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: _____ ☐ a.m. ☐ p.m.

Relationship to member: ☐ Member ☐ Legal representative

Witness' signature: _____

Date: ____/____/____ Time: _____ ☐ a.m. ☐ p.m.

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** or fax it to **855-371-9232**, lf you prefer, mail your completed form to: **Carelon Behavioral Health**, 9250 W Flagler Street, Suite 600, Miami, FL 33174

For Florida Plan Members: **Beacon_M@beaconhealthoptions.com** or fax it to **800-370-1116**. If you prefer, mail your completed form to: **Carelon Behavioral Health**, 9250 W Flagler Street, Suite 600, Miami, FL 33174

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

Humana Healthy Horizons®

* By giving your cell phone number, you give Humana permission to make calls to your cell

** Health includes Medical, Dental, Pharmacy, Behavioral Health, Vison, Long-Term Care

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

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services.

Humana Inc. provides free language assistance services to people whose primary language is not English, people with disabilities or who need reasonable modifications or free auxiliary aids and services to communicate effectively with us. These services include qualified interpreters including sign language and written information in other languages and formats (large print, audio, accessible electronic formats, other formats).

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **800-477-6931 (TTY: 711)**, Monday through Friday, from 8 a.m. to 8 p.m., Eastern time. If you believe that Humana, Inc. has not provided these services or you feel you have experienced discrimination, you can file a grievance in person or by mail, or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **800-477-6931 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a 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, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**.

Auxiliary aids and services, free of charge, are available to you. **800-477-6931 (TTY: 711)**, Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern time.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

French Creole (Haitian Creole): Kreyòl Ayisyen (French Creole) Rele nimewo ki e dike anwo a pou resevwa sèvis éd gratis nan lang.

This notice is available at **Humana.com/FloridaAccessibility**.

Humana Healthy Horizons in Florida is a Medicaid product of Humana Medical Plan, Inc.

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Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Italiano (Italian): Chiamare il numero sopra indicato per ricevere servizi di assistenza linguistica gratuiti.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

Português (Portuguese): Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, należy zadzwonić pod wyżej podany numer.

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.

ภาษาไทย (Thai): โทรไปที่หมายเลขด้านบนเพื่อรับบริการช่วยเหลือด้านภาษาฟรี