Consent for release of protected health information (PHI)

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
Member 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 described below: (Please check only **one** box)

☐ Full disclosure: Any PHI Humana and its affiliate 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, for example: 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®

Humana Healthy Horizons®

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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 and 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 legal representative signature	
☐ Member ☐ Legal representative	Date (MM/DD/YY)

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 make a copy then mail your completed form to: Humana Insurance Company, P.O. Box 14168, Lexington, KY 40512-4168.

<Call If You Need Us>

<If you have questions or need help reading or understanding this document, call us at **855-223-9868 (TTY: 711)**. We are available Monday through Friday, from 7 a.m. to 7 p.m., Central time. We can help you at no cost to you. We can explain the document in English or in your first language. We can also help you if you need help seeing or hearing. Please refer to your Member Handbook regarding your rights.>

<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 **855-223-9868** 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**.>

<Auxiliary aids and services, free of charge, are available to you. **855-223-9868 (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.>

Humana Healthy Horizons in Oklahoma is a Medicaid product of Humana Wisconsin Health Organization Insurance Corporation.

<Language assistance services, free of charge, are available to you.
855-223-9868 (TTY: 711)>

<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.

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

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。

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

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

ةيبرعلا (Arabic) ةيبرعلااتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

မြန်မာနိုင်ငံ (Burmese) အခမဲ့ ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ ရယူရန် အထက်ပါ ဖုန်းနံပါတ်ကို ခေါ်ဆိုပါ။

Hmoob (Hmong) Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.

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

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

ພາສາລາວ (Lao): ໂທຫາເບີໂທລະສັບຂ້າງເທິງ ເພື່ອຮັບບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ.

ภาษาไทย (Thai): โทรไปที่หมายเลขด้านบนเพื่อรับบริการช่วยเหลือด้านภาษาฟรี

اُردُو (Urdu) مفت لسانی اعانت کی خدمات موصول کرنے کے لیے درج بالا نمبر پر کال کریں۔

tsalagi gawonihisdi (Cherokee) ᏫᏴᏓᏏ ᎾᏍᎩ ᏕᏗᏔᏗᏟ ᏗᏎᏍᏓ ᎾᎢ ᎠᏎᏯ ᏕᏅᏂᎯᏍᏗ ᎤᎾᏓᏍᏕᎸᏗ ᎢᏳᎾᏓᏛᏗᏓᎢ.

فارسی (Farsi) .دیریگب سامت قوف هر امش اب ناگیار تروصب ینابز تلایهست تفایرد یارب <

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