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
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 (PHI) 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. 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 Louisiana

Continued on back side →

For Humana use only.

LAHLLGXEN

* 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 protected 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)
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, 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.

Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **1-800-448-3810 (TTY: 711)**. We are available Monday through Friday, from 7 a.m. to 7 p.m. 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 **1-800-448-3810** 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, 1-800-537-7697 (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. **1-800-448-3810 (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 Louisiana is a Medicaid Product of Humana Benefit Plan of Louisiana, Inc.

Language assistance services, free of charge, are available to you.

1-800-448-3810 (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.

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

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。

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

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

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

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

ພາສາລາວ (Lao): ໂທຫາເບີໂທລະສັບຂ້າງເທິງ ເພື່ອຮັບບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

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

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

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

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

ภาษาไทย (Thai): โทรไปที่หมายเลขด้านบนเพื่อรับบริการช่วยเหลือด้านภาษาฟรี