# 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: _____ 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 its affiliates to use or disclose the protected health information described below:** (Please check only **one** box)

☐ Full disclosure: Any protected health information (PHI) Humana and its affiliates 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 protected health information 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 ☐ Prescription ☐ Vision ☐ Dental
☐ Go365 for Humana Healthy Horizons®

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

Or if organization: _____
Name

Address: _____
Street City State ZIP

Email: _____ Phone: _____ ☐ Home ☐ Cell*

Relationship: ☐ Spouse ☐ Sibling ☐ Parent ☐ Child ☐ Agent/Broker ☐ Friend ☐ Organization



**Continued on back.**

# Consent for release of PHI—continued

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. For customers in the following states, CA, CT, GA, IL, MA, MD, MT, NC, NJ, NV, OH, OR, PR, VA, consents will expire in compliance with applicable state laws.† 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: _____ / _____ / _____

**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 mail it back to us in the enclosed postage paid envelope.**

Humana
Healthy Horizons®
in Kentucky

*By giving your cell phone number, you give Humana permission to make calls to your cell.
† Expires in 12 months: CA, CT, GA, IL, MA, MD, NC, NJ, NV, OH, OR
Expires in 24 months: MT, VA and Puerto Rico

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

Auxiliary aids and services, free of charge, are available to you. **800-444-9137 (TTY: 711)**, Monday through Friday, from 7:00 a.m. to 7:00 p.m., Eastern time.

Humana Inc. and its subsidiaries comply with Section 1557 by providing free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

**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.

**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。

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

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

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

**Srpsko-hrvatski (Serbo-Croatian):** Nazovite gore navedeni broj ako želite besplatne usluge jezične pomoći.

**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。

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

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

**Deitsch (Pennsylvania Dutch):** Ruf die Nummer owwe fer koschdefrei Hilf in dei eegni Schprooch.

**नेपाली (Nepali):** निःशुल्क भाषासम्बन्धी सहयोग सेवाहरू प्राप्त गर्नका लागि माथिको नम्बरमा फोन गर्नुहोस् ।

**Oroomiffa (Oromo):** Tajaajila gargaarsa afaan argachuudhaf bilbila armaan oli irratti bilbilaa.

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

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

**Ikirundi (Bantu – Kirundi):** Hamagara izo numero ziri hejuru uronswe ubufasha kwa gusa bw'uwugusobanurira mu rurimi wumva.

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

Humana Healthy Horizons in Kentucky is a Medicaid Product of Humana Health Plan Inc.

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