Consent for release of medical information

Patient Name _____ SSN _____

Address _____

_____

Birth Date _____ Telephone Number _____

I authorize _____

to release copies of my medical records to _____

A. I authorize release of information for: (refer to Sections C and D)

_____ Medical Care (e.g., Physician, etc.)

_____ Personal Use

_____ Other _____ (Attorney, Insurance, Employer, etc.) _____

B. I am transferring from medical office # _____ to # _____ (refer to Sections C and D)

C. I authorize release of my (refer to Section D, if applicable)

_____ Entire medical record

OR

_____ Medical records for the specific treatment dates from _____ to _____

D. I authorize release of the following portions of my medical record (Write your initials beside each area to be included in release)

_____ Mental Health

_____ HIV/AIDS

_____ Substance Abuse

_____ Communicable Disease

Humana
Healthy Horizons™
in Ohio

I understand that:

- This authorization shall be in effect for 180 days following the date of signature
- This authorization may be revoked at any time by giving oral or written notice to the medical office
- A photocopy of this authorization shall constitute a valid authorization
- Once my records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies

I hereby release from any and all liability which may arise as a result of my authorized release of these records:

- Humana Inc., its subsidiaries and affiliates, and
- My medical office

It is with my consent that a copy of these records will be submitted to the agency or medical professional for review when making a final determination, should my case require review by:

- A governing agency, or
- Another medical professional actively involved in my care

_____ _____

Patient (or legal representative) Date

_____ _____

Relationship to Patient Witness

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