

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. However, I understand that 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. I understand that 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 Humana Inc., its subsidiaries and affiliates, and my medical office from any and all liability which may arise as a result of my authorized release of these records.

Should my case require review by a governing agency or another medical professional actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical professional for his review.

Patient (or legal representative) signature

Date

Print name

Relationship to Patient

Witness:

Witness Signature

Date

Print name

To help you understand this notice, language assistance, interpretation services, and auxiliary aids and services are available at no cost to you. Services include, but are not limited to: oral translation, written translation and auxiliary aids. You can request these by calling **877-856-5702 (TTY: 711)**, Monday through Friday, 7 a.m. to 8 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.

Українська (Ukrainian): Зателефонуйте за вказаним вище номером для отримання безкоштовної мовної підтримки.

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

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

Soomaali (Somali): Wac lambarka kore si aad u hesho adeegyada caawimaada luuqada oo bilaash ah.

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

Kiswahili (Swahili): Piga simu kwa nambari iliyo hapo juu ili upate huduma za usaidizi wa lugha bila malipo.

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

Kinyarwanda (Burundi): Hamagara nomero yatanzwe haruguru kugira ngo uhabwe serivisi z'ubufasha bw'indimi ku buntu.

O'zbekcha (Uzbek): Til yuzasidan bepul yordam olish uchun yuqoridagi raqamga qo'ng'iroq qiling.

پشتو (Pashtu): د وړيا ژبې ملاتړ ترلاسه کولو لپاره پورته شميرې ته زنگ ووهئ.

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

ትግርኛ (Tigrinya):- ነፃ ናይ ቋንቋ ሓገዝ ኣገልግሎት ንምርካብ በዚ ኣብ ላዕሊ ዘሎ ቁፅሪ ይደውሉ።

دری (Dari): برای دریافت خدمات رایگان کمک زبانی با شماره بالا تماس بگیرید.

This notice is available at [Humana.com/OhioDocuments](https://www.humana.com/OhioDocuments).

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OHHMQVPEN_0725_Approved