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 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 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.

Describe limitation: _____

_____

If Limited Disclosure was selected, please indicate which product(s) apply:

☐ Medical and/or prescription coverage
☐ Vision
☐ Dental
☐ Gainwell Pharmacy
☐ Go365®

Humana Healthy Horizons® in Ohio

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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/YYYY)

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 Healthy Horizons, P.O. Box 14225, Lexington, KY 40512-9995. Please use the enclosed postage-paid envelope.