

Consent for release of protected health information (PHI)

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 <input type="checkbox"/> Home <input type="checkbox"/> Cell*		
Complete the following only if the person making the request is not the member		
Name of requestor		Relationship to member
Address		
Legal authority	Phone number <input type="checkbox"/> Home <input type="checkbox"/> Cell*	

I understand that this authorization will allow Humana and its affiliates to use or disclose the protected health[†] information (PHI) described below: (Please check only **one** box)

- Full Disclosure:** Any PHI Humana and its affiliates maintain, including sensitive health information as listed below. This also includes sharing information on prescription drug/medication data, wellness products, and health programs with the person being authorized.
- Excluded Sensitive Health Disclosures:** All protected information identified above except for the categories selected below. If no items are checked, all information will be selected. Please check all that apply:
 - Behavioral or mental health
 - Infectious diseases
 - Substance use disorder, subject to 42 CFR Part 2
 - Sexually transmitted disease/HIV/AIDS
 - Genetic data
 - Reproductive health
- Limited Disclosure:** You specify what PHI to share, e.g., 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**
- Dental**
- Go365 for Humana Healthy Horizons[®]**
- Vision**
- Prescription drug/medication data**

Consent for release of PHI—continued

This information may be disclosed to, and used by, the following person or organization 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)	
Or organization name (such as nursing home, care provider or care manager)			
Address	City	State	ZIP
Email		Phone number <input type="checkbox"/> Home <input type="checkbox"/> Cell*	
Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Agent/Broker <input type="checkbox"/> Friend <input type="checkbox"/> 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. For customers in certain states, 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	
<input type="checkbox"/> Member <input type="checkbox"/> 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 fax it to 800-633-8188. Or, if you prefer, mail your completed form to: Humana Healthy Horizons, P.O. Box 14225, Lexington, KY 40512-9995.

* By giving your cell phone number, you give Humana permission to make calls related to this authorization to your cell.
† Health includes Medical, Dental, Pharmacy, Behavioral Health, Vision, Long-Term Care.
‡ Expires in 12 months: CA, CT, GA, IL, MA, MD, NC, NJ, NV, OH, OR. Expires in 24 months: FL, KY, MT, VA & Puerto Rico.
Humana will follow the more stringent of all federal and state laws and regulations.

Humana Healthy Horizons® in Ohio

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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).

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

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