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 inf	formation will be	released)		
Name (First/Middle/Last)		Date of birth (MM/DD/YYYY)		
Address				
City		State	ZIP	
Member ID	Group num (if applicabl			
Phone number □ Home □ Cell*				
I understand that this authorization wil protected health† information described □ Full Disclosure: Any PHI Humana and it status or substance use or disorder rec pharmacy, wellness products and heal	d below: (Please ests affiliates main also in	check only o i tain, includin icludes shari	ne box) g mental health, HIV, health ng information on mail-order	
Limited Disclosure: You specify what Plinformation, a specific date range, or pwill apply to all products and services.	HI to share, for e	xample: cond	dition or treatment	
Describe limitation:				
If Limited Disclosure was selected, plea	ase indicate whic	ch product(s)	apply:	
	ision ental		□ Gainwell Pharmacy □ Go365®	
Humana Healthy Horizons, in Ohio		Continued on back side →		
			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		
			none 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/YY	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.

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): नि:शुल्क 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.

Oʻzbekcha (Uzbek): Til yuzasidan bepul yordam olish uchun yuqoridagi raqamga qoʻngʻiroq qiling.

پشتو (Pashtu): د وړيا ژبې ملاتړ ترلاسه کولو لپاره پورته شميری ته زنګ 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**.

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

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