Consent for release of protected health information

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.

Enrollee information (person whose information will be released):

Name: _____ Date of birth: ____/____/____
First Middle Last Month Day Year

Address: _____
Street City State ZIP

Member ID: _____ Group number (If applicable): _____

Phone number: _____ ☐ Home ☐ Cell*

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

☐ Full disclosure: Any protected health information 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 protected health information (PHI) to share. Ex. 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.

If limited disclosure was selected, please indicate which product(s) apply:

☐ Medical and/or prescription coverage ☐ Vision ☐ Dental
☐ Go365 for Humana Healthy Horizons®

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: _____ Date of birth: ____/____/____
First Middle Last Month Day Year

Or if organization: _____
Name

Address: _____
Street City State ZIP

Email: _____ Phone: _____ ☐ Home ☐ Cell*

Relationship: ☐ Spouse ☐ Sibling ☐ Parent ☐ Child ☐ Agent/Broker ☐ Friend ☐ Organization

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Consent for release of PHI—continued

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 the following states, CA, CT, GA, IL, MA, MD, MT, NC, NJ, NV, OH, OR, PR, VA, 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 Insurance Company, P.O. Box 14168, Lexington, KY 40512-4168.
- 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.

Enrollee or legal representative signature: _____

☐ Enrollee ☐ Legal representative Date: _____/_____/_____

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 mail it back to us in the enclosed postage-paid envelope. Or, if you prefer, fax your completed form to 800-633-8188.

* 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.
‡ Expires in 12 months: CA, CT, GA, IL, MA, MD, NC, NJ, NV, OH, OR
Expires in 24 months: MT, VA and Puerto Rico

Humana will follow the more stringent of all federal and state laws and regulations.