## 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.

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Fi	rst	Middle	Last		Month Day	y Year
Address:						
	Stre	eet	City	State	ZIP	
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Phone number:	one number:			□ Home □ Cell*		
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Humana Healthy Horizons. in Florida

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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	<u>.</u>
□ 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.

## Humana Healthy Horizons in Florida

- \*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.