

Consent for release of protected health information (PHI)

This form is used to authorize consent for Humana to communicate PHI to the person or organization below.

Member 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 # (if applicable): _____ Phone #: _____
 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 maintains, including mental health, HIV, health status or substance abuse 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. 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
 Vision Dental RightSource (becomes Humana Pharmacy in June 2015) HumanaVitality

This information may be disclosed to, and used by, the following person or organization (such as nursing home or care provider) 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

I understand:

·My consent will expire in 24 months unless I cancel it before that time. I can cancel my consent through my MyHumana account 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.

·I am not required to sign this consent and Humana cannot base decisions regarding treatment or payment on whether I sign it.

Member or Legal Representative signature _____ Date: ____ / ____ / ____

Member Legal Representative

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 **1-800-633-8188**. **OR** If you prefer, mail your completed form to: **Humana Insurance Company, P.O. Box 14168, Lexington, KY 40512-4168**

Humana®

* By giving your cell phone number, you give Humana permission to make calls to your cell

** Health includes Medical, Dental, Pharmacy, Behavioral Health, Vision, Long-Term Care

*** Includes web access when available

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