

Consent for release of protected health information (PHI)

Medicare Medicaid Commercial

Member information (person whose information will be released):

Your 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)

- Any and all protected health information Humana and its affiliates maintains, including mental health, HIV, health status or substance abuse records. This also includes information on health programs, plan information and caregiver resources with the person being authorized.***
- Protected health information about treatment for the following condition or injury, or other information (include dates):

This information can be disclosed to, and used by, the following people or organization:

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

Address: _____ Email: _____

City: _____ State: _____ ZIP code: _____ Phone #: _____
 Home Cell*

Relationship: Spouse Sibling Parent Child Agent/Broker Friend Organization

This information is being disclosed to allow the person named above to assist me with my Humana plan.

I understand I have the right to revoke this authorization at any time by sending written revocation to Humana.

I understand the revocation will not apply to information that has been released in response to this authorization.

I understand the revocation will not apply to Humana when the law provides the right for Humana to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 24 months.

I understand I do not have to sign this authorization and that Humana cannot base treatment or payment decisions on whether I sign this authorization. I understand that after the information is disclosed pursuant to this authorization, it can be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

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[®]

Humana.com



* 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.

For Humana Use Only