Consent for Release *of Protected Health Information*

Member information (person whose information will be released): ❑ **Medicare** ❑ **Commercial**

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

Address: _____
Street City State ZIP code

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 maintain, 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, organization or caregiver:

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

Address: _____ E-mail: _____

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 that he/she may receive communications from Humana tailored to my specific conditions or health needs, to help manage my health and wellness. 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

* By giving your cell phone number, you give Humana permission to call your cell
** Health includes Medical, Dental, Pharmacy, Behavioral Health, Vision, Long-Term Care
*** Includes web access when available

Humana®

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