Consent for Release of *Protected Health Information*

Member information (person whose information will be released):

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

Address: _____
Street City State Phone

Member ID: _____ Group # (if applicable): _____ ZIP code: _____

I understand that this authorization will allow Humana and its affiliates to use or disclose the protected health* information described below:

- ❑ Any and all protected health information Humana and its affiliates maintains, including mental health, HIV, or substance abuse records. Cross out any item you do not authorize for release.
- ❑ Protected health information about treatment for the following condition or injury:

  _____
- ❑ Other. Please specify and include dates: _____

Note: It does not apply to information stored on our Website.

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

Name: _____ Date of birth: ____/____/____ Relationship: _____

Address: _____ E-mail: _____

City: _____ State: _____ ZIP code: _____ Phone _____

Name: _____ Date of birth: ____/____/____ Relationship: _____

Address: _____ E-mail: _____

City: _____ State: _____ ZIP code: _____ Phone _____

This information is being disclosed to allow the person(s) 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: _____

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 **1-888-556-2128. OR**
If you prefer, mail your completed form to: Humana Insurance Company, P.O. Box 14601, Lexington, KY 40512-4601

* Health includes Medical, Dental, Pharmacy and Behavioral Health
Humana will follow the more stringent of all federal and state laws and regulations.

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Guidance when you need it most

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