Medicaid sensitive protected health information (PHI) provider consent

This form is to allow information sharing between Humana Healthy Horizons® in Ohio and your treating providers. Your personal health information will be used for care management, disease management and care coordination activities in support of your healthcare needs. The content we will share with your providers will include assessments and plans of care as required by your state Medicaid plan during your participation in Humana Healthy Horizons.

Member information (person whose information will be released)		
Name (First/Middle/Last)	Date of birth (MM/DD/YYYY)	
Address		
City	State	ZIP
Member ID	Group number (if applicable)	
Phone number ☐ Home ☐ Cell*		

I understand that this authorization will allow Humana Healthy Horizons to use or disclose my protected health† information as indicated below: (Select Full or Limited Disclosure)

☐ Full Disclosure: Any protected health information Humana Healthy Horizons and its affiliates maintains, including mental health, HIV, sexually transmitted diseases, or substance use disorder records. This also includes sharing information on mail-order pharmacy, wellness products, and health program participation with the provider(s) being authorized.‡

☐ Limited Disclosure: Non-restricted health information AND the categories of items selected below will be shared. This also includes sharing information on mail-order pharmacy, wellness products, and health program participation with the provider(s) being authorized.‡

When limited disclosure is selected, please initial additional categories to be shared below:

___ Sexually transmitted diseases (STDs) including HIV status

___ Substance use disorders diagnoses and treatment

___ Information about abortion procedures

* 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.
‡ This also ncludes web access when available. Humana Healthy Horizons will follow the most stringent of all federal and state laws and regulations.

Consent for release of PHI—continued

I authorize Humana Healthy Horizons to disclose and share my protected health information with the members of my care team listed below in compliance with federal and state law.

Provider	Name	Address	Phone
Primary care physician (PCP)/group			
Behavioral health provider(s)/group			
Behavioral health provider(s)/group			
Other (note specialty)			
Other (note specialty)			
Other (note specialty)			

- I understand I have the right to revoke this authorization at any time by sending written revocation to Humana Healthy Horizons.
- I understand the revocation will not apply to information shared in response to this authorization.
- I understand the revocation will not apply to Humana Healthy Horizons when the law provides the right for Humana Healthy Horizons to contest a claim under my policy.
- Unless otherwise revoked, this authorization will automatically expire 12 months after the date of my signature below or upon my disenrollment from Humana Healthy Horizons.
- I understand I do not have to sign this authorization and that Humana Healthy Horizons cannot base treatment, payment, enrollment or eligibility decisions on whether I sign this authorization.
- I understand that after the information is disclosed pursuant to this authorization, it can be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

Member or Legal representative signature	
☐ Member ☐ Legal representative	Date (MM/DD/YY)

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 provide this to your Humana Care Management Team to document your preferences as indicated above or mail it back to us in the enclosed envelope.

Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **877-856-5702 (TTY: 711)**. We are available Monday through Friday, from 7 a.m. to 8 p.m., Eastern Time. We can help you at no cost to you. We can explain the document in English or in your preferred language. We can also help you if you need help seeing or hearing. Please refer to your Member Handbook regarding your rights.

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **877-856-5702** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the:
  - **Ohio Department of Medicaid (ODM), Office of Civil Rights** by emailing **ODM_EEO_EmployeeRelations@medicaid.ohio.gov**, faxing **614-644-1434**, or mailing to P.O. Box 182709, Columbus, Ohio 43218-2709; or
  - **U.S. Department of Health and Human Services**, **Office for Civil Rights** electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you. **877-856-5702 (TTY: 711)**

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Humana Healthy Horizons in Ohio is a Medicaid Product of Humana Health Plan of Ohio, Inc.

Language assistance services, free of charge, are available to you.

877-856-5702 (TTY: 711)

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

नेपाली (Nepali): नि:शुल्क भाषासम्बन्धी सहयोग सेवाहरू प्राप्त गर्नका लागि माथिको नम्बरमा फोन गर्नुहोस्।

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

Soomaali (Somali): Wac lambarka kore si aad u hesho adeegyada caawimaada luuqada oo bilaash ah.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

Kiswahili (Swahili): Piga simu kwa nambari iliyo hapo juu ili upate huduma za usaidizi wa lugha bila malipo.

Українська (Ukrainian): Зателефонуйте за вказаним вище номером для отримання безкоштовної мовної підтримки.

繁體中文 (Traditional Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Ikinyarwanda (Kinyarwanda): Hamagara nomero iri haruguru uhabwe serivisi z'ubufasha bw'ururimi ku buntu.

简体中文 (Simplified Chinese): 您可以拨打上面的电话号码以获得免费的语言协助服务。

دری (Dari): برای دریافت خدمات رایگان کمک زبانی با شماره بالا تماس بگیرید.

پشتو (Pashto): د وړیا ژبې ملاتړ ترلاسه کولو لپاره پورته شمیرې ته زنګ ووهئ.

አማርኛ (Amharic): ነፃ የቋንቋ ድጋፍ አገልግሎቶችን ለማግኘት ከላይ ባለው ስልክ ቁጥር ይደውሉ።

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કૉલ કરો.