HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Section I: Requestor Name and Information (Member/Insured)			
Last Name	**First Name**	**ID #**	**Date of Birth**
Address	**City**	**State**	**ZIP Code**
Home Phone	**Cell/Other Phone**	**Email**	

Section II: Authorized Person or Entity (Recipient)			
Person/Entity Authorized to Receive PHI		**Relationship**	
Address	**City**	**State**	**ZIP Code**
Phone	**Cell/Other Phone**	**Email**	

Section III: Description and Purpose of PHI to be Used and/or Disclosed

☐ Appeals/Grievances ☐ Claims ☐ Eligibility & Enrollment
☐ Medical Records ☐ Premiums ☐ Other (*Please specify*): _____

Purpose of Authorization:
☐ At request of individual
☐ For the following purpose(s): _____

Section IV: Expiration and Revocation of Authorization (Check One)

☐ Authorization will expire on: ___ / ___ / _____ (MM/DD/YYYY)
☐ Occurrence of the following event: ___ / ___ / _____ (MM/DD/YYYY) - (must relate to the individual or purpose of the use or disclosure)

☐ Please revoke authorization on the following date: ___ / ___ / _____ (MM/DD/YYYY)

Section V: Your Rights

I understand that (please read):

- **This authorization is voluntary. FBHP will not condition enrollment in its health plan, eligibility for benefits, treatment or payment of claims on my signing this authorization.**
- **This authorization allows FBHP to release my individually identifiable health information to the person or entity named in Section II.**
- **I may revoke this authorization at any time by submitting a written request to Farm Bureau Health Plans, P.O. Box 313, Columbia, TN 38402-0313, Attn: Privacy Officer. If I revoke this authorization, it will not affect any action Farm Bureau Health Plans took before receiving my written notice.**
- **Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient named in Section II and no longer protected by HIPAA.**
- **I am entitled and will be provided with a copy of this signed authorization.**

I have carefully read and understand the above and do herein expressly and voluntarily authorize FBHP to use and/or disclose my protected health information to the person or entity authorized in Section II.

_____ _____
Requestor's or Personal Representative's Signature **Date**

If this request is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____
Relationship to Individual: _____

Return completed form to: Farm Bureau Health Plans, Privacy Office, P.O. Box 313, Columbia, TN 38402-0313 or email to privacyforms@fbhp.com