REQUEST FOR AN ACCOUNTING OF DISCLOSURES

SECTION I: INDIVIDUAL INFORMATION

Name:	ID Number:	Date of Birth:
Address:	City, State:	Zip:
Telephone:	Email:	Date of Request:

SECTION II: PLEASE READ THE FOLLOWING AND COMPLETE ALL INFORMATION REQUESTED

You have the right to an accounting of disclosures ("Accounting") of your protected health information ("PHI") made by Farm Bureau Health Plans ("FBHP") or by a business associate of FBHP for up to six (6) years prior to the date of your request (unless a shorter period of time has been requested) and may not include dates prior to April 14, 2003. The Accounting lists disclosures made for any reason other than (a) for purposes of treatment, payment, or health care operations; (b) to the individual or individual's personal representative; (c) for notification of or to persons involved in an individual's health care or payment for health care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting of disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

FBHP may accept or deny your request for an Accounting. If your request is denied, you will be informed in writing of the reason(s) for denial and what you can do if you disagree. You will be notified whether your request has been accepted or denied within sixty (60) days of receipt. FBHP may extend the response time for up to an additional thirty (30) days by notifying you in writing.

I would like to receive my Accounting in the following format:

☐ **Paper (**US Mail): Special mailing instructions: _____

☐ **Electronic (**Email): Secure/encrypted unless instructed otherwise: _____

☐ **Other** (Specify): _____

You are entitled to one Accounting in any 12 month period at no charge. For each additional Accounting made within the same 12 month period, you will be charged a fee of $ _____ for the cost associated with preparation.

SECTION III: INDIVIDUAL'S SIGNATURE

I request an Accounting of my PHI. If this Accounting is requested by any person other than myself or my Personal Representative, I am providing a signed HIPAA authorization.

_____ _____

Signature of Individual or Personal Representative Date

_____ _____ _____

Personal Representative's Name Relationship to Individual Date

FOR FBHP USE *ONLY* – FORWARD TO PRIVACY OFFICE

Date Request Received: _____ **Accounting of Disclosures:** ☐ **Accepted** ☐ **Denied**

Date Accounting Sent: _____ **Reason for Denial:** _____

_____ _____

Signature of FBHP Privacy Office Representative **Date**

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

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