RESTRICTION REQUEST

SECTION I: INDIVIDUAL REQUESTING RESTRICTION

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

SECTION II: PLEASE READ THE FOLLOWING

You have the right to request Farm Bureau Health Plans restrict the use or disclosure of your protected health information for treatment, payment, or health care operations or to persons involved in your care or payment for that care**. We are not required to agree to any request to restrict the use and disclosure of protected health information.** If we agree to a restriction, our agreement will be in writing. However, we may use or disclose restricted information for emergency treatment if the restricted information is needed to provide emergency treatment, or when the use or disclosure without your written permission is required by law.

You may end the restriction at any time by notifying us orally or in writing. We may end our agreement to restrict use or disclosure of your protected health information at any time by notifying you in writing. If you agree with our decision to end the restriction, your protected health information will no longer be subject to the restriction. If you disagree, our termination of the restriction will apply only to your protected health information that we created or received after we gave you our notice terminating the restriction.

Please state your request for restriction to be applied to your protected health information:

_____

_____

SECTION III: INDIVIDUAL'S SIGNATURE

I request that Farm Bureau Health Plans restrict the use or disclosure of my protected health information as specified in Section II above. I understand that you are under no obligation to agree to my request, and that there will be no agreement unless you inform me in writing that you agree to my request.

Signature: _____ Date: _____

If this request is by a Personal Representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

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