RIGHT TO ACCESS REQUEST

SECTION I: INDIVIDUAL INFORMATION (REQUESTOR)

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

You have the right to access, inspect, and/or obtain a copy of your protected health information ("PHI") that Farm Bureau Health Plans ("FBHP"), or its business associates maintain in designated records sets pursuant to HIPAA Right of Access regulations. I understand those records do not include any psychotherapy notes FBHP may have, any information compiled by FBHP in anticipation of or for use in any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvement Amendments of 1988 (42 U.S.C.§ 263a), and certain other records. In certain circumstances, FBHP may deny a request. If denied, I understand I will be notified in writing with an explanation and description of steps I may take in response to the denial.

Inspect and/or obtain records? ☐ Inspect records ☐ Obtain copies of records Cost to copy per page $_____

Please specify the records you wish to inspect or obtain copies of: _____

SECTION II: INDIVIDUAL/PERSONAL REPRESENTATIVE (PHI RECIPIENT)

Recipient:	Email:
Address:	City, State, Zip:
Telephone:	Fax:

SECTION III: FORMAT SELECTION

I understand FBHP will make reasonable attempts to produce the PHI in the format requested; however, if not readily reproducible in that format, I understand FBHP will contact me to discuss an alternative delivery option. I would like to receive my records by:

☐ **Paper (**US Mail): Special mailing instructions: _____
Standard mailing fee for US Mail is $6.50. Additional postage fees may apply for expedited or special shipping.

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

☐ **Other** (Specify): _____

SECTION IV: INDIVIDUAL'S SIGNATURE

I request access to my PHI. If access is requested by any person other than myself or my Personal Representative, I understand I must provide a signed authorization which can be supplied upon request by contacting the FBHP Privacy Office at (931) 560-0041, ext 3115.

_____ _____
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: _____ **Request to Access: ☐ Accepted ☐ Denied**

Date & Time of Inspection/Records 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