



# Authorization for Release of Protected Health Information (PHI) Medicare Part D Plan

Protected Health Information (PHI) under U.S. law is any information about health status, provision of health care, or payment for health care that is created or collected by a Covered Entity, and can be linked to a specific individual.

By completing and signing this form, I, or my legal representative, authorize Farm Bureau Health Plans to disclose my PHI with the people or companies listed below. By Farm Bureau Health Plans, I also mean the company's subsidiaries, affiliates, employees, agents, and subcontractors. PLEASE COMPLETE ALL SECTIONS.

## THIS AUTHORIZATION IS VOLUNTARY

### 1. Information (Requestor)

|                  |                         |              |                       |                |
|------------------|-------------------------|--------------|-----------------------|----------------|
| First name       |                         | Last name    |                       | Middle initial |
| Member ID number | Birth date (MM/DD/YYYY) | Phone number |                       |                |
| Street           |                         |              | City, state, ZIP code |                |

### 2. Farm Bureau Health Plans can share my PHI with the following people or companies:

|                        |                          |
|------------------------|--------------------------|
| Person or company name | Phone number             |
| Street                 | City, state and ZIP code |
| Person or company name | Phone number             |
| Street                 | City, state and ZIP code |

### 3. Farm Bureau Health Plans will only disclose the personal health information you want disclosed.

Check only one box below:

Any Information

Limited Information (Complete the box below)

Complete only if you want "limited information" disclosed. This authorization cannot be used to share psychotherapy notes. Check all that apply:

Health Plan Benefit Information

Claims

Eligibility/Enrollment

Premium Payments

Other (please explain) \_\_\_\_\_

4. By signing this form I authorize Farm Bureau Health Plans to disclose information below for the following purpose.

|  |  |
|--|--|
| Check one of the following options: _____                    |  |
| <input type="checkbox"/> At my request – no specific purpose | <input type="checkbox"/> Specific purpose: _____ |

5. This form will be valid indefinitely unless a shorter time period is listed below.

|   |            |
|---|------------|
| My authorization is valid from _____ to _____ |            |
| MM/DD/YYYY                                    | MM/DD/YYYY |

6. By signing below, I understand and agree:

- Information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by HIPAA.
- I can get a copy of this authorization form that I have signed by sending Farm Bureau Health Plans a signed request using the address at the bottom of this form.
- I understand that this authorization is voluntary and that Farm Bureau Health Plans may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on signing this authorization.
- Right to Revoke: I understand that 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. I understand that revocation of this authorization will not affect any action the above named Entity took in reliance on this authorization before the revocation was received.

7. My signature or my legal representative's signature

|   |      |
|---|------|
| Signature   | Date |
| Print name  |      |
| If a legal representative signed this form, describe their relationship: (parent, legal guardian, Power of Attorney, conservator) |      |

If this request is being signed by the member's legal representative, you must provide legal documentation authorizing you to act on the member's behalf (e.g., legal guardianship, power of attorney, conservatorship).

If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete. Please sign and return this completed form to:

Farm Bureau Health Plans  
P.O. Box 313  
Columbia, TN 38402-0313  
Or you can email it to: [privacyforms@fbhp.com](mailto:privacyforms@fbhp.com)

Farm Bureau Health Plans complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator  
P.O. Box 1801, Columbia, TN 38402-1801  
Phone: 1-844-223-3451, TTY/TDD 711 Fax: 1-931-388-8326  
Email: [civilrights@fbhealthplans.com](mailto:civilrights@fbhealthplans.com)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights 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, or at 1-800-368-1019, 800-537-7697 (TDD).

Farm Bureau Health Plans is a Medicare Part D Plan with a Medicare contract. Enrollment in Farm Bureau Health Plans depends on contract renewal.