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 Members Health Insurance Company to disclose my PHI with the people or companies listed below. By Members Health Insurance Company, 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. Members Health Insurance Company 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. Members Health Insurance Company 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
☐ Premium Payments
☐ Other (please explain) _____

4. By signing this form I authorize Members Health Insurance Company to disclose information below for the following purpose.

Check one of the following options:

☐ At my request – no specific purpose ☐ 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 Members Health Insurance Company a signed request using the address at the bottom of this form.
- I understand that this authorization is voluntary and that Members Health Insurance Company 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 Members Health Insurance Company, 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:

Members Health Insurance Company
P.O. Box 313
Columbia, TN 38402-0313
Or you can email it to: privacyforms@fbhp.com

Members Health Insurance Company 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

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).

Members Health Insurance Company is a Medicare Part D Plan with a Medicare contract. Enrollment in Members Health Insurance Company depends on contract renewal.