BlueCross BlueShield of Illinois

Request to Access Protected Health Information (PHI)

By law an individual has the right to inspect and obtain a copy of his or her PHI in the Designated Records Set(s) that Blue Cross and Blue Shield of Illinois or its Business Associates maintain, as well as to request this information. **If you need assistance completing the form, please contact the Customer Service number listed on the back of your Member Identification Card.**

WHEN COMPLETED AND SIGNED PLEASE MAIL TO: **Blue Cross and Blue Shield of Illinois**
P.O. Box 805106
Chicago, IL 60680-4112

NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.

Section A: The individual for whom access is being requested. Please complete the following:

Name _____ Group # _____ Identification\Subscriber # _____

Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ ZIP _____

Area Code & Telephone Number _____

Section B: Please place an "X" in the box next to the records you wish to inspect or obtain a copy of and indicate specific dates:

Enrollment Records	From:	To:	Health Records	From:	To:
☐ Application/Underwriting/Attending Physician Statement Record			☐ Medical		
			☐ Dental		
☐ Premium Payment/Billing History (if applicable)			☐ Prescription Drugs		
			☐ Vision		
			☐ Mental Health		

This Request CANNOT be used to disclose Psychotherapy Notes.

Section C: By placing an "X" in the appropriate boxes below please indicate who and in which format/manner you wish to receive/review your information.

Send my PHI to: (select only one)

☐ Me

☐ Designated Third Party: I request that Blue Cross and Blue Shield of Illinois send my PHI as specified in Section B above directly to the designated third party listed below.

Name Address City State ZIP Phone Number

Format/Manner: (select only one)

☐ Send electronic copy. Note: Information will be sent to the email address provided below via secured (encrypted) email unless otherwise specified. **Email address:**

☐ Send paper copy of information via US Mail.

☐ View in person. I understand that I or my designee will be contacted to arrange for this.

Section D: Signature - This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that Blue Cross and Blue Shield of Illinois provide access to my PHI as specified. I understand that I can only sign on behalf of a minor child under the age of 18, unless there is proof of legal guardianship.

Signature _____ Date: month/day/year _____

Section E: If Section D is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the Legal documents. You do **NOT** have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of Illinois.

Personal Representative's Name _____ Relationship to Individual _____

Personal Representative's Address _____ City _____ State _____ ZIP _____

Personal Representative's Area Code & Telephone Number _____ Personal Representative's E-mail address (if available) _____