BlueCross BlueShield of Tennessee

PERSONAL REPRESENTATIVE REQUEST

Purpose: This form is used for an individual's request to designate another person to access and update their protected health information.

SECTION A: Member's Information

The Member's Information: Insert information about the individual requesting a personal representative.

Member Name: _____ Member ID Number: _____

Member Address: _____ Member Date of Birth: _____

_____ Member Social Security No. (optional): _____

Member Phone Number: _____ Member e-Mail: _____

SECTION B: To the individual—please read the following and complete the information requested.

You have the right to request that we give another person access to your protected health information. You may end this designation at any time by notifying us in writing.

Please specify the information regarding the individual designated to act as your personal representative:

First Name: _____ MI: __ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

DOB: _____ Relationship: _____

INDIVIDUAL'S SIGNATURE.

I request that the person named above be allowed to access my protected health information. I understand that I must notify you in writing to have this person's access removed.

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

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

Please return completed form to:

BlueCross BlueShield of Tennessee
Privacy Office
1 Cameron Hill Circle
Chattanooga TN 37402

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