BlueCross BlueShield
of Oklahoma

Request for Accounting of Protected Health Information (PHI) Disclosures

Use this form to request an accounting of how your Protected Health Information (PHI) was disclosed by Blue Cross and Blue Shield of Oklahoma or its Business Associates. You are entitled to receive one free Disclosure Accounting in a twelve (12) month period. Blue Cross and Blue Shield of Oklahoma may charge a fee to process additional requests received within that period. **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 Oklahoma**
P.O. Box 805106
Chicago, IL 60680-4112

NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.

Section A: The individual for whom an accounting of PHI disclosures 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 ____________ **E-mail address (if available)** ____________

Section B: Please indicate the time period for the disclosure accounting being requested.

From: ____________ **month/day/year** **To:** ____________ **month/day/year**

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

I request that Blue Cross and Blue Shield of Oklahoma provide an accounting of my PHI as specified in Section B above. 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 D: If Section C 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 Oklahoma.

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)** ____________

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