



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 Oklahoma 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 Oklahoma**
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 _____	E-mail address (if available) _____			

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:	Claim Records	From:	To:
<input type="checkbox"/> Application/Underwriting/Attending Physician Statement Record	_____	_____	<input type="checkbox"/> Medical	_____	_____
<input type="checkbox"/> Premium Payment/Billing History (if applicable)	_____	_____	<input type="checkbox"/> Dental	_____	_____
			<input type="checkbox"/> Prescription Drugs	_____	_____
			<input type="checkbox"/> Vision	_____	_____
			<input type="checkbox"/> Mental Health	_____	_____
This Request CANNOT be used to disclose Psychotherapy Notes.					

Section C: By placing an "X" in the appropriate box, please indicate the manner in which you wish to receive/review your information. (Select only one option):
<input type="checkbox"/> Paper copy of information via US Mail. <input type="checkbox"/> Send me an electronic copy, if available. Note: You must provide an email address. <input type="checkbox"/> Allow me to view my records in person. I understand that I 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.		
<p>I request that Blue Cross and Blue Shield of Oklahoma provide access to 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.</p>		
<table style="width: 100%;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">Signature</td> <td style="width: 50%; border-bottom: 1px solid black;">Date: month/day/year</td> </tr> </table>	Signature	Date: month/day/year
Signature	Date: month/day/year	

Section E: If Section D is signed by a Personal Representative, please complete the information below:								
<p>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.</p>								
<table style="width: 100%;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">Personal Representative's Name</td> <td style="width: 50%; border-bottom: 1px solid black;">Relationship to Individual</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Personal Representative's Address</td> <td style="border-bottom: 1px solid black;">City</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Personal Representative's Area Code & Telephone Number</td> <td style="border-bottom: 1px solid black;">State</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Personal Representative's E-mail address (if available)</td> <td style="border-bottom: 1px solid black;">ZIP</td> </tr> </table>	Personal Representative's Name	Relationship to Individual	Personal Representative's Address	City	Personal Representative's Area Code & Telephone Number	State	Personal Representative's E-mail address (if available)	ZIP
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