blue of california

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

You have the right request access to inspect or obtain a copy of your PHI that Blue Shield of California maintains in a Designated Record Set. A **Designated Record Set** is a group of records maintained by or for Blue Shield of California, including enrollment, payment, claims adjudication, case or medical management records or other information we use to make decisions about you. You will be notified in writing whether your request has been granted or denied, including the reasons for any denial.

You are not entitled to inspect or obtain a copy of any psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; or information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988.

Please note that we do not maintain medical records. You should contact your healthcare provider or facility to request copies of, or access to, your medical records.

Individual Requesting Access

Name: _____ Subscriber ID Number: _____

Address: _____

Phone Number: _____ Date of Birth: _____

- **Is this a request to inspect or to receive a copy of records? ☐ Inspect ☐ Copies**
- **In what form would you like to receive copies? ☐ Paper ☐ Electronic (if available)**
- **If electronic copies are available, in what format would you prefer to receive them? (We may not be able to accommodate requests for specific electronic formats, but we will make a reasonable effort to do so.):** _____

I understand that if my request for copies of records is granted I may be required to pay a reasonable, cost-based fee for copying (including the cost of supplies and labor) and/or postage, and that Blue Shield will notify me in advance if a fee is required.

Signature of Individual or Personal Representative:

_____ Date: _____

If this form is signed by someone other than the individual or the parent of a minor child, such as a personal/legal representative or guardian, you must **submit documentation** showing your right to act for or on behalf of the individual with respect to their healthcare/PHI such as a valid HIPAA authorization, healthcare power of attorney, or guardianship papers. **Please also provide the following information:**

Representative's name, address and relationship to the individual for whom this request is being made (print): _____

_____

Return the completed and signed request to:
Blue Shield of California Privacy Office PO Box 272540, Chico, CA 95927-2540