



Request to Access Health Records

Use this form to request a copy of your Protected Health Information (PHI) in a Designated Record Set that Blue Cross and Blue Shield of Illinois or one of its Business Associate maintains. If you need assistance completing the form, contact the Customer Service number listed on your Member Identification Card. You must complete all the fields on this form.

WHEN COMPLETED AND SIGNED PLEASE MAIL TO: Blue Cross and Blue Shield of Illinois
P.O. Box 660044
Dallas, TX 75266-0044
OCA\_SSD@bcbstx.com

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

Form fields for Section A: First Name, Last 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:

Form fields for Section B: Enrollment Records (Application/Underwriting/Attending, Physician Statement Record, Premium Payment/Billing History) and Health Records (Medical, Dental, Prescription Drugs, Vision, Mental Health) with From/To date fields.

This Request CANNOT be used to disclose Psychotherapy Notes or phone records that are not part of the Designated Record Set.

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.

Form fields for Section C: Send my PHI to: (Me, Designated Third Party) and Format/Manner: (Send electronic copy, Send paper copy, View in person).

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

Text for Section D: 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 and Date fields.

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

Text for Section E: 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. Form fields for Personal Representative's Name, Address, Area Code & Telephone Number, Relationship to Individual, City, State, ZIP, and E-mail address.

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the HCSC Privacy Office.