



## REQUEST TO ACCESS HEALTH RECORDS

Use this form to request a copy of your Protected Health Information in a Designated Record Set that Blue Cross and Blue Shield of Montana 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 Montana, PO Box 660044, Dallas, TX 75266-0044

[OCA\\_SSD@bcbstx.com](mailto:OCA_SSD@bcbstx.com)

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

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Group Number \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Identification\Subscriber Number \_\_\_\_\_  
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:

| Enrollment Records                                                                     | From: | To:   | Health 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 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.

Send my PHI to: (select only one)

- ☐ Me
- ☐ Designated Third Party: I request that Blue Cross and Blue Shield of Montana send my PHI as specified in Section B above directly to the designated third party listed below.

Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

Format/Manner: (select only one)

- ☐ Send electronic copy. Note: Information will be sent to the email address provided below via secured (encrypted) email unless otherwise specified.  
Email address: \_\_\_\_\_
- ☐ Send paper copy of information via US Mail.
- ☐ View in person. I understand that I or my designee 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.

I request that Blue Cross and Blue Shield of Montana 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 \_\_\_\_\_ Date: month/day/year \_\_\_\_\_

### Section E If Section D 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 Montana.

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) \_\_\_\_\_

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