



Request For Access To Designated Protected Health Information Records

Use this form to request to inspect or obtain copies of your protected health information in the designated record set that we or our business associates, maintain.

Please provide the following information:

Name			Daytime phone number
Address			
City	State	ZIP code	Enrollee ID

You have the right to inspect or obtain a copy of protected health information in your designated record (except certain limited information, including: copies of psychotherapy notes, information we have compiled in anticipation of, or for use in a, civil, criminal or administrative action or proceeding, and certain other records). Elements in the designated record may include: eligibility, enrollment, payment, claims, appeals and case or medical management records. Unless you indicate otherwise, we will provide a summary of the records.

1. I am requesting:

- A summary of all records maintained in the designated record set:

From: _____
 Month Year

To: _____
 Month Year

- Specific records:

2. Does this request include information about services received at a Blue Care Network Health Center? Yes No

3. The manner in which you prefer to access your records:

- Paper copies mailed to: _____
 Name of recipient
- _____
 Street address
- _____
 City, state, ZIP code

- In person. I would like to review the records in person at a location designated by Blue Cross Blue Shield of Michigan or Blue Care Network.

(Please complete the form on the opposite side)

Electronically. Please select the format to receive your copies:

PDF

Other (please specify): _____

I would like my electronic copies delivered to:

An email address: _____

Name of recipient

Email address of recipient

A postal address: _____

Name of recipient

Street address

City, state and ZIP code

Please send the copies on a: CD-ROM

USB storage device

Other (please specify) _____

4. Please sign and date:

Signature

Date

If you are not the member, please sign and write today's date below, then check the box that describes your relationship to the member. If you are not the parent of a minor member, please attach proof of your relationship to the member. An authorization is required if you are not the personal representative.

Name of personal representative: _____

Signature of personal representative and date: _____

Parent of minor child

Legal guardian

Power of attorney

Executor

Other

Please include the fax number as shown below.

Please mail completed form (and all documentation if needed) to: **Customer Individual Rights Unit
BCBSM
600 East Lafayette, MC 1620
Detroit, MI 48226-2998**

or Fax to: **1-877-348-2210**

Blue Cross Blue Shield of Michigan will make reasonable attempts to produce the designated record in the form and format you have requested. However, in the event that we cannot produce the records in the form and format you have requested, we have the right to contact you to establish a mutually agreeable alternative. We reserve the right to charge a reasonable fee to produce the copies in the form and format you have requested.

