ACCOUNTING OF PHI DISCLOSURES REQUEST

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Purpose: Use this form to ask us who received your information.

Please Read This Notice

You have the right to know about some of the times we released your information. We can look back up to six years.

We will not include releases:

- About your treatment, payment for treatment, or our healthcare operations
- Made to you or to your personal representatives
- Made to your family, close friends, and others involved in your care
- Made for national security reasons
- Made to law enforcement

Member Information

Name:		Date of Birth: 01/01/1965	
Street Address:	City:	State: AZ	ZIP Code:
Phone:	Email:	Member ID:	
Please indicate the time frame for which you are requesting an accounting of PHI. From: To:			

Signature

Signature:	Date:

If you are the personal representative of the Member, complete this:

Representative's Name:	Relationship to Member:
Representative's Signature:	Date:

Note: If you are filling out this form for someone else, attach a copy of any legal paper(s) that apply.

Please send the completed form to us. You can mail it to:

AZ Blue Privacy Office
Mail Stop C300, P.O. Box 13466, Phoenix, AZ 85002-3466

Email: privacy@azblue.com **Fax:** 602-544-5661

For questions, or to request a copy of the signed form, call the Privacy Office at 602-864-2255 or 1-800-232-2345, ext. 2255, TTY: 711.

You can get one free report every 12 months. We will charge you $0.10 per page plus $10 per hour for each additional report you request during the same 12-month period.

1809558-24 LE 41820