REQUEST FOR HEALTH RECORDS

An Independent Licensee of the Blue Cross Blue Shield Association

Purpose: Use this form to view or get copies of your records.

Member Information

Name:		Date of Birth:	
Street Address:	City:	State:	ZIP Code:
Phone:	Email:	Member ID:	

If you want the records mailed to an alternate mailing address, please enter it here:

Alternate Address:	City:	State:	ZIP Code:

Who should we send this information to?

Name:	Relationship to Member:
Phone:	Email:

What records do you want?

☐ Medical Records Date Range: |	☐ Claims Date Range: |	☐ Explanation of Benefits Date Range: |	☐ Enrollment/Application Information Date Range: |
☐ Other	Please Specify:		Date Range: |
How do you want us to send the records? ☐ Mail	☐ Email:	☐ Fax:	

Signature

Requestor's Signature:	Date:

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

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

If you are filling out this form for someone else, tell us why you can get this Member's records. 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, TYY: 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.

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