REQUEST TO RESTRICT HEALTH RECORDS

An Independent Licensee of the Blue Cross Blue Shield Association

Purpose: Use this form to limit who can get your records.

Member Information — The person whose information is being restricted.

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

Tell us what information to restrict:

☐ Claims Date Range: |	☐ Medical Records Date Range: |	☐ Other Please Specify:

Tell us how we should restrict your information:

Signature

Requestor's 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