BLUE Benefit
ADMINISTRATORS OF MASSACHUSETTS
An independent licensee of the Blue Cross and Blue Shield Association.

PHI ACCESS REQUEST

Purpose: This form is used for an individual's request to inspect and obtain a copy of his or her protected health information in a designated record set that we maintain or that our business associates maintain for us.

SECTION A: Individual requesting access.

Name:

Address:

Telephone: E-mail:

Identification Number: Social Security Number:

TO THE INDIVIDUAL: Please read the following and complete the information requested.

You have the right to inspect and obtain a copy of your protected health information in our designated record sets. You are not entitled to inspect or obtain a copy of any psychotherapy notes we may have, any information we may have compiled in anticipation of or for use in a civil, criminal or administrative proceeding, and certain other records. To exercise your right of access, please complete Section B.

SECTION B: Protected health information access requested.

Please specify the records to which you wish to have access:

Do you wish to: ☐ Inspect these records? ☐ Obtain a copy of these records?
We will charge you $____ per page to copy these records.

Would you like us to make the records available to you: ☐ On paper? ☐ Electronically?

Do you want us to: ☐ Prepare a summary or an explanation of these records?
We will charge you $_____ for the summary or explanation.

Do you want us to: ☐ Mail the copies?
We will charge you for the postage.

Please list the name and address of each person, including yourself or your personal representative, for whom you want us to make a copy. If you want us to provide access to or a copy of your records to any person other than you or your personal representative, you must provide us with a signed authorization. We can supply you with an authorization form.

INDIVIDUAL'S SIGNATURE.

Date:

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name:

Relationship to Individual:

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT

Return form to:

BLUE Benefit Administrators of Massachusetts
Attention: HIPAA/Privacy Officer
PO Box 55917, Boston, MA 02205-5917
FAX# 877-596-2583