

Request to Access Health Records

Use this form to request a copy of your Protected Health Information (PHI) in a Designated Record Set that Blue Cross and Blue Shield of Illinois or one of its Business Associate maintains. If you need assistance completing the form, contact the Customer Service number listed on your Member Identification Card. You must complete all the fields on this form.

WHEN COMPLETED AND SIGNED PLEASE MAIL TO: Blue Cross and Blue Shield of Illinois

P.O. Box 660044 Dallas, TX 75266-0044 OCA SSD@bcbstx.com

Section A: The individual for wh	om access is being req	uested. Pleas	e complete the followi	ng:		
First Name	Last Name		Group #	Identifica	Identification\Subscriber #	
Social Security Number	Date of Birth					
Address		City			State	ZIP
Area Code & Telephone Number				0 1	1. 1.	• 60 1 /
Section B: Please place an "X" in						
Enrollment Records	From:	To:	Health Records	Fr	om:	To:
☐ Application/Underwriting/A	ttending	-	☐ Medical			
Physician Statement Record			\square Dental			
☐ Premium Payment/Billing H	istory		☐ Prescription D	rugs		
(if applicable)	-		☐ Vision			
, , ,			☐ Mental Health			
TI. D CANNOT I I.	. Paulou Danak dhaa	NI-4	h		D	
This Request CANNOT be used t						
Section C: By placing an "X" in		below please	indicate who and in w	hich format/m	anner you	i wish to
receive/review your i	ntormation.					
Send my PHI to: (select only one)						
□ Me						
☐ Designated Third Party: I re	quest that Blue Cross a	nd Blue Shield	of Illinois send my PH	II as specified in	Section 1	B above
directly to the designated th			,	1		
Name	Address	City	State	ZIP Phor	e Number	
Format/Manner: (select only one)						
` `		nt to the email	addragg provided below	v via sagurad (a	nammtad)	amail unlass
		int to the eman	address provided belov	w via secured (e	nerypied)	eman umess
otherwise specified. Email						
☐ Send paper copy of informa						
☐ View in person. I understar	d that I or my designee	will be contact	ted to arrange for this.			
Section D: Signature -This docum	ent must be signed by	the individua	l, parent of minor chi	ld or the indivi	idual's Pe	rsonal
Representative.			•			
I request that Blue Cross and Blue Shie	d of Illinois provide acces	ss to my PHI as	specified. I understand th	at I can only sign	on behalf	of a minor child
under the age of 18, unless there is produced		•	•			
Signature			Date: month/day/ye	ear		
Section E: If Section D is signed	y a Personal Represe	ntative, please	e complete the inform	ation below:		
If you are signing as a Power of Attorne					uments.	
You do NOT have to attach copies of the	nese documents if they are	already on file	with Blue Cross and Blue	Shield of Illinois		
Personal Representative's Name		<u> </u>	Relationship to Individual			
Personal Representative's Address		City			State	ZIP
Personal Representative's Area Code & Telephone Number			Personal Representative's E-mail address			

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the HCSC Privacy Office.