

Access Request

Purpose: This form is used to make a request to inspect and/or obtain copies of your protected health information maintained by your insurer or its Business Associates. Please check the insurer whose name appears on your health benefits identification card.

____ CareFirst BlueCross BlueShield* ____ CareFirst BlueChoice ____ Federal Employee Program

Please type or print neatly; we will not process incomplete or illegible forms.

Section A: INDIVIDUAL REQUESTING ACCESS

Last Name: _____ **First Name:** _____ **MI:** _____

If not the Policy Holder, Name of Policy Holder:

Last Name: _____ **First Name:** _____ **MI:** _____

Street Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: (home) _____ **(work)** _____

Member ID#: _____ **Date of Birth:** ____/____/____

Note: This is the number on your health benefits identification card.

Section B: 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 maintained by CareFirst or our Business Associates. You are not, however, 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 any civil, criminal or administrative action or proceeding, any information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a), and certain other records.

Please specify the records you wish to inspect or obtain copies of:

I want a summary or an explanation of these records (As allowed by law, CareFirst may charge you to prepare a summary or explanation.)

- Inspect these records on site
- Pick-up copies of these records from our office
- Have copies mailed to me or to whom I designate (As allowed by law, we may charge you for postage)

Please list the name and address of the person for whom you want us to make copies and provide access to if it is different from above. If this person is not you or your personal representative, you must provide CareFirst with a signed authorization. We will direct you to or provide you with the appropriate authorization form upon request. Please contact member services at the number listed on your benefits card or the CareFirst Privacy Office at 1- 800-853-9236.

Signature: _____ Date: _____

Print Name: _____

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

Personal Representative's Name: _____

Personal Representative's Relationship to Individual: _____

- A copy of my personal representative form or legal document is on file.
- Attached is a copy of my personal representative form or legal document.

Please mail or fax the completed form to:

CareFirst BlueCross BlueShield
Attention: Privacy Office
10455 Mill Run Circle
Owings Mills, MD 21117
Fax: 410-505-6692

Please keep a copy of this request for your records.