

## Accounting of Disclosure Request

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**Purpose:** This form is used to make a request for an accounting of disclosures 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

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

### Section A: INDIVIDUAL REQUESTING DISCLOSURE ACCOUNTING

**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 an accounting of certain disclosures that CareFirst, or our Business Associates, have made of your protected health information starting with disclosures made on or after April 14, 2003 for up to six (6) years prior to the date of your request. You are not entitled to receive an accounting for disclosures that CareFirst, or our Business Associates, made to: carry out your treatment, obtain, or make payment for treatment, for our health care operations. CareFirst does not have to account for disclosures made to you, or to your personal representative, your family, close friends and others involved in your health care, or for disclosures made for national security or intelligence purposes, or to certain law enforcement agencies, or for disclosures made pursuant to an authorization.

You are entitled to a free disclosure accounting once in each 12-month period. If this is not the first disclosure accounting that CareFirst has made to you in this 12-month period, we will charge you for preparing the accounting.

I request an accounting of the disclosures of my protected health information made within the \_\_\_\_\_ months prior the date of this request. I understand that the accounting will not include disclosures made before April 14, 2003, or for any disallowed purpose as explained above. I understand that I am entitled to a free disclosure accounting once in each 12-month period. I understand that I will be charged for this disclosure accounting if I have already received a disclosure accounting from my health plan within the last 12 months, and I agree to pay the charge.

**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: \_\_\_\_\_

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.**