Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

ACCESS TO RECORDS REQUEST

You or your representatives have the right to obtain a copy of your protected health information in certain records ("PHI records") maintained by or for Florida Blue, in accordance with our policies and procedures, and applicable law, including the Health Insurance Portability and Accountability Act. To exercise your right to obtain a copy of your PHI records, please complete each section of this form and mail it to the address indicated below. We will provide you with a response to your request within a reasonable time. Under certain circumstances, we have the right under applicable law to deny or limit your request to access PHI records.

Florida Blue
Business Ethics, Integrity & Compliance Division
P.O. Box 44283
Jacksonville, FL 32203-4283
Fax: 904-997-5586

REQUEST A COPY OF PHI RECORDS FOR:

Name of person for whom PHI records are being requested: _____

Address: _____
Street City State Zip Code

Subscriber Contract or Member number: _____

Date of birth: ____/____/____

Daytime telephone number where we may contact you: _____

Your Name: _____

Your relationship to the person whose records you are requesting:
Self _____ Parent _____ Spouse _____ Other (explain) _____

Please specify the *type of* PHI records for which you wish to obtain a copy:

☐ Claim History (Please note that Florida Blue members can receive up to two years of health insurance claim information by logging into floridablue.com. Please also note that Florida Blue does not have copies of your medical records unless your health care providers submitted this documentation to us along with their health insurance claims. You should request copies of your medical records directly from your health care providers.)

☐ Case Management Information

☐ Other: _____

For the time period from: _____(month/year) to: _____(month/year)

Form of Access Requested: (e.g., paper copy, electronic copy): We will provide you with access to the PHI records in the form or format requested, if it is readily producible by us in such form or format, or if not, in a readable hard copy or electronic form or format as agreed to by Florida Blue and you.

Type of Access Requested: (Please check the appropriate box below which applies.)
PHI records will be sent to one of the options selected below:
☐ I wish to have a copy of the PHI records mailed to:
(Specify name of recipient): _____
(Specify recipient's mailing address):_____
_____

☐ I wish to have a copy of the PHI records e-mailed to:
(Specify name of recipient): _____
(Specify recipient's e-mail address): _____

Note: If you share your PHI records with persons outside of Florida Blue, they may not be subject to state or federal privacy laws restricting its use or disclosure.

Signature: _____ Date: _____

If you wish to obtain a copy of the PHI records for someone other than yourself or your dependent minor child, you must submit to Florida Blue a signed written authorization from the individual giving you permission to do so. Please call us at 1-888-574-2583 if you have any questions. Hearing impaired members may contact us by dialing the Florida Relay Service at 711 via TTY.