Florida Blue

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 or fax it to the address or fax number indicated below. 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:

Member Name: _____

Member Contract Number: _____

Member Date of Birth: _____/_____/_____

Member Address: _____
Street City State Zip Code

Member Phone Number: _____

PHI Records Requested: Please specify the date range for the claims history report:

From:_____ (month/year) To:_____ (month/year)

Florida Blue members can receive up to two years of health insurance claims information by logging into floridablue.com.

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:

Option 1

☐ I wish to have a copy of the PHI Records mailed to:
(Name of recipient): _____
(Recipient's mailing address): _____

Option 2

☐ I wish to have a copy of the PHI Records e-mailed to:
(Name of recipient): _____
(Recipient's e-mail address): _____

If you select the e-mail option, you hereby acknowledge and accept the inherent security risks associated with e-mail transmissions, which can place the PHI Records at risk of being read or accessed by someone other than the intended recipient.

Name of Person Requesting PHI Records: _____

Relationship to the person whose PHI Records you are requesting:
☐ Self ☐ Parent ☐ Spouse ☐ Other (explain) _____

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.

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