Request for List of Disclosures of Protected Health Information

WyoBLUE ADVANTAGE
An independent licensee of the Blue Cross Blue Shield Association

Use this form to request an accounting of disclosures of your protected health information.

Section A: Requesting individual Please complete the following:

Name		Daytime phone number	
Address			
City	State	ZIP	Enrollee ID

Please read and complete the following:
You have the right to an accounting of disclosures we, or our business associates, have made of your protected health information in the six years prior to the date of your request. We are not required to account for disclosures we made before April 14, 2003, or disclosures to you, your personal representative or in accordance with your authorization or informal permission; for treatment, payment and health care operations activities; as part of a limited data set; incidental to an allowable disclosure; or for national security or intelligence purposes; or to law enforcement or correctional institutions regarding persons in lawful custody.

Section B: Dates of disclosures:

Please specify the date range for the accounting of disclosures you are requesting:

From	To

You are entitled to one free disclosure accounting every 12 months upon request. We reserve the right to charge you a reasonable fee for each additional disclosure accounting you request during the same 12-month period.

Section C: Signature:
I request an accounting of all disclosures as specified above. I understand that I am entitled to one free disclosure accounting every 12 months. I agree to pay a reasonable fee for this accounting if I have already received one within the previous 12 months.

_____ _____
Signature *Date*

Section D: Personal representative:
If you are not the patient, please sign and date Section D of this form. Check the box that describes your relationship to the patient. **If you are not the parent, please attach proof of your relationship to the patient (e.g. power of attorney, personal representative, documentation, etc.).**

Print name of personal representative: _____

Signature of personal representative and date: _____

☐ Parent of minor child ☐ Legal guardian ☐ Power of attorney ☐ Executor ☐ Other

Please return this form to:

Customer Individual Rights Unit
600 East Lafayette, MC 1620
Detroit, MI 48226-2998

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