



Request for Accounting of Protected Health Information (PHI) Disclosures

Use this form to request an accounting of how your Protected Health Information (PHI) was disclosed by Blue Cross and Blue Shield of Texas or its Business Associates. Such accounting will not include those disclosures exempted from accounting under the law. You are entitled to receive one free Disclosure Accounting in a twelve (12) month period. Blue Cross and Blue Shield of Texas may charge a fee to process additional requests received within that period. If you need assistance completing the form, please contact the Customer Service number listed on your Member Identification Card. You must complete all the fields on this form.

**WHEN COMPLETED AND SIGNED PLEASE MAIL TO: Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, TX 75266-0044
OCA_SSD@bcbstx.com**

Section A: Please identify below the individual for whom an accounting of PHI disclosures is being requested:				
Name		Group #	Identification\Subscriber #	
Social Security Number	Date of Birth			
Address	City	State	ZIP	
Area Code & Telephone Number	E-mail Address (if available)			

Section B: Please indicate the time period for the disclosure accounting being requested. Note: Time period cannot exceed six (6) years prior to date of request.	
From: _____ month/day/year	To: _____ month/day/year

Section C: Signature: This document must be signed by either the individual, the parent of a minor child or the individual's Personal Representative.	
I request that Blue Cross and Blue Shield of Texas provide an accounting of my PHI as specified in Section B above. I understand that I can only sign on behalf of a minor child under the age of 18, unless there is proof of legal guardianship.	
Signature: _____	Date: month/day/year _____

Section D: If Section C is signed by a Personal Representative, please complete the information below:			
If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the legal documents. You do NOT have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of Texas.			
Personal Representative's Name		Relationship to Individual	
Personal Representative's Address	City	State	ZIP
Personal Representative's Area Code & Telephone Number	Personal Representative's E-mail Address (if available)		

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the HCSC Privacy Office.