



**BlueCross BlueShield  
of Texas**

**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. 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 the back of your Member Identification Card.**

**WHEN COMPLETED AND SIGNED PLEASE MAIL TO: Blue Cross and Blue Shield of Texas  
P.O. Box 805106  
Chicago, IL 60680-4112**

**NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.**

<b>Section A: The individual for whom an accounting of PHI disclosures is being requested. Please complete the following:</b>				
Name _____	Group # _____	Identification\Subscriber # _____		
Social Security Number _____	Date of Birth _____			
Address _____	City _____		State _____	ZIP _____
Area Code & Telephone Number _____		E-mail address (if available) _____		

<b>Section B: Please indicate the time period for the disclosure accounting being requested.</b>	
From: _____ month/day/year	To: _____ month/day/year

<b>Section C: Signature - This document must be signed by the individual, parent of a minor child or the individual's Personal Representative.</b>	
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 _____

<b>Section D: If Section C is signed by a Personal Representative, please complete the information below:</b>			
If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the Legal documents. You do <b>NOT</b> 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) _____	