



DISCLOSURE ACCOUNTING REQUEST

Purpose: This form is used to document an individual's request for an accounting of disclosures of protected health information.

SECTION A: Individual requesting disclosure accounting.

The Member's Information: Insert information about the individual requesting confidential communication.

Member Name: Member ID Number: Member Address: Member Date of Birth: Member Phone Number: Member Social Security No.: Member e-Mail:

SECTION B: To the individual—Please read the following.

You have the right to an accounting of the disclosures we or our business associates have made of your protected health information (a) without your permission (whether informal agreement or signed authorization) as allowed by law, (b) to the Department of Health and Human Services for privacy compliance purposes, or (c) pursuant to an express legal permission we obtained before April 14, 2003.

You are entitled to one free disclosure accounting each 12 months. We will charge you \$\_\_\_\_\_ for each additional disclosure accounting you request during the same 12 month period.

To request a disclosure accounting, please complete the signature block below.

INDIVIDUAL'S SIGNATURE.

I request an accounting of the accountable disclosures of my protected health information made within the 6 years prior the date of this request (except not earlier than your compliance date under the federal privacy rules). I understand that I am entitled to one free disclosure accounting each 12 months. I agree to pay \$\_\_\_\_\_ for this disclosure accounting if I have already received a disclosure accounting from you within the previous 12 months.

Signature: Date:

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name:

Relationship to Individual:

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

Please return completed form to:

BlueCross BlueShield of Tennessee Privacy Office 1 Cameron Hill Circle Chattanooga TN 37402