



**PERSONAL REPRESENTATIVE REQUEST**

Purpose: This form is used for an individual's request to designate another person to access and update their protected health information.

**SECTION A: Member's Information**

**The Member's Information:** Insert information about the individual requesting a personal representative.

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

**SECTION B: To the individual—please read the following and complete the information requested.**

You have the right to request that we give another person access to your protected health information. You may end this designation at any time by notifying us in writing.

Please specify the information regarding the individual designated to act as your personal representative:

First Name: _____	MI: ____	Last Name: _____
Address: _____		
City: _____	State: _____	Zip Code: _____
Phone Number: _____		
DOB: _____	Relationship: _____	

**INDIVIDUAL'S SIGNATURE.**

I request that the person named above be allowed to access my protected health information. I understand that I must notify you in writing to have this person's access removed.

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 RETAIN A COPY OF THIS FORM FOR YOUR RECORDS**

Please return completed form to:

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