HISC

Blue Cross and Blue Shield of New Mexico

Request to Access Protected Health Information (PHI)

By law an individual has the right to inspect and obtain a copy of his or her PHI in the Designated Records Set(s) that Blue Cross and Blue Shield of New Mexico or its Business Associates maintain, as well as to request this information. **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 New Mexico**
P.O. Box 805106
Chicago, IL 60680-4112

NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.

Section A: The individual for whom access is being requested. Please complete the following:

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 place an "X" in the box next to the records you wish to inspect or obtain a copy of and indicate specific dates:

Enrollment Records	From:	To:	Claim Records	From:	To:
☐ Application/Underwriting/Attending Physician Statement Record			☐ Medical		
			☐ Dental		
☐ Premium Payment/Billing History (if applicable)			☐ Prescription Drugs		
			☐ Vision		
			☐ Mental Health		

This Request CANNOT be used to disclose Psychotherapy Notes.

Section C: By placing an "X" in the appropriate box, please indicate the manner in which you wish to receive/review your information. *(Select only one option):*

☐ Paper copy of information via US Mail.

☐ Allow me to view my records in person. I understand that I will be contacted to arrange for this.

Section D: Signature - This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that Blue Cross and Blue Shield of New Mexico provide access to 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 E: If Section D 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 New Mexico.

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) _____

Blue Cross Blue Shield of New Mexico refers to HCSC Insurance Services Company, which is a wholly owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.