CareFirst Community Health Plan Maryland

Request for Accounting of Protected Health Information (PHI)

Please complete this form ONLY if you would like to make a request for an accounting of how CareFirst BlueCross BlueShield Community Health Plan Maryland (CareFirst CHPMD) uses and/or discloses your PHI.

1. REQUEST FOR AN ACCOUNTING OF THE USE/DISCLOSURE OF PHI

I hereby request an accounting of the use/disclosure of Protected Health Information maintained by the CareFirst CHPMD.

MEMBER NAME:_____ **DATE OF BIRTH:** _____

ADDRESS: _____

TELEPHONE:_____ **MEMBER ID NO.:** _____

*** NAME OF PERSON COMPLETING THIS FORM IF DIFFERENT FROM MEMBER:**

_____ _____

Name *Relationship to Member*

** Must be parent of a minor, legal guardian, or authorized HIPAA Appointee of the Member.*

2. PLEASE PROVIDE SOME INFORMATION ON YOUR REQUEST

Please provide the reason for why you are requesting an accounting of the use/disclosure of your PHI:

_____

_____

_____

_____

_____

3. RIGHTS CONCERNING YOUR REQUEST TO RESTRICTIONS ON USE/DISCLSOURE OF YOUR PHI:

a. You have the right to request that CareFirst CHPMD provide an accounting of the uses and/or disclosures of PHI in the records that we keep on your behalf;

b. CareFirst CHPMD reserves the right to deny your request for an accounting of the uses/ disclosures of your PHI - in whole or in part- if: such uses and disclosures are pursuant to our normal payment, treatment or operations obligations.

c. Once the decision to grant or deny your request has been made, you or your authorized representative will receive a notification of the decision.

I understand that I may be charged a reasonable fee for copying the requested records and mailing the records (if requested). I further understand that CareFirst CHPMD may or may not honor my request to provide an accounting of the uses/disclosures of the requested PHI.

*Signed: _____ Date: _____

Signature of Member

*Signature must be that of the Member, authorized parent of a minor, legal guardian, or authorized HIPAA appointee of the member

Send your request to this address so that we can process it timely. Requests sent to persons, offices or addresses other than the address listed above might be delayed.

Director of Compliance
PO Box 915
Owings Mills, MD 21117

You may call us toll free at 410-779-9369 or 1-800-730-8530. TTY users call 711.