



DISCLOSURE ACCOUNTING REQUEST

Use this form to request an accounting of disclosures of your protected health information (PHI).

Please complete the following:

NAME		DAYTIME PHONE NUMBER	
ADDRESS			
CITY	STATE	ZIP	CONTRACT NUMBER

Please read and complete the following:

You have the right to an accounting of disclosures we, or our business associates, have made of your PHI in the six years prior to the date of your request. We are not required to account for disclosures we made before April 14, 2003, or disclosures to you, your personal representative or in accordance with your authorization or informal permission; for treatment, payment and health care operations activities; as part of a limited data set; incidental to an allowable disclosure; or for national security or intelligence purposes; or to law enforcement or correctional institutions regarding persons in lawful custody.

Please specify the date range for the accounting of disclosures you are requesting:

FROM	TO
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You are entitled to one free disclosure accounting every 12 months upon request. We reserve the right to charge you a reasonable fee for each additional disclosure accounting you request during the same 12-month period.

Please sign and date:

I request an accounting of all disclosures as specified above. I understand that I am entitled to one free disclosure accounting every 12 months. I agree to pay a reasonable fee for this accounting if I have already received one within the previous 12 months.

Signature Date

If you are not the member, please sign and write today's date below, then check the box that describes your relationship to the member. If you are not the parent of the member, please attach proof of your relationship to the member.

Please Print Name of Personal Representative: _____

Signature of Personal Representative Date

Parent Legal Guardian Power of Attorney Executor Other _____

**Please mail this request to: Customer Individual Rights Unit, MC 2004
 BCBSM/BCN - P.O. Box 2459
 Detroit, MI 48231-2459**