Individual Request to Inspect Health Information

I request to review health information held about me in Octave Blue Cross and Blue Shield's "Designated Record Set" in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A "Designated Record Set" includes information such as medical records, billing records, enrollment, payment, claims adjudication and health plan case or benefits management record systems used to make decisions about individuals.

The period of service for the Designated Record Set being requested is _____ to _____.
(date in mm/dd/yyyy format) (date in mm/dd/yyyy format)

The records being requested were used by Octave Blue Cross and Blue Shield to make what decision?

☐ Denied, amended, discontinued coverage ☐ General information ☐ Denied claim ☐ Other (specify below)

I understand that Octave Blue Cross and Blue Shield has 30 days to respond to this request, and if someone else holds the information or it is off-site, the response time is 60 days. Octave Blue Cross and Blue Shield may extend the response time up to an additional 30 days if needed, with written notice to me prior to the original response date.

I request that the information be provided in the following format:

☐ Paper ☐ Electronic

However, I understand that depending on the record set involved, it may not be possible to receive the information via electronic methods.

I agree to pay any fees for labor involved in copying my health information, whether in paper or electronic form. Fees will be reasonable and cost-based. Electronic copies not to exceed $40 per hour and costs for physical copies include the cost of copying (.25/page) and postage (actual fees). Any fees will be communicated to me prior to the preparation of the request so that I might agree to and arrange payment of the fees.

I understand that this request does not require release to me of certain health information, including:

(1) information that is not held in the Designated Record Set; (2) psychotherapy notes or substance use disorder treatment notes; (3) information compiled in reasonable anticipation of or for litigation or legal review; and (4) other information not subject to the right to access information under HIPAA.

Name	**Daytime Phone Number**	**Member ID or Social Security number**	
Street or PO box	**City**	**State**	**ZIP**

Do you participate in the Federal Employees Program?

☐ Yes ☐ No

Signature

Date signed (mm/dd/yyyy)

Please return this signed form to:
Octave Blue Cross and Blue Shield
Attn: Customer Service
PO Box 2181
Little Rock, AR 72203