



BlueCross  
BlueShield

FEP Vision®

Request for Access

**Member Information**

*(Please Print)*

This section must be completed with the information specific to the individual. A contact number or address is needed in case additional information or clarification is required.

<b>Date:</b> _____	<b>Member ID:</b> _____
<b>Name:</b> _____	<b>Date of Birth:</b> _____
<b>Address:</b> _____	<b>Telephone:</b> _____
	<b>Email:</b> _____

You have the right to inspect and obtain a copy of your protected health information in designated record sets Blue Cross Blue Shield FEP Vision® or its business associates maintain. You are not, however, entitled to inspect or obtain a copy any information BCBS FEP Vision® may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, any information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a), and certain other records. To exercise your right of access, please complete this Section B below, then mail or fax this request to BCBS FEP Vision® at:

BCBS FEP Vision® – Privacy Office  
P.O. Box 507  
Troy, NY 12181  
Fax: 1-866-999-4640

If you have questions, need additional information or assistance in completing your request, please contact the BCBS FEP Vision® Privacy Office at 1-800-571-3366 or the address shown above.

Please specify the records you wish to inspect or obtain copies of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list the name and address of each person, including yourself or your personal representative, for whom you want us to make copies. If you want us to provide access to or copies of your records to any person other than you or your personal representative, you must provide us with a signed authorization. We can supply you with an authorization form.

_____	_____
_____	_____
_____	_____

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*(Person Requesting Access)*

If this form is signed by a personal representative on behalf of the individual, complete the following:

**Personal Representative's Name:** \_\_\_\_\_  
*(Please Print)*

**Description of Personal Representative Authority:** \_\_\_\_\_

**PLEASE RETAIN A COPY OF THIS REQUEST FOR ACCESS FOR YOUR RECORDS**