REQUEST FOR COPIES OF MEMBER RECORDS

hmsa
An Independent Licensee of the Blue Cross and Blue Shield Association

ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED

PART A: INFORMATION of HMSA MEMBER whose records are being requested

Last Name	First Name		MI
Address	City	State	ZIP Code
Email	Home Telephone # ( )	Cell Phone # ( )	
HMSA Subscriber Number(s) (Located on your membership card)		Birth Date _ _ /_ _ /_ _ _ _	

PART B: REQUEST TYPE (Please check all that apply)

I am requesting copies of the following types of records:

☐ **Enrollment** ☐ **Case Management/Appeals** ☐ **Claims**

☐ **All of the above**

☐ **Other (Please specify)** _____

PART C: RECORD DATES (ALL data fields must be completed)

Please specify the period of time for which you are requesting copies of records (for example, records dating from "02/01/2009 through 05/01/2009").

FROM _ _ /_ _ /_ _ _ _ **THROUGH** _ _ /_ _ /_ _ _ _

PART D: RECORD FORMAT

Please indicate the format you would like to receive the records in:

☐ **Paper** ☐ **Electronic (encrypted CD or DVD)**

PART E: DELIVERY METHOD

☐ **Pick up all my communications at an HMSA office** (Check one)

◯ HMSA Center (Oahu) ◯ Hilo Office ◯ Kona Office ◯ Maui Office ◯ Kauai Office

The records will be available to you for pickup at one of our HMSA Customer Relations offices. You will receive a notification when your records are ready to be picked up, and this notification will provide you with instructions for pick up, and the address and times of operation for our Customer Relations offices. If you or your authorized representative are unable to pick up your copies, then you may authorize another person to do so by completing an authorization form. Please contact HMSA's Customer Relations department to obtain a copy of this form.

☐ **Send via Certified Mail –** HMSA, upon request, will mail your records to the address on your HMSA account.

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PART F: YOUR INDIVIDUAL RIGHTS

I understand that (**please read**):

I have the right to obtain a copy of my protected health information in designated record sets HMSA, or its business associates, maintain. I am not, however, entitled to obtain a copy of any psychotherapy notes HMSA may have; any information HMSA may have compiled in anticipation of or for use in any civil, criminal, or administrative action or proceeding; any information not subject to disclose to me under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a); and certain other records. Upon request, I am entitled to receive a copy of this signed form.

PART G: SIGNATURE

I, (print member's name)_____, have had full opportunity to read and understand the contents of this form.

Member/Authorized Signature: _____ Date: _ _ /_ _ /_ _ _ _

If signed by other than the member or parent of minor child, please print your name below and indicate your relationship. Provide a copy of verification of your legal right (e.g., power of attorney documentation) to make this authorization.

Authorized Representative Name: _____

Relationship to Member: _____

INCOMPLETE FORMS WILL NOT BE PROCESSED
ALL FIELDS ARE REQUIRED UNLESS OTHERWISE SPECIFIED

Please complete, sign, and submit this form to:
HMSA Privacy Office, P.O. Box 860, Honolulu, HI 96808-0860, (fax) 952-7580

(00) 0135-5660 6:16 LE