Form F12: Disclosure Accounting Request

Use this form to exercise your rights under federal privacy laws to request an accounting of disclosures of protected health information made by Blue Cross and Blue Shield of Vermont (BCBSVT) and/or The Vermont Health Plan (TVHP).

Section A: Member requesting disclosure accounting

Member Name: _____ Date of Birth: _____

BCBSVT ID Number: _____

Address: _____

_____

Telephone: _____ E-Mail Address: _____

Section B: Please read the following

You have the right to request an accounting of the disclosures BCBSVT/TVHP or our business associates have made of your protected health information (a) without your permission (whether informal agreement or signed authorization) as allowed by law, or (b) to the Department of Health and Human Services for privacy compliance purposes within the 6 years prior to the date of your request. You are not entitled to an accounting for disclosures we or our business associates (a) made for purposes of your treatment, to obtain or make payment for that treatment, or for health care operations (including certain disclosures for the payment or operations of others), (b) made to you or to your personal representative, (c) made pursuant to your authorization or informal agreement, (d) made as part of a limited data set, (e) made incidental to an allowable disclosure, or (f) for national security or intelligence purposes, or to certain law agencies. To request a disclosure accounting, please complete Section C below.

Section C: Individual's Signature

I request an accounting of the disclosures of my protected health information made within the 6 years prior to the date of this enforcement request (except not earlier than BCBSVT/TVHP's compliance date under the federal privacy rules).

Signature: _____ Date: _____

If you are a personal representative, such as a Legal Guardian or an agent acting under a Power of Attorney, you *may* be able to sign on behalf of the Member if the supporting documentation has the required language. This Form shall be accompanied by such supporting documentation for BCBSVT's Legal Department to determine whether authority is granted to authorize this Form.

Personal Representative's Name: _____

Relationship to Member or Authority to act as Personal Representative: _____

Please keep a copy of this document for your records and send the completed Authorization via mail to Blue Cross and Blue Shield of Vermont, Attn: Customer Service, PO Box 186, Montpelier, VT 05601-0186, fax to (802) 371-3658, or email customerservice@bcbsvt.com.