

REQUEST TO AMEND OR CORRECT PROTECTED HEALTH INFORMATION

Date: _____

Name: _____

I. Request for Amendment or Correction

I hereby request to amend protected health information (“PHI”) about me in a “designated record set” held by one of the following plans sponsored by _____ (the “Employer”) _____ (the “Plans”) in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”).

For purposes of this form, a “*designated record set*” is a group of records maintained by or for the Plans including enrollment, payment, claims adjudication and health plan case or medical management record systems; or records used by or for the Plans to make decisions about individuals. The term “record” means any item, collection or grouping of information that includes protected health information that is maintained, collected, used or disseminated by or for the Plans.

Describe Amendment Requested:

Reason for Requested Amendment:

I understand that if the protected health information was not created by the Plans, the Plans are not required to honor my request. For example, if the information I wish to amend is in a medical report created by my health care provider, I must ask the provider to amend the report. I also understand that if the information is not available for my inspection, is not part of the Plans’ designated record set or is already accurate and complete, I cannot amend the information.

II. Other Important Information

I understand that the Plans will respond to my request within 60 days. If the Plans are unable to take action within the applicable time period, the Plans may extend the time for such action by 30 days, provided the Plans, within the original 60-day time period, gives me a written statement of the reasons for the delay and the date by which it will complete its action on the request.

If the Plans accept the requested amendment, the Plans shall make the appropriate amendment to the PHI or record that is the subject of the request by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment. The Plans shall timely inform me that the amendment is accepted and obtain my identification of relevant persons with which the amendment needs to be shared as provided in HIPAA. The Plans shall make reasonable efforts to inform (a) persons identified by me as having received my PHI and needing amendment, and (b) persons, including business associates (as defined in HIPAA) of the Plans, that the Plans know have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information.

If the request is denied in whole or in part, the Plans will provide me with a written denial

III. Signature of Individual or Individual's Representative

Signature of individual or individual's representative
(Form MUST be completed before signing.)

Date

Printed name of the individual's personal representative:

Relationship to the individual, including authority for status as representative:
