Individual Request for
Amendment of Personal Health Information

Purpose: This form is used for an individual's request to amend protected health information or records in our designated record sets or the designated record sets of our business associates.

SECTION A: Individual requesting disclosure accounting.

Covered Employee's Name: ______________________________ Employee's SSN: ________-________-________

Covered Employee's Employer: ______________________________ Current Phone: ________-________-________

Name of Individual Making Request: ______________________________ Individual's SSN: ________-________-________

Current Address: ____

SECTION B: To the Individual – Please read the following and complete the information requested.

You have the right to request that we amend your protected health information in designated record sets we or our business associates maintain. We may decline your request if the information is not part of these designated record sets, we did not create the information, we believe the information is complete and accurate, or the information is psychotherapy notes, compiled in anticipation of or for use in any civil, criminal or administrative action or proceedings, or not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a). To exercise your right of request for amendment, please complete this Section B.

Please specify the records you wish to amend and the amendments you wish to make: ______________________________

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Please state the reasons for the amendments: ______________________________

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SECTION C: Signatures.

I, ______________________________, have had full opportunity to read and consider the contents of this request. I understand that, by signing this form, I am requesting that my protected health information be amended as previously described.

______________________________ ______________________________
Patient's Printed Name Date

______________________________ ______________________________
Patient's Signature Date

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

______________________________ ______________________________
Patient Representative's Printed Name Date

______________________________ ______________________________
Patient Representative's Signature Date

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Relationship to Individual

Please submit this request to HealthSCOPE Benefits at any of the following addresses:

HIPAA Official
P.O. Box 1224
Little Rock, AR 72203
or

Customer Service – HIPAA
PO Box 16526
Columbus, Ohio 43216
or

Customer Service – HIPAA
PO Box 50440
Indianapolis, IN 46250