American Specialty Health

REQUEST TO AMEND PROTECTED HEALTH INFORMATION (PHI)

Please read this Request to Amend form carefully and fill it out completely. Failure to fully complete all applicable sections of the form may result in the form being returned to you. Responses should be printed in spaces provided using blue or black ink.

RETURN THIS FORM TO:
Attn: Privacy Officer
American Specialty Health
10221 Wateridge Circle, San Diego, CA 92121
Tel: 1-877-427-4766; **Fax:** 1-877-414-2746

MEMBER INFORMATION

Member Name _____ Date of Birth _____
Health Plan Name _____ ID Number _____
Street Address _____
City _____ State _____ ZIP _____
Telephone _____

AMENDMENT REQUEST DETAILS

I hereby request that the PHI for the member listed above be corrected and/or amended as follows: _____

(Attach additional pages if necessary.)

AMENDMENT REASON

Please describe why you want this information corrected and/or amended: _____

(Attach additional pages if necessary.)

- Form continues on Page 2 -

American Specialty Health

REQUEST TO AMEND PROTECTED HEALTH INFORMATION (PHI) [CONTINUED]

ACKNOWLEDGEMENT & SIGNATURE

In signing this form, I understand that:

- American Specialty Health (ASH) will respond within 60 days of receiving this request.
- If ASH approves this request, ASH will make the change to the member's PHI, inform me when the change is completed, and inform others that need to know about the change to the member's PHI.
- ASH may deny this request in writing if the PHI is (1) correct and complete, (2) not created by ASH, (3) not allowed to be disclosed, or (4) not part of our records. If ASH denies this request ASH will provide a written response stating the reason for the denial and explaining the right to file a written statement of disagreement (i.e. a rebuttal) with the denial. If I do not file a rebuttal, I have the right to request that the initial request and the ASH denial be attached to all future disclosures of member's PHI.

Signature _____ **Date of Signature** _____

Printed Name _____

Relationship to Member: ☐ Self ☐ Other (complete the information below)

If this request is being made by an individual other than the member, please complete the information below, describe your authority to make this request on the member's behalf and include copies of supporting documentation

Name _____

Street Address _____

City _____ State _____ ZIP _____

Telephone _____

Description of Representative's Authority to Act/Relationship to Member (choose one):

☐ Member is a minor and I am the member's parent or legal guardian.

☐ Member is deceased and I am the member's surviving spouse or next of kin, the executor/administrator of the member's estate, hold durable power of attorney, or I am otherwise legally authorized to act on behalf of a deceased member or the member's estate (please attach necessary documentation).

☐ I am the member's agent, as designated in the member's Durable Power of Attorney for Health Care (please attach necessary documentation).

☐ Other (please describe and attach necessary documentation): _____

_____

_____