Benefit Services, Inc.
Third Party Administration

REQUEST TO AMEND PROTECTED HEALTH INFORMATION FORM

Purpose: This form is used for a Member's request to amend Protected Health Information (PHI) or records about the Member in the Designated Record Set of the Group Health Plan or the Designated Record Set(s) of the Group Health Plan's Business Associate(s), including ACS Benefit Services, Inc. Each Member requesting an amendment must complete a form. Please print clearly and complete sections A and B. **Complete Section C only if applicable.**

SECTION A: Member requesting records amendment.

Member's Name: ____
First Middle Last

Member's Address: ____
Street or P.O. Box City State Zip Code

Member's Date of Birth: ______/_____/______ **Subscriber** ID Number: ______________________
Month Day Year

Member's Telephone: __________________ Member's E-mail *(optional)*: ______________________

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

You have the right to request that the Health Plan amend your Protected Health Information in Designated Record Sets *(that is, records that are reasonably locatable and retrievable)* that the Group Health Plan or Business Associate(s) of the Group Health Plan, including ACS Benefit Services, Inc. ("ACS"), maintains. The Group Health Plan or a Business Associate may decline your request if: (i) the information is not part of these Designated Record Sets; (ii) the Group Health Plan or Business Associate did not create the information; (iii) the Group Health Plan or Business Associate believes the information is complete and accurate; (iv) the information is psychotherapy notes; (v) the information is compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding. To exercise your right to request the Health Plan to amend or a Business Associate to amend PHI or records about you, please complete this Section B.

Please specify the records you wish to amend and the amendment(s) you wish to make:

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Please state the reasons for the amendment(s):

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If you want us to notify a certain person or persons regarding the change(s) ACS has made to your records, please list the name and address of each person:

NAME	**ADDRESS (Street or P.O. Box, City, State, Zip Code)**
______________________________	____
______________________________	____
______________________________	____

You agree that we may notify and provide information regarding your request to amend your Protected Health Information to the person(s) you have identified above.

Signature: ____ Date: ____________________
(Required for this request to be valid)

SECTION C:

If signed by an individual other than the Member:

Print your full name: ____

Relationship to Member (i.e., parent, personal representative, etc.): ______________________

Describe your authority to act for the Member (e.g. power of attorney, court order, parent of minor child, etc.):

____

You must attach the legal document naming you as the personal representative if you have not previously submitted it.

RETURN THIS REQUEST TO THE PRIVACY OFFICIAL AT THE OFFICE OF THE EMPLOYER

Received By: ____ Date: ____________________
(Privacy Official – Employer's Office)

Employer's Name: ____