

MEMBER REQUEST FOR AMENDMENT TO RECORDS FORM

Complete this form to request an amendment of your health information created by Providence Health Assurance (PHA). This request only applies to records that PHA has created. PHA cannot amend records created by other entities, such as your provider’s office or hospital. For those requests, please contact your provider directly. Please use your member identification (ID) card to help you complete the information in Part A.



PART A: MEMBER INFORMATION <i>(Provide your name and personal information)</i>		
Member Last Name	Member First Name	Middle Initial
Member Date of Birth	Member Identification Number (see your ID card)	Group Number (see your ID card)
Member Home/Street Address	City, State, and Zip Code	Preferred Phone Number

PART B: TELL US WHAT INFORMATION YOU WOULD LIKE TO AMEND
<p>Describe the information you believe is incorrect: _____</p> <p>_____</p> <p>_____</p>
<p>Date(s) of service related to request: _____</p>

PART C: INDICATE WHERE TO SEND YOUR AMENDED RECORD(S) IF YOUR REQUEST FOR AMENDMENT IS APPROVED

Paper copy to the above mailing address in Part A

Paper copy to the address below:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Electronic copy emailed to: _____
(Email address)

Information will be sent via secure (encrypted) email unless otherwise specified. Initial if you wish email to be sent unencrypted: _____.

Note, some level of risk is associated with sending your health information via unencrypted email or by mail, as your records could be accessed by an unauthorized third party.

PART D: MEMBER SIGNATURE AND DATE (Sign your name and write the date below)

Member's Signature

Date

Member's Designated Legal Representative/Guardian Signature

Date

Relationship to Member: *Parent of a Minor* **Legal Guardian* **Power of Attorney*

**If this form is signed by someone other than the member, please attach authorizing legal documentation of guardianship or power of attorney.*

PART E: RETURN THE COMPLETED FORM TO PHA

Mail:	Fax:	Email:
Providence Health Assurance PO Box 4327 Portland, Oregon 97208-4327	503-574-8608	phpprivacyprogram@providence.org

If you have any questions, please call Providence Medicare Advantage Plans at 503-574-8000 or 1-800-603-2340. TTY users should call 711. We are open seven days a week, between 8 a.m. and 8 p.m. (Pacific Time). Between April 1st and September 30th, we are closed Saturdays and Sundays.



What does my right to amend my health information mean?

You or your personal representative have the right to request an amendment to your protected health information maintained by PHA in a designated record set (DRS), in accordance with the Health Insurance Portability and Accountability Act of 1996 .

What do I need to understand to use this right?

- PHA cannot amend records created by someone else, such as your provider, or change information that is complete and accurate as-is.
- PHA will respond to your request within 60 days. If more time is needed, we will notify you in writing (up to an additional 30 days). If your request is denied, we will explain why and how you can respond in writing if you disagree
- If your request is approved, your amendment will be added to your record.