

## **Information about Your Request to Amend Protected Health Information (PHI)**

### **What does the right to amend PHI mean?**

You or your personal representative have the right to request an amendment of your protected health information (PHI) in the designated record set maintained by Providence Health Plan (PHP)

### **What do I need to understand to use this right?**

- Providence Health Plan (PHP) may not make changes if it did not originate with the health plan.
- PHP is not allowed to alter the original documentation in your record. Your request for amendment and any action taken on this request, will become a permanent part of your record, and will be included with any future authorized disclosures.
- If your request is granted, PHP will notify Business Associates who have your PHI that needs to be amended and have relied or may rely on it.
- If accepted or denied Providence Health Plan will provide a response in writing within 60 days or you will be informed in writing of the need for an extension of not more than 30 additional days to process the request.
- If denied, PHP will explain the reasons for the denial which may include:
  - The PHI was not created by PHP and the originator of PHI is still available to act on your request
  - The information requested is not part of a designated record set
  - The request includes psychotherapy notes or information PHP has compiled in anticipation of or for use in civil, criminal, or administrative actions or proceedings
  - The PHI or record is accurate and complete.
- If denied, you have the right to submit a written statement of disagreement, detailing the basis for it.
- Requests for amendment of your medical records should be submitted directly to your healthcare provider

### **How do I amend my PHI?**

Enclosed is the Member Request to Amend Protected Health Information (PHI). Please complete the entire form, sign it and return it to PHP. You may send your completed form to PHP at:

Providence Health Plan  
Attn: Customer Service  
P.O. Box 4327  
Portland, OR 97208-4327



You may fax your Member Request to Amend Protected Health Information (PHI) to 503-574-8731 or 800-425-0199 or you may hand deliver it (if mailing, use only the post office box address listed above) to the following address:

Providence Health Plan  
Attn: Customer Service  
3601 SW Murray Blvd. #10  
Beaverton, OR 97005-2359

Please Note: The enclosed Member Request to Amend must be completed, signed and dated.

If you have any questions or concerns, you may contact your Customer Service Team at 503-574-7500 or 1-800-878-4445. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 503-574-8702 or 1-888-244-6642. Customer Service representatives are available Monday through Friday, between 8 a.m. and 5 p.m.

Sincerely,

Providence Health Plan  
Enclosure

### Member Request to Amend Protected Health Information (PHI)

Use this form to request an amendment of your (PHI) in the Designated Record Set that Providence Health Plan (PHP) or one of its Business Associates maintains. If you need assistance completing the form, please contact the PHP Customer Service number listed on your member identification card. You must complete all the fields on this form.

<b>MEMBER INFORMATION</b>		
<b>Member Last Name</b>	<b>Member First Name</b>	<b>Middle Initial</b>
<b>Member Date of Birth</b>	<b>Member Identification Number (See your member ID card)</b>	<b>Group Number (See your member ID card)</b>
<b>Member Street Address</b>	<b>City and State</b>	<b>ZIP Code</b>

Describe the PHI or document you would like to have amended:

\_\_\_\_\_

I request the following correction/amendment be made to the following document or information:

\_\_\_\_\_

Date(s) of services associated with the PHI or document you would like to amend:

\_\_\_\_\_

Please send a copy of the corrected/amended documents to the company or individual(s) listed below:

Person/Company: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**MEMBER SIGNATURE AND DATE**

By: \_\_\_\_\_  
(Member Signature)

Date: \_\_\_\_\_

- OR -

By: \_\_\_\_\_  
(Member's Designated Legal Representative/Guardian Signature)

Date: \_\_\_\_\_

Relationship to member:     Parent     Legal guardian\*     Holder of Power of Attorney\*

**\*If this form is signed by someone other than the member or Parent, please attach legal documentation if you are the legal guardian or Holder of Power of Attorney.**

## Non-discrimination Statement

Providence Health Assurance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Assurance does not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Assurance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call us at 1-800-898-8174 (TTY: 711).

If you believe that Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Assurance  
Attn: Non-discrimination Coordinator  
PO Box 4158  
Portland, OR 97208-4158

If you need help filing a grievance, call us at 1-800-898-8174 (TTY:711) for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW - Room 509F HHH Building  
Washington, DC 20201  
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Access Information

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call 1-800-898-8174 (TTY: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-898-8174 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-898-8174 (телетайп: 711).

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-898-8174 (TTY: 711).

**Traditional Chinese:** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-898-8174 (TTY: 711)。

**Kushite:** XIYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-898-8174 (TTY: 711).

**Arabic:** توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما بگنیرید تماس 1-800-898-8174 با باشد می ف (TTY: 711)

**Ukrainian:** УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-898-8174 (телетайп: 711).

**Japanese:** 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-898-8174 (TTY: 711)まで、お電話にてご連絡ください。

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-898-8174 (TTY: 711) 번으로 전화해 주십시오

**Nepali:** ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्नत भाषा सहायता सेवाहरू निम्नःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-898-8174 (TTY: 711).

**Romanian:** ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați 1-800-898-8174 (TTY: 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-898-8174 (TTY: 711).

**Hmong:** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-898-8174 (TTY: 711).

**Cambodian:** ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-898-8174 (TTY: 711)។

**Laotian:** ໄປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ່ລາງານຊ້ອຍເທົ່ ອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມາພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-898-8174 (TTY: 711).