Providence Health Assurance | health share Health Share of Oregon

ProvidenceHealthAssurance.com/OHP

MEMBER REQUEST FOR AMENDMENT TO RECORDS FORM

Fill out this form if you want to change your health information made by Providence Health Assurance (PHA). You can only ask to change records that PHA has created. PHA cannot change records made by other places, like your provider's office or hospital. For those changes, you should talk to your doctor directly. Use your member ID card to help you fill in the details in Part A.

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PART A: MEMBER INFORMATION *(Provide your name and personal information)*		
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

Describe the information you believe is incorrect: _____

_____

_____

Date(s) of service related to request: _____

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 Plan PO Box 4327 Portland, Oregon 97208-4327	503-584-4234	phpprivacyprogram@providence.org
You can get this form in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 800-898-8174 or TTY:711. We accept relay calls. Customer Service Representatives can be reached Monday through Friday between 8 am and 5 pm.		

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What does it mean to change my health information?

You or someone you choose can ask to change your protected health information maintained by PHA. This follows rules from the Health Insurance Portability and Accountability Act of 1996.

What do I need to know to use this right?

- PHA cannot change records made by someone else, like your doctor, or change information that is already correct and complete.
- PHA will answer your request within 60 days. If we need more time, we will tell you in writing, and it might take up to30 more days. If we say no to your request, we will explain why, and you can write back if you disagree.
- If your request is accepted, the change will be added to your record.