



REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Use this form to request an amendment of your protected health information (PHI) in records that we, or our business associates, maintain in designated record sets.

Please complete the following:

NAME		DAYTIME PHONE NUMBER	
ADDRESS			
CITY	STATE	ZIP	ENROLLEE ID

Please read and complete the following:

You have the right to request that we amend your PHI in the designated record set that we, or our business associates maintain. We may decline your request if we did not create the records; the records are not part of our designated record set; the law does not give you the right to access the records; or the records are complete and accurate.

To exercise your right, please specify which records you want to amend and the amendments you want made to them:

Please specify the reasons for the requested amendments:

Please sign and date:

Signature Date

If you are not the patient, please also complete, sign and date below. Check the box that describes your relationship to the member. Please attach proof of your relationship to the patient (e.g. Power of Attorney, personal representative, documentation)

Please Print Name of Personal Representative: _____

Signature of Personal Representative Date

Parent of Minor Child Legal Guardian Power of Attorney Executor Other _____

Please return this form to:

**Customer Individual Rights Unit, MC 2004
BCBSM/BCN - P.O. Box 2459
Detroit, MI 48231-2459**