AMENDMENT REQUEST FORM

Purpose: This form serves to document the request to amend the information kept by us or by our business partners.

SECTION A: Requester Information:

Name: ____

Address: ____

Phone Number: ________________________ Email: ______________________________

Medical Record Number: ____

TO THE REQUESTER: Please, read the request form and complete all sections.

You are entitled to request that we amend your information. We may reject your request under certain circumstances, for instance: if the information does not appear in our records; if we did not originate the information; if we understand that the information is complete and correct; or if it is not available under the right to access provided in 45 CFR §164.524. Please, submit the supporting documentation for your request.

SECTION B: Information to be amended:

Specify the information to be amended and how it should be changed: ____________________

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State the reason for requesting the amendment: ______________________________

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In case your request is granted, state the name and address of each person you want us to notify of the amendment to your information.

______________________ ______________________

______________________ ______________________

REQUESTER'S SIGNATURE - You are entitled to receive a copy of this request form.

______________________________ Date: ____________________

If this request is submitted on behalf of the insured person, please provide the following information:

Name of Personal Representative: ______________________________

Relationship to the Requester: ______________________________