EHIM Third Party Administration

Request for Amendment of Protected Health Information (PHI)

WHY THIS FORM?

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to request an amendment to your PHI in the Designated Record Set (DRS) that is maintained by EHIM, Powered by ProCare Rx, or its Business Associate (BA). Please complete this form in its entirety so that we may provide you with the correct information you are requesting.

A. Member Information

Last Name:	First Name:	Middle Name:	
Date of Birth:	EHIM Member #:	Phone #:	
Address:	City:	State:	Zip:

B. Amendment Information

1. **Availability of Amendment.** Check and/or complete either Section A or B, or both if applicable. If neither is checked, EHIM, Powered by ProCare Rx, will not send this amendment to those individuals and/or entities that received or relied on my PHI before this amendment, which may be to my detriment (harm).

☐ A. I hereby request that EHIM, Powered by ProCare Rx, send this amendment, if accepted by EHIM, Powered by ProCare Rx, to the following individual(s) and/or entities:

Name:	Address:
Name:	Address

☐ B. I authorize EHIM, Powered by ProCare Rx, to send this amendment, if accepted by EHIM, Powered by ProCare Rx, to other individuals and/or entities that received or relied on my PHI before it was amended.

2. **Description of PHI Records.** The following is a description of the records that I wish to have amended (i.e., all PHI or PHI related to a specific date, illness or treatment):

3. **The Method of Amendment.** My records stated above should be amended in the following manner (i.e., change a specific date):

4. **Reason for Amendment.** The following is the reason I want my PHI to be amendment (i.e., information was incomplete or incorrect). (Request may be denied if a reason is not provided):

5. **Denial of Request.** I understand and acknowledge that **EHIM, Powered by ProCare Rx, IS UNDER NO OBLIGATION TO AGREE TO THIS REQUEST FOR AMENDMENT OF MY PHI**, under the following conditions: (1) the information is not part of my DRS (unless I provide a reasonable belief that the originator of my PHI is no longer available to act on this requested amendment); (2) the information is not accessible to me; and (3) the information is accurate and complete. I further understand and acknowledge **MY REQUEST FOR AN AMENDMENT MAY BE DECLINED IF:** (1) the request is not reasonable; (2) the information I provide is not accurate; (3) this form is not completed in its entirety; and/or (4) I do not sign below. If EHIM, Powered by ProCare Rx, denies this request, it will provide me with the following: (1) a written explanation of the reason(s) for denial; (2) my right to submit and file a written statement disagreeing with the denial or a request by me that EHIM, Powered by ProCare Rx, provide my request and denial of the amendment with any future disclosures of my PHI that is the subject of amendment; and (3) whether I have a right to further review.

6. **Exceptions, Rights and Acknowledgement.** With certain exceptions, I have the right to have my DRS amended. By signing below, I hereby authorize my records to be amended as described on this form. I understand and acknowledge that EHIM, Powered by ProCare Rx, will have up to sixty (60) days after receiving this request to act on it, and that in certain circumstances, EHIM, Powered by ProCare Rx, may be permitted a one (1)-time thirty (30)-day extension. If EHIM, Powered by ProCare Rx, accepts this request, it will abide by the amendment from the date upon which EHIM, Powered by ProCare Rx, approves the request and EHIM, Powered by ProCare Rx, will make reasonable efforts to inform others of the amendment, including individuals and/or entities I name. I understand and acknowledge this request shall not apply to information that has already been released or affect actions taken by EHIM, Powered by ProCare Rx, prior to this request. I further understand and acknowledge that EHIM, Powered by ProCare Rx, is not responsible for any action taken by any authorized recipient and/or discloser of the information released pursuant to any signed authorization to use and/or disclose my PHI. The information described on this form is protected by law and shall only be amended as indicated above, unless otherwise required and/or permitted by law.

Signature:	Date:

If you are signing as a personal representative, complete the section below. A parent/legal guardian must sign below for a minor under the age of eighteen (18). You may be required to provide additional documentation to show that you have a legal right to request the information, unless you have completed a Designation of Personal Representative signed by the Member naming you as a personal representative. Examples of these documents include Letters of Representation or Guardianship Papers.

Signature of Personal Representative:	Date:

Relationship: ☐ Parent/Legal Guardian ☐ Personal Representative ☐ Other

C. TO BE COMPLETED BY EHIM

☐ Request Approved. Effective Date _____ ☐ Request Denied. Reason _____

☐ Additional Comments

EHIM Representative Signature:	Date:

If you have any questions, please contact the EHIM Privacy Officer at 800-311-3446. Please either fax this form to (248) 948-9904 or mail to:

EHIM, Powered by ProCare Rx
ATTN: Privacy Officer
26711 Northwestern Highway, Suite 500
Southfield, MI 48033