

## **Request to Amend or Change PHI**

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy Rule gives Individuals\* the right to change (amend) their Protected Health Information ("PHI") or a record about the Individual in a designed record set (DRS) if they believe that it's incorrect or incomplete. UNITE HERE HEALTH (UHH) may deny an Individual's request if the PHI or record:

- Was not created by UHH (with limited exceptions), is not part of the Individual's DRS or is not subject to inspection
- Is accurate and complete

UHH will notify the Individual (usually within 60 days) if the PHI or record has been corrected or if the request has been denied. If the request is denied, Individuals may file a statement of disagreement.

To request an amendment to your PHI, please complete and send this form as follows:

In person:	By email to:
Hand in at any UHH office (see <u>www.UHH.org</u> for your local office	HIPAA@uhh.org
address)	Please note: If you choose to email personal information to UHH, we cannot
By mail to:	ensure it will remain private or secure until it is received.
UNITE HERE HEALTH Attn: HIPAA Privacy Officer 711 North Commons Dr. Aurora, IL 60504 By fax to: (630) 236-5286	<u>For help:</u> Call: (630) 236-5100 and ask for the HIPAA Privacy Officer

Section A: Individual's Information		
Individual's name:		
Street address:		
City, state and zip:		
Phone number: ( )		
Date of birth: / /		
Member ID or last four digits of Member's Social Security number:		
Relationship to Participant:		
*The Individual is the UHH member or dependent who is the subject of the PHI.		

## Section B: Participant's Information (this section is required if different from Individual)

Participant's name:

Date of birth: / /



Section C: Request for Amendment of PHI		
Describe the PHI or record requested to be changed and	how it should be changed:	
Describe the reason for the change:		
□ If this request for amendment of PHI is approved, UH and/or organizations (include contact information) a		
Name:	Contact Info:	
Name:	Contact Info:	
Section D: Signature		

Section D. Signature
Name of Person completing form:
Phone number: ( )
Relationship to Individual*:
Signature:

Note: This request will not take effect until it is approved by UHH. You'll be notified in writing of UHH's decision.

\*If this form is submitted by a personal representative (e.g. someone who has authority under applicable law to act on someone's behalf, such as a legal guardian, executor, someone with durable power of attorney), please also submit proof of such authority.

For UHH Use Only	
Received by:	
Name:[	Date:/ /
Completed by:	
Name:[	Date: / / / (date accounting sent to individual)