



# PARTICIPANT'S REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Participant Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Work Telephone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Participant Birth Date: \_\_\_\_\_

**Designated Record Set** — a group of records under the control of the MPI Health Plan which contain Protected Health Information and other information used to make decisions about enrollment, premium/contribution payment, case or medical management, claims, billing and EOB information.

After review of my protected health information contained in the MPI Health Plan's Designated Record Set, I do not feel that the original information \_\_\_\_\_

is accurate and should be supplemented with clarifying information in the form of an addendum, as follows:

I understand that the MPI Health Plan may or may not supplement my record with an addendum based on my request. I understand that the MPI Health Plan is not allowed to alter the original documentation in my record. I understand that my request for amendment, if approved, will be made a permanent part of my Designated Record Set and will be sent with any future authorized MPI Health Plan record request for information.

The MPI Health Plan will respond to this request within sixty (60) days. I understand I have the opportunity to provide a statement of disagreement should the MPI Health Plan deny my request.

\_\_\_\_\_  
*Participant Signature*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date*

**If this Request to Amend is to be signed by a personal representative, that personal representative must also sign below before submitting this form to the MPI Health Plan.**

If signed by personal representative, name of personal representative: \_\_\_\_\_

Relationship to Participant or nature of authority: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Personal Representative*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date*

**THIS REQUEST MUST BE COMPLETED IN FULL BEFORE BEING SUBMITTED**