AMENDMENT TO PHI REQUEST

An Independent Licensee of the Blue Cross Blue Shield Association

Purpose: Use this form to ask us to correct or change your health records.

Please Read This Notice

We may not be able to accommodate your request if:

- We did not create the record
- We believe the information is correct
- It is for psychotherapy notes
- The information is for a planned lawsuit
- The information isn't part of your record set
- It is not something we can disclose to you

Member Information

Name:		Date of Birth:	
Street Address:	City:	State:	ZIP Code:
Phone:	Email:	Member ID:	

Tell us what records to correct and the changes you want:

Tell us why these changes are needed. Please include supporting documentation:

If you would like us to notify other entities of the change please include their name and address.
We will consider this signed form as your authorization to notify them.

Name:			
Street Address:	City:	State:	ZIP Code:
Phone:	Email:		

Signature

Signature:	Date:

If you are the personal representative of the Member, complete this:

Representative's Name:	Relationship to Member:
Representative's Signature:	Date:

Note: If you are filling out this form for someone else, attach a copy of any legal paper(s) that apply.

Please send the completed form to us. You can mail it to:

AZ Blue Privacy Office
Mail Stop C300, P.O. Box 13466, Phoenix, AZ 85002-3466
Email: privacy@azblue.com **Fax:** 602-544-5661

For questions, or to request a copy of the signed form, call the Privacy Office at 602-864-2255 or 1-800-232-2345, ext. 2255, TYY: 711.

You can get one free report every 12 months. We will charge you $0.10 per page plus $10 per hour for each additional report you request during the same 12-month period.

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