PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM
REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION (PHI)
AFN: HIP-008 (07/2021)

Participant's Name: **Participant's ID #:**

I hereby request Public Safety/Corp Cancer Insurance Policy Program to amend my protected health information records as follows:

Date Range Affected By Amendment:

Description of Amendment:

I understand that:

1) All health benefit plans and some of their vendors, including Public Safety/Corp Cancer Insurance Policy Program, maintain certain protected health information about me as a participant, such as claims records, and records that are used, in whole or in part, to make decisions about me, my treatment, or payment for services.
2) I have the right to request an amendment to my protected health information mentioned above.
3) Public Safety/Corp Cancer Insurance Policy Program has the right to deny my request if it determines that the protected health information or record that is the subject of the request:
    - Was not created by Public Safety/Corp Cancer Insurance Policy Program, unless I provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment
    - Is not part of the designated record set (category of protected health information mentioned above)
    - Would not be available to individual for inspection as required by 45 CFR § 164.524
    - Is accurate and complete
4) Within 60 days, I will receive a response from Public Safety/Corp Cancer Insurance Policy Program indicating whether my request for an amendment has been accepted or denied, or a notification that an additional extension of 30 days is needed to consider my request. If an extension is required, they will give an explanation of the reason for the delay and the date by which a decision will be made regarding my request. If my request is denied, they will inform me in writing of the reason for the denial, and instruct me on how I can go about disputing a denial. If my request is accepted, they will confirm this in writing and will request that I provide them with a list of individuals or entities which I would like them to provide notice of the amendment.

Signature of Participant *(Participant, Your 'Typed' First and Last Name Constitutes Your Signature.)*

Date *(MM DD YYYY format)*

Printed Name of Participant's Representative (if applicable)

Relationship to Participant (*if applicable*)

- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

Signature of Witness *(Witness, Your 'Typed' First and Last Name Constitutes Your Signature.)*

Date *(MM DD YYYY format)*

Submit Form

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FOR OFFICE USE ONLY

Request Accepted ☐ Denied ☐

Reason for Denial (*if applicable*)

☐ PHI was not created by our company (unless participant provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment)
☐ Requested information is not part of the designated record set (medical records, billing records, and any other PHI that is used to make decisions about individuals)
☐ Information which is the subject of the amendment is accurate and complete
☐ Information is not available to the individual for inspection as required by 45 CFR § 164.524

Date Request Received **Received By**

Date Request Fulfilled **Fulfilled By**

Extension Requested ☐ **Yes** ☐ **No**

Date Participant Notified in Writing of Extension

If Extension Requested, Give Reason