

Request for Amendment of Protected Health Information

Under the Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA, you have the right to request an amendment of your Protected Health Information ("PHI") maintained by the AFTRA Health Fund ("Fund"). You may use this form to make your request to the Fund.

INDIVIDUAL INFORMATION

Date of Request: _____ Date of birth: _____

Name: _____ Participant's SSN: _____

Relationship to Participant: Self Spouse Eligible Dependent

Home Address: _____

Home Telephone Number: (____) ____ - _____

WHAT NEEDS TO BE AMENDED & WHY

Please state what information you would like us to amend:

Please explain how the information is incorrect or incomplete, and how the information should be corrected or completed:

Please specify the name and address of the organizations or individuals you would like us to send this amendment and to whom we may have disclosed this information in the past.

Names & Addresses:

1. _____ 2. _____

I understand if the PHI that I requested to be amended was not created by the Fund (e.g., a medical report created by my doctor), the Fund is not required to honor my request, unless the originator is no

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longer available to act on the request. I also understand that I cannot amend information that (1) is not part of my Designated Record Set (“DRS”)¹; (2) is not accessible to me; or (3) is accurate and complete.

Signature of Participant/Eligible Dependent _____

____/____/____

Date

If signed by Personal Representative:

Name of Personal Representative: _____

Relationship to Participant/Eligible Dependent or nature of authority: _____

Signature of Personal Representative _____

____/____/____
Date

¹ Designated Record Set (“DRS”) means a group of records that comprise the enrollment, payment, claims adjudication, case or medical management record systems maintained by or for the Fund.