

**EMPLOYEE GROUP INSURANCE**

**Request for Amendment of Protected Health Information**

Employee Group Insurance (EGI) recognizes an individual’s right to request the amendment of his medical information, for as long as EGI maintains such information.

EGI may, however, deny your request to amend medical information if any of the following applies:

- Your request is not in writing;
- Your amendment request does not include a reason to support the request;
- The medical information was not created by EGI, unless you can show that the person who created the information is no longer available to make the amendment;
- The medical information is not part of the information kept by or for EGI;
- The medical information is not available for your inspection; or
- The medical information is accurate and complete.

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1. Name: \_\_\_\_\_

2. Date of Birth: \_\_\_\_\_

3. Social Security No.: \_\_\_\_\_

4. Description of the requested amendment to your medical information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Reason for making the amendment (if applicable, this should include a demonstration that the person who created the medical information is no longer available to make the amendment): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the request is signed by a legal representative of the individual:  
 Printed name of legal representative: \_\_\_\_\_  
 Representative’s authority to act for the individual: \_\_\_\_\_

If signed by a legal representative of the individual, please note that we must verify that you are this individual's legal representative for purposes of filing this Request. Please enclose any documents that support this authority (Power of Attorney, Court Order, etc). As this person's representative, can you be contacted at the address, e-mail, or phone number listed above? If not, please provide your mailing address, e-mail address and phone number below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For EGI Use Only**

Name of person processing request for amendment: \_\_\_\_\_

Title of person processing request: \_\_\_\_\_

Date request received: \_\_\_\_\_

Deadline to grant/deny requested amendment: \_\_\_\_\_

Was there an extension of the deadline?

No

Yes: Reason: \_\_\_\_\_

Date written notification given: \_\_\_\_\_

New deadline to grant/deny amendment: \_\_\_\_\_

Amendment:  Granted  Denied Date individual notified: \_\_\_\_\_

If granted:

Date records were appended or linked to the amendment: \_\_\_\_\_

Date individual's agreement to notify recipients received: \_\_\_\_\_

Dates identified recipients were notified: \_\_\_\_\_

If denied:

Did individual submit statement of disagreement?

Yes Rebuttal prepared?

Yes: Notification date: \_\_\_\_\_

No

No Did individual request attachment of request and denial?  Yes

No

Records attached to medical information (check all that apply):

Request for amendment

Denial of the request

Statement of disagreement

EGI's rebuttal