Individual Request to Correct or Amend a Record

THIS FORM WILL ALLOW ME TO REQUEST AN AMENDMENT OF MY PROTETED HEALTH INFORMATION (PHI) THAT THE CITY OF HOUSTON SELF-INSURED MEDICAL GROUP HELATH PLANS MAINTAINS

VERIFICATION – (Please Print)

Identification of Customer: (The following information is needed for verification. Please complete all applicable items).

Name of Customer: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone No.: _____ Employee ID No.: _____

Group or Account No. on ID Card: _____

Subscriber Name (if different from Customer): _____

Subscriber Relationship to Customer: _____

I request that the City of Houston Self-insured Medical Group Health Plans amend the protected health information in the designated record set.

Specific Statement of Correction/Amendment Request

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_____

Specific Reason for Correction/Amendment Request

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I understand that if the protected health information was not created by the group health plan, the group health plan is not required to honor my request. For example, if the information I wish to amend is in a medical report created by my physician, I must ask the physician, not the plan, to amend the report. I also understand that if the information is not available for my inspection, is not part of the plan's designated record set or is already accurate and complete, I cannot amend the information.

I understand that the group health plan will respond to my request within 60 days.

Signature: _____ Date _____

Please Return This Completed Form To: Privacy Officer, City of Houston Self-Insured Medical Group Health Plans, Human Resources Department, 611 Walker, 4th Floor, Houston, Texas 77002; Email: PrivacyOfficer@houstontx.gov; FAX: 832.393.7208.