Collective Health

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Collective Health is contracted by your employer-sponsored health plan ("Health Plan") to administer your Health Plan's benefits. Use this form to request an amendment to your protected health information (PHI) in your designated record set that your Health Plan, Collective Health and/or their business associates maintain. You must complete all the fields on this form.

PLEASE UPLOAD THE COMPLETED FORM AS A NEW MESSAGE IN YOUR MY COLLECTIVE PORTAL OR MAIL TO US AT: COLLECTIVE HEALTH, ATTN: PRIVACY OFFICE, 1557 W. INNOVATION WAY, SUITE 300, LEHI, UT 84043.

Section A: The individual who is requesting an amendment must complete the following:

Name | **Subscriber ID #** | **Date of Birth**

Address | **City** | **State** | **ZIP**

Telephone Number | **E-mail Address (if available)**

Section B: Please describe in detail the exact information you want amended:

Please state the reason(s) you feel this information should be amended:

Section C: List the name(s) and address(es) of individuals to notify should we agree to make the amendment.

Name | **Name**

Address | **Address**

City | **State** | **ZIP** | **City** | **State** | **ZIP**

Section D: Signature - This document must be signed by the individual, parent of a minor child or the individual's personal representative.

I request that my Health Plan amend my information as described in Section B. I understand I will receive a written determination regarding my request. I understand that I can sign on behalf of a child as their parent only if they are under the age of 18, unless there is proof of other legal authority.

Signature* | **Date: month/day/year**

**If you are signing as a power of attorney, legal guardian, executor, or administrator, attach a copy of the legal documents granting authority.*