Request for Amendment of Health Information

As a participant of UPCAP MI Choice Waiver Program, you have the right to request amendments to your Personal Health Information(PHI) that are inaccurate or incomplete. If you want to amend your health information you must complete this form and return it to UPCAP Services, c/o Mary Ross, P.O. Box 606, Escanaba, MI 49829.

If we deny your request, we will let you know in writing with an explanation of why we are denying it. You have the right to submit a written disagreement to our denial. We will put your statement and requested amendment in to your record. If we continue to disagree with your amendment request, we may put a written rebuttal to your disagreement into your record. If this occurs, we will let you know in writing and send you a copy of our rebuttal.

INDIVIDUAL'S INFORMATION	
Name:	Request Date:
Contact Phone Number(s):	Birthdate:
Current Address (No., Street, P.O. Box, City, State, Zip):	

REQUESTED AMENDMENT

1. Date(s) of Entry to be amended/corrected: _____
2. Type(s) of Entry to be amended/corrected: _____
3. Please explain how the entry(s) is incorrect or incomplete:

4. What should the entry(s) say in order to be accurate or complete:

5. Would you like this amendment sent to anyone to whom we may have disclosed information to in the past? ☐ No ☐ Yes If so, please specify the name and address of the organization or individual:

ACKNOWLEDGEMENT-Please sign and date:

Name _____ Signature _____ Date _____

If you are not the participant, please complete, sign and date below. Check the box that describes your relationship to the participant. Please attach proof of your relationship to the participant (e.g. power of attorney, legal guardian).

Name _____ Signature _____ Date _____

☐ **Personal Representative** ☐ **Legal Guardian** ☐ **Power of Attorney** ☐ **Executor** ☐ **Other:** _____

This Section for Company Use Only

Amendment has been: ☐ Accepted ☐ Denied (if denied, check the reason for denial):

- ☐ **PHI (Protected Health Information) was not created by this organization**
- ☐ **PHI is not part of the participant's designated record set**
- ☐ **Federal/State law forbids making corrections to this PHI**
- ☐ **PHI is accurate and complete**

Comments:

Amendment has been reviewed by:

Date	Please print name	Signature

Date	Please print name	Signature

Notification was sent to the participant: _____
Date

Send a copy of completed form to individual. Send original to Support Corrdinator to place in Participant's chart.

Date copy sent: _____ *Copy sent by (print name):* _____