## Request for Amendment of Protected Health information

organization may deny my request if your organization did not create or mair	
Please describe the protected health information that you believe to be inaccurate or incomplete. Please include any person(s) that need to be notified of the amended information.	
Our organization maintains the right to make a determination on this request extension of thirty (30) days is needed, you will notify me at that time.	and notify me of the decision within sixty (60) days. If an
If my request for amendment is denied, I will receive a written response with disagreement statement of your organization's denial and my request will be	
Please print the following information:	
Name:	Date of Birth:
Daytime Phone:	
Alternate Phone:	
Address:	
Signature:	Date:
Signature of Legal Representative	
Only if individual is incompetent*:	Date:
If signed by Legal Representative, relationship to individual:	
*If signed by Legal Representative, must provide representative document Attorney, Health Care Surrogate, Living Will or Guardianship papers.	tation as required by state law, i.e., Health Care Power of
To prevent a delay in fulfilling your request, please verify that all fields on the form will be returned to you for completion.	form are accurately completed. If information is missing, the
Please attach a separate sheet if additional space is needed.	
Please send this form to: Harris, Rothenberg International, Inc. dba Humana EAP and Work Life Ser 100 William St., 10th Floor	vices,

This organization follows the more stringent of all federal and state laws and regulations.

New York, NY 10038