

Request to Amend
Protected Health Information (PHI)



Complete the following chart with information about the person whose PHI is subject to this request.

Name (Last, First, MI):	
Address (City,State,Zip):	
Phone:	
Date of Birth:	

If you are not the employee, complete the following:

Employee Name:	
Employee ID #:	
Employee Date of Birth:	

I am requesting that an amendment be made to the following PHI for the following reason:

If I am a personal representative, I certify and attest that I am the duly authorized representative of the person whose health information is subject to this request. (A personal representative may be requested to provide verification of representative status.)

Signature of applicant or personal representative _____
Date

Relationship of personal representative to member: _____

Send completed form to:
Privacy Official
Human Resources
7575 E. Main Street
Scottsdale, AZ 85251

Phone: (480) 312-7600
FAX: (480) 312-7960

Request approved
Extension needed Reason: _____

Date information will be provided: _____

Request denied Reason for denial _____

By: _____
COS Signature Date Name and Title