CareConnect
Healthier Insurance™

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Purpose: To request an amendment of your protected health information in CareConnect Insurance Company, Inc.'s ("CareConnect") designated record set or the designated record set of CareConnect's business associates.

SECTION A: Member requesting Amendment. (Please Print)

Member's Name:_____

Address:_____

Member Identification Number:_____ Birthdate:_____

Group or Account # on ID card:_____

Phone number where we can reach you to process your request (required):

(_____) _____ -_____

SECTION B: Scope of Amendment

You have the right to request that CareConnect amend your protected health information maintained by CareConnect and its business associates.

We may decline your request if the information is not part of our designated record set, we did not create the information, we believe the information is complete and accurate, the information is psychotherapy notes, the information has been compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, or you do not otherwise have access to the information under applicable law.

Please specify the records you wish to amend and the amendments you wish to make:

Please state the reasons for the amendments:

SECTION C: Signature

If this request is from the **Member**, please complete the following:

I request CareConnect to amend my protected health information. I understand that CareConnect is under no obligation to agree to my request, and that there will be no agreement unless CareConnect informs me in writing that it accepts my request.

_____ _____

(Print) (Signature)

Date:_____

If this request is from a **Personal Representative** on behalf of the Member, please complete the following:

I request CareConnect to amend the Member's protected health information. I understand that CareConnect is under no obligation to agree to my request, and that there will be no agreement unless CareConnect informs me in writing that it accepts my request. Please provide documentation of authority to act as the Member's personal representative and sign below.

_____ _____

(Print) (Signature)

Relationship to Individual:_____ Date:_____

Personal Representative: If you are not the Member or parent of the minor Member, please attach proof of your relationship to the Member. We will require verification of your authority to act on the Member's behalf before this request will be considered complete. Please attach copies of your authorization as required by state law to represent the Member – for example, healthcare proxy or guardianship papers.

Please return this completed form to:

CareConnect Insurance Company, Inc.
Attention: Privacy Officer
2200 Northern Boulevard, Suite 104
East Hills, NY 11548

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS.