Request to Amend Protected Health Information

WyoBLUE ADVANTAGE
An independent licensee of the Blue Cross Blue Shield Association

Use this form to request an amendment of your protected health information in records that we, or our business associates, maintain in designated record sets.

Please complete the following:

Name		Daytime phone number	
Address			
City	State	ZIP code	Enrollee ID

Please read and complete the following:
You have the right to request that we amend your protected health information in the designated record set that we, or our business associates maintain. We may decline your request if we did not create the records; the records are not part of our designated record set; the law does not give you the right to access the records; or the records are complete and accurate.

To exercise your right, please specify which records you want to amend and the amendments you want made to them:

Please specify the reason(s) for the requested amendments:

Please sign and date

_____ _____
Signature *Date*

Personal Representative

If you are not the patient, please sign and date this form below. Check the box that describes your relationship to the patient. **If you are not the parent, please attach proof of your relationship to the member (e.g., power of attorney, personal representative documentation, etc.).**

Print name of personal representative: _____

Signature of personal representative and date: _____

☐ Parent of minor child ☐ Legal guardian ☐ Power of attorney ☐ Executor ☐ Other

Please mail completed form (and all documentation if needed) to: **Customer Individual Rights Unit**
600 East Lafayette, MC 1620
Detroit, MI 48226-2998

or fax: **1-877-522-4767**

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