Form F11: Amendment Request

Use this form to exercise your right under federal privacy laws to request to amend your protected health information or records contained in our designated record set or the designated record sets of our business associates.

Section A: Member Information

Member Name: _____ Date of Birth: _____

BCBSVT ID Number: _____

Address: _____

_____

Telephone: _____ E-Mail Address: _____

Section B: Please read the following and complete the information requested

You have the right to request that we amend your protected health information in designated record sets we or our business associates maintain. We may decline your request if the information is not part of these designated record sets, we did not create the information, we believe the information is complete and accurate, or the information is psychotherapy notes, compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, or not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a). To exercise your right to request amendment, please complete this Section B. Attach additional pages if necessary.

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

_____

_____

Please state the reasons for the amendments:

_____

_____

Please list the name and address of each person you would like us to notify of the amendment if we agree to make the amendment you request. You must provide us with a signed Form F1: Authorization to Release Information (or F1A: Authorization to Release Information Following Termination of Coverage) for us to notify those persons.

Name:_____
Organization (if applicable):_____
Address:_____
Street or Post Office Box
_____

Name:_____
Organization (if applicable):_____
Address:_____
Street or Post Office Box
_____

City State Zip Code
Telephone:_____
E-Mail:_____
Relationship to Member:_____
i.e. mother, attorney, neighbor, friend, benefits administrator

City State Zip Code
Telephone:_____
E-Mail:_____
Relationship to Member:_____
i.e. mother, attorney, neighbor, friend, benefits administrator

Section C: Individual's Signature

Signature: _____ Date: _____

If you are a personal representative, such as a Legal Guardian or an agent acting under a Power of Attorney, you *may* be able to sign on behalf of the Member if the supporting documentation has the required language. This Form shall be accompanied by such supporting documentation for BCBSVT's Legal Department to determine whether authority is granted to authorize this Form.

Personal Representative's Name: _____

Relationship to Member or Authority to act as Personal Representative: _____

Please keep a copy of this document for your records and send the completed Authorization via mail to Blue Cross and Blue Shield of Vermont, Attn: Customer Service, PO Box 186, Montpelier, VT 05601-0186, fax to (802) 371-3658, or email customerservice@bcbsvt.com.