

INDIVIDUAL REQUEST TO CORRECT OR AMEND HEALTH INFORMATION

I request Clackamas County group health plan amend or correct the protected health information in its "designated records set" in accordance with the Health Insurance Portability and Accountability Act of 1996. A "designated records set" includes information such as medical records, billing records, enrollment, payment, claims adjudication and health plan case or medical management records systems or records used to make decisions about individuals.

Specific Amendment or Correction Requested:

Specific Reason for Amendment or Correction Requested:

I understand that if the protected health information was not created by the Clackamas County group health plan, the plan is not required to honor my request. (For example, if the information is in a medical report created by my physician, I must ask the physician – not the plan – to amend the report.) I also understand that if the information is not available for my inspection, is not part of the plan's designated records set or is already accurate and complete, I cannot amend the information. I understand that Clackamas County has sixty (60) days to respond to this request, and that an additional thirty (30) extension may be required under certain circumstances.

Signature/Date:

Name (please print):

Daytime Telephone Number(s):

RESPONSE TO REQUEST TO AMEND OR CORRECT HEALTH INFORMATION

- ☐ Request granted. The plan will make the appropriate amendment to the designated records set.
- ☐ Request reviewed, but a delay in action is necessary for the following reason:

Clackamas County will respond to your request no later than _____ (date)

- ☐ Request denied for the following reason:

You have the right to file a written statement disagreeing with the denial of the amendment. The statement of disagreement must be limited to two single-sided 8 1/2" x 11" pages. The statement of disagreement should be filed within 60 days of this notice with the Clackamas County Benefits Manager. The Plan has the right to prepare a rebuttal statement to your statement of disagreement. If it does so, you will receive a copy.

If you do not submit a statement of disagreement, you may request that the Plan provide your request for amendment and this denial of amendment with any future disclosures of protected health information that is the subject of this request.

You may file a complaint in writing regarding this decision with:

Clackamas County Risk & Benefits
Benefits Manager
2051 Kaen Road
Oregon City, OR 97045

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, DC 20201