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