

**NORTHWESTERN HEALTH SCIENCES UNIVERSITY HEALTH PLAN  
REQUEST FOR AMENDMENT OF PHI**

You have a right to request an amendment of your own protected health information (“PHI”).

Please submit this form to: **Northwestern Health Sciences University  
Deborah Hogenson, Health Plan Privacy Officer  
Attn. Human Resources  
2501 W. 84<sup>th</sup> St.  
Bloomington, MN 55431**

**Your name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Daytime phone number:** \_\_\_\_\_

**Please select one :**

\_\_\_ I participate in or am covered under the following Health Plan(s):

\_\_\_ Medical      \_\_\_ Dental      \_\_\_ Section 125 Medical Reimbursement

\_\_\_ I am the personal representative of an individual participating in or covered under the following Health Plan(s) (*please attach proof of personal representative status*):

\_\_\_ Medical      \_\_\_ Dental      \_\_\_ Section 125 Medical Reimbursement

**I would like to request an amendment to the following information:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The information should be amended in the following manner:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I believe this information should be amended because (required):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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***Please Read Carefully and Sign***

*I understand that the Health Plan will agree to my requested amendment unless it may deny the request under applicable law.*

\_\_\_\_\_

Signature

Date

**Please note:** Applicable law requires us to respond to you within 60 days after receiving your request, unless we send you notification that we will need an additional 30 days to respond.

\_\_\_\_\_  
*For office use only:*

Received by: \_\_\_\_\_ Date: \_\_\_\_\_