Protected Health Information Amendment - Notification Form

I request and authorize Cameron University's Health Plan to notify the individuals or entities listed below of the amendment(s) made by the Health Plan to the medical records of:

_____
Name of Member

Signed: _____ _____ _____
Name | Title, if legal representative * | Date

*May be requested to submit evidence of representative status.

Individuals/Entities Who Need to be Notified of Amendment:

Name: _____	Name: _____
Address: _____	Address: _____
Name: _____	Name: _____
Address: _____	Address: _____
Name: _____	Name: _____
Address: _____	Address: _____

OFFICE USE:

Name/Title of person who completed request: _____

Date Request Completed: _____