# Individual Request to Correct or Amend a Record Maintained

| **Full name** | | | **Date of birth** |
|---|---|---|---|
| **Member ID number** | **Line of business**<br>Octave Blue Cross and Blue Shield | | |
| **Current address** | **City** | **State** | **ZIP** |

I request Octave Blue Cross and Blue Shield (the health plan) to amend the protected health information of _____ (name of the member) in its designated record set within the date range of _____ through _____.
(date in mm/dd/yyyy format) (date in mm/dd/yyyy format)

**Specific amendment request**

**Specific reason for amendment request**

I understand that if the protected health information was not created by Octave Blue Cross and Blue Shield, the health plan is not required to honor my request. For example, if the information I wish to amend is a medical report created by my physician, I must ask the physician – not Octave Blue Cross and Blue Shield – 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 record set or is already accurate and complete, I cannot amend the information.

I understand that Octave Blue Cross and Blue Shield will respond in writing to my request within 60 days.

**Signature**

**Date signed** (mm/dd/yyyy)

**Please return this signed form to:**
Privacy Office
P.O. Box 3216
Little Rock, AR 72203