

## Request to Amend Protected Health Information

Purpose: This form is used for an individual's request to amend protected health information or records in our designated record sets or the designated record sets of our business associates.

### SECTION A: Individual Requesting Records Amendment

Individual's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Social Security #: \_\_\_\_\_

### SECTION B: To the Individual – Please read the following and complete the information requested

You have the right to request that we amend your protected health information in designated record sets we, or our business associates, maintain. We may decline your request if the information is not part of these designated record sets, we did not create the information, we believe the information is complete and accurate, or the information is psychotherapy notes, compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, or not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a). To exercise your right of request amendment, please complete this Section B.

Please specify the records you wish to amend and the amendments you wish to make:

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

Please state the reasons for the amendments:

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

<b>Section C: SIGNATURE</b>
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I have had full opportunity to read and consider the contents of this request. I understand that, by signing this form, I am requesting that American Greetings amend my protected health information as previously described.

**Patient's Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

**Patient's Representative Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient's Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Individual:** \_\_\_\_\_

Please submit this request to: **American Greetings**  
AG Benefits Department  
One American Blvd.  
Cleveland, OH 44145

**YOU ARE ENTITLED TO A COPY OF THIS REQUEST**

REVISED 5/2021