



**Member Request to Amend Protected Health Information (PHI)**

Date of Request: \_\_\_\_\_

Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Member CIN: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Please tell us what Protected Health Information (PHI) or record you would like CalOptima Health to change:

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

Please tell us why you would like this change. You must give a reason:

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

**NOTIFICATION:**

CalOptima Health must notify you within 60 calendar days if the changes were made as you requested or tell you that more time is needed (up to 30 calendar extra days) to decide. Please tell us where to send you a letter:

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

If CalOptima Health decides to change the record as you requested, the change will be sent to any person who received the information before it was changed. Please tell us if there are any such persons who need the changed information.

No

Yes Please list the person's names and addresses:

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

We will also send the change to other persons that we know received the information before it was changed if they relied, or might in the future rely, on the information. Do you agree to this?

No

Yes

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**RESTRICTIONS:**

CalOptima Health does not have to change your record if:

- CalOptima Health did not create the information.
- The information in the record is accurate and complete.
- You do not have the legal right to access the Protected Health Information (PHI) you want changed.
- The Protected Health Information (PHI) you want changed is not part of the information kept by CalOptima Health (Member Designated Record Set; this includes enrollment information, billing records and records containing your Protected Health Information (PHI) that are used by us to make decisions about you.).

**YOUR RIGHTS:**

To learn more about your privacy rights, please refer to your copy of the CalOptima Health Notice of Privacy Practices. It is also be found on our website: [www.caloptima.org](http://www.caloptima.org), or you can call the CalOptima Health’s Customer Service Department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD/TTY line at **1-714-246-8523** or toll-free at **1-800-735-2929**. We have staff who can speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima Health by calling **1-714-246-8500**.

CalOptima Health cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights.

**SIGNATURE:**

Member Signature: \_\_\_\_\_

If Authorized Representative (please include appropriate documentation):

Print Name: \_\_\_\_\_ Relationship to Member: \_\_\_\_\_

**SUBMIT TO CALOPTIMA HEALTH:**

Return this completed form to:

CalOptima Health Privacy Officer  
505 City Parkway West  
Orange, CA 92868  
Fax: 714-338-3166