HIPAA Privacy Form Instructions

HIPAA Privacy Form for:

- CITGO Petroleum Corporation Medical, Dental and Life Insurance Program for Salaried Employees

  and

- CITGO Petroleum Corporation Medical, Dental and Life Insurance Program for Hourly Employees

The above mentioned plans are referred to as the "Plan" on the form.

For definition of "Terms" refer to the Privacy Notice which can be viewed on the CITGO intranet or internet Web sites.

Note: Forms CANNOT be submitted electronically.
Forms must be printed and completed

Completed forms may be submitted via regular mail to:

CITGO Petroleum Corporation
Benefits Department: N5069
HIPAA Services Contact
P.O. Box 4689
Houston, Texas 77210-4689

or

Completed forms may be submitted via fax to 832-486-1842.

CITGO Petroleum Corporation
Request to Amend Personal Health Plan Information

Form Received By	Date

With certain exceptions, you have a right to request that the Plan amend your health information in a "Designated Record Set." The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete; was not created by the Plan (unless the person or entity that created the information is no longer available); is not part of the Designated Record Set; or would not be available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal or administrative proceedings). **Please print, complete and return this form by regular mail or fax.**

1. Employee/Retiree Name	**1a. Employee/Retiree Health Plan ID Number or SSN**
1b. Employee/Retiree Date of Birth	
2. Name of Person Whose Records You Are Requesting to Amend	**2a. Relationship to Employee/Retiree** ☐ Employee ☐ Spouse ☐ Child ☐ Other
3. Your Name (If not Employee/Retiree)	**3a. Your Relationship to Person in Box 2** ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ **Other (please describe relationship):** ____________
4. Mailing Address for Records	**4a. City, State, Zip Code**

I request that the Plan amend the following information in a personal health plan record **[describe the information that is the subject of the Amendment request]**:

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The identified information should be amended because:

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____

I understand that if the Plan approves my request to amend a health plan record, the Plan will not necessarily delete the original information in the Designated Record Set, but instead may choose to identify the information in the Designated Record Set(s) that is the subject of my request for Amendment and provide a link to the location of the Amendment

Signature ____________________ **Date** __________