


Name of Policy: <u>Medical Record Amendment</u> Policy Number: 3364-90-17 Approving Officer: Executive Vice President of Clinical Affairs Responsible Agent: Privacy Officer Director Health Information Management Scope: The Hybrid and Affiliate Covered Entity of The University of Toledo	 Effective Date: 10/16/2017 Initial Date: April 14, 2003
<input type="checkbox"/> New policy proposal <input type="checkbox"/> Minor/technical revision of existing policy <input type="checkbox"/> Major revision of existing policy <input checked="" type="checkbox"/> Reaffirmation of existing policy	

(A) Policy Statement

Individuals may request amendments to their medical records (also known as protected health information or PHI) as long as the protected health information is maintained in the designated record set.

(B) Purpose of Policy

To ensure that amendments to medical records are in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Regulations, CFR 164.524; 164.526 a process has been established by the Compliance & Privacy Office and the Health Information Management (HIM) Department.

(C) Procedure

1. Patients Wishing to Amend Their Protected Health Information

a. Individual rights

Individuals may submit a request to have their PHI amended. Individuals requesting amendments must do so in writing and provide reasons for the amendments by completing the Request for Correction/Amendment of Health Information form located at <http://utmc.utoledo.edu/patientguests/services/privacy.html>. The individual then must submit the completed form to HIM. When The University of Toledo Medical Center (UTMC) or its components are informed of an amendment to an individual's PHI by another HIPAA covered entity, the hybrid and affiliate covered entity will amend its records to reflect such amendments.

A representative from HIM or Privacy Office will provide the original completed form to the author of the entry that is the subject of the request. Requests for amendment to billing information will be forwarded to and coordinated with the Revenue Cycle Department.

The original completed request for amendment form will be scanned into the patient's medical record. A copy will be sent to the individual making the request.

b. Timelines and notifications

The University of Toledo will act on a request for amendment no later than 60 days after receipt of the request. The author of the entry to be amended will be given 30 days from the date of receipt to respond to the request. Where UT is unable to act on a request for amendment within 60 days of its receipt, the individual will be provided with a written notice and reason for the delay with an expected date for response. The expected response date will be no more than 90 days from the receipt of the request for amendment form.

Amendments will be made accessible through the electronic medical record.

Persons who have received PHI about the patient in the past who need to know about the amendment as documented in the patient's record will be notified. Persons identified by the individual as having received PHI and needing the amendment also will be sent a copy of the amendment. The HIM release of information unit will process and make note of the release of information on the original copy of the amendment before placing it in the patient's record.

c. Denial of request for amendment

The hybrid and affiliate covered entity may deny a request for an amendment if:

- i. The document to be amended was not created by the entity and there is no reasonable basis to believe that the originator of the document is no longer available to act on the amendment. In these cases the department chair will be consulted.
- ii. The information to be amended is not part of the designated record set
- iii. The information is not accurate and complete
- iv. The information is not available for inspection under §164.524

Where the request for an amendment has been denied, a basis for denial and the individual's right to submit a statement of disagreement also must be included. The author of the entry that is the subject of the request may issue a statement of rebuttal to the individual's statement of disagreement if necessary. A copy of the rebuttal statement will be sent to the individual if issued.

The notification of denial also must include procedures for filing a complaint at the hybrid and affiliate covered entity and the office of the Secretary of Health and Human Services. The title and telephone number for an official at the Privacy Office responsible for receiving such complaints at the University of Toledo will be provided.

d. Subsequent disclosures after denial

Where an individual chooses **not** to submit a statement of disagreement, he/she may request that UTMC attach a copy of the request to amend and the decision to deny to any subsequent disclosures pertaining to that request.


Where a statement of disagreement is submitted, the statement together with the following will be attached to any subsequent disclosures pertaining to the request:

- i. A copy of the request to amend form
- ii. A copy of the denial to the request

- iii. A copy of the author’s statement of rebuttal to the statement of disagreement, if available

Where a transaction does not allow the attachment of additional documents, UTMC may submit the required attachments separately to the receiving entity part 162 Subchapter C.

<p>Approved by:</p> <p><u>/s/</u> <u>12.20.17</u> Christopher Cooper, MD <u>Date</u> Executive Vice President of Clinical Affairs</p> <p><i>Review/Revision Completed By:</i> HAS Privacy Office Health Information Management Chief of Staff</p>	<p>Review/Revision Date: 09/01/2013 09/01/2016</p>
<p>Policies Superseded by This Policy:</p>	<p>Next Review Date: 9/01/2019</p>

	<p align="center">RESPONSE TO AMENDMENT REQUEST OF PHI</p> <p align="center">Mailing Address: University of Toledo Medical Center Release of Information Unit – Health Information Management 1015 Research Drive Toledo, OH 43614 Phone: 419-383-4982 Fax: 419-383-3001</p>
---	--

Response to Request

Your requested amendment has been: Granted Denied

If granted, date amendment is included in the health information record: ____ / ____ / ____
Date authorized persons you requested we send the amendment to were notified: ____ / ____ / ____

If denied, your request was denied for the following reason(s):

- The PHI that you requested us to amend was not created by our organization and the organization or individual who created the PHI must make the decision to amend. Please contact the organization or individual that created the PHI that you wish to amend about your desire to amend the PHI.
- The PHI that you requested us to amend is not part of the individual’s designated record set. In accordance with the federal regulations, only information that is part of the designated record set is subject to amendment.
- The author of the PHI that you requested us to amend is accurate and complete and therefore, we are not required to amend it.

Author Comments

Signature Author _____ Date of decision ____ / ____ / ____

Decided within 60 days of request? Yes No
If no, date 30-day extension notice sent to requestor: ____ / ____ / ____

Phone: 419-383-4982
 Fax: 419-383-3001

Patient's Rights Upon Receipt of Denial to Amendment Request

Mailing Address: University of Toledo Medical Center
 Release of Information Unit – Health Information Management
 1015 Research Drive
 Toledo, OH 43614

Patient Information	Amendment Information
Patient Name:	Date of Entry to be amended:
Birth Date:	Type of Entry to be amended:
Med Record Number (optional):	
Address:	Reason for amendment:
Phone#:	

If your request for amendment was denied, you may exercise the following rights:

- You may submit a written statement of disagreement (not to exceed 1-page in length) that will be included with the unchanged health information in any future disclosures of or use of the information.
- If you decided not to submit a statement of disagreement, you may direct us to include your amendment request and this denial response with the unchanged health information in any future disclosures or use of information. (Please check this box and return this to our facility)
- If you believe that we have not followed our information privacy policies of the federal regulations, you may file a written complaint with the University of Toledo Privacy Officer or with the U.S. Department of Health and Human Services Office for Civil Rights.
 - o Lynn Hutt UTMC Privacy Officer..... (419) 383-6933
 - o US Department of Health and Human Service...1-877-696-6775
 - <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>

 Signature of Requestor

 Date

To notify us of the above rights you wish to exercise, please return a copy of this form to the address of the Release of Information Unit of the Health Information Management Department. If you do not wish to exercise any of these rights, retain this form for your records.

UTMC Use Only
Written statement received: <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Date: _____
Rebuttal to be included? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date rebuttal copy mailed to requestor _____



THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

Request for Amendment to Protected Health Information (PHI)

Release of Information Unit – Health Information Management
University of Toledo Medical Center
1015 Research Drive, Toledo, OH 43614
Phone: 419-383-4982 Fax: 419-383-3001

Patient Information

Amendment Information

Patient Name: _____	Date of entry to be amended: _____
Birth Date: _____ SS# _____	Type of entry to be amended: _____
Med Record # (optional): _____	_____
Address: _____	Reason for amendment: _____
_____	_____
Phone: _____	

How is the current information inaccurate or incomplete? (please be specific)

What should the entry say to be accurate/complete? (please be specific)

Would you like this information disclosed to any previous recipient of whom this information may have been disclosed to? (include full name and address)

Yes No

Name of Recipient: _____

Address of Recipient: _____

Signed: _____
(Patient or Authorized Representative) *Date* *(Witness Optional)*

(Relationship to patient and authority to act in the patient's behalf)

UTMC Response to Request

Date of Receipt of Request _____

Your request for Amendment has been granted denied

Signature of UTMC Privacy Officer Date