EVMS Medical Group

POLICY: Amendment or Change to Health Record – Patient Request	DATE: 3/2003	
CATEGORY: PRIVACY	REVIEWED/ REVISED: 04/2013	Page 1 of 3

PURPOSE: To ensure that EVMS Medical Group complies with applicable laws that grant individuals or an individual's legal representative the right to request amendment or correction of PHI in the designated record set.

POLICY: Patients have the right to request amendment or correction of PHI in designated record sets for as long as the information is retained in the designated record set. The request must be in writing. It is recommended that the Amendment of Health Record form be used. Action must be taken on the request within 60 days of its receipt. A one-time, 30 day extension to act on the patient's request may be granted by the Privacy Office. Written notice of this extension setting forth the reason for the delay and a date on which action will be taken must be provided to the patient.

PROCEDURE:

A. Request for Review

1. When a request to change or amend the health record is received by the relevant clinical department, the clinical department will forward the patient's request to the administrator or practice manager for processing.

2. The administrator or practice manager of the clinical department will notify the reviewer, who is typically the patient's health care professional (or designated medical professional), of the patient's request to change or amend his or her health record.

3. The patient's health care professional will determine if the patient's health record should be changed or amended as requested by the patient. The request will be denied if the requested:
   a. Information was not created by EVMS Medical Group.
   b. Information is not part of a designated record set.
   c. Information is not available under the access provision.
   d. Information is accurate and complete.

4. The reviewer will complete the bottom portion of the "request form" stating whether the patient's request has been accepted or denied. This denial must give the reason for the denial as well as tell the patient how to file a complaint with the Privacy Office and the Department of Health and Human Services. Furthermore, the denial must tell the patient about his or her right to disagree with the denial.

5. A copy of the determination (bottom of the request form) will be mailed to the patient within 60 days of receipt of the request by the clinical department. The complete original request form shall be scanned into the patient record.

B. Request for Second Review

1. A patient can request a second review of his or her health record if the request to change or amend is denied at first review.

2. The second review must be conducted by a health professional, typically a physician, not involved in the first review of the patient's request to change or amend his or her health record.

3. The determination of the second review must be provided to the patient within 30 days of receipt of the request for a second review. A denial must include information regarding the patient's rights upon request as follows:

a. Right to file a written statement of disagreement.

b. Right to have the amendment request, denial and any statements of disagreement included with any further disclosures of the patient's health record at issue.

C. Amendment or Change to patient health record

1. The following processes should be used when it is determined that an amendment or change to the record is appropriate.

- EHR
  - In the appropriate record, select the information to changed or corrected;
  - Select "remove findings";
  - Select "save";
  - At this point status will be changed from "finalized" to "amended, unsigned" and becomes a "task" to be signed;
  - Select the appropriate category to add information;
  - Select "text" and type information;
  - Finalize.
- Paper Charts
  A corrected entry can be made by drawing a single line through the error and handwriting the correction above, below or beside the original entry. All corrections must be dated and signed. If the correction is more than a few words, the author may wish to dictate or write an addendum to clarify the content.

2. Copies of the amendment/correction form will be scanned into the EHR or entered in the paper chart as appropriate.

3. Copies of the amendment/correction form will be provided to those individuals or organizations the patient deems necessary and documents on the request form.

4. Copies of the amendment/correction form will also be provided to the facility's direct business associates or others who may rely on that information to the detriment of the patient.

5. Disclosures will be documented on the amendment/correction form with notation indicating to whom the amendment/correction form was sent, the date, and the staff member processing the disclosure.

6. When an amendment/correction form is used, the staff member will make an entry at the site of the information that is being corrected or amended indicating, "see amendment/correction" and will date and sign the entry. In most instances, the request to modify the patient's medical information should be attached to the incorrect or amended entry.