

Sample Policy for Amendment of Protected Health Information

Policy: Patients may request that their Protected Health Information be amended.

Procedures:

1. All requests for amendments will be forwarded to the Privacy Officer, or his/her designee, for a determination of whether the information will be amended.
2. The Provider will act on a request for amendment within 60 days of receiving the request, provided, however, if the Provider is unable to act upon the request within the initial 60 days, it may have an additional 30 days. If an extension is needed, the Provider will notify the patient of the extension within the initial 60-day period.
3. Information will not be amended in any of the following circumstances:
 - a. The Provider was not the creator of the information;
 - b. The Provider believes the information is accurate and complete;
 - c. The information is not part of the Provider's designated record set; or
 - d. The patient may be denied access to the Protected Health Information by the applicable federal or state law.
4. If the Provider determines that the information will be amended it will: (i) append the records at issue or provide a link to the location of the amendment, (ii) notify the patient that the amendment has been accepted, (iii) notify individuals identified by the patient as having received the information who need the amendment and any other individuals the Provider is aware of who received the information and who may have relied upon the information to the detriment of the patient.
5. If the Provider denies the amendment it will provide the patient with a written denial letter which sets forth: (i) the reason for the denial, (ii) the patient's right to submit a disagreement statement which will accompany future disclosures of the information at issue, (iii) if the patient does not submit a disagreement statement, a statement that the patient may request that the patient's initial request for amendment and the Provider's denial accompany future disclosures of the information at issue, and (iv) a description of how the patient may file a complaint with the Provider or the Secretary of Health and Human Services.
6. If the patient submits a disagreement statement or requests that the request for amendment and denial accompany future disclosures of the information at issue, the Provider will append or provide a link to that information. The Provider may also document a rebuttal statement to accompany the information. If the Provider issues a rebuttal statement, a copy of the rebuttal statement will be provided to the patient.
7. In the event the patient is incompetent as determined by his/her physician, this policy shall apply to requests for amendment made on behalf of the patient by the patient's personal representative.

Sample Request for Amendment of Information

Patient's Name: _____
Last First MI Previous Name if Any
Birth Date Social Security # H W Telephone #s

Address: _____

Explanation of information to be amended, including whether amendment applies to all records or one record in particular: _____

Explanation of why information should be amended: _____

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices and understand that although I may request that records be amended, Provider does not have to agree to amend them. By accepting this Request, Provider is agreeing only that it will review the request and determine whether or not it will amend the records. I understand that Provider has 60 days in which to act on this request and may request a 30-day extension, provided I am notified of the extension within the original 60-day timeframe. In the event the Provider denies this request, I understand that I will be informed in writing of the reason for the denial and the opportunity to appeal the Provider's decision.

Signature of Patient/Guardian/Representative

Date Signed

If Guardian/Representative- State Relationship to Patient

FOR INTERNAL USE ONLY

Name of Authorized Individual: _____ Position: _____

Initial whichever is applicable:

- Having read the above request, the request is hereby granted: _____
- Having read the above request, the request is hereby denied: _____

Signature of Authorized Individual

Date Signed

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Sample Form Denial of Amendment Letter

Patient/Requestor's Name
Address

Dear _____:

You previously requested that certain protected information created by us in the course of providing you with health care services be amended. This letter is to notify you that your request has been denied based on the following reason marked below:

- ☐ Information to be amended was not created by the Provider, and there is no reason to believe the originator is not available to amend the information
- ☐ Information to be amended is not part of the Provider's designated record set.
- ☐ Information to be amended is information to which you may be denied access.
- ☐ Information to be amended has been found by us to be accurate and complete.

Although your request for amendment has been denied, you do have the right to submit a written statement of disagreement that states why your request should have been granted. Your statement should be sent to my attention at the above address. This written statement of disagreement will be kept in your medical record, and a copy of your statement, along with your original request and our denial, will accompany any future disclosures of the records at issue. If you do not submit a statement of disagreement, we will only send amendment information with future disclosures of the records at issue with your written request asking us to do so. All such requests should be sent to my attention at the address stated above.

Please do not hesitate to contact me if you have questions regarding this denial. In the event you submit a written statement of disagreement, you may receive a rebuttal statement if we determine such a statement is appropriate.

You may also submit a complaint to the Office of Civil Rights for Health & Human Services regarding our handling of your request for amendment and decision to deny your request via

_____.