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| **DEPARTMENT: Doylestown Healthcare Partnership** |
| **FACILITY:**  |
| **DATE OF ORIGIN: 5/4/2021** | **NEXT REVIEW DATE: 5/4/2022** |
| **AUTHOR (ROLE): ADM Director DHP** |
| **APPROVED BY (ROLE): Network Development / DHP Managing Committee** |

## PURPOSE: Process for patient request for amendments to their medical record.

## SCOPE:

## This policy and procedure applies to Doylestown Healthcare Partnership practices.

**POLICY:**

Doylestown Healthcare Practices are requires to promptly review, evaluate and respond to all requests by patients (or their appropriately designated representatives) for amendments to their medical record. The patient’s rights and the practice’s responsibilities in this regard are set forth at 45 C.F.R.§ 164.526.

**PROCEDURE:**

1. Within ten (10) days of a receipt of a patient’s written request for amendments to their medical record, appropriate individual in the practice shall contact the author(s) of the pertinent sections of the record who shall make a determination as to whether there exists a reasonable basis to amend the record. If the initial request for amendment is received verbally (in person or by phone), the patient shall be provided the Request for Amendment of Medical Records Form and Explanation sheet (see attached collectively as Exhibit A) with instructions to complete and return to the Practice.
2. In evaluating any request for amendment, the Practice shall take into consideration the validity/veracity of the request, and any potential adverse clinical implications in granting (or denying) the request. Requests for amendments shall be granted sparingly, recognizing the potential misuse of such requests.
3. If the request for amendment is granted, eCW/EMR shall be consulted, as necessary to effectuate the change. The patient shall be notified in writing that their request was granted and when the amendment was (or will be) made. Additionally or alternatively, the provider may draft an addendum to the record clarifying the relevant clinical information.
4. If the request is denied, the patient shall be notified in writing by letter in the format with the language identical or substantially the same as the attached hereto and marked as “Exhibit B”. This notification shall be sent to the patient by the Practice.
5. Irrespective of whether the request is granted or denied, the patient shall receive a response within sixty (60) days of receipt of the patient’s request.
6. Exhibit B sets forth the process which may be followed once the denial letter is sent. As articulated theirin, the patient may either:
	1. Submit a written statement disagreeing with the denial which shall be scanned into the patient’s medical record, or
	2. Request that the original request amendment be included with any future disclosures of the record. This will be accomplished by scanning the original request into the patient’s medical record.
7. The patient shall also have the right to provide a written complaint regarding the denial to the Regional manager, Office of Civil Rights of the Department of Health and Human Services.

Reviewed:

Revised:

## C:\Users\fortna\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\4QCJF0XF\DHealthPartnership_FC.png

## Exhibit A

# Request for Amendment of Medical Records

If there is information in your medical record about you that you believe is inaccurate or incomplete, you have the right to request the information be changed or amended.

To request an amendment or addendum to your information, follow the procedure outlined below:

* Complete the attached “Request for Amendment of Medical Records” Form
* Submit your request to *Practice*

**By mail:**

## By email:

## By fax:

Your request will be reviewed by staff at your *Primary Care Office*. You will be notified in writing of the decision to accept or deny your request.

Your Provider may deny a request for amendment based on the following circumstances:

* The information in the record is deemed to be accurate and complete, or there is no basis to change it.
* The information you want change was not created by the *Practice*.
* The information is not part of the designated medical record.

If your Provider denies your request, you will receive a written explanation of the denial. If you disagree with the decision, you can submit a written statement to *your Practice*, setting forth the reasons why you disagree with the denial. That statement will be included in your medical records for future providers to review and consider.

If you have any questions or need further information please contact, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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# Request for Amendment of Medical Records

Patient’s Last Name: First Name:\_ Address: City: State: Zip: Phone: Email:

Date of Birth:

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| --- | --- | --- |
| **Name of the Document (Operative Report, History &****Physical, Progress Notes, etc.)** | **Date of Document** | **Author of Document** |
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Please explain what changes you would like made to your medical record and why you believe this change is appropriate.

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| --- | --- | --- | --- | --- |
| Patient Signature |  | Date |  | Time |
| If person requesting is someone other than patient, |  |  |  |  |
| Signature |  | Date |  | Time |
| Print Name |  |  |  |  |

Relationship to patient **and** authority to request (e.g., legal guardian, Power of Attorney)

## Please send this request to *Practice Name and Address*

**Exhibit B**

 , 202\_

Address: [ ]

Dear Mr. / Ms.[ ]:

Please be advised I am in receipt of your [ ] [ ] 202\_ letter to [ ] requesting [amendments / modifications / change]s to

your medical record of [ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_], 20\_ .

We have carefully reviewed and considered your letter, but unfortunately, must deny this request.

[Rationale here]

Please be advised that you have a right under the HIPAA Privacy Rule to submit a written statement disagreeing with this denial. Such requests should be directed to *Practice.*

When we receive your statement of disagreement, we will place that statement into your medical record for future providers or anyone these records are properly disclosed to, to view and consider. If you do not submit a statement of disagreement, you may request that we provide your request for amendment and the denial with any future disclosures of your protected health information.

You may also provide a written complaint regarding this denial directly to the Regional Manager, Office of Civil Rights of the Department of Health and Human Services in Philadelphia at 215-861-4441. This denial and your rights regarding it are consistent with and mandated by 45 C.F.R.§164.526 pertaining to the amendment of Protected Health Information.

I certainly hope you understand our decision in this regard and our inability to amend your medical record. If you have any questions or need additional information, please do not hesitate to contact me. Thank you.

Very Truly Yours,