

ADMINISTRATIVE POLICY AND PROCEDURE

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Subject: AMENDMENT OF PROTECTED HEALTH INFORMATION (PHI): **Policy No.:** A155
DESIGNATED RECORD SET

Supersedes: March 9, 2011	Review Date: March 21, 2023
Origin Date: March 9, 2011	Revision Date: March 21, 2023

PURPOSE:

Establish a policy and procedure according to the HIPAA Privacy Rule to ensure an individual has the right to request Rancho Los Amigos National Rehabilitation Center to correct or amend Protected Health Information.

POLICY:

Establish a policy and procedure according to the HIPAA Privacy Rule to ensure an individual has the right to request Rancho Los Amigos National Rehabilitation Center to correct or amend Protected Health Information.

DEFINITIONS:

Protected Health Information (PHI) means individually identifiable information relating to past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, current or future payment for the health care provided to an individual.

Designated Record Set means a group of records that contain PHI and are maintained, collected, used, or disclosed by or for Rancho Los Amigos National Rehabilitation Center, and that are either medical records or billing records about an individual; or used, in whole or in part, by or for Rancho Los Amigos National Rehabilitation Center to make decisions about an individual.

Business Associate (BA) means a person or entity who, on behalf of the Rancho Los Amigos National Rehabilitation Center but not in the capacity of a workforce member, performs, or assists in the performance of, a function or activity involving the use or disclosure of PHI, or provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services involving disclosure of PHI.

PROCEDURES:

I. Request for Amendment

- A. An Individual has the right to request amendment of their PHI in the Designated Record Set for as long as the PHI is maintained in the Designated Record Set.
- B. Individuals who wish to request an amendment of their PHI must make their request in writing and may use the Request to Amend (Change) or Correct Protected Health Information form (Attachment A). The request must include the reason for the amendment. The Health Information Management Department will process the completed request.

II. Response to Amendment

- A. HIM shall act upon requests within sixty (60) days of Receipt

Revised: 3/23
Reviewed: 3/23

Approved By:

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- B. The period may extend if HIM cannot answer the individual's request within the initial sixty (60) days. Still, no more than 30 days, so long as Rancho is within the initial 60 days, send the individual a written statement about the reasons for the delay and the date by which Rancho will answer the amendment request. Rancho Los Amigos National Rehabilitation Center can take only one extension.
- C. The Amendment request includes clinical PHI. In that case, the practitioner responsible for the documentation will be consulted to review the request and make the determination to either accept or deny the individual's request.
- III. **Accepting the Amendment** if HIM determines that it agrees with the requested amendment, in whole or in part, it must:
- A. **Make the appropriate amendment to the affected PHI or record.** If a revision request is granted, the facility must identify the specific forms or PHI in the Designated Record Set affected and append or provide a written or electronic linkage to the location of the new amended document.
- B. **Inform the individual.** Within the sixty (60) day timeframe, HIM must inform the individual in writing using the ***Letter Responding to Request to Amend (Change) or Correct Protected Health Information form (Attachment B)*** per the time frame (section II above). HIM accepts the requested amendment. Additionally, HIM must request from the individual the facility of all persons with whom the amendment must be shared and must obtain the individual's agreement that the facility will notify those persons of the amendment.
- C. **Inform others.** Rancho must make reasonable efforts to inform other persons and entities and provide the amendment to persons and entities identified by the patient, as stated in their ***Request to Amend (Change) or Correct Protected Health Information form***, the persons identified by the individual, to third party payers or insurers, and to any person, including business associates, known by Rancho to have the PHI that is subject to the amendment. The purpose of notifying such other individuals is to reduce the changes they might rely on previously incorrect information to the detriment of the individual. HIM will use the Notification ***Letter of Amendment to Protected Health Information (Attachment C)*** to inform others of the accepted amendment.
- IV. **Denying the Amendment:** If HIM rejects the amendment, in whole or part, it must provide the individual with a timely denial, written in plain language using the ***Letter Responding to Request to Amend (Change) or Correct Protected Health Information form*** and including the basis for denial.
- A. **Reasons for denial.** A denial may be denied if:
1. Rancho still needs to create the PHI subject to the requested amendment. However, this is not a reason to deny a request for the basis to support the belief that the originator of the PHI is no longer available to act on the requested amendment (e.g., a defunct medical practice):
 2. The PHI subject to the requested modification is not part of the individual's designated Record Set.
 3. The PHI that is the subject of the requested amendment is accurate and complete; or

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4. The PHI subject to the requested amendment would not be available for inspection for the reasons stated in the Access of Individuals to Protected Health Information Policy and Procedure.

B. Individual's Right to Submit a Statement of Disagreement

1. Using the ***Letter Responding to Request to Amend (Change) or Correct Protected Health Information*** form, Rancho must advise the individual of their right to submit a written statement disagreeing with the denial. The letter will inform the individual how to file a statement of disagreement using the ***Statement of Disagreement/Request to Include Amendment Request and Denial With Future Disclosures*** form.
2. Rancho may prepare a written rebuttal to an individual's written statement of disagreement. Rancho shall provide the individual with a copy of any rebuttal to the statement of disagreement.

C. Individuals' Right to have their Health Record Reflect Requested Amendment and Denial

HIM's written denial (using the ***Letter Responding to Request to Amend (Change) or Correct Protected Health Information*** form) must contain a statement that, if the individual chooses not to submit a statement of disagreement, they may ask that the request for amendment and the denial be made part of their health care record and be included in any future disclosures of the disputed documents.

D. Individual's Right to Complain

HIM's written denial (using the ***Letter Responding to Request to Amend (Change) or Correct Protected Health Information*** form) must also advise the individual of how a complaint may be filed with DHS and the Secretary of Health & Human Services.

E. Appending the information

HIM identifies, as appropriate, the PHI in the Designated Record Set that is the subject of the disputed amendment and appends or otherwise links the following to the Designated Record Set.

1. The individual's request for an amendment,
2. The Rancho's written denial of the requested amendment.
3. The individual's statement of disagreement.
4. The entity's rebuttal statement.

F. Future Disclosures

When a request for amendment has been denied, future disclosures of the PHI that is the subject of the disputed amendment must refer to the requested modification and the denial as follows:

1. If an individual has submitted a statement of disagreement, Rancho includes in the disclosure:
2. The individual's request for an amendment, Rancho's written denial of the request, the individual's statement of disagreement, and any Rancho's rebuttal statement; or

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3. A summary of this information.

G. If an Individual has not submitted a written statement of disagreement, Rancho includes in the disclosure:

1. The individual's request for amendment and Rancho's denial, or
2. A summary of the request and denial; This applies only if the individual has so requested by submitting a ***Statement of Disagreement/Request to Include Amendment Request and Denial with Future Disclosures*** form.

H. Rancho may deliver the information separately when a subsequent disclosure is made, and the information transmission method does not allow the inclusion of some additional details due to size, type, or data content.

I. Actions on Notices of Amendment from Other Covered Entities

If a health care provider, plan, or clearinghouse notifies the hospital of an amendment to an individual's PHI that Rancho has received from the other covered entity. In that case, HIM must amend the individual's PHI per this Policy.

J. Documentation Requirements for an Amendment

HIM shall identify a process for receiving and processing requests for health record amendments. Each method must include at least two elements:

1. Documentation of the titles of the persons or officers responsible for receiving and processing requests for amendments: and
2. Retention of the contact and amendment documentation in written or electronic form for at least six (6) years from the date the documents were created.

REFERENCES:

45 Code of Federal Regulations Parts 160 and 164; Section 164.52

DHS Policy No. 361.14, "Designated Record Set"

DHS Policy No. 361.15, "Access of Individuals to Protected Health Information (PHI)/Designated Record Set"

DHS Policy No. 361.18 "Amendment of Protected Health Information (PHI): Designated Record Set"

Rancho Los Amigos Policy No. "Access of Individuals to Protected Health Information PHI/ Designated Record Set"

ATTACHMENTS:

Attachment A: *Request to Amend (Change) or (Correct) Protected Health Information*

Attachment B: *Letter Responding to Request to Amend (Change) or Correct Protected Health Information*

Attachment C: *Notification Letter of Amendment to Protected Health Information*

Attachment D: *Statement of Disagreement/Request to include Amendment Request and Denial Disclosure*

Adopted from DHS Policy 361.18

REQUEST TO AMEND (CHANGE) OR CORRECT PROTECTED HEALTH INFORMATION

Please type or print the patient's information:

Last Name	First	MI	Date of Birth (Mo/D/Yr)	Medical Record #
Street Address	City	State	Zip Code	

Select the DHS facility for which this request for amendment applies

<input type="checkbox"/> LAC+USC Medical Center	<input type="checkbox"/> Rancho Los Amigos National Rehabilitation Center			
<input type="checkbox"/> Olive View-UCLA Medical Center	<input type="checkbox"/> High Desert Regional Health Center			
<input type="checkbox"/> Harbor-UCLA Medical Center	<input type="checkbox"/> Martin Luther King, Jr. Outpatient Center			
<input type="checkbox"/> CHC/Health Center: _____				
<input type="checkbox"/> Other: _____				
Facility Name	Street Address	City	State	Zip Code

REQUEST DHS TO SEND THE RESPONSE TO THIS REQUEST TO:

Name	Phone Number (include area code)		
Street Address	FAX Number (include area code)		
City	State	Zip Code	E-mail Address

PLEASE TELL US WHAT HEALTH INFORMATION YOU WANT TO AMEND (CHANGE) OR CORRECT:

PLEASE TELL US WHY YOU THINK THE AMENDMENT (CHANGE) OR CORRECTION THAT YOU ARE REQUESTING IS APPROPRIATE OR NECESSARY. YOU MUST PROVIDE A REASON:

MRUN

NAME

DOB/GENDER

**USE OFFICIAL COUNTY/FACILITY LETTERHEAD FOR OUTSIDE
CORRESPONDENCE**

**LETTER RESPONDING TO REQUEST TO
AMEND (CHANGE) OR CORRECT PROTECTED HEALTH INFORMATION**

{Mr./Ms./Mrs. Patient's Name}
{Patient's Address}
{City, State Zip Code}

{Date of Letter}

Date of Birth: {Date}
Medical record number:

Dear {Mr./Ms./Mrs. Patient's Name}:

Thank you for submitting to us your ***Request to Amend (Change) or Correct Protected Health Information***. Your request was forwarded to the responsible practitioner for review.

We received your request to (change) or correct your protected health information dated: {date}.

We have determined that:

- We will make the change as you requested and will notify the person(s) you designated of the change.
- We need more time to process your request. We will send you a response to your request by _____.

REASON FOR PARTIAL DENIAL (IF APPLICABLE)

- We will make the change that you requested, but only in part, and will notify the person(s) you designated of the change.
 - The part of the change that we will make is: {specify}
 - The part of the change that we will not make is (include reason):

REASON FOR FULL DENIAL (IF APPLICABLE)

Your request to change your protected health information is denied because:

- You did not include a reason to support your request.
- The information we have is deemed accurate and complete.
- We did not create the information you want changed, and you did not give us a reasonable basis to believe that the originator of the information is no longer available to act on your request to change the information.
- The information you want changed is not information that you have a right to access.
- The information you want changed is not part of the designated record set. This means your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.
- Other:

YOUR RIGHTS IF WE DENIED YOUR REQUEST TO AMEND (Change) (If Applicable)

If we denied your request to change your protected health information, in whole or in part, you may submit a “**Statement of Disagreement**”. If you do not want to submit a Statement of Disagreement, you may ask us to include your amendment (change) request and our denial along with all future disclosures of the information that you wanted changed by completing the appropriate section on the **Statement of Disagreement/Request to Include Amendment Request and Denial With Future Disclosures** form.

If you want to submit a **Statement of Disagreement/Request to Include Amendment Request and Denial With Future Disclosures**, please request the form from the Health Information Management Department (Medical Records Department). Return the completed form to Health Information Management Department (Medical Records Department).

{Facility Name and Address}

For more information about your health privacy rights, ask a staff member for a copy of our **Health Agency Notice of Privacy Practices**. You may also obtain a copy by visiting our website at dhs.lacounty.gov.

If you believe your privacy rights have been violated, you may file a complaint with us or the Federal Government. You will not be penalized or retaliated against for filing a complaint. To file a complaint with us, or if you have comments or questions regarding our privacy practices, contact facility administration or any of the following offices:

**Los Angeles County Department of Health Services
Privacy Officer
313 N. Figueroa Street, Room 708
Los Angeles, CA 90012
800-711-5366**

To file a complaint with the Federal Government, contact:

**Region IX, Office of Civil Rights
US Department of Health and Human Services
50 United Nations Plaza, Room 322
San Francisco, CA 94102
(415) 437-8310
(415) 437-8329 (Fax)
(415) 437-8311 (TDD)**

Thank you for providing us with this opportunity to assist you and we look forward to continuing to serve your health care needs.

Sincerely,

{Name}
{Title}
{Department}
{Facility/Address}

**USE OFFICIAL COUNTY/FACILITY LETTERHEAD FOR OUTSIDE
CORRESPONDENCE**

**NOTIFICATION LETTER OF AMENDMENT TO
PROTECTED HEALTH INFORMATION**

{Company or Person}
{Address}
{City, State Zip Code}

{Date of Letter}

Dear {Company or Person}:

Regarding Patient: {Mr./Ms./Mrs. Patient's Name}
{Street Address}
{City, State Zip Code}

Date of Birth: {Date}
Medical record number #:

In response to our patient's request to correct their health information, LACDHS has agreed to the requested amendment, and has amended its records accordingly: In compliance with the Health Insurance Portability and Accountability Act (HIPAA), we request you make this same amendment to your existing health records immediately.

The amendment to the patient's health information is as follows:

{explanation}

If you have any questions or concerns, please contact us at {PHONE NUMBER}.

Sincerely,

{Name}
{Title}
{Facility}
{Facility Address}

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES



**STATEMENT OF DISAGREEMENT/REQUEST TO INCLUDE AMENDMENT
REQUEST AND DENIAL WITH FUTURE DISCLOSURES**

PATIENT:

Last Name First MI Date of Birth Medical Record Number

Street Address City State Zip Code

I understand that DHS has denied my Request to Amend/Correct Protected Health Information that was dated _____.

Mark only one box below:

I want to file this "Statement of Disagreement." I disagree with the denial because:

DHS may choose to write a rebuttal statement in response to your Statement of Disagreement. If we do so, we will provide you with a copy of that rebuttal statement. For all future disclosures of your health information we make and that is the subject of the request for amendment/correction, we will include your request for amendment/correction, our denial, your statement of disagreement and our rebuttal statement, if any, or a summary of such information.

I do not want to file a "Statement of Disagreement," but I want DHS to include my amendment request and the denial with any future disclosures of my health information that is the subject of the request for amendment/correction.

**STATEMENT OF DISAGREEMENT/REQUEST TO INCLUDE AMENDMENT
REQUEST AND DENIAL WITH FUTURE DISCLOSURES**

You also have the right to submit a complaint to DHS, Los Angeles County or to the Secretary of the Department of Health and Human Services (“Secretary”). Please contact the Health Information Management Department (Medical Records Department) for the form and procedures. You must file the complaint within 180 days of the time DHS denied your request.

SIGNATURE OF PATIENT/REPRESENTATIVE: _____

If signed by other than the patient, state relationship and authority to do so:

DATE: ____/____/____
Month Day Year



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**Los Angeles County Department of Health Services
Privacy Officer
313 N. Figueroa Street, Room 703
Los Angeles, CA 90012
800-711-5366**

Thank you for providing us with this opportunity to assist you and we look forward to continuing to serve your health care needs.