COUNTY OF LOS ANGELES **DEPARTMENT OF HEALTH SERVICES**

HARBOR-UCLA MEDICAL CENTER

SUBJECT: AMENDMENT OF PROTECTED HEALTH INFORMATION (PHI): DESIGNATED RECORD SET **POLICY NO. 723**

PURPOSE:
To establish a policy and procedure pursuant to the HIPAA Privacy Rule to ensure that an individual has the right to request Harbor-UCLA Medical Center to correct or amend Protected Health Information.

POLICY:
Harbor-UCLA Medical Center will act upon an individual's request for correction or amendment to the individual's Protected Health Information (PHI) for as long as the PHI is maintained by Harbor-UCLA Medical Center in a Designated Record Set.

Harbor-UCLA Medical Center may accept or deny the requested amendment and must observe specific practices pertaining to its response, record keeping, future disclosures, and documentation in accordance with the HIPAA Privacy Rule and as set forth in this Policy.

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

Designated Record Set means a group of records maintained, collected, used or disclosed by or for the Harbor-UCLA Medical Center, and that are either medical records and billing records about an individual; or used, in whole or in part, by or for Harbor-UCLA Medical Center to make decisions about an individual.

Business Associate (BA) means a person or entity who, on behalf of the Harbor-UCLA Medical 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.

PROCEDURE:

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 requests must include the reason for the amendment. The completed requests will be forwarded to the Medical Records Information (MRI) Office for processing, PCDC, Room 101.

II. Response to Amendment

A. Harbor-UCLA Medical Center facilities shall act upon requested within sixty (60) days of receipt.

B. If Harbor-UCLA Medical Center is unable to provide an answer to the individual's request within the initial sixty (60) day period, it may extend the period, but no more than 30 days, so long as Harbor-UCLA Medical Center, within the initial 60 days, send the Individual a written statement about the reasons for the delay, and the date by which Harbor-UCLA Medical Center will provide an answer to the amendment request. Only one extension can be taken by Harbor-UCLA Medical Center.

III. Accepting the Amendment

In the event that Harbor-UCLA Medical Center determines that it accepts the requested amendment, in whole or in part, it must:

A. **Make the appropriate amendment to the affected PHI or record.** If a request for amendment is granted, Harbor-UCLA Medical Center will identify the specific records 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.** The Harbor-UCLA Medical Center shall inform the individual in writing using the **Letter Responding to Request to Amend (Change) or Correct Protected Health Information** form (Attachment B) in accordance with the timeframe in Section II above the Harbor-UCLA Medical Center accepts the requested amendment. Additionally, Harbor-UCLA Medical Center shall request from the individual the name of the facility with whom the amendment must be shared and must obtain the individual's agreement that Harbor-UCLA Medical Center will notify those persons of the amendment.

C. **Inform others.** Harbor-UCLA Medical Center shall 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 to the persons identified by the individual, to third party payors or insurers, and to any persons, including business associates, known by Harbor-UCLA Medical Center to have the PHI that is subject to the amendment. The purpose of notifying such other individuals is to reduce the chances they might rely on previously incorrect information to the detriment of the individual. Harbor-UCLA Medical Center will use the **Notification Letter of Amendment to Health Information** (Attachment C) to inform others of the accepted amendment.

IV. Denying the Amendment: If Harbor-UCLA Medical Center denies the amendment, in whole or in 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. The PHI that is the subject of the requested amendment was not created by Harbor-UCLA Medical Center. However, this is not a reason to deny a request for amendment if the individual provides a reasonable 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 that is the subject of the requested amendment 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

4. The PHI that is the subject of the requested amendment would not be available for inspection for the reason stated in 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, Harbor-UCLA Medical Center will advise the individual of his/her right to submit a written statement disagreeing with the denial. The Letter will inform the individual of how to file a **Statement of Disagreement/Request to Include Amendment Request and Denial with Future Disclosures** form (Attachment D).

2. If the individual does not submit a statement of disagreement, the individual may request Harbor-UCLA Medical Center to provide the Individual's request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment using a **Statement of Disagreement/Request to Include Amendment Request and Denial with Future Disclosures** form.

3. Harbor-UCLA Medical Center may prepare a written rebuttal to an individual's written statement of disagreement. Harbor-UCLA Medical Center will provide the individual a copy of any rebuttal to the statement of disagreement.

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

Harbor-UCLA Medical Center'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, she/he may ask that the request for amendment and the denial be made part of his/her health care record and be included in any future disclosures of the disputed records.

D. Individual's Right to Complain

The Harbor-UCLA Medical Center's written denial (using the **Letter Responding to Request to Amend (Change) or Correct Protected Health Information** form will also advise the individual of how a complaint may be filed with both the DHS and the Secretary of Health & Human Services.

E. Appending the Information

Harbor-UCLA Medical Center 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 be Designated Record Set:

1. The individual's request for an amendment,

2. Harbor-UCLA Medical Center's written denial of the requested amendment,

3. The individual's statement of disagreement, if any, and

4. The entity's rebuttal statement, if any.

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 amendment and the denial as follows:

A. If a statement of disagreement has been submitted by an individual, Harbor-UCLA Medical Center includes in the disclosure:
    1. The individual's request for an amendment, Harbor-UCLA Medical Center's written denial of the request, the individual's statement of disagreement, and Harbor-UCLA Medical Center's rebuttal statement;
    or

    2. A summary of this information.

B. If an individual has not submitted a written statement of disagreement, Harbor-UCLA Medical Center includes in the disclosure:
    1. The individual's request for amendment and Harbor-UCLA Medical Center's denial, or

    2. A summary of the request and denial;

    This applies only if the individual has so requested by submitting Statement of Disagreement/Request to Include Amendment Request and Denial with Future Disclosures form.

V. Actions on Notice of Amendment from Other Covered Entities

If Harbor-UCLA Medical Center is informed by a health care provider, plan or clearinghouse of an amendment to an Individual's PHI that Harbor-UCLA Medical Center has received from the other covered entity, Harbor-UCLA Medical Center will make the corresponding amendment to the individual's PHI in accordance with this Policy.

VI. Documentation Requirement for an Amendment

Harbor-UCLA Medical Center identifies its own process for receiving and processing requests for health record amendments. Each process must include at least two elements:

A. Documentation of the titles of the persons or officers responsible for receiving and processing requests for amendments; and
B. Retention of the contact and amendment documentation in written or electronic form for at least 6 years from the date the documents were created.

REFERENCES:

1. 45 Code of Federal Regulations Parts 160 and 164; Section 164.526
2. DHS Policy No. 361.15 "Access of Individuals to Protected Health Information (PHI)/Designated Record Set

ATTACHMENT A

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

REQUEST TO AMEND (CHANGE) OR CORRECT PROTECTED HEALTH INFORMATION

Please type or print the patient's information:

Last Name First MI Date of Birth Medical Record Number

Street Address City State Zip Code

REQUEST DHS 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:

If we decide to amend (change) or correct the health information as you requested, we will send the amendment or correction to the person(s) or organization(s) you identified below.

Please identify any other person(s) or organization(s) you believe have received your health information and need to be notified of the amendment or correction that you are requesting:

1st Person or Organization	Phone Number (include area code)
Street Address	City State Zip Code
2nd Person or Organization	Phone Number (include area code)
Street Address	City State Zip Code

INFORMATION ABOUT YOUR AMENDMENT (CHANGE) RIGHTS

DHS will not process your request for an amendment (change) or correction of your health information if it is not made in writing on this form or does not tell us why you think the amendment is appropriate. We will tell you in writing within 60 days if we will amend or correct your protected health information as you requested, or we will tell you that we need more time (up to 30 extra days) to decide.

If DHS denies your request for amendment (change) or correction, we will tell you in writing how to submit a *Statement of Disagreement*, a complaint, or how to request that we include your amendment request in your protected health information that we maintain.

SIGNATURE OF PATIENT/REPRESENTATIVE: _____ DATE: ____/____/____ Month Day Year

If signed by other than client, state relationship and authority to do so: _____

Form(s) Of Identification Provided:

State Driver's License _____ State Identification Card _____
Birth Certificate _____ Military ID _____
Other (Provide details) _____

For more information about your health privacy rights, ask a staff member for a copy of our Notice of Privacy Practices. You may also obtain a copy by visiting our website at http://www.dhs.co.la.ca.us or by sending a written request to:

Name of Official/Department
Name of Facility/Cluster Designation
Street and Mailing Address
City, State Zip code

OR

DHS Privacy Officer
Los Angeles County Department of Health Services
313 N. Figueroa Street, Room 708
Los Angeles, CA 90012

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

ATTACHMENT B

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.
    - o The part of the change that we will make is: {specify}
    - o 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 ***Notice of Privacy Practices***. You may also obtain a copy by visiting our website at http://www.dhs.co.la.ca.us/.

If you believe your privacy rights have been violated, you may file a complaint with us, Los Angeles County, 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

Los Angeles County Chief Information Office
Chief Information Privacy Officer
500 West Temple Street, Suite 493
Los Angeles, CA 90012
(213) 974-2164
Email: CIPO@cio.co.la.ca.us

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}

ATTACHMENT C

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}

ATTACHMENT D

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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If you believe your privacy rights have been violated, you may file a complaint with us, Los Angeles County or the Federal Government. You will not be penalized or retaliated against for filing a complaint. 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
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Los Angeles County Chief Information Office
Chief Information Privacy Officer
500 West Temple Street, Suite 493
Los Angeles, CA 90012
(213) 974-2164
Email: CIPO@cio.co.la.ca.us

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