

# CONNECTICUT VALLEY HOSPITAL OPERATIONAL PROCEDURE MANUAL

## SECTION II: ORGANIZATION FOCUSED FUNCTIONS POLICY 10: Management of Information PROCEDURE 10.16: Amendment of Protected Health Information

### Purpose:

To inform Connecticut Valley Hospital (CVH) clinical staff and Health Information Management (HIM) staff, that patients have the right to request an amendment of their Protected Health Information (PHI) of documentation found to be in error for as long as CVH maintains the information.

### Definitions:

1. *Business Associate*: A person or entity who on behalf of the Agency, 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.
2. *Individually Identifiable Health Information*: Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Note: Individually identifiable health information is to be treated as protected health information.
3. *Protected Health Information (PHI)*: 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.

### Procedure:

#### A. Patient Request for Amendment

1. If a patient, following review of his/her medical record documentation, finds information to be in error he/she may request that this information be amended. The patient completes a Request for Amendment of Protected Health Information form (CVH-522).

2. The Request for Amendment of Protected Health Information form is sent to the Director of HIM.
3. HIM notifies the appropriate clinician of the patient's request for amendment (correction) of his/her documentation.

#### B. Granting Amendment Requests

1. If the clinician finds the documentation identified by the patient to be in error, the clinician makes the requested amendment by recording the correction on the document in question, and dates and signs the entry. **DO NOT** cross out or otherwise obliterate the original entry.
2. HIM notifies the patient in writing of the clinician's decision regarding their request for amendment on the Request for Amendment of Protected Health Information form (CVH-522) within a reasonable time frame.
3. HIM files the Request for Amendment of Protected Health Information form (CVH-522) in the Correspondence section of the medical record.
4. HIM notifies all relevant persons with whom the amendment needs to be shared, to include:
  - a. persons identified by the patient as having received his/her PHI; or,
  - b. persons, including business associates of CVH, who have previously received the patient's PHI and have relied on the information for the patient's benefit.

#### C. Denying Amendment Requests

1. CVH may deny an amendment request for the following reason(s):
  - a. the portion to which the amendment request is addressed is accurate and complete;
  - b. CVH did not create the entry to which the amendment request is addressed;
  - c. the portion to which the amendment request is addressed, is not in the medical record; or,
  - d. the portion to which the amendment request is addressed, is information to which the patient does not have a right of access.
2. The clinician records the reason for the denial within 30 days on the Request for Amendment of Protected Health Information form (CVH-522), which also informs the patient that he/she has the right to appeal the denial to the Director of Health Information Management.
3. If the patient chooses to appeal the denial, he/she completes the Request for Appeal of Denial form (CVH-666) which is sent to the Director of HIM.

4. The Director of Health Information Management in collaboration with the Chief of Professional Services determines whether or not to uphold the denial and provides a written notice to the patient within 30 days using CVH-666.
5. If the denial is upheld, the patient is informed of the right to a further review by the Office of Healthcare Information, using CVH-666, Request for Appeal of Denial.
6. HIM places the original request for amendment, the denial (CVH-522) and the Request for Appeal of Denial (CVH-666) into the Correspondence section of the medical record.
7. HIM files any subsequent correspondence received from or sent to the patient in the Correspondence section of the medical record.

### **Illustrations/Examples:**

*Example 1:* A patient's medical record reflects a felony history and incarceration. The patient believes the information is both inaccurate and will negatively impact on his ability to obtain employment and wants to amend the record. However, he provides no written documentation to demonstrate the information is inaccurate and his request is denied. The hospital provides a written notification of the denial, and honors the request from the patient to enter into the medical record his written request for amendment.

*Example 2:* A patient submits a letter on November 15<sup>th</sup> requesting that all instances in her medical record be removed that refer to a drug screen that indicated a positive for opiates. She provides verification from the laboratory, which had maintained a portion of the sample for retesting as required, that in fact, the results were a false positive. The hospital then inserts a notation at each place in the record where there was a reference to the drug screen results. The notation directs the reader to the laboratory section of the medical record that has the corrected results. This process was completed by January 14<sup>th</sup>. Those parties that had received copies of the incorrect results were notified.