**PURPOSE**

To establish guidelines for responding to patient requests to amend Protected Health Information (“PHI”).

**POLICY**

[COVERED ENTITY] recognizes a patient’s right to request that [COVERED ENTITY] amend his or her PHI maintained in the Designated Record Set for as long as the PHI is maintained. The policy of [COVERED ENTITY] is to respond to a patient’s request for amendment of PHI in accordance with the HIPAA Privacy Rule. This policy contains the procedures for approving an amendment, denying an amendment, and making an amendment at the request of another covered entity.

**PROCEDURE**

1. Notification of Right to Request Amendment. [COVERED ENTITY]’s Notice of Privacy Practices will inform patients of their right to amend their PHI contained in one or more designated record sets.
2. Procedure for Making Request. Requests for amendment must be made **in** **writing** on the Amendment of Protected Health Information form. Requests for amendment will not be evaluated until the request form is completed and signed by the patient or the patient’s personal representative.
3. Evaluating and Responding to the Request for Amendment.
   1. [COVERED ENTITY] will make a determination to accept or deny the amendment after consultation with the appropriate staff, if needed.
   2. [COVERED ENTITY] shall act on the request for amendment no later than 60 days after receipt of the request.
      1. If the amendment is accepted, [COVERED ENTITY] shall make the amendment and inform the patient within 60 days of the written request.
      2. If the amendment is denied, [COVERED ENTITY] shall notify the patient in writing of the denial within 60 days of the written request.
   3. If [COVERED ENTITY] is unable to act on the request for amendment within 60 days of receipt of the request, it may have one extension of no more than 30 days. The [COVERED ENTITY] will notify the patient in writing of the extension, the reason for the extension and the date by which action will be taken.
4. Acceptance of Request for Amendment.
   1. If [COVERED ENTITY] accepts the requested amendment, in whole or in part, it will take the following steps:
      1. [COVERED ENTITY] will place a copy of the amendment in the patient’s medical record or provide a reference to the location of the amendment within the body of the medical record.
      2. [COVERED ENTITY] will notify the relevant persons with whom the amendment needs to be shared, as identified by the patient on the original Amendment of PHI form.
      3. [COVERED ENTITY] shall identify, and make reasonable efforts to inform and provide the amendment within a reasonable time to, other persons, including Business Associates, who have the PHI and who may have relied on, or could foreseeably rely on, such information to the detriment of the patient.
      4. [COVERED ENTITY] will inform the patient of the amendment, and will obtain the patient’s agreement to notify such other persons or organizations of the amendment.
5. Denial of Request for Amendment
   1. [COVERED ENTITY] may deny the request for amendment in whole or in part if:
      1. The PHI was not created by [COVERED ENTITY]. An exception may be granted if the patient provides a reasonable basis to believe that the creator of the PHI is no longer available to act on the requested amendment and it is apparent that the amendment is warranted;
      2. The PHI is not part of the Designated Record Set;
      3. The PHI would not be available for inspection under the HIPAA Privacy Rule; or
      4. The PHI that is subject to the request is accurate and complete.
   2. If the [COVERED ENTITY], in consultation with the appropriate staff, determines that the request for amendment is denied in whole or in part, the [COVERED ENTITY] will provide the patient with a timely amendment denial letter. The denial shall be written in plain language and shall contain:
      1. The basis for the denial;
      2. A statement that the patient has a right to submit a written statement disagreeing with the denial and an explanation of how the patient may file such statement;
      3. A statement that, if the patient does not submit a statement of disagreement, the patient may request that [COVERED ENTITY] include the patient’s request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment;
      4. A description of how the patient may file a complaint with [COVERED ENTITY] or to the Secretary of the U.S. Department of Health and Human Services. The description must include the name or title and telephone number of the contact person for complaints.
6. Written Statement of Disagreement. If an amendment request is denied, the patient may submit a written statement of disagreement. If the patient submits a written statement of disagreement, [COVERED ENTITY] may prepare a written rebuttal to the statement. [COVERED ENTITY] shall provide a copy of the written rebuttal to the patient who submitted the statement.
   1. The following documentation must be appended (or otherwise linked) to the PHI that is the subject of the disputed amendment:
      1. The patient’s Amendment of PHI form;
      2. [COVERED ENTITY]’s amendment denial letter;
      3. The patient’s statement of disagreement, if any; and
      4. [COVERED ENTITY]’s written rebuttal, if any.
7. Future Disclosures of PHI that is the Subject of the Disputed Amendment
   1. If the patient submitted a statement of disagreement, [COVERED ENTITY] will disclose all information listed in Item 5. above or an accurate summary of such information with all future disclosures of the PHI to which the disagreement relates.
   2. If the patient did not submit a statement of disagreement, and if the patient has requested that [COVERED ENTITY] provide the Amendment of PHI form and the amendment denial letter with any future disclosures, [COVERED ENTITY] shall include these documents (or an accurate summary of that information) with all future disclosures of the PHI to which the disagreement relates.
8. Actions on Notices of Amendment
   1. If another Covered Entity notifies [COVERED ENTITY] of an amendment to PHI it maintains, the [COVERED ENTITY] shall make the amendment to the patient’s Designated Record Set.
   2. Amendments to the Designated Record Set shall be filed with that portion of the PHI to be amended.
   3. Amendments that cannot be physically placed near the original PHI will be filed in an appropriate location.
   4. If it is not possible to file the amendment(s) with that portion of the PHI to be amended, a reference to the amendment and its location will be added near the original information location.
   5. If the actual amendment is not in an easily recognized location near the original information, the reference should indicate where it could be found.

**REQUEST FOR CORRECTION/AMENDMENT OF**

**PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Entry to be Corrected/Amended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be Corrected/Amended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain how the entry is incorrect or incomplete and describe what you believe the entry should state in order to be more accurate or complete.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you agree, [COVERED ENTITY] will make a reasonable effort to provide the amendment to other persons whom [COVERED ENTITY] knows received the information in the past and who may have relied, or are likely to rely, on such information in a manner that may be detrimental to your health care.

* I agree to allow [COVERED ENTITY] to release any amended information to individuals or entities as described above.

Would you like this amendment sent to anyone else who received the information in the past?

* Yes
* No

If yes, please specify the name and address of the organization(s) or individual(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative Date

**RESPONSE TO REQUEST FOR CORRECTION/AMENDMENT OF**

**PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Request Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amendment has been

* Accepted
* Denied

If denied, check reason for denial:

* PHI is not part of the patient’s designated record set
* Record is not available to the patient for inspection
* [COVERED ENTITY] did not create record
* Record is accurate and complete

Comments of Healthcare Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Healthcare Provider Date

**SAMPLE AMENDMENT ACCEPTANCE LETTER**

## [DATE]

[PATIENT NAME]

[ADDRESS]

[CITY, STATE, ZIP CODE]

Dear [PATIENT]:

Your request to amend your Protected Health Information (see attached form) has been approved. We will notify the individuals and/or organizations that you identified in the original amendment request.

Very truly yours,

[AUTHOR SIGNATURE]

[PRINTED NAME AND TITLE]

**SAMPLE AMENDMENT ACCEPTANCE WITH CONSENT TO NOTIFY LETTER**

## [DATE]

[PATIENT NAME]

[ADDRESS]

[CITY, STATE, ZIP CODE]

Dear [PATIENT]:

Your request to amend your Protected Health Information (see attached form) has been approved. We will notify the individuals and/or organizations that you identified in the original amendment request.

In addition, we have identified the following individuals and/or organizations that received your Protected Health Information. We are not permitted to notify these individuals and/or organizations without your written agreement. If you would like us to notify the individuals and/or organizations listed below, you must sign, date, and return this statement to us.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Very truly yours,

[AUTHOR SIGNATURE]

[PRINTED NAME AND TITLE]

I hereby request and consent to the notification of the above-identified persons and/or organizations who have previously received my Protected Health Information regarding the approval of my request for amendment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Patient or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

**NOTIFICATION OF AMENDMENT LETTER**

## [DATE]

[Name of Individual/Organization to Receive *Notification of Amendment*]

[ADDRESS]

[CITY, STATE, ZIP CODE]

**Re: [PATIENT]**

**Approval of *Amendment of Protected Health Information***

Dear [RECIPIENT]:

We have agreed to a request from the above-referenced patient to amend his/her Protected Health Information as outlined on the attached form entitled “*Amendment of Protected Health Information*.”

In compliance with the HIPAA Privacy Rule (45 CFR §164.526—Amendment of Protected Health Information), we are providing you with proper notification of this approved amendment.

Thank you.

Very truly yours,

[AUTHOR SIGNATURE]

[PRINTED NAME AND TITLE]

**AMENDMENT DENIAL LETTER**

[DATE]

[PATIENT NAME]

[ADDRESS]

[CITY, STATE, ZIP CODE]

***RE: Request to Amend Protected Health Information***

Dear [PATIENT]:

Your request to amend your Protected Health Information (see attached form) has been denied for the following reason(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You have the right to submit a written statement disagreeing with the denial. If you choose to do so, submit your statement to [COVERED ENTITY CONTACT INFORMATION].

If you do not submit a statement of disagreement, you may request that [COVERED ENTITY] include your request for amendment and the denial in any future disclosures of your Protected Health Information.

You may file a complaint by contacting [COVERED ENTITY] at [PHONE NUMBER]. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Any such complaint must

* Be filed in writing (paper or electronically);
* Name the entity that is the subject of the complaint along with a description of the acts or omissions believed to be in violation;
* Be filed within one hundred eighty (180) days of when you knew or should have known that the act or omission complained of occurred (unless this time limit is waived by the Secretary of Health and Human Services).

Please contact [COVERED ENTITY] for contact information.

Very truly yours,

[SIGNATURE]

[PRINTED NAME AND TITLE]