Name of Policy: **Medical record amendment**

Policy Number: 3364-90-17

Approving Officer: President

Responsible Agent: Privacy Officer, Director Health Information Management

Scope: Hybrid and affiliated covered entity of University

Individuals may submit a request to have their PHI amended. Individuals requesting amendments must do so in writing and provide reasons for the amendments by completing the request for correction/amendment of health information form located at https://utmc.utoledo.edu/patientguests/pdf/request_for_correction_amendments.pdf

The individual then must submit the completed form to the health information management department. When the university of Toledo medical center (UTMC) or its components are informed of an amendment to an individual's PHI by another HIPAA covered entity, the hybrid and affiliate covered entity will amend its records to reflect such amendments.

A representative from the health information management department or the privacy office will provide the original completed form to the author of the entry that is the subject of the request. Requests for amendment to billing information will be forwarded to and coordinated with the revenue cycle department.

The original completed request for amendment form will be scanned into the patient's medical record. A copy will be sent to the individual making the request.

(b) Timelines and notifications

The university of Toledo (UToledo) will act on a request for amendment no later than sixty days after receipt of

	# RESPONSE TO AMENDMENT REQUEST OF PHI Mailing Address : University of Toledo Medical Center Release of Information Unit – Health Information Management 1015 Research Drive Toledo, OH 43614 Phone: 419-383-4982 Fax: 419-383-3001

Response to Request

Your requested amendment has been : ☐ Granted ☐ Denied

If granted, date amendment is included in the health information record: _____ / _____ / _____

Date authorized persons you requested we send the amendment to were notified: _____ / _____ / _____

If denied, your request was denied for the following reason(s):

☐

If no,
date 30-
day

extension notice sent to requestor: _____ / _____ / _____

Phone: 419-383-4982
Fax: 419-383-3001

Patient Information	Amendment Information
Patient Name:	Date of Entry to be amended:
Birth Date:	Type of Entry to be amended:
Med Record Number (optional) :	
Address:	Reason for amendment:
Phone#:	

If your request for amendment was denied, you may exercise the following rights:

- ‘ You may submit a written statement of disagreement (not to exceed 1-page in length) that will be included with the unchanged health information in any future disclosures of or use of the information.

- ‘ If you decided not to submit a statement of disagreement, you may direct us to include your amendment request and this denial response with the unchanged health information in any future disclosures or use of information. (Please check this box and return this to our facility)

- ‘

- US Department of Health and Human Service...1-877-696-6775

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Signature of Requestor _____ Date _____

To notify us of the above rights you wish to exercise, please return a copy of this form to the address of the Release of Information Unit of the Health Information Management Department. If you do not wish to exercise any of these rights, retain this form for your records.

UTMC Use Only
Written statement received: Yes No
If yes, Date:
Rebuttal to be included? Yes No
If yes, date rebuttal copy mailed to requestor

How is the current information inaccurate or incomplete? (please be specific)

What should the entry say to be accurate/complete? (please be specific)