LAPEER COUNTY COMMUNITY MENTAL HEALTH

Date Issued 10/22/2012
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CHAPTER Information Management	**CHAPTER** 07	**SECTION** 002	**SUBJECT** 15
SECTION Data Management	**DESCRIPTION** Request to Amend the Electronic Health Record		
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APPLICATION:

☒CMH Staff	☐Board Members	☐Provider Network	☒Employment Services Providers
☐Employment Services Provider Agencies	☒Independent Contractors	☒Students	☒Interns
☒Volunteers			

POLICY:

It shall be the policy of Lapeer County Community Mental Health (LCCMH) to maintain a standardized process for responding to persons served who request to amend their health record.

STANDARDS:

A. LCCMH will follow the procedures set forth in this policy and maintain documentation of any and all requests for amendments to records.

B. LCCMH will be responsible for maintaining a complete electronic health record, including following policies and procedures to safeguard the data integrity, security and privacy of the Electronic Health Record.

C. Requests to amend Protected Health Information (PHI) must be made by the person served and/or legal guardian.

D. Response must be timely and in a standardized manner for all requests received from a person served and/or legal guardian to amend their record.

E. All requests from persons served and/or their guardian for amendments of health records that are received by LCCMH will be documented.

F. The request for amendment should be denied if:

1. LCCMH did not create the information
2. the staff that created the information is no longer employed at the agency
3. the information is not part of the individual record
4. the information in the record is currently accurate and complete.

G. The records are to be amended at the discretion of the LCCMH designated clinical staff in consultation from the program supervisor.

PROCEDURES:

Clinical Staff/ Primary Case Holder

A. Reviews the written request made by the person served, which clearly details what is to be amended in their electronic health record and why.

B. Determines if the request for amendment is to be honored or denied.
   1. If approved, staff informs the person served and/or legal guardian that the amendment was accepted and made, and a copy of the amended information is provided to anyone who has received the information subject to that amendment.
   2. If denied, staff (with the consultation of their supervisor) provides to the person served and/or legal guardian, a letter which includes an explanation of the reason for denial and the person's right to submit a written statement disagreeing with the denial. The person served is also provided with information on how to submit a complaint.

C. Reviews person served's letter of disagreement, if submitted. LCCMH prepares a written response to statement of disagreement and provides a copy to the person served that includes: the information that the person served and/or legal guardian wanted amended, the person served's request for amendment, LCCMH's denial of the request, the person served's statement of disagreement and LCCMH's

written rebuttal including the name and title of the staff responsible for receiving and processing the amendment requests.

D. Documents in the health record of the person served the processing of the request for amendment and outcome. Supporting documentation will be submitted for scanning into the electronic health record of the person served.

E. Ensure copies of correspondence with the person served and/or legal guardian is scanned into the electronic health record of the person served in the correspondence section.

DEFINITIONS:

A. Electronic Health Record (EHR) - A longitudinal electronic record of an individual's health information generated by one or more encounters in a care delivery setting which includes demographics, service plan, progress notes, medications, vital signs, past history, etc. The information is maintained in a form able to be processed by a computer that is stored and transmitted securely, and is accessible by multiple authorized users. The EHR has the ability to generate a complete record of a clinical encounter, as well as supporting other care-related activities directly or indirectly via interface – including evidence-based decision support, quality management, and outcomes reporting. Its primary purpose is the support of continuing, efficient and quality integrated health care, and it contains information that is retrospective, concurrent and prospective. An EHR replaces the paper medical record as the primary source of case record information.

B. Protected Health Information (PHI) – individually identifiable health information (1)(i) transmitted by electronic media; (ii) maintained in any medium described in the definition of electronic media or (iii) transmitted or maintained in any other form or medium. (2) Excludes individually identifiable health information in (2)(i) Education records covered by the Family Educational Right and Privacy Act, as amended 20 U.S.C. 1232g; and (ii) records described at 20 U.S.C. 1232g(a)(4)(B)(iv).

REFERENCES:

- HIPAA Privacy Rule, 45 CFR Part 164 (164.502)
- Protected Health Information, 45 CFR Part 160 (160.130)
- Mental Health Code, Act 258 of 1974, 330.114

SK:mgr