



DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

SUBJECT: CLIENT RIGHTS TO AMEND MENTAL HEALTH INFORMATION	POLICY NO. 500.22	EFFECTIVE DATE 04/14/03	PAGE 1 of 5
APPROVED BY:  <div style="text-align: right;">Director</div>	SUPERSEDES	ORIGINAL ISSUE DATE	DISTRIBUTION LEVEL(S) 1

PURPOSE

- 1.1 To establish a uniform policy pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule to ensure clients have the right to request that the Department of Mental Health (DMH) amend their Protected Health Insurance (PHI) maintained in a Designated Record Set. The requirements of this policy apply only to PHI for as long as the PHI is maintained in the Designated Record Set.

POLICY

- 2.1 In accordance with the applicable state and federal laws, it is the policy of DMH to provide clients with the right to amend their PHI that is maintained by DMH in a Designated Record Set.

DEFINITIONS

- 3.1 **“Protected Health Information”** 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.
- 3.2 **“Designated Record Set”** means a group of records that contain PHI maintained, collected, used or disclosed by or for the County of Los Angeles Department of Mental Health that includes medical, billing enrollment, payment, claims adjudication and other records used to make decisions about an individual.
- 3.3 **“Business Associate”** means a person or facility who, on behalf of the County of Los Angeles Department of Mental Health, 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

- 4.1 Request for Amendment/Correction
 - 4.1.1 If a client requests an amendment, the client should be instructed to contact a member of the treatment team.



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- 4.1.2 All requests for amendment of health information must be in writing and must provide a reason to support the amendment. Clients are notified in advance of the written requirement within the Notice of Privacy Practices.
- 4.1.3 A treatment provider may assist the client in completing the Request to Amend/Correct Health Information form (Attachment I).
- 4.1.4 DMH must act on the client's request for amendment no later than sixty (60) days after receipt of the request. DMH may have a one-time extension of up to thirty (30) days to provide an answer to the amendment request as long as DMH gives the client a written statement of the reason for the delay and the date by which the amendment will be processed.
- 4.1.5 Upon receipt of the request, the treatment provider or Program Head shall be responsible for establishing the identity of the requestor by following the procedures outlined in the Verification of Identity and Authority policy. Difficulty in establishing identity shall not intentionally be used to delay or hinder authorized access.
- 4.1.6 Upon completion and submission of the Request to Amend/Correct Health Information form, the treatment provider will give one copy of the form to the client and the original form will accompany the chart and be sent to the responsible practitioner of the client for review and consideration.
- 4.1.7 The responsible practitioner will review the request and make a determination if the request for amendment should be accepted or denied, either in whole or in part. The responsible practitioner will complete the Letter Responding to Request to Amend/Correct Health Information (Attachment II) and sign the letter upon completion. A copy of the completed form will be provided to the client. The original signed letter will become a permanent part of the medical record.
- 4.2 Acceptance of the Request for Amendment
- 4.2.1 If the request is granted, in whole or in part, the responsible practitioner must make the appropriate amendment to the affected PHI or record in accordance with the Department's medical records correction process (refer to Medical Records Amendment policy) by inserting the amendment in the chart. (**for example**, place a red stamp on the front of the medical record identifying that the record has been amended or use an amendment tap placed anywhere an amendment was made within the medical record.) When an amendment form is used, the responsible practitioner will make an entry at the site of the health information that is being corrected or amended indication "see amendment" and will date and sign that entry. The amendment form will be attached to



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the incorrect or amended entry. Health information should remain in its original form and the integrity of the medical record should be maintained at all times.

4.2.2 DMH must inform the client in a timely manner in writing (using the Letter Responding to Request to Amend/Correct Health Information form) that the requested amendment was accepted.

4.2.3 Within thirty (30) days, DMH must make reasonable effort to provide the amendment to persons identified by the client, as stated in the client's Request to Amend/Correct Health Information form, as well as persons, including business associates, that DMH knows have the health information that is the subject of the amendment and that may have relied on or could foreseeably rely on the health information to the detriment of the client. The treatment team must complete and submit the Notification Letter for Amendment of PHI (Attachment III) to the identified persons, organizations or business associates.

4.3 Denial of Amendment Requests

4.3.1 DMH may deny the request if the PHI that is the subject of the request:

4.3.1.1 Was not created by DMH, unless the individual provides a reasonable basis to support the belief that the originator of the PHI is no longer available to act on the request;

4.3.1.2 Is not part of the Designated Record Set;

4.3.1.3 Is not accessible to the client for reasons stated in the Client's Right to Access, Inspect and Copy Health Information policy and in accordance with applicable state and federal laws; or

4.3.1.4 Is not accurate or complete.

4.4 Denial Disputes/Disagreements

4.4.1 DMH must permit the client to submit a Statement of Disagreement (Attachment IV) of reasonable length disagreeing with the Department's denial of all or part of a requested amendment and explaining the basis for the disagreement.

4.4.2 DMH may prepare a written rebuttal to the client's Statement of Disagreement. Whenever such a rebuttal is prepared, DMH must provide a copy to the client who submitted the Statement of Disagreement.



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4.4.3 DMH must, as appropriate, identify the PHI in the Designated Record Set that is the subject of the disputed amendment and append:

4.4.3.1 The Department's denial of the request;

4.4.3.2 The client's Statement of Disagreement, if any; and

4.4.3.3 The Department's rebuttal, if any.

4.5 Future Disclosures

4.5.1 If a Statement of Disagreement has been submitted by the client, future disclosures of the client's PHI shall include the material described above.

4.5.2 If the client does not want to file a Statement of Disagreement, he/she may request that DMH include their amendment request and the denial with future disclosures of their PHI that is the subject of the request using the Request to Include Amendment Request and Denial with Future Disclosures of the Statement of Disagreement. If the client has not submitted a Statement of Disagreement, only the client's request for amendment and the Department's denial shall be included with future disclosures, but only upon the client's request to that effect.

4.5.3 Instead of the materials described above, DMH may attach an accurate summary of such material.

4.5.4 When a subsequent disclosure is made using a standard transaction that does not permit additional material to be included, DMH may separately transmit the material required.

4.6 When DMH is notified by another entity of an amendment to a client's health information, the facility must follow the procedures defined in Section 4.2 of this policy.

DOCUMENT RETENTION

5.1 This policy and associated forms will be retained for a period of at least seven (7) years from the date of its creation or the date when it was last in effect, whichever is later.

AUTHORITY

HIPAA, 45 CFR, Section 164.526



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ATTACHMENTS

Attachment I	Request to Amend/Correct Health Information
Attachment II	Letter Responding to Request to Amend/Correct Health Information
Attachment III	Notification Letter for Amendment of PHI
Attachment IV	Statement of Disagreement

REQUEST TO AMEND/CORRECT HEALTH INFORMATION

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (“LACDMH”)

CLIENT:

Name of Client

Date of Birth

MIS #

Street Address

City, State, Zip

REQUEST DMH SEND THE RESPONSE TO THIS REQUEST TO:

Name

FAX Number (include area code)

Street Address

Phone Number (include area code)

City, State, Zip

PLEASE TELL US WHAT HEALTH INFORMATION YOU WANT TO AMEND/ CORRECT:

PLEASE TELL US WHY YOU THINK THE AMENDMENT OR CORRECTION THAT YOU ARE REQUESTING IS APPROPRIATE OR NECESSARY. YOU MUST PROVIDE A REASON:

REQUEST TO AMEND/CORRECT HEALTH INFORMATION

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (“LACDMH”)

If we decide to amend/correct the health information as you requested, we will send the amendment/correction to the persons or organizations you identified below. Please identify any other persons or organizations you believe have received your health information and need to be notified of the amendment/correction that you are requesting:

1st Person or Organization

FAX Number (include area code)

Street Address

Phone Number (include area code)

City, State, Zip

2nd Person or Organization

FAX Number (include area code)

Street Address

Phone Number (include area code)

City, State, Zip

INFORMATION ABOUT YOUR AMENDMENT/CORRECTION RIGHTS

DMH will not process your request for an amendment/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 act on your request within 60 days (or 90 days if extra time is needed), and will inform you in writing as to whether the amendment will be made or denied.

If DMH denies your requested amendment, we will tell you in writing how to submit a *Statement of Disagreement*, or a complaint, or how to request that we include your amendment request in your health information that we maintain.

Signature of Client / Personal Representative

Date

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



DEPARTMENT OF MENTAL HEALTH

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

LETTER RESPONDING TO REQUEST TO AMEND/CORRECT HEALTH INFORMATION

Date of Birth:
MIS #:

Dear

Thank you for submitting to us your **Request to Amend/Correct Health Information**. Your request was forwarded to the responsible practitioner for review.

We received your request to amend/correct your protected health information dated.

We have determined that:

- We will make the change as you requested and will notify the persons 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 persons you designated of the change.
 - The part of the change that we will make is:

 - 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 (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 Treatment Team. After completing the form, return it to the Treatment Team or mail it to:

**Los Angeles County Department of Health Services (LACDHS)
Patient's Rights Division
550 South Vermont Avenue
Los Angeles, CA 90020**

You have the right to submit a complaint to the County's Privacy Official or to the federal government. To file a complaint with Los Angeles County, contact:



DEPARTMENT OF MENTAL HEALTH

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

**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 for Civil Rights,
US Department of Health and Human Services
50 United Nations Plaza-Room 322
San Francisco, CA 94102
Voice Phone (415) 437-8310
FAX (415) 437-8329
TDD (415) 437-8311**

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.

Sincerely,

Department of Mental Health
Los Angeles County



DEPARTMENT OF MENTAL HEALTH

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

NOTIFICATION LETTER OF AMENDMENT TO HEALTH INFORMATION

Dear

Regarding Client:

Date of Birth:

MIS #:

In response to our client's request to correct their health information, LACDMH 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 client's health information is as follows:

If you have any questions or concerns, please contact us at _____ .

Sincerely,

Department of Mental Health
Los Angeles County

**STATEMENT OF DISAGREEMENT/REQUEST TO INCLUDE
AMENDMENT REQUEST AND DENIAL WITH FUTURE
DISCLOSURE**

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (“DMH”)

CLIENT:

Name of Client

Date of Birth

MIS #

Street Address

City, State, Zip

I understand that DMH has denied my Request to Amend/Correct Health Information that was dated

Mark only one box below:

I want to file this “Statement of Disagreement.” I disagree with the denial because:

DMH 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 that we make and that are 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 DMH to include my amendment (change) request and the denial with any future disclosures of my health information that is the subject of the request for amendment/correction.

You also have the right to submit a complaint to DMH, Los Angeles County or to the Secretary of the Department of Health and Human Services (“Secretary”). Please contact the Treatment Team for the form and procedures. You must file the complaint within 180 days of the time DMH denied your request.

STATEMENT OF DISAGREEMENT/REQUEST TO INCLUDE
AMENDMENT REQUEST AND DENIAL WITH FUTURE
DISCLOSURE

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (“DMH”)

Signature of Client / Personal Representative

Date

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

Facility

Practitioner

Date

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

Patient’s Rights Office
Los Angeles County Department of Mental Health
550 S. Vermont Ave., 5th Floor
Los Angeles CA 90020

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.