RECORDS - CORRECTION OF INFORMATION

THE LAW

"A subject **individual**, or the parent, guardian or person in the place of a parent of a minor, or the guardian of an incompetent may, after having gained access to treatment records, challenge the **accuracy, completeness, timeliness, or relevance of factual information** in his or her treatment records and **request in writing** that the facility maintaining the record **correct the challenged information**. Such request shall be **granted or denied within 30 days** by the director of the treatment facility, the director of the county department under s. 51.42 or 51.437, or the secretary depending upon which person has custody of the record. Reasons for denial of the requested changes shall be given by the responsible officer and the individual shall be informed of any applicable grievance procedure or court review procedure. If the request is denied, the individual, parent, guardian or person in the place of a parent shall be allowed to **insert into the record a statement correcting or amending the information at issue**. The statement shall become a part of the record and shall be released whenever the information at issue is released." § 51.30(4)(f), Wis. Stats. [Emphasis added.]

"(a) Correction of factual information in treatment records **may be requested by** persons authorized under s. 51.30(4)(f), Stats., or by an attorney representing any of those persons. Any requests, corrections or denial of corrections shall be in accordance with s. 51.30(4)(f), Stats., and this section.

(b) A written request shall **specify the information to be corrected and the reason for correction** and shall be entered as part of the treatment record until the requested correction is made or until the requester asks that the request be removed from the record.

(c) **During the period that the request is being reviewed**, any release of the challenged information shall include a copy of the information change request.

(d) If the request is **granted**, the treatment record shall be **immediately corrected** in accordance with the request. Challenged information that is determined to be completely **false**, **irrelevant or untimely** shall be **marked through and specified as incorrect**.

(e) If the request is **granted**, **notice of the correction** shall be sent to the person who made the request and, upon his or her request, to any specified past recipient of the incorrect information.

(f) If investigation **casts doubt** upon the accuracy, timeliness or relevance of the challenged information, but a **clear determination cannot be made**, the responsible officer shall set forth **in writing** his or her doubts and both the challenge and the expression of doubt shall **become part of the record** and shall be included whenever the questionable information is released.

(g) If the request is **denied**, the denial shall be made **in writing** and shall include **notice to the person** that he or she has a right to **insert a statement in the record** disputing the accuracy or completeness of the challenged information included in the record.

(h) Statements in a treatment record which render a diagnosis are deemed to be **judgments based on professional expertise** and are **not open to challenge**."

DHS 92.05(5), Wis. Admin. Code [Emphasis added.]

[NOTE: The federal **Health Information Portability and Accountability Act of 1996** (**HIPAA**) went into effect April 14, 2003. That act contains provisions concerning correction of records that affect or may supercede state law. Level III and IV grievance decisions issued concerning issues that arose prior to that date do not take into account HIPAA standards. The HIPAA standards are:

"(1)... An individual has the right to have a [service provider] **amend** protected health information or a **record** about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

(2) ...A [facility] **may deny** an individual's **request for amendment**, if it determines that the protected health information or record that is the subject of the request:

(i) Was **not created** by the [service provider], unless the individual provides a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;

(ii) **Is not** part of the designated **record** set;

(iii) Would **not be available** for **inspection** under [other provisions]; or

(iv) Is **accurate** and **complete**."

45 CFR 164.526(a) [Emphasis added.]

DECISIONS

1. A client **objected to an entry** in her chart which raised the possibility that the client was **stalking her therapist**. She was informed of her **right to enter a correction** of information into the treatment record per § 51.30(4)(f), Stats. She did enter an addendum in the record and it is now attached to the reference about possible stalking concerns and will be released whenever the related record is released. This was the **appropriate remedy** for her objection. (Level III Grievance Decision in Case No. 04-SGE-07, affirmed at Level IV on 8/15/05)

2. An outpatient client **disagreed with** her therapist assigning her an Axis II Borderline Personality Disorder **diagnosis**. A diagnosis is ultimately a professional opinion and given “due deference”. However, the professional opinion of the therapist did not take into account the physiological factors that the client later became aware of, post-

therapy. It was **recommended** that she **submit a clarification** of her treatment record that included her experiences and the m**edical information** from her **physician**. (Level III Grievance Decision in Case No. 05-SGE-12 on 5/16/06)

3, A discharged patient complained about the **accuracy of his treatment records**. An **addendum was added** to his records by the same doctor who saw him originally. **He was not satisfied** with the addendum and grieved the matter. In the response to his appeal to Level IV, the **provider recommended that he submit a "Statement of Disagreement" setting forth his own version for the treatment records**. Copies of that statement would be disclosed simultaneously with any subsequent release of his records. **That is the appropriate remedy** for a disagreement about the contents of treatment records and is consistent with Sec. 51.30(4)(f), Wis. Stats., DHS 92.05(5), Admin. Code, and federal HIPAA rules. (Level IV decision in Case No. 09-SGE-01 on 8/19/09)

4. A client **complained about the evaluation** she received at a clinic. She **wanted the results of the evaluation removed** from records because of the state of mind she was in at the time of the evaluation. She argued that the result of the assessment were harmful to her in the past and continued to harm her relationship with her current physician. **The remedy available to challenge record inaccuracies was set by the Legislatur**e in ss. 51(30)(4)(f), Stats. The accompanying **right to insert ones own version of the facts** into one's records offers **an appropriate solution** for those who disagree with their records. That process is legally adequate to remedy any perceived errors in the records. (Level IV decision in Case No. 10-SGE-02 on 10/19/10)

5. **Documents will not be removed from records under any circumstances**, **even if flawed.** The appropriate **remedy**, if one was necessary, **would be for the client to include a clarifying document in the records** referring to the original document and stating what the client felt was wrong with it. The **client's version of the facts will be released** along with the client's records to anyone who has the client's consent to obtain copies of those records or to anyone who is exempt under the consent provisions under law. (Level IV decision in Case No. 10-SGE-02 on 10/19/10)

6. If a client feels that there are inaccuracies in her treatment record, she **can prepare a narrative** and have that **placed in her records**. It will be released along with any future releases of records that occur. However, **she cannot undo her diagnosis.** (Level III decision in Case No. 09-SGE-05 on 3/04/11)

7. An ex-patient **felt that her records inaccurately reflected her behavior.** A **rights violation could not be found without a showing of inaccuracies that affected her current treatment.** She **had the right to add any information to her treatment file** that she felt was necessary to accurately depict her status. Her right to inspect, copy or challenge her confidential medical records was not violated. (Level III decision in Case No. 11-SGE-01 on 6/28/11)

8. A patient challenged her medical record. The provider **initiated a medical record amendment process**. Her doctor found her records to be accurate and complete. **Two addenda were added** to her record with clarifications. These addenda show that the provider did allow her to challenge the accuracy of her record and properly considered each of her challenges. Therefore, **her right to challenge her records was respected.** (Level III decision in Case No. Case No. 11-SGE-07 on 06/22/12)

9. Doctors have **discretion to speculate** as to the reasons for a patient's symptoms **without having to match them to the patient's own speculations**. (Level III decision in Case No. Case No. 11-SGE-07 on 06/22/12)

10. A patient challenged the accuracy of her treatment records. Provider refused to change the records to accommodate patient's desires, however facility offered patient the opportunity to add and addendum to the record. Since there is **no requirement to change treatment records to suit a patient's view of events** there was no violation of the patient's right to challenge the accuracy of the records under these facts. (Level III decision in Case No. 16-SGE-08 on 5/26/2017)

[Document last updated: 07/17/2018. Digesting in progress for cases decided after 2013]