Guidelines for Ensuring Accuracy of Medical Records and Responding to Patient Correction Requests

This section will:

- identify requirements to keep paper and electronic records accurate
- explain patients' rights to verify the accuracy of their medical records and ask for corrections

Regardless of the method used to record personal information, the designated privacy officer must ensure that the information is up-to-date and accurate. Personal health information must be documented in the record as soon as possible after an event has occurred, providing current information on the care and condition of the patient. The clinical consequences of inaccurate personal health information can range from personal embarrassment to physical harm or even death.

Under PIPA, individuals have the right to request corrections to their personal information if they believe it is not accurate or complete. Of course, professional or expert opinions cannot be corrected or changed. If the correction is reasonable, the privacy officer must amend the information as requested, and send a copy of the amendment to each organization that received the inaccurate or incomplete information within the past year. If no correction is made, the privacy officer must explain the reasons for refusing the correction, and annotate the personal information with the correction that was requested but not made.

A practice's privacy policy should describe how personal health information is kept accurate and how patients may request corrections to their information. Patients (or their legally authorized representative) may make a request for correction in writing (see Form – Patient's Request to Correct Personal Information) and a practice must respond **within 30 working days** of receiving a request.

The privacy officer must educate staff on how to appropriately respond to such requests. If a patient is not satisfied with the outcome, he or she may request a review by the College of Physicians and Surgeons or make a complaint to the OIPC.

Best practices for maintaining accuracy include that personal health information in paper-based medical records should be:

- written clearly, legibly, and in such a manner that it cannot be erased
- readable on any photocopies or faxes
- accurately dated, timed, and signed, with the name of the author printed alongside the first entry
- wherever possible, written with the involvement of the patient

- clear, unambiguous, and written in terms that the patient can understand (abbreviations, if used, should follow common conventions)
- for any alterations or additions, dated, timed, and signed in such a way that the original entry can still be read clearly
- when not making a requested correction, noted clearly with details of the request and reasons for not making changes
- organized in a consecutive or chronological order

Other medical observations must also be included such as examinations, tests, diagnoses, prognoses, prescriptions, and other treatments.

EMRs should:

- have the ability to correct information through an amendment (e.g., the original data must not be modified or deleted as history should be maintained)
- accurately date and time-stamp a correction, recording who made the amendment
- allow for an annotation whenever a correction is requested but not made
- be able to generate a copy of a medical record with the amended information and correction history