

## ASSEMBLY THIRD READING

AB 1637 (Caloza)

As Amended April 8, 2026

Majority vote

**SUMMARY**

Clarifies that a physician and surgeon is responsible for their own patient medical documentation and prohibits anyone from altering a physician and surgeon's patient documentation.

**Major Provisions**

- 1) Specifies that a physician and surgeon's patient notes are the responsibility of that physician and surgeon, regardless of the clinical setting.
- 2) Prohibits the altering, modification, or editing of a physician and surgeon's patient notes, after-visit summaries, and diagnosis and treatment plans except by the authoring physician and surgeon and any of the following:
  - a) A scribe, medical assistant, or other authorized individual delegated by the authoring physician and surgeon.
  - b) A physician and surgeon who is adding to an authoring physician and surgeon's patient notes if patient care has been transferred from the authoring physician and surgeon to the physician and surgeon who is making the additions.
  - c) A physician and surgeon altering, modifying, or editing the patient notes of a physician and surgeon postgraduate training licensee, intern, resident, or postdoctoral fellow who the physician and surgeon is supervising.

**COMMENTS**

*Background.* The Medical Practice Act requires all physicians to maintain adequate and accurate records of the services they provide to their patients for a minimum of seven years. The act also makes the failure to do so unprofessional conduct, meaning the physician is subject to disciplinary action by the Medical Board of California (MBC). The severity of the action, which ranges from probation to revocation of the license, is proportional to the gravity of the violation.

The act does not specify what constitutes a failure to maintain the records other than adequacy, accuracy, and retention. The sponsor argues that this lack of specificity opens the door for someone other than a physician to modify the physician's records. This bill reinforces that it is the authoring physician who is responsible for the records while also making it unlawful for anyone else to modify the records.

**According to the Author**

"Trust is the lifeblood of any healthcare system. Without it, care is compromised, expertise is doubted, and lives are put at risk. [This bill] protects our patients and strengthens physician-patient relationships. Under current law, any person has the authority to electronically alter medical documentation, leaving patient care vulnerable to manipulation, misinformation, and irreversible harm. There is a discrepancy with who is responsible and who is held accountable for medical record-keeping. [This bill] draws clear lines of responsibility by ensuring that

physician-authored notes, diagnoses, and treatment plans cannot be modified by anyone other than the physician who created them."

### Arguments in Support

The *American Federation of State, County and Municipal Employees (AFSCME)*, *AFL-CIO* writes in support:

[This bill] establishes a clear and essential standard: that a physician and surgeon retains full responsibility for, and control over their patient medical documentation. By ensuring that patient notes, after-visit summaries, and diagnosis and treatment plans cannot be altered, modified, or edited by anyone other than the authoring physician, this bill protects the integrity of the medical record and reinforces the physician's clinical judgment.

This protection is increasingly important in modern healthcare environments where documentation may pass through multiple hands, including administrative staff, third-party contractors, and electronic health record systems that allow for downstream edits. Unauthorized or inappropriate alterations to physician documentation can lead to serious consequences, including compromised patient safety, clinical errors, liability concerns, and erosion of trust between patients and providers.

For public sector physicians in particular who often work in high-volume, resource-constrained settings, maintaining the accuracy and integrity of the medical record is critical. These physicians must be able to rely on their documentation as a true and unaltered reflection of their clinical decision-making. [This bill] ensures that accountability remains where it belongs: with the licensed physician responsible for the patient's care.

### Arguments in Opposition

None on file

## FISCAL COMMENTS

The Osteopathic Medical Board of California (OMBC) and the Medical Board of California (MBC) anticipate minor and absorbable costs to address a small number of additional documentation-related complaints, staff training, updating written guidance, communications to licensees, and creation of a new violation code.

## VOTES

### ASM BUSINESS AND PROFESSIONS: 19-0-0

**YES:** Berman, Johnson, Addis, Ahrens, Alanis, Bains, Aguiar-Curry, Caloza, Chen, Elhawary, Hadwick, Haney, Hart, Irwin, Jackson, Lowenthal, Macedo, Nguyen, Pellerin

### ASM APPROPRIATIONS: 13-0-2

**YES:** Wicks, Hoover, Arambula, Caloza, Dixon, Fong, Mark González, Krell, Pacheco, Pellerin, Solache, Ta, Tangipa

**ABS, ABST OR NV:** Calderon, Muratsuchi

**UPDATED**

VERSION: April 8, 2026

CONSULTANT: Vincent Chee / B. & P. / (916) 319-3301

FN: 0002415