SAMPLE - Confidentiality and Release of Patient Health Information Policy

I. STATEMENT OF PURPOSE:

1. To maintain the security and confidentiality of patient health information
2. To facilitate appropriate disclosure of patient health information
3. To properly document the authorization for and subsequent disclosure of patient health information
4. To abide by statutes and regulations and maintain proper business records

II. STATEMENT OF POLICY:

To the extent that access to a patient’s medical record is restricted to those individuals involved in the patient's care and treatment, use of patient information in this context is permitted by the patient's acknowledgement of receipt of the organization's privacy notice. Beyond such uses of information for treatment, payment and operative purposes, disclosure is permitted only under the following circumstances:

• To the patient or the patient's duly authorized representative
• In accordance with state and federal reporting requirements
• Under a valid court order, search warrant or subpoena
• In an emergency, upon independent verification of the requesting party
• When all patient identifying information has been removed

III. DEFINITIONS:

A. Confidential Information – All patient health information not included in the non-confidential section of a patient record or file, including information on adopted children, substance abuse and psychiatric treatment
B. Court Order – A formal order issued by a judge, either in writing or verbally from the bench
C. De-Identified Health Information – Individually identifiable health information that has had all patient identifiers removed prior to its use or disclosure
D. Department – Any site that is owned, operated or managed by the facility

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E. **Emancipated Minor** – A person under the age of 18 years who, by court order or by operation of law, is considered to have the rights and responsibilities of an adult to consent to his own preventive healthcare, medical care, dental care and mental healthcare, without parental knowledge or liability.

F. **Genetic Information** – with respect to an individual, information about:
   1) The individual’s genetic tests;
   2) The genetic tests of family members of the individual;
   3) The manifestation of a disease or disorder in family members of such individual; or
   4) Any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the individual or any family member of the individual.
   5) Any reference in this subchapter to genetic information concerning an individual or family member of an individual shall include the genetic information of:
      a) A fetus carried by the individual or family member who is a pregnant woman; and
      b) Any embryo legally held by an individual or family member utilizing an assisted reproductive technology.

Genetic information does not include information about the sex or age of any individual.

Source: 45 CFR §160.103

G. **House Staff** – Hospital professional staff members, interns and residents.

H. **Incapacitated** – An adult who lacks capacity to make and communicate responsible decisions concerning his/her treatment, caused by disability, illness, the use of drugs or alcohol, or other causes – This may include a patient who is temporarily incapacitated by a medical condition or the influence of medication.

I. **Legal Guardian** – A person who is appointed by a court to make decisions and provides guardianship for another person.

J. **Individually Identifiable Health Information** – Information which may include demographic information collected from an individual and that is created or received by a healthcare provider, health plan, employer or healthcare clearinghouse and relates to the past, present or a future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual that identifies the individual or provides a reasonable basis to believe that the information could be used to identify the individual.

K. **Medical Durable Power of Attorney (Medical DPOA) or Power of Attorney for Healthcare** – An instrument naming someone other than the patient as the patient advocate to consent to medical treatment on behalf of the patient – It may also be referred to as an advance directive.

L. **Medical Record** – A document of facts and observations of a patient’s medical history, illness, therapy and response to therapy – It consists of the original written documentation, radiographic films, tracings, slides, blocks and tissues.

M. **Minor** – A person who has not reached the age of 18 years and is not an emancipated minor.

N. **Parent** – One or both biological parents, or adoptive parents, if the minor has been legally adopted.

O. **Patient Advocate** – An individual appointed as having medical durable power of attorney (MDPOA) or in the absence of a MDPOA and legal guardian, the next of kin.

P. **Patient Representative/Health Care Proxy or Proxy** – The patient advocate, legal guardian or the person selected to make healthcare decisions on behalf of an incapacitated patient.

Q. **Privacy Officer** – The individual who the healthcare provider has designated as responsible for overseeing and/or implementing policies and procedures, providing education, and conducting investigations of potential violations of state or federal law relative to patient privacy.

R. **Protected Health Information** – Individually identifiable health information transmitted or maintained in any form or medium – Protected health information includes, but is not limited to, the patient’s medical record.

S. **Public Service Worker** – An individual employed by a state or federal agency required to review medical records.

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T. **Search Warrant** – A document which provides legal authorization to search a specified place and/or seize specific property

U. **Subpoena** – A legal notice requiring an appearance in court or at some other legal proceeding to give testimony

V. **Subpoena Duces Tecum** – A legal notice generally requiring submission or production of requested materials to a court

IV. PROCEDURE:

A. Disclosure of Medical Records and/or Protected Health Information

1. **Requests for Information:** The department of health information management (HIM) is responsible for the disclosure of medical records and protected health information (PHI). All requests for PHI should be directed to this department. If the department is closed, the nursing supervisor may be designated to handle requests for disclosure of medical records or PHI.

   Medical emergencies may warrant the disclosure of information to a requesting medical provider when the HIM is closed; if so, the following will occur:
   a. Request the caller’s name and telephone number along with the patient’s name, age, address, and other identifying information.
   b. Pull the record(s) and confirm the provider’s phone number with HIM, the medical staff office record or the telephone directory.
   c. Return the call and request an appropriate authorization signed by the patient to be forwarded as soon as possible, unless it is represented by the requesting provider that the records or information are necessary on an immediate emergency basis.

   **Note:** in a memorandum to the HIM director (which will be added to the patient record), the information that was provided and to whom, the fact that a release was requested, your name and title, the date and time the request was made and filled. Sign the note.

2. **Law Enforcement Officers or Agencies:** Police officers, acting in an official capacity, may be given the time of emergency department admission in order to complete their reports. (See Part B.9, of this policy, "Release of Information to Third Parties," for further instructions.)

   The hospital is also permitted (but not required) to disclose protected health information in response to a law enforcement official’s request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, provided that only the following information is disclosed:
   - Name and address
   - Date and place of birth
   - Social security number
   - ABO blood type and rh factor
   - Type of injury
   - Date and time of treatment
   - Date and time of death

   **Source:** 45 CFR 164.512(f)

   Although it may be acceptable under HIPAA to make such a disclosure, it may not be acceptable under more stringent state laws. In addition, state and/or federal confidentiality requirements may prevent release of specific types of information, for example, confidentiality laws related to mental health or substance abuse patients. Since the more stringent state or federal laws would supersede HIPAA, they must be considered when deciding whether to disclose to law enforcement officials.
3. Prosecuting Attorneys: Some state laws may permit the disclosure of certain test results to prosecutors with an appropriate court order, e.g., results of blood alcohol testing performed for the purpose of medical treatment of the driver of a vehicle involved in an accident.

4. Patient Transfer: A direct transfer from one facility to another may require sending copies of pertinent portions of the patient medical record. (Obtain patient or legal representative authorization).
   a. Copy the portions of the medical record necessary to provide for continuity of care.
   b. Seal the copies in an envelope to accompany the patient.
   c. DO NOT SEND THE ORIGINAL RECORD.

5. Protective Services: Records may be released without written consent upon subpoena presented by protective services, in accordance with state law.

6. Medical Examiner: If the medical examiner is conducting a post-mortem exam, he/she may have access to the patient’s records without written authorization, in accordance with state law.

7. Release for Research Purposes: Medical information may be released upon authorization of the research committee consistent with HIPAA privacy regulations.

8. Requests Related to Adoptee: Requests from an adoptee shall be referred to the county probate court where they were born. Requests from biological parents should be referred to the agency that handled the adoption.

9. Regarding Minors: Some state laws may provide that the treating physician may inform the parent, guardian or person in loco parentis of a minor’s healthcare related to venereal disease, HIV, substance abuse, or prenatal and pregnancy related care, if medically appropriate and appropriate notice is given to the patient. In the case of prenatal or pregnancy care, some state laws may provide that the alleged father may also be informed.

10. Sensitive Information: Use extreme caution when releasing sensitive information. Additional written authorization may be required. Consultation with an attorney may be necessary. Sensitive information includes:
   a. HIV, AIDS and AIDS related complex (ARC)
   b. Sexually transmitted disease treatment
   c. Substance abuse treatment including alcohol
   d. Mental health treatment - Release of psychotherapy records to the patient should be discussed with the therapist first, as these records may, in limited circumstances, be withheld from the patient.
   e. Mental, physical or sexual abuse including rape of a child, adult, elder, disabled/handicapped and/or incapacitated person
   f. Genetic Information - Genetic information may not be used or disclosed for underwriting purposes.

11. Radiology Release: As a rule, radiology will only release copies of digital images or X-ray films to medical providers for continued medical care.
    NOTE: If the radiology department or physician practice receives a subpoena requesting original X-ray films or copies of X-ray films or digital images, notify risk management prior to any release.

12. Workers’ Compensation Records: Medical records may be released to the workers’ compensation carrier for the company at which the incident occurred, with a proper release, and/or to the workers’ compensation bureau with appropriate subpoena for release.

13. Release of Incomplete Records
   a. If the record is incomplete, contact all individuals responsible for completion immediately and inform them of the priority need.
   b. Obtain copies of any other documents specified in a subpoena (e.g., radiology reports, patient bills). Ensure that all documents have the patient’s name.
    NOTE: Copies - Only copies, not original medical records, shall be released upon the receipt of a valid Authorization for Release of Medical Records.
B. Authorization for Release of Records
   1. Have the patient complete an Authorization for Release of Medical Information Form (see the sample form attached).
   2. The completed form must include the name and address of the company or individual (physician, attorney, insurance company, etc.) to whom information is to be released.
   3. The form must be dated within six months of the present date and after the dates of treatment or admission for which the records are requested.
   4. Authorization must be signed by the patient if he/she is a competent adult (18 years or older). If the patient’s signature is not an obvious match to the signature on file in the medical record, the authorization needs to be verified using other means.
   5. Indicate information to be disclosed and limitations, if any.
      a. Authorizations for disclosure of information must specifically authorize the disclosure of records containing information on alcohol, drug abuse or mental health treatment.
      b. Authorizations for disclosure of medical records must also specifically authorize the disclosure of information regarding serious communicable and infectious diseases.
         NOTE: If an authorization is received and it does not contain specific language granting permission to release the above information as stated in Title 42 of Code of Federal Regulations Part II and applicable state law, the responding party shall return the authorization to the requesting party, along with a blank form and request completion.
      c. When an appropriately executed authorization is obtained requesting release or disclosure of the entire medical record (including any and all records, even those generated by another provider), all records shall be released, unless it is specified on the record not to be released to other third parties, and unless such records include records of mental health, substance abuse, HIV or AIDS treatment.
   6. If the patient is a minor, authorization should be signed by the parent or legal guardian. Generally speaking, subject to specific state law:
      a. If the patient is a minor, the authorization must be signed by one of the parents or a legally appointed guardian. If parents are separated or divorced, either parent may sign for release of a minor’s records, regardless of whether they are the custodial parent. However, a parent may not obtain her/his child’s record if she/he is prohibited from having access to the records or information by a protective order or if the parent’s legal rights have been terminated by the court.
         i. A copy of the court papers regarding parental custody should be placed in the minor’s chart.
         ii. Guardianship must be verified by a court order, letter of authority, or acceptance of trust. Conservatorship does not entitle the individual access to the minor’s medical records.
      b. If the patient is an emancipated minor, he/she may sign the authorization, if emancipation can be proven by legal documentation.
      c. If there is any doubt as to custody or emancipation, the county probate court where rights were given shall be contacted.
         i. Ask the custodial parent to provide a copy of any existing protective order for placement in the medical record.
         ii. The order should remain with the medical record until the non-custodial parent provides documentation from the court that the order has been rescinded or is no longer in effect.
      d. If the minor consented to the treatment (e.g., pregnancy, sexually transmitted disease, substance abuse or mental health treatment), the minor may authorize release of their health information.
   7. Deceased Patients: Records may be released to a deceased patient’s family members and others involved in the decedent’s healthcare/payment prior to death unless doing so is known to be inconsistent with the decedent’s prior expressed preferences. [Note: state laws may be stricter].
      NOTE: Any exception to this shall be submitted to the risk manager or health information manager for prior approval.
8. Revocation of Authorization
   A patient may revoke a previous authorization at any time. An authorization stating that no information is to be disclosed or released supersedes all previous authorizations. Place the authorization revocation in the file with a notation at the front of the record regarding restrictions on the release of information.

9. Other Disclosures of Information to Third Parties
   a. Authorization from the patient is always recommended (see above).
   b. Reasonable and customary photocopying charges are posted in the HIM.
   c. HIM personnel will pull the medical record(s), review the content, decide on which records to copy, copy the appropriate records and mail the records.

10. Incapacitated Patients
    When the patient is incompetent or unable to consent, obtain authorization from the legal guardian. Proof of guardianship is required. If the patient does not have a legal guardian, authorization may be obtained from the patient advocate, providing the MDPOA document allows the patient advocate access to the record.
    NOTE: MDPOA expires upon a patient’s death.

11. Patient Signature
    Two witnesses are required when a patient signs the authorization with an “X.”
    NOTE: Signature authorizations for release of medical records shall be honored for six months from date signed.

12. Requests from attorneys (including attorney subpoenas)
    a. A signed authorization must accompany the request.
    b. Notify the attending physician that an attorney request has been received.
    c. Record what information was sent and the date, then file the authorization in the medical record.

13. Requests from insurance companies
    a. If the request is relative to a claim for services provided at this facility, refer it to the business office for processing.
    b. If the request is relative to an application for insurance benefit, require proper authorization.
    c. Release only the information specifically requested and authorized. Use the forms provided by the insurance company to list dates of service, diagnosis and procedures.
    d. Consult with the HIM manager if there are any questions regarding the request for information.

C. Emergency Authorization
   1. In case of a life threatening emergency request for information, use the following precautionary procedure:
      a. Verify the number of the caller by calling back to the institution/business number or by locating the number in the phone book or contacting the telephone operator.
      b. Obtain consent via fax. If the patient/guardian is unable to provide consent via fax or in person, obtain written consent as soon as possible following a witnessed phone consent (e.g., may be mailed).
      NOTE: At the direction of the HIM manager or risk manager, information may be released in the life-threatening situation, when authenticity of the requesting party has been confirmed.

D. Subpoena
   1. When a subpoena duces tecum (subpoena to produce records) is received, specific direction shall be stated in the subpoena on submitting the medical record. Patient authorization is required, except for subpoenas issued from the workers’ compensation bureau or subpoenas signed by a judge or magistrate in the form of a court order, as allowed by state law.
      a. A subpoena duces tecum must be issued to the custodian of the records to allow submission of records as evidence.

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b. A subpoena issued by a copying service such as Record Copy Service or Record Deposition Service requires a properly executed authorization.

c. Practice/department managers must be made aware by the risk manager of all court subpoenas the practice/department receives. Any questions regarding how to handle a subpoena may be directed to the HIM.

d. If an employee receives remuneration for an appearance for a subpoena, the money shall be forwarded to facility’s accounting department. Costs resulting from a court appearance are reimbursable to the employee.

2. Subpoena duces tecum without patient/legal representative authorization:

a. Contact the attorney or the record copying service issuing the subpoena and inform him/her of the lack of appropriate authorization and make arrangements to obtain. Document this in the record. Once the authorization is received, proceed with release. NOTE: In the absence of a patient/legal representative authorization, the subpoena must still be addressed. Consult with an attorney in this situation.

b. Complete Certificate of Medical Record Custodian Authentication. The signature must be notarized.

c. Seal the copies and the certificate in an envelope along with a copy of the subpoena.

d. Insert envelope and address it to the court.

e. Notify the requesting attorney that records were sent directly to the court.

f. Document on the copy of the subpoena the date and location where the records were sent.

E. Search Warrants

A search warrant is a document issued by a judge or magistrate on a showing of probable cause, authorizing police or other governmental agency staff to search and/or seize the private property of a citizen.

When an officer comes into the department with a search warrant requesting a record, notify the HIM manager and risk manager before releasing the records.

NOTE: Attempt to make a copy of any records seized.

F. Court Order

Subject to state law, a copy of the original medical record may be released without patient authorization upon receipt of a court order signed by a judge. This may come in the form of a subpoena or subpoena duces tecum signed by a judge.

NOTE: Always notify risk management of all court orders, prior to releasing records or PHI.

G. Processing Subpoenas and Court Orders

The director of risk management will be notified of subpoenas and other requests for records involved in litigation, retained in the secure file or those perceived to have liability potential.

1. Subpoenas and court orders shall be filed with the patient record and retained under the usual record retention practice.

Upon receipt of the subpoena, review the following while the server is still present, if possible, to determine:

a. Type of subpoena

b. Name of person/organization upon whom the subpoena is being served

c. Name and location of the court (or other official body in which the proceeding is being held)

d. Date and time the witness must appear

e. Name of the plaintiff

f. Name of the defendant

g. Name, address and telephone number of the attorney who caused the subpoena to be issued, signature of the clerk of the court and seal of the court

Note: If the subpoena lacks any of the above information, the attorney who caused the subpoena to be issued shall be notified in writing that the subpoena is incomplete. This notification will be retained.
2. Check for patient authorization. Subject to state law, a patient authorization is needed except for a trial subpoena issued from the court (court order). If the patient is party to the lawsuit, notify the director of risk management to determine release.

3. Subpoena duces tecum without patient/legal representative authorization:
   Contact the attorney or the record copying service issuing the subpoena and inform him/her of the lack of appropriate authorization and make arrangements to obtain. Document this in the record. Once the authorization is received, proceed with release.
   NOTE: In the absence of a patient/legal representative authorization, the subpoena must still be addressed.

4. Determine if the notice has been given in the proper amount of time. The allowed time/date should be stated on the face of the document. If yes, continue processing.

5. Check jurisdiction.
   Review the location of the court or agency and its jurisdiction:
   a. Municipal court
   b. County court
   c. State district court
   d. Federal court
   e. Administrative agency
   f. State government
   g. Federal government
   h. Medical examiner

6. Record receipt of the subpoena on a log register for tracking and follow-up purposes.

7. Determine patient status.
   a. Access computer to determine if and when the patient was seen.
   b. Access current records.
   c. If there is insufficient information to confirm that this particular patient was seen, notify the attorney listed on the subpoena.
   d. Note any special restrictions on access to the record; refer these to risk management.

8. Check record for completeness.
   a. If the record is incomplete, contact all individuals responsible for completion immediately and inform them of the priority need.
   b. Obtain copies of any other documents specific in subpoena (e.g., radiology reports, patient bills).
   c. Ensure all documents have the patient’s name.

9. Review record for selectivity and/or restrictive limits. Remove any documents not subject to subpoenas (e.g., correspondence).

10. Record the number of pages contained in the record.

11. Prepare a photocopy of the record.
    a. Prepare the Affidavit of Custodian statement.
    b. Have the certification notarized.
    c. Prepare the bill for copying fees; send the bill to the requesting attorney.

12. After the appropriate authorization has been determined, mail the copy of the record unless other court direction is provided. Put all copies requested and the Affidavit of Custodian of Record in the envelope with the following information on the face of the envelope:
    a. Name of court
    b. Title of court procedure
    c. Case number
    d. Subpoena

13. Update the log register regarding the release.

14. File the subpoena with the patient’s record, along with any correspondence relating to it.

15. The attending physician will be notified when legal proceedings are undertaken.
H. Original Medical Record
   Original records are not to be released without authorization from the risk manager or
designee. If the medical record is ordered to be kept by the court, a written receipt is obtained
and filed with the risk manager.
   1. After authorization by risk management, if an original medical record document is to be
taken from a facility, a duplicate is made and securely retained in the department
responsible for storage of medical records.
   2. If the radiology department or physician practice receives a subpoena requesting original
   X-rays, contact risk management for authorization to release original X-rays. Copies should
be made of original X-rays before their release.

   NOTE: No original medical records shall be removed from any facility or practice unless
       authorized by risk management

I. Transmission of Medical Information
   1. Facsimile transmission of medical records and protected health information should be
limited to the use of healthcare providers for immediate and/or urgent patient care
purposes. This includes when arrangements are being made to transfer the patient to
another healthcare provider/facility. The following is required:
      a. Before sending the information, verify the number to which the information is to be
         faxed.
      b. Verify by phone the availability of the receiver to receive the information before
         beginning the transaction to maintain confidentiality of the information.
      c. Include a prohibition of re-disclosure statement.

J. Viewing of the Medical Record Document
   1. By students (including medical students)
      a. Students must provide departmental personnel with current college identification card.
      b. Students must have authorization from their instructor or the medical education
director. The authorization must contain the name of the student, name of the patient,
or specified type of case and be signed by their instructor or the medical education
director.

      NOTE: Access to medical records by students/instructors is only applicable when the
      college/school has a current contract/ agreement with the facility.
      c. Students may hand-copy portions of the medical record. Photocopies are prohibited.
      d. Students shall not remove the patient’s medical record from the department where it is
         stored. Students shall return the patient’s medical record to departmental personnel for
         proper filing.
   2. By an outpatient or former patient
      a. The patient’s attending physician shall be informed and have the option of being
         present during the viewing.
      b. Viewing shall take place by appointment, in the department where the record is
         maintained.
      c. Identify the patient or authorized designee by asking to see a driver's license or other
         photo ID. Note on the authorization form that identification was verified.
      d. Department personnel shall be present while the patient is viewing the record to ensure
         the integrity of the record.
      e. Under no circumstances should HIM personnel interpret any information found in the
         medical record.
3. By an inpatient and/or family
   a. The patient’s attending physician shall be informed and have the option of being present.
   b. A member of the nursing staff, the patient care/practice manager or the nursing supervisor shall be present (in the absence of the physician) for viewing of the medical record.
   
   NOTE: Unanswered or interpretive questions should be directed to the attending physician.

4. By physician
   In order for a physician to view a patient’s medical record, the following conditions shall be met:
   a. The physician is a member of the facility’s professional staff.
   b. The physician shall be or has been involved with the patient’s hospital or follow-up treatment or involved in quality of care review by virtue of the responsibility assigned to him by the chief of staff or chief medical officer, with the appropriate consent or authorization having been obtained from the patient.
   c. Upon the physician’s request, the medical record shall be sent to the clinical department/patient care unit where the patient is being treated.
   d. Viewing shall take place in the department/office where the record is stored if the patient is not currently being treated.
   e. No photocopies of the total medical record shall be allowed without a signed patient authorization or approval from the HIM manager or risk manager. If the physician can demonstrate active involvement in treatment and/or follow-up of the patient and is identified in the medical record as a provider of services, including primary care, the physician may, upon request, be provided with pertinent documentation from the medical record in order to assist with the continuing care and treatment of the patient.

5. By interns and residents
   a. Residents and interns actively involved in treatment of the patient may view and have access to patient medical records upon request.
   b. Viewing shall take place in the medical records department if the patient is not currently being treated in the hospital.
   c. Copying a portion of the medical record by hand is allowed. No photocopies of complete sections or the total medical record shall be issued without a properly executed patient authorization. At no time shall residents or interns remove the medical record from the hospital campus site.
   d. Medical record information may be available to residents or interns for purposes of case presentation at the facility, immediately prior to the presentation. Such information will be signed out and must be returned immediately after the presentation.

6. By hospital and employed physicians’ personnel
   a. Ancillary personnel involved in treatment of a patient or administrative function may view the medical record after presenting a reasonable explanation to the HIM (e.g., validation of charges, patient question or complaint, clarification of treatment).
   b. Viewing of the medical record shall take place in the department responsible for storage of the record, unless the record is properly checked out.
   c. The risk management or quality management department may photocopy medical records for completion of their duties as assigned by the hospital.

7. By public service workers
   a. Viewing shall occur if state or federal statute mandates such use of the medical record, after identification of the individual has been verified by an appropriate picture ID and verification of public service work.
   b. Department personnel shall be present during the viewing so that the medical record’s integrity is maintained.
   c. General questions shall be addressed to HIM staff. Questions specifically dealing with child or patient abuse shall be directed to the manager of HIM or the risk manager.
K. Release of Mental Health Records
   Mental health records may only be released in accordance with specified state and federal laws.

L. Charges
   The hospital reserves the right to assess a reasonable charge for the release of medical record documents.

M. Logging
   All releases of hospital records shall be noted in the patient’s record and/or correspondence log register. The information being released shall be noted as well, along with the date of the release. The written authorization will then be filed in the patient’s medical record. If the record is released prior to being complete, such must be noted and the patient informed in writing. In addition, information kept relative to each release of medical records or PHI shall include:
   1. Name of entity or person receiving the information, along with their address
   2. Brief description of the information released
   3. Brief statement of the purpose of the disclosure

N. Disputes
   If the patient disputes information documented in the record, and the healthcare provider who created the information agrees that the entry requires clarification, an addendum shall be made and the patient and all others to whom such information has been provided shall be notified. The addendum shall include note of late entry, with the date and time. If the provider does not agree that a clarification or correction is needed, a written denial should be provided to the patient. The patient may make a written statement disputing the information and offering an amendment. Such statement should be filed with the record and included with any future disclosures.

O. Medical Record Correction
   If an error is made in documenting on a paper record, a single line shall be made through the entry, recording the correct data and signing the correction. The original entry must not be obliterated. When an error is corrected in a computer based record, the system should preserve both the original entry and the amendment as well as identify the person making the correction.

P. Medical Records Retention – Controlled Access
   1. Medical records will be retained according to directives in Document Retention and Records Management Policy and Guidelines.
   2. Paper medical records will be stored in a locked room in the HIM department, in the locked storage area or under the control of appropriate staff when in use. Access to protected health information that is created and maintained electronically will be controlled through various methods such as password protection and limiting staff’s ability to access only those specific portions of the record necessary to carry out their responsibilities.
   3. Physical safety guards, security procedures, access controls, internal audits, personnel training, contingency plans, virus protections, firewalls, monitoring access and technical mechanisms will be utilized to control access to protected health information.