Regions Hospital®
HealthPartners®

Subject Release of Information and Access to Medical Records	**Attachments** ☒ Yes ☐ No
Key words Release of Information, ROI, Medical Records, Access	Number **50:01:01**
Category Management of Information (MI)	**Effective Date** **April 2003**
Manual Health Information Management	**Last Review Date** **04/2016**
Issued By Health Information Management	**Next Review Date** **04/2019~~8~~**
Applicable Health Records Committee	**Origination Date** **March 1974**
	Retired Date

Review Responsibility Health Information Management	**Contact** Health Information Management

I. **PURPOSE**

Provide guidelines on the release of information and access to medical records.

II. **POLICY**

To ensure the confidentiality and security of patient information and to provide access to medical records in accordance with Minnesota State and Federal Laws and Regulations

III. **PROCEDURE(S)**

A. Ownership

The inpatient and portions of the outpatient, hard copy medical records are the physical property of Regions Hospital. The electronic inpatient and outpatient medical record is the physical property of both Regions Hospital and HealthPartners Medical Group.

B. Requests for Information

Requests for copies of the medical record should be forwarded to the Release of Information unit of the Health Information Management Department for proper documentation within the Epic ROI module, tracking of disclosures as needed, and to ensure that applicable State and Federal guidelines for release are met.

C. Patient Access

The patient may view the medical record at no cost. The identity of the patient will be verified by photo identification or signature comparison. Guardians and personal representatives will be required to present appropriate legal documentation. Patients/guardians will be observed by release of information personnel while they are reviewing the record to ensure it is protected from tampering or loss. The patient review of the medial record will be documented in the Epic ROI module. The patient may also obtain copies of the medical record at a standard cost upon receipt of a proper request and authorization.

Information may be withheld from the patient if a healthcare provider determines that the information in the record will be detrimental to the patient or could cause the patient to inflict harm to himself or another. The provider must document this before a request is received. Otherwise, the request must be honored. The patient may choose to appeal to the Vice President of Medical Affairs if this occurs.

If a patient requests to review the medical record during treatment (i.e. while an inpatient or during a clinic visit), the treating/attending physician (or assigned resident) or designee will be responsible for honoring this request, assisting the patient in reviewing the electronic record and assuring that the patient is observed while reviewing the record to ensure that it is protected from tampering of any kind. A notation that the patient has viewed the medical record will become a permanent part of the patient's medical record.

D. A patient amendment request is documentation that is initiated and written by a patient containing information that the patient requests to be added, corrected, moved or changed from their medical record.

- Patients have the right to request an amendment to their protected information if they feel that they information is inaccurate or incomplete.
- The patient has the right to request an amendment for as long as that information is maintained in the designated record set.
- Original documentation is not allowed to be completely deleted from within the electronic medical record system.
- Requests for amendments should be submitted to the Health Information Management Department.
- The amendment request will be routed to the appropriate provider/resource for review.

See Attachment A for procedure to follow when an amendment is requested.

E. Third Party Access:

1. *Nonconsensual* – Disclosure of protected health information can be made without a patient authorization in the following situations:

a. Medical Emergency
b. Transfer for continued patient care by another healthcare provider
c. Provider audits, quality assurance, licensing and accrediting reviews, administrative functions by the provider
d. Statutory reporting requirements (i.e. infectious disease, child abuse, etc.)
e. Judicial court order, search warrants
f. Disclosure of information relating to the claim for third party payers or workers compensation cases

2. *Consensual* – A valid authorization is required if information is requested by the following:

a. Attorney
b. Insurance Company
c. Social Security
d. Military Forces
e. Any third party deemed by the patient/guardian
f. Subpoena

Upon receipt of a proper authorization these third party requesters may view or obtain copies of the patient's medical record at standard cost. The viewing party will be observed by Release of

Information personnel of the HIM department to ensure the record is protected from tampering or loss.

F. Accounting of Disclosures

Patients are entitled to receive an accounting of disclosures of their protected health information, not including disclosures for purposes of treatment, payment and operations. Disclosures to business partners must be included in the accounting. Patients may request an accounting of disclosures that were made up to six years prior to the date of the request, and subsequent to HIPAA implementation date of April 14, 2003. See Attachment B for procedure to follow when a request for accounting of disclosures is received. Requests should be submitted to the Health Information Management Department.

G. Alcohol and Drug Abuse Records:

Healthcare records pertaining to the identity, diagnosis, prognosis or treatment of any patient which are maintained in connection with the performance of any drug/alcohol abuse prevention function may be disclosed only with patient authorization for the purpose specified in the authorization. Each disclosure made with the patient's consent must be accompanied by a written statement of nondisclosure in accordance with Federal regulation 42 CFR Part 2.

H. Medical or Scientific Research:

Healthcare information may be released without patient consent for medical or scientific research unless the patient specifically objected to disclosure for research purposes for records generated before January 1, 1997. For records generated on and after January 1, 1997, patient must be informed, regardless of when the information was generated that their record may be used for medical or scientific research purposes. Appropriate notification, restrictions and provision of information regarding the research will comply with Minnesota Patient Access Law 144.295.

I. Use of Approved Release of Information Tools:

Only approved release of information tools will be utilized for the release of information under the supervision of Health Information Management.

Facsimile Release of Information or Transmission of Orders:

- Medical record information typically will be transmitted by fax only when the original document or photocopies delivered by mail cannot be provided within the necessary time frame for urgently needed patient health information or as required for third party payer for ongoing payment for a hospitalized patient. Any medical record information that is faxed must be kept confidential by assuring that the transmitted information is sent to and received by the appropriate requesting party. The cover page must include a "Confidentiality Statement."
- The use of a fax to transmit physician orders is permissible. No countersignature is necessary if the prescribing physician included his/her signature in the original fax.

J. Cost:

The patient may obtain copies of the medical record after review free for current information only (past six months). All information prior to six months may be obtained at the standard cost (based upon the consumer price index released by the State of Minnesota on an annual basis). All external requesters, except for continuing care, will also be charged the standard cost.

IV. **DEFINITIONS** NOT APPLICABLE

V. **COMPLIANCE** NOT APPLICABLE

VI. **ATTACHMENTS**

A – Request for Amendment Procedure
B – Accounting of Disclosures

VII. OTHER RESOURCES

VIII. APPROVAL(S)
Health Record Committee

IX. ENDORSEMENT
Health Information Management: June 2011

ATTACHMENT A

REQUEST FOR AMENDMENT PROCEDURE

PROCEDURE:
A request for amendment of protected information contained in a patient's health record shall be made in writing to the Health Information Management Department and clearly identify the information to be amended as well as the reasons for the request for the amendment. Upon receipt of a request for amendment, the request is forwarded to the appropriate provider for review and decision. If the request is approved, the physician must document the appropriate changes in the patient record. If the request is denied, the physician must state the reason for denial. Requests for amendment must be completed within 60 days of receipt. One 30 day extension is permitted, provided the patient is notified of this extension during the 60 day period. When the request is processed, the patient is notified by certified mail.

If the request is approved after review by the individual responsible for the entry to be amended:
- The amendment, must be documented by the provider by either adding an addendum to a direct entered note or dictating an addendum to a transcribed note in the electronic record.
- The provider will send the "Request for Amendment" form to the HIM Department stating the approval.
- The HIM Department will send a letter to the patient informing him that the amendment has been approved.

Requests may be denied if the information requested to be amended:
- Was not created by Regions Hospital or HPMG
- The provider is no longer with Regions Hospital
- Is not a part of the patient's medical record
- Is not accessible to the patient because federal and/or state law do not permit it
- Is accurate and complete

If the request is denied, the provider, or individual responsible for the entry to be amended, must provide to the HIM department:
- The "Request for Amendment" form stating the reason for the denial

The HIM Department will provide the patient with a timely written denial which contains the following:
- Reason for the denial
- Patient's right to submit a written statement disagreeing with the denial and how the patient may file the statement
- A statement that if the patient does not submit a statement of disagreement, the patient may ask that the request for amendment and denial be included in future disclosures of information

• Information on how the patient may file a complaint to Regions Hospital or to the Secretary of Health and Human Services
• The title and telephone number of the designated contact person who handles these complaints

Patients' Right to Disagree

The patient must be allowed to submit a written statement disagreeing with the denial of all or part of a requested amendment and the basis of the disagreement. Patients should send this statement to the HIM Department.

A rebuttal to the statement is permitted, but not required. If a rebuttal is prepared, a copy must be provided to the patient.

As appropriate, the HIM Department will identify the record of PI that is the subject of the disputed amendment and append or otherwise link the patient's request for amendment, the denial of the request, the statement of disagreement and the rebuttal, if any.

If a statement of disagreement has been submitted, the information appended, or an accurate summary of the information, must be included with all subsequent disclosures to which the disagreement relates.

If no written statement of disagreement has been submitted, the request for amendment, the denial or an accurate summary of it, must be included with any subsequent disclosure which is related to that information.

If we are informed by another covered entity that an amendment to a patient's PI has been made, we must assure that this information is amended in either written or electronic form, as appropriate.

ATTACHMENT B

ACCOUNTING OF DISCLOSURES

PROCEDURE

1. Maintain an accounting of disclosures of protected health information on each patient for at least six years, beginning April 14, 2003
2. Information that must be maintained (tracked) and included in an accounting include:
   • Date of disclosure
   • Name of individual to whom disclosed and address, if known
   • Brief description of the information disclosed
   • Brief statement of the purpose of the disclosure
3. Information that is excluded from the required tracking:
   • Prior to April 14, 2003
   • To law enforcement agencies as provided in state law
   • For facility directories
   • To the patient
   • For national security or intelligence purposes
   • To persons involved in the patient's care
   • For notification purposes including identifying and locating a family member
   • For treatment, payment and operations
   • Pursuant to the patient's authorization
4. All other disclosures of PI must be tracked. Disclosures are not limited to hard copy information but any manner that provides information, including verbal or electronic data release. The procedure for tracking disclosures is as follows:
   • If a department discloses protected information outside of the ROI process, the individual department is responsible for tracking their disclosures.
   • Each department must keep a log, or database, of the information disclosed (per HIPAA tracking requirements above).
   • ROI staff will maintain an email distribution list of accountable department persons.

- Upon an accounting request, ROI staff will email request to the email distribution list.
- Each department is responsible for submitting disclosures to the ROI department.
- The ROI department personnel will then respond to the patient's request.

5. All systems must be maintained and accessible for at least six years according to HIPAA.
6. Retain a copy of the request and the written accounting that was provided to the patient, as well as the name, departments responsible for completion of the accounting.
7. Provide the accounting within 60 days of request. A one-time extension of 30 days is permitted.
8. Provide the accounting at no charge for a request made once during a 12 month period. A reasonable fee may be charged for additional requests made during the 12 month period, provided the patient is informed of the fee in advance and given an opportunity to withdraw or modify the request
9. Maintain requests for accounting and the accountings provided for at least six years. Maintain the titles and names of the people responsible for receiving and processing the requests for a period of six years.