Authorization for Release of Patient Protected Health Information

POLICY

Please also refer to hospital policy IM 6-025.

The medical record is the property of the hospital and is maintained for the benefit of the patient, the physician and the hospital while maintaining the security of patient data and information. It is the responsibility of the hospital to safeguard the information against unauthorized use.

Original medical records may not be removed from the hospital except in accordance with a court order, subpoena, federal or state law.

There is not a charge for medical records that are released to the patient. All other requests are charged according to the established fee schedule.

Following authorized release of patient information, the signed authorization will be retained in the health record with notation of the specific information released, the date of release and the signature of the individual who released the information.

The hospital must make sure that all authorizations are legitimate. We have the right to question the identity of someone bearing an authorization form, challenge signatures, make certain the person authorizing access is competent to do so and question the currency of the authorization. Please see also HIPAA policy HP 5-595 Verification of Identity and Authority of Persons Requesting Protected Health Information.

HEALTHCARE REQUESTS

- Hospital Personnel: No person shall remove a medical record from the Health Information Management Department without the knowledge of the Health Information Management staff or if the department is not staffed, the request shall be made through the nursing supervisor.

- Physicians: In the event of readmission of a patient, all previous and current medical records shall be made available for the use of the attending physician, or consultant. This shall apply whether the patient is attended by the same physician or by another physician. No written authorization from the patient or the patient's representative is necessary.

Any member of the Jamestown Regional Medical Center Medical Staff may have access to any medical record of any patient whom he/she is currently treating in the hospital or seeing in consultation.

Nonmembers of the JRMC medical staff may review records or be given information about patients only with written authorization from the patient or the patient's representative. Health Information Management staff shall not assume that because the request comes from a physician, written authorization is not required, however, reasonable courtesy shall be extended, keeping in mind, the interests of the patient and the hospital.

- Clinics: Appropriate portions of a patient's medical record are released to their primary care physician and other physicians responsible for follow-up care. i.e. transcribed reports, late lab, x-ray reports.

- Other Hospitals: Written requests for medical information from other hospitals do not require a signed authorization from the patient or the patient's representative, however, JRMC will strive to obtain an authorization if possible.

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In the event a patient is transferred from JRMC to another acute facility, written authorization from the patient or the patient's representative is desirable. If this is not possible, because of the patient's condition, the reason shall be documented in the medical record.

In an emergency situation, JRMC has the right to release information needed for immediate care of the patient without the patient's permission. It shall document the release and the surrounding circumstances as soon as possible. In such cases that a telephone request is made, the staff shall verify the identity of the caller and document the date, the name of the caller, the nature of the information to be released and the signatures of two persons who receive the request, verify the caller's identity and release the information. This documentation shall be filed with the record.

- Nursing Homes & State Hospital: When patients are returning to a nursing home or the North Dakota State Hospital, from JRMC, medical information will accompany the patient without an authorization.

EXPRESS AUTHORIZATION BY THE PATIENT IS REQUIRED TO RELEASE THE FOLLOWING TYPES OF RECORDS:

- Alcohol and/or drug abuse treatment and information.
- Communicable diseases.
- HIV testing and treatment
- Psychiatric treatment, and
- genetic testing

LEGAL REQUESTS

- Attorney: All requests for medical information from legal agencies shall be released only after written authorization from the patient or the patient's representative has been received. If there are any questions with the release or other concerns, please refer to the Health Information Management Manager or the Risk Manager.

An attorney may be permitted to view the medical record only after written authorization from the patient or the patient's representative has been obtained. This viewing will be done in the Health Information Management Department under the direct supervision of the Health Information Management staff or the Risk Manager.

In the event of a potential or actual litigation, medical information may be released or reviewed by the legal representative for the hospital without written permission of the patient. Fees shall be waived.

- Subpoena Duces Tecum: All subpoenas will be referred to the Health Information Management Manager or to the Risk Manager. Please refer to separate Health Information Management policy and procedure "Subpoena Duces Tecum".

- Deposition: All deposition requests shall be referred to the Health Information Management Manager or to the Risk Manager. Please refer to separate Health Information Management policy and procedure, "Deposition".

- Law enforcement: Limited information can be released to a law enforcement official under special circumstances. Please refer to HIPAA policy HP5-585 Use & Disclosure of Protected Health Information for Legal Purposes.

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INMATE RECORDS

Inmates are never allowed access to their health records during incarceration, even after they become members of the community. If an inmate wants his records released they are required to submit an application to the court after approval by the Department of Corrections. An inmates written authorization is void or ineffective. However, they are required to sign for treatment and informed consent. All reports normally sent to the follow-up physician will be sent to the prison, i.e. dictated reports. If an inmate is transferred to another healthcare facility a copy of the records may be sent with the patient. All other releases must be approved by the Department of Corrections. Inmate records are flagged in Epic. Please see the attached ND Century code 12-47-36 pertaining to inmate records.

PATIENT ACCESS TO MEDICAL RECORDS

Subject only to specific contraindications, to any legal constraints such as those governing minors and those adjudicated as incompetent, a patient or his representative may have access to his/her health record for review, upon written request and with reasonable notice. A patient may have access to records of his/her care during or after discharge from treatment. A copy of the requested health information will be provided after completion and upon written request by the patient.

All patients or guardians requesting access to a medical record shall be questioned regarding the destination of the information. If information is needed for continuing medical care, photocopies will be sent to another physician and/or health care facility with proper authorization from the patient or guardian.

If information is requested for the personal use of the patient or guardian because of concerns with patient care, either by viewing the medical record or reproduction of the medical record, the request will be referred to the Health Information Management Manager or Risk Manager. The physician will also be notified if necessary.

All viewing of a medical record shall be done in the Health Information Management Department during normal working hours at no charge. If the patient chooses to have another person present during the review, he/she will be asked to sign a statement to that effect, allowing the viewing and discussion of his/her record in the accompanying person's presence.

DECEASED PATIENTS

Records of deceased patients can be released to the patient's guardian or persons who have been named as the "Administrator" or "Personal Representative of the Will" or "Executor of the Estate", according to state law, or someone involved in patient's care. A Durable Power of Attorney for Healthcare is no longer valid after the death of the patient and cannot be used to obtain copies of the medical record.

If an estate is less than $50,000, the surviving next of kin can request an Affidavit or Affidavit of Collection instead of the options above. An Affidavit is much less expensive to obtain and verifies three things: Who is the legal next of kin, that the legal next of kin is not going to file probate because the estate is less than $50,000 and that the legal next of kin is entitled to the benefits of the estate.

Under the Privacy Law, protected health information of deceased individuals may be provided to health care providers for the purposes of treatment. If the protected health information about the deceased person is relevant to the treatment of a family member, the family member's health care provider may obtain that information. Please see HIPAA Policy HP 5-545 Deceased Persons Privacy Restrictions.

Amendments: Please see HIPAA Policy HP 5-530 Patient Privacy – Right to Amend.

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MISCELLANEOUS

- Employers: A signed authorization of the patient is always required to release medical information to an employer.

- Government Agencies: Medical information may be released without authorization to the following:
  - The State Department of Health in the case of a reportable disease.
  - North Dakota Workforce Safety & Insurance (WSI).
  - Stutsman County Social Services Department.

Requests for medical information from the Social Security Administration requires written authorization from the patient or the patient's representative.

Requests for medical information from all federal intermediaries can be answered without the written consent of the patient (i.e. Medicare, Medicare's Peer Review Organization - North Dakota Health Care Review, Inc. (NDHCRI), Medicaid, Bureau of Indian Affairs).

- News Media: Refer to the JRMC policy manual. Health Information Management staff shall not release any information to news media agencies.

- Research: Access to medical records shall be granted for research projects at the discretion of the Health Information Management Manager or the Risk Manager.

- Telephone Requests: Telephone calls are to be answered promptly and courteously, but information shall be given very cautiously. When in doubt, never disclose any information. If you are unable to get advice immediately, take the name and telephone number of the caller and contact the Health Information Management Manager.

- County Social Services requests records in abuse cases: We are authorized to release records without patient consent according to ND Century Code 50-25.1-03.1 and also according to HIPAA regulations.

STUDENTS

- Medical Students: A medical student may have access, without authorization, to any medical record of any patient in the hospital whose care he/she has been involved with. The medical student shall present a properly signed authorization prior to obtaining information regarding a patient who is not under the medical student's care. A medical student may use medical record information for the purpose of research provided all identifying information is removed and he/she has prior approval from the Health Information Management Manager.

The viewing of medical records belonging to patients who are not currently inhouse, shall be done in the Health Information Management Department or in a designated area.

- Nursing Students: A nursing student may have access to a medical record only upon presentation of documentation from his/her instructor specifying the medical record to be reviewed, the student to whom the record is to be released to, and the reason for the request.

THIRD PARTY PAYERS

Medical records can be released to a 3rd party payer using the signature on the Authorization and Release form if the requesting Insurance Company has been listed by the patient.

NOTE: In all cases of this policy and procedure, when the word "patient" is used, the statement refers to "patient, guardian, or next of kin", the person who is legally authorized to give consent for the release of information concerning a particular individual.