

Maricopa Integrated Health System: Administrative Policy & Procedure

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Policy #: 01287 S

Policy Title: Administration/HIPAA: Patient Requests for Records

Scope: District Governance (G)
 System-Wide (S) Administration
 Department (T)

Signature: _____

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Definitions:

Designated record set: means “the designated record set that includes the patient’s medical record and any other record MIHS personnel use to make decisions about a patient. The designated record set does not include quality assurance or other peer review information or documents.”

Medical record: means “all records maintained for purposes of patient treatment, including reports, notes, orders, diagnoses, treatments, test results, photographs, medical images, records obtained from other providers and psychological records. The medical record includes billing records. The medical record does not include quality assurance or other peer review information or documents.”

Minor: means “any patient under the age of eighteen (18) years who is not emancipated (where there is strong evidence the minor lives away from parents and is self-supporting or otherwise free of parental care, custody or control), married, or homeless (lives away from parents and either has no regular nighttime residence or is living in a shelter or other similar temporary housing accommodation).”

Patient: means “a person whose treatment occasioned the making of the medical record.”

Psychotherapy notes: means “notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session; they are separated from the rest of the individual’s medical record. These are records that are kept as private records of a mental health professional.”

Note: Psychotherapy notes do not include medical records concerning psychiatric or psychological consultations at MIHS, or records made by MIHS personnel concerning the mental health, well being, or complaints by patients. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies or treatment furnished, results of clinical tests, and any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.

Representative: means “an individual who is authorized, either by the patient or by Arizona law, to make health care treatment decisions for the patient when the patient is unable to do so.”

Policy:

Patients are permitted in most circumstances to inspect and obtain copies of their protected health information (“PHI”). This policy describes MIHS’s process for: (1) determining whether to provide access

to and a copy of PHI to a patient or patient representative or surrogate; (2) making such disclosures; (3) denying disclosure and copying in certain circumstances; and (4) providing for appeal of that denial in certain circumstances.

Procedure:

1. Right to Inspect and Copy Records

Except as set forth in this policy, a patient or patient's representative is entitled to inspect or have copies made of PHI in the designated record set.

2. Processing Requests for Inspection and Copies

- a. **Written request:** A request for a patient's designated record set or any part of the designated record set must be in writing. A person may ask for a record request form by telephone. If this occurs, obtain the requestor's address and mail the request form. Alternatively, have the requestor fax a written request containing the elements included on MIHS's request form.
- b. **Route to appropriate department:** HIM will handle requests for the medical record, and Patient Accounting/Billing will handle requests for the billing record.
- c. **Log in request:** Upon receipt of a written request for all or part of a patient's designated record set, log in the request. Log in a reminder that a response must be made thirty (30) days after the date of receipt.
- d. **Identification:** Upon receipt of a written request, obtain identification from the requestor or confirm that such identification has already been obtained. If the requestor is not the patient, follow the procedures set forth in Section 4, below.
- e. **Other records:** If the requestor requests medical images or other records not maintained in HIM, retrieve those records.
- f. **Off-site records:** If records are not accessible on site, determine whether they can be retrieved and copied within thirty (30) days. If not:
 - Log in a reminder that the off-site records must be copied or provided or a written denial made no later than sixty (60) days after the request; and
 - Mail to the requestor a written statement explaining the delay and setting forth the date by which MIHS will provide records or a response.
- g. **Psychiatric or psychological records:** Before copying or otherwise providing access to the designated record set, conduct a review of the records to determine whether the record set contains records of psychiatric or psychological care or treatment for a mental disorder or serious mental illness.
 - If the record set may contain any such records, notify the ROI Supervisor. Before copying or otherwise disclosing such records, obtain physician/psychologist approval of access if feasible, in accordance with Section 6, below.
 - If the physician/psychologist is not available within a reasonable time, contact the Chief of Staff for Psychiatric Services to review and decide whether access can be granted or must be denied in accordance with Section 6, below.
 - If the physician/psychologist or administrator advises you that patient access to all or a portion of the record should be denied, follow the instructions in Section 6, below.

4. Requestors Who Identify Themselves as Patient Representatives.

When the requestor is not the patient, but identifies him or herself as representing the patient, access to records and copying is permitted in the following circumstances:

- a. The requestor has a written authorization from the patient to obtain access, and the authorization meets the requirements set forth in Policy: Authorization to Use and Disclose Protected Health Information.

- b. The requestor is an adult patient's guardian: Obtain a copy of the court order appointing the requestor as guardian, or a written and notarized statement that a court appointed the requestor as the patient's guardian and that the appointment still is valid.
- c. If a guardian has not been appointed, and the requestor is the patient's agent under a healthcare power of attorney or mental health care power of attorney, obtain the signed, valid medical power of attorney naming the requestor as the patient's agent and confirm with the patient's physician that the patient is unable to make his or her own health care decisions.
- d. If a guardian has not been appointed and the patient does not have a health care or mental health care power of attorney, the requestor is the patient's health care decision-maker under state law. Confirm that the requestor is a person in the following list, and that a person at a higher level of priority is not immediately available:
 - (i) The spouse, unless the patient and spouse are legally separated.
 - (ii) An adult child
 - (iii) A parent
 - (iv) If the patient is unmarried, the patient's domestic partner if no other person has assumed any financial responsibility for the patient.
 - (v) An adult brother or sister.
 - (vi) A close friend of the patient. This must be an adult who has exhibited special care and concern for the patient, who is familiar with the patient's health care views and desires and who is willing and able to become involved in the patient's health care and to act in the patient's best interests.

**Confirm with the patient's physician that the patient is unable to make his or her own decisions.

- e. The requestor is a minor patient's parent or guardian.
 - (i) Review the records to determine whether the patient has been considered emancipated or is otherwise competent to give informed consent. If so, require written consent from the patient before providing parent or guardian access to records.
 - (ii) Before copying or otherwise providing access to records to the requestor, review the records to determine whether the patient received reproductive health services. If so, contact ROI Supervisor, or, if necessary, the Compliance Office, before granting access to or copying records.
 - (iii) Obtain identification verifying that the requestor is the parent or guardian.
- f. The requestor is a person entitled to see the records of a deceased patient. See Policy: Uses and Disclosures of Protected Health Information Concerning Decedents.

5. Time Frames for Responding to Requests to Inspect and Copy Medical Records.

- a. Copies of records will be provided, or a written denial made, in response to requests from patients or their representatives for access to all or part of the patient's designated record set within thirty (30) days of receipt of the request.
- b. The thirty (30) day time limit in paragraph 5(a) above will be extended to sixty (60) days if the records requested are not accessible on-site. If this time extension is required, mail to the requestor a written statement explaining the delay and setting forth the date by which MIHS will provide records or a response.
- c. If MIHS personnel cannot produce the records within the time limits in paragraphs 5(a) or 5(b), mail to the requestor a written statement explaining the delay and setting forth the date which the Hospital will provide records or a response. MIHS personnel may have only thirty (30) extra days under this extension.

- d. HIM personnel processing a request for access will log in these dates.

6. Denial of Access to the Patient's Designated Record Set.
 - a. A decision to deny access to or copying of a patient's designated record set, in response to a request by the patient or patient representative, may be made on the following grounds:
 - (i) MIHS does not maintain the records.
 - (ii) The requestor, if not the patient, is not authorized to receive the records under paragraph 4, and the patient has not authorized the disclosure.
 - (iii) The requestor is a parent or guardian but is not authorized to receive the records because the minor patient is emancipated, married, and homeless [or the records involve reproductive health care.
 - (iv) The patient's physician or psychologist has determined that the release of the record to the patient is not in the patient's best interest due to the treatment of the patient for a mental disorder, and that the release of this information would be reasonably likely to endanger the life or physical safety of the patient or another person, or to cause substantial harm to such other person.
 - (v) The patient's physician or psychologist has determined that the patient's raw test data and psychometric testing materials should not be disclosed, and that the release of this information would be reasonably likely to endanger the life or physical safety of the patient or another person, or to cause substantial harm to such other person.
 - b. In all cases in which access to records will be denied, HIM personnel will make reasonable efforts to provide access to all records that do not provide grounds for denial.
 - c. The Procedure for denying access to a designated record set is as follows:
 - (i) In all cases, the requestor will be notified in writing of a decision to deny access to all or part of the designated record set, including a short statement of the basis for the denial.
 - (ii) The notice will contain a description of how the requestor may file a complaint with the Compliance Office, and with the Department of Health and Human Services.
 - (iii) In cases in which the requestor is entitled to an appeal of a denial, the requestor will be so notified and receives instructions for filing an appeal.
 - (iv) If MIHS does not maintain the requested records, but knows where the information may be obtained, the requestor will be notified of this information.
 - d. Appeals of denials of access to designated record set.
 - (i) For denials based on the grounds set forth in Section 6(a) (iv) and (v), set forth above, the notice will give the requestor the right to an appeal.
 - (ii) The appeal is an internal review process whose purpose is to review the initial decision to deny access to a record and determine whether that denial satisfied the grounds for denial set forth in Section 6(a)(iv) and (v) set forth above.
 - (iii) All appeals will be in writing.
 - (iv) Upon receipt of a written appeal, HIM personnel will log the appeal.
 - (v) The Director of HIM will forward the appeal and the reasons for denial to the Compliance Office.
 - (vi) If the Compliance Office has not previously participated in the matter, the Director of HIM will confer with the Compliance Officer to review the matter.
 - (vii) The appeal review will be completed in a reasonable time. The reviewer will provide a decision in writing to the Director of HIM.
 - (viii) Upon receipt of the appeal review decision, the Director of HIM or his/her designee will notify the requestor promptly in writing.
 - (ix) Documentation of the requestor's written appeal, the appeal reviewer's decision, and the notice to the requestor will be maintained in the correspondence section of the medical record.

- (x) The title of the person or office designated to receive and process requests for protected health information will be maintained for at least six (6) years in Medical Record Department.

7. Methods of Granting Requests for Record

- a. The requestor will have access to the records in the format he or she requests if it is readily producible in that format.
- b. "Readily producible" means in hard copies via the ChartMaxx System.
- c. If more than one (1) set of identical records exists, the requestor will be entitled only to one (1) copy.
- d. The requestor may request a summary of the designated record set, in lieu of a copy of the entire record. A summary will include copies of the history and physical and discharge summaries or discharge progress notes of each admission and the operative report, if applicable, for each admission.
- e. Documentation of the records disclosed to the requestor will be kept for a period of at least six (6) years.
- f. If the patient is in-house and the patient requests to inspect or copy PHI in the designated record set, the request will be granted upon approval of the attending physician.

8. Charges

- a. If a copy of the record is for the following purposes, MIHS may **not** charge for the copies under Arizona law:
 - (i) To the patient or the patient's representative for the demonstrated purpose of obtaining further health care for the patient;
 - (ii) To another health care provider for the purpose of providing continuing care to the patient; or
 - (iii) To an officer of the Arizona Department of Health Services or the local health department requesting records related to an investigation of reportable communicable diseases, or to the medical boards.
- b. If a copy of the record is requested for any other purpose, MIHS may charge a reasonable cost-based fee to the patient or the patient's representative, and may charge a reasonable fee to others.
- c. MIHS's Request for Records form asks the requestor to indicate the purpose for seeking records. If the purpose falls within paragraph 8(a), MIHS will not charge for the copies.

References: 45 C.F.R. 164.524. MIHS Administrative Policy and Procedure: Authorization to Use and Disclose Protected Health Information; Uses and Disclosures of Protected Health Information Concerning Decedents.