NORTHEAST REHABILITATION HOSPITAL NETWORK
POLICIES AND PROCEDURES MANUAL
HOSPITAL-WIDE POLICY

SECTION: HW.ADM

SUBJECT:	Confidentiality of Patient Information, Access to Patient Health Information
EFFECTIVE DATE:	4/03
REVIEWED:	Annually
REVISED DATE:	12/03, 10/06, 12/09, 3/11, 1/16, 3/17
REPLACES:	Regulatory Compliance/HIPAA Privacy: Current Patient's Access to PHI; Removed from Confidentiality and Privacy of Patient Information

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POLICY STATEMENT:

It is the policy of Northeast Rehabilitation Hospital Network (NRHN) to protect and respect patient confidentiality and privacy of protected health information as mandated by Federal HIPAA rules and regulations, NH State Law and Medicare's Conditions of Participation. NH RSA 151.21 and CFR 164.508-165.514.

PURPOSE:

To establish content and purpose for the medical record, to define its ownership, retention, removal and destruction, right to inspect, right to request access, to discuss the role of confidentiality, security from unauthorized access, loss or tampering, and to list and define those situations that appropriately justify the release of medical record information. Patient information includes hard paper copy and electronic patient information databases, stored electronically. This policy applies to all departments who maintain any confidential patient information within NRHN.

PROCEDURE:

NRHN through its Health Information Management Department (HIM), reserves the right to deny access to information in the medical record of any patient, at any entity, until such time as criteria for legitimate disclosure, as evidenced by the following have been met. Such criteria either, or in combination, may be:

- Appropriate and reasonable (48 hours' notice) notification to HIM except in urgent/emergent patient care instances.
- Proper identification of the patient, i.e. correct spelling of name, date of birth.
- Full identification of the requesting party is known.
- Valid right to access has been established. Legal documentation of executor of estate, or spouse, if for deceased patient.
- The purpose for which the information is needed, or is to be used, has been determined.

- Submission of a valid authorization, if applicable.
- Approval of NRHN Director of HIM or designee, or NRHN Legal Counsel.

The above limitations on disclosure in no way shall be viewed as obstructing legitimate access, but rather, the exercise of a cautious approach to disclosure of patient medical information, since information, once disclosed, cannot be retracted, and with the assurance that if an individual/agency/institution is genuinely entitled to information, ultimately they shall be given access to it.

SPECIAL AUTHORIZATION

- HIV/AIDS
- Substance Abuse
- Alcohol Abuse
- Psychiatric Treatment : mental or Behavioral Health
- Sexually Transmitted Diseases
- Genetic Testing

Highly sensitive information which needs special authorizations; examples include, but are not limited to:

- Adoption, birth anomalies, fetal deaths (if contained in the Medical Record)
- Mental illness/psychiatric treatment, alcohol or drug dependency
- Sexually transmitted diseases, rape and child/adult abuse

OWNERSHIP

The actual record itself is the property of the facility generating it during the ordinary course of business. However the content of the record belongs to the patient and the patient can receive a copy of their record, which may include a reasonable fee, in accordance with NH state law.
Medical records, in the possession of NRHN, but generated by another health care provider:
HIM staff will encourage the patient to request copies of the medical record generated by another health care provider from that health care provider. If the patient cannot get a copy of the record from the originator, or time is of the essence (emergencies, etc.), NRHN will provide medical records, at the patients request, regardless of whether NRHN created the records or the records were provided by another health care provider*.
*New Hampshire Board of Registration Administrative Rule 501.02(f) (2).

PURPOSE OF THE MEDICAL RECORD

NRHN initiates a medical record for every individual assessed or treated:

- To facilitate patient care
- Serve as a financial and legal record
- Aid in clinical research
- Support decision analysis
- Guide professional and organizational performance

RECORD CONTENT

- Only authorized individuals make entries in the medical record as per hospital policy and other health care providers credentialed through Medical Staff Affairs office.
- Only forms approved by NRHN Forms Committee are included in the patient's permanent paper medical record.
- Correspondence, although technically not part of the medical record, is stored in the medical record for the convenience of the HIM staff and to document what information has been released.
- Copies of records from other facilities are historically deemed the property of those facilities and thus, copies are not necessarily or automatically provided by the HIM, exception (see Ownership section above). However, they are stored in the record for continuity of care purposes only.
- Patient's request for amendment to their record and the denial of amendment will be kept with the original record and in accordance with the Amendment/Correction to PHI policy.

RIGHT TO REQUEST RELEASE, ACCESS TO OR COPIES OF PHI
REQUEST FOR RELEASE OF PHI

- **Valid Release or Authorization**

A valid release constitutes a written permit or authorization, signed by the patient, or his legal representative, to release information from the medical record maintained during the ordinary course of business by NRHN.

A properly completed and signed authorization shall include at least the following:

- Name of the institution that is to release the information.
- Name of the individual/institution/agency to receive the information
- Patient's correct name, date of birth, and address
- Purpose of need for the information
- Specific as to dates of treatment, medical condition/injury or other information requested
- Date that the consent is signed
- Date of signature must be subsequent to the dates of information to be released. A patient cannot authorize the release of information that has yet to be generated; nor shall the phrase, "Ongoing condition" be interpreted as covering "future treatment" and its release, unless specifically noted by the patient or legal representative on the release form.
- Signature of patient or legal representative
- A statement that the authorization may be revoked in writing
- A statement that we can no longer guarantee confidentiality after the information is released

A photocopy or fax transmittal of an authorization shall be accepted in lieu of an original.
NRHN does not honor a release which has been dated longer than 1 year, and a statement that the consent can be revoked, but not retroactive to the release of information made in good faith.

ACCESS TO PHI/REQUESTS FOR PAPER OR ELECTRONIC COPIES OF PHI

1. Right to Access Records

Who Can Access: A patient, a patient's guardian or a patient's personal representative may access a record after submitting a written request to physically inspect the medical record. A patient or patient's personal representative is any patient, parent, guardian, or committee of a patient that has been deemed non-competent.
What Information: Patients have the right to inspect and obtain a copy of the protected health information that NRHN, or one of its business associates, maintains in "designated record sets." "Designated record sets" are sets of records that may be used to make decisions about the patients or their treatment.
The designated record set for each patient generally includes the patient's medical record.
For How Long: A patient, a patient's guardian or personal representative may access a record. Patients must submit a written request to physically inspect the medical record. Patients have the right to access their protected health information for as long as the information is contained in their designated record set.
In Writing: All requests for access must be made in writing.
Proper Identification: In the interest of protecting the confidentiality of the record, the person requesting access should present identification such as a government issued picture card, a driver's license or ID card that carries a valid signature. Individuals requesting access in the capacity of guardian, Durable Power of Attorney when invoked, or conservator of the person should send a copy of their appointment papers when requesting copies or present such papers at the time of inspection. The signature will be compared with the signature on the consent for treatment and any discrepancy clarified.

2. Response Time
The Director HIM or designee, must respond to a patient's requests for access to their protected health information (by either granting or denying the request) as soon as possible after the request is received.

3. Granting Requests for Inspection of Records

- If NRHN is granting a patient's request to inspect his or her protected health information, the Director HIM or designee, will arrange an appointment with the individual to review their records. Copies may be provided in lieu of inspection.
- **Proper Identification:** The person requesting access must present a government-issued picture identification, such as a driver's license or ID card which carries a valid signature. Individuals requesting access in the capacity of guardian or conservator of the person should send a copy of their appointment papers when requesting copies or present such papers at the time of inspection. The signature will be compared with the signature on the consent for treatment and any discrepancy clarified.
- **Assisting Patient With Review:** The Director HIM or designee may ask the patient whether a staff member may assist the patient in reviewing the information requested. The patient is free to refuse any assistance, and cannot be penalized or denied access for doing so. HIM Staff will not interpret the information contained in the Medical Record but will refer the patient to the Attending Physician or the patient's PCP.
- **Supervising Patient's Independent Review:** If the patient is not reviewing his or her information jointly with a staff member, the Director HIM will be present in the room at all times to ensure that the integrity of the records is maintained. The Director of HIM or designee should remain in view of the patient to prevent inappropriate tampering, but far enough away so that the patient is afforded appropriate privacy when reviewing the content

of his or her records. The Director of HIM or designee will not answer any questions regarding the content of the record but will refer the patient to the Attending Physician or patient's PCP. If the patient wishes to be completely alone, he or she must request copies of the records.

- **Miscellaneous:** A patient's review of his or her information should take place only where the patient will not be able to view information or records concerning other patients. A patient may be accompanied by a family member or other individual and may view their records with that companion.

4. Requests for Copies

The patient must submit a valid authorization form to obtain paper or electronic copies of medical records. If the patient requests an electronic copy of their medical records, NRHN must provide the patient a copy in the electronic form and format as requested, as long as NRHN can readily produce such information in the form requested. Otherwise, NRHN should cooperate with the patient to provide a readable electronic form and format of the records as agreed between NRHN and the patient.

Copies should be delivered to the patient in the method specified on the patient's request form or letter. The patient may visit NRHN to pick up the copies or request that the copies be delivered by mail to the address provided on the authorization form.

5. Denying Access

Reasons for Denial: In the following circumstances, a patient's request to access his or her health information should be denied**:**

(1) The request is not in writing;

(2) The information was obtained from someone other than a healthcare provider, and:

(a) NRHN agreed to keep the identity of that person confidential, and

(b) HIM Department staff determines that providing the patient with access to the information requested would reveal the identity of that person;

(3) If NRHN, in the exercise of professional judgment, determines that such access requested is reasonably likely to cause substantial harm, endanger the life or endanger the physical safety of the individual or another person.

(a) Access is reasonably likely to endanger the life or physical safety of the patient or another person.

(b) The PHI refers to another person and access is reasonably likely to cause substantial harm to such persons

(c) The request for access is made by the patient's personal representative and allowing access if reasonably likely to cause substantial harm to the patient or another person.

(4) If the patient is in a correctional institution and release of the protected health information would endanger the health or safety of the patient, other inmates, officers, employees or other persons associated with the prison.

Notice of Denial: If the patient's request is being denied, the patient must be notified. Denial should include the basis for the denial, a statement of the patient's right to review and a description of how the patient may complain to NRHN by providing contact information of the Privacy Officer.

6. Requests For Access By A Patient's personal representative

If a patient's personal representative requests access to the patient's records, the Director HIM or designee generally should grant or deny access according to the procedures in this policy as though the patient personal representative were the patient, *unless one of the following exceptions applies.*

Patient Lacking Capacity: When a patient lacks capacity to make health care decisions and the patient's personal representative must be given access to the patient's information in order to make health care decisions on behalf of the patient, the Director HIM should grant such access to the patient's personal representative.

Patients Who have Expired: The right to inspect and obtain copies of patient information is extinguished with the death of the qualified person. A duly appointed or qualified estate representative of the individual has the right of access to the medical record. Additionally, the restriction to access patient information does not apply to the health information of an individual who has been deceased for more than 50 years; thus, a personal representative need not authorize disclosures of the decedent's health information nor does a personal representative have rights with respect to such information if the patient has been deceased for more than 50 years.

Documentation: The Director HIM must retain the documentation in connection with any request by a patient or a patient's personal representative to access protected health information. These documents must be maintained for six (6) years from the date of their creation. When possible, these documents will be kept in the patient's medical record.

COMPLETION

Standards for completion are found in the Medical Staff Bylaws, Rules & Regulations, Joint Commission standards, Federal and State law, and relevant hospital policies.

REMOVAL FROM HOSPITAL PREMISES

The original record shall not be removed from the facility except by specific court orders received only when certified copy has been refused and will be hand carried only by Director of HIM (or designee), Legal Counsel or Administrator of NRHN. Certified copy will be used in all other instances.

Records may be removed from the treating location for offsite storage, requested by the HIM department to process a release, when patient is transferring to another location, or with the approval of the Director of HIM. Except in approved circumstances all records will be transported by the hospital courier or contracted courier service.

MAINTENANCE/SECURITY

When in use for patient care, the records shall be kept in secure areas at all times:

Department Directors of patient care units, ancillary departments, Pain Clinic., Therapy areas etc. are responsible for the safety and security from unauthorized access and tampering of the records while they are housed in their areas (both current and prior visits).

The medical record shall be available and accessible to health care providers directly involved in patient care.

The caregiver providing treatment is responsible for the safety and security of the entire medical record, both current and previous records.

Once the record is taken from the HIM Department to any other department, that department assumes responsibility for the safekeeping and security of the record, that department assures:

- Its orderly transfer with the patient to the next patient care area if needed
- That, along with, all discharged patients' records the "archived chart" must be available for the HIM Staff within 4 days of discharge. Delayed record retrieval is to assist clinical staff with completion of the record and have record available for easy retrieval of medical information when phone call is received within 3 days of discharge from another facility or continuum of care environment such as Home Care.
- Access by personnel directly involved with patient care, 4 days after discharge, shall occur in HIM.

RELEASE OF INFORMATION TO EXTERNAL AGENCIES STATE MANDATED REPORTING:

Child Abuse/Neglect/Abandonment
Any hospital personnel having reason to believe a child under the age of 18 has been abused or neglected shall report it to the Division of Children & Youth Services.
Requests for information for investigative purposes from HIM shall be cleared through the Correspondence section of those departments who shall determine legitimate right of access.
The representative of the division authorizes release of the medical record or a child placed in foster care, under the Division of Child & Youth Services.
Court appointed guardian would authorize release of information with proof of appointment.

Death Certificates
The physician attending at the last sickness shall fill out the death certificate or may be completed by nursing (see policy on Death Pronouncement by an RN: Clinical)
The physician in attendance shall notify the Medical Examiner, per State Law.

Elderly Abuse
The representative (with proper identification) to present patient/guardian authorization or:
Certification by the ombudsman may be accepted, if verified.

Communicable/Infectious Diseases, Sexually Transmitted Diseases, Sexual Assault and Related Offenses, and Injuries:
Records shall be released only according to state law.

EXTERNAL REQUESTS FOR PATIENT INFORMATION MUST BE FORWARDED TO THE HIM DEPARTMENT:
Worker's Compensation
Attorneys
Employers
Patient, Spouses, relatives
Divisions of the Armed Forces
Commercial Insurance Carriers
Federal, State and Local Authorities
All other law enforcement

All External Reviewers must show proper identification and cannot document in the medical record.

SUBJECT: Confidentiality of Patient Information, Access to Patient Health Information

PHYSICIANS
Medical Staff physicians, upon stating he/she is the physician of record, or presenting a release shall have access to that patient's record.
Medical Staff physician shall submit valid authorizations for access to their own family members' records.

CONTINUITY OF PATIENT CARE
Patient information shall be released at the time of discharge to subsequent care providers without patient authorization in order to facilitate the continuity of care.
Patient information shall be released to subsequent care providers in emergent situations without patient authorization.
Documentation must include specific parts of the chart that were copied.

SUBPOENA
A subpoena is an order of a court or an authorized agency commanding the person subpoenaed to appear as a witness. It should bear the local, state or federal court's seal to be valid.
A subpoena that is not sent by a New Hampshire Court, but sent by an attorney's office, or some other office should be referred to the Legal Department.
A subpoena without a written authorization from the patient is not valid.
OUT OF STATE subpoenas are not valid and require a written authorization

COURT ORDER
Only a New Hampshire Court Order, signed by a judge with the appropriate jurisdiction is valid and does not need patient's written authorization to respond. Any questions or concerns should be referred to the Legal Department.

MEDIA REQUESTS
Highly sensitive information (HIV, substance abuse, alcohol abuse, psychiatric treatment) requires a special authorization in all instances.
All press/television/radio requests shall be handled as per the Media Policy process
(Refer to ADM: Media Policy and /or Patient Privacy and Use of Photography Equipment)

PATIENT ACCESS TO RECORD
Discharged patients shall be permitted to inspect or obtain copies of their designated record set, upon the medical record completion, with adequate (48 – 72 hours) notification to the HIM Department and will sign an appropriate authorization. If release will be delayed patient will be informed as to the reason and the expected delivery date
Patients shall be informed of the charges for records other than for continuing care.
Patients shall be informed of the charges for records copied and released due to the patient transferring out of the NRHN network.
Inpatient access requires notification to the Director of HIM, or designee and the attending M.D.
The patient may view his/her record in the presence of the physician or nurse upon signing a release and in coordination with the clinician schedule

TELEPHONE REQUESTS
Generally no clinical information may be released over the telephone.

Exceptions:
Case Manager, Physician or Therapy in accordance with contract or patient authorization for continuum of care treatment or referral

RETENTION
Medical Records shall be maintained in accordance with the NH and MA Laws (see policy on Medical Record Retention and Destruction)

LEGAL ACTION
If a claim against the facility or the medical staff is threatened, pending or actually filed, legal counsel shall determine whether, when, how, or under what circumstances access shall be granted or copies furnished, in accordance with NRHN System policies and state laws.
At all times, the medical record shall be available and accessible to healthcare providers directly involved in patient treatment. All healthcare providers are responsible for the safety, security from unauthorized access, loss or tampering, while the records, both current and previous are in their possession. Records identified through Legal Dept. shall be secured in the Medical Record Department.

LEGAL USE OF THE MEDICAL RECORD
Any request from the medical record for use in a potential legal case, please contact the Risk Management Department for direction and/or HIM Department Director.

APPROVALS:

_____	_____
HIM/Privacy Officer	CFO