PURPOSE

This policy of Huntington Memorial Hospital (HMH or Hospital) describes the scope of a patient’s right to access his/her protected health information (PHI) in a Designated Record Set (DRS), the circumstances under which a patient’s request for such access may be denied, and the Hospital’s requirements for processing a request for access to a patient’s PHI. This policy also defines the Medical Records Department’s responsibilities for responding to a patient’s or the patient’s authorized representative’s request to access the patient’s PHI.

POLICY

The Hospital will abide by all applicable federal and State of California requirements related to a patient’s or authorized representative’s right to access PHI.

APPLICABLE TO

All employees
Medical Records Department
Medical Staff
Nursing Departments

DEFINITIONS

Designated Record Set: A group of records maintained by or for the Hospital that is:
  1. The medical records and billing records about individuals maintained by or for the Hospital;
  2. The enrollment, payment, claims adjudication, and case or medical management records systems maintained by or for a health plan; or
  3. Used, in whole or in part, by or for the Hospital to make decisions about individuals.

The Hospital’s DRS for an individual patient generally will include that patient’s Hospital medical record and billing records, and also may include, for example, medical records obtained from other health care providers that are used to make decisions about the patient’s care.

Protected Health Information: Protected Health Information is individually identifiable health information, whether oral or recorded, transmitted or maintained in any form or medium that is created or received by the Hospital.
Record: For purposes of this policy, a record is any item, collection or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for the Hospital.

PROCEDURE

Request for Access to PHI

1. Each patient has a right of access to inspect and/or obtain a copy of his/her DRS for as long as the patient’s PHI is maintained in the DRS, except in the situations described below in the section entitled “Denial of Access to PHI.”

2. To request access to his/her PHI, a patient must complete the Authorization to Use and Disclose Protected Health Information form (attached), and submit the completed form to the Assistant Director of Medical Records (or his/her designee) in the Medical Records Department.

3. In the event that a patient or a patient’s authorized representative requests access to the patient’s PHI from a clinical staff member, such clinical staff member will contact the Medical Records Department. The Medical Records Department staff will contact the patient to assist with completion and submission of the form.

Who May Request Access to PHI

1. The following persons, upon written request in accordance with this policy, have the right to review and receive a copy of a patient’s DRS or a part of it (except as discussed below in the section entitled “Denial of Access to PHI”):
   a. the patient;
   b. the patient’s parent or guardian if the patient is a minor, except with respect to records of treatment to which the minor could consent (and as to which the minor therefore would have his/her own right of access as the patient), or if one of the patient’s health care providers determines that such access would have a detrimental effect on the provider’s professional relationship with the minor patient or the minor’s physical safety or psychological well-being;
   c. another person on the patient’s behalf, if the patient signs a written Authorization to Use and Disclose Protected Health Information form authorizing disclosure to that person (proper identification will be required prior to the release of information);
   d. the legal guardian or conservator of an adult patient if the guardian or conservator has been granted authority by the court to make health care decisions for the patient;
   e. the beneficiary or personal representative of a deceased patient; and
   f. the patient’s agent under a power of attorney for health care (PAHC), to the extent necessary for the agent to carry out his/her responsibilities under the PAHC.

2. If there is any question about whether a person’s request for access to his/her own or another person’s PHI should be granted, the Assistant Director of Medical Records
should contact the HMH Compliance Officer immediately, and should not release the information unless and until the issue has been resolved.

3. Employees, independent contractors (such as physicians) and volunteers of the Hospital who are treated as patients in the Hospital are required to submit formal requests to access their PHI through the same channels as all other patients. Independent accessing of an employee’s, volunteer’s, or physician’s personal PHI in paper, electronic or any other format is strictly prohibited.

4. Employees, independent contractors (such as physicians) and volunteers of the Hospital are prohibited from accessing PHI, in any format, pertaining to family members, friends, co-workers, or any other persons for whom they do not have a direct care-giving role or for whom they are not performing a legitimate function for purposes of treatment, payment or health care operations.

Access to PHI During a Patient’s Inpatient Stay

1. A patient or the patient’s authorized representative may view the patient’s DRS during a Hospital stay if a written request is submitted to the Assistant Director of the Medical Records Department (or his/her designee) as described above and granted in accordance with this policy and applicable law. If the request is granted, the Medical Records Department staff will schedule an appointment with the patient. A patient is NEVER allowed access to the DRS without an authorized representative of the Hospital being present.

2. Medical Records Department staff will notify the patient’s attending physician of the request for access to the patient’s DRS.

3. Medical Records Department staff or other authorized Hospital staff will be in attendance for surveillance at all times during the patient’s or authorized representative’s review of the DRS, but will not answer questions regarding contents.

Denial of Access to PHI

1. Circumstances in Which Access May Be Denied with No Opportunity for Review. The Hospital may deny a patient or authorized representative access, without providing the patient or representative an opportunity for review of the denial, in the following circumstances:
   a. The information was compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
   b. If acting under the direction of a correctional institution, the Hospital may deny, in whole or in part, an inmate’s request to obtain a copy of PHI, if obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the patient or of other inmates, or the safety of any officer, employee, or other person responsible for the inmate.
   c. A patient’s access to PHI created or obtained in the course of research may be temporarily suspended for as long as the research is in progress, provided that the
patient has agreed to the denial of access when consenting to participate in the research, and the Hospital has informed the patient that the right of access will be reinstated upon completion of the research.

d. A patient’s access may be denied if the PHI was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

2. Circumstances in Which the Patient Must be Given an Opportunity for Review of a Denial of Access to PHI. The Hospital may deny a patient or the patient’s authorized representative access to the patient’s PHI, provided that the patient or representative is given a right to have such denial reviewed, in the following circumstances:

   a. A licensed health care professional has determined that the access requested is reasonably likely to endanger the life or physical safety of the patient or another person;
   
   b. The PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined that the access requested is reasonably likely to cause substantial harm to such other person; or
   
   c. The request for access is made by the patient’s personal representative, and a licensed health care professional has determined that the provision of access to such personal representative is reasonably likely to cause substantial harm to the patient or another person.

If access is denied on a ground permitted under this section #2, the patient has the right to have the denial reviewed by a licensed health care professional. The Hospital will designate a licensed health care professional, who was not directly involved in the denial, to review the decision to deny access, and refer the request for review to such designated reviewing official. The designated reviewing official must determine, within a reasonable period of time, whether or not to deny the access requested. The Hospital will provide written notice to the individual of the determination of the designated reviewing official, and take other action as required to carry out the designated reviewing official’s determination.

3. Psychotherapy Notes. The Hospital shall deny a patient access to psychotherapy notes when a health care provider determines there is a substantial risk of significant adverse or detrimental consequences to the patient in granting the request. The Hospital shall permit inspection and/or copying of the psychotherapy notes by a licensed professional (a physician, psychologist, marriage and family therapist, clinical social worker, or professional clinical counselor) designated in a written authorization by the patient, but such designated licensed professional shall not permit inspection and/or copying by the patient. The Hospital will inform the patient that he/she has the right to designate a licensed professional to review such records. The patient’s health care provider must make a written record to be included with the records being requested that notes the date of the patient’s request for access, and specific adverse or detrimental consequences anticipated if the request were granted, and whether the patient authorized a licensed professional to inspect and/or copy the records.

4. Written Notice of Denial. The Assistant Director of Medical Records (or his/her designee) shall deny a request for access to PHI if applicable law prohibits the Hospital from disclosing the information to the patient or the patient’s authorized representative, or under circumstances where disclosure would jeopardize the safety of the patient or another person or persons. If the Hospital denies access in whole or in part to requested PHI, the Hospital
will, to the extent possible, give the patient access to any other PHI requested, after excluding the PHI as to which the Hospital has a ground to deny access. In addition, the Hospital will provide a timely, written denial to the patient within five (5) working days after the Assistant Director of Medical Records (or his/her designee) receives the written request. The denial must be in plain language and contain:

   a. The basis for the denial;
   b. If applicable, a statement of the patient’s review rights including a description of how the patient may exercise such review rights; and
   c. A description of how the patient may complain to the Hospital or to the Secretary of the federal Department of Health and Human Services for failure to comply with the patient’s request. The description must include the name, or title, and telephone number of a contact person or office related to privacy and security.

5. **Directing a Request for PHI to the Appropriate Party.** If the Hospital does not maintain the record or information that is the subject of the patient’s or authorized representative’s request for access, and the Hospital knows where the requested information is maintained, the Hospital will inform the patient or authorized representative where to direct the request for access.

### Provision of Access

1. **Processing Times.** This section of the policy identifies the Hospital’s requirements for processing a request for access to a patient’s DRS.

   a. The Hospital will act on a written request for access no later than five (5) working days after receipt of the request as follows:
      i. If the request is not denied, the Hospital will inform the patient that the request has been granted and provide the access requested.
      ii. If the request is denied, in whole or in part, the Hospital will provide the patient with a written denial, in accordance with the section of this policy titled “Denial of Access.”

   b. If the Hospital is unable for any reason to take an action within the above timeframe, the Hospital will maintain open communication with the requestor until the organization completes its action on the request.

2. **Multiple Medical Records.** If the Hospital will provide the access requested by a patient or authorized representative, such access shall include inspection and/or copies of the PHI in a patient’s DRS. If the same PHI that is the subject of a request for access is maintained in more than one DRS or at more than one location, the Hospital will produce the PHI only once in response to a request for access.

4. **Form/Format.** The Hospital will provide the patient or authorized representative with access to the PHI in the form or format requested by the patient or authorized representative, if it is readily producible in such form or format; or, if not, in a readable hard copy form or such other form or format as agreed to by both parties. If the patient or
authorized representative requests an electronic copy of PHI that is maintained electronically in one or more designated record sets, Huntington will provide the patient with access to the electronic information in the electronic form and format requested by the patient or authorized representative, if it is readily producible, or if not, in a readable electronic form and format as agreed to by Huntington and the patient or authorized representative.

3. **Summary.** The Hospital may provide the patient or authorized representative with a summary of the PHI requested, in lieu of providing access to the PHI, or may provide an explanation of the PHI to which access has been provided, if the patient or authorized representative voluntarily agrees in advance to such summary or explanation, and to any fees that the Hospital may require the patient or authorized representative to pay. The Medical Records Department must disclose any fees that may be imposed. The Hospital will provide the summary within ten (10) working days of the written request, or within thirty (30) days if Hospital notifies the patient or authorized representative that more time is necessary because of the length of the record or because the patient was discharged from the Hospital within the previous ten (10) days.

4. **Timely Access.** The Hospital will provide the access as requested by the patient or authorized representative in a timely manner, including arranging with the patient or authorized representative for a convenient time and place to inspect or obtain a copy of the PHI. Hospital will mail a copy of the PHI within fifteen (15) days of the patient's or authorized representative's written request. The Hospital may discuss the scope, format, and other aspects of the request for access with the patient or authorized representative as necessary to facilitate the timely provision of access.

5. **Fees.** If the patient or authorized representative requests a copy of the PHI or agrees to a summary or explanation of such information, the Hospital may impose a reasonable, cost-based fee, provided that the fee includes only the cost of:
   a. Copying, including the cost of supplies for and labor of copying, the PHI requested by the patient or authorized representative;
   b. Postage, when the patient or authorized representative has requested the copy, or the summary or explanation, be mailed; and
   c. Preparing an explanation or summary of the PHI, if agreed to by the patient or authorized representative.

For release of information fees, refer to the Medical Records Department fee chart.

7. **Documentation.** The Medical Records Department will create and/or maintain documentation relating to patient/authorized representative requests for access to PHI and HMH’s responses, as follows:
   a. the Medical Records Department will retain a copy of a patient’s or authorized representative’s written request for access to PHI, and note the date it was received;
   b. the Medical Records Department will document (i) the name(s) of personnel who processed and responded to each request, (ii) the information provided in response (if any) including any correspondence and a copy of the information provided (e.g., the
patient’s DRS), and/or (iii) the written denial of a request and the date of denial, if the request is denied.

c. The Medical Records Department will retain a copy of any patient’s or authorized representative’s request for review of a denial of a request for access to the patient’s PHI, note the date it was received, and document the process and outcome of the review.

Each piece of documentation relating to patient/authorized representative access to PHI, including any request, denial, or review, and copies of information provided (e.g., the patient’s DRS), will be retained for six (6) years from the date of document creation. A copy of any policy relating to patient/authorized representative requests for access to PHI (e.g., this policy) will be maintained for six (6) years from the date it last was in effect.

REFERENCES

45 C.F.R. §164.501
45 C.F.R. §164.524
Cal. Health & Safety Code §§ 123100, 123105, 123110, 123115

SOURCE

Compliance & Internal Audit Services
Medical Records Department
Medical Staff
Professional Nurse Practice Committee
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

MR #: __________________________ (if available)

Patient Name: ____________________________________________________________

Last       First       Middle

Home Address: ______________________________________________________________________

Street

City       State       Zip

Home Telephone: ___________________________ DOB: ___________________________

RECIPIENT: Name of person, entity, or class of persons or entities to whom Huntington Memorial Hospital (HMH) may disclose my protected health information (PHI):

Name: ____________________________________________________________

In addition, PLEASE CIRCLE ONE, if applicable:

Attorney    Doctor    DPA    Insurance    Self    Other: __________________________

I would prefer to:

☐ Pick up a copy of or view the requested PHI at HMH; OR

☐ Have the requested PHI mailed to the Recipient at the following address:

__________________________________________

Street

City       State       Zip

Phone Number ___________________________    Fax Number ___________________________
TERM: This Authorization will expire on (required):

☐ The _____ day of _____________________, 20__________.

(If no date specified, it will expire six (6) months from the date signed.)

Specify date(s) of service requested or event:

________________________________________________________________________

Please check appropriate box(es) to indicate the specific PHI that may be disclosed:

☐ Pertinent Records - Package A
☐ Face Sheet
☐ Discharge Summary
☐ ER Report
☐ History and Physical
☐ Consultation Reports
☐ Operation Reports
☐ Pathology Reports
☐ Laboratory Tests
☐ Radiology Reports
☐ Cardiology Reports

☐ Pertinent Records - Package B
☐ Progress Notes
☐ Physician Orders
☐ Graphics
☐ Medications
☐ Special Test/Therapy
☐ Nurses Notes
☐ Rhythm Strips
☐ Labor/Delivery

☐ All Records (Package A and Package B)

Highly Confidential PHI (will not be released without specific consent)

By checking the box next to a category of highly confidential PHI listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential PHI indicated next to my signature, if any such information will be used or disclosed pursuant to this authorization:

☐ Mental Health Treatment: _____________________________________________
☐ Developmental Disability: ____________________________________________
☐ Communicable Disease: _____________________________________________
☐ Sexual Assault: ______________________________________________________
☐ Child Abuse or Neglect: ______________________________________________
☐ Genetic Testing: _____________________________________________________
☐ Domestic Abuse: _____________________________________________________
☐ Adult Abuse: ________________________________________________________
□ Substance Abuse: _________________________________________
(Prevention or Treatment for Alcohol or Drug Abuse)

□ HIV/AIDS: _________________________________________
(Testing, Diagnosis, or Treatment (regardless of result))

A separate authorization is required for the release of psychotherapy notes.

If you want only the PHI from certain dates of service or events disclosed, specify such date(s) of service or event(s):
__________________________________________________________________

PURPOSE: I authorize HMH to use or disclose my PHI (including the highly confidential PHI I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: “at the request of the Patient” is a sufficient purpose if the Patient is initiating this Authorization:
__________________________________________________________________

I understand that once HMH discloses my PHI to the recipient, HMH cannot guarantee that the recipient will not re-disclose my PHI to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my PHI.

I understand that I may at any time make a written request to HMH to inspect and/or obtain a copy of my PHI, and that HMH will either, within five (5) working days for a request to inspect and fifteen (15) days for a request to copy, grant the request and contact me to arrange for a convenient time to inspect and/or copy my PHI or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at HMH; except, however, if my treatment at HMH is for the sole purpose of creating PHI for
disclosure to the recipient identified in this Authorization, in which case HMH may refuse to treat me if I do not sign.

I understand that, at any time during which this Authorization is in effect, I may make a written request to receive a copy of this Authorization. Such written request shall be made to HMH at the address listed below.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to HMH at the address listed below. The revocation will be effective immediately upon HMH’s receipt of my written notice, except that the revocation will not have any effect on any action taken by HMH in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my PHI. By my signature below, I hereby, knowingly and voluntarily, authorize HMH to use or disclose the indicated PHI in the manner described above. I understand that failure to provide all requested information may invalidate this Authorization.

___________________________________________________________  __________________
Signature of Patient                                      Date

___________________________________________________________

If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signature and information (required):

Signature of Personal Representative:________________________________________________________

Description of Authority: ________________________________________________________________

Date: ____________________________

**For Internal Use Only (REQUIRED):** The identity of the requestor has been validated either with a government issued picture ID, such as a driver’s license or passport, or comparison of signatures documented in the PHI records.

___________________________________________________________  __________________
Signature of employee validating identity                      Date
Please return this form to:

By mail or in person to: Huntington Hospital
Medical Records
100 W. California Blvd.
Pasadena, CA 91105

By Fax: (626) 397-2928

Please contact Medical Records with any questions at (626) 397-5054.