



University of Connecticut Health Center

POLICY NUMBER 2003-17

April 14,2003

**POLICY: PATIENT RIGHT TO INSPECT, COPY, AND AMEND
THEIR MEDICAL RECORD
(Privacy & Security of Protected Health Information (PHI))**

PURPOSE:

To allow patients, or their authorized representatives, the right to:

- Request to review records of their health information as outlined in the designated record set (defined as the patient's medical/dental record & billing records maintained by or for the UCHC to make decisions about these individuals)
- Request copies of their health information in their medical/dental record or billing records
- Request that an amendment be made to their medical/dental record or billing records

SCOPE:

All Health Center staff involved in the care of patients as well as staff in other areas where patient information is released will comply with this policy and procedure when patients request to inspect, copy or amend PHI.

POLICY STATEMENT:

The UCHC is committed to safeguarding PHI in order to fulfill its mission to patients and to operate in a manner that is consistent with applicable federal and state laws and regulations.

The original patient's medical/dental/billing record is the property of the facility and may not be removed from the facility except by court order. This policy will ensure the patient's right to access for review, obtain copies of, and/or amend his/her PHI when necessary.

I. INSPECTION AND COPYING OF RECORDS– Patients and/or their legal representatives have the right to review their medical/dental/billing record information upon request. The request to do so must be in writing. Patient representatives have the right to act on the behalf of the patient when this is a court appointed status, or when they have the expressed authorization of the patient should the patient not be able to act on their own behalf.

UCHC must act upon a patient request to access their medical/dental/billing record information within (thirty) 30 days by either supplying the information or sending written notification of denial.

- A. Patients or their representatives requesting review and/or copies should be encouraged to wait until discharge and, when possible, until the record has been completed and proper authorization for the review has been obtained. All reviews to be performed post - discharge will be handled under the strict supervision of the Director of Medical Records

- or his/her designee, or the Principal Investigator for research records only or his/her designee. Post discharge patient review of psychiatric records is subject to attending psychiatrist approval.
- B. Patients insisting on reviewing their record during the current episode of care may be allowed to do so after the patient's attending physician/dentist or Principal Investigator or designee has been notified of the request and approves. Reviews done during the current episode of care must take place under the strict supervision of one of the following: the attending physician/dentist, case manager, primary nurse or the Director of Medical Records (or a designee) or the Principal Investigator (or designee). The patient is required to complete a proper authorization.
- C. Documentation must be included within the record when the patient reviews his/her Medical/dental/billing information with specific reference to what was reviewed and/or copied for the patient.
- D. Only Medical Records staff are authorized to make copies of a patient's medical/dental record. For research records, only the Principal Investigator or designee is authorized to make copies. Patients requesting copies of their medical record for their own personal use will be charged a fee in accordance with State Law. Patients will not be charged a fee when the information is for use by another healthcare provider. Fees for copies requested by attorneys, insurance companies and other such third parties will be directly billed to the requestor. **It is recommended that copies only be made once the chart is deemed "complete"**.
- E. The following information is not available for inspection or copying:
- Psychotherapy notes recorded by a mental health professional, in any medium, and maintained separately from the rest of the patient's medical record. Psychotherapy notes document or analyze conversation during a private, joint, family or group counseling session. By definition psychotherapy notes do not include medication records, counseling start and stop times, treatment records, results of clinical tests, diagnoses, functional status, symptoms, prognosis and progress and notes maintained with the individual's regular health record.
 - Information subject to Clinical Laboratory Improvement Amendments of 1988 (CLIA). Labs that are subject to CLIA must not grant patients access to test results if CLIA bans them from doing so. Research labs that are exempt from CLIA may also deny patients access to health information.
 - Information compiled in reasonable anticipation of or for use in a civil, criminal or administrative action or proceeding or pending litigation. Incident reports generated when a medical error occurs are not included in the designated record set and thus requests to review this information by the patient or their representative will be denied.

UNREVIEWABLE GROUNDS FOR DENIAL TO REVIEW AND/OR OBTAIN COPIES

Listed below are reasons/cases that would constitute denial for a patient to inspect and/or obtain copies of their records which are not contestable by the patient or their representative:

- The PHI is excepted from the right of access above.
- The patient agreed to temporary denial of access when consenting to participate in research that includes treatment, and the research is not yet complete.
- If the patient is an inmate and obtaining a copy of his/her health information would jeopardize the health, safety, security, custody or rehabilitation of himself/herself or other inmates, or the safety of an officer, employee or any other person at the correctional facility or responsible for the transporting of the inmate.
- The PHI was obtained from someone other than a healthcare provider under a promise of confidentiality, and access would be reasonably likely to reveal the source of the information.

If the patient is denied access to their record information, the Health Center must provide written explanation in plain language, containing basis for denial, a statement of the individual's review rights, and instruction on how to file a complaint with the Patient Relations Department or the Secretary of the Department of Health and Human Services.

REVIEWABLE GROUNDS FOR DENIAL TO REVIEW AND/OR OBTAIN COPIES

- A licensed healthcare provider has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of the patient or of another person
- The PHI makes reference to another person who is not a healthcare provider and a licensed healthcare professional has determined that the access requested is reasonably likely to cause substantial harm to such other person
- The request for access is made by the individual's personal representative and a licensed healthcare professional has determined that access is reasonably likely to cause substantial harm to the individual or another person

If the patient is denied access to their record information the Health Center must provide written explanation in plain language, containing basis for denial, a statement of the individual's review rights, and instruction on how to file a complaint with the Patient Relations Department or the Secretary of the Department of Health and Human Services. The patient may request that the denial be reviewed, in which case another licensed health care professional chosen by the Health Center will review the patient's request and the denial. The person conducting the review will not be the person who denied the patient's first request. If the denial is overturned the patient will have the right to access their record. If the denial is upheld the patient will be unable to access their records. UCHC will promptly provide written notice to the individual of the determination of the reviewing official.

II. AMENDMENT TO HEALTH RECORDS – A patient or their legal representative has the right to request that the Health Center amend his/her PHI. The patient has the right to request an amendment for as long as the records are kept by or for the Health Center. Such requests for amendments to the record must be in writing and must include a reason to support the

amendment. All requests for amendment must be submitted to the Director of the Medical Record Department for handling or the Principal Investigator for research records only. UCHC must act on the patient's request for amendment no later than sixty (60) days after receipt of such request. UCHC will have a one-time extension of up to 30 days for an amendment request if necessary, provided the covered entity gives the individual a written statement of the reason for the delay, and the date by which the amendment will be processed.

If a patient believes an entry in his/her record is incomplete or inaccurate upon inspection, the following steps are to be followed:

- i. The patient may initiate a request for amendment form (see form attached) that must be submitted to the Medical Record Department or Principal Investigator.
- ii. The Medical Record Department staff or Principal Investigator will assist the patient in completing the form if necessary. Upon completion of the form the employee will give one copy to the patient, file one copy in the record in question, and forward the original to the author of the entry.
- iii. The author of the inaccurate/incomplete entry may request the record for review to determine the validity/feasibility of the addendum and following that review will complete the appropriate section of the amendment form, sign it and return it to the Medical Record Department or Principal Investigator. The original form with the author's comments and signature will remain a permanent part of the patient's record (replacing the copy which was previously filed in the record at the time of the request).
- iv. If an amendment is made based on the patient's request, Medical Record Department staff or Principal Investigator will make a notation at the site of the information being amended indicating, "see amendment" and will date and sign that entry. The amendment form will be attached to the entry that was amended.
- v. A copy of the completed amendment form will be sent to the patient indicating that an amendment was made and will also be sent to others who have already received the information subject to the amendment and that may have relied or may rely on that information to the detriment of the patient.
- vi. Copies of the amendment form will also be furnished to additional individuals or organizations the patient deems necessary as documented on the amendment form.
- vii. Whenever a copy of the amended entry is disclosed, a copy of the amendment form will accompany the disclosed entry.

GROUND'S FOR DENIAL OF AMENDMENT

UCHC may deny the request for amendment if the PHI that is the subject of the request:

- was not created by the UCHC
- is not part of the individual's designated record set
- is accurate and complete

If the request for amendment is denied, the patient must be informed in writing, in plain language. Included in this notification to the patient will be:

- The basis for the denial
- A description of how to file a complaint or disagreement
- A description of the organization's complaint process including the name and telephone number of a contact person or office
- A description of the complaint process for filing with the U.S. Secretary of HHS.
- A statement that if the patient does not submit a statement of disagreement, the individual may request that UCHC provide the request for amendment and the denial with any future disclosure of the information that is the subject of the requested amendment.

If the patient disagrees with the denial, UCHC must permit the patient to submit a statement of disagreement. UCHC may provide a written rebuttal to the individual's statement of disagreement after review of the statement and submit that back to the individual.

The letter of disagreement from the patient and the letter of rebuttal by the Health Center will both be kept on file within the patient's record and will be included with any subsequent disclosures of the PHI to which the disagreement relates.

Reference: American Health Information Management Association (AHIMA)
§ 164.524 Health Insurance Portability and Accountability Act of 1996
Policy: Privacy Definitions

Attachments: HCH

Elena Albini (signed)

2/10/03

Director of Medical Records

Date

Iris Mauriello (signed)

2/12/03

Privacy Officer

Date

Vice President for Research

Date

Peter Deckers, M.D. (signed)

2/14/03

Executive Director for Health Affairs

Date

Replaces: NEW POLICY

Attachment(s):

REQUEST FOR AMENDMENT OF HEALTH INFORMATION

REQUEST TO ACCESS /NOTIFICATION OF ACCESS OR DENIAL ACCESS REQUEST