SECTION – MEDICAL/NURSING SERVICES
ADMINISTRATIVE DIRECTIVE NO. 581
(Replaces AD 581 Dated 11/10/05)

Effective Date: October 5, 2006

SUBJECT: HIPAA PATIENTS' ACCESS TO THE MEDICAL RECORD

I. PURPOSE

To provide Individuals and their conservators or guardians with the opportunity to inspect and obtain copies of their own Individual medical records, except when the health care provider determines there is a substantial risk of significant adverse or detrimental consequences to the Individual.

II. AUTHORITY

By order of the Deputy Director of Long Term Care Services, consistent with Section 5328 of the Welfare and Institutions Code; Special Order No. 501.03; Section 1798 et seq. of the Civil Code (Information Practices Act); Health and Safety Code Section 123100 et seq. and Title 42 of the Code of Federal Regulations, Section 2.1 et seq.

III. POLICY

An Individual, an Individual's conservator, parent, or legal guardian may inspect and receive copies of the Individual's medical record in the custody or control of state hospitals under the jurisdiction of the Department of Mental Health, as specified in Special Order 501.03.

Information is to be made available to Individuals regarding their rights and the procedures regarding exercising their rights to inspect and receive copies of their records. The statement of Access Procedures is to be posted on every unit.

IV. METHOD

In order to provide equal access to all Individuals, conservators and guardians, only one (1) request per 90 days per medical record will be accepted for processing. All additional requests will be returned with a resubmission date.

V. DEFINITIONS

A. "Patient" means any current Individual or former patient of a state hospital under the jurisdiction of the Department of Mental Health (DMH).

B. "Conservator" means a Lanterman-Petris-Short (LPS) or probate conservator of an Individual.

C. "Guardian" means any legal guardian of an Individual.

D. "Medical Record" means a record in any form or medium maintained by or in the custody or control of a state hospital, relating to the health history, diagnosis, or condition of an Individual, or relating to treatment provided or proposed to be provided, to the Individual. "Medical record" includes only the record pertaining to the Individual requesting the record or whose conservator or guardian requests the record. "Medical record" does not include information given in confidence to a health care provider by a person other than another health care provider or by the Individual, and such material may be removed from any medical record prior to inspection or copying.

VI. INPATIENT REQUESTS

A. In order to inspect and/or receive copies of their records, inpatients need to submit a completed "Patient Request for Access to Medical Records" (CSH 072) to the Unit Supervisor and Treatment Team for review. The request must indicate what material they wish to review, be dated and should include the Individual's name, CO number, and unit. It is not mandatory that the Individuals indicate the reason for the request.

B. The Individual's psychiatrist and treatment team will review the document and make a decision per request. The completed document is then forwarded to Health Information Management Department (HIMD) within two (2) working days of receipt of request. There are statutory time limitations in which access requests must be addressed.

1. Denial of an Individual's right to access and/or have copies of their medical record can only be done when it has been determined that there is a substantial risk of significant adverse or detrimental consequences to the Individual in seeing or receiving a copy of his mental and or medical health records. A description of the specific adverse or detrimental consequence(s) must be filled in on the "Patient Request for Access to Medical Records" (CSH 072) form by the treating psychiatrist. A member of the Treatment Team must review the denial with the Individual. The completed copies of the "Patient Request for Access to Medical Records" (CSH 072) form will be distributed as follows: one placed in the Individual's chart under "Patient Input Tab;" one given to the Individual; one forwarded to HIMD.

   A partial approval may also be done in order to allow access to or copies of some of the requested documents but not to all of the requested documents. In addition, a summary of the requested information may also be provided to the Individual in lieu of approving access to and/or copies of the actual medical record.

2. When HIMD receives the completed "Patient Request for Access to Medical Records" (CSH 072) form it will be distributed to the appropriate HIMD staff for processing. If the form is listed as a denial, they will then notify the

Individual by letter that they may choose a Licensed Physician/Psychiatrist, or a Licensed Psychologist to have access to their record for inspection. To exercise this option, a letter authorizing the designated professional must be completed by the Individual and returned to HIMD. The Licensed Professional may decline the request. If they choose to accept then they will sign the "Record Review Log" in the Individual's chart upon review.

3. If the Individual wishes to appeal the denial, he will contact the Patients' Rights Advocate for assistance. The Patients' Rights Advocate will present the appeal to the Medical Director for a final decision. The Individual may resubmit a new "Patient Request for Access to Medical Records" 90 days after the final decision of the last request.

C. Upon receipt of an approved request to view the record, HIMD will send a Medical Records Access Notification (CSH 009) to the Unit Supervisor to obtain the Individual's signature. This serves as notification to the unit and the Individual of the scheduled appointment. A one (1) hour appointment will be scheduled. HIMD staff cannot comment on or interpret information contained within the record. Therefore, treatment team staff must accompany the Individual in order to assist in the interpretation of the record. At the time of the review, the Individual may tab documents for which copies are being requested.

D. Upon receipt of an approved request for copies of the record, HIMD will total the number of pages requested and will notify the Individual of the amount due. Cost of copying is $.10 a page; however, an Individual may not be denied a copy of the Individual's record because of lack of funds.

E. Upon notification of receipt of funds, copies will be made and each page will be stamped "Confidential - Patient's Copy". This will be sent to the Individual's unit along with the yellow copy of "Patient Request for Access to Medical Records" (CSH 072) .

F. A treatment team member will give the Individual the copies and be available for any questions and concerns the Individual may have.

VII. FORMER INDIVIDUAL REQUEST

A. All former Individuals' requests for access to and/or copies of their Individual record shall be submitted in writing to HIMD.

B. Upon receipt of written request, within five days, HIMD personnel will:

1. Log the request.

2. Request the medical record and verify the Individual's signature with authorizations in the chart.

3. Forward the request and clinical record to the Medical Director.

C. The Medical Director will review the Individual's record to determine if the record contains information that would be medically or psychologically detrimental to the Individual; information about another Individual or information given in confidence by members of Individual's family or other non-health care professional; information that is used solely for verifying and paying governmental health care service claims; enter a note in the Physician's Progress Notes stating that the record has been reviewed and the request is approved or denied. If denied, include reason for denial.

D. Return request to HIMD for further processing.

E. When request to access is approved, HIMD will send letter scheduling an appointment for record review.

F. When a request for copies is approved, HIMD will send a letter requesting fees ($.10 per page) for processing requested information. Upon receipt of funds, copies will be made and stamped "Confidential - Patient's Copy" and mailed to requestor.

VIII. TIME FRAME IN WHICH TO RESPOND TO REQUEST

A medical record will be made available for inspection within five (5) working days of receipt of the written request. A copy of the medical record will be made available within fifteen (15) working days of receipt of a written request. These time frames are the same for current and former Individuals. When a record cannot be made available within these time frames, the Individual will be notified of the need for extended time. This extended time may not exceed thirty calendar days for records that are stored on site or sixty calendar days for records that are stored off site.

An Individual may request a correction or an amendment if they believe any material in the chart is incorrect. It must be submitted in writing to the Health Information Management Director. Within thirty days, hospital staff will either enter the request of correction/addition in the Individual's chart under "Patient Input" or notify the Individual of why the request is denied.

W. T. VOSS
Executive Director