POLICY TITLE: Patient's Request to Inspect a Medical Record	SYSTEM POLICY AND PROCEDURE MANUAL
POLICY #: 800.44	**CATEGORY:** Compliance & Ethics
System Approval Date: 05/22/2024 **Site Implementation Date:** 07/08/2024	**Effective Date:** 08/15/2013 **Last Reviewed/Approved:** 04/20/2023
Prepared by: Office of Corporate Compliance	**Notations:** N/A

GENERAL STATEMENT of PURPOSE

The purpose of this document is to outline the established requirements for when a patient makes a request to inspect the patient's medical record.

POLICY STATEMENT

It is the policy of Northwell Health that the Health Information Management Department ("HIM") will provide the opportunity to make the patient's medical record available for inspection within 10 days of receipt of the validly executed oral or preferably written request, as applicable.

SCOPE

This policy applies to all Northwell Health employees, as well as medical staff, volunteers, students, trainees, physician office staff, contractors, trustees and other persons performing work for or at Northwell Health; faculty and students of the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell or the Hofstra Northwell School of Nursing and Physician Assistant Studies conducting research on behalf of the Zucker School of Medicine on or at any Northwell Health facility.

DEFINITIONS

Designated Record Set:

1. A group of records maintained by or for a covered entity that is:
    a. The medical records and billing records about individuals maintained by or for a covered health care provider;
    b. The enrollment, payment, claims adjudication, and case or medical management

record systems maintained by or for a health plan; or

c. Used, in whole or in part, by or for the covered entity to make decisions about individuals.

2. For purposes of this paragraph, the term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

Protected Health Information ("PHI"): Any oral, written, or electronic individually identifiable health information. PHI is information created or received by Northwell that (i) may relate to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual; and (ii) identifies the individual who is the subject or based on which there is a reasonable basis to believe that the individual who is the subject can be identified. The Health Insurance Portability and Accountability Act (HIPAA) further clarifies that PHI includes information that identifies the individual by one or more (depending on context) of the following 18 identifiers:

1. Names;
2. Geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of a ZIP code in certain situations;
3. All elements of date (except year) for dates directly related to an individual, including birth date, discharge date, date of death; and all ages over 89 and all elements of dates indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers;
13. Medical device identifiers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code.

PROCEDURE

Inspection of the Medical Record

The Health Information Management Department ("HIM") or the individual Practice, where appropriate, shall provide an opportunity for the information concerning or relating to the examination or treatment of the patient contained in the patient's Designated Record Set available for inspection within 10 days of receipt of a valid oral or preferably written request, as applicable. For special provisions (i.e., Skilled Nursing Facilities, etc.), please refer to *Policy #800.02 - Disclosure, Release, and Use of Protected Health Information.*

During such inspection, the HIM representative, Practice Manager, or designee will only observe the review and will not serve to interpret any portion of the medical record. If the patient is admitted to a Northwell Health facility at the time of such request, a clinical member must observe the review.

In the case of research that includes treatment, including clinical trials, under the HIPAA permits a covered entity to suspend the individual's access rights until the end of the research study, provided the individual agreed to the suspension when consenting to participate in the research and was informed that right of access would be reinstated upon completion of the research study. The Privacy Rule permits the covered entity to insert in the request a statement by which the subject agrees to the suspension of right to access during the clinical trial and that informs the individual that the right to access will be reinstated upon completion of the research study.

Access to the following information may be restricted upon the discretion of the practitioner:

- Personal notes and observations.
- Information disclosed to the practitioner under the condition that it would be kept confidential.
- Information that the practitioner believes should not be disclosed regarding the treatment of a minor. A patient over age 12 may be advised of a records request and, if the patient objects, the provider may deny the request.
- Information the physician believes may cause substantial harm to the patient or others.
- Information obtained from other physicians who are still in practice. That information should be requested directly from those practitioners.
- Substance abuse program records and clinical records of facilities licensed or operated by the Office of Mental Health. Mental Hygiene Law provides a separate process for release of these records.

Training

The Office of Corporate Compliance will provide training on HIPAA on, at least, an annual basis.

Sanctions

In compliance with HIPAA, violations of this policy will be subject to disciplinary action as outlined in the Human Resources Policy and Procedure Manual and in the Bylaws, Rules and Regulations of the Medical Staff.

Documentation

Any documentation generated in compliance with this policy will be retained for a minimum of six years from the date of its creation.

REPORTING AND ENFORCEMENT

All violations of this policy or questions regarding the access, use, disclosure of PHI shall be reported to the appropriate manager/supervisor/director or to the Office of Corporate Compliance (516-465-8097) for appropriate resolution of the matter. The HelpLine is available 24 hours a day, seven days a week at (800) 894-3226 or online at www.northwell.ethicspoint.com, is accessible and allows for questions regarding compliance issues to be asked and for compliance issues to be reported. Reports of potential fraud, waste and abuse and compliance issues also may be made directly to the Chief Corporate Compliance Officer or designee in person, in writing, via email, mobile device via a QR code, or by telephone.

All reports received by the Office of Corporate Compliance are investigated and resolved to the fullest extent possible. The confidentiality of persons reporting compliance issues shall be maintained unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by Medicaid Fraud Control Unit, Office of Medicaid Inspector General or law enforcement, or disclosure is required during a legal proceeding, and such persons shall be protected under the required provider's policy for non-intimidation and non-retaliation.

Violations of this policy will be subject to disciplinary action as outlined in the Human Resources Policy and Procedure Manual and Northwell Health Policy #800.73 – Compliance Program Disciplinary Standards for Non-Employees.

REFERENCES to REGULATIONS and/or OTHER RELATED POLICIES

- Northwell Health Policy #800.02 – Disclosure, Release, and Use of Protected Health Information
- Northwell Health Policy #800.73 – Compliance Program Disciplinary Standards for Non-Employees

CLINICAL REFERENCES/PROFESSIONAL SOCIETY GUIDELINES

N/A

ATTACHMENTS

N/A

FORMS

https://secure.vitaldocs.cexpforms.com/

VD001 – Authorization for Release of Health Information
VD087 – Request for Access to Health Information by Patient or Personal Representative

APPROVAL:	
Northwell Health Policy Committee	4/23/2024
System PICG/Clinical Operations Committee	05/22/2024

Standardized Versioning History:

Approvals: * =Northwell Health Policy Committee; ** = PICG/Clinical Operations Committee; ✠ = Provisional; ❖ = Expedited

4/21/16*
6/18/18❖
3/28/19✠
4/25/19* 5/10/19**
5/27/21* 6/17/21**
3/21/23* 4/20/23**

Authorization for Release of Health Information

Patient Name (Print)	Date of Birth
Patient Address (Print and include Apt#)	Telephone Number
	E-mail Address

1.

Contact information or health care provider or entity to release this information (from who):	
Name:	Address:
Phone #:	

2.

Contact information of person(s) or entities who will receive this information (to who):		
Name:	Address:	
Phone #:	Fax:	E-mail:

3.

Manner	**Form/Format**	**Delivery Details**
☐ Regular Mail	☐ Paper copy ☐ Secure USB Flash Drive ☐ CD	Mailing Address:
☐ Pick up at facility	☐ Paper copy ☐ Secure USB Flash Drive ☐ CD (where available)	N/A
☐ Electronic mail	☐ Secure email ☐ Unsecure email (By checking here, I acknowledge that e-mail sent unencrypted means others may be able to access the information and read it once it is transmitted over the internet.)	Email Address:
☐ Fax	N/A	Fax Number:
☐ Other	Please explain:	

Copy 1 – Patient Medical Record
Copy 2 – Patient or Patient's Personal Representative

VD001 (09/28/2021)

Authorization for Release of Health Information

4. **Verbal _____ PLEASE INITIAL HERE** to authorize the person or a representative from the entity specified in Section 1 to discuss the health information being released under this Authorization with the person, or representative from the entity, specified in Section 2. I understand that if this Authorization covers laboratory testing results, the laboratory CANNOT answer any questions in reference to interpretation, diagnosis or treatment of these results. Please address all questions with the PATIENT'S PHYSICIAN ONLY.

5. **Requested Health Information:**

   ☐ Medical Record Abstract (summary of record)

   ☐ Medical Record from (insert date) _____ to (insert date) _____

   ☐ Entire Medical Record

   ☐ Laboratory results for date of service _____

   ☐ Radiology images and reports for date of service _____

   ☐ Itemized bill for _____

   ☐ Other: Please explain _____

6. **Reason for release of information:**

   ☐ At request of individual ☐ Other: _____

7. **I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed as stated on this form. In accordance with New York State Law, 42 CFR Part 2 and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:**

   a. I have the right to revoke this Authorization and my Permission to Send Information Requested by Unencrypted E-mail (if indicated in section 3 of this document) at any time by writing to the health care provider listed in Section 1. I understand that I may revoke this Authorization except to the extent that action has already been taken in reliance on this Authorization.

   b. I understand that signing this Authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

   c. Information disclosed under this Authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law. However, if I am authorizing the release of substance abuse treatment, mental health treatment or HIV-related information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.

Authorization for Release of Health Information

8. The following types of information may be released <u>unless</u> you or your authorized representative initial in the appropriate spaces provided below to opt out of releasing these types of health information:

___ Substance Abuse Treatment Information from an OASAS licensed unit or program[1] only (including diagnostic information, medications and dosages, lab tests, allergies, substance use history summaries, trauma history summary, employment information, living situation and social supports, and claims/encounter data)

_____ Mental Health Treatment information from an OMH licensed unit or program[2] only

_____ HIV-Related Information

9. <u>Expiration Date or Event</u>

This authorization will expire on (please check one and complete as applicable):
☐ One (1) year
☐ Other (please specify expiration date) _____
*This field must be completed with date or event

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID #	Date	Time		
OR				
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

[1] Units or programs licensed by OASAS only include programs whose specific purpose is to treat substance abuse disorders.
[2] Units or programs licensed by OMH only include programs whose specific purpose is the treatment of mental Illness.

Copy 1 – Patient Medical Record
Copy 2 – Patient or Patient's Personal Representative

REQUEST FOR ACCESS TO HEALTH INFORMATION BY PATIENT OR PERSONAL REPRESENTATIVE

I or my Personal Representative hereby request that Northwell Health provide access to my health information as described in this form. I am making this request under the provisions of the Health Insurance Portability and Accountability Act "HIPAA") that entitle me to access my own health information including directing it to another person or entity (45 CFR 164.524).

Patient Name: _____ **Patient Date of Birth:** _____

Patient Address: **Patient Telephone #:**

_____ _____

_____

1. Northwell Health Entity/Facility to Release this Information (From Who): _____

2. Person or Entity Who Will Receive this Information (To Who):

☐ To me ☐ To Another Person or Entity - Provide Name _____

3.

Manner	**Form/Format**	**Delivery Details**
☐ Regular Mail	☐ Paper copy ☐ Secure USB Flash Drive ☐ CD	Mailing Address:
☐ Pick up at facility	☐ Paper copy ☐ Secure USB Flash Drive ☐ CD (where available)	N/A
☐ Electronic mail	☐ Secure email ☐ Unsecure email (By checking here, I acknowledge that e-mail sent unencrypted means others may be able to access the information and read it once it is transmitted over the internet.)	Email Address:
☐ Fax	N/A	Fax Number:
☐ Other	Please explain:	

REQUEST FOR ACCESS TO HEALTH INFORMATION BY PATIENT OR PERSONAL REPRESENTATIVE

4. Requested Health Information:

☐ Medical Record Abstract (summary of record)

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record

☐ Laboratory results for date of service _____

☐ Radiology images and reports for date of service _____

☐ Itemized bill for _____

☐ Other: Please explain _____

5.

Please complete this section ONLY IF the information you are requesting to access contains substance use disorder treatment information[1] or HIV/AIDS Information:

Purpose of request: _____

Expiration date: _____

If the information contains substance use disorder treatment information please note the following:

- This consent is subject to revocation at any time except to the extent that the Part 2 program that is permitted to make the disclosure has already acted in reliance on it.
- The information may include diagnostic information, medications and dosages, lab tests, allergies, substance use history summaries, trauma history summary, employment information, living situation and social supports, and claims/encounter data.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID #	Date	Time		
OR				
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to Signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

[1] Units or programs licensed by OASAS only include programs whose specific purpose is to treat substance abuse disorders.

VD087 (09/28/2021)