PATIENT ACCESS TO MEDICAL RECORDS

OPS.033

Approved By:	**Chief Operations Officer**	Adopted Date:	**5/30/01**
Distribution:	**Site Administrators, Clinical Site Directors, Medical Records, Front Office, Executive Team**	Revision Date(s):	**1/23/13**

PURPOSE:

To set forth guidelines and procedures relating to a patient's access to his or her own medical records.

POLICY:

Any adult patient, patient representative or minor patient authorized by law to consent to medical treatment is also authorized by law to inspect medical records for those treatments for which he or she is authorized to consent. Procedures for patient access to medical records shall conform with legal requirements as defined in the California Health and Safety Code Section 123100 through 123149 and with privacy regulations set forth in the federal Health Insurance Portability and Accountability Act.

PROCEDURE:

1. The request to inspect shall be made in writing on a Authorization For Use or Disclosure of Health Information. The request shall clearly state if release is requested for personal inspection of records or for a copy of records.
2. Reasonable verification of the patient's identity may be requested prior to release.
3. Upon receipt of a valid request, the following apply:

   For personal inspection of records:

   - The patient shall be appointed with his or her primary care practitioner (PCP) for the purposes of medical record review.
   - By law, this appointment must be within 5 working days of the request to inspect.
   - Because this appointment is a face-to-face encounter with a medical practitioner for the purposes of reviewing the patient's care, it is a billable visit and shall be treated as such.
   - If the PCP is not available, an appointment shall be made with another practitioner or Register Nurse (RN), but only as a last resort.
   - A patient may bring one other individual to the record inspection.

   For a photocopy of records:

   - The Release of Health Information shall be routed to the PCP for review prior to release as a courtesy notification.
4. A patient that inspects his or her records has the right to provide a written addendum with respect to any item or statement the he or she believes to be incomplete or incorrect. The rules regarding this addendum are as follows:

   - It must be limited to 250 words per alleged incomplete or incorrect item.
   - It must clearly indicate that the patient wishes the addendum to be made part of the medical record.
   - It must be made a part of the medical record, scanned into the EMR.
   - It must be released with the record whenever disclosure of the alleged incomplete or incorrect items occurs.

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5. A health care provider may decline to release records to a patient only if **ALL** of the following conditions are met:
   - The provider determines that there is "substantial risk of significant adverse or detrimental consequences to a patient" in seeing the records.
   - The records in question (or portions thereof) specifically relate to evaluation or treatment of a mental disorder or substance/alcohol abuse.
   - The provider permits inspection by, or provides copies to, a physician or mental health professional designated by the patient (who may not, in turn, release them to the patient).
   - The provider notifies the patient of his or her refusal to permit inspection, and of the patient's right to have another physician or mental health professional inspect the records.
   - The provider records all of the above in the patient record.
6. A health care provider may provide a summary of the patient record (in lieu of the full record) only if **ALL** of the following conditions are met:
   - The summary must be made available within 10 days of receipt of a valid request.
   - The summary shall cover all information requested by the patient. The provider may confer with the patient to determine if only certain illnesses, injuries or episodes are requested.
   - For each illness, injury or episode requested, the summary must include:
     Chief complaint
     Results of consultations or referrals
     Diagnosis
     Treatment plan, including medications
     Progress of treatment
     Prognosis, including significant continuing problems or conditions
     Pertinent reports of diagnostics tests or procedures and discharge summaries
     Objective findings from most recent physical, including vitals and actual lab values
7. The above requirements pertain only to requests for records initiated by the patient. During the course of providing medical treatment, a health care provider may personally review records with, or release record copies to, the patient that is the subject of those records. Such releases shall be documented in the clinical record, but do not require a records release form.

Approved:

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