ADMIN-HEALTH INFORMATION MANAGEMENT
GENERAL POLICY ON RELEASE OF INFORMATION

ADMINISTRATIVE DIVISION APPROVAL MATRIX POLICY NO. ADM – HEALTH INFORMATION MANAGEMENT – 001	
Reviewed by:	Reviewed by:
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Approved by:	Approved by:
Jefferson R. Pagsisihan, MD, MHM **Hospital Administrator**	**Ephraim Neal C. Orteza, MD, MHA** **Hospital Director**
Date of Last Review: July 2018	

OBJECTIVE: To keep the confidentiality of the patient's records and to safeguard the fundamental human right of every individual to privacy while ensuring free flow of information for innovation, growth, and national development.

COVERAGE: All Department/Sections

RESPONSIBILITIES:

I. It shall be the responsibility of theHealth Information Management Officer to safeguard patient and employee information.
II. Thefinal decision as to the release of medical records relies on the discretion of the Health Information Management Officer upon the approval of the Hospital Administrator and the Hospital Director.
II. It should be the discretion of the Hospital Director, Hospital Administrator and the Health Information Management Officer to release information in cases where the patient is unconscious, delirious or very seriously ill.

POLICY:

1. Medical records are confidential documents and should only be released when permitted by law or with proper written authorization of the patient.
2. Any information of a medical nature in the hospital's possession must not berevealed by an employee of the hospital except as herein after outlined.

3. It shall be the general policy that the hospital will not voluntarily use patient's medical records in any manner, most importantly in instances that will jeopardize patient's interests.

IV. The release of information is reserved to Hospital Director or the Hospital Administrator and their duly authorized representative.

V. The medical record is aconfidential physical property of the hospital. Therefore:

1) The Medical Director or Hospital Administrator can refuse any person whether authorized by the patient or not to inspect or photocopy the records until a court order or some other valid legal process relieves him of his discretionary authority.
2) When it appears that litigation is intended against the hospital, and attending physician the decision to give out information or to photocopy the patient's chart will be left to the Medical Director or Hospital Administrator and the Hospital's Attorney.

VI. Request for medical information or certificate for patient who is currently confined in the hospital will be referred to the attending physician.

XIII. The patient's written authorization is always necessary for the release of information.

XIV. In case of death of the patient, the authorization must be signed by the identified nearest of kin or administrator of the deceased's estate.

XV. If the patient is a minor or incompetent, the authorization should be signed by one of the parents, the legally appointed guardian or the nearest of kin who is of legal age.

XVI. Medical Information of Mental Patient may be released only upon presentation of a written authorization from one of the parents, the legally appointed guardian or the nearest of kin who is of legal age.

XVII. In cases where the patient is unconscious delirious or very seriously ill and cannot give the required written authorization the Health Information Management Officer or the MRD Clerk after consultation with the Medical Director will decide on the release of pertinent information.

XVIII. In Emergency cases in which a delay in the release of the needed information will endanger the life of the patient or cause deterioration of his condition, all requirements in these policies will be waived.

XIV. On reproduction of records, only patients or his/her legal representative must be given proper authorization before release of medical information or records. Only a portion of the chart, which is essential to the patient's needs can be reproduced apart from discharge summary and/or medical abstract.

XVI. Medical Records may not be taken out of the hospital except with a subpoena duces tecum.

Date of Implementation:

1979

Date Reviewed:

2003, July 2018

ADMIN-HEALTH INFORMATION MANAGEMENT
POLICY ON RELEASE OF INFORMATION TO DOCTORS

ADMINISTRATIVE DIVISION APPROVAL MATRIX POLICY NO. ADM – HEALTH INFORMATION MANAGEMENT – 002	
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Date of Last Review: July 2018	

OBJECTIVE: To keep the confidentiality of the patient's records and to safeguard the fundamental human right of every individual to privacy while ensuring free flow of information for innovation, growth, and national development.

COVERAGE: This Section, the Chief of Clinics and all physicians

RESPONSIBILITIES:

I. It shall be the responsibility of the head of this section to monitor the effectiveness of this policy.

II. It shall be the responsibility of the Medical Staff to secure the requirements necessary to access patient's record.

POLICY: This policy shall ensure confidentiality and security of records.

PROCEDURES:

I. The consent of the attending physician for released of Medical Information is technically not needed. The privilege against disclosure belongs to the patient and not to the treating physician. But as a matter of courtesy, whenever possible, the attending physicians will be notified of any request to review or photocopy the entire medical records of the patients or any type of request in which there is a suspicion that the patient is contemplating charges against the doctor.

II. Physicians who make inquiries about patients not under their care must present proper authorization to the medical records officer.

III. Doctors shall present to the Health Information Management Officer/Medical Record Officer or his duly authorized representative an authorization coming from the patient.

4. Doctors may not give authorization to insurance companies or attorneys to review record.

V. Record required for medical conferences or department meetings are to be signed out (Borrowers logbook) on the day of meeting. The Medical Records Officer or his representative will prepare and bring the chart requested to the conference room. The consultant/resident, physician, or nurse who signed out for the charts should see to it that the records do not circulate after the conference has officially terminated. Records should be returned to the Medical Records Section right after the meeting.

V. AttendingPhysicians may consult in the Medical Records Section such records needs for Case Studies and bonafide research work unless there is suspicion that one of these individual wishes to consult a record for purposes not favorable to the interest of the patient or hospital.

Date of Implementation:

1979

Date Reviewed:

2003, July 2018

ADMIN-HEALTH INFORMATION MANAGEMENT
POLICY ON RELEASE OF INFORMATION TO NURSES

ADMINISTRATIVE DIVISION APPROVAL MATRIX POLICY NO. ADM – HEALTH INFORMATION MANAGEMENT – 003	
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Date of Last Review: July 2018	

OBJECTIVE: To keep the confidentiality of the patient's records and to safeguard the fundamental human right of every individual to privacy while ensuring free flow of information for innovation, growth, and national development.

COVERAGE: This Section and Nursing Service

RESPONSIBILITIES:

It shall the responsibility of the Medical Records Officer or his authorized representative to release Patient's medical record / information to the chief of the nursing Division or to his authorized representative upon the chief nurse's request only for case presentation purposes.

POLICY: This policy shall ensure confidentially and security of records.

PROCEDURES:

I. The Chief Nurse may borrow medical records for purposes of individual conference.

II. Supervisors and Head Nurses may review medical records in the Medical Records Section/HIM Section. They may not take the record out of the office except for conferences. Records are to be prepared by the Medical Records Officer or his/her representative and bring to the conference room shortly before the meeting starts.

III. Private Nurse may review records for their assigned case studies only in the Medical Records Section upon approval of the Chief Nurse.

IV. Student nurses may review records for their assigned studies only in the Medical Records Section upon approval of the Chief Nurse. They are not allowed to replicate or photocopy patient's records.

Date of Implementation:

1979

Date Reviewed:

2003, July 2018

ADMIN-HEALTH INFORMATION MANAGEMENT POLICY ON RELEASE OF INFORMATION TO ATHIRD PARTY

ADMINISTRATIVE DIVISION APPROVAL MATRIX POLICY NO. ADM – HEALTH INFORMATION MANAGEMENT – 004	
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Date of Last Review: July 2018	

OBJECTIVE: To keep the confidentiality of the patient's records and to safeguard the fundamental human right of every individual to privacy while ensuring free flow of information for innovation, growth, and national development.

COVERAGE: All Departments / Sections and other agencies

RESPONSIBILITY:

It shall be the responsibility of the **Insurance Agents, Authorized member or representative of the PNP, NBI agents, Employee, Attorneys Employees** and any investigating agents. To secure photocopies of patient's medical records / information from the Medical Records Office certified by the medical Records Officer provided that it is being requested by a Subpoena Duces Tecum.

POLICY: This policy shall ensure confidentially and security of records.

PROCEDURES:

I. Lawyers – Lawyers my review complete medical records after submitting a written authorization from the patient. The authorization should be signed by the lawyer, dated and filed with Health Information Management.

II. Employees – No medical information concerning a patient may be given to an employee without written authorization from the patient. This applies to telephone calls as well as written request.

III. Insurance Agents – Insurance agents may examine complete medical records. The written authorization of the patient also be signed by the agent, dated and filed with the Health Information Management. A Carbon Copy of the abstract should be signed by him/ representative and filed in the Medical Records**.**

IV. NBI, PNP and any investigating government agents may examine completed medical records after presenting a written authorization from the patient.

V. Charges will be made for medical abstract or discharge summaries of all medical records except to the patient's physician, social services and attorneys representing the hospital.

Date of Implementation

1978

Date Reviewed:

2003, July 2018

ADMIN-HEALTH INFORMATION MANAGEMENT
POLICY ON RELEASE BIRTH CERTIFICATE

ADMINISTRATIVE DIVISION APPROVAL MATRIX POLICY NO. ADM – HEALTH INFORMATION MANAGEMENT – 005	
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Date of Last Review: July 2018	

COVERAGE: This policy shall cover Medical Records Section.

OBJECTIVE: Birth Certificate registration.

RESPONSIBILITIES:

I. It shall be the responsibility of the Health Information Management/ Medical Records Section Clerk to correctly accomplish the Live Birth Forms.

II. It shall be the responsibility of the Health Information Management/Medical Records Section Clerk/Section Chief to issue registered Birth Certificates to the respective patients/ parents.

POLICY: This policy shall ensure the prompt and proper registration and issuance of Birth Certificate.

PROCEDURE:

I. **For Legitimate Child**

a) The Medical Records Staff will accurately fill up the Certificate of Live Birth form acknowledged by the attending physician, MRD officer, and mother/father of the child.

b) The assigned MRD Staff will furnish a copy of the birth certificate. Upon completion of signatures, HIM/MRD staff will forward this to the Local Civil Registrar's Office for registration. Registration period is within 30 days.

c) Informant will be advised to come back after 10 working days. Two copies will be issued by the Local Civil Registrar's Office, one copy to the HIM/Medical Records Clerk for filing and one copy to be issued to the informant.

II. For Illegitimate Child

a) The Medical Records Section Staff will completely accomplish the Certificate of Live Birth form to be released to the mother. (4 copies) one copy as file copy for MRD, and 3 copies given to the parents for LCR registration.

c) To use the surname of the father, an affidavit must be accomplished by the father (RA 9255). Acknowledgement of this agreement will be evident as the father will sign at the back of the child's birth certificate.

III. For Delayed Registration – Beyond 30 Days

a) The Medical Records Section staff must accomplish 4 copies of Certificate of Live Birth forms. Upon completion, the parents of the childshall forward it to the Local Civil Registrar with complete requirements listed at the City Hall.

b) For 18 years old and above, the Medical Records Section Clerk shall accomplish the Certificate of Live Birth form.The child or the mother will be the one to register it to the Local Civil Registrar, after registration 4th copy will be given to the Medical Records Section.

D) All reconstructed forms shall be released within 10 working days after filing. A charge of Php 50.00 shall be paid at the cahier.

Date of Implementation

1978

Date Reviewed:

2003, July 2018

ADMIN-HEALTH INFORMATION MANAGEMENT
POLICY LATE REGISTRATION OFBIRTH CERTIFICATE

ADMINISTRATIVE DIVISION APPROVAL MATRIX POLICY NO. ADM – HEALTH INFORMATION MANAGEMENT – 006	
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Date of Last Review: July 2018	

OBJECTIVE: To establish the rules on proper late registration of the birth certificate.

RESPONSIBILITIES:

I. It shall be the responsibility of the Health Information Management clerk to reconstructa Certificate of Live Birth upon completion of requirements submitted by the informant/ parents of the child.

II. It shall be the responsibility of the Health Information Management clerk to secure the signature of the attending physician.The medical Director can sign in behalf of the Attending Physician.

III. It shall be the responsibility of the parent/ informant to register the reconstructed Birth Certificate in the local Civil Registrar.

IV. It shall be the responsibility of the Health Information Management clerk to get one copy of the reconstructed Birth Certificate with complete corresponding signature for file copy.

PROCEDURE:

I. Informant to present requirements for late registration to the Health Information Management clerk.

II. Health Information Management clerk to receive complete requirements and issue request of forms to the cash section

III. Health Information Management clerk will furnish a copy of the Certificate of Live Birth form and ask the informant to come back after 5 working days. Upon completion of the form and

completion of signatures, the Certificate of Live Birth form will be released to the informant.

IV. Health Information Management clerk to have the informant sign four (4) copies of the reconstructed Birth Certificate and get one (1) copy for the file.

Date of Implementation:

1979

Date Reviewed:

2003, July 2018

ADMIN-HEALTH INFORMATION MANAGEMENT
POLICY ON ISSUANCE OF DEATH CERTIFICATE

ADMINISTRATIVE DIVISION APPROVAL MATRIX POLICY NO. ADM – HEALTH INFORMATION MANAGEMENT – 007	
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Date of Last Review: July 2018	

OBJECTIVE: To issue and register Death Certificate.

COVERAGE: Health Information Management

RESPONSIBILITIES:

I. It shall be the responsibility of the Medical Records Section Clerkto accomplish the Death Certificate.

II. It shall be the responsibility of the informant to accurately accomplish the Death Certificate and have it registered at the Local Civil Registrar.

POLICY: This policy shall ensure prompt and proper registration of DeathCertificate.

PROCEDURE:

I. TheHealth Information Management clerk shall accurately accomplish the Death Certificate form attached at topatient's chart.

II. Four (4) copies of theDeath Certificate from must be furnished. The Medical Records Officer shall interview the immediate relative of the deceased.

III. The head of this section and the immediate relative will sign the Death Certificate. In the absence of the section head, the clerk may sign on his/her behalf.

IV. Three (3) copies shall issued to informant; the 4th copy shall remain for Medical Records Section's file.

V. For DOA (Dead On Arrival), ER's notice of death shall be forwarded to the City Health Office by the deceased immediate relative.

VI. For NICU death, Death Certificates shall be released immediately by the Health Information Management clerk.

VII. For unclaimed death certificates, the Health Information Managementclerk and the funeral parlor shall be notified by this office within two (2) days, especially those with unpaid charges.

Date of Implementation

1979

Date reviewed

2003, July 2018

ADMIN-HEALTH INFORMATION MANAGEMENT POLICY ON ATTENDANCE TO COURT ORDERED BY SUBPOENA DUCES TECUM

ADMINISTRATIVE DIVISION APPROVAL MATRIX POLICY NO. ADM – HEALTH INFORMATION MANAGEMENT – 008	
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Date of Last Review: July 2018	

COVERAGE: This section and the medical department

OBJECTIVE: For proper presentation of medical records to court.

RESPONSIBILITIES:

I. It shall be the responsibility of the medical records officersor his representative to receive the summon/Subpoena Duces Tecum.

II. The medical records section clerk shall release the corresponding patient's chart to the COC.

III. It shall be the responsibility of the doctors, be it resident or consultant to attend court hearing once summoned by the court for their expert opinion. A manifestation shall be submitted in case doctors are not available to appear.

IV. It shall be the responsibility of the attending physician to bring, the patient's records when ordered or summoned by the court.

V. In the absence of the attending physician, the records custodian may present patient's records and the medico-legal certificate if any unless, otherwise, the court specifically summoned the attending physician.

POLICY: This policy shall ensure authorized representation for testifying in court and presenting, patient's medical record.

PROCEDURES:

I. Subpoena Decus Tecum is delivered by registered mail or hand carried.

II. Subpoenas shall be delivered at least a week before the hearing. The records custodian or the attending physician may refuse to attend when subpoenas are delivered only a day before the hearing.

III. HIM officer/Medical records clerk receives the Subpoena Decus Tecum issued by the court.

IV. HIM/Medical records clerk notifies the attending physician and retrieves the patient's records; releases the same to the attending physician when needed.

V. Patient's records shall not be left in the court. A photocopy may be issued upon request of the court.

VI. The attending and the records custodian shall submit certificate of appearance to the administrative office to validate the appearance and for reimbursement purposes.

Date of Implemantation:

1980

Date Reviewed:

2003, July 2018

ADMIN-HEALTH INFORMATION MANAGEMENT
POLICY ON RETRIEVAL OF PATIENT'S CHART

ADMINISTRATIVE DIVISION APPROVAL MATRIX POLICY NO. ADM – HEALTH INFORMATION MANAGEMENT – 009	
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Date of Last Review: July 2018	

OBJECTIVE: To establish proper retrieval of patient's records.

COVERAGE: Health Information Management Section

RESPONSIBILITY:

It shall be the responsibility of the HIM/medical record section staff to log borrowed charts.

POLICY:

This policy when implemented shall ensure proper and timely retrieval of charts.

PROCEDURES:

1. All patients for treatment and for consultation shall present their numbered hospital cards to the medical records section clerk.
2. Charts retrieved shall be recorded in the prescribed logbook.
3. Retrieval is set for 15 minutes; if not located, another 5 minutes is allotted for tracking down and checking.
4. Retrieved for tracking shall be forwarded by the MRS staff to their perspective areas.
5. Charts shall be returned by the perspective staff from the areas to the medical records section.

Date of Implementation:

This policy was implemented since 1978

Date of Review:

March 2011, July 2018

ADMIN-HEALTH INFORMATION MANAGEMENT
POLICY ON RETENTION OF MEDICAL RECORDS

ADMINISTRATIVE DIVISION APPROVAL MATRIX POLICY NO. ADM – HEALTH INFORMATION MANAGEMENT – 010	
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Date of Last Review: July 2018	

OBJECTIVE: Proper archiving of medical records.

COVERAGE: This policy shall cover Health Information Management Section/Medical Records Department

RESPONSIBILITY: It is the responsibility of the Health Information Management officer to safe keep medical records until its retention period of 15 years.

PROCEDURE:

1. It shall be the responsibility of the HIM/medical records department clerk to prepare an inventory of medical records segregated by year.
2. It shall be the responsibility of the chief of the medical records section to accomplish the prescribed from (Form 2) which will be subject to approval of the national archives of the Philippines (NAP).
3. It shall be the responsibility of the chief of the medical records section to submit to the national archives of the Philippines (NAP) four (4) copies of accomplished “request for authority to dispose of records”. (Form 3)
4. It shall be the responsibility of the medical records chief to witness the disposition including other witnesses.
5. The records officer shall be responsible for the safekeeping of the records of their section until its disposal is authorized.

POLICY:

1. All health care facilities shall dispose medical records beyond fifteen (15) years.
2. Medical records section shall not destroy or sell any patient's records without having first secured authority of the director of the hospital and the NAP director.

PROCEDURE:

1. HIM/MRS prepares an inventory of medical records.
2. HIM/MRS determines the medical records to be sent to archives.
3. Forms for archiving must be completely accomplished.
4. Certificate of disposal shall be prepared in triplicate, one copy for HIM, another for the national archives of the Philippines and another for the commission on audit. It shall indicate the nature of records, the manner place and date of disposal and their approximate volume in cubic meter and weights.

Date of Implementation:

1978

Date of Review:

March 2011, July 2018