
 <b>OSPITAL NG PARAÑAQUE</b> 		Document Code: <b>OSPAR-ADM-HIM-0001</b>
		Issue Date:
<b>ADMINISTRATIVE DIVISION APPROVAL MATRIX</b>		Section / Department
Policy Title: <b>POLICY ON RELEASE OF INFORMATION</b>		<b>HEALTH INFORMATION MANAGEMENT SECTION</b>
Page No. 1 of 2		Approved by:
Prepared By:  <b>Frederick C. Dacanay</b> OIC, Health Information Management	Reviewed By:  <b>Arnaldo S. Cortes, RN</b> Supervising Administrative Officer  <b>Darius J. Sebastian, MD, MPH, PHSAE</b> Hospital Administrator	<b>Jefferson R. Pagsisihan, MD, MHM</b> Hospital Director

**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 the Health Information Management Officer to safeguard patient and employee information.
- II. The Final 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 be revealed by an employee of the hospital except as hereinafter outlined.
3. It shall be the general policy that the hospital will not voluntarily use a patient's medical records in any manner, most importantly in instances that will jeopardize the patient's interests.
- I. The release of information is reserved to the Hospital Director or the Hospital Administrator and their duly authorized representative.
- II. The medical record is confidential 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.

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- 2) When it appears that litigation is intended against the hospital, and the 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. Requests for medical information or certificate for patients who are currently confined in the hospital will be referred to the attending physician.
    - I. The patient's written authorization is always necessary for the release of information.
    - II. 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.
    - III. 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.
    - IV. Medical Information of a 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.
    - V. 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.
    - VI. 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, August 22

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- V. Attending Physicians may consult in the Medical Records Section such records needed for Case Studies and Bonafide research work unless there is suspicion that one of these individuals wishes to consult a record for purposes not favorable to the interest of the patient or hospital.

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