

Privacy - Sample Facility Policy

Privacy - MODEL Facility Policy

POLICY NAME: Designated Record Set

DATE: (facility to insert date here)

NUMBER: (facility to insert number here)

Purpose: To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and all Federal regulations and interpretive guidelines promulgated there under. To establish guidelines for the definition and content of the designated record set (§164.501).

Policy: A facility must specifically define, maintain and allow patient's/patient's personal representative (as defined by state law) certain rights to a designated record set (DRS) per the procedure outlined below. The DRS will encompass information beyond the traditional medical record and billing record. A facility must include information received from another facility during the patient's visit in their DRS unless they have documented facts that the information was not used in whole or in part to make a decision about the patient. Information received from other facilities after the patient is discharged must be sent back to the originator, placed into the shredding bin and destroyed or incorporated in to the DRS.

Some states have separate patient privacy laws that may apply additional legal requirements. Consult your Operations Counsel to identify and comply with any such additional legal mandates.

Refer to the HIPAA Privacy Standards, 45 CFR Parts 160.101 and 164.501, and IP.PRI.001, the Patient Privacy Program Requirements Policy, for definitions.

Procedure:

1. Each facility must identify which forms and reports, when present in a patient's paper or electronic file, **will be included in the DRS** based on the HIPAA DRS definition. At a minimum, the following forms and reports must be included in the facility's DRS:
 - Facesheet
 - Coding summary
 - Discharge summary or labor and delivery summary
 - History and physical examination report or prenatal record
 - Obstetrical and newborn forms
 - Consultation report
 - Operative, surgery or procedure report
 - Pathology reports

- Results of any special tests or treatments (depending on the study, the results may or may not include tracings, but when final will include the interpretation (*e.g.*, EKG/ECGs, holter monitors, stress test, pulmonary function study, blood transfusion records, or sleep study))
 - Progress Notes (including medical student notes that are co-signed by the supervising physician (*with or without an addendum*))
 - Order or prescription for a test/treatment
 - Nursing documentation, including items such as vital sign graphics, intake and output records, neurocheck, medication sheets, intravenous fluid flow sheets, shift assessments, nursing notes, telemetry, admission history, care plan, discharge instructions, and release of body form.
 - Interdisciplinary education record
 - Laboratory reports, including blood typing or crossmatching
 - Imaging/Radiology reports
 - Cardiology reports
 - Fetal and newborn monitoring strips
 - Peri-operative documentation, including items such as surgery checklist, anesthesia records, intraoperative nursing forms, and recovery room forms
 - Documentation of miscellaneous services, including social service, case management, food and nutrition, physical therapy, speech therapy, occupational therapy, respiratory treatments, arterial blood gas reports, and ventilator sheets
 - Medication administration records
 - Transfer forms
 - Emergency Room (ER) records, including items such as facesheet, triage sheet, order sheet, T-chart, EMS form, and ER point form
 - Consent to treat and any other admission forms signed by the patient
 - A form acknowledging a patient is leaving against medical advice
 - Informed consent forms for items such as surgery, blood, and dialysis
 - Patient education records/discharge instructions
 - Copies from physician offices or other healthcare facilities used to make health care decisions, such as a history and physical examination or surgical records
 - Hospital Issued Denials or Advanced Beneficiary Notice forms
 - Advanced Directives (*e.g.*, durable power of attorney or living will), power of attorney, custody papers or other legal papers
 - Detail Bill (includes detail of charges; also known as “itemized statement”)
 - Uniform Bill (UB-04)
2. The following information is usually considered part of the source data of the DRS. A narrative of the interpretation from the source data would generally be acceptable. In most cases, individuals cannot interpret source data, so such data is meaningless. There may be times, however, when an individual has a legitimate need to access source data. When such a need arises, the covered entity will want to provide the individual with greater rights of access, allowing the individual access to or copies of the source data when possible. A

specific request, authorization or subpoena is required to produce the original or to obtain a copy (if retained and/or able to copy) of this information:

- Birth certificates, birth certificate worksheets, paternity papers
- Imaging/Radiology films
- Electrocardiology tracings (EKG or fetal/newborn monitoring)
- Videotapes and digital recordings of procedures.
- Photographs that are not maintained as part of the medical record
- All release of information related correspondence (*e.g.*, requests for copies from insurance companies, authorization forms, interdepartmental requests for records, and fax cover sheets)
- Copies of driver's licenses, insurance or social security cards

3. The following are **not part of the DRS**:

- Psychotherapy notes as defined by the Standards for Privacy of Individually Identifiable Health Information (§164.501)
- Peer review information
- Incident reports
- Infection control reports
- Administrative, attorney-client privileged and any other protected reports
- Medical student notes not co-signed by the supervising physician
- Temporary notes or worksheets, reminders, and concurrent coding worksheets
- Incomplete record coversheets, clarification notes to/from physicians, etc.

4. The facility must have a process in place for the patient/patient's personal representative to access, amend or request restrictions on the use or disclosure of their DRS. In addition, a process must be in place to track and provide an accounting of disclosures made for their DRS.

References:

Patient Privacy Program Requirements Policy, IP.PRI.001

Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information 45 CFR Part 164

Privacy Official Policy, IP.PRI.002

Patients' Right to Access Policy, IP.PRI.004

Patients' Right to Amend Policy, IP.PRI.005

Patients' Right to Request Privacy Restrictions Policy, IP.PRI.006

Accounting of Disclosures Policy, IP.PRI.009

Authorization for Uses and Disclosures of Protected Health Information Policy, IP.PRI.010

Records Management Policy, EC.014

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Privacy Act of 1974. 5 USC, Section 552A