COCHISE REGIONAL HOSPITAL

Health Information Management Policies and Procedures
Patient Rights and Organization Ethics

POLICY

It is the intention of the Health Information Management department to support Cochise Regional Hospital’s mission to help improve patient and resident outcomes by respecting each person’s rights and conducting business relationships with all in an ethical manner.

We believe and teach our employees that patients/residents have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values. We are a richly diverse community and by attending to and being sensitive to divergent values of those we serve, we will be best able to serve the needs and expectations of our patients/residents.

With this ethical framework in mind, we have developed, reviewed, revised, teach and adhere to the policies/procedures in the following section of this manual.
Mission Statement - Health Information Management Department

POLICY
To maintain a single medical record for each patient.

Maintain each medical record in a safe and secure environment.

Maintain each medical record in accordance with federal/state rules and regulations

Maintain patient confidentiality

Abide by AHIMA's Code of Ethics

Reviewed: 10/82, 10/87, 6/91, 6/93, 5/99, 12/01, 12/08, 6/14
Revised: 12/08, 6/14
Release of Information: FORM LETTER - 3

Subject:

We have received your request for information on above-named individual. Please refer to the checked paragraph below.

[ ] We are unable to identify this individual. Please furnish additional information, such as:

- Date of birth
- Verify spelling of name
- Admission or discharge date: _______________________
- Was this patient an out-patient: _____________________

[ ] Medical information is confidential and may be released only upon written consent of the patient concerned. Please submit an authorization dated within the last 90 days.

[ ] We have received your request regarding a birth certificate. Complete the enclosed form and submit to the address indicated on said form.
[ ] The information that you have requested is not available at this time. We will send the information to you as soon as it becomes available.

[ ] Enclosed is the information you requested.
[ ] Other: ____________________________________________________
Improving Organizational Performance

POLICY

As stated in its mission statement, Cochise Regional Hospital is committed to continuously improve patient health outcomes and satisfaction.

HIM coordinates the physician clinical pertinence review. This is a retrospective review of charts designed to provide feedback to physicians to support improved patient care.

Effective Date: 3/98
Reviewed Date: 8/00, 2/01, 12/01, 12/08, 6/14
Revised: 12/08, 6/14
Scope of Service

POLICY

The Health Information Management Department shall provide functional support to all components of the health care facility and the various departments with respect to health information services. These functions are not limited to, but include:

• Patient identification and number system
• Identify and correct duplicate medical record numbers
• Monitoring of medical record documentation
• Performance improvement review
• Release of information, coordination of patient access to information, and response to court subpoenas and depositions
• Coding and abstracting for billing and indexes
• Special studies
• Storage and retrieval system
• Data security, privacy, and confidentiality
• Inservice education

Reviewed Date: 5/99, 12/01, 12/08, 6/14
Revised Date: 12/08, 6/14
Confidentiality of Medical Records

POLICY

It is the policy of Cochise Regional Hospital to adhere to the requirements of HIPAA.

The patient has the right within the law to personal and information privacy. Cochise Regional Hospital respects this right of privacy for all of our patients.

It is Cochise Regional Hospital's responsibility for safeguarding both the patient's medical record and its information content against loss, destruction, tampering and from access or use by unauthorized individuals. Medical records may not be removed from the hospital except in response to a court order, subpoena, or statute.

PROCEDURE

Each member of the HIM staff is trained to handle requests for patient information.
Penalty for Release of Confidential Information without an Authorization

POLICY

Release of confidential information pertaining to a patient, verbally or written, intentional or unintentional, to an unauthorized person or organization, by an employee of the health information management department, will be cause of immediate discharge with approval of the Chief Executive Officer.

Reviewed Date: 8/82, 10/85, 10/87, 6/91, 6/93, 5/99, 12/01, 12/08, 6/14
Revised: 12/08, 6/14
Release of Information: Requests from Federal and State Agencies

POLICY

Section 1160 of the Social Security Act, Public Law 92-703 indicates that any data or information acquired by HSAG in exercise of its duties and functions is confidential and not disclosed, with the following exceptions:

1. Data may be provided to Federal and State agencies for the purpose of identifying and investigating cases or patterns of fraud or abuse.

2. Data may be provided to Federal and State agencies to assist in carrying out health care planning and related activities. This data is restricted to aggregate statistical data without any individual patient identifiers.

Any person disclosing information, other than that specified above, is subject, upon conviction to a $1,000 fine, six (6) month imprisonment, or both, as prescribed by law.
Authorized Access Levels

POLICY

In consultation with the administrative staff, medical staff, and the Director of Health Information Management, the Director of Data Processing shall determine the content, schedule of production, and distribution of routine reports.

In determining the distribution of routine reports and the processing of requests for data of a nonroutine nature, authorized users and defined in the following three categories:

• **Restricted Access**
  - Hospital Board and chief executive officer or designee
  - medical staff (individual staff member for information pertaining to self, members of designated committees and review boards carrying out a specific function)

• **Access to Routine Reports Data for Purposes of Carrying Out a Specific Responsibility** (e.g., committee functions, review board activities, or approved projects)
  - intraorganizational personnel
    - board of trustees and chief executive officer or designee
    - risk management, utilization review, and PI coordinators and committee members
    - medical staff committees and review boards carrying out specific functions
    - professional practitioners carrying out specific committee or review functions
  - external agencies or individuals
    - licensing and accrediting bodies and third-party payers in a contractual relationship with the facility (e.g., Blue Cross, workmen’s compensation)
    - federal-mandated or state-mandated agencies within their defined jurisdiction (e.g., Peer Review Organization)

• **Special Authorization Required**
  - students assigned to the facility under a formal affiliation agreement need the approval of the director of the program and the director of the clinical affiliation at the facility; medical staff approval will be required as needed
  - outside researchers need the approval of the chief executive officer and medical staff

Reviewed: 5/99, 12/01, 12/08, 6/14
Access to Storage and Retrieval Areas

POLICY

Only authorized personnel shall be permitted direct access to the file room areas so that the following are achieved:

• proper safeguards against unauthorized use are maintained
• fixed responsibility for file integrity and accuracy is assigned

The following personnel are authorized to retrieve medical records from the HIM department: Administrator, Administrator on Call, Admitting Clerk, and Nursing Supervisor.

Reviewed: 5/99, 12/01, 6/14
Revised: 12/08, 6/14
Release of Information: Requests from a Noncustodial Parent

POLICY

Access to medical records and information pertaining to a minor child including but not limited to medical, dental, law enforcement and school records may not be denied to a parent because such parent is not the child's custodial parent. UHCI Act Section 50-16-521.

Reviewed Date: 5/99, 12/01, 12/08, 6/14
Revised: 12/08, 6/14
Assigning Medical Record Numbers

POLICY

• Medical record numbers are auto-assigned via the Empower system, by the admitting office.

• When a patient comes in for treatment, the admitting personnel check in the Empower Medical Records Menu to see if the patient has ever been treated at the facility. If not, a new medical record number is assigned.
Master Patient Index

POLICY

An electronic permanent master patient index is maintained which includes the following information:

- full name of patient
- sex
- address
- medical record number
- visit number
- account number
- date of admission(s)
- date of discharge(s)
- attending physician

The mother’s name for newborns and the name of both parents or guardians for minors shall also be added if necessary.

This index is confidential; access is permitted only to authorized users.

Reviewed: 5/99, 12/01
Revised: 12/08, 6/14
Legal Records

POLICY

- Legal records which pertain to the dispensation of patient care by any department will be kept with the patient record in the Department of Health Information Management.

- Legal records which do not pertain to the care of a patient will be kept by Administration.

Reviewed Date: 5/99, 12/01, 12/08, 6/14
Revised Date: 12/01
Medical Record Audit Requests

POLICY

Clinical departments that are required to perform quality of care audits should submit their request for medical records to the HIM department at least 48 hours in advance.

Reviewed Date:  5/99, 12/01, 12/08, 6/14
Revised:  12/08
13.1 WHAT IS INCLUDED IN THE PATIENT'S RECORD?

13.1.1 VITAL STATISTICS

A.R.S.36-343 requires that institutions, including hospitals and nursing homes, keep, concerning each person admitted to or confined in the institution, a record which includes the information that is required by the standard certification of birth, death and fetal death forms. The record must be made within 24 hours of the time of admission or confinement from information provided by such persons. When it cannot be so obtained, it must be obtained from relatives or other persons acquainted with the facts. The name and address of the person providing the information must be a part of the record. Such records must be retained for not less than 10 years and are open to inspection by representatives of the State Registrar of Vital Statistics. (For patient care records, see 14.c)

1.1.2 RECORD OF DISPOSAL OF REMAINS

When dead human remains are released or disposed of by an institution, such as a hospital or nursing home, the institution must keep a record showing:

- The name of the deceased
- The date of death
- The name and address of the person to whom the remains are released
- The date of removal from the institution, or if the remains are finally disposed of by the institution, the date, place and manner of the disposition.

Such records must be retained for not less than 10 years and are open to inspection by representatives of the State Registrar of Vital Statistics.
13.4 HOW LONG SHOULD PATIENTS' MEDICAL RECORDS BE RETAINED?

13.4.1 IN GENERAL

All patient records should be permanent and should be wither typewritten or legibly written with pen and ink. For medical-legal purposes, the longer a patient's records is kept the better; however, space and cost consideration are significant. Arizona statutes deal only with Vital Statistics records (see 13.1). The Arizona Department of Health Services has proposed a regulation that would require retention for 10 years. J.C.A.H.O. and some lawyers have suggested 10 years as a minimum. The Arizona statute of limitations for minors is now 3 years past the age of 7. We therefore recommend that patient care records be kept for a minimum of 10 years following discharge of a patient.

13.4.2 PARAMEDIC COMMUNICATIONS

Hospitals which are in voice communication with paramedics in the field should remain for not less than 2 years a record of the communication between the emergency room and the paramedic for each patient. When such patients are admitted as inpatients, the records should be retained for at least 10 years. It is recommended that voice communication be taped and these tapes retained for a period of not less than 2 years. The tapes need not be transcribed. A permanent record should be kept listing tapes which have been destroyed.

13.4.3 MICROFILMING RECORDS/RETENTION OF ORIGINAL

It is permissible to microfilm records under the regulations of the Arizona Department of Health Services. The use in court of microfilm, photostats and other facsimile copies is expressly authorized by A.R.S.12-2262 and by Rule 44(s) of the Arizona Rules of Civil Procedure, regardless of whether the originals have been retained or destroyed.

13.4.4 POSSESSION OF THE RECORD

The hospital has the obligation to retain possession and maintain integrity of the patient record. Exceptions:
  • Possession of x-ray plates may be relinquished temporarily to doctors requiring the plates for follow-up care. It is recommended that this not exceed
30 days.
• Storage may be provided by the hospital in a responsible warehouse in which the confidentiality and safety of the records are protected.

13.4.5 DESTRUCTION OF RECORDS

When records are destroyed, a careful report should be kept of the date and the name of the organization or person doing the destruction as well as the list of the names of the patients' records destroyed. Appendix A, pp A-36, 037, contains a listing of common hospital records and a suggested length of time these records should be retained.

13.5 DISCLOSURE OF PATIENT RECORDS AND PEER REVIEW RECORDS

13.5.1 THE GENERAL RULE: THE HOSPITAL-PATIENT PRIVILEGE

A.R.S.12-2235 is the statutory basis, in Arizona, for the physician-patient privilege. That statute provides that a physician or surgeon may not, without the consent of his or her patient, or guardian of the patient, testify in a civil action regarding any communication made by the patient with reference to any physical or mental disease or disorder or any knowledge obtained by personal examination of the patient.

Arizona courts have expanded upon the scope of the privilege, holding that the privilege also extends to testimony in civil action regarding the physician's diagnosis or advice to the patient. Although the statute relates only to testimony in civil litigation, the general right to privacy of the patient should prevent any unauthorized disclosure of privileged information, except as provided for in Chapter 12 and in later sections of this chapter. Although no Arizona statute expressly prohibits hospitals or their employees from disclosing communications from patients and information obtained from the examination of patients, the Arizona Court of Appeals recently held that evidence which privileged under A.R.S.12-2235 remains privileged when it is contained in hospital records. The Court further held that the hospital has the legal right and duty to protect the confidentiality of hospital patient records. Improper disclosure by a hospital of a patient's records may result in liability on the part of the hospital for invasion of privacy or defamation.

13.5.2 THE EXCEPTIONS TO THE GENERAL RULE

There are several classes of persons to whom disclosure of information can be made without substantial risk of liability. These classes are as follows:

• The attending physician or physicians.
• Hospital personnel, in general, when necessary for the care of the patient.
Physicians who have a professional or academic interest in the case.
• Peer review groups and medical staff committees who are charged with the
duty of monitoring and evaluating patient care.
• Insurance companies and third party payers, to the extent authorized in the
"Conditions of Admission" agreement, or other authorizations signed by the
patient. (See Section 13.7) (Sample authorization, Appendix A, p A-24)
• Personnel of the Industrial Accident Commission
• The patient or his or her authorized representative
• Law enforcement agencies and other governmental agencies or personnel as
discussed in Chapter 12.

13.6 THE PATIENT'S RIGHT TO INFORMATION FROM HIS OR HER OWN
HOSPITAL RECORD

13.6.1 THE GENERAL RULE

As a result of a number of recent court decisions, a patient now enjoys a right to the information contained in his or her own hospital record.

This right may be exercised by the patient or by a duly authorized representative of the patient, including the patient's attorney.

The hospital may not refuse to disclose information contained in hospital records merely because it may reveal negligence on the part of the hospital or attending physician.

13.6.2 PROCEDURE FOR IMPLEMENTATION OF THE GENERAL RULE

The hospital is not required to release the original hospital record to the patient or his or her representative. The original record is the property of the hospital and the patient should not be allowed to review it or to remove it.

Ordinarily, upon receipt of a proper written authorization or request, the hospital should make a copy of the requested record, place the record in a sealed envelope, and transmit the record to the patient or his or her representative. The hospital may charge the patient or representative for the reasonable cost of duplication of the record. The request form (Appendix A, p. A-24) should be retained.

When a person claiming to be the authorized representative of the patient seeks to obtain a copy of the patient's hospital record, the hospital should require the representative to present identification and a written authorization signed by the patient.
13.6.3 THE EXCEPTION TO THE GENERAL RULE

When a patient or former patient requests access to his or her medical record, the hospital may contact the attending physician to determine if the information contained in the medical record would be medically or psychologically harmful to the patient. If the physician advises against disclosure of the record because of the risk of harm to the patient, the hospital should not make the potentially harmful information available without legal advice or court order.

13.6.4 THE PRIVACY ACT OF 1974

This Act pertains only to records maintained by federal agencies, including hospitals operated by federal agencies. It extends to the patient parallel, broader rights with respect to his or her hospital records.

13.7 THE RIGHT OF A THIRD PARTY PAYOR OR INSURANCE COMPANY TO INFORMATION FROM THE PATIENT'S HOSPITAL RECORD

Because the patient's insurance carrier is often ultimately responsible for payment of some portion of the hospital bill, it has a legitimate interest in reviewing information in the hospital record to verify the claim. The "Conditions of Admission" agreement signed by the patient upon his or her admission to the hospital normally contains an assignment of benefits clause which expressly permits the insurance carrier to obtain a copy of the hospital record.

Insurance companies sometimes seek access to records of prior hospitalizations. Unless the "Conditions of Admission" agreement or other signed document expressly authorizes the insurance company to review records of prior hospitalizations, the hospital should release only those hospital records pertaining to the hospitalization which is the subject of the present claim.
Release of Information

POLICY

The hospital will not voluntarily use the record in any manner which will jeopardize patient interests; however, the hospital will use the medical record, as necessary, for treatment, payment, and operations.

Members of the medical staff may freely consult in the health information management department such records as pertain to their work. Should evidence exist that an individual's wish to consult a record for purposes not favorable to the interests of the patient or of the hospital, access to the particular record should be refused, and the matter referred to the Administrator.

Patients can secure a copy of their own medical record upon signing an Authorization to Release Information and showing a photo ID.

Information on medical records shall be given out only on written authorization signed and dated by the patient (guardian, if a minor or if mentally incompetent, or nearest relative in case of death) unless otherwise specified in these policies. All authorization must also be signed and dated by the person viewing the medical record and filed with it.

Charges will be made for abstracts or medical records copies except when processing from patients, patient's physician, social service bureaus, and attorneys representing the hospital.

Outside physicians who make inquiries concerning patient must present proper authorization from the patient before information or medical record copies are released.

Medical records shall not be taken outside the hospital except upon receipt of a subpoena duces tecum or a court order. Medical records are the property of the hospital, and as such may not be removed from the premises, except in the specific cases mentioned above.

Administration will, at its discretion, permit use of the medical records for research purposes.
Requests for copies of hospital records by insurance companies shall be honored upon written authorization of the patient or other responsible party. (Written authorization is not required in furnishing information to Blue Cross and Blue Shield only. Authorization for future release of medical information is obtained at the time the insurance is taken out.)

If a medical record has been subpoenaed, a photocopy of the record is made prior to leaving the hospital and left in lieu of the original upon request of the court.

If an employer has paid, or has agreed to pay, the hospital expenses of an employee, he is not authorized confidential medical information without written authorization from the patient or his legal guardian.

The only exception recognized in Arizona in releasing information without written consent of the patient is when the request is made by a workman's compensation carrier. Should the patient request that information is not to be given to the compensation carrier, the carrier is under no obligation to pay for any hospital expenses. The patient would be responsible for payment.
Release of Information: When a Patient Authorization is Not Required

POLICY

- Hospital personnel, in general, when necessary for the care of the patient while he is in the hospital.
- The patient's attending physician, even if it is not the patient's physician in a previous illness.
- Information used by medical staff members or teaching staff and purposes of bona fide research, education, or other significant investigation.
- State Workers' Compensation Representatives - except Psychology.
- Hospital insurance carrier when representing the hospital in a liability suit or Workers' Compensation case.
- The hospital's attorney if the patient is bringing suit against the hospital.
- The physician's attorney in a malpractice suit.
- Compulsory Processes: Subpoenas and court orders.
- Information sent to another hospital treating the patient when the patient's authorization is unable to be obtained.
- The state of County Health Department for patients with reportable conditions only: TB, VD, and certain other communicable diseases.
- Blue Cross Insurance Co., both Medicare and non-Medicare patients because of contract with HEW - except Psychology.
- Licensing agencies or approving agencies:
  - STATE BOARD OF HEALTH
  - BLUE CROSS UTILIZATION COMMITTEE INSPECTOR
  - JCAHO
  - AUDITORS
- Child Health Services and Bureau of Indian Health Department because of contract with the hospital.
- Arizona Foundation for Medical Care, Inc.
- Arizona Medicare and Arizona Medicaid - except Psychology.

Reviewed Date: 5/99, 12/01, 12/08, 6/14
Revised: 12/08, 6/14
Authorization to Release Patient Information

Patient: __________________________  Date: ______________  Time: _______

Name of Physician: ____________________________________________________

Name of Hospital: _____________________________________________________

Name of company or persons authorized to receive information: ______________
______________________________________________________________________

Dates of hospital confinement: ___________________________ to
__________________________

The undersigned hereby authorizes the above named hospital to provide the above named persons with a copy of any or all records, documents, reports, clinical abstracts, histories and charts, or every kind and description, relating to the above described hospitalization. It is understood that the copy of the records will be provided to the designated company or individual only upon payment of the reasonable charge for reproduction of the records. In furtherance of this authorization, I hereby waive all provisions of the law and privileges relating to the disclosures hereby authorized.

________________________________________
Patient

If the patient is unable to consent by reason of age or some other factor, state reasons:
______________________________________________________________________

Witness ____________________________

Signature of Legally Authorized Representative

________________________________________
Relationship to patient

Reviewed: 5/99, 12/08, 6/14
Revised: 12/08
Release of Information: Fee Schedule for Medical Record Copies

POLICY

• All requests for information (written, telephone, in-person) are processed in a timely manner and in accordance with HIPAA regulations. Charges for copies of a partial medical record:
  - Pertinent Data: $5.00 (History, Physical, Discharge Summary, Operation Report, Pathology Report)
  - Pertinent Data plus extra: $7.00 (History, Physical, Discharge Summary, Operation Report, Pathology Report, Laboratory & X-ray Reports)

• Charges for an entire medical record:
  - 25 pages will cost: $15.00
  - 30 pages will cost: $17.50
  - 50 pages will cost: $22.50
  - over 50 pages: $30.00

Reviewed: 5/99, 12/01, 12/08, 6/14
Revised: 12/08, 6/14
Release of Information: Form Letter - 1

To Whom It May Concern:

The records you have requested are no longer available here at our facility.

The only records we have available are those from 1965 to the present. We no longer have the records prior to 1965.

We are very sorry if this has put you at an inconvenience, but if we can be of further assistance to you, please do not hesitate to contact us.

Sincerely,

Health Information Management Department

Reviewed: 5/99, 12/01, 12/08, 6/14
Revised: 12/08
Release of Information: Form Letter - 2

Date: __________________________

Address: ______________________________________________________________

_____

Re: ________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

________________________

To Whom It May Concern:

The patient you have requested information on has never been a patient here at our facility. We have checked our files and the admission records and there is no record of this patient.

We are very sorry we could be of no assistance to you. If we may be of further assistance, please do not hesitate to contact us.

Sincerely,

Health Information Management Department

Reviewed Date: 5/99, 12/01, 12/08, 6/14
Release of Information: Invoice for Medical Record Copies

Release of Medical Records on:

Date Released:

Released To:

Amount Due:

Records Released Per:

Reviewed: 5/99, 12/01, 12/08, 6/14
Revised: 12/08
Release of Information: Release of ‘Public’ Information

POLICY

General: The following policy procedures for release of public information including photos and inquiries concerning the hospital and condition of patients, is published for the information and guidance of all concerned.

Responsibility: All public information, excluding inquiries about condition of patients, will be approved by Administration and released through the proper information channels.

Inquiries from the News Media and police on condition of patients in the hospital will be released by the Director of Nursing Service during normal duty hours and by the Nursing Supervisor after normal duty hours.

Code for uniform procedures for Police Cases. The following items of public information may be given to a Law Enforcement Agency without the patient's consent.

- Cases of Poisoning: a) No statement is to be made that a patient is poisoned; b) no information as to the kind of poisonous substance, such as mercuric, chloride, phenol or carbon monoxide may be given; c) no statement concerning the motive, whether accidental or suicidal, may be given, and d) no prognosis may be made.

- Shooting: a) A statement may be made that there is a penetrating wound; b) no statement may be made as to how the accident occurred; i.e., accidental, suicidal, homicidal, or in a brawl, not may the environment under which the accident occurred be given.

- Stabbing: a) The same general statements may be made for stabbing as for shooting accidents.

- Intoxication: No statement may be made as to whether the patient is intoxicated or otherwise.

- Burns: a) A statement may be made that patient is burned, also the member of body involved; b) a statement as to how the accident occurred may be made only when the absolute facts are known, and c) no prognosis may be given.
• Attending Physicians: Hospitals may state to the representatives of Newspapers, the name of the attending physician or private patients and refer such representatives to the physician for information about the case, but the newspapers shall not use the name of the physician without his consent.

• Pictures: When newspapers request the privilege of photographing a patient in the hospital, such permission will only be given a) with the opinion of the doctor in charge of the case, the patient's condition will not be jeopardized and b) if the patient (or in the case of a minor, the parents or guardian) are willing to have a photograph taken.

For other police cases, the following rule has been adopted: "If the patient is conscious and can communicate with the doctor or nurse in charge, or relatives, he should be asked whether he will permit any information to be given and his decision is final."

If the patient agrees to permit information to be given, the conditions are identical with those quoted above except that item 3 c) does not permit an opinion to be given as to the severity of the head injuries even when the condition is definitely determined.

Code of Uniform Procedures for Newspapers and Other News Media:

• The primary obligation and responsibility of the hospital is the welfare of the patient. This responsibility includes both the physical care of the patient and the protection of his/her good name and reputation. This is the reason that hospital and medical records are universally held as confidential documents.

• From the above, it follows that the hospital may not release information regarding a patient to the press or permit photographers to take pictures of patients without the written consent of the patient and the attending doctor. It would seem, however, the final consent rests with the patient and the patient's consent is sufficient unless the condition of the patient is such as to preclude interviews or pictures without the approval of the attending physician.

• Newspapers exist for the common good and function so as to bring matters of general public interest to their readers quickly and correctly. Hospital authorities should realize that the news media business is highly competitive and that equal courtesy and cooperation should be extended to all representatives.

• Hospital authorities should also recognize that time is an all important factor in newspaper work. Therefore, inquiries and releases should be expedited as much as possible.
• Good relations between the hospital and the press will be enhanced if the duly authorized representative of the hospital will obtain or cooperate in obtaining the consent of patient and doctor in cases in which the newspapers are interested in obtaining information or pictures. With regard to photographs, it must be emphasized that good hospital administration and the best interests of the patient may sometimes preclude pictures even consent of the patient has been obtained. Sound judgement must govern such exceptions.

• Hospitals should recognize that reporters and photographers are sent out to get story and pictures. In cases where consent is denied by the patient or the doctor, much bother will be avoided if the hospital will inform the city editor and picture editor by telephone the consent is denied. Newspapers in return should recognize that when such information is received, reporters and photographers should be recalled.

The foregoing are general principles designed to contribute to a better working relationship between hospitals and the press.

The following rules have been developed as a guide in specific instances:

Attending Physician: When releasing information to newspapers, in consideration of professional ethics, the name of the attending physician should not be divulged without first obtaining his permission.

Private Cases: While the presence of certain public figures should be acknowledged by the hospital, the hospital will not confirm their presence if either the patient or the attending physician objects.

It is suggested that in instances where there is wide-spread public interest, a member of the staff in charge of the case arrange for periodic bulletin as to the patient's condition, and if the physician cannot be reached that he/she delegate someone to issue such bulletins.

Deaths: News of the death of a patient is presumed to be public property, and if a patient is of such prominence that newspapers will be interested, the hospital will notify all news media through the Administrator's office.

Effective: 4/78
Reviewed: 4/78, 5/99, 12/01, 12/08, 6/14
Revised: 12/01, 12/08, 6/14
Release of Information: When a Patient is Denied Access

POLICY

Upon written request, a patient may be granted access to the information contained in their record.

- A health care provider may deny access to health care information by a patient if the health care provider reasonably concludes that:
  - the knowledge of the health care information would be injurious to the health of the patient;
  - the knowledge of the health care information could reasonably be expected to lead to the patient’s identification of an individual who provided the information in confidence and under circumstances in which confidentiality was appropriate;
  - the health care information was compiled and is used solely for litigation, quality assurance, peer review, or administrative purposes;
  - the health care provider obtained the information from a person other than the patient;
  - access to the health care information is otherwise prohibited by law.

- A health care provider may deny access to health care information by a patient who is minor if:
  - the patient is committed to a mental health facility; or
  - the patient's parents or guardian have not authorized the health care provider to disclose the patient's health care information.

- If a health care provider denies a request for examination and copying under this section, the provider, to the extent possible, shall segregate health care information for which access has been denied under subsection (1) from information for which access cannot be denied and permit the patient to examine or copy the disclosable information.
• If a health care provider denies a patient's request for examination and copying, in whole or in part, under subsection (1) (a) or (1)(c), the provider shall permit examination and copying of the record by the patient's spouse, adult child, or parent of guardian or by another health care provider who is providing health care services to the patient for the same condition as the health care provider denying the request. The health care provider denying the request shall inform the patient of the patient's right to select health care provider under this subsection.
Release of Information: Patient’s Request to Review/Copy Their Medical Record

POLICY

• A written request from the patient is required (see Form 14.127). Proper identification from person making request is obtained. A request may come from the patient, a person who is acting with the authority of the patient, or stands in such relationship to the patient as to entitle him to examine the record.

• No later than ten days after receiving the request, Health Information Management shall:

  q make the information available to the patient for examination during regular business hours or provide a copy if requested;
  q inform the patient if the information does not exist or cannot be found;
  q if the information is not maintained in medical records, inform the patient and provide the name and address, if known, of the health care provider who maintains the record;
  q if the information is in use or unusual circumstances have delayed the patient, inform the patient and specify in writing the reasons for the delay and the earliest date, not later than 21 days after receiving the request, when the information will be available for examination or copying or when the request will be otherwise disposed of.

• Notify the physician or psychologist regarding the request:

  □ The physician or psychologist will be notified in writing or by telephone that his patient has requested to see his record and/or requested a copy of his record.
  □ If the physician objects to the request, he must document in the chart OR on the request form, the medical reasons for denying the request. In the event of a persistent patient, such request will be referred to Administration for handling before a flat refusal is made.
  □ If the psychologist objects to the request, he/she must:
    - Furnish the court with an affidavit and an explanation of why the information is withheld.
    - Make arrangements to transfer the records to an independent qualified practitioner.
q If the physician or psychologist has died or left the country and there are no associates, the request will be referred to the Director of Health Information Management or Administration for handling.

q If the physician or psychologist fails to contact the Health Information Management Department within 2 days, the records shall be processed.

- Upon request, an explanation of any code or abbreviation used in the record shall be provided.

- When a patient's request is approved by the attending physician or psychologist:
  
  q A patient may make notes from the medical record.
  q A reasonable fee will be charged based on the amount of time locating the chart, time spent with the individual making the request, completion of forms for notification of the physician, cost of the forms, postage, attorney fees, etc. ($15.00 clerical fee). If the patient desires a copy of any or all of the record, the hospital will make copies and a fee will be charged based on the above plus $.50 per copy.
  q Examination or receipt of information will not be permitted until fee is paid.
  q Strict adherence to reasonable business hours for viewing the record by the patient will be followed. Patients will be allowed to view their chart between the hours of 8:00 a.m. and 4:00 p.m. Monday-Friday.
  q Patients will be allowed access to their record only in the presence of the attending physician, or psychologist or an authorized hospital employee.

q The above procedures will apply whether the patient is currently hospitalized or not and all such requests must be referred to the Health Information Management Department for proper handling.
SOUTHEAST ARIZONA MEDICAL CENTER
Health Information Management Policies

Release of Information: Patient’s Request to Correct/Amend Their Medical Record

POLICY

• For purposes of accuracy or completeness, a patient may request in writing to correct or amend his record.

• As promptly as required under the circumstances but no later than 10 days after receiving a request from a patient to correct or amend their record, Health Information Management Department shall:

  q make the requested correction or amendment and inform the patient of the action and of the patient's right to have the correction or amendment sent to previous recipients of the health care information in question;
  q inform the patient if the record no longer exists or cannot be found;
  q if the information is not maintained in the Health Information Management Department, inform the patient and provide him with the name and address, if known, of the agency who maintains the record;
  q if the record is in use or unusual circumstances have delayed the handling of the correction or amendment request, inform the patient and specify in writing the earliest date, no later than 21 days after receiving the request, when the correction or amendment will be made or when the request will otherwise be disposed of; or
  q inform the patient in writing of the provider's refusal to correct or amend the record as requested, the reason for the refusal, and the patient's right to add a statement of disagreement and to have that statement sent to previous recipients of the disputed health care information.

Reviewed Date: 5/99, 12/01, 12/08, 6/14
Revised: 12/008
PROCEDURE

• In making a correction or amendment, the health care provider shall:
  q add the amending information as part of the health record; and
  q mark the challenged entries as corrected or amended entries and indicated the place in the record where the corrected or amended information is located, in a manner practicable under the circumstances;
  q this will be made on an 8 1/2 x 11 piece of plain white paper and attached behind the medical record form that is being amended is corrected.

• If the health care provider maintaining the record of the patient's health care information refuses to make the patient's proposed correction or amendment, the provider shall:
  q permit the patient to file as part of the record of his health care information, a concise statement of the correction or amendment required and the reasons therefore; and
  q mark the challenged entry to indicate that the patient claims the entry is inaccurate or incomplete and indicate the place in the record where the statement of disagreement is located, in a manner practicable under the circumstances.

Reviewed Date: 5/99, 12/01, 12/08, 6/14
Revised: 12/08
Release of Information: Requests from Law Enforcement Officers / Agencies

POLICY

When properly identified officers present themselves, the hospital should cooperate in giving what information possible without compromising confidentiality. Any authorized (authorization required) information should be granted only through the due process of law (court order or subpoena) or current authorization by patient. Gunshot or stab wounds are to be reported within 24 hours of treatment. This is the responsibility of the treatment M.D. Emergency Room M.D.’s may request that information from the E.R. record be given to law enforcement officers, and this request should be complied with.

Law Enforcement Agencies: Patient’s Authorization Required

• Court, adult and juvenile
• FBI
• Food and Drug Administration
• Penal Institutions (No authorization required if patient is currently in institution.)
• Internal Revenue Service
• Police Department

Reviewed: 5/99, 12/01, 12/08, 6/14
Release of Information: Preparing a Medical Record for Court

POLICY

A subpoena duces tecum should be delivered by server at least 48 hours in advance so that all papers may be collected. While the server is still present, check for the name and phone number of the attorney responsible for the subpoena, and the Docket Number of the case.

Check immediately to verify that the person or persons have been hospitalized, or admitted to the E.R. or out-patient department.

Collect material requested in subpoena - medical record or records, x-ray films (from x-ray department), statement of account (from business office), E.R. and out-patient reports, etc. However, all extraneous material should not be included as they are not part of the record and are filed in the folder only for the convenience of the hospital personnel.

Photostat the record. Number the pages of the photocopied record.

Take the photocopy and the original medical record to court. Upon request by the court, leave the medical record copy with the court.

Reviewed: 10/82, 5/99, 12/01, 12/08, 6/14
Revised: 12/08, 6/14
POLICY

Confidential information may not be given to governmental agencies except with the patient’s authorization. A request from a governmental agency does not in itself constitute a waiver.

The following is a list of governmental agencies frequently requesting PRIVILEGED information from hospital records and what the requirements are for each.

- Medical agencies for which no authorization is needed to view medical records.
  - Health Department when checking reportable conditions
  - Licensing facilities

- Social and Welfare Agencies: Patient's Authorization required:
  - Social Security Administration
  - Veteran's Administration
  - State Department of Rehabilitation
  - Railroad Retirement Board

- Other governmental agencies: Patient's Authorization required:
  - Armed Service
  - Civil Service
  - Selective Service

Reviewed Date: 5/99, 12/01, 12/08, 6/14
Revised: 12/08
Release of Information: Requests for Research Studies

POLICY

If the information in the record is to be used for the purpose of bona fide research, education, or other scientific investigation by the medical staff, permission is not necessary from the patient or the attending physician. The following procedure is to be followed for requests for publications which use information from the medical records for their articles.

- All requests to publish articles using Cochise Regional Hospital's medical records will be directed to the Administrator for approval.

- If the information is used in such a way that the patient can be identified in the article, permission must be obtained from the patient and the attending physician, in addition to item number one.

All requests to use hospital medical records for research other than by the medical staff will be referred to the hospital Administrator for approval. (Professors at the University, non-staff physicians, nursing students, etc.)

Reviewed Date: 5/99, 12/01, 12/08, 6/14
Revised: 12/08, 6/14
Release of Information: Requests by Physicians for Copies of Medical Records for Use in Testifying

POLICY

Occasionally, an attending or consulting physician will ask for copies of a patient's medical record for purposes of review prior to court testimony. These physicians will be allowed copies of medical records only in the following circumstances:

- The case in question do not involve the hospital. Requests for copies in cases in which the hospital is involved will be referred to Administration for consideration.

- The requesting physician consents to return the copies of the records when he is finished testifying to the Health Information Management Department. The Health Information Management Director will destroy these copies.

NOTE: This matter applies only to attending or consulting physicians. COPIES WILL NOT BE GIVEN TO PHYSICIANS NOT INVOLVED IN ANY WAY WITH THE TREATMENT GIVEN IN THE RECORDS WHICH ARE REQUESTED.

Reviewed: 5/99, 12/01, 12/08, 6/14
Revised: 12/08, 6/14
Release of Information: Faxing Patient Health Information

POLICY

Facsimile transmission of health information should be done only when the original record or mail-delivered copies will not meet the needs of immediate patient care. The sensitive information contained in health records should be transmitted via facsimile only when:

1. Urgently needed for patient care, or
2. Required by a third-party payor for ongoing certification of payment for a hospitalized patient.
3. The information transmitted should be limited to that necessary to meet the requestor's needs. Routine disclosure of information to insurance companies, attorneys, or other legitimate users should be made through regular mail.

Except as required by law, a properly completed and signed authorization should be obtained prior to the release of patient information. If authorization cannot be obtained in cases of explained medical emergency, information may be released for patient care without authorization from the patient or legal representative.

In furtherance of this policy and procedure, we should assure that:

1. Fax machines are located in secure areas and limit access to them,
2. Identify and limit the individuals to monitor incoming documents on each machine. These persons will remove incoming documents and examine them to assure receipt of all pages in a legible format and direct them as addressed,
3. Take corrective action in the case of a misdirected transmission, and
4. The fax cover MUST contain a Confidentiality Notice.

Reviewed Date: 8/00, 2/01, 12/01, 12/08, 6/14
Revised Date: 2/98, 8/00, 12/08, 6/14
Retention of Medical Records

POLICY

Medical records will be retained at Cochise Regional Hospital Health Information Management Department for at least ten (10 years) from the date of service and/or discharge. Records of services provided to minors shall be maintained for three (3) years past the patient's 18\textsuperscript{th} birthday.

This policy applies to all patients served by the Cochise Regional Hospital, regardless of final disposition of the patient, or if the hospital discontinues operation.

If the patient is transferred to another facility, a copy of the record, or summaries as appropriate, accompanies the patient.

Effective: 6/84
Reviewed: 8/00, 12/01, 12/08, 6/14
Revised: 5/92, 2/94, 2/98, 12/01, 12/08, 6/14
Retention Schedule

POLICY

The most stringent requirements shall be met, and the following special considerations shall be noted: (according to state regulations)

Minors Retain data until patient reaches majority, plus 3 years

Patients treated under specific Determine, with legal counsel, whether OSHA 30 year Contract with an employer retention requirement applies

Intra organizational Coordination

The schedule shall be coordinated with the overall facility policies on record retention. Particular coordination shall be undertaken concerning the following:

- Billing data with diagnostic and/or coded information
- Employee records
- X-rays, EEG and EKGs
- Quality improvement and utilization review.

Reviewed/Revised: 5/99, 12/01, 12/08, 6/14
## Record Retention Schedule

<table>
<thead>
<tr>
<th>Type of Medical Records</th>
<th>Period of Retention</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual reports to government Agencies</td>
<td>Permanent</td>
<td>Maintained by Hospital Administration</td>
</tr>
<tr>
<td>Birth registration copy and</td>
<td></td>
<td>On file at County Clerk</td>
</tr>
<tr>
<td>Financial stats on admits, Services and discharges</td>
<td>Permanent</td>
<td>On file at County Clerk</td>
</tr>
<tr>
<td>Death registration copy and</td>
<td></td>
<td>On file at County Clerk</td>
</tr>
<tr>
<td>Diagnostic imaging films kept</td>
<td>5 Years</td>
<td>Mammography films are permanently</td>
</tr>
</tbody>
</table>

Reviewed/Revised: 5/99, 12/01, 12/08, 6/14
Destruction of Medical Records

POLICY

Destruction of records shall be carried out according to the approved record retention schedule of the facility. This shall be carried out under the direct supervision of the Director of Health Information Management or designee.

Inadvertent Destruction

When records are destroyed inadvertently (such as with fire or flood), notification shall be made as follows:

• **Internal notification of Administrator.** For records that meet minimum regulatory requirements but not organizational requirements, the certificate of destruction shall carry the information relating to the inadvertent destruction.

• **External notification of licensure/regulatory and accrediting agencies.** For records that do not meet minimum regulatory or accrediting agency time frames, notification shall be made by the chief executive officer. The notice to the chief executive officer shall carry the information relating to the cause of the inadvertent destruction.

Method of Destruction

Medical record information shall be destroyed in such a way that there is no possibility of reconstructing any of the information. One of the following methods shall be used: shredding or incineration. The Director of Health Information Management, along with Administration, shall determine the specific method, based on the availability of timely, cost-effective record destruction services.

Documentation of Destruction

The Director of Health Information Management or designee shall complete the certificate of destruction for both planned and inadvertent record destruction. This certificate of destruction shall include the following:

• date of destruction
• method
• patient names and medical record numbers
• appropriate statement
  - destroyed in normal course of business
  - inadvertently destroyed but met basic regulatory/accrediting agency retention requirements
  - inadvertently destroyed but did not meet basic regulatory/accrediting agency retention requirements
• signature of individual supervising the destruction
• signature of witness

When a commercial records destruction company carries out the destruction process, the designated official of the company shall complete the record destruction certificate and provide it to the facility. All certificates of destruction shall be maintained indefinitely in a central file in the Health Information Management Department.
Health Information Management Services

POLICY

The hospital maintains medical records that are legible, complete, accurately documented and in a timely manner, are readily accessible, systemically organized, and permit prompt retrieval of information, including statistical data.

A medical record is initiated and maintained for each individual who is assessed or treated as an inpatient, ambulatory care patient, or emergency patient. Only authorized individuals may make entries in medical records.

The purposes of the medical record are as follows:

• To serve as a basis to facilitate patient care and for continuity in the assessment of the patient’s condition and treatment.

• To furnish documentary evidence of the course of the patient’s medical assessment, treatment, and change in condition during the hospital stay, during an ambulatory care or emergency visit to the hospital.

• To document communication between the practitioner responsible for the patient and any other health care professional who contributes to the patient’s care.

• To assist in protecting the legal interest of the patient, the hospital, and the practitioner responsible for the patient.

• To provide data for use in continuing education and in research.

• To support decision analysis and to guide professional and organizational performance improvement.

All significant clinical information pertaining to a patient is incorporated in the patient’s medical record.

The medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately and facilitate
continuity of care among health care providers. Each medical record contains at least the following:

A. The patient's name, address, date of birth, and the name of any legally authorized representative.
B. The patient's legal status, for patients receiving mental health services.
C. Emergency care provided to the patient prior to arrival, if any.
D. The record and findings of the patient’s assessment.
E. A statement of the conclusions or impressions drawn from the medical history and physical examination.
F. The diagnosis or diagnostic impression.
G. The reason(s) for admission or treatment.
H. The goals of treatment and the treatment plan with dated signatures of medical staff.
I. Evidence of known advance directives.
J. Evidence of informed consent for procedures and treatment for which informed consent is required by organizational policy.
K. Diagnostic and therapeutic orders, if any.
L. All diagnostic and therapeutic procedures and test performed and the results.
M. All test results relevant to the management of the patient's condition.
N. All operative and other invasive procedures performed, acceptable disease and operative terminology that includes etiology, as appropriate.
O. Progress notes made by the medical staff and other authorized individuals.
P. All reassessments and any revision of the treatment plan.
Q. Clinical observations.
R. The patient's response to care:
   • Nursing notes
   • Documentation of complications, if any
   • Other pertinent information necessary to monitor patient's progress, such as vital sign graphics
S. Consultation reports.
T. Every medication ordered or prescribed for an inpatient.
U. Every medication dispensed to an ambulatory patient or an inpatient on discharge.
V. Every dose of medication administered and any adverse drug reaction.
W. All relevant diagnoses established during the course of care.
X. Any referrals/communications made to external or internal care providers and to community agencies.
Y. Conclusions at termination of hospitalization disposition
Z. Discharge instructions to the patient and family.
At discharge from inpatient care, a discharge summary concisely summarizes the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the patient’s condition on discharge, and any specific instructions given to the patient and/or family, as pertinent. It also serves to provide important information to other caregivers and facilitate continuity of care. For patients discharged to ambulatory care, the discharge summary summarizes previous level of care; it contains the following:

- Reason for hospitalization
- Significant findings
- Procedures performed and treatment rendered
- The patient’s condition at discharge
- Instructions to the patient and family, if any.

A final progress note is substituted for the discharge summary in the case of the transfer of the patient to a different level of hospitalization or residential care within the organization.

The medical record of patients undergoing operative or other invasive procedures and/or anesthesia includes the additional following information:

- The licenses independent practitioner who is responsible for the patient records a preoperative diagnosis prior to surgery.
- Operative reports are dictated or written in the medical record immediately after surgery and describe the findings, the technical procedures used, the specimen removed, the postoperative diagnosis, and the name of the primary surgeon and any assistants.
- The completed operative record is authenticated by the surgeon and filed in the medical record as soon as possible after surgery.
- When the operative report is not placed in the medical record immediately after surgery (for example, there is a transcription and/or filing delay), an operative progress note is entered in the medical record immediately after surgery to provide pertinent information for any individual required to attend the patient.

Postoperative documentation includes at least a record of:

- Vital signs and level of consciousness.
- Medications (including intravenous fluids) and blood and blood components.
- Any unusual events/postoperative complications, including blood transfusion reactions,
and the management of those events.

- Identification who provided direct patient care nursing services and who supervised that care if it was provided by someone other than a qualified registered nurse.

- The patient’s discharge from the post-anesthesia care area by the responsible licensed independent practitioner or by the use of relevant discharge criteria (approved by the medical staff and are rigorously applied to determine the patient’s readiness for discharge).

- The name of the licensed independent practitioner responsible for the discharge.

The medical record for patients receiving continuing ambulatory care services includes a list of known significant diagnoses, conditions, procedures, drug allergies, and medications.

When emergency care is provided, the following additional information is recorded in the medical record.

- Time and means of arrival.

- The patient’s leaving against medical advice.

- Conclusions at termination of treatment, including final disposition, patient’s condition at discharge, and any instructions for follow-up care.

- It is authorized by the patient or his or her legally authorized representative, a copy of the record of emergency services provided is available to the practitioner or medical organization responsible for follow-up care.

Medical record data/information is managed in a timely manner. Timely entries are essential if a medical record is to be useful in a patient's care. A complete medical record is also important when the patient is discharged, because information in the record may be needed for clinical, legal or performance improvement purposes. A patient's medical record when:

- Its content reflect the patient's condition on arrival, diagnosis, test results, therapy, condition and in-hospital progress and condition at discharge.

- Its content, including any required discharge summary or final progress note are assembled and authenticated, and

All final diagnosis and complications are recorded.
Medical records are confidential, secure, current, authenticated, legible, and complete.

- The medical record is the property of the hospital and is maintained for the benefit of the patient, the medical staff, and the hospital.

- The hospital is responsible for record access safeguarding both the record and its informational content against loss, destruction, and tampering and from access or use by unauthorized individuals.

- Written consent of the patient or his or her legally qualified representative is required for the release of medical information to persons not otherwise authorized to receive the information.

  This does not mean that written consent is required for the use of the medical record for:

  - Automated data processing of designated information.
  - Use in activities concerned with the monitoring and evaluation of the quality and appropriateness of patient care.
  - Departmental review of work performance.
  - Official surveys for hospital compliance with accreditation, regulatory, and licensing standards.
  - Educational purposes and research programs.

- There is written hospital and medical staff policy that medical records may be removed from the hospital’s jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute.

- Any other restrictions on record removal are in addition to this basic requirement.

When certain portions of the medical record are so confidential that extraordinary means are necessary to preserve their privacy, such as in the treatment of some psychiatric disorders, these portions may be stored separately, provided the complete record is available when required for current medical care or follow-up, review functions, or use in quality assurance activities. Policy statements exist addressing those record components not filed with the master record.

The Health Information Management Department is provided with adequate direction, staffing, and facilities to perform all required functions.
The role of Health Information Management personnel in the hospital’s overall quality assurance program and in committee functions is defined in the Performance Improvement/Risk Management Plan.
Incomplete / Delinquent Medical Records

POLICY

No member of the medical staff is permitted to complete a medical record(s) on any patient unfamiliar to him in order to retire a record(s) that was the responsibility of another staff member. Example: Retirement, death, permanent or protracted absence, etc.

In case of the above, the Health Information Management Director will contact the Hospital Administrator and the Quality/Risk Committee for guidance and actions to be taken in order to have such records completed and subsequently filed.

Effective: 10/82
Reviewed: 10/82, 10/87, 6/91, 6/93, 5/99, 12/01, 6/14
Revised: 12/01, 6/14
Incomplete Chart Time Frames

POLICY

Medical record documentation shall be completed in an ongoing manner throughout the stay. When data entries are not completed by the time of discharge, the following time frames and definitions shall apply or time frames as outlined by the Medical Staff rules and regulations:

- **incomplete status**: any record not complete within 14 days of discharge
- **delinquent status**: any record not complete beyond the initial 14 days

Medical Records personnel shall obtain the medical records of discharged and ambulatory care patients the day after discharge and/or the visit. Assembly and quantitative review will be carried out in a timely manner so that the record is available by the following workday. Any day during which the record is unavailable to the responsible health care provider for record completion will be omitted from the counting of days when incomplete or delinquent status is determined.

Noncompliance

Physicians will be subject to suspension of privileges if physician has more than 5 delinquent records organization wide, except for the ability to care for patients already admitted. The time period for such suspensions is as follows:

- **effective date**: fourteen workdays after notification that records are delinquent
- **in effect**: until records are complete

The source of authority for these penalties is their adoption by the medical staff. The responsibility for enforcement rests with the president of the medical staff and/or administration.

Completion of documentation is a legal and ethical responsibility.

Reviewed/Revised: 5/99, 12/01, 12/08, 6/14
Birth Certificates

POLICY
Pursuant to Arizona Revised Statute § 36-33.A, a birth certificate should be filed with the state registrar within seven (7) days after a live birth.

Newborn deliveries occur in the Emergency Department. The Emergency Department (ED) staff work in harmony with the HIM staff to collect the birth certificate information needed to complete the state’s birth certificate form in a timely manner. The state’s birth certificate form is completed/filed by Health Information Management (HIM) personnel.

PROCEDURE
1. The Emergency Department (ED) staff gives the mother the hospital’s birth certificate worksheet to complete.
2. The ED staff place the completed worksheet in the mother’s emergency room record. When the emergency room documentation is complete the mother/newborn medical record is placed in the HIM pickup basket.
3. The HIM staff uses the information on the birth certificate worksheet and the mother/newborn’s medical records to complete the state’s birth certificate form. The HIM staff contacts the mother directly when the information provided on the birth certificate worksheet is unclear or blank.
4. If the mother is not married to the baby’s father and would like the father’s information on the birth certificate, the HIM staff will make the Paternity Affidavit form available to the mother. This affidavit must be completed and returned to the HIM staff before the father’s information can be added to the birth certificate form.
5. The HIM staff sends the original birth certificate form to the state registrar within seven days of the birth. When a birth certificate is filed after seven days the HIM Director will send the following documents along with the birth certificate form,
   a. a letter explaining why the submission is late
   b. a copy of the mother’s medical record
   c. a copy of the newborn medical record
6. A copy of the original birth certificate is placed in the newborn’s medical record and maintained for ten years after the date of submission.

Effective Date: 10/82
Reviewed Date: 10/82, 6/93, 5/99, 12/01, 12/08, 6/14
Revised Date: 12/01, 12/08, 6/14
Staffing Pattern

POLICY

The Medical Records office is open Monday-Friday from 8:00 A.M. to 4:30 P.M.

Holidays are usually not covered. It is upon occasion that a holiday will be covered.

When the office is closed for the day, only personnel authorized by HIM policy may enter the Health Information Management department.

Reviewed: 10/82, 10/87, 6/91, 6/93, 5/99, 12/01, 12/08
Revised: 12/01
Reconciliation of Discharge Medical Records

POLICY

All discharge charts are received/retrieved by the HIM staff and available for processing within 48-72 hours of discharge.

PROCEDURE

1. Within 24 hours of discharge, the clinical unit will place the discharge patient charts in the HIM pickup basket.

2. One day post discharge, the HIM staff will make rounds to each clinical unit and pick up all discharge charts placed in the HIM basket.

3. HIM staff will reconcile all charts secured against a discharge patient listing.

4. Missing discharge charts will be logged and a note will be sent to the unit’s clinical manager for follow up regarding those charts not received within 48-72 hours of discharge.

5. The clinical manager will locate the missing charts and place them in the HIM pick up basket.

Effective Date: 8/08
Reviewed: 6/14
Revised: 6/14
Correcting Duplicate Medical Record Numbers

POLICY

Each patient will be assigned a single medical record number. Once it is identified that a patient may have a duplicate medical record number, the HIM staff will take steps to verify this fact and merge the duplicate pair when appropriate.

PROCEDURE

1. Use the Duplicate MR# Worksheet to document the processing of this possible duplicate MR# pair.

2. Write all of the MR#s for this patient on the worksheet.

3. Review the History Number Log. Write the history number associated with each of the medical record numbers on the worksheet.
   a. Note: The “merge” in Empower will be done by ‘History Number’, not medical record number.

4. Pull the medical record folders for each of the MR#s recorded on the worksheet.

5. Thoroughly review each medical record and compare the demographic information to confirm that this is the same patient, that this is a duplicate pair. (Refer to Decision Tree below to confirm the duplicate pair).

6. If it is determined that this is not a duplicate pair, refile both medical records. If it is determined that this is a duplicate pair, review the ‘visit history” for each MR# to determine which medical record number will be retained and which medical record number will be deleted.
   a. The rule of thumb is that you will retain the medical record number that was first issued, that is, the medical record number with the oldest visit.
   b. On the Duplicate MR# Worksheet, mark an ‘X’ to the left of the medical record number that will be retained.
7. Check the Empower system to see if this patient is a patient in the hospital today.
   a. If this patient is being seen today, stop, do not merge the medical record numbers until the patient has been discharged.

8. Before merging the two MR##s, review the demographic information on both.
   a. If the demographic information on the two MR##s is different, contact the admitting office to update the demographic information on the medical record number that will be retained.
   b. Once admitting has notified you that the demographic information been updated, proceed with merging this duplicate pair.

9. Perform the electronic merge in Empower using the ‘history number’.
   a. Access the Empower system. Select File Maintenance. Select Modify History Number.
   b. Enter the History Number to be retained.
   c. Enter the History Number to be deleted.
   d. Select OK to process the merge.

10. Merge the two paper medical records.
    a. Remove the medical records from the file of the number that was deleted. Correct the medical record number of the face sheet of each record.
    b. Interfile the medical records into the medical record folder for the medical record number that was retained.
    c. Staple the medical record folder shut, from the medical record number that was deleted. On the outside cover of the folder, write: “See Correct MR#: XXXX”. Refile this medical record folder in the HIM permanent files.
11. Empower will print a list of the medical record numbers that were merged. Send a copy of this listing to:
   a. Director of Business Office
   b. Director of Laboratory Department
   c. Director of Radiology Department

12. Perform a quality check on the merge.
   a. Access Empower Medical Record Abstracting system.
   b. Enter the medical record number that was deleted.
   c. If the patient name appears, notify the HIM Director that the merge was performed incorrectly so that immediate corrective action can be taken.
   d. If the patient name does not appear, mark an X in the “Quality Check” on the Worksheet.

**DECISION TREE TO CONFIRM THE DUPLICATE PAIR:**

A duplicate pair must ‘match’ on a minimum of three (3) primary identifiers:
- Name, date of birth, social security number
- Name, date of birth, address
- Name, date of birth, next of kin/emergency contact

You can NOT verify a duplicate pair if only two identifiers match:
(i.e., common name, date of birth)

When uncertain, discuss the possible duplicate pair with the HIM Director.

Effective Date: 11/08
Reviewed: 6/14
Revised: 6/14