

HARBOR-UCLA MEDICAL CENTER

SUBJECT: TRANSMISSION OF MEDICAL RECORDS BY
FACSIMILE/TELECOPIER (FAX)

POLICY NO. 623

PURPOSE:

To provide instructions for protecting patient privacy and confidentiality when transmitting confidential information, including Protected Health Information (PHI), via facsimile (FAX).

POLICY:

Harbor-UCLA Medical Center ensures that confidential information including PHI which may be transmitted via facsimile or other electronic means, provides a reasonable level of security to transmissions when it is deemed medically necessary to avoid an interruption or delay in the patient’s medical treatment.

PROCEDURE:

Upon determination of necessity by the Attending Physician or designee and/or Medical Records Director/designee, confidential information, including PHI may be electronically transmitted to other health care providers in accordance with the medical center’s release of medical information policy as follows:

1. Complete FAX cover letter (Appendix 1).
2. Call and advise the requestor when ready to transmit the information. Verify his/her identity. Verify the Fax number. Request that s/he stand by the receiving machine to intercept documents.
3. Transmit FAX cover letter and confidential information to receiving party.
4. Call the receiving party to confirm receipt of documents.
5. Scan original of the FAX cover letter, the Consent to Release of Medical Information and the transmission confirmation into the patient’s medical record.

Approved by: Chief Information Officer
Director, Health Information Management

EFFECTIVE DATE: 10/02/92
REVISED: 1/96, 1/99, 2/05, 3/13, 8/14, 9/17
REVIEWED: 1/96, 1/99, 2/02, 2/05, 3/13, 8/14, 9/17
REVIEWED COMMITTEE:

SUPERSEDES:

APPROVED BY:

Kim McKenzie, RN, MSN, CPHQ
Chief Executive Officer

Anish Mahajan, MD
Chief Medical Officer

Patricia Soltero Sanchez, RN, BSN, MAOM
Chief Nursing Officer

Signature(s) on File.

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LOS ANGELES COUNTY

DEPARTMENT OF HEALTH SERVICES

Harbor-UCLA Medical Center
1000 W. Carson St.
Torrance, CA 90509

FAX COVER SHEET

Date Transmitted: _____ Time Transmitted: _____

Number of Pages (including cover sheet): _____

TO: _____ Fax #: _____

Facility: _____ Telephone #: _____

Address: _____

FROM: _____ Fax #: _____

Telephone #: _____

Comments:

The information contained in this facsimile is privileged and confidential and is intended only for the use of the recipient listed above. If you are neither the intended recipient nor the intended recipient responsible for the delivery of this information, you are hereby notified that the disclosure, copying, use or distribution of this information is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone to arrange for the return of the transmitted documents to us or to verify their destruction.

Please contact _____ at _____ to verify receipt of this Fax or to report problems with the transmission.

I verify the receiver of this Fax has confirmed its transmission:

Name: _____ Date: _____ Time: _____

DHS Representative

Approved 4/03

APPENDIX 1

COUNTY OF LOS ANGELES

DEPARTMENT OF HEALTH SERVICES

HARBOR-UCLA MEDICAL CENTER

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