

ADMINISTRATIVE POLICY AND PROCEDURE

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Subject: ACCESS OF INDIVIDUALS TO PROTECTED HEALTH INFORMATION (PHI)/DESIGNATED RECORD SET

Policy No.: A149

Supersedes: July 26, 2022

Review Date: June 30, 2023

Origin Date: March 1, 2011

Revision Date: June 30, 2023

PURPOSE:

To establish guidelines for responding to an individual's right to access Protected Health Information (PHI) contained within their health record/Designated Record Set.

POLICY:

Rancho Los Amigos National Rehabilitation Center (Rancho) grants individuals the right to access, inspect, and obtain copies of their protected Health Information (PHI) that is contained in a Designated Record Set except for PHI that has been compiled for use in a civil, criminal, or administrative proceeding or disclosure is prohibited by the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

A minor legally authorized by law to consent to treatment and an individual's Personal Representative have the right to request access to his/her PHI.

DEFINITIONS:

Access means to inspect, copy, or arrange to copy Protected Health Information maintained by Rancho or Rancho business associates in a Designated Record Set.

Designated Record Set means a group of records that contain PHI and are maintained, collected, used, or disclosed by or for the County of Los Angeles, Department of Health Services, and that are either medical records or billing records about an individual; or used, in whole or in part, by or for Rancho to make decisions about an individual.

Emancipated Minor means, under California law, an adult for the purpose of consenting to medical care who meets any of the criteria of the following categories:

- 1) Emancipated by court order,
- 2) Minors on active duty with U.S. Armed Forces regardless of age,
- 3) Married or formerly married.

Minor, under California law, means a person under the age of 18.

Protected Health Information (PHI) means individually identifiable information relating to past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the health care provided to an individual.

Self-sufficient Minor means, under California law, a minor 15 years of age or older who is living separately and apart from his/her parents or legal guardian; and manages his/her own financial affairs, regardless of the source of income.

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Personal Representative means (1) the guardian or conservator of an adult; (2) a parent or guardian of a Minor, or (3) the executor or administrator of the estate of a deceased individual. Refer to DHS Policy No. 361.17, Use and Disclosure of Protected Health Information (PHI) of Deceased individuals, Minors to Personal Representatives.

PROCEDURES:

I. Processing a Request for Access to Protected Health Information

1. Access for inspection or copying of information requires a written request from the individual using the *Request for Access to Protected Health Information* form (attachment A). If the individual request to access, inspect, and/or to obtain copies of his/her PHI contained within the Designated Record Set held at another DHS facility, the facility receiving the request will process the request.
2. If Rancho grants the request for access, in whole or in part, it must inform the individual of the acceptance of the request, and provide the access requested using the Letter Responding to Request for *Access to Protected Health Information* (Attachment B).
3. Rancho shall arrange with the individual for a convenient time and place to inspect or obtain a copy of the individual's PHI. The inspection must take place during business hours, Monday through Friday, 8:00 a.m. to 4:30 p.m. If requested, Rancho may provide a copy via mail or fax.
4. The individual is allowed to have one other individual accompany him or her during the inspection of the PHI.
5. If the PHI is maintained at more than one location, Rancho need only produce the PHI once in response to a request for access.
6. Rancho shall respond to written requests for inspection of PHI within five (5) days after receipt of the request. Requested copies shall be provided at the time of inspection or mailed within 15 days after receipt of the request. Within these designated time periods, the facility will either make the information available, inform the individual that the information does not exist, or deny the request in whole or in part.
7. Rancho may provide a written summary of the PHI requested or an explanation of the PHI to which access has been provided if the individual agrees in advance. A reasonable fee may be charged for preparing the summary or written explanation.
8. Copies of an individual's PHI will be provided at a cost of .25 cents per page. Patient request for copies of PHI up to 10 pages or less is free. Patient request for copies of PHI up to 11 pages or more has a max fee of \$6.00.
 - A. The cost of retrieving or handling the PHI cannot be part of the fee.
If a person needs copies for an appeal regarding eligibility for public benefits, Rancho shall waive the fees pending the outcome of the hearing. If the individual's appeal is successful, Rancho may bill the patient. However, the fees may not be waived if the patient is represented by an attorney.
 - B. Upon receipt of the request for access, Rancho shall establish the identity and the authority of the individual making the request in accordance with the policy and

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procedures outlined in DHS Policy No. 361.16, Verification of Identity and Authority of Individuals Requesting Protected Health Information.

II. Unreviewable Grounds for Denial

1. An individual may be denied access without opportunity for review in the following circumstances:
 - A. PHI compiled for use in a civil, criminal, or Administrative proceeding.
 - B. PHI maintained by Rancho clinical laboratories which are subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) to the extent that is prohibited by law, and
 - C. PHI maintained by Rancho clinical laboratories which are exempt from CLIA.
2. When acting under the direction of a correctional institution, Rancho may deny an inmate's request to obtain a copy of PHI without providing an opportunity for review when the access would jeopardize the health, safety, security, custody, or rehabilitation of the individual or other inmates, the safety of any officer, employee or person at the correctional institution, or the safety of a person responsible for transporting the inmate.
3. When an active research project includes treatment, Rancho may temporarily deny access to PHI without providing an opportunity for review provided that:
 - A. The individual agreed to the denial when the individual agreed to participate in the research,
 - B. The health care provider has informed the individual that access to the information would be available at the completion of the research.
4. Rancho may deny an individual access to requested PHI without providing an opportunity for review if that PHI was provided by someone other than the health care provider under a promise of confidentiality, the confidentiality is reasonable, and the access would likely reveal the source of the information.
5. Access to PHI is otherwise prohibited by law.

III. Reviewable Grounds for Denial

Individual must be provided an opportunity to review the determination for denied access if an individual's access is denied for any of the following reasons:

1. When a licensed health care professional, exercising professional judgment determines that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person;
2. The PHI refers to another person (not including the health care provider) and a licensed health care professional, exercising professional judgment, determines that the access requested is reasonably likely to cause substantial harm to the person referenced;
3. The request for access is made by the individual's Personal Representative and a licensed healthcare provider, exercising professional judgment, determines that providing access to the

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personal representative is reasonably likely to cause substantial harm to the individual or another person.

IV. Denial of Access

1. If access is denied in whole or in part, the Rancho must:
 - A. To the extent possible, provide the individual access to any other PHI requested in the Designated Record Set after excluding PHI as to which Rancho has a ground to deny access.
 - B. Provide a written denial to the individual using a Letter Responding to Request for Access to Protected Health Information within fifteen (15) working days of the determination that includes the following information:
 - The basis for the denial,
 - A statement of the individual's review rights including a description of how the individual may exercise such rights.
 - A description of how the individual may file a complaint with DHS or with the U.S. Secretary of Health and Human Services.
 - The names or titles of the contact person/office.
 - The telephone number of the contact person/office; and
 - If Rancho does not maintain the requested PHI but knows where the requested PHI is maintained, then Rancho will inform the individual where to direct the request for access.

V. Denial of Access - Individual's Rights to Request Review of Denial

1. When an individual is denied access, Rancho is required to give the individual the right to have the denial reviewed where the grounds for denial are subject to review.
2. The individual may request a review of the denial using the Request for Review of Denial of Access to Protected Health Information form (**Attachment C**).
3. The denial must be reviewed by a licensed healthcare provider designated by the facility to act as a reviewing official. The reviewing official must not have participated in the earlier decision to deny access.
4. The reviewing official must act on the request for review within a reasonable period and decide whether to deny access to the records requested based on the standards set forth in this policy. The reviewing official's decision must promptly be communicated to the individual in writing using the Final Letter of Response to Request for Review of Denial of Access to Protected Health Information form (**Attachment D**). Rancho will abide by the final determination made by the reviewing official.

VI. Documentation Requirements for Access to Information

All documents required to be created or completed under this Policy shall be retained for a period of at least 6 years from the date of its creation or the date when it was last in effect, whichever is later.

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Rancho shall document and retain the following documentation in electronic or written format in accordance with the facility's record retention policies and procedures (which meet or exceed the HIPAA record retention requirements):

1. The Designated Record Sets that are subject to access by individuals; and
2. The titles of the persons or offices responsible for receiving and processing requests for access by individuals.

REFERENCES:

45 Code of Federal Regulations: Parts 160 and 164; Section 164.524.

Cal. Health & Safety Code: 123100 et seq,

California Family Code: 6500, 6922, 7002 (a)(b) ©), 7120.

DHS Policy No. 361.16, Verification of Identity and Authority of Individuals Requesting Protected Health Information.

Adopted from DHS Policy 361.15

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Please type or print the patient's information:

Last Name First MI Date of Birth (Mo/D/Yr) Medical Record #

Street Address City State Zip Code

REQUEST TO ACCESS AND INSPECT MY PROTECTED HEALTH INFORMATION ONSITE

<input type="checkbox"/> LAC+USC Medical Center	<input type="checkbox"/> Rancho Los Amigos National Rehabilitation Center			
<input type="checkbox"/> Olive View Medical Center	<input type="checkbox"/> High Desert Multi-Service Ambulatory Care Center			
<input type="checkbox"/> Harbor-UCLA Medical Center	<input type="checkbox"/> Martin Luther King, Jr. Multi-Service Ambulatory Care Center			
<input type="checkbox"/> CHC/Health Center: _____				
<input type="checkbox"/> Other: _____				
Facility Name	Street Address	City	State	Zip Code

REQUEST THE FACILITY ABOVE SEND A COPY OF MY REQUESTED PROTECTED HEALTH INFORMATION TO:

Name Phone Number (include area code)

Street Address City State Zip Code

INFORMATION TO BE ACCESSED, COPIED OR INSPECTED:

INSPECTION PERIOD: I request information during the following time period:

FROM ____ / ____ / ____ **TO** ____ / ____ / ____
Month Day Year Month Day Year

REQUEST SUMMARY OF REQUESTED PROTECTED HEALTH INFORMATION (if available)

Copy fees: DHS may charge you a reasonable fee for making copies of your protected health information at a charge of 25 cents per page for paper or fax copies; 50 cents per page for copies from microfilm.

YOUR RIGHTS REGARDING THIS REQUEST TO ACCESS:

Right to Receive a Copy of This Request - I understand that I am entitled to a signed copy of the form if I submit this form in person.

MRUN

NAME

DOB/GENDER



T-HS1016

Right to Request Review of Denial of Access- I understand that DHS may deny my request to access my protected health information, in whole or in part. If I am denied access, I may request a review of their decision by submitting a **Request for Review of Denial of Access to Protected health information**. In most circumstances, DHS will then designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of your request.

SIGNATURE OF PATIENT: _____

OR

SIGNATURE OF PERSONAL REPRESENTATIVE: _____

If signed by other than patient, state relationship and authority to do so:

DATE: ____ / ____ / ____
Month Day Year

FOR OFFICE USE ONLY

Form(s) Of Identification Provided:

- State Driver's License _____
- Birth Certificate _____
- Other (Provide details) _____
- State Identification Card _____
- Military ID _____

Facility: _____

Processed by: _____ Title: _____ Date: _____
Employee Name

For more information about your health privacy rights, ask the facility staff member for a copy of our **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at <http://www.dhs.co.la.ca.us/>.

MRUN

NAME

DOB/GENDER



USE OFFICIAL COUNTY/FACILITY LETTERHEAD FOR OUTSIDE
CORRESPONDENCE

**LETTER RESPONDING TO REQUEST
FOR ACCESS TO PROTECTED HEALTH INFORMATION**

{Date}

{Patient's name}

{Address}

Medical Record #: _____

Dear {Mr./Ms.}

Thank you for submitting your ***Request for Access to Protected Health Information***. Your request was forwarded to the responsible health care provider for review.

We received your written request, on _____, to access your protected health information. We have determined that:

- Your request has been granted, and the information is included with this letter. The cost for this service is \$_____, based on authorized costs permitted under 45 CFR 164.524(c)(4) Health Insurance Portability and Accountability Act (HIPAA)
- Your request has been granted, and the following appointment time has been scheduled to for your record review:

Date: _____

Time: _____

Location: _____

If you have any questions or need to reschedule, please contact us at (PHONE NUMBER).

- We will grant your request to access, but only in part (see below regarding the reason for partial denial). We will provide access to the following health information:

REASON FOR DENIAL (if applicable). Your request to access your protected health information is denied because:

- You are not legally authorized access to the health information.
- We are not permitted to release health information regarding information compiled in anticipation of or use in a civil, criminal, or administrative action or proceeding. This denial is not subject to the right to review.

- ❑ You did not provide all the information we need to complete your request. Please provide the items listed and return to us.
- ❑ You were unable to provide satisfactory personal identification to access your own information.
- ❑ You were unable to provide satisfactory personal identification as proof of status as a patient's representative (parent, guardian or conservator).
- ❑ Other:

REQUEST FOR REVIEW OF DENIAL OF ACCESS (if applicable): If we denied your request to access your protected health information, in whole or in part, you may submit a ***Request for Review of Denial of Access of Health Information***, included with this letter. After completing the form, return it to the DHS facility.

For more information about your health privacy rights, ask the facility representative for a copy of our ***Health Agency Notice of Privacy Practices***. You may also obtain a copy by visiting our website at www.dhs.lacounty.gov.

If you believe your privacy rights have been violated, you may file a complaint. You will not be penalized or retaliated against for filing a complaint. To file a complaint with us, or if you have comments or questions regarding our privacy practices, contact facility administration or any of the following offices:

Los Angeles County Department of Health Services
Privacy Officer
313 N. Figueroa Street, Room 703
Los Angeles, CA 90012
800-711-5366

Thank you for providing us with this opportunity to assist you and we look forward to continuing to serve your healthcare needs.

Sincerely,

{Facility Representative}
Program / Unit Manager
Facility Address

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES



**REQUEST FOR REVIEW OF DENIAL OF ACCESS TO PROTECTED
HEALTH INFORMATION**

Date: _____

Please type or print the patient's information:

_____	_____	_____	_____	_____
Last Name	First	MI	Date of Birth	Medical Record Number
_____			_____	_____
Street Address			City	State Zip Code

I am requesting a review of denial of access to my protected health information.

DHS will designate a licensed health care provider, who was not involved in the decision to deny access, to review the determination.

We will notify you in writing of the determination of the reviewing health care provider. DHS will abide by the final determination made by the reviewing health care provider.

SIGNATURE OF PATIENT: _____

OR

SIGNATURE OF PERSONAL REPRESENTATIVE: _____

If signed by other than patient, state relationship and authority to do so:

DATE: ____/____/____
Month Day Year

For more information about your health privacy rights, ask the facility representative for a copy of our **Health Agency Notice of Privacy Practices**. You may also obtain a copy by visiting our website at www.dhs.lacounty.gov or by sending a written request to:

Facility Stamp Here

**USE OFFICIAL COUNTY/FACILITY LETTERHEAD FOR OUTSIDE
CORRESPONDENCE**

**FINAL LETTER OF RESPONSE FOR REVIEW OF DENIAL OF ACCESS
TO PROTECTED HEALTH INFORMATION**

{Date}

{Patient's Name}

{Address}

{City, State, Zip Code}

Medical Record #:

Dear {Mr./Ms.}

We have completed a separate, independent review of your initial ***Request for Access to Protected Health Information*** in response to your ***Request for Review of Denial for Access to Protected Health Information***.

We have determined that:

Your request has been accepted, and the information is included with this notice. The cost for this service is \$_____. based on authorized costs permitted under 45 CFR 164.524(c)(4) Health Insurance Portability and Accountability Act (HIPAA)

Your request has been accepted, and the following appointment time has been scheduled for your records review:

Date: _____

Time: _____

Location: _____

If you have any questions or need to reschedule, please contact us at (PHONE NUMBER).

- We will grant your request to access, but only in part (see below regarding the reason for partial denial). We will provide access to the following health information:

{EXPLAIN}

- Your request to access your protected health information is denied because:

{EXPLAIN}

If your request has been denied, either partially or in whole, after submitting a ***Request for Review of Denial for Access***, we would like to remind you that you, as stated in the **Health Agency Notice of Privacy Practices**, if you believe your privacy rights have been violated, you may file a complaint. You will not be penalized or retaliated against for filing a complaint. To file a complaint with us, or if you have comments or questions regarding our privacy practices, contact facility administration or any of the following offices:

**Los Angeles County Department of Health Services
Privacy Officer
313 N. Figueroa Street, Room 708
Los Angeles, CA 90012
800-711-5366**

Thank you for providing us with this opportunity to assist you and we look forward to continuing to serve your health care needs.

Sincerely,

{Facility Representative}
{Program/Unit Manager}
{Facility address}