Department of Health Information Management POLICY AND PROCEDURE

POLICY NUMBER: 713
VERSION: 1

SUBJECT: Medical Records Access

PURPOSE: To ensure the accessibility, security, confidentiality, and privacy of patient's medical records.

POLICY: It is the policy of High Desert Health System that only authorized personnel have access, or use of the Medical Record.

PROCEDURE:

Only Health Information Management employees and after hours nursing staff have access to the Health Information Management offices where medical records are maintained. Access to and review of a patient's chart is acceptable for the following:

1. HDHS Staff
2. Students receiving training at High Desert Health System
3. Administration
4. HDHS Committee members
5. State Department of Health Licensing
6. JCAHO/CMA surveyors
7. Medicare/Medi-Cal representatives
8. Fiscal Intermediaries
9. USC Cancer Surveillance Program

Health Information Management employees are responsible for monitoring and maintaining the medical records by physically being present with the record or by having them in a locked location when staff is not present, to provide security and meet all State and Federal requirements. The original medical record can be removed from the facility only by court order or subpoena or at the direction of the Health Information Management director.

Violation of the above will be documented by the Safety Police and appropriate citation sent to the Department Manager for follow-up.

Patients may view their medical record by contacting the Correspondence Office whereby an appointment will be scheduled with a Technical Support staff member at least 48 hours in advance.

Chart Files staff will ensure that the record is complete by checking incoming and prepared filing to assure that all filing is in the patient's record at the time of the appointment or make access available via electronic data .

Technical Support staff will sit with the patient while the patient reviews the record, no advice or interpretation of the record contents is permitted.

Per law a patient has the right to rebut, correct, or add information to his/her medical record, if the patient elects this course of action he/she is to write the information on stationary, sign, and date it and then it will be filed in the patient's record.

If the patient requests copies from the record, the patient may identify with paper clips the pages they want copied, complete an authorization form indicating that all such identified pages are to be copied.

Reference:

California Health and Safety Code
California Evidence Code
California Welfare and Institutions Code Sections 5328
Title 22, Health Facilitator and Referral Agencies, Section 72527, Patient Rights, Item a) (9)
JCAHO IM 2.1 and IM 2.3
Confidentiality of Medical Information Act (Civil Code Section 56)
DHS HIPAA Privacy Policies 360 & 361 & 361.15

Approved By: Sharon Nolan (MEDICAL RECORDS DIRECTOR II)	
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Supersedes:	