POLICY & PROCEDURE

TITLE: Management of Medical Records				
Scope/Purpose: To ensure proper maintenance of Protected Health Information (PHI)				
Division/Department: All HealtPoint Clinics		**Policy/Procedure #:**		
Original Date: 12/15/12		**___New _X__Replacement for:**		
Date Reviewed:	**Date Revised:**	**Implementation:**	**CPIC Approved:**	**Board Approved:**
05/14/14	05/26/14	07/11/2014	07/11/2014	
Responsible Party: Director Of Practice Management				

DEFINITIONS:

Protected Health Information (PHI)

All individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. Individually identifiable health information is information, including demographic data that relates to:

- the individual's past, present or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual,
  and
- that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

Medical records

Any records pertaining to the identity, diagnosis, evaluation or treatment of a patient by a physician that are created or maintained by a physician.

Patient

Any person who consults or is seen by a physician to receive medical care.

Minor

A person under 18 years of age who is not and has not been married or who has not had his disabilities of minority removed for general purposes (Texas Family Code Annotated Subsection 11.01, 12.04, 14.02, 14.04, 35.01-35.09).

Legally authorized representative

Texas law identifies the following individuals as meeting the requirement for authorizing disclosure of health care information about a patient:

- A legal guardian of a patient who has been judged incompetent by a court to manage his or her personal affairs

- An agent of the patient under a durable power of attorney for health care
- An attorney or guardian ad litem appointed by a court for the patientA personal representative or statutory beneficiary of a deceased patient
- An attorney retained by the patient or the patient's legally authorized representative

POLICY:

It is the policy of HealthPoint to handle the release and/or disclosure of all confidential patient medical records and PHI in a manner that strictly adheres to state and federal laws, rules and regulations. Likewise, it is the policy of HealtPoint to grant access to a patient's on-line PHI only to those who are legally authorized to have access.

On-line access to Protected Health Information (PHI)

Individuals to whom we give access to a patient's on-line PHI:

1. The patient, if 18 years old or older
2. An individual who is legally authorized to consent to the release of the patient's PHI; either:
    a. A legal guardian if the patient has been adjudicated incompetent to manage his/her own personal affairs, if the patient's age is greater than or equal to 18 years old;
    or
    b. An agent of the patient authorized under a durable power of attorney for health care, if the patient's age is greater than or equal to 18 years old

3. Individuals who are authorized to access the patient's PHI, as indicated on the *Consent for Disclosure of Health Information (To Third Parties) form*. Authorization must have been granted to the individual by:
    a. the patient, if the patient's age is greater than or equal to 18 years old;
    or
    b. an individual authorized to consent to the release of the patient's PHI.

Transfer/Protection of Records

Clinical record information shall be safeguarded against loss or unauthorized use. The use of clinical records shall be limited to professional and administrative staff members of HealthPoint. At no time may clinical records or other confidential information relative to the client or his/her family be utilized in any way other than accepted and necessary to the provision of care ordered by the provider.

At certain times it may necessary to transport paper records. Staff or administrative members shall transport records in a locked briefcase to the required destination. The Medical records staff must track the record on required log and return it to storage once the required information is obtained or the task completed.

Availability of Record to Client/Parent
A patient may request in writing at anytime his/her record to find out what information about him/her has been requested, by whom, and how it is being used.

Format of Record
All records will be kept in the Electronic Medical Records system

Use of Interpreter/Translator
An interpreter/translator may be utilized according to the Limited English Proficiency (LEP) Policy in order to provide patient care. The interpreter/translator will sign underneath the staff signature on all forms.

Retention of Records
Clinical records shall be retained for a period of seven (7) years for all adult patients and until a pediatric patient reaches age 21 or seven (7) years after the last date of service whichever is longer (reference the **Texas Administrative Code, Title 22**, **Chapter 165**). This retention standard shall continue in effect until the agency discontinues operation. Clinical records shall be retained and protected in the medical records office of the clinic.

If a patient transfers to another health facility, a copy of the record or abstract may accompany the patient.

Upon closure of the clinic, BVCAA, Inc/HealthPoint will abide by the American Medical Association and Texas Medical Aassociation standards relative to record transfer.

Lost or Misfiled Records
The Medical Records staff will use all available measures to find any lost or misplaced records.

Proper Disposal of Records /Medical Records Storage
Records must be maintained seven (7) years past the last date of service rendered or until the patient's 21st birthday, whichever is greater.

All client/patient files that qualify for storage and disposal shall be kept or shredded by
Iron Mountain Shredding Company, Inc.
1101 Enterprise Dr.
Royersford, PA 19468
The shredding company will provide a certificate of destruction of the shredding of files.

PROCEDURE

If any record is lost or misfiled, the following procedure should be followed:

Verification: The name and date of birth are entered into the EMR system to verify the client as an established patient of the clinic. The Medical staff will obtain the approximated date of the last visits, and any name changes since the last visit.

Search: if the search under the date of birth is unsuccessful, the last name is attempted or the social security number of the patient if available. For example, if the last name is Smith, the entire S section will be searched for the missing record in HealthPro and EMR system to obtain a medical record number. Once the medical record number is obtained, all areas of the clinic shall be searched for the missing record.

HealthPro and EMR System: These computer programs contain client information including the client name, date of birth, social security number, date of last visit, type of visit and any appointments scheduled. If an attempt to find the record in unsuccessful, client information is verified using these programs, and a paper chart is made only if the EMR is not available. If it has been over two years (2) since the last visit, the clerk will create a new chart and preload any paper chart to the EMR system. The client is not refused services.

RELATED POLICY:

Release of Medical Records

REFERENCES:

See also

U.S. Department of Health and Human Services HIPAA web site: ww.hhs.gov/ocr/hipaa
Texas Medical Association
Texas Family Code
Texas Medical Board

REQUIRED BY:

Federal Law
State Law
Department of State Health Services

ATTACHMENTS/ENCLOSURES:

TRACKING

POLICY/PROCEDURE TRACKING FORM

TITLE: Management of Medical Records				
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Division/Department: Practice Management		**Policy/Procedure #:**		
Original Date: 05/14/2014		**___New _X_Replacement for: Same**		
Date Reviewed:	**Date Revised:**	**Implementation:**	**CPIC Approved:**	**Board Approved:**
	07/11/2014	07/11/2014	07/11/2014	

Date of Revision	**Description of Changes**
07/11/2014	Reformatted; expanded P&P in accordance to DSHS and HIPAA requirements.