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| Buchanan County Health Center             | Policy #HIM 2       |
| SUBJECT: RELEASE OF INFORMATION POLICY    | PAGE: 1             |
| DEPARTMENT: HEALTH INFORMATION MANAGEMENT | OF: 5               |
|   | EFFECTIVE: 10/04/96 |
|   | REVIEWED: 09/20/05  |

**PURPOSE:** To provide guidance in releasing of information. Referral to the HIPAA policy book will be utilized as well as referral to Iowa Guide to the Medical Records Laws, published by the Iowa Health Information Management Association, will also be followed.

**PROCEDURE:**

1. All information in the patient medical records shall be kept confidential and secure. Release of information from patient records will comply with federal, state and local laws.
2. Requests for copies of patient medical records are processed by the Health Information Management department. The department's personnel copies the requested records, mails them and bills for this service.
3. It shall be the general policy that the Hospital will not voluntarily use the record in any manner which will jeopardize any of the interests of the patient, with the exception that the Hospital itself will use the record, if necessary, to defend itself or its agents against accusations made by patients or others.
4. Medical Records are kept on file as original hard copy for approximately 10 years and then prepared for microfilming.
5. Medical Records shall not be taken outside of the Hospital except upon receipt of a subpoena duces tecum and the proper fee or specific written authorization of the Administration.
6. From the legal point of view, any medical record may be subpoenaed. If a medical record has been subpoenaed, it must not be left at the court without permission of the Administration. In cases when the judge orders that a medical record be held, a receipt must be procured from the Clerk of the Court and filed in the folder until return of the record. A request should be made of the judge to have a photostatic copy of the medical record made and substituted for the original after admission of the record as evidence.
7. Applicable information relative to a patient's condition may be released by Nursing Service only to the two designated names placed on the admission form.

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8. Per authority of the Buchanan Count Attorney's office, law enforcement personnel may be provided names of patients treated in the Emergency Room/Outpatient Department for injuries potentially related to suspicious activity.
9. As per amendment to Sec. 85.27 under Section 3 of House File 863 of the Code of Iowa, the Hospital does not need a patient's authorization for release of medical information to the insurance carrier in a possible Worker's Compensation case.
10. Release of information to local fire chief regarding a patient who has been involved in a fire, needs only to include "the degree of burns" suffered by the victim.
11. When a patient requests a copy of their own record, a release of information is filled out. It will be stressed to the patient that they should speak to the physician if there is any question regarding the chart or terminology used.
12. Members of the Medical Staff may freely consult in the Health Information Management Department such records as pertain to their work, unless there is suspicion that one of these individuals wishes to consult a record for purposes not favorable to the interests of the patient or the Hospital. Should there be such doubt in the mind of the Health Information staff, access to the particular record may be refused, and the matter referred to the Administration for decision. In no instance are copies of the medical records to be made for Medical Staff members without specific approval of the Health Information Management Manager who will confer with Administration in case of doubt.
14. Staff physicians may not give authorization to insurance companies or attorneys to secure records.
15. Information on medical records may be turned over to the Hospital's legal representative to protect the interests of the Hospital in cases involving liability or compensation.
16. Outside physicians who make inquiries concerning patients must present proper authorization from the patient or legal representative. The Administration will extend all reasonable courtesy to outside physicians in this regard, keeping in mind, that the interests of the patient and the Hospital are primary.
17. Information may be released in a bona fide medical emergency in which "not releasing" might be detrimental to the patient's medical condition. Request for medical information over the telephone should be handled by asking the caller to send a written request.

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18. Medical Records shall not be taken from any of the various files to other parts of the Hospital, except as is necessary in the transaction of the business of the Hospital. When possible, these records shall be examined in the Health Information Management Department, thus making the record accessible at all times to all who need it. If it must be taken out of the department the usual check-out method shall be followed.
19. The fact that an employer has paid, or has agreed to pay, hospital charges on an employee does not thereby authorize the Hospital to give the employer confidential medical information without written authorization from the patient or legal representative.
20. An informed consent or authorization to release information is one in which the patient has knowledge of the general contents of the medical record, understands what information is being released and for what it will be used. This must be 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 rules. Date of authorization must be current, no more than one year old. A properly executed authorization should be addressed to the Hospital, should designate the name of the person, company or agency (or name of employee or agent thereof) to which the information is to be given; the patient's full name, address, and date of birth. The authorization should specify if there are any limitations as to what is to be released, such as records of a certain time period or of a specific illness. If there is any doubt of the validity of the authorization, it will be the Health Information Manager's responsibility to make determination of validity.
21. Specific authorization for release of information is required by state and federal law in the following areas: AIDS/HIV related information, mental health, and substance abuse. This is an additional signature required on the Consent to Release Information.
22. If the request for medical information is from the Buchanan County Law Enforcement Offices (BCLEO), we must have an authorization from the patient as well as a request form from the BCLEO signed by an authorized individual.
23. The signed authorization should be retained in the "insurance correspondence" folder with notation of what information was released, date of the release and the identification of the individual who released the information.
24. The patient may revoke a prior authorization at any time in writing.

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25. In cases of minors, the authorization must be signed by a parent or legal guardian if the patient is under 18. If the parents are deceased and no legal guardian or custodian has been appointed, the authorization may be signed by the patient's representative. If the minor is married, and/or self supporting and not living with parents, or serving in the U.S. Armed Forces, is considered an emancipated minor, and may sign his/her own authorization. There are circumstances in which only minors may authorize release of information from their medical records, for example, minors who seek treatment for chemical substance abuse or venereal disease. Iowa statues pertaining to HIV/AIDS include specific provisions regarding authorizations for release of information, see Iowa Guide to Medical Records Laws.
26. If a patient has died, authorization disclosing information in the descendant's patient record must be signed by the administrator or executor of the descendant's estate. If there is no probate administrator, authorization can be signed by the surviving spouse or next of kin.
27. If physicians (not on the medical staff) and other healthcare facilities request copies of a patient's record no authorization is needed where there is a direct referral or transfer to another health care provider. No authorization is required where there is a showing of compelling circumstances affecting a patient's health or safety. Otherwise, authorization is required where it can be obtained. In emergency situations, information can be given over the telephone.
28. Authorization is required for release to Social Services, Welfare Agencies, and other third party contractors unless: Disclosure is needed on behalf of patient to determine benefits entitlement and patient is unable to give authorization, or pursuant to hospital-third party agreement allowing inspection of certain portions of medical records in claim processing or financial audit (Blue Cross/Blue Shield).
29. Written consent for release of information is not required for the following:
  1. Automated data processing of in-house information.
  2. Use in activities concerned with the assessment of the quality and appropriateness of patient care.
  3. Departmental review of work performance.
  4. Official surveys for hospital compliance with accreditation, regulatory and licensing standards.
  5. Educational programs.
  6. Research by physicians and other health care professions.

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7. Blue Cross, Medicare, Medicaid and IFMC.

30. For possible litigation records, any chart requested by either an attorney or patient that is felt to be a possible litigation case, the record will be locked up in the file cabinet in the Health Information Management department. The administrator and physician will be notified of the potential litigation. In the event that there were x-rays taken the radiology department supervisor will also be notified. These records will be kept in the locked file for 10 years or until the litigation is settled. If the patient is a minor, it should be kept locked up for 1 year after the minor reaches majority.
31. Charges for copying a medical record will be made as follows:  
A \$10.00 minimum charge per inpatient admission up to 10 pages, plus \$.50 for each page over 10 pages.  
A \$5.00 minimum charge per outpatient admission, up to 5 pages, plus \$.50 for each page over 5 pages.  
Additional initial charge for copying records from rolled microfilm, \$20.00 and two or more microfilm rolls, additional charge of \$20.00.
32. There is no charge for providing information to the patient's physician and the PRO (IFMC), Blue Cross, Medicaid, the Armed Forces and Workman's Comp. cases. There is also no charge for the Iowa State Reformatory, attorneys representing the Hospital or other health care institutions requesting information of a patient known to be in their care. Also, no charge is made to the Community Care Service or for possible abuse case reports to BCLEO and/or county attorney.
33. A patient is not charged for copies when request has been made by their physician to forward records to another healthcare provider, however, records will be sent directly from the Health Information Management department to the receiving healthcare institute unless it is an emergency situation.
34. A patient will be charged the copying fee when the records are being obtained for an attorney, insurance company or self information.
35. All requests for release of information received by the facility should be directed to the Health Information Management department for processing.