

SAN MATEO COUNTY
BEHAVIORAL HEALTH AND RECOVERY SERVICES

DATE: December 14, 2000

BEHAVIORAL HEALTH POLICY NO.: 00-06

SUBJECT: Client Access to Protected Health Information (PHI)

AUTHORITY: 45 CFR, Part 160 (HIPAA Privacy Rule); California Health and Safety Code Sections 123100-123135; W & I Sections 5328 – 5328.9)

SUPERSEDES: Patient Access to Mental Health Record, Policy of 1/1/83

AMENDED: February 25, 2003; effective April 14, 2003; February 9, 2010, 1/22/11

POLICY

Behavioral Health and Recovery Services (BHRS) clients and certain client representatives shall be guaranteed access to their protected health information, upon written request. Clients and/or their representatives shall be assisted, wherever necessary, to complete the required written request and forms. The goal is to enhance access by assisting the client or his/her representative to determine what it is that is wanted. Based upon this determination, the further goal is to provide a timely response that meets the client's wishes and is also clinically and legally sound

Under all circumstances, responsibility for the disclosure of protected health information and documentation of such disclosure resides with the clinical team or specific clinician treating the client.

PURPOSE

This policy is intended to facilitate the process by defining relevant terms and describing chart access procedures including documentation requirements, access limitations, and allowable denials of access.

DEFINITIONS

Access - the right, pursuant to proper authorization, to inspect or obtain copies of all or part of the client record.

Alcohol and Drug Abuse Records – client records, or discrete portions thereof, specifically relating to evaluation and treatment of alcoholism or drug abuse. Note: This definition does not include services within behavioral health services for clients with co-occurring substance use and mental health conditions.

Business Associates – A business associate relationship exists when an individual or entity, acting *on behalf* of the covered entity, assists in the performance of a function or activity involving use or disclosure of PHI. May include an individual or entity that receives PHI in the course of providing legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services. Other examples are benefit management, utilization review, and quality assurance.

Client - a client or former client of a behavioral health provider.

Client Representative - the parent or legal guardian of a minor client, the guardian or legal conservator of an adult client, or the personal representative of a deceased client (as defined by CA Probate Code Sec. 58).

Healthcare Provider - any:

- Licensed hospital, clinic, and home health agency
- Licensed physician and a wide variety of licensed healthcare workers, including but not limited to, marriage and family therapists, clinical social workers and psychologists

Behavioral Health Records - client records, in any form or medium maintained by, or in the custody of, a behavioral health care provider, or discrete portions thereof, specifically relating to evaluation or treatment of a behavioral health disorder. The definition includes, but is not limited to, alcohol and drug abuse records.

This definition excludes information contained in aggregate form, such as indices, registers, or logs. Also excluded is information given in confidence to a healthcare provider by a person other than another healthcare provider. Such material may be removed from the records prior to inspection and copying.

Protected Health Information (PHI) - information relating to a person's health, the care received and payment for services, including demographic information.

PROCEDURE

1. All requests by clients or client representatives for access to PHI must be in writing using the Request for Access to Protected Health Information (Attachment A) or other substantially equivalent written communication.
2. The written request should include the following:
 - a. Name of the client;
 - b. Name and signature of the requester;
 - c. Statement of the relationship of the requester to the client (when an agent of the client is requesting access to medical records).

- d. Identification of the portion(s) of the record to be inspected or copied;
 - e. Date of the request; and
 - f. Whether inspection or copies or both are requested.
3. If received by Behavioral Health Administration, the request shall immediately be referred to the appropriate clinic having primary responsibility for the care of that client. The client may also choose to initiate this request at the treatment site.
 4. The Behavioral Health Clinic administrative support staff will, upon receipt of the written request:
 - a. Identify the client and client record;
 - b. Monitor and keep a record of the processing of the request for access; record initial information on the Log of Requests for Access to Behavioral Health Record (Attachment B); and
 - c. Coordinate with and advise the assigned clinician of problems contributing to delay or incomplete processing.
 5. The clinic or clinician will contact the client or client representative to determine what is being requested, and to consult about the most appropriate response. If the client requests record inspection, copying, or record summaries, then an estimate of anticipated charges, if any, for the services requested will be specifically described prior to processing the request.
 6. The clinician must verify the identity of the person requesting the health information and the authority of such person to have access, if the authority is not known to the clinician.
 7. If the client chooses to inspect his/her record, the client or the client's representative may be accompanied by one other person of his/her choosing. At no time shall the client/client's representative be left alone with the original (not copy) of the client chart. A clinician shall be present during an inspection of the actual client record to assist the client's understanding of the content of the record.
 8. Complete written information concerning the request for access and the process of facilitating this request is to be retained in the client record. The clinician must document all releases of information to clients/client representatives by:
 - a. Enclosure in the record of a completed Request for Access to Protected Health Information
 - b. Completing and filing Log of Requests for Access to Protected Health Information

- c. Entry(ies) in the client record which specify the date and circumstances of disclosure, specific information disclosed, manner of disclosure (inspection, copies or summary), names and relationships to the client of person(s) to whom the information is disclosed and any other pertinent information.

9. What information to provide:

- a. Behavioral Health Services (the provider) must assure the client or the client's representative access to PHI even if he/she did not create the information (for example, hospital records from a different provider). If the provider does not maintain the requested PHI and the provider knows where the information is maintained, it must inform the individual where to direct the request for access.
- b. Providers do not have to make available duplicative information (material kept in more than one record set or more than one location).
- c. Providers must give access to information held in the records of business associates unless the information is duplicative.

10. Time Period for Compliance:

- a. Clinicians must comply with correctly served requests and must allow an inspection within 5 working days of receipt of a request, or provide copies within 15 days of receipt of a request.
- b. If a client requests a summary of medical information, this must be complied within 10 working days of receipt of a request, or within a maximum of 30 days if the provider notifies the client that more time is necessary, generally because of the length of the record.
- c. If the client asks that PHI be sent elsewhere, this must occur within 15 days of receiving a written request.

11. Inspection and Copy Charges: Behavioral Health Services may charge for clerical costs of

locating records and for personnel who observe during an inspection, up to \$0.25 per printed page or up to \$0.50 per page of microfilm records, and other charges based on actual costs incurred when providing summaries of the medical record.

12. Manner of Access: The provider must arrange with the individual for a convenient time and place to inspect or obtain a copy of the medical information, or mail a copy of the requested medical information at the individual's request. The provider shall discuss the scope, format, and other aspects of the request for access with the individual as necessary to facilitate timely provision of access.

RECORD SUMMARY

A summary of the record may be provided in lieu of a copy of the records, but only if the client agrees, in advance, to a summary and any related fees. Under Federal regulation, the summary option is now the client's, not the provider's, choice. A summary must meet the following requirements:

1. Only applies to requests by a client or his/her representative.
2. Client must be provided the opportunity to inspect and/or copy the summary within 10 working days from the date of request. If more time is needed due to the extraordinary length of the record, the clinician must notify the client of the need for more time and the date the summary will be completed. In such a case the summary must be available for inspection and/or copying within 30 days after the request.
3. Entire record must be summarized unless the request is limited to specific episodes.
4. Must contain the following:
 - a. Chief complaint(s), including pertinent history.
 - b. Findings from consultations/referrals.
 - c. Diagnosis, where determined.
 - d. Treatment Plan and regimen.
 - e. Progress of the treatment.
 - f. Prognosis including significant continuing problems or conditions.
 - g. Pertinent reports of diagnostic procedures and tests.
 - h. Objective findings from the most recent physical exam, including vital signs and actual values from routine laboratory tests.
 - i. A list of all medications prescribed, including dosages and any allergies to medications recorded by the healthcare provider.
 - j. Information not included in the original record is not required to be in the summary.

LIMITATIONS

1. Minors shall only be entitled to inspect records pertaining to healthcare of a type for which the minor is lawfully authorized to consent. The representative of a minor shall not be

entitled to inspect or obtain copies of the minor client's records in either of the following circumstances:

- a. Where the minor has the right of inspection.
 - b. Where the therapist/team determines that access to the client records requested would have a detrimental effect on the provider's professional relationship with the minor, or on the minor's physical safety or psychological well being.
2. Drug and Alcohol Abuse Records: Only released to the extent allowed by federal laws. Note: This does not refer to substance use dual-diagnosis treatment included within the mental health chart.

DENIALS TO RIGHT OF ACCESS (Reviewable)

1. Record inspection/copying of mental health records may be denied when a licensed health care provider determines, in the exercise of professional judgment, that
 - a. There is a substantial risk of significant adverse consequences to the client or others in seeing or receiving a copy of mental health records
 - b. The material makes reference to another person and the access requested is likely to cause substantial harm to such other person
 - c. The request is made by the client's personal representative and the provision of access to such personal representative is reasonably likely to cause substantial harm to the client or to another person.

Under these circumstances, the client may request review of the denial of access to the patient health information.

2. Refusal to allow access is subject to the following conditions:
 - a. The therapist shall make a written record indicating the date of the request, to be included with the client's mental health records.
 - b. The reason for refusal, including a description of the specific adverse consequences to the client that the therapist anticipates would occur if inspection or copying were permitted, must be documented in the client record.
 - c. The client is to be informed in writing within five working days of the denial of access and of his/her right to request a health care professional who is designated by the provider to act as a reviewing official. This person must not have participated in the original decision to deny access.

- d. If client is conserved, formal notice of the refusal shall be transmitted to the Superior Court of the county in which client resides.
3. Non-reviewable grounds under which a client may be denied access include but are not limited to:

When a family member or individual other than another medical professional has given information in the record in confidence to the therapist. (Whenever possible, such information shall be maintained in the record separately from episode activity notes, and stored behind the Confidential file back.)

Approved: _____
Louise Rogers, Director
Behavioral Health and Recovery Services

Attachments:

- A. Request for Access to Protected Health Information
- B. Log of Requests for Access to Protected Health Information