Policy Statement

The University of Toledo’s Health Information Management Department (“HIM”) maintains a medical record for each inpatient and outpatient encounter. The medical record is made available upon request to individuals by the HIM Department. Patients may request access and amendments to their medical records (“PHI”) through processes established by the HIM Department.

Purpose of Policy

To ensure that availability, access and amendment to medical records are in accordance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) Privacy Regulations, CFR 164.524; 164.526.

Procedure

The University of Toledo’s Health Information Management Department maintains a medical record for each inpatient and outpatient encounter. The legal definition of the medical record is found in Policy 3364-100-53-06. The medical record is made available to individuals who have completed an authorization form provided by the HIM Department or a form that is provided to the HIM Department that is in compliance with HIPAA.

INDIVIDUAL PATIENT RIGHT TO ACCESS PROTECTED HEALTH INFORMATION.

1. **Individual rights** - Individuals have a right to have access to, inspect and obtain a copy of their PHI through a written request however this does not mean that the covered components must provide original records or permit unsupervised access to a record containing health information. An individual does not have the right to access, inspect or obtain a copy of their medical records in the following instances:
   a. Where the request is for access to psychotherapy notes that are maintained separately from the medical record.
   b. Where the access pertains to information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding.

While present and under care at a University of Toledo covered component and with assistance by a clinical caregiver, a patient or their authorized representatives may view their medical record.

Patients may request to view or obtain copies of their medical record by providing HIM with a signed HIPAA authorization form obtained from HIM. HIM will coordinate with the Patient Accounting department with respect to requests concerning billing information records. HIM will verify the identity of the individual making the request using any or all of the following:
   b. Comparison of address on request form with address on file where copies of the medical record are to be sent by mail.
   c. A government issued picture ID such as a driver’s license or state-issued ID card may be used as verification.
   d. When an executor of an estate or durable power of attorney request is made, the appropriate legal documents must be submitted as verification.
2. **Denial of request for access.** The University and its affiliates maintain the right to deny an individual’s request for access to protected health information within the confines of the law and in exercise of professional judgment. Where only a portion of the request for PHI is denied, any other information that does not form part of the denial will be provided.

   a. A denial of access is **not** subject to review in the following instances:
      1. Where the individual has no legal right to access the information requested as outlined in (1) above.
      2. Where the request is from an inmate for records that would jeopardize the health or safety of the inmate or other inmates.
      3. Concerning a temporary suspension of access to information created or obtained in connection with the individual’s participation in a research study that includes treatment if the individual has agreed to be denied access and is informed that access will be reinstated at the completion of the study.
      4. Where the request is for PHI that was originally obtained from someone other than a healthcare provider under a promise of confidentiality and thus providing the access would reveal the source of information.
      5. Where the protected health information is contained in records that are subject to the Federal Privacy Act and a denial would fulfill the requirements of such law.

   b. Denial of access is subject to review where a licensed healthcare provider in the exercise of professional judgment has decided that:
      1. The request is reasonably likely to endanger the life or safety of the individual or others.
      2. The request includes information which makes reference to other person (s) other than a healthcare provider and is likely to cause substantial harm to that person if access is granted.
      3. The request was made by the individual’s personal representative and such release would harm the patient or another person.

3. **Review of denials.** Individuals may request a review of a decision to deny access to protected health information. Only denials made in exercise of professional judgment by a healthcare provider at UTMC or its affiliates as outlined in (2) (b) of this section are subject to review.

   Licensed healthcare professionals who were not directly involved in the initial decision to deny may conduct the review. The Medical Director and/or Chief of Staff at UTMC will serve as review officers. The review officers will promptly evaluate requests for reviews using the standards set forth in (2) (b) of this section. A written notice will be provided to the individual about the final decision of the reviewing officers and other action(s) to be taken if any. The decision of the reviewing officers is final and not subject to appeal.

4. **Notification.** Individuals will be notified about the status of their requests within 30 days from the date of receipt of the request. The notification will inform the individual whether all or part of the request has been granted or denied and what actions if any, needs to be taken by the individual.

   Where UTMC is unable to respond to a request for access within 30 days after receipt, the individual will be notified in writing stating the reason for the delay. The notification will include an estimated date of response which will not exceed 60 days from the date of receipt of the initial request for access.

   Where the request for access is denied, a written notification will include the basis for denial, a statement of the individual’s right for review if applicable and process for exercising those rights. The statement will also include information on how to file a complaint with UTMC including the title and phone number of the officer authorized to receive such complaints at the UTMC and the Secretary of Health and Human services.

   Where the information requested is not maintained by UTMC or its components but UTMC has knowledge of where the information is located, the individual will be directed to such entity accordingly.

5. **Form of Access.** If a request for access is granted, UTMC will provide the individual with access in the form or the format requested if the information is readily producible in such form or format. If the information is not producible in the format or form requested, a readable hard copy or other format as agreed will be provided.
6. **Fees.** Copy fees for records include the cost of labor, supplies and postage if the copies are to be mailed. Copy charges apply for records that are requested for non-patient care reasons, which is defined as anything other than treatment, payment or operations.

7. **Documentation-** UTMC will maintain documentation sufficient to meet its burden of proof regarding designated record sets that are subject to access by individuals and the titles of the persons or offices responsible for receiving and processing requests for access by individuals.
Request For Correction/Amendment of PHI

Mailing Address: University of Toledo Medical Center
Release of Information Unit – Health Information Management
1015 Research Drive
Toledo, OH 43614
Phone: 419-383-4892 Fax: 419-383-3001

Patient Name ________________________________ Birth Date ______________

Medical Record Number __________________________ Date of Visit/Admission ______________

Patient Address ________________________________________________________________

Patient Telephone Number: ______________________________

Date of Entry to be Amended: ______________________________

Type of Entry to be Amended: ______________________________

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Would you like this amendment sent to anyone to whom we have disclosed the information in the past? If so, please specify the name and address of the organization or individual.

Name ________________________________ Address ________________________________

Signature of Patient /Legal Representative (relationship) ________________________________ Date ______________

Distribution: Original Patient Record
Copy to Patient
Response to Request

Your requested amendment has been:  □ Granted  □ Denied

If granted, date amendment is included in the health information record:  _____/_____/_____
Date authorized persons you requested we send the amendment to were notified:  _____/_____/_____

If denied, your request was denied for the following reason(s):

☐ The PHI that you requested us to amend was not created by our organization and the organization or individual who created the PHI must make the decision to amend. Please contact the organization or individual that created the PHI that you wish to amend about your desire to amend the PHI.

☐ The PHI that you requested us to amend is not part of the individual’s designated record set. In accordance with the federal regulations, only information that is part of the designated record set is subject to amendment.

☐ The author of the PHI that you requested us to amend is accurate and complete and therefore, we are not required to amend it.

Author Comments

______________________________________________________________
______________________________________________________________
______________________________________________________________

Signature Author ____________________________________________ Date of decision _____/_____/_____

Decided within 60 days of request?  □ Yes  □ No
If no, date 30-day extension notice sent to requestor:  _____/_____/_____
Patient’s Rights Upon Receipt of Denial to Amendment Request

Mailing Address: University of Toledo Medical Center
Release of Information Unit – Health Information Management
1015 Research Drive
Toledo, OH 43614
Phone: 419-383-4982 Fax: 419-383-3001

Patient Information

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Entry to be amended:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td>Type of Entry to be amended:</td>
</tr>
<tr>
<td>Med Record Number (optional):</td>
<td>Reason for amendment:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone#:</td>
<td></td>
</tr>
</tbody>
</table>

Patient Information

If your request for amendment was denied, you may exercise the following rights:

☐ You may submit a written statement of disagreement (not to exceed 1-page in length) that will be included with the unchanged health information in any future disclosures or use of the information.

☐ If you decided not to submit a statement of disagreement, you may direct us to include your amendment request and this denial response with the unchanged health information in any future disclosures or use of information. (Please check this box and return this to our facility)

☐ If you believe that we have not followed our information privacy policies of the federal regulations, you may file a written complain with the University of Toledo Privacy Officer or with the U.S. Department of Health and Human Services Office for Civil Rights.
  o Lynn Hutt UTMC Privacy Officer.................... (419) 383-6933
  o US Department of Health and Human Service...1-877-696-6775
  http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Signature of Requestor ___________________________ Date ________________

To notify us of the above rights you wish to exercise, please return a copy of this form to the address of the Release of Information Unit of the Health Information Management Department. If you do not wish to exercise any of these rights, retain this form for your records.

UTMC Use Only

Written statement received: ☐ Yes ☐ No
If yes, Date:

Rebuttal to be included? ☐ Yes ☐ No
If yes, date rebuttal copy mailed to requestor