2023 TOOLKIT
Medical Records Requests

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MEDICAL RECORD REQUEST AUTHORIZATIONS POLICY AND PROCEDURE

Policy:

It is the policy of this facility to provide its residents with the right to access and inspect their medical record as well as obtain a copy of their medical records in compliance with applicable State and Federal law, including the 21st Century CURES Act.

Procedure:

1. Residents may request access to their medical records, including billing records, via a verbal or written request.
2. Records will be produced in the form and format requested by the resident, including through access through the Patient Portal, if the records are readily producible in the requested form and format.
3. Requests for a printed copy of the records or access to the Patient Portal must be directed to an authorized facility representative and documented in the resident's business file. An authorized facility representative **only** includes the following:
    a. Director of Nursing (DON)
    b. Administrator/Executive Director
    c. Facility records custodian
    d. Social services
4. If a staff member in a role other than identified above, receives a verbal request from a resident to review or access medical records, the staff member shall refer the resident to one of the individuals identified above who will then provide the resident with a release form (Appendix A).
5. If a staff member in a role other than identified above, receives a verbal request from a resident for access to medical records through the Patient Portal, the staff member shall refer the resident to one of the individuals identified above who will then provide the resident with a release form (Appendix B).
6. Access to the records will be granted within the period set by applicable local, state, or federal regulations. (Refer to F573, 483.10; CURES Act).
7. A clinical manager, or in the absence of a clinical manager, a member of the management team, will be available to conduct a face-to-face review of the record with the resident and/or authorized representative if desired.
8. A face-to-face review will not replace producing a copy of the medical record or providing access through the Patient Portal if the resident/authorized representative requests one.
9. The face-to-face review will be documented in the resident's medical record to include:
    a. The date and time of review
    b. Staff member in attendance
    c. Who was in attendance including authority designation

    d. Response to record review/comments
10. In accordance with the Department of Health and Human Services policy and any state and local laws, the resident/authorized representative may be charged for the reasonable costs for copying and/or mailing a printed copy of the records.
11. Residents will not be charged for access to medical records through the Patient Portal.
12. Record requests from a third party (I.e., any party other than the resident) will be logged on the tracking record (Appendix C).
13. Record requests from a third party must be accompanied by a valid authorization signed by the resident or the resident's legal representative.
14. All requests from a third party will be reviewed to ensure:
    a. Name of person requesting the records
    b. Identifiable information for the resident whose records are to be released to include:
        i. Name
        ii. Social security number
        iii. Date of birth
        iv. Address
    c. To whom and how the records are to be released
    d. Description of records to be released
    e. Signature and date of the resident or the resident's authorized representative
15. Each release will be reviewed, dated, and signed to ensure compliance with provisions included in the request.
16. If a validity period is not specified on the release, requests will be honored within _____ days or per state and/or local requirements.
17. If the resident is legally determined to lack capacity or is not his/her/their own responsible party, the request must be signed by an authorized representative.
18. An authorized representative of the resident may be:
    a. Legal guardian or valid power of attorney (living resident)
    b. Next of kin, if allowed by State law (deceased resident)
    c. Administrator/personal representative of the estate (deceased resident)
    d. Individual otherwise authorized by State law
19. Authorizations signed by an authorized representative must be accompanied by the appropriate documents verifying the signer's authority to access/request the medical records.
20. Requests by anyone other than a resident will require a valid power of attorney document that includes language specifically empowering the designated individual to request access to the resident's records or court records demonstrating legal guardianship.
21. Only records requested within the requested time period, with the appropriate authorization, will be released.

22. If the request seeks specially protected records, a clinical manager must review the request prior to the records being assembled. Specially protected records may include but are not limited to:
    a. Alcohol/drug abuse treatment/referral
    b. Sexually transmitted diseases
    c. HIV/AIDS-related treatment
    d. Mental health (other than psychotherapy)
23. When the validity of the authorization is verified, and the requested records are determined not to be protected, the records will be assembled. (Appendix D).
24. A designated member of the management team shall review the Record Request Log monthly to ensure compliance with the facility policy and procedure on the release of medical records.

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MEDICAL RECORDS REQUESTS – ASSEMBLING RECORDS POLICY AND PROCEDURE

Policy:

This facility's policy is to provide its residents with the right to access and inspect their medical record and obtain a copy of their medical records in compliance with applicable State and Federal law.

Procedure:

The following list of records constitutes the medical record to produce when a request is received. Note, Quality/QAPI reports, incident reports, investigations, survey documents and witness statements are ***NOT considered*** part of the medical record and should not be produced.

1. The following is a list of the types of records that should be considered part of the designated medical record and released upon a legally verified request:
    a. Hospital/referral records
    b. Physician progress notes
    c. Wound consult notes
    d. Resident progress notes/narrative nursing notes
    e. Medication administration records (MARs)
    f. Treatment administration records (TARs)
    g. Care plans/service plans
    h. Minimum Data Set (MDS)
    i. Activities of Daily Living flow sheets (ADLs)
    j. Dietary
    k. Social Services
    l. Activities
    m. Physical therapy
    n. Occupational therapy
    o. Speech therapy
    p. Bowel/bladder assessment/tracking
    q. Skin/wound tracking (individual)
    r. Skin checks
    s. Face sheet
    t. Vital sign flow sheets
    u. Radiology
    v. Laboratory
    w. Behavior flow sheets
    x. Assessments (skin, fall, elopement, smoking, pain, etc.)
2. The individual assembling the records shall review the Location of Record Log (Appendix A) if records are maintained in a hybrid model (electronic and hard copy format) to ensure all requested documents are provided.

3. Records will be assembled as requested on the authorization form.
4. If the request does not specify how to assemble the records, the default will be to make paper copies.
5. If paper documents are two-sided, both sides will be copied.
6. Two copies of the requested records will be made, one to be maintained per facility policy in a secure location (I.e., administrator's office, medical records office, etc.) and in electronic format.
7. Pages of each record will be paginated (numbered).
8. If there is a signed arbitration agreement, a copy of that agreement should be placed on top of the records being released.
9. Once records are assembled, a designated clinical manager shall review the records for compliance with this policy and confirm the production of all requested records.
10. The facility copy of the requested records will be maintained for seven (7) years or per state and local regulations.

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HIPAA AUTHORIZATION FORM
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

RESIDENT/PATIENT INFORMATION		
Last name, First name	Date of Birth	SSN or Medical Number
Street Address	City, State Zip	

DISCLOSURE BY AND RECEIPT OF INFORMATION	
Information to be disclosed by:	Information is to be provided to:
Name of Facility	Name of Person/Organization
Street Address	Street Address
City, State Zip	City, State Zip

PURPOSE OF REQUEST[i]	
Records to be Disclosed	**Specialty Records to be disclosed**
☐ Only information related to: ☐ Only records from _____ to _____ ☐ Entire record ☐ Other: _____	☐ Alcohol/Drug Abuse treatment ☐ Sexually Transmitted Diseases ☐ HIV/AIDS-related Treatment ☐ Mental health ☐ Psychotherapy Notes

I, _____, hereby voluntarily authorize the disclosure of information from my health record.

I, _____, hereby voluntarily authorize the disclosure of _____ information, for whom I am ☐ power of attorney or personal representative ☐ next of kin

Disclosures and Disclaimers

I understand that I may revoke this authorization in writing submitted at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different date or expiration event is stated herein.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

_____ _____

Signature of Resident or Personal Representative | Date

_____ _____

Printed Name of Personal Representative | Relationship to Resident

APPENDIX B

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RECORD LOCATION LOG

Record Type	Type of Record	Location of Record	Notes
Hospital/ referral records	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Physician progress notes	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Resident progress notes/Narrative nursing notes	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
MARs	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
TARs	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Care Plans	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
MDS	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	

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Record Type	Type of Record	Location of Record	Notes
ADL Flow Sheets	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Dietary	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Social services	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Activities	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Bowel/Bladder assessment/tracking	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Skin/Wound tracking	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Skin Checks	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	

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Record Type	Type of Record	Location of Record	Notes
Face sheet	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Vitals	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Behavior flow sheets	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Skin assessment	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Fall risk assessment	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Elopement assessment	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Smoking assessment	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	

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Record Type	Type of Record	Location of Record	Notes
Pain assessment	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Other assessments	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Wound consult notes	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Labs	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Radiology	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Physical therapy	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Occupational therapy	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	

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Record Type	Type of Record	Location of Record	Notes
Speech therapy	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	
Hospice	☐ Electronic ☐ Paper ☐ Both; Converted to electronic on: _____	☐ EMR system ☐ Office of _____ ☐ File cabinet/file room ☐ Other _____	

Monthly Reviewer: _____ Date: _____

Monthly Reviewer: _____ Date: _____

Monthly Reviewer: _____ Date: _____

Monthly Reviewer: _____ Date: _____

Monthly Reviewer: _____ Date: _____

Monthly Reviewer: _____ Date: _____

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AUTHORIZATION TO DISCLOSE AND/OR RELEASE OF HEALTH INFORMATION THROUGH PATIENT PORTAL

(All items on this authorization MUST be completed or the request will not be honored.
Use "X" if not applicable).

Patient/Resident Name: _____ **Birth Date:** _____

Address: _____ **Phone #:** _____

City/State/Zip: _____ **Medical Record #:** _____
(If known)

I hereby authorize (Facility Name) _____ to release protected health/medical information through the [INSERT NAME OF PATIENT PORTAL].

- I understand that I may revoke/withdraw this Authorization at any time.
- I understand that once my Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases mental health, drug and alcohol abuse, etc.

Proxy Access (optional)

☐ I permit (Facility Name) _____ to release protected health/medical information through the [INSERT NAME OF PATIENT PORTAL] to (Proxy Name) _____.

☐ I understand that giving proxy access to this person will allow him/her to view the same information that I can view in the Patient Portal. This includes records that were created prior to signing this form.

☐ I further understand that once information has been disclosed, there is potential for it to be re-disclosed by my proxy and will not be protected by state or federal privacy laws.

☐ I wish to exclude my proxy from accessing the following records:

- ☐ Allergies
- ☐ Care Plans
- ☐ Diagnoses (all)
- ☐ Diagnoses (confidential)
- ☐ Lab and Radiology
- ☐ Immunizations
- ☐ Medications
- ☐ Practitioners
- ☐ Progress Notes
- ☐ Vital Signs

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If you are not the patient but signing on behalf of the patient, please complete below.

I, _____ am the (check which applies)
Print your Name

- ☐ Parent with Parental Rights
- ☐ Court Appointed Guardian
- ☐ Medical Power of Attorney
- ☐ Surrogate Decision Maker
- ☐ Registered Kinship Care Relative
- ☐ Legally Appointed Healthcare Agent
- ☐ Power of Attorney with Right to see Medical Record(s)
- ☐ Court Appointed Personal Representative of Deceased

_____ _____
Patient or Resident/Representative's Signature Date

_____ _____
Address Phone

Attach proof of authority to act on behalf of the patient as checked above.

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. Patient's Name: **[NAME]** Social Security Number**:** Date of Birth:

2. I authorize the disclosure of the above named individual's health information as described below.

3. The following individual or organization is authorized to make the disclosure:

   [FACILITY]

   All physicians, hospitals and other health facilities, institutions, and other custodians that maintain any health information about the individual.

4. The type and amount of information to be disclosed is as follows:

   All protected health information regarding the individual in your custody, from the individual's date of birth to the present, which may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), information about behavioral or mental health services, treatment for alcohol and drug abuse and information regarding communicable diseases and serious communicable diseases and infections as defined by Michigan Department of Public Health rule. Such information will be in writing, and should include all notes, consultations, orders, medications, prescriptions, operative reports, pathology reports, pathology slides, x-ray reports, x-rays, graphic records, nurses notes, subjective symptoms, opinions, diagnoses, prognoses, contributing factors, complications, reports, correspondence, photographs, medical records, and any other medical information you may have.

5. This information may be disclosed to, and used by any representative of, the following law firm:

   [LAW FIRM NAME AND ADDRESS]

   for the following purpose:

   [Insert purpose; Ex. Litigation]

   I understand that any disclosure of information carries with it the potential for redisclosure and that once disclosed to the law firm, the information will not be protected by federal confidentiality rules.

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6. I understand that I have a right to revoke this authorization at any time by sending a written revocation to the custodian of the information. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

[*This authorization will expire at the conclusion of litigation.*]

If I fail to specify an expiration date, event or condition, this authorization will expire in three years.

7. I understand that I need not sign this form in order to ensure treatment, payment for treatment, or eligibility for health benefits.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, State Relationship to Patient

_____

Signature of Witness