Riverside Physician Network  
Quality Management

Subject: Medical Record Confidentiality

Department: Medical Management  
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Approved by:  

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PURPOSE
To protect the patient’s right to privacy and the records pertaining to medical care from loss, alteration, unauthorized use or damage. To ensure the confidentiality of member information used for any purpose including safeguarding the privacy of a member record and information in transit. To protect the patient’s right to access their medical records in any form or medium maintained by, or in the custody or control of a health care provider. To define guidelines for release of patient information.

POLICY
It is the policy of Riverside Physician Network to maintain the patient’s right to privacy and right to timely access of their medical records in accordance with all applicable state and federal laws (including but not limited to the Confidentiality of Medical Information Act, Welfare and Institutions Code and Insurance Information and Privacy Protection Act, 45 C.F.R. § 160-164 and the Knox Keene Act and any amendments thereto and Health and Safety Code §123100 et.al.). Any disclosure of “PHI” (Protected Health Information) is in accordance with Health Insurance Portability Act of 1996 (“HIPAA”) and any amendments thereto or other applicable confidentiality laws.

DEFINITION
Protected Health Information or “PHI” is medical information that includes information obtained from a healthcare provider and electronic data that relates to the past, present, or future physical or mental health condition, the provision of health care to the member, or the past, present or future payment for provision of health care to the member. Individually identifiable information is defined as patient name, age, employer, occupation, work and home telephone numbers, address, e-mail address, social security number, insurance information, marital status or anything else that would reveal the identity of the individual and emergency contact person information.

PROCEDURE
1. The contracted medical group’s contracts will explicitly state expectations about the confidentiality of patient information and records.
2. The medical group will inform their patients/patient representative(s) of its Confidentiality Policy and Procedure and document this notification within the medical record.
3. All requests for patient information will be reviewed to determine whether or not the party requesting the information will be allowed access to the information. Violation of the
Confidentiality of Medical Information Act ("Act") is punishable as a misdemeanor (Civil
Code 56.36). A patient may not waive his/her rights under this Act.

4. The identity of the patient will be blinded when using data for reporting, training, research, publication and/or marketing unless a written release if obtained from the patient.

5. Professional personnel involved with the patient’s care and related activities (i.e., physician, nurse, and other appropriate staff) are permitted access to the patient’s medical record upon signing an employee confidentiality form.

6. Individuals not involved with the patient’s care and related activities are not permitted access to the patient’s medical record without a completed and signed Patient Medical Record Release Form.

7. Disclosure of medical records by a physician is permitted without patient authorization when otherwise specifically authorized by law. All such disclosures will be documented and accompanied by a statement that the information may not be further disclosed except in accordance with Confidentiality of Medical Information Act. The following areas where disclosure is discretionary include the following:
   - Other Health Care Practitioners/Providers
   - Third Party Payors
   - Peer Review and Professional Liability
   - Licensing
   - Coroner
   - Research
   - Insurance Examination and Other Insurance Requests
   - Probate Court Investigation
   - Outpatient Psychotherapy Records
   a. AB 1178 permits the disclosure of medical information by a psychotherapist, consistent with applicable law and standards of ethical conduct. The psychotherapist must, in good faith, believe the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a victim or victims, and the disclosure may be made to a person reasonably able to prevent or lessen the threat, including the target of the threat.

8. In the disclosure of medical information the medical group is prohibited against the following:
   - Negligent disposal or destruction of medical information
   - Intentional sharing, sale, or use of medical information for any purpose not necessary to provide health care services to the patient, except as otherwise authorized
   - Prohibits practitioners from requiring a patient, as a condition to receiving health care services, to sign an authorization, release, consent, or waiver permitting the disclosure of any medical information subject to confidentiality protections
   - A physician or health care professional is prohibited from releasing medical information on a patient’s psychotherapy outpatient treatment to a requesting agent without a written request to the practitioner (specifying what the information will be used for and how long it will be kept), and a notice to the patient (unless the patient has signed a waiver of this notice requirement)
   - Anyone sending a copy of the written request to a patient’s psychotherapy treatment shall send a copy of the written request to the patient within 30 calendar days of receiving the information, unless the patient signs a letter waiving notification

9. Patients are afforded the opportunity to consent to or deny the release of identifiable medical or other information except as required by law.
10. The medical group assigns the Quality Management Committee to review confidentiality policies and to review practices regarding the collection, use and disclosure of medical information.
11. Authorization for release of medical records must come from the patient or from the patient’s legal guardian or conservator.
   - It is assumed that a patient is competent to make a rational decision unless there is documentation in the chart to the contrary or unless the patient is a minor.
   - If the patient is already known to you, you must verify the identity and authority of the person requesting the PHI, even if that person is the patient him/herself.
   - If an authorization is signed by a guardian or conservator, a copy of the Power of Attorney, the Court Order, or other documentation must show the authority to authorize release of medical information. A copy of that document shall be attached to the medical record.
   - A valid authorization to release patient information shall include the following:
     - Name of institution that is to release the information
     - Name of the individual or institution that is to receive the information
     - Patient’s full name, address and date of birth
     - Purpose or need for information
     - Extent or nature of the information released, including inclusive dates of treatment
     - Specific date or condition upon which consent will expire unless revoked earlier, either verbally or in writing
     - Date of medical record release and specific date after which the practitioner/provider may no longer disclose the medical information
12. The Patient Medical Record Release Form may be signed and dated by any one of the following:
   - The patient (if a minor, only for medical services to which the minor can lawfully consent)
   - The legal representative of an incompetent or minor patient (but not for services for which the minor can consent)
   - The spouse or the person financially responsible for the patient where the information is sought solely for the purpose of processing applications for dependant health care coverage.
   - The beneficiary or personal representative of a deceased patient
13. Release of information must be documented in the patient medical records. The documentation must include:
   - Date and circumstances under which disclosure was made,
   - Names and relationships to the patient, if any, of persons or agencies to whom disclosure was made,
   - Specific information disclosed
14. Medical record information will never be released via telephone by medical record personnel. Any discussion of a member’s confidential medical information may be accessed when using an analog cell phone; therefore, the member’s name is to be protected from disclosure during such a conversation.
15. Patient medical records may be transmitted to a requesting physician or facility via facsimile machines making sure that the transmission is confidentially directed and received.
16. Computerized Medical Records
   - Appropriate steps will be taken to reduce the likelihood of record destruction and to back up information adequately, such as anti-virus software, stringent protocols on data sharing and introduction of software programs, and off-site automatic tape back up systems
Physicians will implement a system for documenting corrections to computerized records, and make sure that no improper alterations are made.

Computerized medical record storage should be only in systems that are protected against unwarranted third-party access.

Appropriate security steps will be taken to ensure protection of other patients’ electronic medical records during a patient review of their own electronic medical records.

17. Release with consent – once a consent has been signed, information may be released to the following:
   - Other health care providers currently treating the patient
   - Medical researchers (when using patient identifiable data)
   - Patient’s employer
   - Sponsor, insurer, or administrator of a group insurance plan for purposes of evaluating the patient’s application for coverage or benefits
   - Patient’s attorney

18. Release without consent – a valid authorization is not required before releasing information to the following:
   - Person or entity responsible for paying the patient’s bill (if member has a signed statement on the health plan information sheet allowing the same [except in the case of HIV results])
   - Peer review
     - Medical Record information must be protected from disclosure when utilized for UM/QM, Case Management and claims
     - Licensing or Accreditation Surveyors
     - County Coroner
     - Other health care providers treating the patient in an emergency situation
     - Public Health Department for follow up on communicable diseases

19. Exceptions – The medical group may release medical information without obtaining the patient’s written authorization to comply with the following:
   - Court Order
   - Administrative Agency Order
   - Subpoena Duces Tecum
     - Documents not subject to Subpoena Duces Tecum are psychiatry, alcohol and drug abuse and AIDS related medical records
   - Investigative Subpoenas
   - Arbitration Order
   - Search warrant issued by a judge
   - Specific laws that require release of medical information:
     - Attorney Pre-Litigation Requests Evidence Code §1158

20. Copying the Medical Record
   a. Only the information specifically requested will be released.
   b. If the authorization does not state what is to be released, then only the pertinent information will be released. (this usually involves providing the last 2 years’ worth of records)
   c. Patients may receive a copy of their own records after completion of a valid authorization and payment is received to cover the reasonable cost of providing the record and/or copy.
     - A provider must furnish the patient a copy of his record within fifteen (15) days of receiving the written request. [CA H&S Code §123110 (b)]
     - Per page copying fee is statutorily set at 25¢ for regular photocopies and 50¢ for microfilm pages. [CA H&S Code §123110 (a) and (b)]
d. Information in the medical records may be provided to the medical group legal representatives to protect the interests of the medical group involving liability or compensation.

e. Information in the record will be provided to the medical group departments in the course of completing business (i.e. Patient Relations, Quality and Utilization Management).

f. All appropriate aspects of patient confidentiality will be maintained by those employee/physicians reviewing the records.

21. Medical Records Patient Review

a. Under SB 1903 for adult patients who inspect their medical records are allowed to provide a written addendum to the records if the patient believes that the records are incomplete or inaccurate. Health care providers are not subjected to liability for the receipt and inclusion of these addenda in patient records.

b. A health care provider shall permit this inspection during business hours within 5 working days after receipt of the written request.

c. The inspection shall be conducted by the patient or patient’s representative requesting the inspection, who may be accompanied by one other person of his/her choosing.

d. Any adult patient who inspects his/her patient record pursuant to SB 1903 shall have the right to provide to the health care provider a written addendum with respect to any item or statement in her/her record that the patient believes to be incomplete or inaccurate. [CA H&S Code §123111]

e. The addendum shall be limited to 250 words per alleged incomplete or inaccurate item in the patient’s record and shall clearly indicate in writing that the patient wishes the addendum to be made a part of his/her record.

f. The health care provider shall attach the addendum to the patient’s record and shall include that addendum whenever the health care provider makes a disclosure of the allegedly incomplete or inaccurate portion of patient’s records to any third party.

22. The Right to Complain

- The patient can report any improper use or disclosure of nonpublic personal health and/or financial information or personally identifiable health and/or financial information or personally identifiable health and/or financial information. If patients have any questions about privacy, wish to exercise their rights, or file a complaint, inquiries are to be directed to:

  Riverside Physician Network  
  Attn: V.P. of Legal Affairs  
  1650 Iowa Ave., Suite 220  
  Riverside CA  92507  
  (951) 788-9800

- The patient may contact their Health Plan or the California Department of Managed Care with concerns. The patient also has the right to directly complain to the Secretary of the United States Department of Health and Human Services. The medical group will not retaliate against the patient for filing a complaint against the Riverside Physician Network.