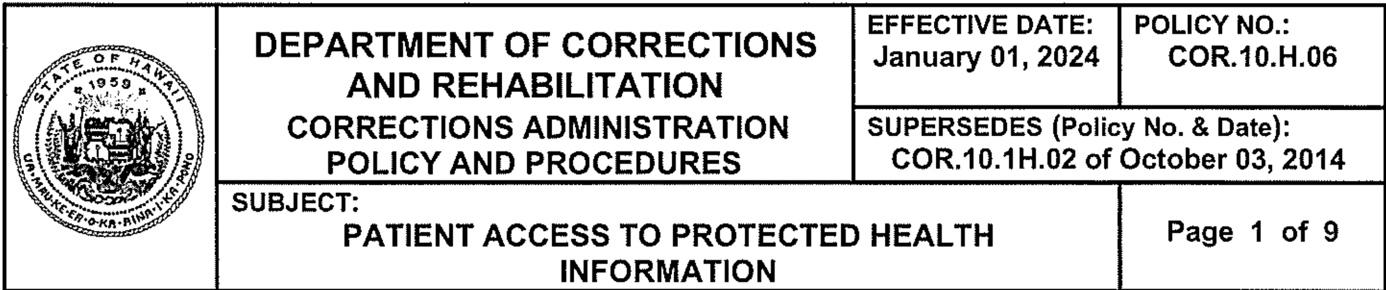


	DEPARTMENT OF CORRECTIONS AND REHABILITATION CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	EFFECTIVE DATE: January 01, 2024	POLICY NO.: COR.10.H.06
		SUPERSEDES (Policy No. & Date): COR.10.1H.02 of October 03, 2014	
	SUBJECT: PATIENT ACCESS TO PROTECTED HEALTH INFORMATION		Page 1 of 9

1.0 PURPOSE

To establish procedures for patient access to their medical record information.

2.0 SCOPE

This policy and procedure shall apply to all correctional facilities and their assigned personnel.

3.0 REFERENCES, DEFINITIONS & FORMS

.1 References

a. Hawaii Revised Statutes (HRS), Section 26-14.6, Department of Public Safety; and Section 353-A, Director of Corrections and Rehabilitation, Powers and Duties; Chapters 92F, Uniform Information Practice Act; and Chapter 622-56 & 57.

b. Hawaii Revised Statutes, Chapter 92F, Freedom of Information Act, 2004 Cumulative Supplement.

c. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Subtitle A, Subchapter C, Section 164.508.

.2 Definitions:

a. Custodian of medical Records (CMR): The facility Health Record Librarian where available, or the facility Clinical Section Administrator.

b. Electronic Medical Record (EMR): A digital version of a patient's paper chart. EMRs are real-time, patient-centered records that make information available instantly and securely to authorized users.

c. Medical Record: A record representing a patient's medical and mental health history and care from the moment of incarceration until they are released from custody.

d. Medical Record Data Set: A grouping of health record documents defined by the Health Care Division Administrator of designee, as the component parts of the medical record.

e. Protected Health Information: Any health information that can be identified as belonging to a particular individual.

f. Verifiable legal action: A legal action in which a case number has been assigned by the court.

.3 Forms:

a. DCR 0477, Purchase Agreement Form (attached)

b. DCR 0485, Cost to Patient for Copies of Medical Records

c. DCR 0487, In Receipt of Request for Information (attached)

d. DCR 0490, Information Reviewed or Released from this Medical Record (attached)

4.0 POLICY

.1 Medical records are the property of the State of Hawaii, Department of Corrections and Rehabilitation, Health Care Division.

.2 Patients shall have access to his or her health information. The patient may inspect or obtain copies of their health information unless, in the opinion of the facility's medical authority or a psychiatrist, disclosure of the information would be detrimental to the health of the patient. The patient shall be asked specifically what part of the medical record they wish to review.

.3 The cost to a copy a medical record is fifty (50) cents per single sided page (one dollar for a two-sided page). The patient must have sufficient funds available in his or her spendable account to cover the entire copying cost before the information is duplicated and released. Records requiring mailing shall have the cost of postage calculated and included in the record cost.

.4 Indigent patient shall be required to sign a Purchase Agreement form [DCR 0477] authorizing the copying cost to the withheld from the patient's account prior to record duplication.

.5 Patients are restricted to one full medical record data set per year.

.6 A patient review of the paper medical record or a paper copy of the electronic medical record shall be granted when sufficient facility staff is available to oversee the review at no cost to the patient. The patient shall not alter the record and shall leave the record in the clinic upon completion of the review.

.7 The CMR shall create a patient file for the paper copies of the electronic medical record adding any additional review data to the file as the patient requests future medical record reviews.

.8 A record review shall be limited to no more than thirty (30) minutes per session and is restricted to one review per every six (6) months.

.9 Except as provided for by proper authorization, a patient shall not have access to any medical information relating to another individual.

.10 Facility health care personnel shall not interpret any medical information released to the patient.

.11 A facility physician may choose to complete a summary of the patient's medical history in lieu of copies of the medical record data set. The copy cost of the summary is fifty (50) cents per page.

.12 The Paper Medical Record Data Set consists of the following:

a. Medical History and Physical Examination
b. Post Mental Health Evaluation
c. Multidisciplinary Progress Notes
d. Medication Administration Record
e. Emergency Room, Hospital and Consultation Reports
f. Diagnostic and Laboratory Reports
g. Dietary Documents
h. Injury Reports

.13 The Electronic Medical Record Data Set consists of the following:

a. Encounters
b. Labs
c. Diagnostic Imaging
d. EMAR (electronic medication administration record)
e. Patient Housing

AND the following scanned document directories:

a. Advanced Directives
b. Consent Forms
c. Consults/Referrals
d. Court Documents
e. Diet Memos
f. Drawings
g. EKG/Cardiac Testing
h. Emergency Logs/ER/Acute Admissions Records
i. Health Status Classification
j. Intake Screening
k. Lab Documents
l. Logs
m. Mainland Records
n. Medical Infirmary Forms
o. Medical Request Forms
p. Mental Health Assessment/Treatment/Diagnostic Forms
q. Mental Health other
r. Photos
s. Rehab Treatment Records
t. SRE/Restraint/Logs/Orders
u. X-rays/Diagnostic Imaging

.14 Upon release of medical record information requested to the patient, it shall be the patient's responsibility to protect the confidentiality of the information. The State of Hawaii, the Department of Corrections and Rehabilitation, the facility the Health Care Section and all correctional employees, contractors, business partners or associates shall not be held responsible for the further dissemination of the information once it is released to the patient.

5.0 PROCEDURE

.1 All requests for record inspection or copying shall be subject to the following:

a. Upon receipt of a valid written request from a patient to copy or inspect the patient's medical information, the CMR shall review the medical record for information that is not part of the paper medical record data set or may be protected from disclosure to the patient under Hawaii Revised Statues or this policy. Such information shall be removed from the original paper

medical record prior to duplication or review or shall not be included in the paper copy of the electronic medical record for the patient's review.

b. Medical information that is commingled with non-medical information that is exempt from disclosure, or information that may reasonably be expected to cause danger to the life or safety of an individual or the safety of the institution, the non-medical information shall be redacted or segregated prior to duplication or review. Working tools, informative or tracking tools, screenings and Quality Improvement instruments that are temporarily maintained in the paper medical record for auditors prior to an audit, shall be removed from the record prior to duplication or review.

c. The treating provider shall determine if the requested medical information poses a potential detrimental effect on the patient's health. Should that determination be made, the patient shall be notified of this decision using the In Receipt of Request for Information [DCR0487]. The CMR shall advise the patient that he or she has the right to appeal this decision through the facility grievance process.

d. The patient shall not be required to disclose the purpose of the medical record request however sufficient information must be provided to properly identify the record or the information requested.

Record Review

.1 Patients shall submit a medical request to the Health Information Section or CMR requesting to be scheduled for an appointment to review their health record information.

.2 Medical record reviews shall be conducted when staff resources are available, with the frequency limited to every six (6) months. Each review session is limited to thirty (30) minutes.

.3 Patient reviews of the electronic medical record shall be conducted by printing the electronic record data set at no cost to the patient. The patient shall follow the same guidelines as required for reviewing an original paper record. The copy of the electronic record shall remain in the clinic in a patient specific file for reference should future requests for a medical record review occur.

.4 An appropriate location shall be designated for the review of the medical record. The location of the review shall be such that a Correctional Officer is in sufficient

proximity to the patient to observe that nothing is removed or damaged from the paper original record but not so close as to be able to read the record content.

.5 Correctional employees are not required to transport original medical records to the requester for review, except for locations within a facility.

.6 All medical record information provided for review shall be recorded on DCR 0490, Information Reviewed or Released from this Medical Record. The form shall be filed in the record under the Miscellaneous Index, Sub-Section: Consent in the original paper record and scanned under Document Management/Misc. Section in the electronic record. Once the document is verified as having scanned successfully, it shall be shredded.

.7 The CMR shall seal the medical record prior to the scheduled record inspection and deliver the record to the review site and witness the patient breaking the seal. The CMR shall retrieve the record from the patient upon completion of the review session.

Record Copying

.1 Patients shall submit a medical request to the Health Information Section or CMR to request a copy of their health information.

.2 The CMR shall release the requested documents to the patient by the tenth (10) working day from the date of the receipt of the request for information.

.3 The cost to copy a medical record information is fifty (50) cents per single sided page (one dollar for a two-sided page). The patient must have sufficient funds available in his or her spendable account to cover the entire copying cost before the information is duplicated and released.

.4 The CMR shall inform the patient of any non-processable requests within ten (10) working days of the request submission using the In Receipt of Request of Information form [DCR 0487]. The reason the request cannot be processed shall be documented on the form.

.5 Form DCR 0487, In Receipt of Request of Information, shall also be utilized to notify a patient when unusual circumstances will delay the record release beyond the stipulated ten (10) working days. The deadline for the release of records maybe extended up to an additional ten (10) working days to a total of twenty (20) working days from the date of the request.

.6 Indigent patients shall be required to sign a Purchase Agreement form [DCR 0477] authorizing the copying cost to be withheld from the patient's account prior to record duplication. Patients refusing to sign the agreement shall not be provided with the requested medical record documentation.

.7 The number of pages copied and cost per page shall be forwarded to the facility fiscal office, patient accounting, on Form DCR 0485, Cost to Patient for Copies of Medical Records.

.8 Patients are limited to one complete data set per year unless the patient is involved in a verifiable legal action, where additional health information occurring after the release data of the complete data set and before the next annual data release date is required. Under this circumstance, patients must:

a. Submit a medical request for copies of the additional health information,

b. Have sufficient funds available in his or her account, or if indigent, sign a Purchase Agreement form to cover the entire copying cost prior to the duplication of the requested information.

.9 The CMR shall secure the requested information in an envelope marked "Confidential" and shall be given to an assigned nurse to personally deliver the envelope to the patient.

.10 The patient shall sign for the released documents on the data release record.

.11 The patient shall be responsible for the further copying, release or distribution of medical information released to him or her.

.12 The patient shall be responsible for the safe keeping of released health documents. Patients shall be responsible for the replacement copying costs should released records become lost or damaged. Replacement documents shall be copied as time allows and shall not be subject to a ten (10) working day turn.

.13 All information released from the medical record shall be recorded on form DCR 0490, Information Reviewed or Released from this Medical Record including the documents or date range of documents released, date of the release, the signature of the releasing person and the patient. The forms shall be field in the medical record in the Miscellaneous Index, Sub-Section: Consent in the original

paper record and scanned under Document Management/Misc. section in the electronic record. Once the document is verified as having scanned successfully, it shall be shredded.

.14 Patients with concerns regarding a possible error in their medical record may submit a written statement to the CMR documenting the concern.

.15 Upon receipt of a valid request to correct an alleged erroneous entry in the medical record, the CMR shall consult with the Clinical Section Administrator and/or staff member involved to review and assess whether or not the information is:

a. Accurate – the CMR shall inform the patient in writing that the request to amend the record is denied and the reason for the denial. In addition, the patient shall be notified of their right to write a concise statement regarding the alleged error setting forth his or her disagreement with the refusal to amend or correct the medical record. Patients do not have the right to request removal of medical record documentation from their record.

Upon receipt of a patient disagreement statement, the staff member originating the entry shall initial the disagreement statement from the patient and the CRM shall add the statement to the medical record. The statement of disagreement shall be filed with the document in question, if possible, or in the Miscellaneous Index, Subset: Correspondence of the medical record.

b. Erroneous – The erroneous entry shall be amended, corrected, or removed from the data set depending on whether it is in an original paper or electronic medical record and if the error is a misfiling of a document or an entry error. If the entry to be corrected is a self-contained sheet(s) or report(s) such as a laboratory or consultation report that is not commingled with any other information, a misfiled document the determination may be made by the CMR to remove it from the original paper or electronic record.

Erroneous data that is comingled with other necessary and accurate information on an original paper record such as handwritten documentation occurring on the incorrect chart shall have the entry lined or "X" out. The erroneous entry shall be marked "error" and shall be dated and initialed by the person who made the erroneous entry. If available, corrected information shall be added to the data set as an addendum or late entry and shall reference the patient's request.

Erroneous data discovered in the electronic record shall be corrected by adding an addendum to the document containing the error explaining the error followed by the name and date of the person making the entry. All data entries and modifications made to the electronic medical record shall be tracked by data logs retrievable by Health Care Administrative staff.

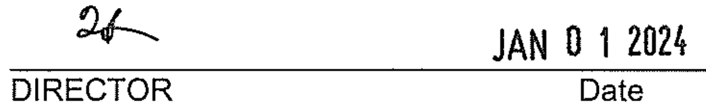
The CMR shall inform the patient that the requested changed were made.

APPROVAL RECOMMENDED:

JAN 0 1 2024

Deputy Director for Corrections — Date

APPROVED:



JAN 0 1 2024

DIRECTOR — Date