

UNIVERSITY PHYSICIANS OF BROOKLYN, INC.

POLICY AND PROCEDURE

		No: _____
Subject:	<u>DESIGNATED RECORD SETS</u>	Page <u>1</u> of <u>3</u>
Prepared by:	<u>Shoshana Milstein</u>	Original Issue Date: <u>NEW</u>
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Approved by:	<u>HIPAA Oversight Committee</u>	Approval Date: <u>12/02</u>
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- I. **Purpose:** To ensure that all records containing protected health information (PHI) that may be used to make prospective decisions about individual patients or their treatment are maintained as part of UPB's designated record set and are made accessible to patients, when requested, in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

II. **Definitions**

Records- Any item, collection or grouping of information that includes PHI and is maintained, collected, used or disseminated by or for a covered entity.

- III. **Policy-** UPB will permit patients to access and request amendment of any PHI maintained in UPB's or any of its business associate's designated record set.

A. Types of Records

1. The designated record set includes all groups of records containing PHI that may be used to make prospective decisions about individual patients or their treatment. This includes:
 - a. Medical records maintained by UPB or its business associate;

- b. Billing records; and
- c. Any other record maintained by UPB or its business associate to make prospective decisions about individual patients.
 - i. Quality assurance records, such as quality assurance reports and peer review records, and any other records used to retrospectively review the quality of care or services provided are not included in the designated record set.

2. There are circumstances where information contained in a designated record set may not subject to disclosure (See policy on Patient Requests for Access). Examples include, but are not limited to:

- a. Information maintained by a provider concerning or relating to the prior examination or treatment of a patient received from another provider (Ex: Correspondence records maintained in the back of each patient's medical record)- The patient should be referred to the original provider for access to these records;
- b. Information disclosed to a provider in confidence by another individual on the express condition that it would never be disclosed;
- c. Personal notes and observations maintained by the provider and not disclosed to any other individual.

B. Format of Records

1. Records may be in a variety of different formats, including:

- a. Handwritten notes;
- b. X-rays;
- c. Printouts or readings from equipment;
- d. Index or note cards;
- e. Electronic databases, spreadsheets or documents; or
- f. Microfiche, magnetic tape, diskette or CD.

2. Duplicate information (Ex: The same information maintained on index cards and in electronic databases)

- a. Patients need not be granted access to duplicate records containing the same information.
- b. If a duplicate copy of a record is altered from the original in any way, the patient has a right to access both records.
- c. Approved patient amendments must be made throughout the designated record set, including duplicate records.

IV. Responsibilities: It is the responsibility of all medical staff members and practice staff members to comply with this policy. Medical staff members include physicians as well as allied health professionals. Practice staff members include all employees, medical or other students, trainees, residents, interns, volunteers, consultants, contractors and subcontractors at the practice.

V. Reasons for Revision- Regulatory changes

VI. Attachments- None

VII. References- Standards for Privacy of Individually Identifiable Health Information, 45 CFR §164.501, §164.524(e)(1), §164.526(c)(1), NY Public Health Law §18(1)(e)