TRI-COUNTY MEDICAL ASSOCIATES, INC.

Effective Date: September 2016 **Manual:** Operations
Distribution: All Departments

Originating Dept. Operations
Committee:
Senior Management:

Senior Administrator	**Signature:**	Nancy Jolicoeur **Nancy Jolicoeur**
Corporate Compliance Liaison Officer	**Signature:**	Zofia Bibeault **Zofia Bibeault**
President	**Signature:**	Philip Ciaramicoli **Philip Ciaramicoli**
Medical Director	**Signature:**	Elizabeth Siraco, MD **Elizabeth Siraco, MD**

____ **New**
__X__ **Supersedes:** Medical Records Release Policy (Policy Name) | 5/1/2009 (Effective Date) | N/A (Origination Date)

Subject: Medical Records Release Policy

Purpose: To define the process to release patient medical records.

Policy: The medical record is the property of Tri-County Medical Associates, Inc. (TCMA). It is maintained for the benefit of the patient and the medical staff. It is TCMA's responsibility to protect the record against loss, defacement and tampering, as well as unauthorized use.

Health Insurance Portability and Accountability Act (HIPAA) permits TCMA to disclose patient medical information for treatment, to obtain payment and for health care operations without written authorization. Written authorization, signed by the patient or legally qualified representative, is required for all other disclosures of patient information.

Procedure:

Receive the Request:

- Stamp the date received on the request.
- Start a Patient Authorization update in the Electronic Medical Record (EMR). At a minimum, enter the received date and the requestor's name. Hold the document to the Medical Records Coordinator.

Verify the Authorization:

- The Medical Records Coordinator, will review all authorizations for completeness and appropriate signatures. Whenever possible, the TCMA form "Authorization for Release of Information" (sample attached) should be used. If a different release form is received it must be reviewed to ensure it contains at a minimum the data on the TCMA form. If it does not, the patient must complete and sign a TCMA form prior to the release of any information.
- If the patient is deceased it is necessary to obtain a copy of the probate documents to ensure the requestor is entitled to the medical record.
- If the patient is under the age of 18 and not an emancipated minor, the parent or legal guardian must sign the "Authorization for Release of Information".
- Subpoenas and requests from attorneys where the reason is not obvious (i.e. auto accident, worker's compensation, etc.) will be reviewed by the Director of Risk Management prior to taking any action.

Print/Copy Records:

- Particular attention should be paid to patient restrictions regarding the release of information relative to alcohol and controlled substance abuse, psychiatric/social services issues, venereal disease, HIV or AIDS status, domestic abuse and sexual assault treatment and genetic testing. In the EMR, review the history tab and the patient's problem list for this type of data. Also, on the documents tab at the top of the chart, select document types 'HIV' and 'confidential' to see if these documents are contained in the record. Keep in mind that all pre-natal patients will have HIV testing and likely genetic testing. If the record contains any information regarding these issues the patient must specify that this data can be released.
- Requests for records for specific dates of service and/or related to a particular incident (i.e. auto accident) should only receive the requested material. If no records exist for the requested information the request should be returned to the requestor stating this.
- Requests for the entire chart should include all services rendered by TCMA, services ordered by a TCMA provider, including consultations and related services. Records from paper charts will be photocopied and records from the EMR will be printed. If the chart contains prior medical records from a non-TCMA provider, these may also be released.
- Print the chart from the EMR and obtain a copy of the paper chart from the warehouse, if necessary. Verify scanned documents are in the correct chart. If a document is scanned into the incorrect chart, scan the document into the correct chart and notify the Director or Risk Management so the document can be removed from the incorrect chart.
- Write on the "Authorization for Release of Information" form the date the records were released. The completed form and any supporting documentation will then be scanned into the patient's chart.

Charging for Records:

- A fee may not be charged for requests from the Social Security Administration or any state financial needs based program or court ordered records. All other requests, including requests directly from the patient, may be assessed a fee.
- The charge for copying medical records is a base fee of $22.30 for each request. In addition, the cost per page is .75¢ for the first 100 pages and .39¢ per page in excess of 100 pages. The maximum self pay fee charged will be $50.00 for adults and $20.00 for children. An additional $25.00 is added if record retrieval from storage is required. Once the fee has been calculated, generate a Medical Records Charge Letter (sample attached) from the EMR and send the bill to the requestor. Note the date the invoice was sent in the Patient Authorization update.
- The fee for copying medical records must be paid prior to releasing the records.
- Checks and Credit Cards are both acceptable forms of payment. Checks should be made out to TCMA. Credit Card information can be received by phone by completing the "Credit Card Information" form (sample attached) from the Cash Office.

Mailing Records:

- Confirm the postage machine is set to the correct cost center (9916 warehouse).
- The envelope/package should be weighed and a stamped tape printed and adhered to the item. The item can be dropped in the outgoing mail box.

Verifying Patients Picking Up Records:

- Persons picking up medical records must present photo identification to verify their identity. The identification should be copied and scanned in the patient's chart with the authorization form.
- If the patient has requested another individual to pick up their medical records, the patient must sign a statement indicating this and naming the individual that will be picking up the records. This individual will be required to show photo identification and the verification process stated above will be followed.

Subpoenas:

- All subpoenas shall be reviewed by the Medical Records Coordinator and the Director of Risk Management. Particular attention should be paid to the due date. Generally, a timely response will prevent the need for court appearances. If a court appearance is necessary contact the Director of Risk Management. A signed patient release is not necessary for subpoenas.

Certification of Medical Records:

- If the request requires certification of the medical records, print the certification form from the EMR (sample attached) and complete as necessary.

Tri-County Medical Associates, Inc.
9 Industrial Road, Suite 5 • Milford, MA 01757
h: 508-473-1480 • Medical Records Fax: 508-478-0694
Affiliated with Milford Regional

Tri-County Medical
The Benchmark for Quality Care

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

PATIENT INFORMATION

Patient Name:_____ Patient Date of Birth:_____

Patient Address: Street:_____ Apt #:_____

City:_____ State:_____ Zip:_____

Telephone Contact #: Day:_____ Evening:_____

E-Mail Address:_____

Physician/office providing the information:

_____

_____

_____

Person(s)/organization receiving the information ***(please provide complete mailing address)***:

_____

_____

_____

PURPOSE

(Please check the appropriate box)

- ☐ I am receiving treatment by a specialist.
- ☐ Insurance
- ☐ Legal Matter
- ☐ Personal
- ☐ School
- ☐ Other (please specify) _____
- ☐ I am transferring my care to another healthcare provider.

  May we ask why you are leaving?

  - ☐ Moving
  - ☐ Change of insurance
  - ☐ Dissatisfied (please explain)_____

    _____
  - ☐ Other

Continue Page 2 on Reverse

INFORMATION TO BE RELEASED

There is NO charge for:

☐ Patient summary, immunization record, most recent physical and labs.

There IS a charge for:

☐ Laboratory, X-ray or other Diagnostic Testing for Date(s) of Service: _____

☐ Office Notes for Date(s) of Service: _____

☐ Medical Record - Unless specified, only the last three years of the record will be sent.

Please answer YES or NO to each of the following questions, to indicate if we may release the information below (if it is in your medical record):

OYes ONo HIV/AIDS diagnosis and treatment.

OYes ONo Genetic test results and records relating to any genetic condition.

OYes ONo Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSIVELY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request.

OYes ONo Other(s): Please list
Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (*I understand that my permission may not be required to release my mental health records for payment purposes)*

OYes ONo Confidential Communications with a Licensed Social Worker

OYes ONo Details of Domestic Violence Victims' Counseling

OYes ONo Details of Sexual Assault Counseling

OYes ONo Details of Sexually Transmitted Disease

Incomplete forms will be returned and could delay your request.

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Tri-County Medical Associates, Inc.
- I understand that this authorization will automatically expire in 12 months unless otherwise specified:

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ **Date:** _____

Signature of Legal Representative: _____ **Date:** _____

Print Name:_____ **Relationship of representative to patient:**_____

Please note: Tri-County Medical Associates may charge a fee for copies

Tri-County Medical

The Benchmark for Quality Care

CREDIT CARD INFORMATION

LOCATION/PROVIDER NAME: _____

PATIENT ACCOUNT NUMBER: _____

PATIENT NAME: _____

PATIENT STREET #: _____ZIP CODE: _____

CC#_____

Type: Visa ☐ MC ☐ AMEX ☐ Discover ☐ Flex Card ☐

EXPIRATION DATE: _____ SEC Code (3) digits: _____

DATE OF SERVICE: _____

CHARGE AMT: $_____ 30% PROMPT PAY adj to be posted ☐ Y or ☐ N

Please be sure to verify the address!

DATE: _____ TAKEN BY: _____

PATIENT REQUESTS RECEIPT: ☐ YES ☐ NO

AUTH#_____

Updated: 09/10/15

Tri-County Medical Associates, Inc.
9 Industrial Road
Milford, MA 01757
508-473-1480 Fax: 508-473-1210

Medical Records Fax: 508-478-0694

Tri-County Medical

Date: {

To:

RE: DOB:

_____ Please let us know how many years of your medical record you are requesting. There is a fee up to $50.00 for medical records. An additional $25.00 is added if record retrieved from storage is requested.

_____ We have no records for this patient for the dates of service specified.

_____ Patients must complete and sign the enclosed medical record release form prior to releasing these records. Please answer yes or no to questions on page 2.

_____ Please forward payment of $_____, payable to Tri-County Medical Associates. The requested material will be sent upon receipt of payment.

Information that may be released at no charge includes: patient summary, immunization record, most recent physical and labs. If you would like this option please circle and return.

Sincerely,

Medical Record Department

Certification of Medical Records
Under M.G.L. c233, §79G

I hereby attest that the attached record is a true and accurate medical record of the treatment rendered to _____ which I hereby certify under Massachusetts General Laws, Chapter 233, Section 79G and Chapter 111, Section 70.

Subscribed and sworn to under the penalties of perjury.

_____ _____

Medical Provider or Authorized Agent Date