Release of Information in California: General Releases

E-book Series, 2 of 12

The Release of Information (ROI) in California is a series of 12 E-books that will help you navigate and understand the complex state and federal laws, as well as best practices related to managing and releasing protected health information. The ROI E-book series contains content that falls under HIPAA, federal regulations, and is specific to California state laws.

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Table Of Contents

Acknowledgments ........................................................................................................................................ III

ROI E-book Series ................................................................................................................................ IV

Forward .................................................................................................................................................. V

Release with and without authorization .............................................................................. 1

Definition of ‘patient’ and ‘patient records’ ........................................................................ 1

Release of patient information and authorization ...................................................... 1

To copy records or complete a narrative summary? ..................................................... 1

Required contents of a narrative summary ........................................................................ 1

Patient’s right to access protected health information ............................................. 2

Relevant laws ................................................................................................................................. 2

Person granted access .................................................................................................................. 2

  Patient .................................................................................................................................. 2
  Personal Representative ........................................................................................................... 2
  Executor or administrator ....................................................................................................... 2

Records covered for patient access ................................................................................. 2

Authorization consents and completion ........................................................................ 3

Procedures for releasing information .............................................................................. 4

Turnaround time for response to patient record ........................................................ 4

Allowable charges for providing release of information ......................................... 5

Electronic copies ......................................................................................................................... 5

Treatment, payment and operations (TPO) ................................................................. 5

Treatment ........................................................................................................................................ 5
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples of release for treatment purposes</td>
<td>6</td>
</tr>
<tr>
<td>Payment</td>
<td>6</td>
</tr>
<tr>
<td>Examples of release for payment purposes</td>
<td>6</td>
</tr>
<tr>
<td>Health care operations</td>
<td>7</td>
</tr>
<tr>
<td>Examples of release for operation purposes</td>
<td>7</td>
</tr>
<tr>
<td>Resource</td>
<td>8</td>
</tr>
<tr>
<td>Patient Authorization for Release of Information form</td>
<td>9</td>
</tr>
<tr>
<td>Self-Assessment Quiz</td>
<td>12</td>
</tr>
</tbody>
</table>
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Instructor

Donna Paine has served the HIM community in various capacities since April, 1979. Spending her entire career specifically in the area of release of information, Ms. Paine has held different posts within three nationally-based corporations. In all three companies, she served as a vice president. Since 1999, Ms. Paine has been the owner and President of Trackstar Release of Information Services. Working within Southern California, she considers herself fortunate to work with colleagues she has known for many, many years. Education in California, Ms. Paine holds a bachelor of science degree in Business Administration.

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Each ROI E-book includes an overview of the topic and extensive references. Self Assessment Quizzes are designed in multiple-choice and true/false format, and assess your understanding of the subject matter. A link to the Quiz is provided with each purchased E-book, and corrected answers will be displayed so you can receive automatic feedback.

Upon completion of the Self Assessment Quiz, a Certificate of Completion (CEU) will be made available to download and print. You will not be able to access the Certificate after exiting the Quiz, so be sure to download it immediately and retain as evidence of the earned continuing education.

<table>
<thead>
<tr>
<th>Product Code</th>
<th>Release of Information in California:</th>
<th>CEU’s Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-book 001</td>
<td>Introduction **</td>
<td>Two</td>
</tr>
<tr>
<td>E-book 002</td>
<td>General Releases</td>
<td>Two</td>
</tr>
<tr>
<td>E-book 003</td>
<td>Medical Records and the Court System</td>
<td>Three</td>
</tr>
<tr>
<td>E-book 004</td>
<td>Workers Compensation</td>
<td>Three</td>
</tr>
<tr>
<td>E-book 005</td>
<td>Child, Dependent and Elder Abuse</td>
<td>Two</td>
</tr>
<tr>
<td>E-book 006</td>
<td>Coroner’s Office</td>
<td>Two</td>
</tr>
<tr>
<td>E-book 007</td>
<td>Public Health Agencies</td>
<td>Two</td>
</tr>
<tr>
<td>E-book 008</td>
<td>Business Associates</td>
<td>Two</td>
</tr>
<tr>
<td>E-book 009</td>
<td>Government Agencies</td>
<td>Two</td>
</tr>
<tr>
<td>E-book 010</td>
<td>Inmates</td>
<td>Two</td>
</tr>
<tr>
<td>E-book 011</td>
<td>Law Enforcement</td>
<td>Two</td>
</tr>
<tr>
<td>E-book 012</td>
<td>Special Health Records</td>
<td>Two</td>
</tr>
</tbody>
</table>

** CHIA recommends you read the *Release of Information in California: Introduction* E-book first. This E-book is offered at no charge and includes the “Glossary of Terms” that is used in all subsequent ROI E-books.

Additional CHIA Resources

To view sample pages or purchase these E-books, or to view more details about CHIA’s publications and Webinar Replays, visit [www.CaliforniaHIA.org/Resources](http://www.CaliforniaHIA.org/Resources)
Forward

The purpose of this E-book is to provide accurate and authoritative information on proper and adequate disclosure of health information. The California Health Information Association (CHIA) is not engaged in rendering legal services, and providing legal advice is beyond the scope and intent of the E-books.

Release of Information in California: General Releases

These days, patients are encouraged to keep their personal health records [visit http://www.myPHR.com]. For this reason, it has become crucial for the health information management (HIM) department staff to act as an advocate for each patient who enter the HIM department. As the patient advocate, it is important for you to know that all patients possess the right to have their medical records released, even if the patient is deceased!

This E-book will help you to understand when and to whom patient records can be released with and without authorization.

Student Learning Outcomes and Objectives

Upon completion of the CHIA Release of Information in California: General Releases E-book, students will be able to:

- Articulate the importance of releasing patient-specific health information according to current laws and regulations
- Understand and appreciate the complexities and responsibilities inherent to releasing protected health information to internal and external requestors
- Understand the importance of maintaining the confidentiality of patient records and protected health information (PHI).
- Utilize resources to maintain current competencies and keep abreast of changing requirements
- Define the basic terms associated with patient privacy and release of patient information.
- Describe federal and state legislation regarding patient privacy and release of information.
- Differentiate between the different state of California and federal laws regulating release of patient-specific information and apply them appropriately in all situations.
- Understand the release of information with and without authorization to/for: Patients, patient’s family, minors, deceased patients, and/or the patient’s legal representative.
Release of Information in California: General Releases

Release with and without authorization

Definition of 'patient' and 'patient records'

According to the California Health and Safety Code, Section 1603.3, 123105 (c), “a ‘patient’ means a former patient of a health care provider.”

‘Patient Records’ are defined under this same California Health and Safety Code, Section 1603.3, 123105 (d), as:

“Patient records means records in any form or medium maintained by, or in the custody or control of, a health care provider relating to the health history, diagnosis, or condition of a patient, or relating to treatment provided or proposed to be provided to the patient.”

‘Patient records’ include only records pertaining to the patient requesting the records or whose representative requests the records. ‘Patient records’ does not include information given in confidence to a health care provider by a person other than another health care provider or the patient, and that material may be removed from any record prior to inspection or copying under Section 123110 or 123115. ‘Patient records’ does not include information contained in aggregate from, such as indices, registers or logs.

Release of patient information and authorization

In clinics, physicians’ offices, hospitals, etc., requests for medical records will arrive in many different ways. The medical facility may receive requests from patients who walk through the doors and sign an authorization for release of their records. Other ways requests for patient information are received include through the mail, via the fax, or even with a subpoena.

To copy records or complete a narrative summary

A medical facility may give patients the choice of receiving copies of their medical records or a “summary” of their records. A patient, however, must agree in advance to a summary and the fees associated with creating the summary.

Additionally, the provider may give a verbal summary of the patient’s information if the patient agrees in advance. (Health and Safety Code Sections 123110 and 123130; 45 C.F.R. Section 164.524 (c)(2)(ii).

Required contents of a narrative summary

The patient’s entire record must be summarized unless the patient limits his or her request to specific injuries or illnesses.