SAN FRANCISCO HEALTH PLAN
Here for you

Policy and Procedure

Subject:	Release of Medical Records
Facility Site Review Source:	Department of Health Care Services (DHCS) All Plan Letter 20-006, Site Reviews: Facility Site Review and Medical Record Review or any superseding APL
Relevant Law/Standard:	Title 45, Code of Federal Regulations Section 164.524. The CFR is searchable at: https://www.ecfr.gov Confidentiality of Medical Information Act CALIFORNIA CIVIL CODE SECTIONS 56-56.16 Health Insurance Portability and Accountability Act (HIPAA) sets national standards for the security of electronically stored or transmitted medical data. 22 CCR 73524, 22 CCR 51009, and Title 45, Code of Federal Regulations Section 164.524
Agency/Organization Source:	
Agency/Organization URL	

Background:

Medical records are considered highly sensitive, available only to those who need to know and/or have been given consent. Federal laws, CFR § 164.520, govern the privacy protection of medical records, along with some state laws. California Health & Safety Code Section 123100 et seq. establishes a patient's right to see and receive copies of his or her medical records, under specific conditions and/or requirements. California medical records laws state that a patient's information may not be disclosed without authorization unless it is pursuant to a court order, or for purposes of communicating important medical data to other health care providers, insurers, and other interested parties.

Purpose:

A system must be in place at the clinic to assure the confidentiality of client records. The system is compliant with State and Federal Regulations when a release of protected health information is requested.

Definitions:

1. Medical Information is any individually identifiable information that is kept in either physical or electronic form.

2. Medical Record is any recorded information, regardless of medium or characteristics. A "medical record" includes both clinical and non-clinical information, from the patient's medical history and demographics to relevant clinical research and financial data. There is no one-size-fits-all definition, and your practice should clearly define a "medical record" as it relates to the systems in place at your individual practice.

Procedure:

1. Parties required to comply with the Medical Information Act include heath care providers, health care service plan providers (insurers), pharmaceutical companies, and any other entities involved in handling sensitive medical data.
2. Ensure the security of electronically stored or transmitted medical data according to the federal Health Insurance Portability and Accountability Act (HIPAA)
3. A primary care provider must permit the patient to view his or her records during business hours within five working days after receipt of the written request.
4. A valid authorization to release protected health information includes:
    a) Identity verification such as a driver's license.
    b) A description of the information to be used or disclosed.
    c) The name of the person or organization authorized to disclose the information.
    d) The name of the person or organization that the information is to be disclosed.
    e) Signature of the person authorized to release the information.

Resource:

1. Find sample ROI authorization form attached

_____ _____
First Name Last Name – Title Date

_____ _____
First Name Last Name – Title Date

Appendix A:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize _____ to
(Name of individual) (Name of person or facility which has information)

release the following health information:

_____

To:

_____
(Name of person/title or facility to receive health information)

_____ _____ _____
(Street address, city, state, ZIP code) (Telephone number) (Fax number)

For the purpose of: _____

_____

This authorization is in effect until _____ (date or event) when it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I understand that this authorization is voluntary.
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this authorization.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT

Signature **Date**