Policy and Procedure

McMinnville Free Clinic

PATIENT CONFIDENTIALITY AND MEDICAL RECORDS

LAST BOARFD REVIEW DATE: 5/4/17
LAST QA REVIEW DATE: 04/20/17
INITIAL APPROVAL: 8/27/12

Policy

McMinnville Free Clinic (MFC) is committed to protecting patient confidentiality, including paper and computer records, and following applicable state and federal statutes, including HIPAA, in the protection of them, to the best of our ability.

Procedure

RECORD DEVELOPMENT AND CONFIDENTIALITY

1. Upon first entering as a patient of MFC, the Consent to Treatment Form will be reviewed and signed. A medical record will be established for each patient.

2. Records will be filed alphabetically by last name, using date of birth as a confirmation of patient identity as needed.

3. All patient medical records (paper and electronic) and the information contained within shall be kept confidential in accordance with applicable federal and state statutes, including HIPAA, to the best of the staff's abilities.

4. Paper records shall be kept in a locked cabinet in a locked room when staff is not present. Electronic records shall be kept on a secure database protected by password systems that are only accessible by MFC staff. All records are the property of the McMinnville Free Clinic.

5. All clinic staff shall be educated regarding patient confidentiality and HIPAA and each person is responsible for maintaining security and confidentiality of these records, verbal and written.

RECORDS REVIEW

1. While patients are at clinic and seen by providers, the medical records are checked for general completeness (signatures, etc.) by receptionists, nurses, provider assistants, and providers. Medical Records performs the final review and the chart is filed once completed.

2. As patient lab/imaging, etc. results return, they are reviewed by a licensed nurse or medical provider and review documented before filing. Patients are notified of results as indicated by the provider and scheduled for follow-up appointments as requested.

3. Peer review of records will be completed as a part of each clinic (a minimum of one chart per clinic provider) to assure completeness of documentation within the record. Also see quality assurance policy.

RELEASE OF INFORMATION AND ACCESS TO RECORDS

1. Release of information contained in the patient's medical record requires written consent, which is filed in the patient record with the date records sent (and what records were sent) noted.

    a. For those under fifteen (15) years of age, parents must provide this consent, except in cases of communicable diseases (including STDs), mental health issues, family planning, and alcohol and drug treatment.

    b. For those fifteen (15) years of age and older, either the patient or the parent may provide consent. Patients eighteen (18) years of age and older need to sign their own request and sign a release of information for anyone else to receive information, including parents and other family members.

    c. Oregon law allows parents/guardians of minors (those under 18, not married, and not legally emancipated) access to their medical records even though persons fifteen (15) years of age and over can give consent for their own medical care. However, there are exceptions to this in the cases of sexually transmitted diseases, mental health issues, family planning, and alcohol and drug treatment: see second section.

2. Any part of the record containing information about sexually transmitted diseases (with the exception of HIV status, which may not be released without separate, specific client consent), mental health issues, contraceptive use, or drug or alcohol problems may be released to the parents of patients under the age of eighteen (18) only in accordance with

ORS 109.610, ORS 109.640, and ORS 109.675, if the provider feels that it is in the best interest of the client.

a. Patients over the age of 14 may consent to mental health care (including alcohol and drug treatment) without parental consent and should specifically consent for their mental health records to be released to their parents or elsewhere.

b. Those of any age may seek family planning or STD evaluation or treatment without parental consent and should specifically consent for these records to be released to parents or elsewhere.

c. If possible, the clinic staff should inform the patient if such information is contained in their health record prior to consent.

3. The decision to release a copy of a patient's medical record will be made using the guidelines above.

a. Client/Parent/Guardian will sign MFC records release (including specialized release for STD, Alcohol and Drug, Mental Health records), and staff will be given records request.

b. Staff will assess the request, using the guidelines and will determine what records may be released in accordance with HIPAA and Oregon State guidelines. Medical records received from other providers are not to be released.

c. The consent and the records that the consent allows to be released will be copied and given/mailed or faxed to the requesting body.

d. A notation will be made on the consent as to what information was sent, date, and signature, and the original consent will be placed in the chart.

e. If it is determined that records cannot be released, the reason for said denial will be noted in the progress notes, and the requesting body will be notified if appropriate that by law they cannot be released (without a specific reason given in order to protect patient confidentiality).

f. Requested records or denial of such a request will be sent to the requesting party within five (5) business days (business days being defined as days that MFC is open) or thirty (30) days, whichever is sooner.

4. When MFC is requesting medical information, the Authorization for Release of Information form is to be completed by the patient. A copy of this form is filed in the patient's record after being faxed or mailed.