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| MEDICAL RECORDS - CONFIDENTIALITY | | | | NO. 172B | |
| POLICY:  The medical record is the property of the facility and is maintained for the benefit of the patient, physician, and the facility. The contents of the medical record are privileged communication and in all aspects of the work performed in the medical record, the confidential nature of the record must be respected.  PROCEDURE:  1. Confidentiality  All employees within the facility must be assigned the responsibility for maintaining the confidentiality of the medical record. The employee must recognize this responsibility to hold all information in confidence and is aware of the legal penalties which may be imposed for unauthorized disclosure of such information.   1. A chart or any material from the chart may be seen or removed from the nursing station only by authorized staff. 2. The chart or material from it may NOT leave the patient care unit without special exception by the Administrator or Medical Director, who then assumes the responsibility for the individual authorized to remove the chart or portion of its content. 3. Absolutely No Information from the chart is to be given to anyone other than authorized individuals. Individuals not authorized to see or remove chart contents are to be referred to the Administrator, the DON, or Director of Social Services during regular hours. During off-duty hours the Administrator, the DON, or Director of Social Services should be notified. Only she may authorize any subsequent action. 4. When the chart or any contents of the chart are to be removed from the facility, it is to be placed in a manila envelope, sealed and labeled, "Medical Records - Confidential Material." The chart must be delivered into the hands of the individual requesting it. The chart and/or its contents must be returned to the unit as soon as possible.   2. Location of the Medical Record  All medical records are kept in the nursing station or Area in an individual chart holder or "back file" for excess material.   1. The physician's orders will be maintained in the medical record. Outdated material is to be placed in the patient's back file. | | | | | |
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| MEDICAL RECORDS - CONFIDENTIALITY , continued | | | | NO. 172B | |
| 1. The medication administration record will be kept in the medical record and will be placed in the patient's back file when thinned by Medical Records Dept. 2. When the chart has been authorized to leave a unit, a sign-out log located on the chart rack will be completed stating: Patient's name, where the chart has gone, name of the individual receiving the chart, and date and time signed out. 3. The back file will be an individual folder which will contain material no longer necessary for reference to daily care. The back file may be seen or removed from the file only by authorized individuals. 4. Release of Medical Information   It is the facility's policy to treat patient information in a confidential manner and all requests for medical record information must go to the Medical Records Department.   1. The only department authorized to release confidential patient information is the Medical Records Department. 2. A patient's authorization, subpoena or court order must be on file prior to the release of any information. The only exception would be a request from the patient's attending physician, or consulting physician, or the facility's legal counsel. 3. Fee covering cost for reproducing records will be at the current rate. Medical Records Dept. will bill the individual requesting such records as copies are sent. 4. A detailed procedure is in effect in the Medical Records Department and all inquiries respecting this policy should be directed to the Medical Records Coordinator   A release of information form is completed to allow medical records to be taken outside of the facility for appointments or other purposes per patient authorization only. | | | | | |
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