

UNIVERSITY PHYSICIANS OF BROOKLYN

POLICY AND PROCEDURE

Subject: DESIGNATED RECORD SETS

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Page 1 of 3

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Standards: Privacy of Individually Identifiable Health §164.526(c)(1), NY Public Health Law §18(1)(e1)

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I. PURPOSE

To ensure that all records containing protected health information (PHI) that may be used to make prospective decisions about individual patients or their treatment are maintained as part of SUNY Downstate's designated record set and are made accessible to patients, when requested, in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

II. POLICY

University Physicians of Brooklyn will permit patients to access and request amendment of any PHI maintained in SUNY Downstate's or any of its business associate's designated record set.

III. DEFINITIONS

Records- Any item, collection or grouping of information that includes PHI and is maintained, collected, used or disseminated by or for a covered entity.

IV. RESPONSIBILITY

It is the responsibility of all medical staff members and hospital staff members to comply with this policy. Medical staff members include physicians as well as allied health professionals. Hospital staff members include all employees, medical or other students, trainees, residents, interns, volunteers, consultants, contractors and subcontractors at the hospital.

DESIGNATED RECORD SETS

The development of the procedure section is the responsibility of the respective department. It is dependent upon the unique needs of each department's operating structure and shall be advanced and customized accordingly.

V. PROCEDURE/GUIDELINES

A. Types of Records

1. The designated record set includes all groups of records containing PHI that may be used to make prospective decisions about individual patients or their treatment. This includes:
 - a. Medical records maintained by or its business associate;
 - b. Billing records;
 - c. Research records or results maintained by UPB or its business associate; and
 - d. Any other record maintained by UPB or its business associate to make prospective decisions about individual patients.
 - i. Quality assurance records, such as quality assurance reports and peer review records, and any other records used to retrospectively review the quality of care or services provided are not included in the designated record set.
2. There are circumstances where information contained in a designated record set may not be subject to disclosure (See policy on Patient Requests for Access). Examples include, but are not limited to:
 - a. Information maintained by a provider concerning or relating to the prior examination or treatment of a patient received from another provider (Ex: Correspondence records maintained in the back of each patient's medical record)- The patient should be referred to the original provider for access to these records;
 - b. Information disclosed to a provider in confidence by another individual on the express condition that it would never be disclosed;
 - c. Personal notes and observations maintained by the provider and not disclosed to any other individual;

B. Format of Records

1. Records may be in a variety of different formats, including:
 - a. Handwritten notes;
 - b. X-rays;
 - c. Printouts or readings from equipment;
 - d. Index or note cards;
 - e. Electronic databases, spreadsheets or documents; or
 - f. Microfiche, magnetic tape, diskette or CD.
2. Duplicate information (Ex: The same information maintained on index cards and in electronic databases)
 - a. Patients need not be granted access to duplicate records containing the same information.
 - b. If a duplicate copy of a record is altered from the original in any way, the patient has a right to access both records.

DESIGNATED RECORD SETS

- c. Approved patient amendments must be made throughout the designated record set, including duplicate records.

C. Record-Keeping- In order to efficiently respond to patient requests for access to or amendment of their records, either one of the following two methods should be followed by all departments and clinics maintaining a designated record set relating to a particular patient:

1. A copy of each designated record set must be forwarded to the Health Information Management (HIM) Department.
 - a. New copies must be sent any time a staff member alters the record in any way, even with a small notation.
2. The department or clinic must notify the HIM Department the first time a designated record set relating to a patient is created (Ex: Hospital Business Office must notify HIM the first time it opens a billing file for a patient).
 - a. Notification for subsequent changes to a designated record set relating to the same patient would not be necessary.
 - b. Each department or clinic should document in the patient's designated record set when notification has been given to the HIM Department.
 - c. The HIM Department must keep a database of all the departments and clinics maintaining a designated record set on each patient so that it can respond to the patient's request for access to or amendment of his/her record.

VI. ATTACHMENTS

None

VI. REFERENCES

Standards for Privacy of Individually Identifiable Health Information, 45 CFR §164.501, §164.524(e)(1), §164.526(c)(1), NY Public Health Law §18(1)(e)

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