Patient Request for Records Policy	Department: General Operations	
Origination Date: 11/01/2021	**Effective Date:** 3/23/2022	**Next Review Date:** 3/23/2025
Policy Contact: Nicole Jobson, Nicole.jobson@wacbd.org	**Version:** #1	
Written By: Savannah Simmons, Savannah.simmons@wacbd.org		

PURPOSE: Washington Center for Bleeding Disorders (WACBD) strives to appropriately communicate patient care needs and ensures that requests on time sensitive information and other personal health information (PHI) are received within a timely manner. Following HIPAA, patients have the right to request copies and/or review their PHI at any time.

SCOPE: The scope of this policy applies to WACBD and WACBD patients

POLICY STATEMENT: WACBD will provide medical/ personal healthcare information upon the request of a patient or their legal representative in a timely manner as provided by Washington State regulations.

DEFINITIONS:

Term	Definition
Personal Health Information (PHI)	Protected Health Information means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. PHI, under HIPAA (Health Insurance Portability and Accountability Act), is any identifiable health information that is used, maintained, stored, or transmitted by a HIPAA covered entity, a healthcare provider, health plan or health insurer, or a healthcare clearinghouse, or a business associate of a HIPAA covered entity, in relation to the provision of past, present, or future healthcare or payment for healthcare services.
Records Set	Medical records, billing records, payment and claims records, health plan enrollment records, case management records, as well as other records used, in whole or in part, by or for a covered entity to make decisions about individuals.

PROCEDURES:

Procedure 1- Roles/ Responsibilities	
Providers	WACBD providers will review, complete, and sign off on patient PHI (test results, office visit notes, prescription refills, etc.) within a timely manner in the EMR system.
Administrative Assistant	WACBD administrative assistants will document patient request and verify information including fax number (if request is electronic) and consent form. They will either send out the requested, signed, PHI or will reach out to the clinical staff to have them do so.
Clinical Staff	Clinical team members will have patient complete WACBD's Authorization to Release Personal Health Information (PHI) in full when a patient requests their records be sent to an outside person/ facility. This will be completed for every outside

	person/ facility request and when the timeline on the form expires. The completed form will then be uploaded into the patient's chart

Procedure 2- Guidelines	
Request Time Frame	Federal rules under HIPAA ensures patient rights to their medical records. In Washington State, patients' rights are further protected under the Washington State Healthcare Information Access and Disclosures statutes and regulations. In Washington, healthcare providers must respond to patients' medical records request within 15 working days. If the request cannot be fulfilled within 15 working days, WACBD will inform the patient and specify in writing the reasons for the delay no longer than 21 working days after receiving the request. There is no charge to patient for any records request. Certain payers may be charged a fee per contract terms. WACBD must document the following and retain the documentation as required by 45 CFR § 164.530: (1) The designated record sets that are subject to access by individuals; and (2) The titles of the persons or offices responsible for receiving and processing requests for access by individuals.
Electronic/ Email Records	If a patient requests any PHI through email, all WACBD staff members must send the following through email to the patient before any PHI is released: *"Washington Institute for Coagulation d/b/a Washington Center for Bleeding Disorders, a Washington non-profit corporation, wishes to communicate with you via electronic communication (e-mail). Please keep in mind communications sent via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.* *By acknowledging and understanding the above statement, you are consenting to receive electronically transmitted notices under the Washington Nonprofit Corporation Act."* Once patients accept the risks and responsibilities, staff members may send requested PHI through email.
Patients	WACBD will collect the Patient Notification Consent form with every new patient, and it will be renewed every 3 years. Upon a request for medical records to be send to an outside person/ facility, a patient must complete the Authorization to Release Personal Health Information (PHI) form.
Non-patients	An individual, or the individual's personal representative, may direct WACBD to transmit the individual's PHI directly to another person or entity. Such a request must

	be in writing, be signed by the individual, clearly identify the person or entity being designated to receive the PHI, and state where the PHI should be sent. WACBD may accept an electronic copy of a signed request, as well as an electronically executed request that includes an electronic signature. If a patient is deceased, the personal representative of the Individual may exercise all of the deceased's rights under RCW 70.02.140. If there is no personal representative, or upon discharge of the personal representative, a deceased enrolled Individual's rights may be exercised by persons who would have been authorized to make decisions for the deceased Individual when the Individual was living under RCW 7.70.06 WACBD may disclose medical information about a patient internally and to an outside healthcare professional to provide treatment and to coordinate or manage healthcare services provided. WACBD may disclose medical information to obtain payment for healthcare services provided. Meaning, WACBD may use medical information to arrange payment, prepare bills, and to manage accounts. WACBD may also disclose medical information about you to others, such as insurers. WACBD may disclose medical information as required by law. There are federal, state, and local laws requiring the disclosure of medical information. This disclosure includes worker's compensation.
Power of Attorney (POA)	WACBD follows Washington State Uniform Power of Attorney Act- RCW 11.125. WACBD requires a copy of the POA for each specified patient. The POA shall be authorized to provide informed consent for health care decisions on the patient's behalf.
Minors	Both parents of a minor have access rights to a minor's record. The following are situations when the parent would not be the minor's personal representative under the Privacy Rule. These exceptions are: 1. When the minor is the one who consents to care, and the consent of the parent is not required under State or other applicable law; 2. When the minor obtains care at the direction of a court, or a person appointed by the court; and 3. When, and to the extent that, the parent agrees that the minor and the health care provider may have a confidential relationship. 4. For individuals 18 and older, who are considered an adult by Washington state, but are also considered a pediatric patient, can consent to their parents obtaining their medical records. If one parent wants to block the other parent from records, a court order mandate or other legal documentation must be provided to WACBD.

Procedure 3- Written/Verbal Records Request	
Records Request Type	A record of a patient visit is made each time a patient has an encounter with a WACBD healthcare provider. Typically, this record contains patient symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. A patient may request their records by written request or verbal request. This can be done through email, over the phone, in person, patient portal, or by mail.

Procedure 4- Types of PHI Released Without Prior Patient/Representative Authorization	
Treatment, Payment, or Healthcare Operations	WACBD may use and disclose PHI for treatment, payment and healthcare operations without patient authorization
Public Health Surveillance and Intervention	WACBD can disclose the minimum necessary PHI to: - Public health authorities to precent/control disease - U.S. Food and Drug Administration (FDA) who has responsibility for the quality, safety and effectiveness of an FDA-regulated product
After potential infectious exposure	After exposure of an employee to communicable diseases
Workers Compensation	To the extend necessary and required by WA State worker's compensation and similar programs
Health Oversight Activities	- Audits – provided PHI is removed at earliest opportunity and not further disclosed except for the initial audit - Civil, administrative or criminal investigation authorized by law - Investigation of unprofessional conduct
Deceased patients	PHI may be disclosed to a coroner or medical examiner to determine cause of death
Serious health threat	If reasonably able to prevent or lessen the threat
When PHI is required by law	In any other situation where disclosure of PHI is required by law

Deidentified data	PHI that excludes the following: - Names - Postal address information, other than town or city, state and zip code - Telephone, Fax numbers or e-mail address - Social security numbers - Medical record numbers, Health plan beneficiary numbers, Account numbers, Certificate/license numbers, Vehicle identifiers and serial numbers, including license plate numbers - Device identifiers and serial numbers - Web universal resource locators (URLs), Internet protocol (IP) address numbers - Biometric identifiers, including finger and voice prints - Full face photographic images and any comparable images
Records Request Type	A record of a patient visit is made each time a patient has an encounter with a WACBD healthcare provider. Typically, this record contains patient symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. A patient may request their records by written request or verbal request. This can be done through email, over the phone, in person, patient portal, or by mail.

RELEVANT REFERENCES:

- Patient Privacy and Security: Right to Access | COSMOS Compliance Universe (compliancecosmos.org)
- RCW 70.02
- RCW 11.125
- 45 CFR §160.103
- 45 CFR § 164.524
- 45 CFR § 164.530
- 20 CFR § 401.55 Access to medical records.
- WAC 246-08-400
- https://www.hhs.gov/hipaa/for-professionals/faq/227/can-i-access-medical-record-if-i-have-power-of-attorney/index.html
- Health Insurance Portability and Accountability Act of 1996 | ASPE (hhs.gov)

APPROVING COMMITTEE(S):

Policy and Compliance Committee (PCC)

REVISION HISTORY

	Final Approval by	Date	Brief description of change/revision
Revision			
Revision			

Patient Notification Consent

Patient's Name: _____ DOB: _____

At the Washington Center for Bleeding Disorders (WACBD) we would like to ensure that you receive information about your healthcare in a time-sensitive manner. This could include laboratory or test results and treatment recommendations. In order to share information with you, we can use various modes of communication, including letters, phone calls, fax, e-mail and texting.

Communications may contain sensitive and protected health information (PHI – such as your age, address, insurance/financial information, diagnosis, treatment, prognosis of your medical condition). Some communication methods may not be secure since messages can be intercepted, delivered and/or addressed to an unintended recipient, and/or improperly accessed while in storage and/or during transmission.

WACBD will send healthcare related information to you if you opt-in to receive such information. WACBD limits the information sent to you via less secure methods (such as non-encrypted text messaging or e-mail). By signing this consent form, you are opting-in to receive such notifications from WACBD.

I consent to receive notifications from WACBD, including communications that may include my PHI, by the following methods of communication:

- ☐ Mobile Device*: (_____)_____
- ☐ Text Message*: (_____)_____
- ☐ E-Mail: _____
- ☐ Opt-out of receiving text message and email communications from WACBD

*Wireless carrier's standard message rates, data rates, and/or restrictions may apply, and by consenting to receive notifications from WACBD you agree to be solely responsible for all fees that you incur from receiving notifications from WACBD.

You have the right to revoke this consent by providing written notice of revocation to WACBD. The revocation will become effective on the day the WACBD receives the revocation of the consent.

I understand the risks involved with such notifications from WACBD and shall not hold WACBD liable in case of a data breach as a result of using the above communication method. I agree to inform WACBD in writing of any changes to any of the methods of communications above.

Patient/Legal Guardian Signature: _____

Patient/Legal Guardian Name: _____

Date: _____

WACBD
WASHINGTON CENTER FOR BLEEDING DISORDERS

Authorization to Release Personal Health Information (PHI)

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Information:

Print Name of Patient: _____
(include all other name changes, e.g., maiden, etc.)

Date of Birth: _____

Street Address: _____

City, State, Zip Code: _____

Home/Cell Phone: _____

Email Address: _____

Release Information to or Discuss Information with:

Health Care Provider/Facility/Family Member or Friend:

_____

Street Address: _____

City, State, Zip Code: _____

Phone: _____

Email Address: _____

Send a copy of released records either by U.S. Mail, Fax or Encrypted Email

Please send all medical records including lab reports from the most recent two years or date range specified, or specify exactly what information is to be shared below.

_____

_____

_____

Date Range: _____ to: _____

Patient Authorization

Information released may include information regarding the testing or diagnosis of HIV/AIDS or sexually transmitted diseases. I hereby give my authorization for this information to be released.

I authorize the Washington Center for Bleeding Disorders to release information regarding my patient history diagnosis or treatment to the organization or person listed above.

I have the right to revoke my authorization at any time in writing to the Washington Center for Bleeding Disorders' Medical Director. Signed authorizations will expire 1 year from the date of signing.

Once disclosed, this medical health information may be subject to re-disclosure by the recipient and may no longer be protected under health information privacy laws.

Signature – Patient/Guardian/Authorized Representative Date

(*Documentation may be required to verify signature authority*)

Form Submission

Please submit the signed form via the following ways:

- ☐ U.S. Mail to the Washington Center for Bleeding Disorders, 701 Pike Street, Ste. 1900, Seattle, WA 98101
- ☐ Fax to (206) 614-1178
- ☐ Email to info@wacbd.org

If you have any inquiries, please call the Washington Center for Bleeding Disorders' Office at

(206) 614-1200