

# UConn HEALTH

**POLICY NUMBER 2003-17-A  
DECEMBER 10, 2013**

**POLICY: PATIENT RIGHT TO VIEW HIS/HER MEDICAL/DENTAL/RESEARCH AND/OR BILLING RECORD (Privacy & Security of Protected Health Information (PHI))**

**PURPOSE:**

To allow patients, or their authorized representatives, the right to request to view records of their health information as outlined in the designated record set (defined as the patient's medical record, dental record, research record & any billing records maintained by or for the UConn Health to make decisions about these individuals). This policy does NOT cover releasing copies of the records. Please refer to UConn Health Policy 2003-17 B Patient Right to Request Copies of His/Her Medical/Dental/Research and/or Billing Record.

**SCOPE:**

All UConn Health staff involved in the care of patients as well as staff in areas managing billing of patient care services will comply with this policy and procedure.

**POLICY STATEMENT:**

The UConn Health is committed to safeguarding PHI in order to fulfill its mission to patients and to operate in a manner that is consistent with applicable federal and state laws and regulations. The original patient's medical, dental, research, and/or billing record is the property of UConn Health and may not be removed from UConn Health's control except by court order. This policy will ensure the patient's right to view his/her PHI when necessary.

**I. VIEWING OF RECORDS:**

**A. Request To View Record Form:**

1. Patients and/or their authorized representatives have the right to view their medical, dental, research, and/or billing record information upon request. With the exception of the billing record, the request to do so must be in writing. (See attached form titled "Request to View Record / Notification of Approval or Denial to View" Form HCH 1351.)
2. Patient representatives have the right to act on the behalf of the patient when this is a court appointed status, or when they have the written authorization of the patient should the patient not be able to act on his/her own behalf.
3. UConn Health must act upon a patient request to view his/her medical, dental, research, and/or billing record information within thirty (30) days by either supplying the information or providing written notification of denial.

4. Completed Forms HCH 1351 are kept in the patient's medical, dental, and/or research record.

## **B. Management Of Request By Patient Type:**

### **1. Inpatients:**

- a. Inpatients or their authorized representatives are required to complete Form HCH 1351.
- b. Inpatients or their authorized representatives requesting to view should be encouraged to wait until discharge and, when possible, until the record has been completed and proper authorization for the review has been obtained.
- c. Patients insisting on reviewing their record during the current episode of care may be allowed to do so after the patient's attending physician/dentist or designee or in the case of research records the Principal Investigator or designee has been notified of the request and approves. Viewing done during the current episode of care must take place under the strict supervision of one of the following: the patient's provider or designee, the Director of Health Information Management or designee, or the Principal Investigator or designee.
- d. All viewing to be performed post-discharge will be handled under the strict supervision of the Director of Health Information Management or designee. This assures that the record is not physically changed in any way. Questions regarding the content of the record will be referred to the patient's provider.
- e. In the case of Inpatient Psychiatric Records, for post discharge, as well as reviews during the current episode of care, viewing of the record may only be done under the direct supervision of the treating physician. This assures that the patient understands what he/she is viewing and also assures the record is not physically changed in any way.

### **2. Outpatients:**

- a. Outpatients or their authorized representatives are required to complete Form HCH 1351.
- b. Viewing can only include information available to the HIM Department at the time of the viewing.
- c. When electronic records are requested to be viewed, HIM staff will access the electronic record and provide a hard copy for the patient's viewing. This hard copy may not be removed from UConn Health unless the proper procedure is followed for releasing copies of medical records. See UConn Health Policy 2003-17 B.
- d. Viewing must take place under the strict supervision of one of the following: the patient's provider or designee, the Director of Health Information Management or designee, or the Principal Investigator or designee. This assures that the patient understands what he/she is viewing and also assures the record is not physically changed in any way.
- e. In the case of Outpatient Psychiatric Records, viewing of the record may only be done under the direct supervision of the patient's provider. This assures that the

patient understands what he/she is viewing and also assures the record is not physically changed in any way.

**C. Documentation of the Viewing:**

Documentation of the approval for patient viewing is entered on the original Form HCH 1351 which is signed by the patient and by one of the staff noted above. A note must be included within the record when the patient reviews his/her medical, dental, and/or research record with specific reference to what was viewed for the patient.

**D. Information That Is Not Available For Viewing:**

**The following information is not available for viewing:**

1. Psychotherapy notes recorded by a mental health professional, in any medium, and maintained separately from the rest of the patient's medical record. Psychotherapy notes document or analyze conversation during a private, joint, family or group counseling session. By definition psychotherapy notes do not include medication records, counseling start and stop times, treatment records, results of clinical tests, diagnoses, functional status, symptoms, prognosis and progress and notes maintained with the individual's regular health record.
2. Information subject to Clinical Laboratory Improvement Amendments of 1988 (CLIA). Labs that are subject to CLIA must not grant patients access to test results if CLIA bans them from doing so. Research labs that are exempt from CLIA may also deny patients access to health information.
3. Information compiled in reasonable anticipation of or for use in a civil, criminal or administrative action or proceeding or pending litigation. Incident reports generated when a medical error occurs are not included in the designated record set and thus requests to review this information by the patient or their representative will be denied.

**II. UNCONTESTABLE GROUNDS FOR DENIAL TO VIEW:**

**Reasons Constituting Uncontestable Grounds:**

Listed below are reasons that would constitute denial for a patient to view his/her records which are not contestable by the patient or his/her representative:

1. The PHI is excepted from the right of access noted above in section I D.
2. The patient agreed to temporary denial of access when consenting to participate in research that includes treatment and the research is not yet complete.

3. If the patient is an inmate and viewing his/her health information would jeopardize the health, safety, security, custody or rehabilitation of himself/herself or other inmates, or the safety of an officer, employee or any other person at the correctional facility or responsible for the transporting of the inmate.
4. The PHI was obtained from someone other than a healthcare provider under a promise of confidentiality, and viewing would be reasonably likely to reveal the source of the information.

### **III. CONTESTABLE GROUNDS FOR DENIAL TO VIEW:**

#### **Reasons Constituting Contestable Grounds:**

Listed below are reasons that would constitute denial for a patient to view their records which are contestable by the patient or their representative:

1. A licensed healthcare provider has determined, in the exercise of professional judgment, that viewing is reasonably likely to endanger the life or physical safety of the patient or of another person.
2. The PHI makes reference to another person who is not a healthcare provider and a licensed healthcare professional has determined that the viewing requested is reasonably likely to cause substantial harm to such other person.
3. The request for viewing is made by the individual's personal representative and a licensed healthcare professional has determined that this is reasonably likely to cause substantial harm to the individual or another person.

### **IV. DOCUMENTATION OF DENIAL:**

- A. Denial (whether contestable or uncontestable) of the patient's request to view his/her record is noted using the original Form HCH 1351 filled out by the patient. This Form provides written explanation in plain language, containing basis for denial, a statement of the individual's review rights, and instruction on how to file a complaint with the Patient Relations Department or the Secretary of the Department of Health and Human Services.
- B. In the case of denials that can be contested by the patient, the patient may request that the denial be reviewed. This request is made by the patient on the original signed Form HCH 1351. When this request is made, another licensed health care professional chosen by the Health Center will review the patient's request and the denial. The person conducting the review will be someone other than the person who denied the patient's first request. If the denial is overturned the patient will have the right to access their record for viewing. If the denial is upheld the patient will be unable to access their records for viewing.
- C. UConn Health will promptly provide written notice to the individual of the determination of the reviewing official.

D. Completed Forms HCH 1351 are retained in the patient's medical, dental, and/or research record to document the full request and action process.

Attachments: [Request To View/Notification Of Approval Or Denial To View Form HCH 1351](#)

References:

American Health Information Management Association (AHIMA)  
§ 164.524 Health Insurance Portability and Accountability Act of 1996  
[Privacy Definitions \(Privacy and Security of PHI\) Policy #2003-03](#)  
[Patient Right to Request Copies of His/Her Medical/Dental/Research And/Or Billing Record Policy #2003-17-B](#)

Elena Albini (Signed)

1/10/14

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**Elena Albini**  
**Director of Health Information Management**

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**Date**

Iris Mauriello (Signed)

1/9/14

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**Iris Mauriello**  
**Compliance Integrity/Privacy Officer**

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**Date**

Victor Hesselbrock (Signed)

1/20/14

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**Victor Hesselbrock, Ph.D.**  
**Interim Senior Associate Dean**  
**Research Planning and Coordination**

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**Date**

Frank M. Torti (Signed)

3/3/14

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**Frank M. Torti, M.D., M.P.H.**  
**Executive Vice President for Health Affairs**

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**Date**

Revised: 12/10/13

Replaces Portions of Policy #2003-17 on 04/12/11