

UConn

Administrative Policy

2012-07 Legal Health Record

Title	Legal Health Record
Policy Owner and Contact Information	Health Information Management (860) 679-8829
Campus Applicability	UConn Health
Applies to	All faculty, staff, residents/fellows, students, and applicable contractors
Effective Date	6/25/2020

PURPOSE:

This policy defines what constitutes the Legal Health Record for patients of UConn Health and describes the purposes of the Legal Health Record.

POLICY STATEMENT:

UConn Health will create and maintain a Legal Health Record (LHR) for each individual who is evaluated or treated as an inpatient, outpatient, emergency patient, ambulatory clinical practice patient or dental patient at UConn Health.

The LHR will:

1. Document and substantiate the patient's clinical care;
2. Serve as legal testimony regarding the patient's illness or injury, response to treatment, and caregiver decisions;
3. Provide supporting documentation for reimbursement of services provided to the patient;
4. Provide a method of clinical communication and care planning among the individual healthcare practitioners evaluating or treating the patient;
5. Serve as a teaching tool for healthcare practitioner education in clinical settings; and
6. Serve as the legal business record in support of business decision-making.

DEFINITIONS:

Designated Record Set: A group of records maintained by or for UConn Health, that is: (a) the medical records and billing records about a patient, and/or (b) used in whole or in part, by or for UConn Health, to make decisions about a patient. For purposes of this definition, the term "record" means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for UConn Health.

Legal Health Record (LHR): The LHR is a collection of information concerning a patient and his/her health care that is created and maintained in the regular course of UConn Health business. The LHR is a subset of the Designated Record Set and is the record that is released for legal proceedings or in response to a valid request to release patient medical records.

PROCEDURES/FORMS:

The LHR is comprised of individually identifiable data in any medium, paper or electronic, that is collected and directly used in and/or for documenting health care or health status. Documentation that comprises the LHR may physically exist in separate and multiple paper-based or electronic based formats.

The LHR does **not** include the following:

1. Administrative data - Patient identifiable data used for administrative, regulatory, healthcare operations and/or payment (financial) purposes. Examples include, but are not limited to:
 - a. Authorization forms for release of information;
 - b. Birth and death certificates;
 - c. Event history and audit trails;
 - d. Logs, including but not limited to patient identifiable data reviewed for quality assurance or utilization management;
 - e. Financial and insurance forms;
 - f. Cancer registry data;
 - g. Databases containing patient information;
 - h. Incident or patient safety reports;
 - i. Indices such as disease, operation or death;
 - j. Research records;
 - k. Institutional review board lists;
 - l. Psychotherapy notes;
 - m. Staff roles, access rights and work lists.

2. Derived data - Data that is derived from the LHR and contains selected data elements to aid in the provision, support, evaluation and/or advancement of patient care. Derived data consists of information aggregated or summarized from patient records but has no means to identify patients. Derived data includes, but is not limited to, accreditation reports; best practice guidelines created from aggregate patient data; quality indicators; quality measures; quality improvement/quality assurance reports and abstracts; public health reports; statistical reports; data transmission reports; and anonymous patient data for research purposes.

3. Clinical pathways, best practice alerts, and other knowledge sources that do not imbed patient data.

REFERENCES:

Conn. Agency Regs. § 19-13-D3(d); 42 C.F.R. § 482.23

RELATED POLICIES:

[Policy #2012-06 Designated Record Set](#)

ENFORCEMENT:

Violations of this policy or associated procedures may result in appropriate disciplinary measures in accordance with University By-Laws, General Rules of Conduct for All University Employees, applicable collective bargaining agreements, the University of Connecticut Student Code, other applicable University Policies, or as outlined in any procedures document related to this policy.

APPROVAL:

Andrew Agwunobi (Signed)
UConn Health Chief Executive Officer

7/1/2020

Kiki Nissen (Signed)
Administrative Policy Committee Chair

7/1/2020

Janel Simpson (Signed)
Administrative Policy Committee Chair

7/1/2020

POLICY HISTORY:

New Policy Approved: 11/13/2012
Reviewed Without Changes: 12/8/2015
Revised: 6/25/2020