The basic research and assembly of this material, which now becomes an AMRA Position Statement, was first prepared as a Report by the Legislative Committee of the Pennsylvania Medical Record Association in 1976-77, as funded by AMRA's Executive Board. For these efforts, AMRA is most grateful.

That Report was then modified and subsequently adopted by the AMRA Executive Board in December 1977.

Confidentiality of Patient Health Information

A Position Statement of the American Medical Record Association

Preface

The Executive Board of the American Medical Record Association is proud to present this confidentiality document which states our position regarding the appropriate collection, dissemination and protection of an individual's personal health information.

At this time, when legislation is being prepared at the national, state and local levels regarding protection of privacy, confidentiality and freedom of information, it is imperative that our Association and its members, who are responsible for development of ethical practices to safeguard the information entrusted to their care, clearly affirm their position in this regard—to health care providers, third-party payors, government agencies, national and state health officials and legislators.

The Executive Board strongly encourages each member to work diligently toward implementation by all health care providers of the letter and spirit of this report, including adoption of policies based on the model included herein by all health care providers.

Note:

The following excerpts from the above document deal with the matter of confidentiality and Informed Consent.

D. *Informed Consent*

As may be inferred from the preceding paragraphs, the practice of obtaining informed consent is notable chiefly by its absence. There are at least three facets to this particular problem.

First, in "blanket consent", patients or guardians are asked to sign releases which allow facilities to disseminate "any and all" identifiable information to whomever is offering a benefit or service to the patient. The patient is not himself "informed" as to the full extent of the record's content, which segments of it will be open to third party access, or what will happen to the information once it is in the third party's possession. "Blanket consent" does not serve to instill a sense of responsibility in the collectors, storers and users of patient data.

Second, difficulty arises from the common third-party practice of requesting "prospective consent", or consent of release of information prior to treatment. This means that the patient is consenting to the dissemination of that which is not yet collected, a practice which precludes any intelligent decision-making on the part of the patient.

Third, most insurance companies request a form of consent which could be construed as "perpetual consent," since there is no attendant time limit set for validity of the consent. With other requestors, health care institutions vary in the time limits within which they accept patient consent as "current." In some cases health care institutions are adopting more stringent limits, but there is no uniformity of policy in this area.

1.0 *Data Collection*

1.1 The types and amount of information gathered and recorded about a patient shall be limited to that information needed for patient care. Supplementary data which is *not* required for patient care but desirable for research, education, etc., may be recorded with the permission of the patient, following explanation of the purpose for which the information is requested.

1.2 All individuals engaged in the collection, handling or dissemination of patient health information shall be specifically informed of their responsibility to protect patient data and of the penalty for violation of this trust. Proven violation of confidentiality of patient information shall be cause for immediate termination of access to further data, and immediate termination of any employer-employee relationship with prejudge for rehire. This policy shall be made known to all employees at the time of employment and each employee shall indicate understanding of this policy through a signed statement at the time of employment, kept with employee's personnel record. An example of statement is attached. Once yearly they will read the policy and again sign a statement of compliance and understanding.

Note: Continued development of State and Federal legislation to impose penalties of fine and/or imprisonment for such violation is recommended.

1.3 The collection of any data relative to a patient, whether by interview, observation or review of documents, shall be conducted in a setting which provides maximum privacy and protects the information from unauthorized individuals.

2.0 *Storage*

2.1 All primary health records shall be housed in physically secure areas under the immediate control of the Director of the Medical Record Department.

2.2 Secondary records, indices or other individually identifiable patient health information maintained by the institution are subject to the stated policies for maintenance of confidentiality of patient health information. A listing of these secondary records with a brief description of content and location shall be maintained in a central location, preferably in the Medical Record Department.

2.3 Primary and secondary health records shall be retained according to legal, accrediting or regulatory agency requirements, then destroyed according to an approved institutional retention schedule unless there is specific need for preservation of these records. The method of destruction shall be specified and the actual destruction witnessed or attested to in writing by the individual(s) responsible for destruction.

2.4 Original health records may not be removed from the premises, except on order of subpoena.

2.5 Access to areas housing health information records shall be limited to Medical Record Department personnel. The sole exception to this policy shall be the individual designated by the Director of Medical Records for access at times when the Department is not staffed. Health records must be available and accessible at all times for patient care.

2.6 When in use within the institution, health records should be kept in secure areas at all times. Health records should not be left unattended in areas accessible to unauthorized individuals.

2.7 If facsimilies of the health record are provided to authorized internal users, the same controls will be applied for return of these facsimilies as for return of the original health record. Wherever possible, internal users will be encouraged to use the original health record rather than to obtain a facsimile.

2.8 When photocopies or other reproductions of the health record are provided to authorized external users, these copies will be accompanied by a statement:

a) prohibiting use of the information for other than the stated purpose.
b) prohibiting disclosure by recipient to any other party.
c) requiring destruction of copies after the stated need has been fulfilled.

3.0 *Access.*

3.1 All requests for health records shall be directed to the Medical Record Department.

3.2 Release of information from the health record shall be carried out in accordance with all applicable legal, accrediting, regulatory agency requirements, and in accordance with written institutional policy.

3.3 Health records shall be available for use within the facility for direct patient care by all authorized personnel as specified by the chief executive officer, and documented in a policy manual.

3.4 Direct access to patient health records for routine administrative functions, including billing, shall not be permitted, except where the employees are instructed in policies on confidentiality and subject to penalties arising from violation of these as specified in **1.2.**

3.5 Original health records may not be removed from the premises, except on order of subpoena.

3.6 Subject only to specific contraindications by the attending physician and to any legal constraints such as those governing minors and those adjudicated as incompetent, a patient may have access to his own health record for review upon written request with reasonable notice. A patient may have access to records of his care after discharge and completion of the health record. Photocopies of health record will be provided on written request by the patient and payment of a reasonable fee.

3.7 *All* information contained in the health record is confidential and the release of information will be closely controlled. A properly completed and signed authorization is required for release of all health information except:

a) as required by law
b) for release to another health care provider currently involved in the care of the patient
c) for medical care evaluation
d) for research and education in accordance with conditions specified in Policies **3.11** and **3.12** below.

3.8 In keeping with the tenet of informed consent, a properly completed and signed authorization to release patient information shall include at least the following data:

a) name of institution that is to release the information
b) name of individual or institution that is to receive the information
c) patient's full name, address and date of birth
d) purpose or need for information
e) extent or nature of information to be released, including inclusive dates of treatment

Note: An authorization specifying "any and all information . . ." shall not be honored

f) specific date, event or condition upon which consent will expire unless revoked earlier
g) statement that consent can be revoked but not retroactive to the release of information made in good faith
h) date that consent is signed

Note: Date of signature must be *later* than the dates of information to be released

i) signature of patient or legal representative.

3.9 All requests for information from health records shall be directed to the Medical Record Department for processing.

3.10 Information released to authorized individuals/agencies shall be strictly limited to that information required to fulfill the purpose stated on the authorization. Authorizations specifying "any and all information . . ." or other such broadly inclusive statements shall not be honored. Release of information that is not essential to the stated purpose of the request, is specifically prohibited.

3.11 Following authorized release of patient information, the signed authorization will be retained in the health record with notation of what specific information was released, the date of release and the signature of the individual who released the information.

3.12 Health records shall be available to authorized students enrolled in educational programs affiliated with the institution for use within the Medical Record Department. Students must present proper identification and written permission of the instructor with their request. Data compiled in educational studies may *not* include patient identity or other information which could identify the patient.

3.13 Health records shall be made available for research to individuals who have obtained approval for their research projects from the appropriate medical staff committee and administrator or other designated authority. Data compiled as part of research studies may not include patient identity or other information which could identify the patient unless prior authorization from the patient has been obtained. Any research project which would involve contact of the patient by the researcher must have written permission of the patient's attending physician, or in his absence a physician designated by the current chief executive officer of the facility, and consent of the chief executive officer to conduct this study prior to contact. Research projects which involve use of health records shall be conducted in accordance with institutional policies on use of health records for research.