



**MONTANA STATE HOSPITAL  
POLICY AND PROCEDURE**

**PATIENT REQUEST TO SEE,  
COPY, AND/OR AMEND HIS/HER OWN CHART**

**Effective Date:** October 10, 2014

**Policy #:** HI-11

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**I. PURPOSE:** To maintain standards and procedures of release of information to patients who request to view, copy and/or amend their medical/psychiatric records per M.C.A. §: 50-16-541, 50-16-542, 50-16-543, 50-16-544 and 50-16-545.

**II. POLICY:**

A. In accordance with established hospital practices, a patient may not view his/her own record unless, and until, the record is first reviewed by the patient's Licensed Independent Practitioner (LIP) or designee in order to:

1. determine if the information will be harmful to the best interests of the patient's health;
2. determine if third party confidentiality is being violated by such disclosure; and
3. determine if the information could reasonably be expected to cause danger to the life or safety of any individual.

**III. DEFINITIONS:** None.

**IV. RESPONSIBILITIES:**

A. Health Information Services will verify authorization is complete and adequate. Will notify patient's LIP of request. Upon approval or denial, staff will complete release/review procedure.

B. LIP or designee will review record for appropriateness of information to be reviewed or released for those requests from persons currently residing in a correctional facility, or those on a forensic commitment while at MSH. LIP will document in medical record what may be reviewed or released and/or what portions of the record may not be reviewed or released including justification for the denial.

**V. PROCEDURE:**

A. Upon receipt of a written request to view or copy his/her medical record Montana State Hospital (MSH) shall within 10 days of receiving the request:

1. make the information available to the patient for examination during regular business hours or provide a copy, if requested, to the patient;
2. inform the patient if the information does not exist or cannot be found;

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3. inform the patient and provide the name and address, if known, of the provider who maintains the record, if MSH does not maintain a record of the information;
  4. inform the patient and specify in writing the reasons for the delay and the earliest date, not later than 21 days after receiving the request, when the information will be available for examination or copying or when the request will be otherwise disposed, if the information is in use or unusual circumstances have delayed handling the request;
  5. deny the request in whole or in part based on doctor order and justification for denial.
  6. Upon request MSH shall provide an explanation of any code or abbreviation used in the health care information.
- B. In the case of in-patients, inmates at a correctional facility, or patients who were at MSH on a forensic commitment, The record should first be reviewed by the LIP or designee having primary responsibility for the patient's care and treatment, who will decide what material in the record is restricted as to confidentiality, such as information received from third parties. The LIP or designee should also screen any reports that might be harmful to the patient or require interpretation on the part of the LIP or designee. The LIP or designee will write an order to specify record may be reviewed or released and/or what portions of the record may not be reviewed or released including justification for denial.
- C. An appointment to view the record can be made for the patient during regular business hours.
- D. Following the review by the LIP or designee, who will verify what can be sent to the patient/guardian an explanation of the copying fee (no charge for the first 20 pages and \$.10 for each additional page), the number of pages involved and the total charges will be sent to the patient/guardian. The copies will be sent upon receipt of the copying fee. Refer to the MSH Policy #HI-02, Billing for Photocopies.
- E. MSH may deny access to health care information by a patient if the health care provider reasonably concludes that:
1. knowledge of the health care information would be injurious to the health of the patient;
  2. knowledge of the health care information could reasonably be expected to lead to the patient's identification of an individual who provided the information in confidence and under circumstances in which confidentiality was appropriate;
  3. knowledge of the health care information could reasonably be expected to cause danger to the life or safety of any individual;
  4. the health care information was compiled and is used solely for litigation, quality assurance, peer review, or administrative purposes;
  5. access to the health care information is otherwise prohibited by law.

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- F. For purposes of accuracy or completeness, a patient may request in writing that MSH correct or amend his/her record.
1. MSH should reply no later than 10 days after receiving the request for amendment and inform the patient if the correction or amendment information in question or cannot be found; and
  2. if the record is in use or unusual circumstances have delayed the handling of the correction or amendment request, inform the patient and specify in writing the earliest date, not later than 21 days after receiving the request, when the correction or amendment will be made or when the request will otherwise be disposed of; or
  3. inform the patient in writing of refusal to correct or amend the record as requested, the reason for the refusal and the patient's right to add a statement of disagreement and to have that statement sent to previous recipients of the disputed health care information.
- G. In making a correction or amendment MSH shall:
1. add the amending information as a part of the health record; and
  2. mark the challenged entries as corrected or amended entries and indicate the place in the record where the corrected or amended information is located.
- H. Refusing to make the patient's proposed correction or amendment, the MSH shall:
1. permit the patient to file as a part of the record of his health care information a concise statement of the correction or amendment requested and the reasons therefore; and
  2. mark the challenged entry to indicate that the patient claims the entry is inaccurate or incomplete and indicate the place in the record where the statement of disagreement is located.
- I. Dissemination of corrected or amended information or statement of disagreement.
1. MSH upon request of the patient, shall take reasonable steps to provide copies of corrected or amended information or of a statement of disagreement to all persons designated by the patient and identified in the health care information as having examined or received copies of the information sought to be corrected or amended.
  2. MSH may charge the patient a reasonable fee, not exceeding the provider's actual cost, for distributing corrected or amended information or the statement of disagreement, unless a MSH error necessitated the correction or amendment.
- VI. REFERENCES:** M.C.A. §: 50-16-541 "Requirements and Procedures for Patient's Examination and Copying," 50-16-542 "Denial of Examination and Copying," 50-16-543 "Request for Correction or Amendment," 50-16-544 "Procedure for Adding Correction, Amendment, or Statement of Disagreement," 50-16-545 "Dissemination of Corrected or

