



**MONTANA STATE HOSPITAL
POLICY AND PROCEDURE**

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

Effective Date: May 22, 2020

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 Montana State Hospital (MSH) 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 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:** Verifies authorization is complete and adequate and notifies the patient's Licensed Independent Practitioner of the request. Upon approval or denial, Health Information staff will complete the release/review procedure.
- B. **Licensed Independent Practitioner or designee:** Reviews the medical record for appropriateness of information to be reviewed or released for requests from persons currently residing in a correctional facility or residing at MSH on a forensic commitment. The Licensed Independent Practitioner will document in the medical record items which may be reviewed or released and/or which portions of the record may not be reviewed or released including the justification for denial.
- V. PROCEDURE:**
- A. Upon receipt of a written request to view or copy his/her medical record 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. if MSH does not maintain a record of the requested information, inform the patient and provide the name and address, if known, of the provider who maintains the record;
 4. if the requested information is in use or unusual circumstances have delayed handling the request, 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;
 5. deny the request in whole or in part based on the Licensed Independent Practitioner's order and the 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 Licensed Independent Practitioner 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 Licensed Independent Practitioner or designee should also screen any reports which may be harmful to the patient or require interpretation on the part of the Licensed Independent Practitioner or designee. The Licensed Independent Practitioner or designee will write an order to specify the record may be reviewed or released and/or the portions of the record which may not be reviewed or released including the 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 Licensed Independent Practitioner or designee, who will verify items which 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 and Scans of Health Information.
- E. MSH may deny access to health care information by a patient if the health care provider reasonably concludes:
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 the individual providing 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 used solely for litigation, quality assurance, peer review, or administrative purposes;
 5. access to the health care information otherwise prohibited by law.
- F. For purposes of accuracy or completeness, a patient may request in writing for MSH to 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 record in question does or does not exist; 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 a refusal to correct or amend his/her record as requested, the reason for the refusal and the patient's right to add a statement of disagreement, and to have the statement sent to previous recipients of the disputed health care information.
- G. In making a correction or amendment MSH shall:
1. add the amended information as a part of the health record; and
 2. mark the challenged entries as corrected or amended indicating the place in the medical record where the corrected or amended information is located.
- H. Upon refusal to make the patient's proposed correction or amendment 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; and
 2. mark the challenged entry to indicate the patient states 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 the 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 Amended Information or Statement of Disagreement.", 45 CFR 164.524 "Access Of

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Individuals To Protected Health Information”, DPHHS Policies; 002 “Uses and Disclosures of Protected Health Information”, 004 “ Client Access to Protected Health Information”, 005 "Amendment of Protected Health Information”, 010 “Criteria for Compliant Authorization to Release Protected Health Information”,

VII. COLLABORATED WITH: Director of Nursing; Medical Director.

VIII. RESCISSIONS: HI-11, *Patient Request to See, Copy, and/or Amend His/Her Own Chart* dated October 10, 2014; HI-11, *Patient Request to See, Copy, and/or Amend His/Her Own Chart* dated November 9, 2009; HI-11, *Patient Request to See, Copy, and/or Amend His/Her Own Chart* dated October 30, 2006; HI-11, *Patient Request to See, Copy, and/or Amend His/Her Own Chart* dated September 1, 2002; HI-11, *Patient Request to See, Copy, and/or Amend His/Her Own Chart* dated February 14, 2000; HOPP 12-03P.051480, *Patient Request to See Copy and/or Amend his/her own Record*, August 12, 1976.

IX. DISTRIBUTION: All hospital policy manuals.

X. ANNUAL REVIEW AND AUTHORIZATION: This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

XI. FOLLOW-UP RESPONSIBILITY: Director of Health Information.

XII. ATTACHMENTS: None.

Signatures:

Kyle Fouts
Hospital Administrator

Melinda Bridgewater
Director of Health Information