Category: Health Information	Subject: Client and Parent/Legally Responsible Person Access to the Record Scope: SLO Behavioral Health Department Effective Date: 12/17/2019

Purpose:

- To clarify the expectation that a client has a right to access to the record unless specified exceptions are clearly documented
- To clarify the client access process and staff responsibility for its implementation
- To identify and contrast client access situations that require an access determination with those that are considered routine business or treatment operations
- To describe a process for allowing a client to request and BH to consider amending the record

Scope:

- Applies to all Behavioral Health staff and contractors who provide Behavioral Health services (outpatient <u>and</u> inpatient)
- Replaces Policy & Procedure 13.02

References:
Health & Safety Code §123100 – 123149.5
Code of Federal Regulations, Title 45, Part 164, §164.500 – 164.534 (HIPAA)
Code of Federal Regulations, Title 42, Part 2, §2.23, §2.12(d)

Legislative Statement of Intent:

"… every person having ultimate responsibility for decisions respecting his or her own health care also possesses a concomitant right of access to complete information respecting his or her condition and care provided. Similarly, persons having responsibility for decisions respecting the health care of others should, in general, have access to information on the patient's condition and care." (H&S 123100)

Procedure:

A. Access and Exceptions

Any of the persons listed below may request and will be granted access to the record unless an exception is documented on the BH Access Request/Determination assessment.

1. Client: An adult client or a minor client who could or did consent for services on his/her own
   Exception:
   Access must only be denied when a provider determines that the access requested is "reasonably likely to endanger the life or physical safety of the individual or another person". (CFR 45 §164.524(a)(3)(i))

2. Parent/Legally Responsible Person of a minor client.
   Exceptions:
   a. Parent access to the record must be denied when the minor could or did consent for services on his/her own. The minor client may access the record (see 1 above).
   b. Parental access to the record must be denied when the provider determines that access to the record would have a detrimental effect on (either or both):
      - The provider's professional relationship with the minor
      - The minor's physical safety or psychological well-being
   c. When minor client over age twelve is able to consent for themselves, declines to consent to release to the parent/legally responsible person.
   d. Parental access must be denied, and a parent must not be permitted to authorize third party disclosure of the record when a minor is a W&I Code 300 dependent of the court

(WIC 5328.03) and has been removed from the physical custody of the parent (e.g., "detained").

- The court may make a finding that parental access would not be detrimental to the minor and may issue an order permitting the parent to access to record. The court's order permits, but does not require, staff to allow parental access to the record.
- The parent must present a copy of the court order to a Health Information Technician (HIT), who will make the court order part of the record.
- The "psychotherapist"[1] determines what the parent may safely access based on 2a and 2b above.

[1]Evidence Code §1010: MD, Psychologist, LMFT, LCSW, LPCC and Masters' level RNs with clinical or psychiatric certifications. Interns and trainees of the above disciplines must obtain Clinical Supervisor approval and co-signature prior to access to the record by a parent whose child is a detained 300 dependent.

3. Court Appointed Special Advocate (CASA) for a W&I Code 300 dependent minor
   a. A CASA may inspect of request and be given copies of the record but must first present a court order that documents the appointment of the CASA.
   b. The HIT will scan the court order into the record.
   c. When the CASA requests access to the record, an LPHA must review the record as described in D below to remove information given in confidence by persons other than the client.

4. Legally Responsible Person for an adult client
   a. Access must only be denied if a provider determines that the access requested by the representative is "reasonably likely to cause substantial harm" to the client or another person by allowing the Legal Guardian to have access to the record. (CFR 45 §164.524(a)(3)(iii))
   b. When the Public Guardian, acting as the LPS conservator, requests access to the record, the request will be approved without a need for clinical review/access determination because the reasonable presumption is that the Public Guardian will act in the best interest of the client and there will be no detrimental consequence for the client.

B. Extent of Access

1. A client or Parent/Legally Responsible Person must only be allowed to access records pertaining to the client (H&S §123105(d)). This means that information about others is removed whenever the record "…makes reference to another person…and a licensed health care professional has determined…that the access requested is reasonably likely to cause substantial harm to such other person". (CFR 45 §164.524(a)(3)(ii))

2. Information given in confidence by a person other than another health care provider or the client must be removed from any records prior to inspection by (or giving copies to) a client or parent. This includes information about other family members or reported by family members other than the client or parent who is requesting access to the record. (H&S §123105(d) and CFR 45 §164.524(a)(3)(ii)

Note: Make every effort to avoid adding information to the record that could be potentially damaging to a client or to the person who discloses it to the provider if inadvertently released!

C. Access Determination

1. An LPHA staff member must review the record and determine if an access exception, as described in section A above, exists. Unless an exception is specifically documented, the request must be approved as requested.

2. Whenever possible, the LPHA making the access determination will be an LPHA involved in the client's treatment. When the client is currently in treatment, the LPHA will consult with the current treatment team to discuss the client's request. This discussion will lead to a plan to help the client understand the clinical information that will be released. The results of this discussion will be considered when making the access determination.

3. The LPHA will confer with the client to determine the nature of the request and the best strategy for producing the information the client wants in a manner that is usable for the client. The LPHA will discuss the risks, limits and benefits of obtaining detailed treatment information with the client. The results of this discussion will be considered when making the access determination. When the person requesting access is no longer involved in treatment, the LPHA will offer to help the client understand the clinical information that will be released.

4. The LPHA approves as requested, approves in part, or denies the request for access.

5. Generally, we must provide the individual with access to the protected health information in the form and format requested by the individual. The LPHA may approve inspection of the record, photocopies of all or part of the record, an electronic copy of all or part of the record or may create a summary of treatment. However, a summary may only be provided if the client agrees in advance to receipt of a summary instead of copies or inspection (see below).

6. The LPHA must remove any extraneous or inappropriate material prior to permitting access, if inspection or copies of the record are approved.

7. The LPHA will document discussion with the client and treatment team and the time spent reviewing the record as Case Management or Non-Billable Progress Note. The LPHA will document the discussion with the client that supports the decision to provide a summary rather than the actual record, if this option is selected.

   Recommended documentation:
   - *Client requested access to his entire medical record (XX volumes from XX to XX). I reviewed the record and removed information that was obtained from another person, is about another person, and/or that, in my professional judgment, is reasonably likely to endanger the life or physical safety of the individual or another person.*
   - *I wrote a treatment summary based on the record review.* (If applicable)

D. Access Determination Workflow

1. Whenever possible, a client or Parent/Legally Responsible Person is directed to a HIT, who helps the requesting person complete and sign the Client Access Request.
   a. Signatures can be obtained in person or via DocuSign. The HIT can document verbal consent obtained if other options are not available and providing signature is burdensome to the client. HIT must verify identity and/or legal right to the record.

2. The HIT (or other staff who assists with the completion of the Request for Access if a HIT is not available) confers with the requestor to help clarify the nature of the request and the types of information needed.

3. After the Client Access Request has been completed, an LPHA must review the record and complete the Client Access Determination. If the staff member who helps clarify the access request is not an LPHA, the BH Access Request/Determination is routed to an LPHA designated by the Program Supervisor to make these determinations.

4. After the LPHA completes the access determination, the Client Access Request and Client Access Determination must be routed to the HIT.

5. The HIT scans the Client Access Request and Client Access Determination into the Electronic Health Record as one document. Completes the Disclosures/Requests in SmartCare and produces the record for the client and/or Parent/Legally Responsible Person.

E. Types of client access, timelines and costs

1. Inspection
    a. Timeline: The inspection must occur within five business days after the receipt of the written request.
    b. Cost: N/A
    c. The HIT arranges and supervises the inspection.

2. Copies of all or part of the record
    a. Timeline: Copies must be given or sent to within fifteen calendar days after the receipt of the written request.
    b. Current Client cost: $.10 per page *(If copies are needed because the client's application for a public benefit was denied and the records will be used to appeal the decision, then the copies are free to the client.)*
    c. The HIT produces the photocopies that are approved by the LPHA.

3. Electronic copy
    a. Timeline: Three business days
    b. Cost: N/A (subject to change)
    c. If the request is for an electronic copy of all or part of the record, the HIT will contact Health Agency IT to obtain an encrypted CD or thumb drive, which will contain the records to be released.

4. Summary
    a. H&S 123130(a), which allows a provider to elect to provide a summary of treatment, is preempted by HIPAA, which only allows a summary if:
        - "The individual agrees in advance to such a summary or explanation; and
        - The individual agrees in advance to the fees imposed, if any…" (CFR 45 §164.524(c)(2)(iii))
    b. Timeline: Ten working days from the date of the client's request; may be extended to no more than thirty calendar days if the record is of "extraordinary length" or because the patient was discharged from an inpatient setting within the 10 days preceding the request.
    c. Cost must be **reasonable** *(H&S 123130 (f): "… made available at the lowest possible cost to the patient")* and the client must agree to pay the fee.
        1) 0-60 minutes $30.00
        2) 60+ minutes $50.00

d. A summary of the record must cover the entire period of treatment unless the client requests information about only certain illnesses or episodes.

e. The summary shall contain the following:
   1) Chief complaint or complaints, including pertinent history
   2) Findings from consultations and referrals to other health care providers
   3) Diagnosis
   4) Progress in treatment
   5) Prognosis, including significant continuing conditions or focus of treatment
   6) Pertinent reports of diagnostic procedures and tests and discharge summaries
   7) Objective findings from the most recent physical examination, such as blood pressure, weight, and actual values from routine laboratory tests, if applicable
   8) A list of all current medications prescribed, including dosage, and any sensitivities or allergies to medications recorded by the provider

f. The LPHA who completes the summary gives it to the HIT, who produces it for the client or Parent/Legally Responsible Person after scanning it into the record and completing the Disclosures/Requests log in SmartCare.

F. Denial actions

If the LPHA determines that an exception exists and access is denied in whole or in part, the following must occur:

1. The Client Access Determination must include a detailed description of the specific adverse or detrimental consequences anticipated by the LPHA.

2. The client will be given access to all parts of the record that are permitted.

3. The LPHA must inform the client of the denial and that the client has a right to request, in writing, that the record be inspected by a licensed MD, Psychologist, LMFT, LCSW or LPCC of the client's choosing. (H&S §123115(b)(3))

4. The LPHA must inform the client that the client may complain to the HA Privacy Officer (see Notice of Privacy Practices for detail).

G. Information shared verbally with a client and/or Parent/Legally Responsible Person does not require a Client Access Request and does not need to be logged in the Disclosures/Requests log.

H. Amendments to the record

1. A client or representative may request that their record be amended to correct any information that the client or representative believes is inaccurate.
2. Requests are handled by the Medical Record Supervisor.

I. Common Scenarios: Client Access or Routine Business Operations?

Some information that is generated during the course of treatment or as part of general business operations may be freely shared with a client and/or Parent/Legally Responsible Person without the need for a formal access determination as described in this procedure. The table below lists examples of common situations encountered during treatment. An exhaustive list would be impossible to create, but the general principle is that clinical content and treatment history require an access determination because there is at least potential for the information to be harmful to the client.

Client Access: Access Determination REQUIRED	Routine Business Operations: Access Determination NOT REQUIRED

• Inspection of the record
 	
• Copy of the record
 	
• Treatment Summary
(Includes history of treatment, including dates of stay/dates of service)
 	
• Letters to the client (or Parent/Legally Responsible Person) which contain a summary of treatment or:
    ○ Clinical content
    ○ Recommendations
    ○ Clinical decisions
 	
Note: Letters written on behalf of a client (or Parent/Legally Responsible Person) are third party disclosures. See Disclosure to third party procedure for detail.
	• Letters to the client or Parent/Legally Responsible Person which contain logistical or appointment information only *(Examples: appointment reminders, "contact or close" letter, etc.)*
	
	• Safety Plan
	
	• Notice of Certification Form (*AB 2275 process occurring in non-LPS designated facilities)*
	
	• Copies of Release of Information Authorization and/or Multi-Party Release of Information *(Required by law)*
	
	• Copy of Consents
	
	• Prescriptions/labs
	
	• Bills
	
	• Discharge Plan *(Required by DHCS for SUD Treatment Services)*
	
	• SUD-Progress Report

§2.23 (a) Patient access not prohibited. These regulations do not prohibit a part 2 program from giving a patient access to their own records, including the opportunity to inspect and copy any records that the part 2 program maintains about the patient. The part 2 program is not required to obtain a patient's written consent or other authorization under the regulations in this part in order to provide such access to the patient.

(b) Restriction on use of information. Information obtained by patient access to his or her patient record is subject to the restriction on use of this information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient as provided for under §2.12(d)(1).

§2.12(d) Applicability to recipients of information— (1) Restriction on use of information. The restriction on the use of any information subject to the regulations in this part to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient applies to any person who obtains that information from a part 2 program, regardless of the status of the person obtaining the information or whether the information was obtained in accordance with the regulations in this part. This restriction on use bars, among other things, the introduction of that information as evidence in a criminal proceeding and any other use of the information to investigate or prosecute a patient with respect to a suspected crime.

Revision History

Date:	Section Revised:	Details of Revision:
11/19/2014		Original procedure
1/27/2015	H	Clarified that Referrals are routine business operations

6/15/2015	A, B, D, E, G, H	Clarified redaction, summary, and business operations table
2/3/2017	Scope D	Replaces P&P 13.02. The LPHA will involve current treaters in the decision to allow access. LPHA discussion with the client is required.
12/28/2021	E2a E2c	Changed with new law change to 15 Calendar Day and not business days Removed
10/14/2024	Entire	
10/30/2024	Common Scenarios	Updated Common Scenarios Routine Business Access not needed list
12/12/2025	D.1.a Client Access/ Routine Business grid	Added clarification for verbal consent, updated the Client Access/Routine Business grid