CONNECTICUT VALLEY HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	Organization Focused Functions
CHAPTER 9:	Management of Information
PROCEDURE 9.36:	**Confidentiality of Patient Information – Patient Requests to Examine Records - Inpatient Status**
REVISED:	09/97; 8/12; 3/3/16; 5/1/18; Reviewed 1/2007; 11/16/18
Governing Body Approval:	11/19/18*(electronic vote)*

Purpose:
Under the authority of the Connecticut General Statutes and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 C.F.R. Parts 160 through 164), the Department of Mental Health and Addiction Services (DMHAS), has adopted regulations to establish the rights of patients who wish to examine their medical records.

Scope: All Clinical Staff, HIM and Unit Clerks

Policy:
It is the policy of DMHAS that staff should make records available for inspection and comment by recipients of care unless the information in the records would create a reaction that would cause a substantial risk that the patient would inflict life-threatening injury to his/her self or to others or experience a severe deterioration in mental state. Information that would violate the confidentiality of another person is also protected. The department believes that allowing consumers to read their own records and discuss them with their clinicians reduces suspicion, creates opportunities for discussion between consumers and treaters, and increases consumer participation in treatment.

Procedure:
When a patient requests to review their medical record:

1. The patient completes the Medical Record Examination Request form (CVH-131). Upon completion, ~~send~~ the completed form is sent to Health Information Management (HIM) for processing.
2. HIM forwards the request to the appropriate Attending Psychiatrist for approval or denial of the request.
   a. If the request to review the medical record is approved, HIM sends a Medical Record Examination form (CVH-APT) to the Head Nurse to schedule an appointment with the patient to review their medical record. A clinician must be with the patient at all times during the review to answer questions and to insure the safety of the medical record.
   b. If the request to review the medical record is denied, HIM notifies the Chief of Professional Services to review the request with the attending psychiatrist.
   c. If the COPS agrees that the request to review the medical record should be denied, HIM notifies the patient of the Attending Psychiatrist's decision and advises the patient that they

may name an alternate (physician) of their choice to review their request or they may have the request reviewed by the Medical Director for the Connecticut Department of Mental Health and Addiction Services, Office of the Commissioner (CVH-184D). Upon completion of the form, forward to HIM.

d. HIM notifies the Alternate Physician of the patient's request for further consideration of their request to review their medical record. (CVH-184-F).

e. HIM notifies the patient (and Attending Psychiatrist) of the Alternate Physician decision regarding access to their medical record. If access is denied, the patient is notified (CVH-184G) and is provided with information regarding further judicial relief.

Clinician Review of Medical Record with Patient:

The clinician assigned to review the medical record with the patient provides the patient with the following forms (information):

1. Request for Copy of Medical Record Documentation (CVH-151). If the patient requests a copy of any documentation, forward the form to HIM for processing.

   Processing by HIM includes:

   a. Obtaining the authorization for the release of information to the patient by the Attending Psychiatrist.

   b. Obtaining the patients' signature when they are furnished with the requested documents.

2. Requests for Correction (CVH-RCP). If during the patient's review of the medical record they find what they believe to be an error in the information recorded they have the right to request that the error be corrected (amended). Upon completion of the Request for Correction form, send to HIM for processing.

   Processing by HIM includes:

   a. Notifying the appropriate Clinician of the request for correction of their documentation by the patient.

   b. Notifying the patient of the Clinician's decision regarding their request for correction (amendment).

INSTRUCTIONS FOR AMENDING DOCUMENTATION:

Record the correction on the document in question, date and sign the entry. DO NOT cross out or otherwise obliterate the original entry.

See Also:
Policy and Procedure 9.15 Access to Protected Health Information