CONNECTICUT VALLEY HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 9:	Management of Information
PROCEDURE 9.37:	**Confidentiality of Patient Information Patient (Or Conservator) Requests to Examine or Receive Copies of Medical Records - Patient Discharged Admin/ Executor or Next-of-Kin - Patient Deceased**
REVISED:	08/97; 09/2006; 10/20/09; 04/2013; Reviewed 4/25/18; 11/16/18
Governing Body Approval:	04/25/13; 11/19/18*(electronic vote)*

PURPOSE: Under the authority of the Connecticut General Statutes, 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

POLICY:

It is the policy of the 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:

Patient requests to obtain copies or to review their medical record(s).

1. The patient will complete the Medical Record Examination Request form (CVH-131) or the Authorization for Release of Information form (CVH-184) Upon completion, the completed form is submitted to Health Information Management (HIM) (Medical Record Department) for processing.

2. HIM will forward the request to the appropriate Attending Psychiatrist for approval or denial of the request. If the patient's Attending Psychiatrist is no longer on staff at CVH, the request will be reviewed by the Chief of Professional Services (COPS) or their designee.

    a. If the request to review the medical record is approved, HIM will process the request. If the review Psychiatrist wishes to meet with the patient, an appointment will be coordinated by HIM. If the patient is requesting to review their (entire) record(s), HIM staff will be present during the review to answer questions and to insure the safety of the medical record. Any questions regarding diagnosis or treatment will be referred to the review psychiatrist.

b. If the request to review the medical record is denied, HIM will notify the patient of the Physician/Psychiatrist's decision and advise the patient that they may name an alternate (physician) to review their request. (CVH-184d). The completed form is sent to HIM.
c. HIM will notify the Alternate Physician of the patient's request for further consideration of their request to review their medical record. (CVH-184f).
d. HIM will notify the patient (and Attending Psychiatrist) of the alternate Physician decision regarding access to their medical record. If access is denied, the patient will be notified (CVH-184g) and will provide the patient with information regarding further judicial relief.

Review of Medical Record with Patient:

HIM staff assigned to review the medical record with the patient will provide the patient with the following forms (information):

1. Requests for Copy of Medical Record Documentation (CVH-151 or CVH-184). HIM will process their request.

2. Requests for Correction (CVH-522). If during the patients 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).

Processing by HIM will include:

1. Notifying the appropriate Clinician of the request for amendment/correction of their documentation by the patient.

2. 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.