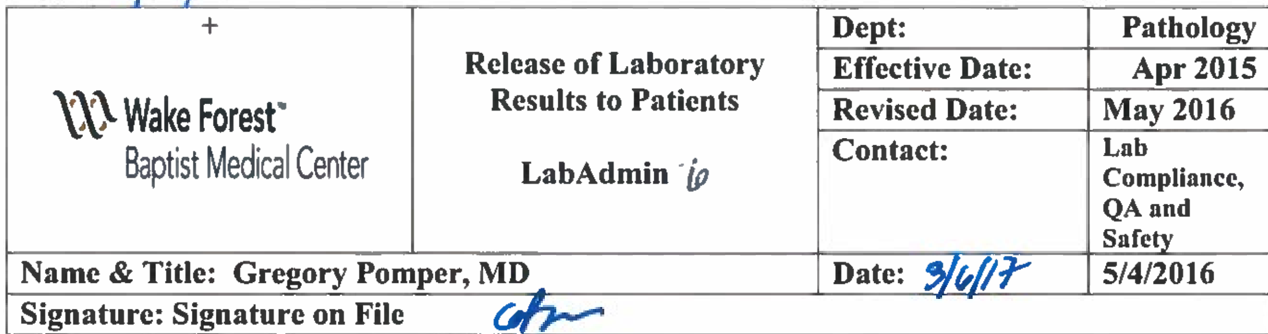

Wake Forest Baptist Medical Center	Release of Laboratory Results to Patients LabAdmin	Dept:	Pathology
		Effective Date:	Apr 2015
		Revised Date:	May 2016
		Contact:	Lab Compliance, QA and Safety
Name & Title: Gregory Pomper, MD		Date: 3/6/17	5/4/2016
Signature: Signature on File			

1) **General Procedure Statement:**

   a. **Scope:** Provides a means for Pathology Laboratory results to be given to patients upon request.

   When the Pathology Laboratories, managed by the Department of Pathology, receive a request from a patient or legal representative for laboratory results, the laboratory will provide the results within 30 days as required by HIPAA. This procedure will comply with the WFBMC Privacy Policy (PPB-MC-26).

   b. **Responsible Department/Scope:**

      i. Procedure owner: Department of Pathology
      ii. Procedure: Clinical and Anatomic sections of the Department of Pathology
      iii. Supervision: Manager, Client Services and Supervisor, Surgical Pathology
      iv. Implementation: Department of Pathology Chairman and Administrative Director

2) **Definitions:** None

3) **Procedure:**

   a. A request for laboratory results may be received by the laboratories via phone, electronic communications, or other reasonable forms of communication.
   b. Release of Clinical results will be handled by Client Services and Anatomic results by Surgical Pathology. After hours the request form will be completed by Central Processing and results can be picked up the next day.
   c. Upon receipt of a request, the patient or legal representative is to be provided with the "Authorization for Use or Disclosure of Protected Health Information" form found in Privacy Policy (Appendix A). The form can be obtained on the intranet:

      - English or Spanish: http://intranet.wakehealth.edu/Tools/Forms

- Go to Consent Forms
- Select "Authorization for Use and Disclosure of Protected Health Information"

d. Laboratory personnel may assist the patient or legal representative with completion of the form.

e. The laboratory MUST obtain a signed form before further assistance can be provided. The form is not considered complete unless the information is completed, signed and dated by the patient or legal representative per Privacy Policy (PPB-MC-26):
   - PHI may be used or disclosed in the following circumstances upon receipt of WFBMC's Authorization for Use and Disclosure of PHI Form (or a valid alternative) that has been signed by the patient or the patient's legal representative.

f. Upon receipt of a signed Authorization for Use and Disclosure of PHI Form, the Laboratory personnel may either:
   - Provide the patient with the requested results; or
   - Refer the patient or legal representative to Health Information Management (Medical Records) for results.

g. If the Laboratory personnel provides the results directly to the patient:
   - Identity of the patient should be verified. At least two identifiers are necessary for verification of identity. Identifiers can include other PHI, such as name, date of birth, which would reasonably establish that the requestor is who he/she claims to be. A current valid official photo identification is required and should be copied and retained by the Laboratory.
   - Results should only be provided directly to a patient or patient representative once duly identified as the appropriate representative.
   - The patient should be an adult (greater than or equal to 18 years of age); pediatric results requests should be processed through Health Information Management (Medical Records).
   - Copies of the patient's identification and the authority for the request should be obtained, and retained by the Laboratory.
   - Upon verification of patient identification, the laboratory personnel should provide a printed copy of the requested laboratory results, and retain a copy of the Release of Laboratory Results form.
   - Record retention:

When providing results directly to the patient the Laboratory should retain copies of:

i. Copy of completed Release of Laboratory Results form
ii. Copy of two forms of identification provided by the patient
iii. Completed and signed "Authorization for Use or Disclosure of Protected Health Information" form

When referring patient request to Health Information Management (Medical Records):

i. Completed Release of Laboratory Results form
ii. Completed and signed "Authorization for Use or Disclosure of Protected Health Information" form

- At all times, records of information release should be readily available for regulatory inspectors, compliance, privacy office, and laboratory Manager, Regulations/QA.

h. If the laboratory personnel refers the patient or requesting individual to Health Information Management (Medical Records), then the form can be delivered to Health Information Management (Medical Records) either by mail or fax (336-716-5271 and follow instructions) or hand-delivered to medical records department on the 4th floor South Building. Results will be provided per medical records policy.
i. The requested results will be provided to the patient by the laboratory within 7 days of receipt of the request, or sent to medical records within 7 days of receipt of the request. All requests for laboratory results must be handled by the laboratory personnel within 7 days of receipt of request. See Documentation.
j. Results may NOT be provided directly to a patient by phone because of the inability to adequately verify the patient's identity.

Documentation:

1. Documentation will be forwarded to Client Services to handle the request and maintain documentation.
2. Client Services is responsible for maintaining documentation of requests for patient results including:

   When providing results directly to patient:
   a. Completed Release of Laboratory Results form
   b. Completed and signed "Authorization for Use or Disclosure of Protected Health Information" form

   When referring patient request to Health Information Management (Medical Records):
   a. Complete the Release of Laboratory Results form
   b. The laboratory result request documentation is considered complete when the "Authorization for Use or Disclosure of Protected Health Information" form is complete and received by Health Information Management (Medical Records)

3. Client Services will ensure that Release of Laboratory Results form (clinical and anatomic) is scanned into the patient's medical record once the request is completed.
4. A patient's request for results should be completed by the laboratory within 7 days, or received by Health Information Management (Medical Records) within 7 days, to allow sufficient time for processing of the request by medical records.

5. If it is anticipated that a request for laboratory results cannot be completed within 7 days or any other questions or problems, contact the medical director on-call immediately, not to exceed 7 days from receipt of request, so that an exception to the request can be managed and documented.
6. If a patient or legal representative fails to receive their requested laboratory results within 30 days, the event should be reported to the WFBH compliance office and privacy office for investigation.
7. The Manager, Regulations/QA should be notified of all requests as they occur to ensure that the timeline and documentation is completed and in compliance with regulatory requirements.

Exceptions:

1. Laboratory personnel may provide laboratory results to a patient in a clinic or phlebotomy setting when the laboratory result is being tested immediately and is the purpose of the visit (ie. Point of Care PT/INR results to a patient who presented to have their PT/INR tested).

4) Review/Revision/Implementation:

All procedures must be reviewed at least every 2 years.

- All new procedures and procedures that have major revisions must be signed by the CLIA Medical Director.
- All reviewed procedures and procedures with minor revisions can be signed by the designated section medical director.

5) Related Procedures: WFBMC Privacy Policy (PPB-MC-26)

6) References:

7) Attachments:

a. Authorization for use or Disclosure of Protected Health Information form

b. Release of Laboratory Results form

8) Revised/Reviewed Dates and Signatures:

Exhibit A

WAKE FOREST BAPTIST HEALTH
(NCBH WFUHS WFBMC Lexington Medical Center
Davie Medical Center Wake Forest Baptist Imaging
NCBH Outpatient Endoscopy Center)

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

Patient Name ____________________
Medical Record # ____________________
Department Name WFBMC Health Information Management
Telephone Number (336) 716-3230 ______
Date Rec'd ________ Date Sent ________
Copy given to requestor (Date) ____________
THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize Wake Forest Baptist Medical Center / WFBMC Health Information Management
(Person(s) or class of persons authorized to use/disclose the information)

Medical Center Blvd. – Winston-Salem, NC 27157
(Address)

to release to ____
(Person(s) or class of persons authorized to receive the information)

____
(Address)

Description of information that may be used/disclosed:
(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)

☐Medical Information from the most recent visit/admission to include physician notes/summaries and diagnostic results. Specify which department and location ____.

☐Medical Information including physician notes/summaries and diagnostic results for the periods from ____________________ to ____________________.

☐Other: Specify information to release ____
for the periods from ____________________ through ____________________.

The information will be used/disclosed for the following purposes:
Please specify the reason for this request, e.g. treatment, insurance, legal, etc

____

____

☐ At the request of the individual

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed or required by law.

I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the WFBH Privacy Office. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization. Information about the right to revoke has been shared with me in the WFBH Notice of Privacy Practices. This authorization expires______________. Unless specified or revoked, this authorization will expire one (1) year from the date signed.

______________________________ ______________________________
Signature of Patient or Personal Representative (*if applicable*) Patient's Date of Birth

______________________________ ______________/______________
Relationship to Patient Requestor's Home Phone/Work Phone

______________________________ ______________________________
Authority to Act Date

This release is limited to the department specified at the top of this form.
To obtain information from another department or from Wake Forest Baptist Health) individual authorizations will be needed.
Please contact the specific department or WFBH HIM Department at (336) 716-3230.

Revised 9/2013

Form associated with Lab Admin 6 Policy

Exhibit A

WAKE FOREST BAPTIST HEALTH
(NCBH WFUHS WFBMC Lexington Medical Center
Davie Medical Center Wake Forest Baptist Imaging
NCBH Outpatient Endoscopy Center)

Patient Name ____________________
Medical Record # ____________________
Department Name ____________________
Telephone # (336) ____________________
Date Rec'd ____________ Date Sent ____________
Copy given to requestor (Date) ____________
THIS FORM MUST BE COMPLETED IN FULL

AUTORIZACIÓN para USO *o* DIVULGACIÓN *de* INFORMACIÓN PROTEGIDA *de* SALUD

Doy consentimiento y autorizo a

____
(Dirección)
que le divulgue a

____
(Persona(s) o clase de personas autorizada a recibir la información)

____
(Dirección)

FOR OFFICE USE ONLY
__Entire __Abstract __OutPt. __ER
__Face __D/S __HP __OP __Path
__Lab __Xray __EKG __ProgNote
__PhyOrd.
Date: ____________ WF ______
Pages: ____________ NC ______
Comments: ____________
Copied by: ____________ Date: ____________

Descripción de información que puede usarse / divulgarse:
(La información puede incluir información médica relacionada con tratamiento de alcohol, atención psiquiátrica, evaluaciones psicológicas, abuso de sustancias, y/o VIH / SIDA, si aplica.)

☐ Información Médica de visita / internada más reciente, incluyendo notas / resúmenes de médicos y resultados de diagnóstico.

☐ Información Médica incluyendo notas / resúmenes de médicos y resultados de diagnóstico para el periodo de ____________ a ____________.

☐ Otra: Especifique información a divulgar ____________________
para el periodo de ____________ a ____________.

La información se usará / divulgará para los siguientes propósitos:

Por favor especifique la razón de esta solicitud, e.g. tratamiento, seguro, legal, etc.

____

____

☐ A solicitud del individuo

Entiendo que si la persona o entidad que recibe la información no es un proveedor de atención de salud o plan de salud cubierto bajo los reglamentos federales de privacidad, la información antes descrita podría volver a divulgarse y ya no quedar protegida por estos reglamentos.

Entiendo que puedo rehusar firmar esta autorización y que el rehusarme a firmar no afectará mi habilidad de obtener tratamiento o pago, ni mi elegibilidad a beneficios. Puedo inspeccionar o copiar cualquier información usada / divulgada bajo esta autorización hasta donde lo permita la ley.

Entiendo que puedo revocar esta autorización en cualquier momento al enviar un aviso de revocación por escrito a la Oficina de Privacidad. También entiendo que no puedo revocar esta autorización para acciones ya tomadas en base a la misma. Se ha compartido conmigo información sobre el derecho a revocar, en el Aviso de Privacidad de WFBH Davie Hospital. Esta autorización vence el ____________ (si no especificado, este formulario vence en 90 días).

Firma de Paciente o Representante Personal (*si aplica*)	Fecha de nacimiento del Paciente
______/______ Parentesco o Relación con el Paciente	Tel. de Solicitante Casa/ Trabajo
Autoridad para Actuar	Fecha

Esta divulgación se limita al departamento especificado al principio de este formulario.
Para obtener información de otro departamento o de Wake Forest Baptist Health (WFBH) se necesitarán autorizaciones individuales.
Favor de llamar al departamento en específico o a WFBH Health Information Management (336) 716-3230

MRRO

Form associated with Lab Admin 6 Policy

Exhibit B

DEPARTMENT OF PATHOLOGY

RELEASE OF LABORATORY RESULTS FORM

Complete part A. OR part B.

A. Laboratory RELEASE of Results to Patient:

Patient Name:	
Medical Record number:	
Date and time of request:	
Date and time results provided to patient:	
Name of lab staff providing information to patient:	
Attach copy of 2 forms of identification provided by the patient per policy	
Attach completed and signed "Authorization for Use or Disclosure of Protected Health Information" form	

List results released to patient:

Test Name	Test Date	Accession #

B. Laboratory REFERRAL of Patient to Medical Records for Results:

Patient Name:	
Medical Record number:	
Date and time of request:	
Date and time of delivery of disclosure form to Medical Records:	
Name of lab staff handling request:	
Attach completed and signed "Authorization for Use or Disclosure of Protected Health Information" form	

Medical Records release of information to the patient should be verified by the Manager, Regulations/QA

Date information released:

Verified by: Name: Date: