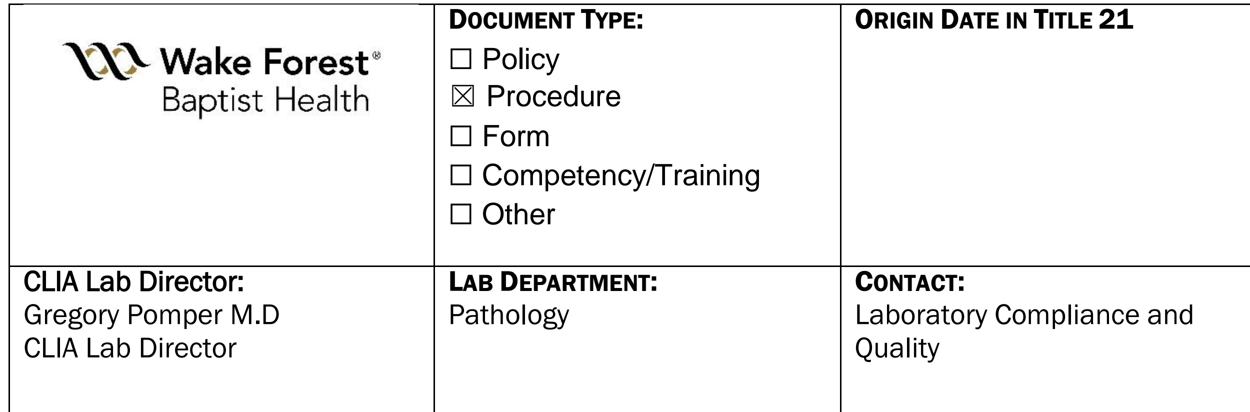

Wake Forest Baptist Health	**DOCUMENT TYPE:** ☐ Policy ☒ Procedure ☐ Form ☐ Competency/Training ☐ Other	**ORIGIN DATE IN TITLE 21**
CLIA Lab Director: Gregory Pomper M.D CLIA Lab Director	**LAB DEPARTMENT:** Pathology	**CONTACT:** Laboratory Compliance and Quality

APPLICABLE LABORATORY(S))

☒ North Carolina Baptist Hospital (NCBH)
☐ Lexington Medical Center (LMC)
☐ Davie Medical Center (DMC)
☐ Wilkes Medical Center (WMC)
☐ High Point Medical Center (HPMC)
☐ Westchester
☐ Clemmons

PROCEDURE STATEMENT

It is the policy of Wake Forest Baptist Medical Center Department of Pathology to provide patients or their legal representatives with copies of laboratory results within 30 day as required by HIPAA and our own Medical Center Privacy Policy.

PURPOSE

The purpose of this procedure is to provide laboratory staff with the direction needed to compliantly meet the requests of the patient or their legal representative.

SCOPE

Laboratory staff of the Department of Pathology.

DEFINITIONS

Procedure: A process or method for accomplishing a specific task or objective.

WFBH Lab System: Wake Forest Baptist Lab System is a health system that includes Wake Forest Baptist Medical Center and all affiliated organizations including Wake Forest University Health Sciences (WFUHS), North Carolina Baptist Hospital (NCBH), Lexington Medical Center (LMC), Davie Medical Center (DMC), Wilkes Medical Center (WMC), High Point Medical Center (HPMC), Lab at Westchester and Lab at Clemmons.

PROCEDURE GUIDELINES

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 while Anatomic results will be handled by Surgical Pathology. After hours the request form will be completed by

Central Processing and results can generally be picked up the next day, excluding holidays and weekends.

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:
        - 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 Medical Center Privacy Policy:
    a. 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:
    a. Provide the patient with the requested results; or
    b. 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:
    a. Identity of the patient should be verified.
        i. 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.
    b. A current valid official photo identification is required and should be copied and retained by the Laboratory.
    c. Results should only be provided directly to a patient or patient representative once properly identified as the appropriate representative.
    d. 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).**
    e. 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.
    f. Copies of the patient's identification and the authority for the request should be scanned in to the patient medical record under the media tab, and copies sent to the Laboratory Compliance Office to be held there.

H. Records Retention Summary:
    a. 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

b. When referring patient request to Health Information Management (Medical Records) the Laboratory should retain copies of:
    i. Completed Release of Laboratory Results form
    ii. Completed and signed “Authorization for Use or Disclosure of Protected Health Information” form
    iii. At all times, records of information release should be readily available for regulatory inspectors, compliance, privacy office, and laboratory Manager, Regulations/QA. Therefore copies of this information should be forwarded to the Laboratory Compliance Office for storage.

l. Documentation:
    a. Documentation will be forwarded to Client Services to handle the request and maintain documentation.
    b. Client Services is responsible for coordinating the documentation flow of requests for patient results including:
        i. When to provide results directly to patient or legal representative
        ii. When to refer the patient or legal representative to Medical Records
        iii. Accurate completion of the Release of Laboratory Results Form
        iv. Accurate completion of the Authorization for Use or Disclosure of Protected Heatlh Information Form
        v. Ensuring that all completed forms are scanned in to the patient EMR to track the occurrence of the disclousure
        vi. Follow up with patient or legal representative if there are any anticipated delays that would prevent the lab from providing the results within 7 days.
        vii. g. Follow up with the patient or legal representative at the end of 30 days if Medical Records was to provide the lab results. 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.

References:

Attachments/Linked Forms:

Authorization for use or Disclosure of Protected Health Information form

Release of Laboratory Results form

REVISION DATES: REVIEW CHANGE SUMMARY AS REPRESENTED IN TITLE 21.

Exhibit A

Patient Name ____________________
Medica 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

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

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

Exhibit A

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

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

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

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.

DEPARTMENT OF PATHOLOGY

RELEASE OF LABORATORY RESULTS FORM

Exhibit B

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: