STANTON TERRITORIAL HEALTH AUTHORITY

POLICY/PROCEDURE

CATEGORY:	Health Records	**PAGE NUMBER:**	1 of 11
SUBJECT:	Release of Patient Information	**DISTRIBUTION:**	Hospital Wide
CURRENT EFFECTIVE DATE:	May 2014	**NEXT REVIEW DATE:**	May 2017

This "Release of Patient Information Policy" applies to all patient records (also known as the "health record") which are the property of Stanton Territorial Health Authority (STHA). This includes the records within Stanton Territorial Hospital as well as the Medical Clinic, the Medical Centre and the Ophthalmology Clinic.

The policy also applies to the sharing of verbal information about a patient such as information known by a physician or hospital employee. Where the term "patient information" is used, it includes both patient records and any patient information known by hospital employees and medical staff.

SPECIAL POINTS

A STHA employee can move the patient's health record within the Authority Premises, for medical care purposes, in a sealed pouch that is obtained through the STHA Health Record Department.

The patient's health record is the property of STHA and shall not be removed from the Authority Premises unless authorized by the Access to Information and Protection of Privacy Coordinator.

There is no charge for a patient to have a copy of their **own record.**

Whenever a copy of a document from a patient record is released to the patient or to a third party, other than a Post-Discharge Health care Provider, the date, the name of the staff member releasing the information, and a comprehensive list of what documents were released must be recorded on the signed STHA "Consent for Release of Information Form", which is filed on the patient's health record. Copies of these forms can be obtained from the Health Record Department.

Authorization must be obtained from STHA's Access to Information and Protection of Privacy Act Coordinator (Quality & Risk Management Coordinator) to disclose patient information in situations not covered by this policy.

DEFINITIONS

Authority Premises: Stanton Territorial Hospital and each of the STHA Clinics.

Continuity of Care: the follow up and future health care provided by post discharge health care providers.

Continuity of Care Information: the information given to a post discharge health care provider in order to provide continuity of care.

Post Discharge Health Care Providers: members of the health care team who will be the primary care providers after the patient's discharge from the hospital. This includes Physicians, Midwives, Nurse Practitioners, Rehabilitation Providers (Occupational Therapists, Physiotherapists, Audiologist and Speech Language Pathologists), or Community Health Centre Nurses who are the primary care providers for the patient after discharge.

DISCLOSURE GUIDELINES

Boards of Education

Patient information may only be released to a School or Board of Education upon written consent of a parent or the child's legal representative. If the child is capable of understanding what is being requested, to whom and for what purpose, the child can provide written consent for the release of information.

Chief Public Health Officer

The *Public Health Act* and applicable regulations allows the Chief Public Health Officer or his/her designate to access patient information without patient consent. The Chief Public Health Officer must provide verification, in writing of their designate.

Coroner

Section 11(1)(c)) of the *Coroner's Act* of the NWT states "The coroner has the authority to seek a warrant and seize anything that the coroner believes is material to the investigation."

In the spirit of cooperation, STHA has interpreted this authority to mean that with a written request and authorization signed by the Coroner, the Coroner may receive a **copy** of the appropriate patient record. See the policy "Coroner: Reportable Deaths", section "C" page 0230 of the Hospital Policy Manual.

These requests will be handled by the Health Record Department. If the request occurs after hours, and cannot wait until the next business day, the Patient Care Coordinator or Senior Manager may respond.

Employers

An employer may **not** receive any patient information without prior written consent from the patient.

Health Services Administration Office of the Department of Health & Social Services

The dates of treatment, diagnoses, procedures, attending health care worker name and patient demographic information for billing/statistical purposes may be released by STHA employees to the Health Services Administration Office of the Department of Health & Social Services. Copies of the medical record cannot be given without the patient written consent.

Lawyers

Requests by lawyers for medical information must be accompanied by written consent of the patient or legal guardian. In the case where a lawyer wishes to speak to a practitioner about the patient there must be written consent of the patient or legal guardian or a court subpoena. If a practitioner has any doubt, the Quality & Risk Management Coordinator should be contacted.

Media

Requests for patient information from the news media should be referred to the Coordinator, Communications Policy and Planning. For more detailed information, refer to STHA Hospital Wide Policy C-0210 Communications: Media Communications.

Office of the Public Guardian

All requests will be forwarded to the Health Record Department. Section 11(2) of the *Guardianship & Trusteeship Act* states the authority of the guardian. Proof of the Guardianship Order must be presented prior to release of any patient information. If a representative from the Public Guardian's office is conducting an assessment as to the patient's condition and there is no Guardianship order, the consent of the next-of-kin is required. **Note: The Guardianship orders must be from an NWT Jurisdiction.**

Office of the Public Trustee

If the Public Trustee is the personal representative of a deceased patient's estate, then the Public Trustee has the authority of a personal representative and must provide proof of this authority.

Other Third Parties

An original written consent from the patient or their legal representative must accompany any requests from a third party for patient information, for example, an Insurance company or a lawyer. All requests from third parties will be processed through the Health Record Department with the exception of those pertaining to STHA on or off site clinics. STHA clinics shall use the Health Record Department or ATIPP Coordinator as a resource when in doubt as to a disclosure.

Patients

When a patient asks to see his/her own health record, the patient may be given supervised access only. The supervising staff member or physician charts the activity in the progress notes. If the patient wishes to obtain a copy of all or a portion of his/her health record, the patient must provide signed consent. Refer the patient to the Health Record Department.

During a visit, if requested, or when clinically appropriate, a patient may be provided a copy of their medical information. When appropriate, the health care practitioner may provide a copy to the patient **however** must document in the progress notes the title of each document given.

Personal Representative of Estate

The personal representative of a deceased person's estate is able to obtain a copy of the deceased patient's chart upon written request. The personal representative must provide written proof of his or her authority. If a patient has died with a Will, the personal representative is called an Executor and the written authority is called Letters Probate. We will also accept a copy of the Will certified by a Notary Public or Commissioner of Oaths. If a patient has died without a Will, the personal representative is called an Administrator and the written authority is called Letters of Administration. It is recommended to consult with the ATIPP Coordinator on these requests.

Post-Discharge Health Care Providers

For Continuity of Care, the patient's Post-Discharge Health Care Providers upon discharge may require information about the client from the client record. The transfer of information for follow up care is important in order that those providing continued treatment have the most current medical history and treatment plans. It is important however to ensure that circulation of this discharge information is limited only to the direct Health care Providers involved in the patient's care. However, should a patient request that no follow up information to be shared, the patient's wishes must be honoured.

Provision of Birth and Death Certificates

All certificate requests are referred to the Office of Vital Statistics 1-800-661-0830 as only the Registrar General can issue Birth and Death Certificates. **No photocopies of registration forms are to be provided by the Hospital.**

The original "Registration of Death" is completed by the attending physician or coroner. The original Registration of Death is normally provided to the funeral director or coroner. One photocopy of the Registration of Death is made for the patient's health record for all deaths occurring or being declared in Stanton Territorial Hospital.

If the family requires proof of death, please refer them to the funeral director who is caring for the deceased. Occasionally, a family will choose not to use a funeral director's services. In this situation the family will require the original Registration of Death to take to the City of Yellowknife in order to obtain a burial permit.

Psychiatric Record

In the case of psychiatric illness, it is not always in the best interest of the patient to know all the details involved in the case at the time of a request. Both section 49(2) of the *Mental Health Act* and section 21(2) of *ATIPP*, give the attending physician discretionary powers relating to disclosure of information.

Release of information from a psychiatric patient's health record is essentially the same as with any health record with particular attention being paid to the well-being of the patient. If the patient wishes to receive a copy of his/her own health record, the patient must provide signed consent. There may be information that could be harmful to the patient and it is for this reason that severing or blacking out portions of the record may occur prior to its release. This would be done pursuant to the applicable sections of *ATIPP*:

Disclosure harmful to another individual's safety	21.(1) The head of a public body may refuse to disclose to an applicant information, including personal information about the applicant, where the disclosure could reasonably be expected to endanger the mental or physical health or safety of an individual other than the applicant.
Disclosure harmful to applicant's safety	(2) The head of a public body may refuse to disclose to an applicant personal information about the applicant if, in the opinion of a medical or other expert, the disclosure could reasonably be expected to result in immediate and grave danger to the applicant's mental or physical health or safety.

Social Services Agency of the Northwest Territories:

Child Abuse Investigations

When an **investigation** into allegations of child abuse/neglect is reported to a Child Protection Worker, the Child Protection Worker must have the consent of a parent to obtain written medical information for that child. If the attending physician suspects neglect/abuse, there is a legal obligation for the physician to report suspicions to Health & Social Services, and give a verbal or written summation to Child Protection Worker. See the Child Abuse/Neglect: Duty to Report Policy under section "S" page S-2020, of the Hospital Policy Manual.

Child Under Apprehension:

This agency **may** have a legal right to patient information if the patient is currently under apprehension status. Written proof, in a written letter, of this apprehension status **must** accompany the request for medical information which must also include the Child Protection Worker designation number. The Child Protection Worker must state in writing that the child is currently under apprehension status.

If the case has not gone to a court proceeding, the *Child & Family Services Act* section 35(2) allows the Child Protection Worker to apprehend the child. This gives the Child Protection Worker certain rights:

Limitation on rights of Director

(2) For the purposes of subsection (1), the rights of a parent in respect of the person of the child means only those rights in relation to the following:

(a) where and with whom the child will live;
(b) consent to the examination of the child by a health care professional and, except where a child has been apprehended by reason of any refusal described in paragraph 7(3)(n), consent for medical care or treatment for the child if, in the opinion of the Director, the care or treatment should be provided;
(c) the child's education;
(d) the child's social and recreational activities.

The results (a copy) of an examination as described above, can be released to the Child Protection Worker once the Worker provides a written request that indicates that the child is under apprehension status **and** the child was under apprehension during the medical exam.

Child Under Temporary or Permanent Custody

If a child is under temporary or permanent custody of the Director of Child and Family Services, a copy of the custody order must be provided to the Health Record Department. The custody order must be from the Northwest Territories jurisdiction

Relatives

When a patient provides verbal consent, a designated relative/family member may discuss progress of the patient's care with the health care practitioner. The health care practitioner must document this verbal consent in their notes. All other health care team members treating the patient should refer relatives back to the patient or designated relative/family member as appropriate. Relatives/family members cannot view or receive copies of the patient's records without prior written consent from the patient.

Research

In the case of an outside agency's request to use patient records for research purposes as outlined in section 49 of the *Access to Information Protection of Privacy Act*, the request is directed to the CEO or their designate. The STHA Ethics Committee, the Clinical Practice Advisory Committee and the Aurora Research Institute must also approve research projects.

See policy "Research Projects: Ethical and Clinical Approval of" section "R" page R-1930 of the Hospital Policy Manual.

Royal Canadian Mounted Police (RCMP)

The RCMP are **not** entitled to disclosure from patient charts or any other patient information, including verbal information. Patient information may be released with written consent by the patient or patient's legal representative or if there is a Search Warrant or Production Order from a NWT jurisdiction. Only a copy of the patient medical record is provided, the original record is **never** released.

Upon the presentation of a Warrant or Production Order, if after hours, the Senior Manager on-call will be notified immediately. The Senior Manager will contact the Quality/Risk Management Coordinator to verify what the Warrant or Production Order requests. During regular business hours, the Warrant or Production Order for patient information will be handled by the Quality/Risk Management Coordinator.

Verbal Requests

Release of Information requests **must** be in writing with the exception of attending physicians or the Post-Discharge Health care Provider when his or her identity is known to the department holding the information.

Refer any such requests to the "Release of Information" staff member in the Health Record Department.

After hours verbal requests occur from time to time. When a request to provide emergency care comes in after the Health Record Department has closed, the requestor must fax a written request for the information. If the request is not to provide emergency care, refer the requestor to the Health Record Department on the next business day.

Veterans' Affairs

Information may only be provided upon written consent of the patient or their legal representative.

Vital Statistics

Information requested by Vital Statistics shall only be given with the patient's or legal representative's written consent.

Written Requests

Requests for access to copies of any portion of a patient record must be in writing. The Health Record Department has the consent forms for this purpose (see Appendix). Once verification is made that the requester has the legal right to have a copy of the patient record, the following are requirements for the consent for release:
A properly completed and signed consent will include the following data:

- The name of the individual or facility being authorized to release the information;
- The name of the receiving individual or facility;
- The full name, address and date of birth, as well as any known previous names they may have used, of the patient whose information is being requested;
- The date that the consent/authorization is signed;
- If the patient is unable to sign, he or she must be present and show picture identification. This fact is recorded on the consent form and witnessed.

Workers' Safety Compensation and Commission (WSCC)

Subsections 25 (1) and 25 (2) of the *Workers Compensation Act* establishes a legal obligation on the part of the health care provider to provide a medical report of the specific injury seen for and any information the WSCC considers necessary.

The duty of the health care facility is pursuant to section 25 (3).

Other than the report in subsection 25 (1) and (2) other requests from the WSCC are to be in writing.

Report by health care provider	25 (1) A health care provider who examines or treats a worker under this Act **shall** submit a report to the Commission.
Timing and contents of report	(2) The report must be submitted within three days after the examination or treatment, and must contain the information required by the Commission

Duty of health care facility	(3) If a health care facility employs the health care provider referred to in subsection (1), the health care facility is responsible for ensuring that the report is submitted in accordance with this section.

APPLICABLE LEGISLATION

The *Access to Information and Protection of Privacy Act* outlines the management of personal information. Although the ATIPP legislation does not deal specifically with patient records, the term "personal information" encompasses the information contained on a patient chart.

The release of patient information, which is not authorized by the disclosure guidelines in this policy, is not permitted and could result in hospital, professional or legal disciplinary action.

REFERENCES

1. *Access to Information and Protection of Privacy Act,* S.N.W.T. 1994, c.20.
2. *Public Health Act,* S.N.W.T. 2007, c. 17 as amended.
3. *Hospital and Health Care Facilities Standards Regulations* R.-036-2005, as amended
4. Criminal Code of Canada, 2013.
5. *Mental Health Act,* R.S.N.W.T. 1988,c.M-10, as amended.
6. *Workers' Compensation Act,* R.S.N.W.T. 2007,c.21, as amended
7. *Vital Statistics Act*, R.S.N.W.T. 2011,c.34.
8. *Child and Family Services Act,* S.N.W.T. 1997,c.13, as amended
9. *Coroners Act*, R.S.N.W.T. 1988,c.C-20, as amended
10. *Guardianship and Trusteeship Act*, S.N.W.T. 1994, c.29, as amended
11. Czecowski-Bruce, Jo Anne, Privacy and Confidentiality of Health Care Information., American Hospital Publishing Inc., AHA, 1984.
12. Rozovsky, L. E., Inions, N. J., Canadian Health Information, A Practical Legal and Risk Management Guide., Third Edition. Butterworths Canada Ltd., October 2002.

Reviewed and approved by:

MAY 1 2014
Chairperson of CPAC (Sign & Date)

Reviewed and approved by:

MAY 1 2014
Chief Executive Officer (Sign & Date)

Appendix

STANTON TERRITORIAL HEALTH AUTHORITY

Authorization for Release of Patient Information

I _____ hereby authorize Stanton Territorial Health Authority to release the following information from the indicated health records:

Information specific to the following illness/injury/problem: _____

for a visit, or visits, dated on or about: _____

From the Records Of: Name of Patient: _____

Any Previous/Other Names Used: _____
(eg: Maiden Name, Alias, Nickname, Birth Name)

Date of Birth: _____
(Please write out month in full)

Address: _____

Home Phone #: (____) _____ Work Phone #: (____) _____ (Contact Numbers for

Cell Phone #: (____) _____ Fax #: (____) _____ Patient)

To be Released To: Name: _____

Address: _____

Home Phone #: (____) _____ Work Phone #: (____) _____ (Contact Numbers for

Cell Phone #: (____) _____ Fax #: (____) _____ Requesting Party)

I hereby release the Stanton Territorial Health Authority, as named above, its employees and agents, from any and all claims whatsoever which may arise as a result of the release of the above information.

X _____
*(Signature of Patient/*Patient's Guardian/*Patient's Legal Representative)*

_____
(Relationship of the above signatory to the Patient, eg: Self, Mother, Father, Legal Guardian)

_____
(Date)

Witness:

_____
(Signature of Witness)

_____
(Print Name of Witness)

This authorization will expire ninety (90) days from the above date, or on the _____ day of _____, 20_____.

***Note:** If authorization is given by someone other than the patient, proof of guardianship or appointment as legal representative must be provided (eg: court order, custody agreement, guardianship agreement, etc.).

Hospital/Health Record Department Use Only:

Date: _____ **Person Releasing Information (please print):** _____

Information Released: _____

_____

_____

_____

Signature:

STHA # 7500-007-07