TRAINING UPDATE

Lab Location: Department:

SGAH & WAH Client Service

 Date Distributed:
 1/5/2015

 Due Date:
 2/1/2015

 Implementation:
 2/2/2015

DESCRIPTION OF PROCEDURE REVISION

Name of procedure:

Patient Requesting Results SGAH / WAH.CS12 v1

Request to Access PHI and HIPAA Notification Letter AG.F223.1 (SG) and AG.F224.1 (WAH)

Description of change(s):

Section 5: add phone number as level one identifier

Section 6: added updated PHI forms

Updated forms to match Corporate versions

The revised SOP and forms will be implemented on February 2, 2015

Document your compliance with this training update by taking the quiz in the MTS system.

Approved draft for training (version 1)

Non-Technical SOP

Title	Patient Requesting Results	
Prepared by	Leslie Barrett	Date: 10/27/2009
Owner	Samson Khandagale	Date: 10/27/2009

Print Name and Title	Signature	Date
Refer to the electronic signature page for		
approval and approval dates.		

Review:				
Print Name	Signature	Date		

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1. PURPOSE

This procedure defines the process for providing test results to patients.

2. SCOPE

This procedure applies to all Laboratory staff.

3. RESPONSIBILITY

All staff must comply with all applicable laws and regulations that govern our business operations, including but not limited to those laws, rules and regulations governing test reimbursement under the Medicare and Medicaid programs.

All employees are required to complete compliance training on an annual basis.

4. **DEFINITIONS**

Protected Health Information (PHI): All individually identifiable patient health information obtained, maintained, used or disclosed, regardless of its format (oral, electronic, and paper). PHI is the patient health information we use every day to do our job – the personal and medical information that relates to specific patients. Examples include completed requisitions, patient reports, and completed insurance claim forms.

5. PROCEDURE

A. Patient Rights

- 1. Patients have certain rights concerning their PHI and how it is used, disclosed, obtained and or maintained by Quest Diagnostics.
- 2. If the report contains results relating to drug and alcohol abuse, AIDS, and sexually transmitted diseases, physician approval is required before releasing to the patient.

- B. Process when a patient requests test results:
 - 1. Instruct the patient that they must appear in person and bring valid identification.
 - 2. Provide the patient with a PHI form to complete. Forms are maintained in the Laboratory client service area.
 - 3. Patient returns completed PHI form and provides valid identification.
 - 4. Staff verifies ID with information on PHI form and information in LIS.

Ensure that the records match. Information requested by the patient is considered a match to the retrieved record if both of the following two criteria are met.

The record must match A TOTAL OF 4 DIFFERENT ITEMS.

♦ Patient name (last name and first name)

AND

<u>Two</u> of the Level One Identifiers and <u>One</u> of Level Two Identifier, OR <u>One</u> Level One and <u>Two</u> Level Two.

LEVEL ONE Identifiers:

- Patient date of birth
- ♦ Patient phone number
- Patient social security number (or last four digits of patient social security number)

LEVEL TWO Identifiers:

- Patient address of record (the most recent address we have)
- ♦ Patient insurance ID number
- ♦ Ordering physician's name (or practice name)
- Ordering physician's address
- Ordering physician's phone number. The business unit or function can call the practice to confirm the phone number if it is different from the number in the system.

Note: If positive identification is NOT obtained as specified above, results are NOT to be given to the patient.

- 5. Print lab reports using the appropriate LIS function.
- 6. Give the patient the printed results.
- 7. If the patient designates an alternate address for mailing or a fax number, then the report should be faxed and/or mailed as indicated.
- 8. The state of Maryland requires that the physician be notified when results are provided to his/her patient. Complete the HIPAA notification letter and mail/fax to the physician's office.
- 9. The completed PHI form:

At SGAH - form is attached to the patient's initial test requisition, filed and held for 3 months in case any issues that arise. After 3 months the information is sent to Iron Mountain storage.

At WAH – form is filed alphabetically by patient name in the PHI section of the file cabinet. After 3 months the information is sent to Iron Mountain storage.

C. Requests by someone other than the patient

- 1. If the request is made by a parent/guardian of the patient Check the patient's date of birth to ensure that the patient is under the age of 18 Verify with the parent/guardian that he/she is the parent/guardian of the patient and/or has the right to the records (i.e., the requestor is the custodial parent and the patient is not an emancipated minor).
- 2. If the request is made on behalf of a patient by the patient's personal representative –

Obtain personal identification and valid written documentation (proof) that the requestor is authorized to represent the patient, for example, a health proxy, court order, legal guardianship, or living will that clearly establishes the authority of the personal representative.

3. If the request indicates that the report will be picked up by a personal representative –

The person picking up the record must present a picture ID and, in addition, the personal representative must provide proof that he or she is authorized to represent the patient (see 2 above).

6. RELATED DOCUMENTS

HIPAA Policy, Laboratory policy manual Request to Access PHI and HIPAA Notification Letter (AG.F223, AG.F224)

7. REFERENCES

Quest Diagnostics Incorporated Corporate SOP 703A Patient Access Requests

8. REVISION HISTORY

Version	Date	Reason for Revision	Revised By	Approved By
		Supersedes SOP L052.000		
000	12/1/2014	Section 5: add phone number as level one identifier Section 6: added updated PHI forms Section 9: removed outdated documents Footer: version # leading zero's dropped due to new EDCS in use as of 10/7/13	L Barrett	S Khandagale

9. ADDENDA AND APPENDICES

- A. Request to Access PHI form (example attached to this document, see Attachment Tab of Infocard for actual form)
- B. HIPAA Notification Letter (see Attachment Tab of Infocard)



Patient Request to Access or to Disclose Protected Health Information (PHI)

In order for us to identify the requested patient PHI, please complete all <u>required</u> information. Using the information provided, we will attempt to identify the laboratory tests results and or order form. *Indicates REQUIRED information.

A. Patient's	Information:			
Name*:	First Name	Middle Name/Initial		Phone Number: ()
			Last Name	
		iternate spellings, former nar	ne, etc.):	
Date of Birt	th*: (MM/DD/YYYY)			
Address*: _				
		digits)		surance ID#
	ler Information:			
Ordering P	hysicians' (or Office)	Name(s)*:		
Ordering P	hysician's Address(s)*:	Approximate	e Date(s) of Service*: (MM/DD/YY)
			()	
Requested	PHI: Laboratory	Test Results □ Ord	der Form	
C. Request	er Authorization:			
requested.		_		r the individual I request in box D below, with a copy of the PHI sation as requested (healthcare proxy, court order, power of attorn
Printed Nar	me*:		*Relat	ationship: (Check One)
				If Parent Legal Guardian Legal Representative (Provide Proof) (Provide Proof)
Signature*			Date*:	:
				·
D. Delivery	Instructions for Labo	oratory Test Results or Order	Form:	For easy electronic access to your lab results, please
Send to (Na	ame)*:			visit www.questdiagnostics.com/MyQuest or download the MyQuest App for iPhone or Android.
Address (If	different than above)*:		
or Fax Numbe	•r*:			
or				
E. Please s	ubmit the completed	form (and any proof of repres	sentation, if required)	d) to:
•	re Medical Center al Center Drive		Or fax to: (240	40) 826-5411
Quest Diag	nostics will respond	within 30 days of receipt of th	nis request.	Internal use only: Date received:
				Tracking #: Initials:



Quest Diagnostics at

Shady Grove Medical Center 9901 Medical Center Drive Rockville, MD 20850 Date Doctor Name Address Re: Release of Patient's Medical Records Maryland COMAR 10.10.06.04 requires that we inform you that your patient has submitted to us a written request for a copy of their records. This form is to notify you that we have forwarded a copy of those records as requested by the patient. No further action is required by your office. This is to notify you that your patient _____ has requested their laboratory results for the following date(s) of service: In accordance with the request, a copy of the report (s) has been provided to: Patient name Patient address Sincerely, **Laboratory Services** 240-826-6085



Patient Request to Access or to Disclose Protected Health Information (PHI)

In order for us to identify the requested patient PHI, please complete all <u>required</u> information. Using the information provided, we will attempt to identify the laboratory tests results and or order form. *Indicates REQUIRED information.

A. Patient's in	formation:			
Name*:				Phone Number: ()
	First Name	Middle Name/Initial	Last Name	
All other Name	es*: (nicknames,	alternate spellings, former nam	e, etc.):	
Date of Birth*:	·			
	(MM/DD/YYYY	")		
Address*:				
Social Security	Number (last fou	r digits)	Insura	nce ID#
B. Test Order	Information:			
Ordering Phys	sicians' (or Offic	e) Name(s)*:		
Ordering Phys	sician's Address	. ,	••	te(s) of Service*: (MM/DD/YY)
Phone Number				
Requested PH	l: Laborato	ry Test Results Orde	er Form	
C. Requester	Authorization:			
requested.		_		individual I request in box D below, with a copy of the PHI as requested (healthcare proxy, court order, power of attorney
Printed Name*:			ship: (Check One) Parent Legal Guardian Legal Representative (Provide Proof) (Provide Proof)	
Signature*: _			Date*:	
D. Delivery Ins	structions for La	boratory Test Results or Order I	Form:	For easy electronic access to your lab results, please visit www.questdiagnostics.com/MyQuest or
Send to (Name	e)*:			download the MyQuest App for iPhone or Android.
Address (If dif	ferent than abov	re)*:		
or Fax Number*:				_
or Email address			(PLEASE PRINT)	
)•		(FLEASE FRINT)	
E. Please sub	mit the complete	d form (and any proof of repres	entation, if required) to:	
Quest Diagnos Washington Ac 7600 Carroll Av	Iventist Hospital		Or fax to: (301) 89	91-6192
Takoma Park,				
Quest Diagno	stics will respon	d within 30 days of receipt of th	is request.	Internal use only: Date received:
				Tracking #: Initials:



Quest Diagnostics at Washington Adventist Hospital 7600 Carroll Ave Takoma Park, MD 20912 Date Doctor Name Address Re: Release of Patient's Medical Records Maryland COMAR 10.10.06.04 requires that we inform you that your patient has submitted to us a written request for a copy of their records. This form is to notify you that we have forwarded a copy of those records as requested by the patient. No further action is required by your office. This is to notify you that your patient _____ has requested their laboratory results for the following date(s) of service: In accordance with the request, a copy of the report (s) has been provided to: Patient name Patient address Sincerely, **Laboratory Services**

301-891-5142