New Vision
Medical Laboratories

Dear Valued Client,

New Vision Medical Laboratories would be happy to honor your request for test results, but please be aware of these specific items:

- Because of privacy laws, we must ask you for identification, and your permission to make a copy of it.
- Because of privacy laws, we must ask you to either sign an authorization form to release your tests results to you, or we may need to copy your authorization to access test results. Patients of legal age may sign the authorization for themselves or give permission to others. You may produce a power of attorney document if applicable.
- Only tests that are completed can be released. In some cases, only a preliminary result may be available, but it would be a disservice to you to release it. Please allow for the tests to be completed.
- Some tests may be sensitive in nature, or they may be very complex and subject to other clinical factors. We appreciate your concerns, but we must defer to your doctor to evaluate your test results. Our laboratory staff are permitted to only give you your test results along with a reference range. Questions regarding the test itself, what the results mean, or why they were ordered must be referred to your doctor.

Thank you for your understanding.

New Vision Medical Laboratories HIPAA Policy Manual Chapter 1: Access/Amendments/Accounting of Disclosure/Authorizations		Policy Number: nvml.hipaa.01.03 Initiation Date: 01/01/2003

This procedure is electronically produced, revised, monitored, reviewed and/or retired. For a full document history of initiation, revisions, and reviews with electronic signatures and dates, please open document in the procedure publishing software.

Patient Access to Laboratory Test Results

Patients have the right to review their own laboratory test results and may receive copies of them. Since this is Personal Health Information (PHI), there are conditions that must be met in order to protect both the patients and our laboratory.

1. Laboratory staff may release laboratory results only, but not until the proper forms have been submitted and have been deemed to be acceptable. Requests for other information that may be part of the medical record must be made through the Medical Records Department for the respective facility being served.
2. Out Patients or their personal caregivers, and Non Patients (not registered with a hospital account number) may request laboratory test results. In Patients, attorneys, government agencies, insurance companies, etc. must request desired information from the Medical Records Department for the respective facility being served.
3. Upon request for laboratory test results, an authorization form must be filled out. Before any anything can be released, the authorization must be determined to be valid. Valid authorization forms are those that are properly signed by the patient or the patient's representative, all applicable information is included on the form and not known to be inaccurate or false, and the form has not expired or been revoked. If an expiration date has been designated by the patient, it must be specific by date or an event directly relevant to the patient or the purpose of the use of the disclosure.
4. When an authorization form is signed by the patient and the patient is seeking their own test results, the following must take place depending on the situation:
   a. The request is made in person – verify the person using photo identification and make a copy of the photo identification.
   b. The request is made by mail, fax, phone, or email, contact the patient by telephoning or email and request identifying information such as date of birth, social security number, date(s) of admission or treatment or testing, or a notarized statement of identity.
   c. Optionally, the patient or caregiver can give a password for to use as a single identifier when later requesting results. The password must be entered in the LIS so that it will be accessible when the patient or caregiver calls in.
5. If an authorization form is signed by the patient's representative, the identity of said representative must be valid. If the person is physically present, request photo identification, and make a copy of the photo identification. If the representative is not physically present, they must supply identifying knowledge of the patient, such as date of birth, social security number, date(s) of admission or treatment or testing, or a

notarized statement id identity. More than one item should be used, and in any case, use your best judgment as to whether anything is questionable.

6. A patient's representative must establish their authority to act in that capacity. This may be accomplished by first providing, and then by permitting copies being made of guardianship, or power of attorney. If the representative is the parent of a minor child, the representative must provide information about the child such as date of birth, social security number, date(s) of admission or treatment or testing.
7. If you have any reservations as to the identity of a person, or the authority of a person to receive PHI, request assistance from the Privacy Officer or their designee at your facility. The requesting person may be required to sign an affidavit of identity or authority, or may be required to appear in person.
8. When the above conditions have been met and laboratory test results have been made available to the requester, the authorization/disclosure form must be sent to the respective facility's Medical Records department for documentation. In addition to the preprinted information being sought on the form, we must also document:
   a. The information that has been released (Eg: specific tests, or date range, etc.)
   b. To whom it has been released
   c. The format in which it was released (Eg: on paper, email, fax, etc.)
9. When a request for a patient's laboratory record has been made, but the patient is not associated with a hospital account (i.e. non-patient or drop off, etc.), an authorization/disclosure form should still be used as in step 8, but the information must be documented in the NVML Released Information database for a permanent record.
10. If for any reason NVML cannot release the requested information within 30 days (Eg: the test may be at a reference laboratory and not reportable within the time frame), a letter of explanation including an extension of an additional 30 days may need to be sent to the requester. Please notify either the NVML Privacy Officer or the NVML Site Manager.
11. If for any reason NVML cannot release the requested information (Eg: suspicious identification of the requester, or test information that we do not have), notify the NVML Privacy Officer or the NVML Site Manager. A denial notice may need to be sent to the requester.
12. Contact information:
    a. St. Rita's Medical Center
       1. NVML Privacy Officer – Ron Bibler – 419-996-5103
       2. NVML Site Manager – Tom Geis – 419-226-9372
       3. SRMC Privacy Officer – Lisa Carroll – 419-226-9324
    b. Van Wert Community Hospital
       1. NVML Site Manager – Dan Myers – 419-238-8613
       2. VWCH Privacy Officer – Denetria Harding - 419-238-8639
    c. Joint Township District Memorial Hospital
       1. NVML Site Manager – Carla Pond – 419-394-3387 Ext.3513
       2. JTDMH Privacy Officer – Lori Miller – 419-394-3387 Ext.1125

Policy Approval:

Approved by Ronald C Bibler - Laboratory Compliance Officer
9/22/2014 5:00:02 PM

Patient Access to Laboratory Test Results Quick Tips

Only Technical staff should release this information on weekends and off shifts.

I. **Check patient stay comment to see if HIPPA code was entered.**

A. If the hippa code is entered here the patient has already completed an authorization form.

1. **Verify hippa code with patient. If correct you may send results to patient per their request.**

2. **Document in call comments of the LIS, who requested the information, where, when and what was sent (what test results or what stay was sent) and who sent it. When sending by email be sure to type "secure" in the subject line. Place the documentation in Ron Bibler's mailbox. If you are unsure how to do this tell the patient you prefer to fax or have the patient pick up in person if able. Otherwise we will email the next business day for the office staff.**

B. If there is no hippa code entered for the patient stay an authorization form will need to be completed. Forms may be found in the office cupboard noting authorization forms.

1. **The patient may complete in person or by fax, email.**

   a. ***Must have a copy of driver's license and all identifying information is needed on the authorization form. Once all information is verified you may give the results to the patient.**

   b. **Document on the authorization form and in the LIS call comment, who requested the information, where, when and what was sent (what test results or what stay was sent) and who sent it. When sending by email be sure to type "secure" in the subject line. Place the documentation in Ron Bibler's mailbox. If you are unsure how to do this tell the patient you prefer to fax or have the patient pick up in person if able. Otherwise we will email the next business day for the office staff.**

2. **If a caregiver or parent is calling for results on a patient they may use the hippa code if noted in the patient stay or complete authorization form with a notarized statement of identity for caregiver. If a parent of a child they must be able to give name and DOB of patient as well as stay information.**

3. **When in doubt refer to nvml.hippa.01.03 and if things just don't seem right, the person says something out of place or seems nervous, we reserve the right to have them show up in person so that we can validate their ID. If the requestor is unhappy with our responses, they have the option of getting their results from Med Records.**

4. **Sensitive tests results such as: HIV, Hepatitis or Pathology reports should only be given to the patient by their care provider. You may tell the patient that testing is complete and they will need to contact their care provider.**

For All other tests you may use the following script with patients: We are only permitted to give you test results along with a reference range. Any questions regarding the test itself, what the results mean and why they were ordered should be referred to your care provider.

St. Rita's Medical Center
Lima, OH

AUTHORIZATION FOR USES AND DISCLOSURES OF PATIENT INFORMATION

4259642

Patient Name: _____ SSN: _____ DOB: _____ MR #: _____

I hereby authorize the use or disclosure of personal health information about me as described below: Acct. #: _____

1. Check the information that is the subject of this authorization which will be used or disclosed as set forth below:

☐ Discharge Summary	☐ Entire Medical Record	☐ All Dictated Reports
☐ History & Physical	☒ Laboratory Reports	☐ Emergency Room Reports
☐ Consultation	☐ Radiology Reports	☐ Other (specify): _____
☐ Operative Report	☐ EKG	_____
☐ MPI Sheet	☐ Physician Orders	_____
☐ Discharge Instruction Sheet	☐ Progress Notes	_____

From my visit of (Date of Service or Acct. #): _____

* This disclosure may include records disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of a medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

2. Select one of the following:
   A. St. Rita's Medical Center may release my personal health information, which is described above, to the following person, group of persons, or organization:
      Name: _____
      Address: _____
      _____
   B. _____ may release my personal health information, which is described above, to St. Rita's Medical Center, or physicians treating me for treatment purposes.
   C. The following person or group of persons employed or working for St. Rita's Medical Center may use my personal health information, which is described above, (i.e. Marketing): _____
3. The purpose of the authorized use or disclosure of the information described above is as follows:
   ☒ Individual Use ☐ Medical Care ☐ Attorney / Legal ☐ Insurance ☐ Disability / SS
   ☐ Other (describe) _____
   If the use or disclosure is for marketing purposes, I have been informed that St. Rita's Medical Center ☐ Does, ☐ Does Not, expect to receive any remuneration or payment from a third party as a result of the marketing.
4. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
5. As described in the Notice of Privacy Practices of St. Rita's Medical Center, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by St. Rita's Medical Center in reliance on this authorization, by sending a written revocation to: St. Rita's Medical Center, Medical Records Department, 730 W. Market St., Lima, OH 45801
6. This authorization will expire 60 days from the date below unless otherwise specified.
   ☐ Other (Insert applicable date or specific event) _____
   ☐ End of a research study (applicable only if the authorization is for a research study or for creation and maintenance of a research database or research repository.
7. I understand that I am not required to sign this authorization form and that St. Rita's Medical Center will not condition the provision of treatment or payment to me on the signing of this authorization, except that St. Rita's Medical Center may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for disclosure to a third party on the signing of this authorization.

_____ _____
Patient Name (Print) Name of personal representative, if applicable (Print)

_____ _____ _____
Signature of patient (or patient's representative) Date Relationship of personal representative to patient or statement of authority

Records Prepared for Release By: _____ Date _____ Time _____

Records Given To Patient By / Witness: _____ Date _____ Time _____

St. Rita's Medical Center
Lima, OH

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☐ Discharge Summary	☐ Entire Medical Record	☐ All Dictated Reports
☐ History & Physical	☐ Laboratory Reports	☐ Emergency Room Reports
☐ Consultation	☐ Radiology Reports	☐ Other (specify): _____
☐ Operative Report	☐ EKG	_____
☐ MPI Sheet	☐ Physician Orders	_____
☐ Discharge Instruction Sheet	☐ Progress Notes	_____

From my visit of (Date of Service or Acct. #): _____

* This disclosure may include records disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of a medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

2. Select one of the following:
   A. St. Rita's Medical Center may release my personal health information, which is described above, to the following person, group of persons, or organization:
      Name: _____
      Address: _____
      _____
   B. _____ may release my personal health information, which is described above, to St. Rita's Medical Center, or physicians treating me for treatment purposes.
   C. The following person or group of persons employed or working for St. Rita's Medical Center may use my personal health information, which is described above, (i.e. Marketing): _____
3. The purpose of the authorized use or disclosure of the information described above is as follows:
   ☐ Individual Use ☐ Medical Care ☐ Attorney / Legal ☐ Insurance ☐ Disability / SS
   ☐ Other (describe) _____
   If the use or disclosure is for marketing purposes, I have been informed that St. Rita's Medical Center ☐ Does, ☐ Does Not, expect to receive any remuneration or payment from a third party as a result of the marketing.
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_____ _____
Patient Name (Print) Name of personal representative, if applicable (Print)

_____ _____ _____
Signature of patient (or patient's representative) Date Relationship of personal representative to patient or statement of authority

Records Prepared for Release By: _____ Date _____ Time _____

Records Given To Patient By / Witness: _____ Date _____ Time _____