New Vision Medical Laboratories HIPAA Policy Manual Chapter 1: Access/Amendments/Accounting of Disclosure/Authorizations	New Vision Medical Laboratories	Policy Number: nvml.hipaa.01.03.01 Initiation Date: 01/01/2003 Revised: 02.07.17

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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 requesters can properly identify themselves. 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. Casual requests for test results from admitted patients, and from emergency room patients will not be accepted. Test results and explanations must come from their physician while they are still undergoing testing and/or treatment.
3. Outpatients or their personal caregivers, and Non Patients (not registered with a hospital account number) may request laboratory test results. Inpatients, attorneys, government agencies, insurance companies, etc. must request desired information from the Medical Records Department for the respective facility being served.
4. Telephone requests for results can be honored, but the requesting person must be able to validate their right to know by supplying one of the following, in addition to the patient's name: date of birth, account number, social security number (if recorded), date of service. In host facilities where HIPAA security codes are utilized, the code may be used solely for identity validation. After the results have been communicated, a record of the communication must be documented on a Patient Request to Access or Copy Health Information form (SRMC) or a form for similar use. Record what information was released, to whom it was released, the date, and time. This info is necessary for auditing purposes. Please submit the completed form to:
   Ron Bibler – SRMC facilities
   Carla Pond – JTDMH facilities
   Greg Murphy - VWCH
5. If anything seems questionable about the call, the person should be instructed to show up in person, or be able to supply identification electronically.
6. In person requests for laboratory test results, 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.
7. 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.

8. 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.
9. 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.
10. 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.
11. 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.)
12. 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.
13. 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.
14. 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.
15. 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 – Krista Swinehart – 419-226-9331
    b. Van Wert County Hospital
        1. NVML Site Manager – Greg Murphy – 419-238-8613

2. VWCH Privacy Officer – Ashley Rose - 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

Approved by:

2/15/2017

02.15.2017

Verbal Requests for Test Results

When calls are received from patients or caregivers for test results, some form of identification must be established to validate the right to have access. In addition to the patient's name, any of the following are acceptable as a second identifier that the caller must provide:

- Date of birth
- Account number
- Social Security number

Pathology reports that have not been signed out by a Pathologist cannot be released to anyone. Refer such requests to a Pathologist. Laboratory results, to the exclusion of anything else, can be released by laboratory staff. Anything else must be released by SRMC Medical Records.

If people want to pick up the information in person, we reserve the right to ask for proof of identity. Otherwise, test reports can be mailed, faxed, or emailed. NVML cannot be responsible for non-secure methods of delivering the report.

Upon validating the caller and giving the results out, fill out a Mercy Health Patient Request to Access or Copy Health Information. Fill out the form and document for example, the sample number from the results that you gave out. Place the caller's name in the Signature of Patient area and identify them as a caller. You sign and date the Witness area. Submit the form to Ron Bibler.

If something seems really off about the call, inform the caller that they will have to show up in person and be able to produce some identification. If the caller wishes to submit identification electronically, that is acceptable as long as you receive it and can produce a paper copy to be included with the request form that you filled out.

Keep in mind that we are required to reply to any request within 30 days, so if something doesn't feel right, don't be pressured by threats that it is Federal Law.

MERCYHEALTH

PATIENT REQUEST TO ACCESS OR COPY HEALTH INFORMATION

Complete all sections entirely. If this request is not complete, it may be returned and result in delay in processing. Photo ID required at the time of request and pick up.

OFFICE USE ONLY
Acct/MRN
Initials
Pages
Date

Patient name:	Date of Birth:	Last 4 digits of SS#:	Telephone #:
Doe, John	08.08.2016		419-999-0000

Address: 222 West Corner St (Street) Lima (City) OH (State) 45801 (Zip Code)

Mercy Health Hospital or Physician office health information requested from: (Check all that apply)

- [X] St. Rita's
- [ ] Physician/Practice Name: _____
- [ ] Other Healthcare Provider: _____

Dates of service to release: (from): _____ (to): _____

Specific reports to be disclosed: (Check all that apply)

- [ ] Abstract of record (Discharge Summary, H&P, Operative Report, Consults, Test results....)
- [ ] Office Visit
- [ ] Emergency Department record
- [ ] History & Physical
- [ ] Operative report
- [ ] Discharge Summary
- [ ] Immunization record
- [X] Test results (Lab, Pathology, Radiology, and Cardiac)
- [ ] Other (Images, Photos): _____
- [ ] Entire record (standard two years of information, unless otherwise specified): _____

If pick up or mailing records, format selected: [ ] Paper [ ] Electronic (CD)

Information to be disclosed via: (Check one)

Name of requestor (if different): Doe, Betty

- [ ] Mail to address above
- [X] Verbal report
- [ ] Fax to number: _____ (page limitation may apply)
- [ ] Email to: _____ (I acknowledge and accept the risks associated with unsecure transmission and Mercy Health is not liable for disclosures that occur in transit. I acknowledge file size limitations. If file cannot be sent by email due to file size, I will provide mailing address or will pick information up)
- [ ] Pick up location/site: _____

- I understand and acknowledge there is no charge to access (read/review) my health information or to provide me with a copy of specific reports/tests/abstract. (by appointment 24/48 hour notice required) If I request my entire record of health information, there will be a fee. Health information maintained in electronic format and provided in electronic or paper media will be $6.50 flat fee. Health information maintained in paper format will $0.10 per page.
- I understand and acknowledge if I am requesting my health information while I am In House/Admitted or receiving on-going services, my record may not be complete and I will need to request after services are completed and finalized

Via telephone — Signature of Patient/Patient's Legal Representative

02.21.2017 — Date

Relationship to patient: _____ *(Supporting documentation of authority must be provided)*

Witness (optional): Your Name