



Release of Patient Records: What You Must Do, What You Should Do, and What You Should Not Do

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Your patients' clinical records are the core of your chiropractic practice. How they are arrayed, secured and accessed has become a matter of increasing regulatory focus, and every DC must pay close attention to record-keeping, both in terms of recording all relevant clinical data on each patient on a timely and comprehensive basis, as well as on how they are physically (or electronically) maintained and secured.

You should be fully familiar with the federal HIPAA (Health Insurance Portability and Accountability Act of 1996) confidentiality requirements and have a records security and access plan in place with which all of your associates and employees are familiar and closely follow. You should know what your state, provincial or national regulatory body expects in terms of record content. You should also know how and who can access patient records and how to protect yourself and your practice against mistakes such as releasing the only copy of a file, allowing improper access, or unauthorized changes or additions to a patient file. Common sense and a thorough knowledge of the official rules in your jurisdiction are your best protection.

Who owns the record?

The question of ownership of patient records is clear and absolute. The doctor owns the records. The patient, however, also has rights to the information in those records. Within the rules as established by your state, province or national regulatory bodies, you must provide patients copies of their records when requested in writing. You must always obtain a signed release from the patient that contains their original signature. Agents of the patient, including attorneys, guardians and other representatives can also request such records on a patient's behalf, but always get the signed authorization to release. There should never be any exceptions to this rule, except when a court order or subpoena is involved.

You may charge for the expense of making copies of those records, and every US state has a schedule that establishes and/or limits such charges. It is interesting to note that even in states where the rules regarding patients' rights to their own health care records might be vague or limited, there exists a strict and specific schedule for charging for copies. You should always maintain a full record of who has received copies or summaries of patient records and any such information should always be consistent down to the smallest detail with what is in your master file.

Do patients have access?

Practitioners need to be aware of and be alert to potential problems and

issues when a patient wants a copy of their personal records. In recent years, patients have become increasingly interested in and demanding of access to the exact details of what is in their personal files. This represents a relatively new series of challenges and issues since a patient's absolute right to access their personal records and obtain copies, has not always been on the statute books. In fact, as recently as 1995, only 28 states had rules that guaranteed patients access to their own records. Today, nearly every state seeks to provide patients with both access as well as confidentiality through statutes and regulations for their personal health care records.

Doctors should develop a written release of records policy and have it immediately available to any patient that asks about getting copies of their personal files. Doctors should also have a written copy of the formal laws and rules relating to patients' rights on file and readily available, especially those portions of the formal rules that limit access if this is the case in your jurisdiction, and those portions of the rules that deal with charges for such copies. It is hard for any patient to argue with the law.

Doctors should also recognize that requests for records often represent a goodwill frontier, and a friendly, prompt and complete response is almost always in the best interests of the practice. Avoiding long delays in responding to all requests for records is another important consideration. This is easier to do if you keep those records current and complete.

The motives of patients for access-

ing their records are diverse, and range from the most innocent and reasonable to questionable or even sinister. In some instances, patients are concerned that records of illness, injury or chronic conditions might disqualify them from accessing life or health insurance in the future, limit their ability to compete for some kinds of employment, or impact a disability finding. There are emerging patterns of patient behavior where some patients even want to change what you put in their files, deleting vital data, or amending your findings to present an altogether different conclusion from what you originally found. This most definitely falls into the category of "must not do."

A patient's desire or demand to change their records raises very serious questions from both professional responsibility and ethical perspectives. As well, the malpractice implications of such changes can be profound. Correcting a fact, such as date of birth or even accurately reflecting a patient's height or weight is one thing. Changing or deleting a clinical finding is an entirely different issue and should be avoided at all times. Again, don't do it.

Why do you need to be alert?

The reality of chiropractic practice today is that a request for records by a patient is a signal to which you must pay attention. What exactly it is a signal of needs to be explored, carefully and diplomatically, but quickly. It is in your best interest to find out why the request is being made and to move swiftly to address any issue, complaint or concern that your communication with the patient reveals. In many instances, records are requested because a patient is relocating. Some may simply have decided to change providers. Often, other health care professionals have asked for more information on their chiropractic care, or patients are just curious as to what you are saying about their status, often based on cost concerns. Again, there are more problematic motives, and here is where having a policy in place, sound procedures for security and a good procedure and commitment to keep records complete and up to date, as well as well-arranged, tends to pay off.

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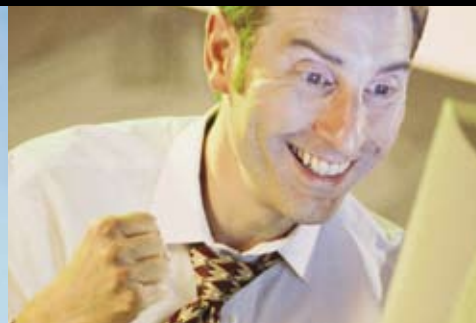
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