Indian Health Service

Release of Information – Everything You Should, ROI Reports, BRN Enhancements

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RELEASE OF INFORMATION

RELEASE OF INFORMATION (ROI)

EVERYTHING YOU SHOULD KNOW AND MORE

OBJECTIVES

- Overview of Patient Rights under the Health Insurance Portability and Accountability Act (HIPAA)
- Review Release of Information (ROI) Process and IHS Forms
  - Request
    - Core elements
  - Valid Authorization
  - Compound Authorizations
- IHS Policies – Release of Information
- RPMS ROI Package (BRN) and Reports Overview
- BRN Enhancements – New Features

WHAT IS THE ROI PROCESS?

- For each request, staff must validate a requestor's authorization
- Locate records
- Select requested documents
- Review the record to ensure the authorization is valid for the release of all requested information
- Prepare and send the request
- Log the request in BRN package

ROI – DISCLOSING PATIENT IDENTIFIABLE INFORMATION (PII)

ROI: the process of disclosing PII from the health record to another party

Who makes these requests?

- Individuals (Patients) or Personal Representatives
- Family
- Payers/Insurers
- Government agencies (Social Security, HHS, etc.)
- Public Health (child abuse services, STD's, etc.)
- Attorneys
- Courts

DEFINITION OF PERSONAL REPRESENTATIVE

- Under the Privacy Rule, a person authorized (under State or other applicable law, e.g., tribal or military law) to act on behalf of the individual in making health care related decisions is the individual's "personal representative."
- A personal representative may also authorize disclosures of the individual's protected health information.

PERSONAL REPRESENTATIVES' AUTHORITY

The personal representative has ***broad authority*** to act on the behalf of a living individual in making decisions related to health care, ***such as is usually the case with a parent with respect to a minor child or a legal guardian of a mentally incompetent adult***, the covered entity must ***treat the personal representative as the individual for all purposes under the Rule,*** unless an exception applies.

Where the authority to act for the individual is ***limited or specific to particular health care decisions***, the personal representative is to be ***treated as the individual only with respect to protected health information that is relevant to the representation.***

PERSONAL REPRESENTATIVES TYPES

If the Individual is:	The Personal Representative is:
Adult or An Emancipated Minor	A person with legal authority to make healthcare decisions on behalf of an individual Examples: Healthcare power of attorney, Court appointed legal guardian, general power of attorney of durable power of attorney for healthcare *Exceptions: Abuse, neglect and endangerment situations*
Unemancipated Minor	A parent, guardian, or other person acting in loco parentis with legal authority to make healthcare decisions on behalf of the minor child *Exceptions: Parent and unemancipated minors, and abuse, neglect and endangerment situations*
Deceased	A person with legal authority to act on behalf of the decedent or the estate (not restricted to persons with authority to make healthcare decisions) *Examples: Executor or administrator of the estate, Next of kin or other family member (if relevant law provides authority)*

WHEN CAN RECORDS BE RELEASED?

- Facilities do not release a patient's records to someone else without a direct authorization to disclose the records to a third party form signed by the patient.
- If the patient is incapacitated or deemed incompetent, legal documents must be drawn up and presented at the HIM department before another person can access the records.
- Documents, such as powers of attorney, grant different rights at different stages.
  - Some expire at the patient's death, and others only become effective at that point.
  - Some may not be effective when the patient reaches "diminished capacity" and is in the greatest need of assistance managing his or her records.

WHAT ABOUT RELATIVES?

- Patients don’t have an automatic right to one another’s records, even if they are married
- Spouses can sign an authorization allowing their partner to have access
- One estranged spouse may try to access the other’s medical records
- Some patients may choose to not disclose certain medical treatment or testing information from their spouse, parent or family members

WHAT ARE THESE REQUESTS USED FOR?

- Continuity of Care
- Patient Requests
- Payer Requests
- Legal/Litigation
- Regulatory Requirements (public health, disability, etc.)

OVERVIEW OF PATIENTS RIGHTS

- Access
- Revoke
- Amendments
- Restrictions
- Accounting of Disclosures
- Confidential Communications

RIGHT TO ACCESS

- Patients have the right to access and inspect his/her medical record (45 CFR §164.524)
- Patient has the right to request a copy of his/her medical record (45 CFR §164.524)
  - 30/60 day response time. This timeline changed – used to be 60 days to complete the request
  - If you decide to deny, this request must be in writing

PATIENT AUTHORIZATION

- The Privacy Rule (45 CFR § 164.508(c)(1)) gives requirements for the patient authorization to release health information
- IHS must obtain the individual's authorization, unless the disclosure is otherwise permitted by another provision of the Privacy Rule
- The authorization must meet all requirements of the Privacy Rule to be valid
- In other words, you do not have to use the IHS-810 form, but the form does have to contain certain core elements to be accepted

CORE ELEMENTS OF A VALID AUTHORIATION

- A meaningful description of the information to be disclosed
- Name of the individual or the name of the person(s) authorized to make the requested disclosure
- The name or other identification of the recipient of the information
- A description of each purpose of the disclosure (The statement “at the request of the individual” is sufficient when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose)
- An expiration date or an expiration event that relates to the individual
- A signature of the individual or their personal representative (someone authorized to make health care decisions on behalf of the individual) and the date

ADDITIONAL PATIENT AUTHORIZATION REQUIREMENTS

- The following statements are also required to be on the authorization:
  - The individuals right to revoke the authorization in writing, the exceptions to this right, and a description of how he/she may revoke it
  - Advise the patient that information released pursuant to the authorization may be subject to the redisclosure by the recipient and no longer protected
  - The inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization

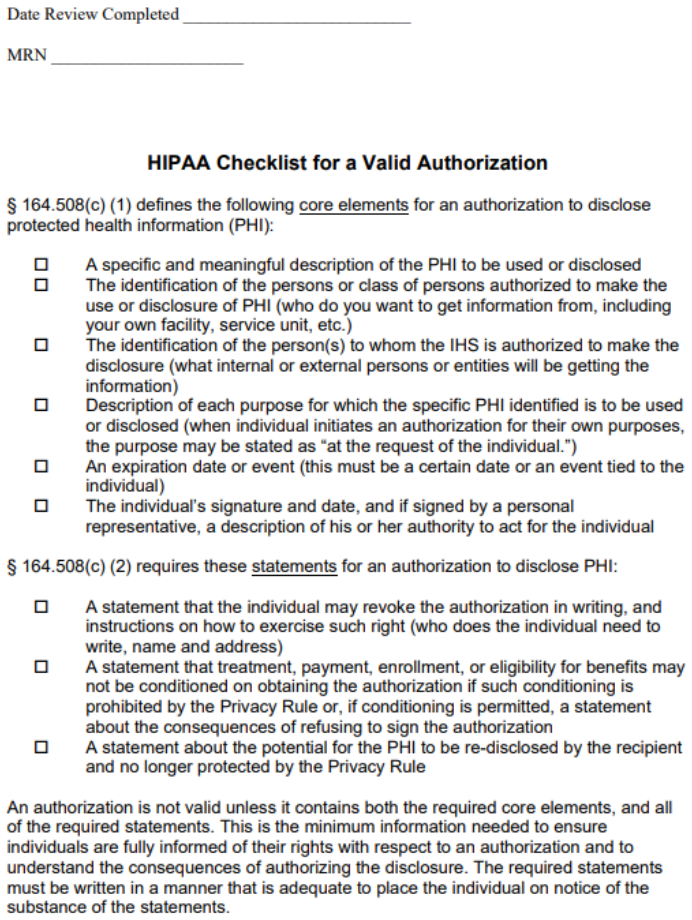
VALID AUTHORIZATIONS

- Patients are not required to use the IHS-810 but the request must have those elements to be considered valid
- Must be in writing – we don’t honor verbal requests
- State requirements vary and may require more information

TIP: KEEP A CHECKLIST FOR ROI STAFF

- It may be easier for your staff to have a checklist they can refer to in order to ensure an outside authorization has the required elements
- Sample checklist on next slide
- If in doubt that the authorization is not valid, please send an IHS-810 form to the requestor to be completed by the patient

CHECKLIST FOR A VALID AUTHORIZATION



Date Review Completed _____

MRN _____

HIPAA Checklist for a Valid Authorization

§ 164.508(c) (1) defines the following core elements for an authorization to disclose protected health information (PHI):

- ☐ A specific and meaningful description of the PHI to be used or disclosed
- ☐ The identification of the persons or class of persons authorized to make the use or disclosure of PHI (who do you want to get information from, including your own facility, service unit, etc.)
- ☐ The identification of the person(s) to whom the IHS is authorized to make the disclosure (what internal or external persons or entities will be getting the information)
- ☐ Description of each purpose for which the specific PHI identified is to be used or disclosed (when individual initiates an authorization for their own purposes, the purpose may be stated as "at the request of the individual.")
- ☐ An expiration date or event (this must be a certain date or an event tied to the individual)
- ☐ The individual's signature and date, and if signed by a personal representative, a description of his or her authority to act for the individual

§ 164.508(c) (2) requires these statements for an authorization to disclose PHI:

- ☐ A statement that the individual may revoke the authorization in writing, and instructions on how to exercise such right (who does the individual need to write, name and address)
- ☐ A statement that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization if such conditioning is prohibited by the Privacy Rule or, if conditioning is permitted, a statement about the consequences of refusing to sign the authorization
- ☐ A statement about the potential for the PHI to be re-disclosed by the recipient and no longer protected by the Privacy Rule

An authorization is not valid unless it contains both the required core elements, and all of the required statements. This is the minimum information needed to ensure individuals are fully informed of their rights with respect to an authorization and to understand the consequences of authorizing the disclosure. The required statements must be written in a manner that is adequate to place the individual on notice of the substance of the statements.

- This checklist can be used by new ROI staff to verify the authorization has the required elements
- It can also be used by HIM Directors as a QA or auditing tool when checking the work of the ROI staff.

INVALID AUTHORIZATIONS

- Invalid authorizations can not be processed by the ROI staff; explain to the requestor what is lacking or needs corrected.
- Examples of invalid authorizations:
  - Incomplete (missing required elements or lacks signature)
  - Expired
  - Revoked
  - Contains information known by the facility to be false
  - Compound Authorization

SENSITIVE INFORMATION

- Keep in mind that certain requests are for sensitive information such as:
  - AIDS/HIV
  - STD’s
  - Alcohol and Drug Abuse
  - Mental Health/Behavioral Health
  - Abuse (sexual, minors, etc.)
- These conditions must be specifically indicated on the request

COMPOUND AUTHORIZATIONS

- Compound Authorizations: authorizations that are combined with any other legal permission
- Compound Authorizations are NOT permitted for the following:
  - Psychotherapy notes with a general authorization
  - General authorizations that conditions treatment, payment, enrollment or eligibility for benefits with another general authorization

INSTRUCTIONS FOR COMPLETING IHS 810

- The IHS 810 has instructions for completion on the back of the form, make sure to print both sides.
- Make sure the ROI staff are familiar with these instructions so they can assist the requestors and pull the correct information to be released.
- Note that e. and f. have specific instructions regarding alcohol/drug abuse, HIV/AIDS, sexually transmitted diseases, mental health and psychotherapy notes. Patients must specifically indicate which notes they are requesting and, in the case of psychotherapy notes, may not be combined with other notes.

Instructions for Completing IHS Form 810 --
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of patient whose information is to be released.
3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.
4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc. For an Health Information Exchange (HIE) other than IHS, please provide the name of the HIE.
5. Section IV, check the appropriate box as applicable.
   a. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.
   b. **Only the period of events from** -- specify date range, e.g., Jan. 1, 2002, to Feb. 1, 2002.
   c. **Other *(specify)*** -- e.g., Purchased Referred Care (PRC), Billing, Employee Health.
   d. **Entire Record** -- complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).
   e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.**
   f. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.
   g. When you opt-in to share information through the HIE, an expiration date must be entered.
6. Section V, if a different *expiration* date is desired, specify a new date. For HIE, a date 5 years in the future is recommended in order to provide health information for continuity of care.
7. Section V, Please sign (or mark) and date.
8. A copy of the completed IHS-810 form will be given to you.

COMPOUND AUTHORIZATIONS – IHS 810

f. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

EXAMPLE - COMPOUND REQUEST

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

- ☐ Only information related to *(specify)* _____
- ☐ Only the period of events from _____ to _____
- ☐ Other *(specify) (CHS, Billing, etc.)* _____
- ☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☒ Alcohol/Drug Abuse Treatment/Referral
- ☐ HIV/AIDS-related Treatment
- ☒ Sexually Transmitted Diseases
- ☐ Mental Health *(Other than Psychotherapy Notes)*
- ☒ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

RIGHT TO REVOKE

- The Privacy Rule gives individuals the right to revoke, at any time, an Authorization they have given.
- The revocation must be in writing and is not effective until IHS receives it.
- The written revocation is not effective with respect to actions IHS took in relying on a valid authorization.

IHS FORMS AVAILABLE

- https://www.ihs.gov/forpatients/patientforms/
- IHS-810: Authorization For Use of Disclosure of Patient Information
- IHS-963: Request for Confidential Communication by Alternate Means or Alternate Location
- IHS-912-1: Request for Restrictions
- IHS-912-2: Request for Revocation of Restriction(s)
- IHS-913: Request for An Accounting of Disclosures
- IHS-917: Request for Correction/Amendment of Protected Health Information

IHS FORMS

- Remember to use clean, readable copies of these forms
- These are legal documents and are filed as Administrative documents in VistA
- They are available for everyone to use on the IHS website
- These forms are self-explanatory, but the IHS-810 and IHS-917 have detailed instructions for patients on the second page

INDIAN HEALTH MANUAL PART 2 CHAPTER 7 – HIPAA AND THE PRIVACY ACT

- Many of these forms correlate with the Indian Health Manual, Part 2, Chapter 7 – Health Insurance Portability and Accountability Act, Privacy Rule and the Privacy Act policies and procedures
    - Procedures for Patients' Rights to Access, Inspect and Obtain a Copy of their PHI
    - Procedure for Matters Related to Accounting of Disclosures of PHI
    - Procedure for the Transmittal of Confidential Communication by Alternate Means or to an Alternate Location
    - Procedure for Requests for Correction/Amendment of PHI

IHS RELEASE OF INFORMATION POLICIES/PROCEDURES

- RPMS Release of Information Disclosure User Manual
- PROCEDURES FOR PATIENTS' RIGHTS TO ACCESS, INSPECT, AND OBTAIN A COPY OF THEIR PHI
- Procedures for Access to Deceased Patient Records or Records of Non-U.S. Citizens not Lawfully Admitted for Permanent Residence
- Request for Access to Deceased Patient Records by Persons Who Are Not The Deceased Patient's Personal Representative
- PROCEDURE FOR MATTERS RELATED TO ACCOUNTING OF DISCLOSURES OF PHI
- PROCEDURE FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION PURSUANT TO AUTHORIZATION OR VALID WRITTEN REQUEST
- PROCEDURE FOR SENDING AND RECEIVING PHI BY FACSIMILE
- PROCEDURE FOR THE MAINTENANCE, USE, AND DISCLOSURE OF PSYCHOTHERAPY NOTES
- PROCEDURE FOR ACCESS TO OR DISCLOSURE OF PHI OF UNEMANCIPATED MINORS
- PROCEDURE FOR THE USE AND DISCLOSURE OF PHI FOR EMANCIPATED MINORS AND ADULTS WITH PERSONAL REPRESENTATIVES OR LEGAL GUARDIANS
- PROCEDURE FOR VERIFICATION OF IDENTITY PRIOR TO DISCLOSURE OF PHI
- PROCEDURE FOR THE DISCLOSURE OF PHI TO LAW ENFORCEMENT OFFICIALS
- Procedure for limiting the use or disclosure of and requests for PHI to the Minimum Necessary
- IHS Patient Forms

RIGHT TO REQUEST AN AMENDMENT

Why?

- Correct a perceived error
- Omission
- Add relevant information

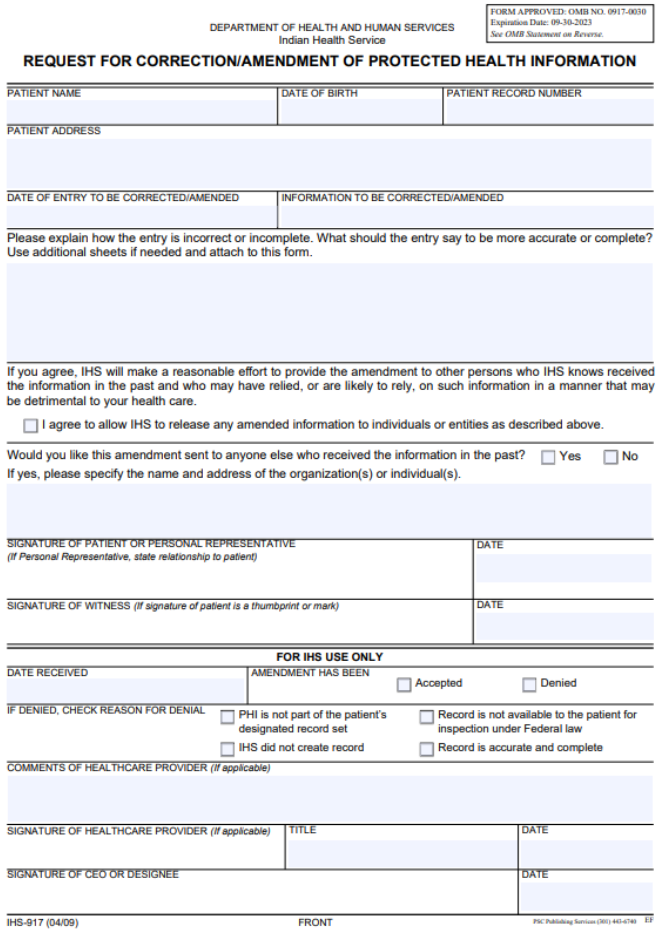
Remember – they have the right to request, that does not necessarily mean it will be amended

IHS has the right to accept or deny the request

REQUEST FOR CORRECTION/AMENDMENT OF PHI (1 OF 3)

- A patient who believes their health information is inaccurate or incomplete may submit a request, using the IHS 917 form, to the CEO or (his or her) designee for correction or amendment of the record in question.
- This is part of patient's rights under HIPAA. 45 CFR §164.526
- While this is ultimately signed by the CEO, it is a ***clinical determination*** whether the record is changed/amended.
- If a decision on the request for correction or amendment can be made within 10 working days of the IHS' receipt of the request, the IHS will notify the patient of the receipt of the patient's correction or amendment request and its decision within that 10 day period.

IHS 917 FORM



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09-30-2023
See OMB Statement on Reverse.

REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

PATIENT NAME | DATE OF BIRTH | PATIENT RECORD NUMBER

PATIENT ADDRESS

DATE OF ENTRY TO BE CORRECTED/AMENDED | INFORMATION TO BE CORRECTED/AMENDED

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? Use additional sheets if needed and attach to this form.

If you agree, IHS will make a reasonable effort to provide the amendment to other persons who IHS knows received the information in the past and who may have relied, or are likely to rely, on such information in a manner that may be detrimental to your health care.

☐ I agree to allow IHS to release any amended information to individuals or entities as described above.

Would you like this amendment sent to anyone else who received the information in the past? ☐ Yes ☐ No

If yes, please specify the name and address of the organization(s) or individual(s).

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(If Personal Representative, state relationship to patient)* | DATE

SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)* | DATE

FOR IHS USE ONLY

DATE RECEIVED | AMENDMENT HAS BEEN ☐ Accepted ☐ Denied

IF DENIED, CHECK REASON FOR DENIAL
☐ PHI is not part of the patient's designated record set
☐ Record is not available to the patient for inspection under Federal law
☐ IHS did not create record
☐ Record is accurate and complete

COMMENTS OF HEALTHCARE PROVIDER *(If applicable)*

SIGNATURE OF HEALTHCARE PROVIDER *(If applicable)* | TITLE | DATE

SIGNATURE OF CEO OR DESIGNEE | DATE

IHS-917 (04/09) FRONT

- The **IHS 917 Request for Correction/Amendment of Protected Health Information** has specific instructions for completion on Page 2 so ROI staff should be familiar with these so they can assist requestors.
- *Note there is also a space that needs to be completed by the facility on Page 2 when this form is used*:

10. This form and subsequent information pertaining to this request will become part of your permanent health record.

FOR IHS CEO: Insert Service Unit address, CEO's name & Title, and Telephone # into area below.

REQUEST FOR CORRECTION/AMENDMENT OF PHI (2 OF 3)

- The CEO or (his or her) designee, in consultation with the appropriate staff member, will review the request for correction or amendment and will inform the patient in writing within 60 days after receipt of the request, of approval or denial of the request for correction or amendment.
- The IHS may extend the time frame one time only for no more than 30 days, if it informs the patient in writing using one of the reasons for the delay and the date by which the IHS will act on the request.
- Final approval will need to be received from the OGC.
- The IHS-917 form will be electronically filed at the site of the contested entry in the individual's medical record and maintained for the life of the record.

REQUEST FOR CORRECTION/AMENDMENT OF PHI (3 OF 3)

- The Indian Health Manual, Part 2, Chapter 7, has sample letters that can be used to respond do these requests
- These letters will be scanned into VistA as an administrative document
- Model Letters 2-7.9
  - Model Letter Approving Request for Correction or Amendment
  - Model Letter of Acknowledgement of Receipt of Request for Correction or Amendment
  - Model Letter Denying Request for Correction or Amendment – Service Unit Letterhead and Address

MODEL LETTER FOR CORRECTION OR AMENDMENT

- **Model Letter of Acknowledgement of Receipt of Request for Correction or Amendment**.
- This letter will be sent to the patient that submits a 917 while the request is reviewed.

Service Unit Letterhead and Address

Date:

Jane Doe
1234 Main Street
Main, AZ 12341

Dear Ms. Doe,

This is to acknowledge receipt of your request for correction or amendment of your health information.

1. Your request is being reviewed and a decision will be made and sent to you within 60 days from the date of this letter.
2. We are currently unable to make a decision on your request for correction or amendment of your health information within 60 days for the following reason(s): [INSERT REASON(S)] therefore, we are extending this period up to an additional 30 days.
3. The record requested is maintained by another government agency; therefore, your request has been forwarded to the agency responsible for your request. Please contact the agency at the address below for all future inquiries regarding this request:

   (Insert name and address of the Agency)

_____

Signature of CEO or (his or her) designee

APPROVED CORRECTION AMENDMENT

- If the request to correct/amend is approved, follow the local policy to amend the record in the EHR and involve the appropriate staff – including if anything was billed with the incorrect diagnosis/procedure that now needs to be corrected by the billing staff.
- The difference is that the ***patient*** initiated this correction or amendment.

MODEL LETTER APPROVING REQUEST FOR CORRECTION OR AMENDMENT

Service Unit Letterhead and Address

Date:

Jane Doe
1234 Main Street
Main, AZ 12341

Dear Ms. Doe,

After reviewing your letter requesting correction or amendment of your health information, I am pleased to inform you that your requested correction or amendment has been approved. Your record now reflects the correction or amendment requested.

Thank you for allowing us to continue to serve you.

Signature of CEO or designee

REQUIREMENTS IF REQUEST IS DENIED

- If the patients request to correct/amend is denied:
- Inform the patient (45 CFR § 164.526)
- Timely, written denial must be issued
  - Plain language
  - Reason for denial
  - Describe the individual's right to submit disagreement and how to file
  - Statement that the individual can request all documentation pertaining to the request be released along with all future releases
  - How to file a complaint and to whom as well as the Secretary

MODEL LETTER DENYING REQUEST FOR CORRECTION OR AMENDMENT

Dear Ms. Doe,

After reviewing your request for the correction or amendment of your health information, I regret to inform you that your request is denied for the reason(s) specified below:

1. Your information is not part of the record.
2. The Indian Health Service (IHS) did not create the record.
3. Your record is not available for inspection under applicable Federal law.
4. Your record is accurate and complete.

Since your request is denied, you may do the following:

1. If you are a United States citizen or alien lawfully admitted for permanent resident, you may submit to the Area Director a written statement disagreeing with the denial and the reason of such disagreement within 30 days of the denial. The IHS has the right to prepare a written rebuttal to any statement of disagreement. You will be provided a copy of any rebuttal statement.
2. If you do not submit a statement of disagreement, you may request in writing that the IHS provide this request for correction or amendment (or summary) and the denial with any future disclosures.
3. If you are not a U.S. citizen or an alien lawfully admitted to permanent residence, you may do the following:
    a. Submit to the Service Unit Chief Executive Officer (CEO) a one page written statement disagreeing with the denial and the basis of such disagreement;
    b. If you do not submit a statement of disagreement, you may request that the IHS provide this request for correction or amendment (or summary) and the denial with any future disclosures;
    c. The IHS has the right to prepare a written rebuttal to any statement of disagreement. You will be provided a copy of any rebuttal statement. Any written rebuttal prepared by the IHS is not subject to correction or amendment.

If the IHS did not create the information and the originator (healthcare provider or facility) is no longer available to act on your correction or amendment and is the basis for this denial, you may submit to the CEO in writing, evidence of the originator's unavailability and request a supplemental review of the IHS decision.

If you are a United States citizen or an alien lawfully admitted for permanent residence, you may also appeal the denial to amend the requested information to the Area Director at the following address:

> *(Insert address of Area Director)*

In the event your appeal is ultimately denied, or if you elect not to appeal, you may submit a statement of disagreement as described above. If you appeal and your appeal is denied, you may also seek judicial review of the denial.

If you have complaints about the IHS' policies and procedures regarding health information, you may file such complaint with the CEO or designee or with the Secretary, Department of Health and Human Services, Washington D.C., 20201.

> *(Insert address of Service Unit)*

Thank you.

Signature of CEO or (his or her) designee

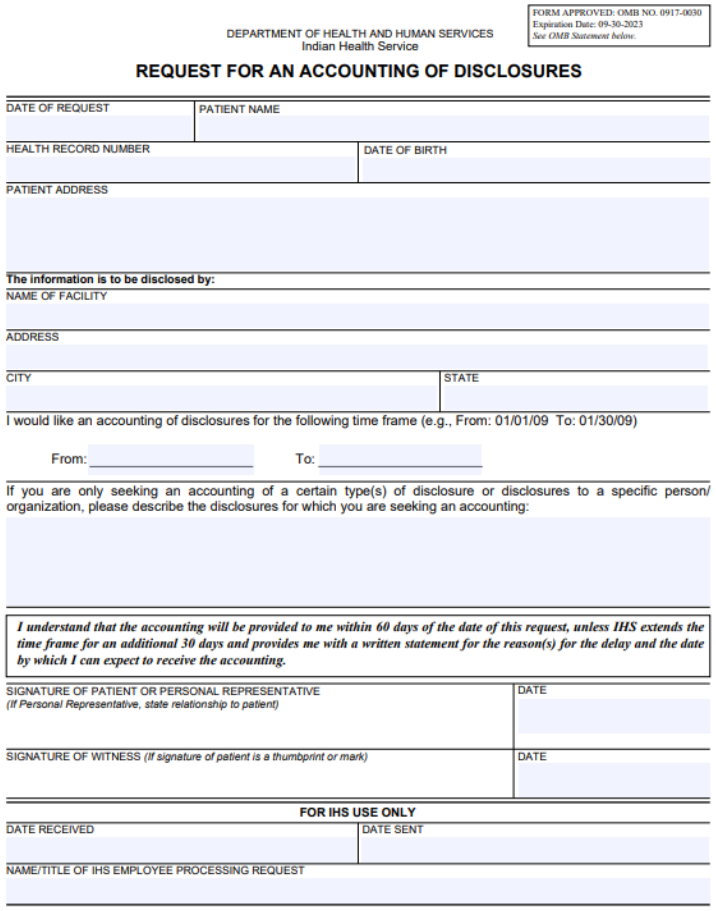
ACCOUNTING OF DISCLOSURES (1 OF 2)

- This is a part of patient's rights. 45 CFR § 164.528
- Individuals have a right to receive, upon request, an accounting of disclosures of PHI made by IHS, with certain exceptions
- These exceptions include disclosures for treatment, payment or health care operations and disclosures that were authorized by the individual

ACCOUNTING OF DISCLOSURES (2 OF 2)

- Disclosures that are subject to the accounting of disclosures requirement include those made when IHS is not a party to the litigation or proceeding that are made:
  1. As required by law
  2. For a proceeding before a health oversight agency
  3. In response to a subpoena, discovery request, or other lawful process
- IHS uses form IHS-913 (Request For An Accounting of Disclosures) for these requests

IHS-913



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09-30-2023
See OMB Statement below.

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

DATE OF REQUEST | PATIENT NAME

HEALTH RECORD NUMBER | DATE OF BIRTH

PATIENT ADDRESS

The information is to be disclosed by:

NAME OF FACILITY

ADDRESS

CITY | STATE

I would like an accounting of disclosures for the following time frame (e.g., From: 01/01/09 To: 01/30/09)

From: _____ To: _____

If you are only seeking an accounting of a certain type(s) of disclosure or disclosures to a specific person/ organization, please describe the disclosures for which you are seeking an accounting:

I understand that the accounting will be provided to me within 60 days of the date of this request, unless IHS extends the time frame for an additional 30 days and provides me with a written statement for the reason(s) for the delay and the date by which I can expect to receive the accounting.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE
(If Personal Representative, state relationship to patient) | DATE

SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)* | DATE

FOR IHS USE ONLY

DATE RECEIVED | DATE SENT

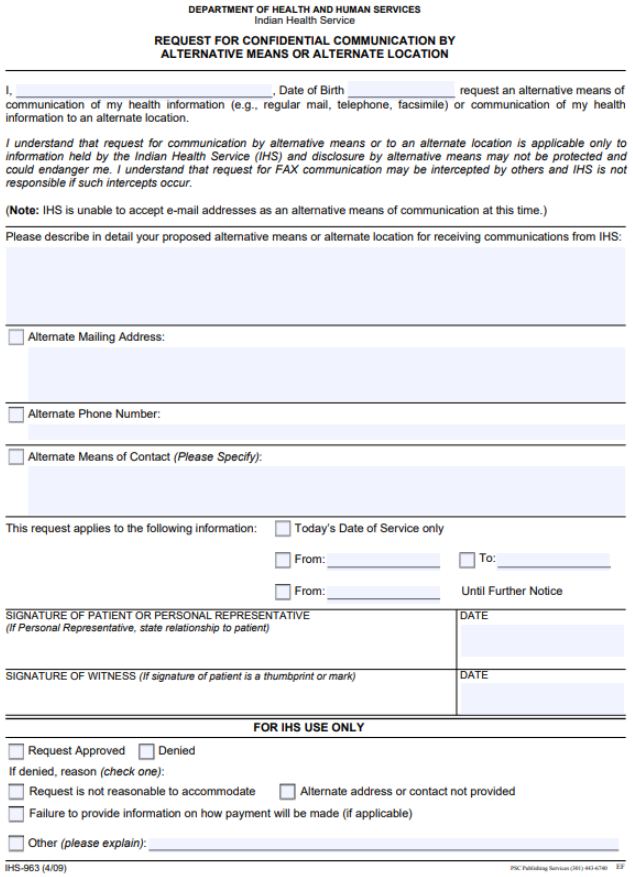
NAME/TITLE OF IHS EMPLOYEE PROCESSING REQUEST

- **IHS 913 Request for An Accounting of Disclosures Form**.
- Note: The list may be very long so ROI staff should assist the requestor with this form – it should be as specific as possible (dates, entities, other organizations, etc.) to narrow the scope and provide the information needed.

CONFIDENTIAL COMMUNICATIONS

- Confidential communications requirements.
- This is a part of patient's rights. 45 CFR § 164.522(b)(1)
- Individuals may request to receive confidential communications from the IHS, either at alternative locations or by alternative means
- For example, an individual may request that the health care provider call her at her office, rather than her home. A health care provider must accommodate an individual's ***reasonable*** request for such confidential communications
- IHS uses form IHS-963 (Request for Confidential Communication by Alternative Means or Alternative Location) for these requests

IHS-963



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

REQUEST FOR CONFIDENTIAL COMMUNICATION BY ALTERNATIVE MEANS OR ALTERNATE LOCATION

I, _____, Date of Birth _____ request an alternative means of communication of my health information (e.g., regular mail, telephone, facsimile) or communication of my health information to an alternate location.

I understand that request for communication by alternative means or to an alternate location is applicable only to information held by the Indian Health Service (IHS) and disclosure by alternative means may not be protected and could endanger me. I understand that request for FAX communication may be intercepted by others and IHS is not responsible if such intercepts occur.

(**Note:** IHS is unable to accept e-mail addresses as an alternative means of communication at this time.)

Please describe in detail your proposed alternative means or alternate location for receiving communications from IHS:

☐ Alternate Mailing Address:

☐ Alternate Phone Number:

☐ Alternate Means of Contact *(Please Specify)*:

This request applies to the following information: ☐ Today's Date of Service only

☐ From: _____ ☐ To: _____

☐ From: _____ Until Further Notice

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(If Personal Representative, state relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

FOR IHS USE ONLY

☐ Request Approved ☐ Denied

If denied, reason *(check one)*:

☐ Request is not reasonable to accommodate ☐ Alternate address or contact not provided

☐ Failure to provide information on how payment will be made (if applicable)

☐ Other *(please explain)*: _____

IHS-963 (4/09)

- Note that the **IHS 963 Request for Confidential Communication By Alternative Means or Alternative Location** requires action by the facility – *request must be approved or denied:*

FOR IHS USE ONLY

☐ Request Approved ☐ Denied

If denied, reason *(check one)*:

☐ Request is not reasonable to accommodate ☐ Alternate address or contact not provided

☐ Failure to provide information on how payment will be made (if applicable)

☐ Other *(please explain)*: _____

REQUEST FOR RESTRICTIONS

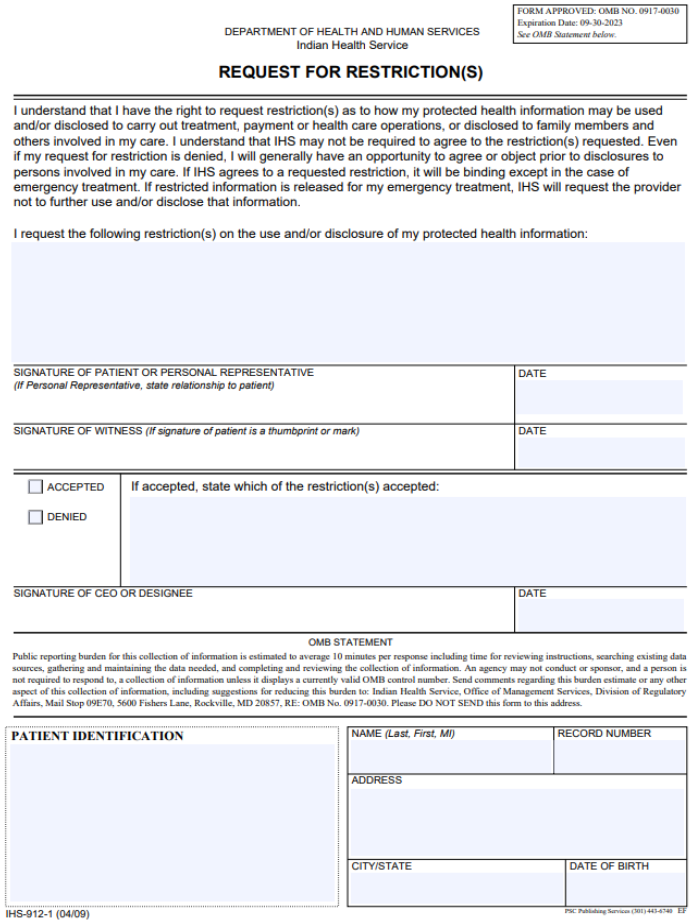
- Right of an individual to request restrictions on uses and disclosures. 45 CFR § 164.522(a)(1)
- Individuals have the right to request restrictions on how IHS will use and disclose protected health information about them for treatment, payment, and health care operations
- IHS is not required to agree to an individual's request for a restriction, but is bound by any restrictions to which it agrees
- We typically see this when a patient requests an employee not have access to their medical record
- IHS uses form IHS-912-1 (Request for Restrictions) for these requests

EXCEPTIONS TO RESTRICTIONS

Exceptions include:

- Emergencies
- Public health authority
- FDA disclosures
- Work-related illness or injury
- OSHA compliance

IHS-912-1



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09-30-2023
See OMB Statement below.

REQUEST FOR RESTRICTION(S)

I understand that I have the right to request restriction(s) as to how my protected health information may be used and/or disclosed to carry out treatment, payment or health care operations, or disclosed to family members and others involved in my care. I understand that IHS may not be required to agree to the restriction(s) requested. Even if my request for restriction is denied, I will generally have an opportunity to agree or object prior to disclosures to persons involved in my care. If IHS agrees to a requested restriction, it will be binding except in the case of emergency treatment. If restricted information is released for my emergency treatment, IHS will request the provider not to further use and/or disclose that information.

I request the following restriction(s) on the use and/or disclosure of my protected health information:

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(If Personal Representative, state relationship to patient)* | DATE

SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)* | DATE

☐ ACCEPTED
☐ DENIED

If accepted, state which of the restriction(s) accepted:

SIGNATURE OF CEO OR DESIGNEE | DATE

OMB STATEMENT

Public reporting burden for this collection of information is estimated to average 10 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Indian Health Service, Office of Management Services, Division of Regulatory Affairs, Mail Stop 09E70, 5600 Fishers Lane, Rockville, MD 20857, RE: OMB No. 0917-0030. Please DO NOT SEND this form to this address.

PATIENT IDENTIFICATION

NAME *(Last, First, MI)* | RECORD NUMBER

ADDRESS

CITY/STATE | DATE OF BIRTH

IHS-912-1 (04/09)

PSC Publishing Services (301) 443-6740 EF

- The **IHS-912-1 Request for Restriction(s)** form is used to restrict uses and disclosures.
- *Note there is also a space that needs to be completed by the facility to accept or deny the request and indicate which restriction(s) will be applied when this form is used. Depending on the request, this may require collaboration with other staff (clinical, patient registration, HIM, etc.)*:

☐ ACCEPTED
☐ DENIED

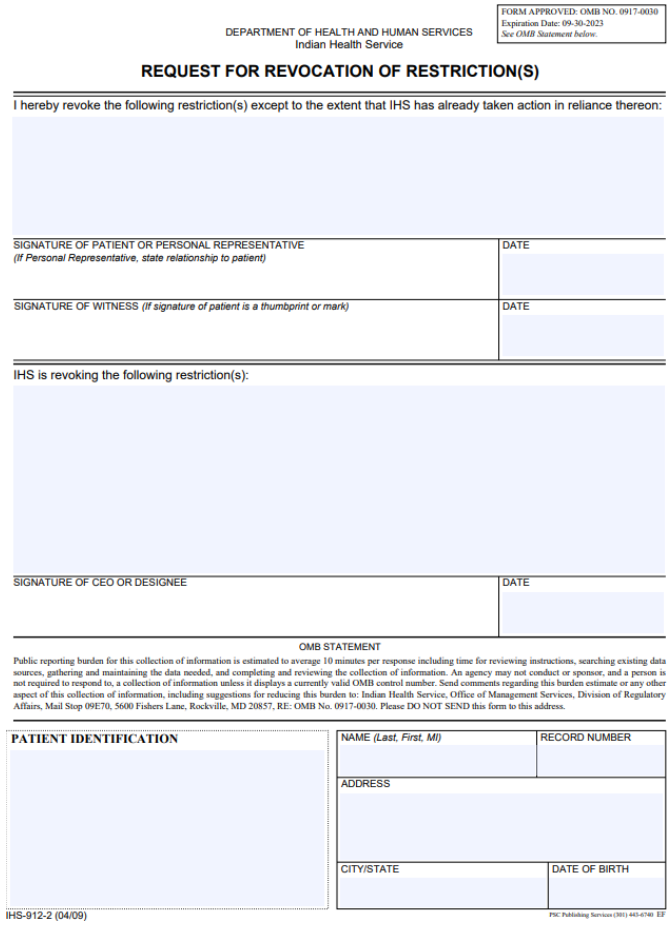
If accepted, state which of the restriction(s) accepted:

SIGNATURE OF CEO OR DESIGNEE | DATE

REVOCATION OF RESTRICTIONS

- Terminating a restriction.
- This is a part of patient's rights. 45 CFR § 164.522(a)(2)
- Patients can remove the request for restrictions they previously requested
- IHS uses form IHS-912-2 (Request for Revocation of Restriction(s)) for these requests

IHS-912-2



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09-30-2023
See OMB Statement below.

REQUEST FOR REVOCATION OF RESTRICTION(S)

I hereby revoke the following restriction(s) except to the extent that IHS has already taken action in reliance thereon:

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE
(If Personal Representative, state relationship to patient)

DATE

SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*

DATE

IHS is revoking the following restriction(s):

SIGNATURE OF CEO OR DESIGNEE

DATE

OMB STATEMENT

Public reporting burden for this collection of information is estimated to average 10 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Indian Health Service, Office of Management Services, Division of Regulatory Affairs, Mail Stop 09E70, 5600 Fishers Lane, Rockville, MD 20857, RE: OMB No. 0917-0030. Please DO NOT SEND this form to this address.

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*

RECORD NUMBER

ADDRESS

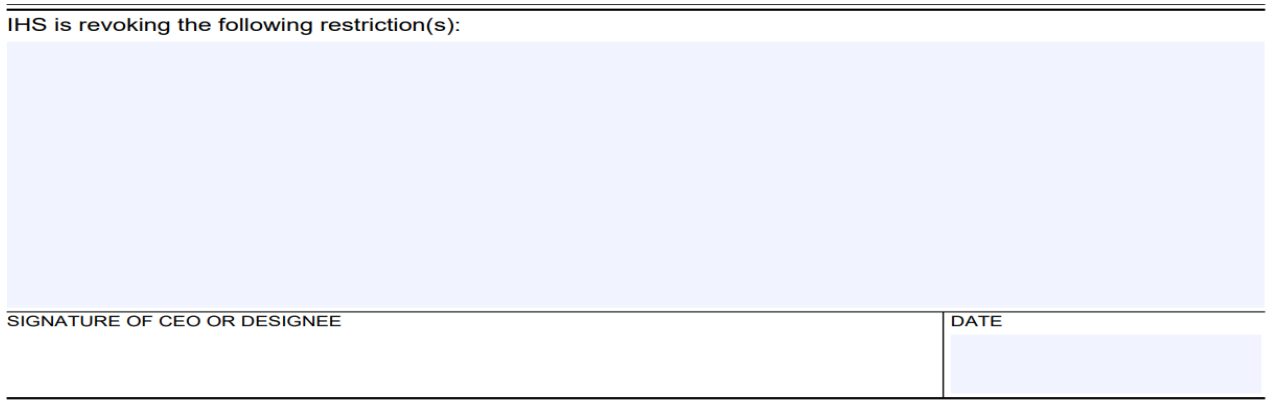
CITY/STATE

DATE OF BIRTH

IHS-912-2 (04/09)

PSC Publishing Services (301) 443-0740 EF

- If a patient decides to change they no longer want the restriction they previously requested, the **IHS-912-2 Request for Revocation of Restriction(s)** is used.
- *Note the facility doesn't have a space on the form outlining the action taken but **this revocation must be communicated to the rest of the facility.** Depending on the request, this may require collaboration with other staff (clinical, patient registration, HIM, etc.).*



IHS is revoking the following restriction(s):

SIGNATURE OF CEO OR DESIGNEE

DATE

OTHER TYPES OF REQUESTS

I RECEIVED A REQUEST ABOUT A PATIENT, WHAT DO I DO?

Type of request:

- Subpoena
- Court Order
- Law enforcement
- Informal request

SUBPOENA

Two types of subpoena:

- Subpoena for testimony – appear in court to give testimony
- Subpoena duces tecum – requires production of record

WHAT COURT ISSUED THE SUBPOENA?

- Federal
- State
- Tribal
  - The Federal government only complies with subpoena's from "courts of competent jurisdiction"
  - Federal courts are considered "courts of competent jurisdiction"

FEDERAL COURT SUBPOENA

- HIM Supervisor – Review subpoena ensuring all applicable requirements of the Privacy Act and HIPAA have been met
- If necessary, have OGC review subpoena

COURT ORDER

- Court orders follow the same process as subpoena's
- Ensure the order comes from a "court of competent jurisdiction"

LAW ENFORCEMENT

Valid law enforcement request:

- Must be a written request
- Identifies in detail the particular records sought
- Identifies the specific nature of the law enforcement activity (why records are needed – investigating assault, murder, etc.)
- From the head of the local law enforcement division

LAW ENFORCEMENT – INVALID REQUEST

- Verbal request from a law enforcement officer presenting at facility
- Request from a jail for an incarcerated individual without written authorization

OTHER ENFORCEMENT AGENCIES

These entities may be:

- Federal
- State
- Tribal law enforcement officials
- State licensure boards that have law enforcement authority
- Disclosures of PHI to law

INFORMAL REQUESTS

- Telephone calls from state agency requesting employee information
- Tribal organization requesting statistical information on IHS employees
- Determine if a FOIA needs to be completed.
  - Any information that is not publicly available is generally required to follow the FOIA process

HOW ARE INFORMAL REQUESTS HANDLED?

- Telephone/Verbal - have the requestor put their request in writing
- Review if the request – will this violate HIPAA or the Privacy Act?
- If needed, forward request to OGC for final approval

RPMS ROI

BRN PACKAGE AND REPORTS

HIPAA REQUIREMENT – LOG DISCLOSURE

- Patients have the right to an accounting of disclosures of PHI (45 CFR §164.528) made by a covered entity in the six years prior to the date on which the accounting is requested (exceptions for TPO, etc.).
- Disclosures are logged in RPMS in the BRN package.
- These should be entered into the BRN as soon as the request is processed.

RPMS SECURITY KEYS FOR BRN

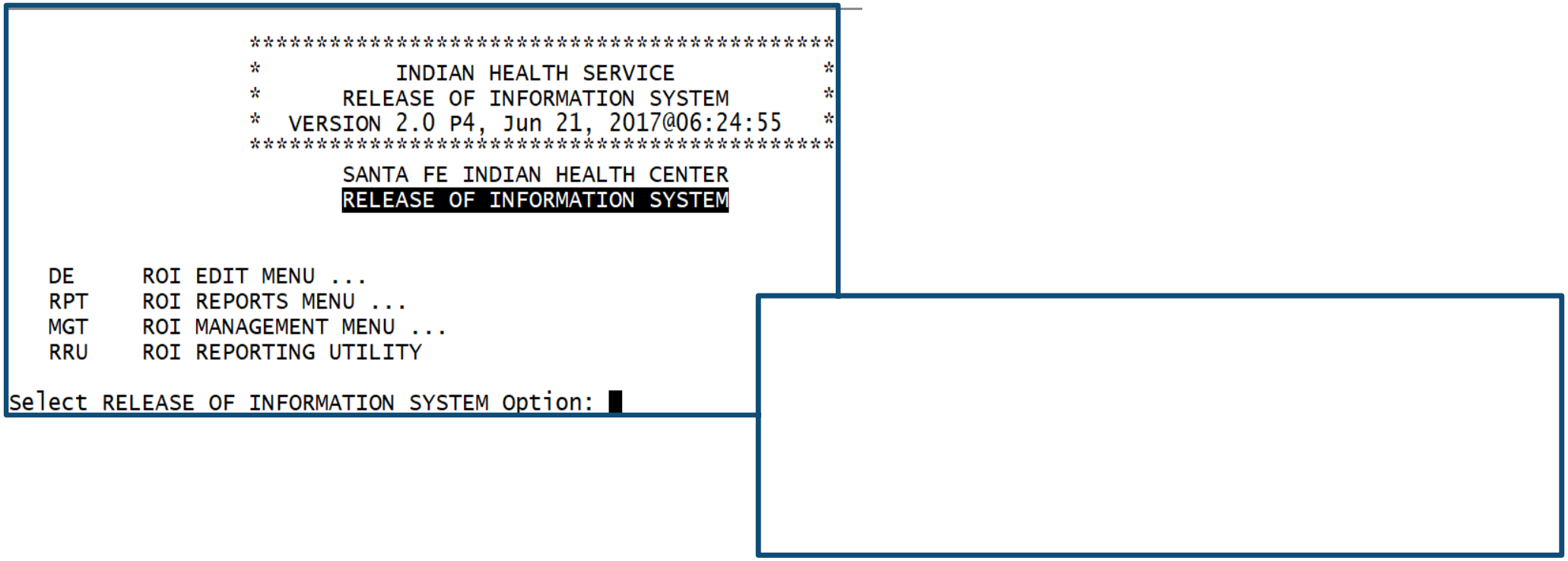
HIM Manager security keys:

- BRNZMENU
- BRNZMGR
- BRNZDELETE
- BRNZEDIT

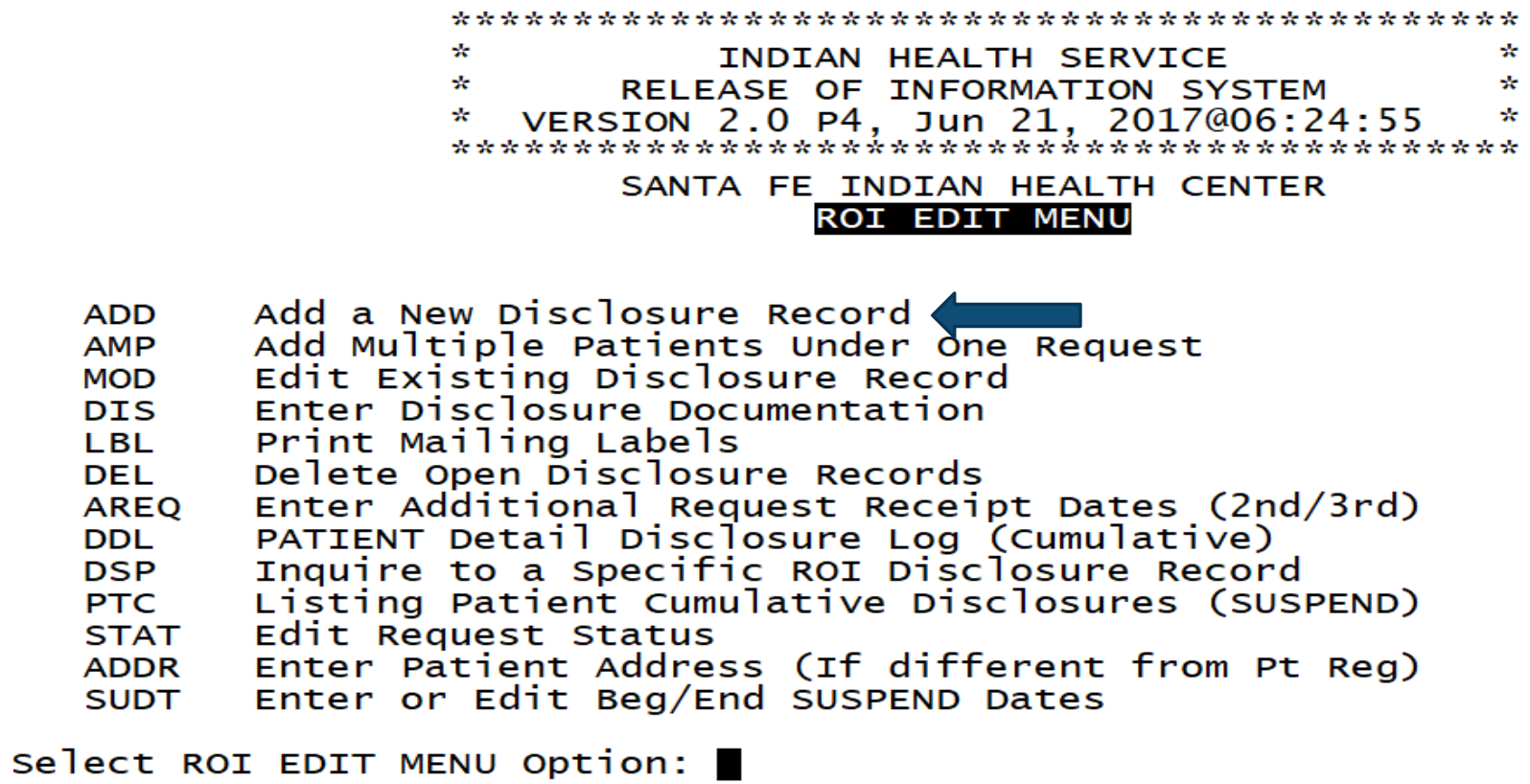
HIM ROI staff security keys:

- BRNZEDIT
- BRNZMGR

RELEASE OF INFORMATION (ROI) MENU



ADDITIONAL MENU OPTIONS



ADDING A NEW DISCLOSURE

```
Select ROI EDIT MENU Option: add  Add a New Disclosure Record
Select PATIENT NAME: DEMO,BABY GIRL
  DEMO,PATIENT L                    <WA>    F 09-28-2016 XXX-XX-5555    SFH 99992
0

                          **********************
                          **LAST 4 DISCLOSURES**
                          **********************

  04/26/19 157433556 DEMO,PATIENT L                PARENTS
                  04/26/19                         Purpose:  FURTHER MEDICAL CARE
                  Status: CLOSED                   Type:  MEDICAL RECORD

  04/26/19 157433555 DEMO,PATIENT L                PARENTS
                  04/26/19                         Purpose:  FURTHER MEDICAL CARE
                  Status: CLOSED                   Type:  MEDICAL RECORD

  10/07/14 157421999 DEMO,PATIENT L                PARENTS
                  10/07/14                         Purpose:  FURTHER MEDICAL CARE
                  Status: CLOSED                   Type:  MEDICAL RECORD


Do you want to continue with adding a new Disclosure? Y//
```

EXAMPLE OF ADDING A DISCLOSURE

```
Do you want to continue with adding a new Disclosure? Y// ES

DATE REQUEST INITIATED: TODAY//   (APR 26, 2019)

DISCLOSURE NUMBER: 157433558
TYPE: M  MEDICAL RECORD
REQUEST METHOD: ??

     Choose from:
       1         IN PERSON
       2         TELEPHONE CALL
       3         REGULAR MAIL
       4         ELECTRONIC MAIL
       5         FAX
REQUEST METHOD: 1  IN PERSON
REQUESTING PARTY: PARENTS       SELF
PURPOSE: ??

     Choose from:
       1         FURTHER MEDICAL CARE
       2         INSURANCE
       3         ATTORNEY
       4         PERSONAL
       5         SCHOOL
       6         TORT
       7         FOIA
       8         SUBPOENA
       9         OTHER
       A         DISABILITY
       B         HEALTHCARE OPERATIONS
       C         PAYMENT
       D         TREATMENT
PURPOSE: 1  FURTHER MEDICAL CARE
REQUEST PRIORITY: NON-CRITICAL//
```

ɛmember at any prompt- 2
ıestion “??” marks will display
e choices available

ADDING FREE TEXT

```
PATIENT/AGENT REQUEST TYPE: ??

     Choose from:
       H         HAND DELIVER
       I         IN PERSON
       MR        MAIL REGULAR
       MC        MAIL CERTIFIED
       F         FAX
       O         OTHER
       E         ELECTRONIC
PATIENT/AGENT REQUEST TYPE: I  IN PERSON
STAFF ASSIGNMENT: YAZZA
     1   YAZZA,STAN D       SDY          188SDY     MEDICAL RECORDS

     ENTIRE RECORD:
     BEGINNING EVENT DATE: T  (APR 26, 2019)
     ENDING EVENT DATE: T  (APR 26, 2019)
     SPECIFIC RECORD INFORMATION: 4/26/2019 WELL CHILD VISIT
     DISCLOSURE DESCRIPTION:
       1>HAND DELIVERED TO PARENT

Select RECEIVING PARTY: PARENTS       SELF
  Are you adding 'PARENTS' as a new RECEIVING PARTY (the 1ST for this ROI LISTIN
G RECORD)? No// N  (No) ??
Select RECEIVING PARTY: PARENTS       SELF
  Are you adding 'PARENTS' as a new RECEIVING PARTY (the 1ST for this ROI LISTIN
G RECORD)? No// Y  (Yes)
  DISCLOSURE DATE: T  (APR 26, 2019)
  RECORD DISSEMINATION:
  NUMBER OF PAGES:
  COST PER PAGE:
```

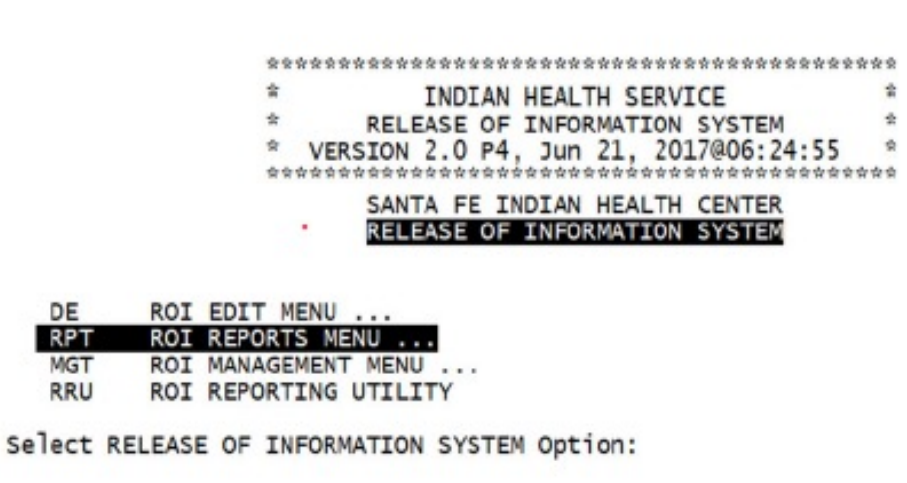
A few more prompts and this process is complete.

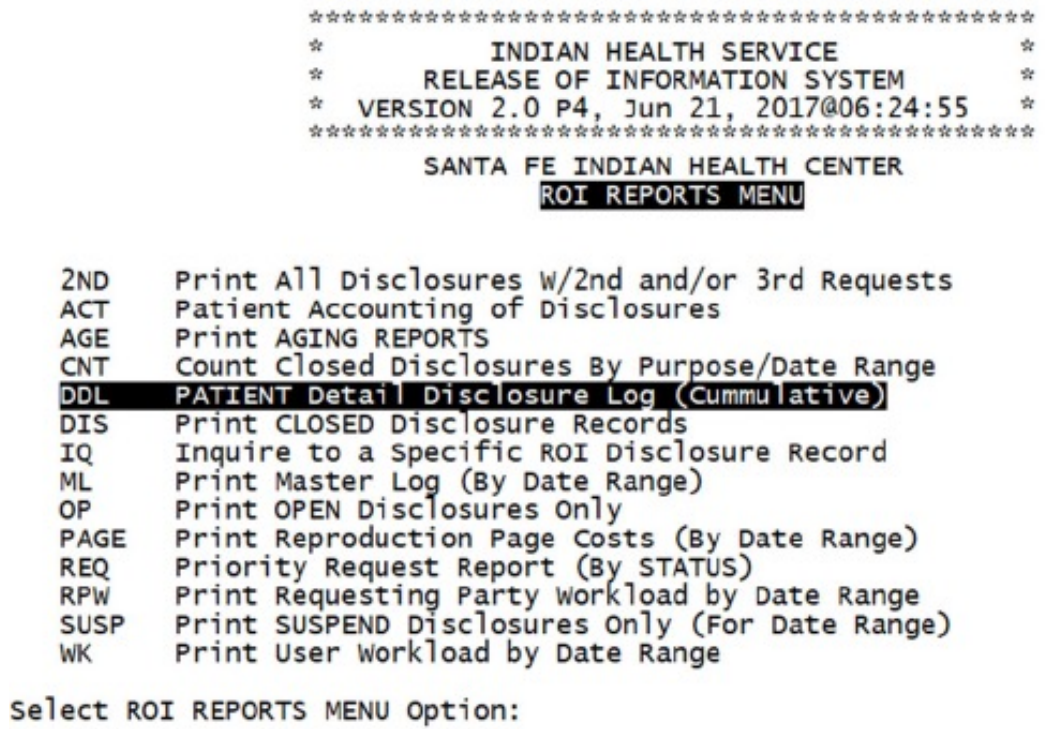
Along the way some can be jumped, while others are required for completion.

DOCUMENTING DISCLOSURE DESCRIPTION

```
PATIENT/AGENT REQUEST TYPE: ??

     Choose from:
       H         HAND DELIVER
       I         IN PERSON
       MR        MAIL REGULAR
       MC        MAIL CERTIFIED
       F         FAX
       O         OTHER
       E         ELECTRONIC
PATIENT/AGENT REQUEST TYPE: I  IN PERSON
STAFF ASSIGNMENT: CANDELARIA,JACQUE L       JLC             PHARMD
ENTIRE RECORD: ??

     Choose from:
       Y         YES
ENTIRE RECORD: N??
     Enter Y if entire record is to be sent; otherwise hit return
     Choose from:
       Y         YES
ENTIRE RECORD:
BEGINNING EVENT DATE: T  (APR 26, 2019)
ENDING EVENT DATE: T  (APR 26, 2019)
SPECIFIC RECORD INFORMATION: WELL CHILD VISIT 4/26/2019
DISCLOSURE DESCRIPTION: FREE TEXT
```

RPMS MENU OPTION – PATIENT DISCLOSURE LOG





PATIENT DETAIL DISCLOSURE LOG

```
                    PATIENT Detail Disclosure Log (Cumulative)


Enter a Patient Name: DEMO,MALE SR       M 06-28-2016                CR T00061

DEVICE:   VIRTUAL
               **CONFIDENTIAL PATIENT DATA COVERED BY PRIVACY ACT**
 ROI CUMMULATIVE PATIENT RECORD              NOV 10,2016          PAGE   1
  DEMO,MALE SR -HR#: T00061        RECORD INFORMATION        REC PTY   DT DISC
-------------------------------------------------------------------------------

11/10/16   224821312  FU  IMMUNIZATION                SELF              11/10/16

11/10/16   224821313  OT  TEST                       SELF              11/10/16

11/10/16   224821314  DI  IMMUNIZATION               SELF              11/10/16
```

WORKLOAD REPORTS

- Used when HIM Directors want to monitor workload of ROI staff for various reasons; PMAPs, auditing, etc.
- Also can be used to look at how many ROIs are coming into the facility per month/quarter/year – justify additional staff, OT, etc.

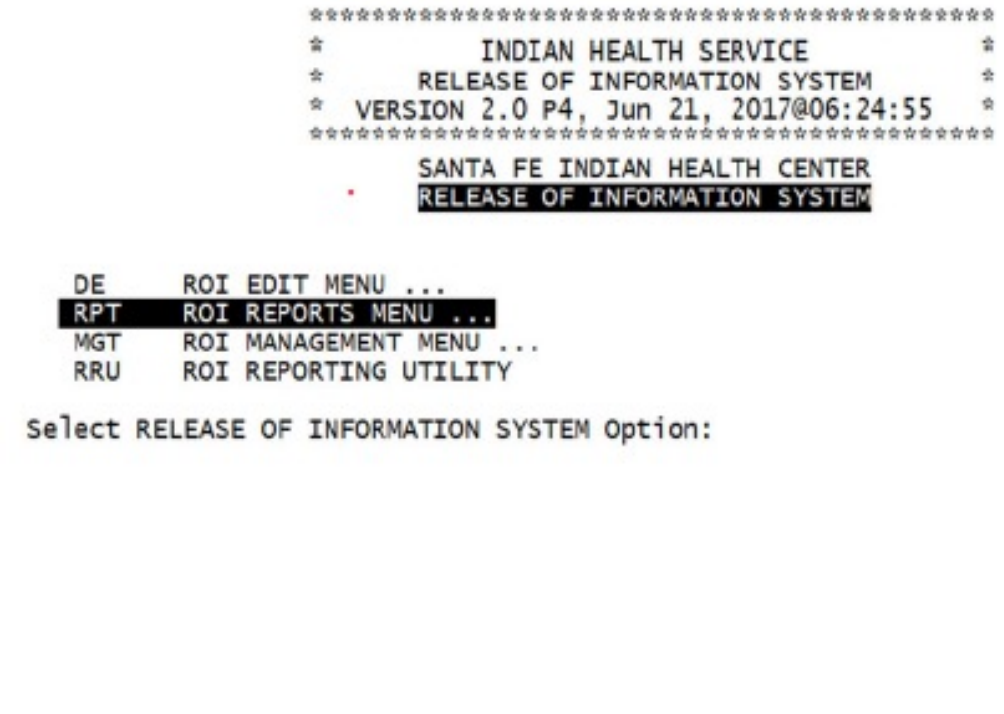
MANAGEMENT REPORT OPTIONS

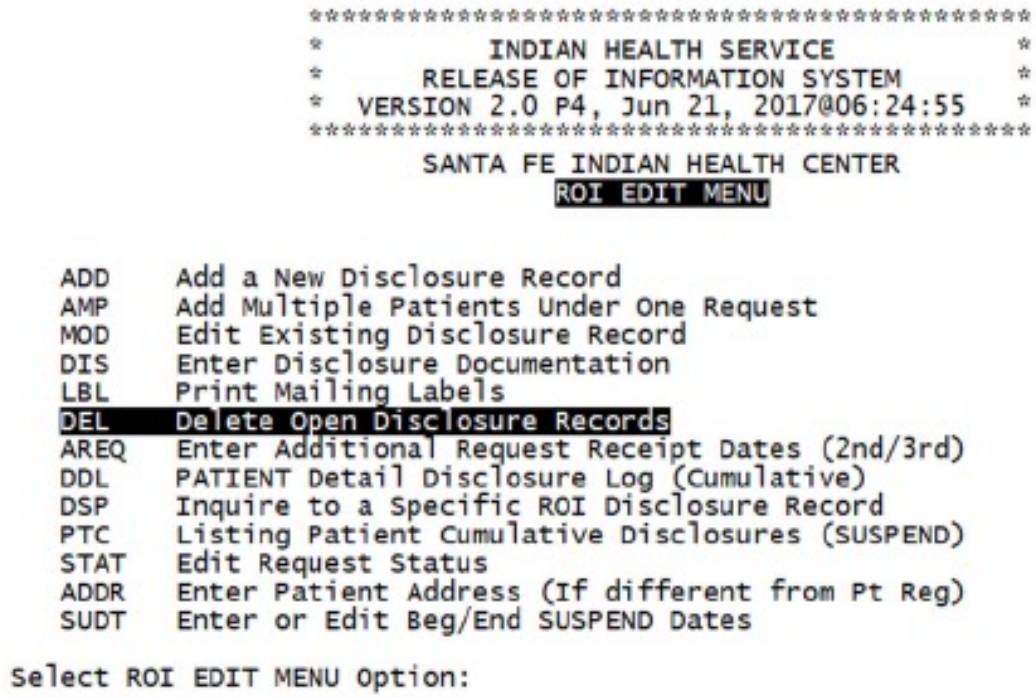
```
 DE      ROI EDIT MENU ...
 RPT     ROI REPORTS MENU ...
 MGT     ROI MANAGEMENT MENU ...
 RRU     ROI REPORTING UTILITY


2ND     Print All Disclosures W/2nd and/or 3rd Requests
ACT     Patient Accounting of Disclosures
AGE     Print AGING REPORTS
CNT     Count Closed Disclosures By Purpose/Date Range
DDL     PATIENT Detail Disclosure Log (Cummulative)
DIS     Print CLOSED Disclosure Records
IQ      Inquire to a Specific ROI Disclosure Record
ML      Print Master Log (By Date Range)
OP      Print OPEN Disclosures Only
PAGE    Print Reproduction Page Costs (By Date Range)
REQ     Priority Request Report (By STATUS)
RPW     Print Requesting Party Workload by Date Range
SUSP    Print SUSPEND Disclosures Only (For Date Range)
WK      Print User Workload by Date Range
```

LOOKING AT WORKLOAD

```
   2ND     Print All Disclosures W/2nd and/or 3rd Requests
   ACT     Patient Accounting of Disclosures
   AGE     Print AGING REPORTS
   CNT     Count Closed Disclosures By Purpose/Date Range
   DDL     PATIENT Detail Disclosure Log (Cummulative)
   DIS     Print CLOSED Disclosure Records
   IQ      Inquire to a Specific ROI Disclosure Record
   ML      Print Master Log (By Date Range)
   OP      Print OPEN Disclosures Only
   PAGE    Print Reproduction Page Costs (By Date Range)
   REQ     Priority Request Report (By STATUS)
   RPW     Print Requesting Party Workload by Date Range
   SUSP    Print SUSPEND Disclosures Only (For Date Range)
   WK      Print User Workload by Date Range

Select ROI REPORTS MENU Option: WK  Print User Workload by Date Range


Enter beginning ROI Initiated Date:  01012023  (JAN 01, 2023)

Enter ending ROI Initiation Date:  (1/1/2023 - 7/25/2023): T  (JUL 25, 2023)


     Select one of the following:

          I         User Who INITIATED Request
          A         User Who was ASSIGNED Request
          C         User Who CLOSED Request

Select USER'S ROLE for Workload Reporting:
```

RPMS MENU OPTION TO DEL – DELETE OPEN DISCLOSURE RECORDS





DEL DELETE OPEN DISCLOSURE RECORDS

- Use this Option to DELETE an *Open* Disclosure.
- Closed disclosures cannot be deleted.
- The disclosure and verification message are displayed to ensure that you selected the correct disclosure.

1. To delete an open disclosure, type DEL at the prompt in the ROI Disclosure Edit Menu.
2. Type the date the disclosure was initiated, the disclosure number, the patient's name, or the patient's HRN at the "Select Disclosure by Patient or by Disclosure Date or Disclosure #:" prompt.
3. The message Disclosure Record Deleted will be displayed.

ROI REPORTS MENU

```
2ND     Print All Disclosures W/2nd and/or 3rd Requests
ACT     Patient Accounting of Disclosures
AGE     Print AGING REPORTS
CNT     Count Closed Disclosures By Purpose/Date Range
DDL     PATIENT Detail Disclosure Log (Cummulative)
DIS     Print CLOSED Disclosure Records
IQ      Inquire to a Specific ROI Disclosure Record
ML      Print Master Log (By Date Range)
OP      Print OPEN Disclosures Only
PAGE    Print Reproduction Page Costs (By Date Range)
REQ     Priority Request Report (By STATUS)
RPW     Print Requesting Party Workload by Date Range
SUSP    Print SUSPEND Disclosures Only (For Date Range)
WK      Print User Workload by Date Range
```

CNT – COUNT CLOSED DISCLOSURE BY PURPOSE/DATE RANGE

```
        FACILITY: COCHITI H.ST
                  PURPOSE: DISABILITY
SUBCOUNT                  2
        FACILITY: SAN FELIPE HS
                  PURPOSE: FURTHER MEDICAL CARE
SUBCOUNT                 17
                  PURPOSE: INSURANCE
SUBCOUNT                 14
                  PURPOSE: PERSONAL
SUBCOUNT                  4
                  PURPOSE: SCHOOL
SUBCOUNT                 15
                  PURPOSE: OTHER
SUBCOUNT                 29
                  PURPOSE: DISABILITY
SUBCOUNT                 12

        FACILITY: SANTA CLARA HC
                  PURPOSE: FURTHER MEDICAL CARE
SUBCOUNT                 65
                  PURPOSE: PERSONAL
SUBCOUNT                  2
                  PURPOSE: SCHOOL
SUBCOUNT                 27
                  PURPOSE: OTHER
SUBCOUNT                 23
                  PURPOSE: DISABILITY

SUBCOUNT                 10
```

```
        FACILITY: SANTA FE HOSPITAL
                  PURPOSE: FURTHER MEDICAL CARE
SUBCOUNT                126
                  PURPOSE: INSURANCE
SUBCOUNT                108
                  PURPOSE: ATTORNEY
SUBCOUNT                 10
                  PURPOSE: PERSONAL
SUBCOUNT                 23
                  PURPOSE: SCHOOL
SUBCOUNT                 26
                  PURPOSE: OTHER
SUBCOUNT                 33
                  PURPOSE: DISABILITY
SUBCOUNT                 43
                  PURPOSE: HEALTHCARE OPERATIONS
SUBCOUNT                  2
                  PURPOSE: TREATMENT
SUBCOUNT                  3
COUNT                   594
```

EDIT/CORRECT ERRORS

```
   DE      ROI EDIT MENU ...
   RPT     ROI REPORTS MENU ...
   MGT     ROI MANAGEMENT MENU ...
   RRU     ROI REPORTING UTILITY

Select RELEASE OF INFORMATION SYSTEM Option:


   CHG     Change Spelling of Requesting Party
   EDT     Edit Date Request Initiated
   PE      Enter or Edit Requesting/Receiving Parties
   PRT     Print Listing of all Parties
   RR      Inquire to a Specific Requesting Party
   SITE    Enter or Edit Site Parameter

Select ROI MANAGEMENT MENU Option:
```

This menu contains options which allow a user to edit/enter several fields in the ROI system.

RPMS BRN

ENHANCEMENTS & FEATURES

BRN – ROI NAMESPACE

- BRN v2.0 p5
  - Beta Testing 7/10-8/22
  - Release date 8/31/2023

NEW FEATURES IN BRN V2.0 P5

- Six new features
  - Most new features are in the Report option
  - ACT Report changes: add ability to view by Facility, ability to select facility or ALL facilities
  - DDL Report Update: Add print function for patient without any disclosures; for all disclosures
  - Modification to field length on the disclosure ticket number in Patient Detail Disclosure Log
  - Enhancement to disclosure entry – current limit set to 1000
  - ACT report changes: bug fix when the report requested is the same day

QUESTIONS?

Contact Information

Jennifer Farris, MHSA MJIL, RHIA, CHPS

Oklahoma City Area Office, IHS

405-951-3708

jennifer.farris@ihs.gov

Jacqueline L. Candelaria, CPC

Albuquerque Area Office, IHS

505-256-6740

jacque.candelaria@ihs.gov

RESOURCES

- Office for Civil Rights. Disclosures for Emergency Preparedness – A Decision Tool: Authorization https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/authorization/index.html
- Office for Civil Rights. Personal Representatives https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/personal-representatives/index.html
- "How To Request Your Medical Records", Journal of AHIMA. Dimick, Chris and Butler, Mary. https://journal.ahima.org/2012/03/01/how-to-request-your-medical-records/
- Office for Civil Rights. Uses and Disclosures for Treatment, Payment and Health Care Operations https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html
- HIPAA Checklist for Valid Authorizations
- RPMS Release of Information User Manual Release of Information Disclosure System (BRN) (ihs.gov)
- Health Information Portability and Accountability Act
- IHS/OIT/DIT Practice Management Program-Practice Management Informaticist (Toni Johnson)
- And a THANK YOU to Patricia Cerna for the list of links for IHS ROI Policies/Procedures (slide 30)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