Purpose:

This policy provides a definition of a medical record, identifies confidential information, and outlines what information may be released and to whom it may be released.

Policy:

1. Definition:

   - A medical record is hereby defined as:
     - Personal information on the patient, including: name of the patient, date of birth; sex; marital status; occupation; other items of identification and next of kin or other contact person.
     - Financial data on the patient, including: name of patient's employer; health insurance information; and other information to assist in billing.
     - Medical data on the patient, including physical examinations; medical history; treatment administered; progress reports; physician's orders; clinical laboratory records; radiological reports; consultation reports; anesthesia reports; operation records; consent forms; and discharge summaries.

2. Information and Data

   - Information regarding the patient's personal information or medical data will not be given out to anyone not directly involved in the patients care or those involved in quality assurance or billing operations.
A copy of the Patient Care Report will be left with the hospital or faxed in a timely manner to the emergency department once the report is complete.

3. Ownership of Records

All original medical records generated by the department shall be recognized as the property of the City of West Des Moines Emergency Medical Services. Any original documents should not leave the Department.

4. Release of Medical Records to Patient

The patient may have a legitimate interest in the information contained in their medical records. A copy of medical records may be released to the patient when he/she presents in person to the EMS Administrative office, during normal business hours, signs a release and presents valid photo identification such as a driver's license or passport.

Written Release:

- A release of any information in a patient's record requires a release in the form of a written authorization.
- The written authorization should contain, at a minimum, the following:
  - Request for release of the records;
  - The date;
  - The patient’s signature;
  - The portion of the record authorized to be released; and
  - The identification of the party to receive the records.

5. Release of Records Relating to Minor Patients:

- Release of any record which may disclose any of the following conditions shall be conditioned upon legal approval by the City Attorney:
  - Pregnancy;
  - AIDS/HIV infection;
  - Sexually transmitted diseases;
  - Substance abuse.
- Request for Minor Records: A request for access to or release of a minor patient’s records should be made by a patient’s parent or legal guardian.
- Denial of Request: Instances where the request might not be honored include: (a) pregnancy; (b) AIDS/HIV infection; (c) sexually transmitted diseases; and (d) substance abuse.
6. Release of Deceased Patient’s Medical Records:

- Any release signed by the patient prior to his/her death becomes null and void at the time of the patient’s death.
- The executor or administrator of the estate should execute a release of information for a decedent’s records. (The executor may be an individual other than the deceased patient’s spouse.)
- If no estate has been opened, the Chief of Emergency Medical Services should be consulted prior to the release of any information.

7. Disclosure of Medical Records to Third Parties

- The City shall strictly comply with the provisions of Chapter 22, Code of Iowa, Examination of Public Records (Open Records), and shall keep confidential any medical records of the condition, diagnosis, care or treatment of a patient or former patient, and any report which identifies a person infected with a reportable disease.

- Prohibition on Disclosure Without Consent of Patient

  - General Prohibition: Medical records will not be disclosed to a third party without prior written consent of the patient or other statutory authorization.

8. Disclosure of Medical Records Without Patient’s Consent

- Child Abuse: Under the state’s child abuse law, ECPs who, in the scope of their employment responsibilities, examine, attend, counsel or treat a child under 12 years of age, and reasonably believe a child has suffered abuse, shall report said suspected child abuse within 24 hours. (Section 232.60, Code of Iowa)

- Dependent Adult Abuse: Similar to the state law on child abuse, state statute requires immediate reporting of suspected dependent adult abuse by emergency care providers. (Section 235B.3, Code of Iowa)

- Criminal Investigation: Law enforcement personnel may obtain a copy of the ambulance report once they have established the necessity of having access to the report in terms of the state’s interest in well-founded criminal charges and the fair administration of criminal justice. A subpoena shall be necessary for the release of any patient care information used for criminal investigation.

9. Handling of patient care reports
Care should be taken to prevent the visibility of patient care reports that are in the process of being completed or are awaiting delivery to the billing specialist. Incomplete reports should be stored using the following guidelines:

- Incomplete reports in an EMS unit should be kept in a clipboard, cabinet or other secure location within the EMS unit.
- Incomplete reports in crew and station areas should be placed in a drawer or secure office. Paperwork should be placed face-down and out of plain view when placed in an area subject to potential visitors.

10. Audit Procedures

- Patient care records which are audited, are reviewed solely for QA/QI purposes. The exchange of information regarding a patient’s care should be held in strict confidentiality in accordance with HIPAA standards.

- All reports submitted for audit will be marked appropriately by staff.

11. Fees

- An administrative fee of $10.00 will be assessed for all report copies provided by this department.
- No fee will be charged for duplication of records for criminal investigations or abuse cases.