

UNIVERSITY OF FLORIDA
INFORMATION PRIVACY POLICIES & PROCEDURES
HEALTH INFORMATION OPERATIONAL GUIDELINES

I. Health Information and Record Management

A. POLICY

Rev. 06/01/2009

1. Ownership and Commitment:

- a) *Information contained in health and financial records belongs to the patient, whereas the physical health and financial records, in all formats, are the property of the University of Florida or the Shands HealthCare System.*
- b) *The University is committed to protecting the confidentiality of all patient information it receives, creates, maintains, and transmits.*

2. Custodianship:

- a) *The Chief Privacy Officer is the officially designated Custodian for Health Information / Patient Records in all formats for the University of Florida in all locations. The Chief Privacy Officer may delegate these custodial duties as appropriate.*
- b) *Shands Healthcare is the delegated record custodian for a very limited group of clinics, due to previous history and logistics; questions about custodianship should be directed to the Privacy Office.*

3. Management:

- a) *Use and Disclosure: The University has the right to use and disclose protected health information (PHI) for treatment, internal health care operations, and as required by law, without the authorization of the patients, unless restricted by other state or federal laws.*
- b) *Personnel: Each patient care area and department that creates, receives, maintains, uses, and/or discloses individually identifiable health information in any format must designate at least one staff member to manage the health information and patient records for that area. The staff member is not required to be solely dedicated to the management of health information, but must be specifically trained and responsible for maintaining the confidentiality, security, and accessibility of patients' information.*
- c) *Storage: All primary and shadow records that contain protected health information, including healthcare, financial, and research records, must be stored in physically secure areas.*

4. Documentation:

- a) *Only physicians, other credentialed caregivers, UF employees acting within the scope of their assigned duties, and contracted individuals with an equivalent competency process, are authorized to document in UF's health records.*

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b) General Documentation Requirements:

- (1) Patient identification information on each document.
- (2) All handwritten entries written legibly in black or blue ink.
- (3) The date and time preceding each entry and the signature of the author following all entries.

(a) The author's unique identification number should be included unless the provider's name and title display on the document. If the author does not have a unique practitioner identification number, the title should follow the signature.

(b) Stamped signatures are not allowed without a separate hand written signature.

(c) Applications with electronic signature capabilities must have the signature system reviewed and approved by UF's Legal Services, Information Services and the Privacy Office to assure that the electronic signature meets standards.

(4) Co-Signatures

(a) Co-signature of a health record entry signifies acknowledgement by the co-signer that the entry was made, and implies concurrence with the statements or conclusions contained in the entry.

(b) If there is significant disagreement with the conclusion of the author, the cosigner should record such conclusions or expand on the entry as appropriate.

c) Additions/Corrections to Inaccurate Medical Record Documentation: Use only approved error-correction procedures; never remove, destroy or obliterate parts of the primary record. (See facility-specific policy.)

(1) If the documentation error is on paper, the correction should be made by drawing a single line through the entry, initialing and writing "error" above the entry.

(2) Late entries in the medical record can be made by entering the current date and time, identifying the entry as a 'late entry' and concluding the note with the author's official legible signature.

(3) If the error is in electronic documentation, late entries may be made as long as the individual application permits entries.

(a) The author should include the date and time, the title as 'late entry,' and a complete explanation of the correct information.

(b) If the computer application does not permit a late entry, the author may write the note on an appropriate form and send the completed entry to the appropriate clinic for scanning or filing in the health record.

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d) Specific charting privileges of non-physician authors will be delineated and supervised by the department head or faculty member to whom the author report

B. DEFINITIONS

1. Legal Health Record: A formally defined legal business record for a healthcare organization, comprised of individually identifiable data, recorded in any medium, collected from multiple healthcare disciplines, and used by healthcare professionals while providing patient care or services, reviewing patient data, or documenting observations, actions, or instructions.

a) The records are the legal account of the services provided to an individual, and are made in the routine course of business at or near the time that events occurred.

b) Documentation may include personal identification, diagnoses, treatment, services provided, and payment for services. Documentation may also include copies of records created elsewhere that are considered relevant to decisions made about care or services provided at UF.

c) The primary purposes of a health record are to:

- (1) Serve as a communication tool for health care professionals involved in the management of a patient,*
- (2) Provide documentary evidence of illnesses, diagnostics, and treatments,*
- (3) Protect the legal interests of the patient, healthcare facility and provider(s), and*
- (4) Preserve clinical data for research and education.*

2. Primary Records: Original documentation created and maintained in any format as a direct result of a patient or client encounter in any of UF's healthcare facilities, including faculty practice clinics and student health clinics. Primary records are usually maintained in and/or by the entity where the care or service was provided.

3. Shadow Records: Copies of primary record materials that are temporarily maintained separately from the primary record, usually for the convenience of health care providers or their staff.

a) Shadow records may contain original documents that will eventually be included in the primary record, as well as materials that health care personnel desire to save temporarily, but that are not required in the primary record (material to be purged).

b) Shadow records may include billing information, extra copies of outside records, correspondence, raw test data, telephone notes, etc.

4. NOTE: Records that are created and maintained in UF clinics are not shadow records, even though they may share documents with other parts of UF and with Shands HealthCare System.

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5. **Designated Record Set:** A defined group of health and billing records that contain protected health information. (See Designated Record Set Matrix.)
6. **Active Records:** Healthcare records that are being used for ongoing patient care, payment, litigation, or research activities.
7. **Inactive Records:** Records of patients who have not received healthcare, made payments for care, or been involved in litigation or research for a designated period of time.
8. **Archiving / Storage:** Physically moving inactive records to a storage location until the retention requirements for those records are met.

C. PRIVACY REQUIREMENTS

1. **Health Information Management:** Individually identifiable health information created, received, maintained, or transmitted by the University may only be used and disclosed in accordance with the University's policies and procedures or with the approval of the Privacy Officer.
 - a) *Patient information may be used as stated above, by:*
 - (1) University faculty, staff, and volunteers, when acting within the course and scope of their official duties related to University of Florida business.
 - (2) Authorized students enrolled in health care and health-related education programs affiliated with the University of Florida.
 - b) *Under Florida Statutes, patient information may only be used or disclosed for payment purposes with the written consent of the patient. Such consent is usually obtained within the Consent for Treatment.*
 - c) *Students, for assigned projects, may review protected health information held in UF clinics and departments after obtaining the authorization of the appropriate clinic or department manager. No individually identifiable patient information may be removed from the clinic or department.*
2. **Authorizations:** A complete and valid Authorization (see Forms) is required for disclosures of PHI for purposes not related to treatment, health care operations, or as otherwise required by law, including:
 - a) *To patients or their legal representatives (See Access to Records; Authorizations; and Verification of Identity and Authority, in this manual.)*
 - b) *To third parties (See Authorizations in this manual.)*
 - c) *To healthcare professionals who do not have a treating relationship with a patient*
 - d) *To researchers (See Uses and Disclosures: Research in this manual.)*
 - e) *Requests for records of deceased individuals should be referred to the appropriate Department or Clinic, wherever the primary records are held.*

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3. Storage and Security of Active Records:

- a) *Paper records must be stored in areas that are protected from unauthorized access, damage by fire, water, insects, and other pests, and are environmentally controlled for temperature and humidity.*
 - (1) Department and clinic staff, including faculty, fellows, and residents, may not remove records from record storage or patient care areas without notifying the designated records manager.
 - (2) Staff members who are not directly responsible for the records should not be allowed in the record storage areas without supervision.
- b) *Paper records must be organized to facilitate easy retrieval by authorized staff members.*
 - (1) Paper records should be maintained in, at minimum, manila folders that will organize and protect the contents.
 - (2) Folders or other binders should be clearly marked on the outside with the year of the last episode of care, payment, or research activity, along with pertinent patient / client / participant identification data.
 - (3) Primary records or original documents generated by or used for patient care or payment purposes must be accounted for daily.
- c) *Paper records that are received from the Shands HI/RM or other centralized record storage areas for use in patient care must be stored in physically secure areas in the receiving clinics or departments.*
 - (1) All records received must be accounted for daily, and either returned to the original storage area or a notification sent concerning the record's location.
 - (2) Healthcare staff or their designees may not remove records from the storage or patient care areas without notifying the designated records manager. Any records removed are the responsibility of the clinic administrator or supervisor for that area.
 - (3) All pertinent information generated during a patient visit should be included in the medical record when it is returned to the original storage area.
- d) *Patient records in electronic formats are maintained in a technologically secure environment according to established policies. (See Shands HI/RM Core Policies on the Shands website: <http://intranet.shands.org/licacc/core.htm>)*

- 4. Removal of Patient Related Information from the University or Shands:** Patient information, whether original or copied, in paper or electronic formats, that is generated or received for the care of patients by the University of Florida, may NOT be removed from the premises by anyone, except upon receipt of a court order, subpoena duces tecum, or written departmental administrative approval.

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- 5. Duplication of Patient Information:** Patient records maintained in any format may not be duplicated for any reason without departmental administrative authorization.
- a) Records may be duplicated when necessary to transmit health information to another health care provider, if the information is essential to the ongoing treatment of the patient. Administrative approval must be obtained before making such copies. (See also Minimum Necessary Rule: Routine and Non-Routine Disclosures in this manual.)*
 - b) Records may be duplicated for educational purposes if all identifying information is removed or obliterated (patient and family names, addresses, phone numbers, email addresses, clinic or department names, staff names, initials, titles, and all dates, except years). Administrative approval must still be obtained before making such copies. (See Minimum Necessary Rule in this manual.)*
 - c) Records may also be duplicated in preparation for legal proceedings, following UF policies and procedures. (See Uses and Disclosures of PHI: Subpoenas, Court Orders, and Attorney Requests in this manual.)*
- 6. Recovery of Lost and/or Damaged Paper Records:**
- a) Reasonable efforts will be made to recover patient information lost due to misplacement or theft, or to water or fire damage.*
 - b) Unrecoverable records should be recreated as much as possible, by any methods currently available for such purposes.*
 - c) If applicable, the fact that portions of the record were unrecoverable must be documented*

D. PROCEDURES

- 1. Health Information Management:** Route all requests related to disclosure of protected health information to the designated record manager for the primary record.
- 2. Use of Records:** Track and account for all health records and record documents used in the area.
 - a) Keep all record documents inside a protective folder or binder that is clearly labeled with the patient's name and record number. Label all pages of the record with the patient's name and number.*
 - b) Do not eat or drink when working with or near records to avoid damage to the documentation.*
- 3. Storage of Active Records:**
 - a) Inventory records used in patient care areas at the beginning of the day, and account for all inventoried records at the end of the day.*

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- b) *If any records are maintained and stored in the clinic or department, use a sign-out process in the record file area to document the location of any record that is removed and its return.*
 - c) *Keep all records received from Shands HI/RM or other centralized storage area in one central location when they are not in use for patient care. The area should be one that is constantly monitored and that can be secured.*
- 4. Removal of Records:** If it is necessary for faculty or staff to remove an original paper health record from the record's normal storage area, and the removal has been approved by the administrator:
- a) **Sign the Record Out:** *Document the name of the person who has assumed responsibility for the record, where the record is being taken, and the date it was removed.*
 - b) **Sign the Record In:** *Document the date of the record's actual return.*
 - c) **Return or Retrieve:** *If the record is not returned within 3 business days, contact the responsible person, and continue to follow up until it has been returned.*
 - d) *(See also Uses and Disclosures: Subpoenas, Court Orders, and Attorney Requests in this manual.)*
- 5. Disaster Preparations:** Refer to your facility's Disaster Manual for protection of non-electronic records during potentially damaging situations. Refer to your Unit Information Security Guidelines for protection of electronic records.
- 6. Recovery of Lost and/or Damaged Paper Records:**
- a) **Lost Records:**
 - (1) Search thoroughly in all probable areas:
 - (a) *The place where the record was last used,*
 - (b) *The place where the record is usually filed: Look for common filing errors (transposed names or numbers) or two records filed together, etc.,*
 - (c) *The office of the care provider,*
 - (d) *Wastebaskets and/or dumpsters.*
 - (2) Notify staff members of the loss, and allow reasonable time for a response.
 - (3) Notify the patient of the loss if there is reasonable cause to believe that:
 - (a) *The patient may have removed the record themselves;*
 - (b) *An unauthorized person may have acquired the patient's personal information and could use it for fraudulent purposes.*
 - b) **Fire and Water Damaged Records:**
 - (1) Prioritize the rescue of paper records using the UF Records Retention Schedules, and based on current operational needs.

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- (2) Remove records from fire and/or water-damaged areas within 48 hours to prevent growth of mold and bacteria.
 - (3) Restore water-damaged paper records as much as possible using available technologies:
 - (a) *Air-Drying: Spread record pages on absorbent materials and use fans to increase airflow.*
 - (b) *Freezing: Keep records frozen or in cold storage temporarily to prevent deterioration until they can be dried out.*
 - (c) *Freeze-Drying and other recovery methods by professional document or disaster recovery specialists.*
 - (4) If it is determined that paper records that are fire- or water-damaged will deteriorate quickly in spite of rescue efforts, photocopy, microfilm, or digitally image them as soon as possible.
 - (5) Create a log of the disaster event that lists the patient records affected, and the recovery efforts and results. Retain the log for the maximum retention period of the affected records.
- c) *Recreate unrecoverable records as much as possible and label each page: "Recreated Document" with the date it was recreated. Methods include:*
- (1) Print available documentation from (undamaged) electronic sources.
 - (2) Retrieve copies of previously distributed documents from recipients (shadow charts, referring physicians, other health care agencies, the patient, etc.)
 - (3) Request re-transcription of reports from dictation systems.
- d) *Document, if applicable, the fact that portions of the record were unrecoverable in a new record as follows:*
- (1) Patient name and Health Record Number
 - (2) Types and dates of unrecovered materials, if known
 - (3) When and how the information was lost or destroyed
 - (4) Who was notified of the loss or destruction and how (include copies of notifications, if available)
 - (5) Signature of the record custodian or designee and date
- e) *Recovery: If an original record that was lost or stolen is eventually recovered, merge the old and new documentation without duplication.*

E. REFERENCES:

1. **HIPAA:** 45 CFR §164.501 (Definitions); § 164.502 (Use and Disclosure)
2. **Florida Statutes:** 456.057 (Ownership and Control of Patient Records)

F. EXHIBITS

Designated Record Set