

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL**

<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.14:</b>	<b>Provision of Notice of Privacy Practices for Protected Health Information</b>
<b>Governing Body Approval:</b>	April 27, 2018
<b>REVISED:</b>	

**PURPOSE:** To inform staff of the patient’s/personal representative’s right to adequate notice of the uses and disclosures of Protected Health Information (PHI), the patient’s rights, and Whiting Forensic Hospital’s (WFH) legal duties with respect to PHI.

**SCOPE:** Nursing, Social Workers, Unit Directors and Health Information Management

**POLICY:**

All patients or their personal representative are provided a “Notice of Privacy Practices” upon or shortly following admission to WFH.

***Definitions:***

1. ***Individually Identifiable Health Information:*** Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. *Note:* Individually identifiable health information is to be treated as protected health information.
2. ***Notice of Privacy Practices:*** The notice of privacy practices relating to the agency’s use and disclosure of PHI that is mandated under Health Insurance Portability and Accountability Act (HIPAA) regulations for distribution to all individuals whose information will be collected by or on behalf of the agency.
3. ***Personal Representative:*** A person who has authority under applicable law to make decisions related to health care on behalf of a patient.

4. Protected Health Information (PHI): Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.

#### **PROCEDURE:**

1. The staff admitting the patient provides the patient/personal representative with a copy of the Notice of Privacy Practices WFH-681 upon admission.
2. The admission staff member reviews the content with the patient/personal representative and obtains his/her signature on the Receipt for the Notice of Privacy Practices (WFH-681). The patient's/personal representative's signature acknowledges receipt of the notice.
3. If the patient refuses to sign the Receipt for the Notice of Privacy Practices, the staff member who reviewed the content documents an explanation of the refusal and signs and dates the receipt.
4. The admission staff member copies the Receipt for the Notice of Privacy Practices, gives a copy to the patient/personal representative, and files the original in the Legal and Fiscal section of the patient's medical record.
5. If the patient presents with symptoms of an acute nature which preclude the patient from being able to understand the explanation of the Notice of Privacy Practices on admission and/or the personal representative is not available, the assigned Social Worker follows-up with the patient, reviews the notice as soon as is reasonably possible, and obtains the patient's signature.
6. The Social Worker copies the Receipt for the Notice of Privacy Practices (WFH-681), gives a copy to the patient/personal representative, and files the original in the Legal and Fiscal section of the patient's medical record.
7. The Unit Director is responsible for posting the Notice of Privacy Practices in a clear and prominent location which is easily accessible to all patients on each unit.
8. The WFH Privacy Officer revises and distributes the Notices of Privacy Practices (WFH-681), incorporating any material changes made to the notice by the Office of Healthcare Information.
9. The Unit Director posts the revised Notice of Privacy Practices and makes a copy available to anyone upon request.

*Example 1:* A new client at your facility/statewide program is presented with the **Notice of Privacy Practices** during the admission process and asked to sign at the bottom, acknowledging receipt. If the client refuses to sign, the staff person who asked for the signature documents on the form that the *Notice of Privacy Practices* was offered, that the client refused to sign, and the reason for the client's refusal to sign.

*Example 2:* A new client is admitted to your facility/statewide program who is in crisis, or

presenting with symptoms of an acute nature which preclude the client from being able to understand the explanation of the *Notice of Privacy Practices* make it inappropriate to review under the circumstances. A specific staff person should be assigned to follow-up with the client and review the *Notice of Privacy Practices* as soon as it is reasonably possible (for example, in a hospital unit, a Social Worker could be assigned to review the *Notice of Privacy Practices* with all new admissions who come in and are unable to have the notice reviewed with them).

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL**

<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.15:</b>	<b>Access To Protected Health Information</b>
<b>Governing Body Approval:</b>	April 27, 2018, October 20, 2020
<b>REVISED:</b>	October 14, 2020

**PURPOSE:** To inform Whiting Forensic Hospital (WFH) clinical staff and Health Information Management (HIM) staff, that the patient (or conservator), the Administrator/ Executor, or Next-of-Kin for deceased patients have the right to access, inspect or obtain a copy of their Protected Health Information (PHI) for as long as WFH maintains the information.

**SCOPE:** All Clinical Staff, HIM and Office Assistant

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) in accordance with state and federal laws, that all patients have the right to access, inspect or obtain a copy of their Protected Health Information (PHI) for as long as WFH maintains the information.

***Definitions:***

1. ***Correctional Institutions:*** Any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody include juvenile offenders adjudicated delinquent; aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.
2. ***Disclosure:*** The release, transfer, provision of access to, or the divulging in any other manner of information outside the agency holding the information.

3. Individually Identifiable Health Information: Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Note: Individually identifiable health information is to be treated as protected health information.
4. Personal Representative: A person who has authority under applicable law to make decisions related to health care on behalf of a patient.
5. Protected Health Information (PHI): Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.
6. Use: With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

## **PROCEDURE:**

### **A. General Information**

1. The Medical Records Supervisor (HIM) provides oversight for patient access to PHI.
2. HIM staff receives all patient requests to access, inspect or copy PHI in writing.
3. HIM staff acts on all requests for access no later than 30 days after receipt of the written request as follows:
  - a. If WFH grants the request, in whole or in part, the patient will be informed and provided the access requested.
  - b. If the request for access is for PHI that is not maintained at WFH, or is not accessible to WFH, HIM staff will notify the patient of the status of access.
  - c. If WFH does not maintain the PHI that is the subject of the patient's request, and knows where the requested information is maintained, HIM staff will inform the patient where to direct the request for access.

B. Request to Access or to Inspect PHI: Active Inpatient Status

1. The patient completes the Medical Record Examination Request form (WFH-131) which is sent to Health Information Management (HIM) for processing.
2. HIM staff forwards the request to the appropriate Attending Psychiatrist for approval or denial of the request. The Attending Psychiatrist records a decision on the Medical Record Examination Request form (WFH-131) and returns the form to HIM for further processing.

C. Granting of Request to Access or to Inspect PHI

1. If the request to review the medical record is approved by the Attending Psychiatrist;
  - a. HIM sends a copy of the Medical Record Examination Request form (WFH-131) to the patient and the Head Nurse to notify them that the request to review the medical record has been granted; and
  - b. HIM files the original WFH-131 in the Correspondence section of the medical record.
2. The Head Nurse provides the Medical Record Examination Appointment form (WFH-131a) to the patient for notification of an appointment to review the medical record, provides a copy to the treatment team member, and places a copy in the Correspondence section of the medical record.
3. WFH provides access to inspect the requested PHI in a timely manner, and in a location that is convenient to the patient.
4. The treatment team member designated to review the record with the patient ensures that he/she and the patient signs Medical Record Examination form (WFH-131b) attesting to the review.
5. The treatment team member sends a copy to HIM for data entry purposes and files the original WFH-131b, Medical Record Examination Form in the Correspondence section of the medical record.
6. HIM staff works with the Attending Psychiatrist to provide the patient with a summary of the requested PHI, or to provide an explanation of the PHI to which access has been approved, in lieu of providing access to the medical record if:
  - a. the patient agrees in advance to such a summary or explanation; and,
  - b. the patient agrees in advance to fees imposed, if any, by WFH for such summary or explanation.

7. WFH documents and retains the following for a period of 10 years:
  - a. the designated record sets that are subject to access by patients; and,
  - b. the titles of the persons or offices responsible for receiving and processing requests for access by patients.

#### D. Request for a Copy of PHI

1. Active Inpatient:
  - a. The patient completes the Request for Copy of Medical Record Documentation form (WFH-151) and Authorization for Use and Disclosure of Protected Health Information form (WFH-184) which is sent to HIM for processing.
  - b. HIM forwards the request to the appropriate Attending Psychiatrist for approval or denial of the request. The Attending Psychiatrist records a decision on the Request for Copy of Medical Record Documentation form (WFH-151) and returns the form to HIM for further processing.
2. Discharged or Deceased Patients:
  - a. HIM staff has the requester complete the Authorization for Use and Disclosure of Protected Health Information form (WFH-184) to examine or receive copies of medical records. The patient (or conservator) signs the authorization for patients that have been discharged and the Administrator/Executor or Next-of-Kin for deceased patients. The requester sends the form to HIM for processing.

#### E. Granting of Request to Obtain a Copy of Medical Record Documentation

1. Active Inpatient:
  - a. HIM processes the request within 30 days of receipt, as approved by the Attending Psychiatrist.
  - b. HIM staff ensures that the patient signs an Authorization for Use and Disclosure of Protected Health Information form (WFH-184) and Request for Copy of Medical Record Documentation form (WFH-151) to indicate receipt of the information and to acknowledge understanding that information is being released under the provisions of the Connecticut General Statutes and Federal Regulations. HIM staff also advises the patient that he/she assumes responsibility for the confidentiality of the documents and WFH is released from legal responsibility or liability for the release of the information to the extent indicated and authorized by the patient.

2. Discharged or Deceased Patients:

- a. HIM processes the request according to State and Federal Regulations within 30 days of receipt.
  - b. HIM sends the requester a cover letter stating information is sent as requested or otherwise limited. The information is mailed to the patient, conservator, or next-of-kin by Certified, Return Receipt Mail to verify receipt of the confidential PHI.
3. If the patient receives copies of his/her PHI, or agrees to a summary or explanation of such information, WFH may impose a reasonable, cost-based fee, not to exceed \$.66 per page that includes:
- a. copying, including the cost of supplies for and labor of copying the PHI requested;
  - b. postage when the patient has requested the copy or the summary or explanation be mailed; and
  - c. preparing an explanation or summary of the PHI, if this method is agreed to by the patient.

F. Denial of Access

1. HIM does not release the following PHI for inspection according to state and federal law:
  - a. psychotherapy notes; (notes not maintained in the medical record);
  - b. information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding;
  - c. PHI used for research;
  - d. PHI received from correctional institution records; or,
  - e. information obtained from other health care providers.
2. WFH denies a patient access, without providing the patient an opportunity for review, in the following circumstances:
  - a. the patient has agreed to the denial of access when consenting to participate in research that includes treatment, and the covered health care provider has informed the patient that the right of access may be reinstated upon completion of the research; or,
  - b. the PHI was obtained from someone other than a health care provider under a promise of confidentiality and access requested would be reasonably likely to reveal the source of the information.

3. WFH may deny a patient access, provided that the patient is given a right to have such denial reviewed, in the following circumstances:
  - a. the Attending Psychiatrist or Chief Medical Officer (CMO) has determined, in the exercise of professional judgement, that the access requested is reasonably likely to endanger the life or physical safety of the patient or another person;
  - b. the PHI makes reference to another person (unless such other person is a health care provider) and the Attending Psychiatrist or CMO has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or,
  - c. the request for access is made by the patient's personal representative and the Attending Psychiatrist or CMO, in the exercise of professional judgement, determines that the provision of access to such personal representative is reasonably likely to cause substantial harm to the patient or another person.
4. If the Attending Psychiatrist or CMO denies access to PHI, in whole or in part, efforts will be made to make other information accessible, by giving the patient access to any other PHI requested after excluding the PHI which WFH has grounds to deny.
5. If access to PHI is denied, in whole or in part, the Attending Psychiatrist or CMO provides a timely, written denial to the patient which must be in clear language and contain:
  - a. the basis for the denial; and
  - b. a description of how the patient may exercise his/her right to have the denial reviewed by an Alternate Physician.
6. HIM notifies the patient of the decision and provides the patient with a Denial of Access and Request for Alternate Review of your Medical Record form (WFH-184d) which instructs the patient that he/she may request an Alternate Physician to review his/her medical record.
7. The Alternate Physician reviews the patient's request and makes a determination.
  - a. If the determination is that the information may be released, then the Alternate Physician notifies HIM, who releases the information following notification of the CMO.
  - b. If the determination is to deny access, the Alternate Physician notifies HIM, who advises the patient that he/she has the right to appeal the denial to the Service Medical Director, using WFH-666, Request for Appeal of Denial Form.
8. HIM staff files the original WFH-666 in the Correspondence section of the medical record, gives a copy to the patient, and sends a copy to the Quality and Compliance Officer.
9. The Quality and Compliance Officer forwards the request for appeal to Chief Medical Officer, who has 30 days to make a determination.

10. If Chief Medical Officer does not uphold the denial, WFH will grant access.

11. If Chief Medical Officer denies access, HIM informs the patient using Denial of Access to Your Medical Record by Alternate Physician Form (WFH-184g) that he/she may seek a review through the Judicial System, by filing a petition with the Superior Court.

Illustrations/Examples:

*Example 1:* A patient signs an authorization to obtain his own record for a particular episode of care, specifically requesting copies of his psychotherapy notes. Upon review of the chart, the Attending Psychiatrist believes releasing this information would create a reaction that would cause a substantial risk that the patient would inflict life-threatening injury to his/her self or to others or experience a severe deterioration in mental state. The patient is informed that his/her request has been denied, the reason for that denial, and the process for requesting further review by a physician of their choice. Upon review, the denial of access is upheld. The patient is informed of his/her right to further judicial relief as outlined in CGS 4-104 and his/her right to file a complaint with the WFH Quality and Compliance Officer as outlined in the Notice of Privacy Practices.

**WHITING FORENSIC HOSPITAL  
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<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.16:</b>	<b>Amendment of Protected Health Information</b>
<b>Governing Body Approval:</b>	April 27, 2018, October 20, 2020
<b>REVISED:</b>	October 14, 2020

**PURPOSE:** To inform Whiting Forensic Hospital (WFH) clinical staff and Health Information Management (HIM) staff, that patients have the right to request an amendment of their Protected Health Information (PHI) of documentation found to be in error for as long as WFH maintains the information.

**SCOPE:** All Clinical Staff and HIM

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) to allow a patient to request an amendment of their Protected Health Information (PHI) for documentation found to be in error for as long as WFH maintains the information.

***Definitions:***

1. ***Business Associate:*** A person or entity who on behalf of the agency, but not in the capacity of a workforce member, performs or assists in the performance of a function or activity involving the use or disclosure of PHI; or provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services involving disclosure of PHI.
2. ***Individually Identifiable Health Information:*** Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. **Note:** Individually identifiable health information is to be treated as protected health information.

3. Protected Health Information (PHI): Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.

## **PROCEDURE:**

### **1. Patient Request for Amendment**

- A. If a patient, following review of his/her medical record documentation, finds information to be in error he/she may request that this information be amended. The patient completes a Request for Amendment of Protected Health Information form (WFH-522).
- B. The Request for Amendment of Protected Health Information form is sent to the Chief Quality and Compliance Officer (CQCO), who notifies the appropriate provider of the patient's request for amendment (correction) of his/her documentation.

### **2. Granting Amendment Requests**

- A. If the provider finds the documentation identified by the patient to be in error, the provider makes the requested amendment by recording the correction on the document in question, and dates and signs the entry. **DO NOT** cross out or otherwise obliterate the original entry.
- B. The CQCO notifies the patient in writing of the provider's decision regarding their request for amendment on the Request for Amendment of Protected Health Information form (WFH-522) within a reasonable time frame not to exceed 30 days.
- C. HIM files the Request for Amendment of Protected Health Information form (WFH-522) in the Correspondence section of the medical record.

### **3. Denying Amendment Requests**

- A. WFH may deny an amendment request for the following reason(s):
  1. the portion to which the amendment request is addressed is accurate and complete;
  2. WFH did not create the entry to which the amendment request is addressed;
  3. the portion to which the amendment request is addressed, is not in the medical record; or,
  4. the portion to which the amendment request is addressed, is information to which the patient does not have a right of access.

- B. The provider records the reason for the denial within 30 days on the Request for Amendment of Protected Health Information form (WFH-522), which also informs the patient that he/she has the right to appeal the denial.
- C. If the patient chooses to appeal the denial, he/she completes the Request for Appeal of Denial form (WFH-666) which is sent to the CQCO.
- D. The CQCO forwards the appeal to the appropriate discipline head for review of the provider's documentation. The discipline head determines whether or not to uphold the appeal and provides the patient with written notice, within 30 days, on the Request for Amendment of Protected Health Information form (WFH-522). This will also serve to inform the patient that he/she has the right to appeal the denial.
- E. If the patient chooses to appeal the discipline head's determination, the patient fills out the Request for Appeal of Denial form (WFH-666). The CQCO, in collaboration with the Chief Medical Officer (CMO), determines whether or not to uphold the denial and provides a written notice to the patient within 30 days using WFH-666. This serves as the last appeal.
- F. HIM places the original request for amendment, the denial (WFH-522) and the Request for Appeal of Denial (WFH-666) into the Correspondence section of the medical record.
- G. HIM files any subsequent correspondence received from or sent to the patient in the Correspondence section of the medical record.

### **Illustrations/Examples:**

*Example 1:* A patient's medical record reflects a felony history and incarceration. The patient believes the information is both inaccurate and will negatively impact on his ability to obtain employment and wants to amend the record. However, he provides no written documentation to demonstrate the information is inaccurate and his request is denied. The hospital provides a written notification of the denial, and honors the request from the patient to enter into the medical record his written request for amendment.

*Example 2:* A patient submits a letter on November 15<sup>th</sup> requesting that all instances in her medical record be removed that refer to a drug screen that indicated a positive for opiates. She provides verification from the laboratory, which had maintained a portion of the sample for retesting as required, that in fact, the results were a false positive. The hospital then inserts a notation at each place in the record where there was a reference to the drug screen results. The notation directs the reader to the laboratory section of the medical record that has the corrected results. This process was completed by January 14<sup>th</sup>. Those parties that had received copies of the incorrect results were notified.

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<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.17:</b>	<b>Accounting of Disclosure of Protected Health Information</b>
<b>Governing Body Approval:</b>	April 27, 2018
<b>REVISED:</b>	

**PURPOSE:** To inform staff of the patient’s/personal representative’s right for an accounting of disclosures of Protected Health Information (PHI) when requested in writing. The patient is entitled to an accounting of disclosures in the six years prior to the date on which the accounting is requested.

**SCOPE:** All Clinical Staff and HIM

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) to provide patients/personal representatives with an accounting of disclosures of Protected Health Information (PHI) made by WFH in the six years prior to the date on which the accounting is requested in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. The accounting is provided within 60 days of receipt of the request.

***Definitions:***

1. ***Correctional Institutions:*** Any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody include juvenile offenders, adjudicated delinquents; aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.
2. ***Disclosure:*** The release, transfer, provision of access to, or the divulging in any other manner of information outside the agency holding the information.
3. ***Health Oversight Agency:*** A governmental agency or authority, or a person or entity acting under a grant of authority from or a contract with such a public agency, including the employees or agents of the public agency, its contractors and those to whom it has granted

authority, that is authorized by law to oversee the public or private health care system or government programs in which health information is necessary to determine eligibility or compliance.

4. Personal Representative: A person who has authority under applicable law to make decisions related to health care on behalf of a patient.
5. Protected Health Information (PHI): Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.
6. Public Health Authority: A governmental agency or authority, or a person or entity acting under a grant of authority from or a contract with such a public agency, including the employees or agents of the public agency, its contractors and those to whom it has granted authority, that is responsible for public health matters as part of its official mandate.
7. Treatment, Payment, and Health Care Operations (TPO): Includes all the following:
  - A. *Treatment* – The provision, coordination, or management of health care and related services, consultation between providers relating to an individual, or referral of an individual to another provider for health care.
  - B. *Payment* – Activities undertaken to obtain or provide reimbursement for health care, including determinations of eligibility or coverage, billing, collections activities, medical necessity determinations and utilization review.
  - C. *Health Care Operations* – Includes functions such as quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, conducting or arranging for medical review, legal services and auditing functions, business planning and development, and general business and administrative activities.

#### **PROCEDURE:**

1. Health Information Management (HIM) provides an accounting of disclosures of PHI in response to a written request by the patient/personal representative.
2. HIM ensures that the patient/personal representative completes the Request for Accounting of Disclosure of PHI form (WFH-531).
3. HIM provides the patient with an accounting of disclosures for up to 6 years prior to the date on which the accounting is requested within 60 days of receipt of the request.
4. HIM includes an accounting of the following disclosures of PHI which do not require patient authorization (See *Operational Procedure 9.23 Use and Disclosures of Protected Health Information Without Authorization*):
  - A. for public health activities and purposes;
  - B. for health oversight activities;
  - C. for judicial or administrative proceedings;

- D. for matters concerning deceased individuals; and
5. HIM does not include an accounting of the following disclosures:
    - A. disclosures made for carrying out treatment, payment and health care operations;
    - B. disclosures made to the individual about their PHI;
    - C. disclosures for national security or intelligence purposes;
    - D. disclosures not created by Whiting Forensic Hospital (WFH), unless the individual provides a reasonable basis to believe that the person who created the PHI is no longer available to act on the individual's request;
    - E. if the disclosure is not part of the individual record;
    - F. if the disclosure is for psychotherapy notes;
    - G. if it is information collected and held in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; or if it is a record that is subject to the Clinical Laboratory Improvements Amendments of 1988;
    - H. if the disclosure is part of a Limited Data Set (LDS); or
    - I. disclosures made as a result of an authorization (WFH-184).
  6. Any staff member, in his/her capacity to report or disclose specific information containing PHI, to a public health authority or health oversight agency for example, documents the disclosure on the Accounting of Disclosure of Protected Health Information Log Form (WFH-532) located in the Correspondence section of the patient's medical record. Information documented on the log includes:
    - A. the date of the disclosure;
    - B. the person/entity requesting PHI and address (if known);
    - C. a brief description of PHI disclosed;
    - D. a brief statement of the purpose of the disclosure; and
    - E. the name/title of person providing the disclosure.
  7. The Research Committee is responsible to ensure that the researcher documents an accounting of disclosures made pursuant to a research project consisting of 50 or more individuals on the Accounting of Disclosures of Protected Health Information Log Form (WFH-532) which includes:
    - A. the date or period of time during which such disclosures occurred or may have occurred, including the date of the last such disclosure during the accounting period;
    - B. the name, address and telephone number of the entity that sponsored the research and of the researcher to whom the PHI was disclosed;
    - C. a brief description of the type of PHI that was disclosed;
    - D. the name of the protocol or other research activity; and
    - E. the name/title of person providing the disclosure.
  8. HIM provides the patient/personal representative an accounting of PHI disclosures, based on information from the Accounting of Disclosure of Protected Health Information Log Form (WFH-532). HIM staff includes the name and title of the staff member processing the

request on the cover letter form (WFH-269).

9. HIM retrieves from the Research Committee, a description of the research protocol or activity, including the purpose and the criteria for selecting particular records and includes this information in the accounting provided to the patient.
10. HIM adds a statement to the cover letter (WFH-269) that the PHI of the patient may or may not have been disclosed for a particular protocol or other research activity. This only applies when the patients' records are utilized for research purposes in a research project consisting of 50 or more individuals.
11. HIM staff files the request and a copy of the accounting provided to the individual in the Correspondence section of the patient's medical record.
12. WFH retains the request and a copy of the documentation provided to the individual in accordance with the State of Connecticut retention guidelines.
13. WFH temporarily suspends an individual's right to receive an accounting of disclosures to a health oversight agency or law enforcement official, for the time specified by such agency or official, if such agency or official provides WFH with a written statement that such an accounting to the individual would be reasonably likely to impede the agency's activities.

### **Illustration/Example**

*Example:* On November 15, 2005, an individual believes that a rash of health insurance advertisements mailed to his home are the result of information provided by a facility/statewide program from which he recently received services. He has provided a written document requesting an accounting of all disclosures made in the past six years. The request provided included all the required elements and the information is provided him. The medical records department does not include an accounting of disclosures made that were required to carry out treatment, payment and health care operations. The medical records department also did not include disclosures made to the Secret Service who requested information on this patient because the patient had publicly threatened the Vice President of the United States in the past, and the Vice President was scheduled to make a visit to the city in the near future. It should be noted that the Secret Service representative provided validation of her identity prior to the disclosure being made.

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OPERATIONAL PROCEDURE MANUAL**

<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.18:</b>	<b>Request for Confidential Communication of Protected Health Information</b>
<b>Governing Body Approval:</b>	April 27, 2018, October 20, 2020
<b>REVISED:</b>	September 10, 2020

**PURPOSE:** To inform Health Information Management (HIM) staff that patients/personal representatives have the right to receive their requested Protected Health Information (PHI) at alternative locations or by alternative means. HIM staff is required to make reasonable accommodation for the patient in receiving PHI.

**SCOPE:** All Clinical Staff, HIM and Office Assistant

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) that the Hospital obtains a patient’s written authorization prior to using or disclosing his/her Protected Health Information (PHI) for specified purposes other than treatment, payment or health care operations.

**Definitions:**

1. ***Individually Identifiable Health Information:*** Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. *Note:* Individually identifiable health information is to be treated as protected health information.
2. ***Personal Representative:*** A person who has authority under applicable law to make decisions related to health care on behalf of a patient.
3. ***Protected Health Information (PHI):*** Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.

## **PROCEDURE:**

1. HIM honors any reasonable request made by patients/ personal representatives in writing for the patient's protected health information to be provided at alternate locations or by alternate means.
2. HIM ensures that the patient/personal representative submits the request for confidential communication in writing using form WFH-184: Authorization for Use and Disclosure of Protected Health Information.
3. HIM will not require an explanation from the patient or personal representative as to the basis for the request as a condition of providing confidential communication of PHI at alternative locations or by alternative means (i.e., fax number, P.O. Box).
4. If HIM determines that the request is unreasonable, HIM will respond to the patient or personal representative in writing, informing him/her of his/her right to appeal the denial to the WFH Quality and Compliance Officer.
5. If the patient chooses to appeal the denial, he/she completes the Request for Appeal of Denial form (WFH-666) which is sent to the Quality and Compliance Officer.
6. The Quality and Compliance Officer determines whether or not to uphold the denial and provides a written notice to the patient within 30 days using WFH-666.
7. If the denial is upheld, the patient is informed of his/her right to a further review by the Chief Executive Officer, using WFH-666, Request for Appeal of Denial.
8. HIM staff files the forms WFH-184 and WFH-666 in the Correspondence section of the medical record.

## **Illustration/Example**

*Example:* A patient/client sends a request to have his lab results faxed to his place of business, rather than sent to his home address. The hospital determines that this is a reasonable request and therefore faxes the lab results to his place of business.

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL**

<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.19:</b>	<b>Authorization for Use and Disclosure of Protected Health Information</b>
<b>Governing Body Approval:</b>	April 27, 2018, October 20, 2020
<b>REVISED:</b>	October 14, 2020

**PURPOSE:** To inform staff that Whiting Forensic Hospital (WFH) obtains the patient’s written authorization prior to using or disclosing his/her Protected Health Information (PHI) for specified purposes *other* than treatment, payment or health care operations.

**SCOPE:** All Clinical Staff, HIM and Office Assistant

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) that the Hospital obtains a patient’s written authorization prior to using or disclosing his/her Protected Health Information (PHI) for specified purposes other than treatment, payment or health care operations.

Use and disclosure of PHI is to be in accordance with the WFH Notice of Privacy Practices-WFH-681.

***Definitions:***

1. ***Disclosure:*** The release, transfer, provision of access to, or the divulging in any other manner of information outside the agency holding the information.
2. ***Individually Identifiable Health Information:*** Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. ***Note:*** *Individually identifiable health information is to be treated as Protected Health Information (PHI).*

3. Personal Representative: A person who has authority under applicable law to make decisions related to health care on behalf of a patient.
4. Protected Health Information (PHI): Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.
5. Treatment, Payment and Health Care Operations (TPO): Includes all the following:
  - a. Treatment – The provision, coordination, or management of health care and related services, consultation between providers relating to an individual, or referral of an individual to another provider for health care.
  - b. Payment – Activities undertaken to obtain or provide reimbursement for health care, including determinations of eligibility or coverage, billing, collections activities, medical necessity determinations and utilization review.
  - c. Health Care Operations – Includes functions such as quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, conducting or arranging for medical review, legal service and auditing functions, business planning and development, and general business and administrative activities.
6. Use: With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

## **PROCEDURE:**

1. Health Information Management (HIM) and other authorized clinical staff ensures that the authorization (WFH-184) obtained from the patient:
  - a. covers only the uses and disclosures and only the PHI stipulated in the authorization;
  - b. has an expiration date not to exceed twelve months or a specified event or condition (i.e., discharge, death);
  - c. states the purpose for which the information may be used or disclosed;
  - d. specifies the recipient of the information;
  - e. specifies WFH as the institution releasing the information;
  - f. is signed by the patient or his/her personal representative and if it is signed by the personal representative it must contain a description of the representative's authority to act for the patient;
  - g. is dated after the episode record of care;
  - h. includes a statement specifying:
    1. that WFH will not refuse to treat, pay for services, enroll in a health plan, or refuse to provide benefits if a patient refuse to provide authorization;
    2. that the patient may inspect or copy information to be used or disclosed;
    3. that the patient may refuse to sign the authorization;

4. that the information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by Title 45 CFR Parts 160 and 164;
  5. how the patient revokes the authorization.
2. If the authorization is not completed in full, HIM staff returns it to the requestor noting the deficiency(ies) and encloses a WFH Authorization (WFH-184) for his/her completion.
  3. HIM or clinical staff provides the patient with a copy of the signed authorization if requested.
  4. HIM or clinical staff files the original signed authorization in the Legal and Fiscal section of the medical record.
  5. HIM staff accepts written instructions from the patient or personal representative to revoke an authorization at any time, except to the extent that WFH has taken action in reliance thereon.
  6. The admission staff member provides the patient with a copy of the signed authorization.
  7. The admission staff member files the original signed authorization in the Legal and Fiscal section of the medical record.
  10. Any staff member who becomes aware of an unauthorized use or disclosure of PHI immediately reports this to their immediate supervisor and completes an incident report.
  11. A copy of the incident report is sent to the Department Director and the hospital Privacy Officer/CQCO.
  12. All incidents of unauthorized use or disclosure will be reviewed in accordance with *Commissioner's Policy 3.13 Unauthorized Disclosure and Breach Notification of Unsecured PHI.*

### **Illustration/Example**

*Example:* A patient stops by WFH's HIM Unit and drops off an authorization from his new employer requesting a copy of the history and physical his principal physician completed less than a month ago. The authorization does not include all the necessary requirements for a complete and proper authorization. The HIM Unit assists the individual in completing a properly executed authorization to release the information.

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL**

<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.20:</b>	<b>Resolving Conflicting Authorizations</b>
<b>Governing Body Approval:</b>	April 27, 2018
<b>REVISED:</b>	

**PURPOSE:** To inform Health Information Management (HIM) staff that conflicting authorizations to disclose Protected Health Information (PHI) are to be identified and resolved.

**SCOPE:** HIM and Unit Clerks

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH), that conflicting authorizations to disclose Protected Health Information (PHI) shall be identified and resolved.

***Definitions:***

1. ***Individually Identifiable Health Information:*** Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. *Note:* individually identifiable health information is to be treated as Protected Health Information (Protected Health Information).
2. ***Protected Health Information (PHI):*** Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.

**PROCEDURE:**

1. When Whiting Forensic Hospital (WFH) is presented with conflicting authorizations to disclose PHI, the HIM staff:

- A. communicates in writing with the patient in order to determine the individual's preference regarding the authorization to disclose PHI; and
  - B. resolves the conflict by obtaining a new written authorization from the patient or having the patient cancel the authorization(s) that is/are in conflict with his/her preference by signing the cancellation section on the authorization(s).
2. Until such time as the conflict is resolved WFH defers to the most restrictive authorization.

**WHITING FORENSIC HOSPITAL**  
**OPERATIONAL PROCEDURE MANUAL**

<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.21:</b>	<b>Verification Requirements for the Use and Disclosure</b>
<b>Governing Body Approval:</b>	April 27, 2018
<b>REVISED:</b>	

**PURPOSE:** To inform all Health Information Management (HIM) staff who, in the course of their work, disclose Protected Health Information (PHI) that they need to verify the identity and authority of those requesting PHI.

**SCOPE:** HIM and Unit Clerks

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) that verification of the identity of a person requesting Protected Health Information (PHI) and their authority in receiving PHI be determined by the Health Information Management (HIM) staff prior to providing any disclosures.

***Definitions:***

1. *Disclosure:* The release, transfer, provision of access to, or the divulging in any other manner of information outside the agency holding the information.
2. *Individually Identifiable Health Information:* Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. *Note:* Individually identifiable health information is to be treated as protected health information.

3. Protected Health Information (PHI): Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.
4. Use: With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

**PROCEDURE:**

1. HIM staff implement one of the following methods of verification of identity and determination of authority based on the entity/person making the request as illustrated below:

<b>Entity/Person Making Request</b>	<b>Method</b>
Patient	<p><b>In Person:</b> Identification (i.e., driver’s license, passport, birth certificate or state issued identity card)</p> <p><b>On Phone:</b> Caller is sent an authorization form to complete prior to disclosure of PHI. Upon receipt of authorization form, HIM staff verify signature with signed documents on file.</p>
Patient’s personal representative, (i.e., Conservator, Guardian, Executor of Estate)	Copy of legal appointment.
For request made pursuant to legal process	Warrant, subpoena, court order, or other legal process issued by a grand jury, judicial or administrative tribunal.

2. HIM staff records all disclosures as follows:
  - A. HIM records to whom the disclosure is made and how the requestor’s identity was verified on the cover letter (WFH-269).
  - B. HIM records what information was disclosed and the purpose for the disclosure on the Authorization for Use and Disclosure of Protected Health Information (WFH-184).
3. HIM staff files WFH-269 and WFH-184 in the patient’s medical record to ensure that this information is in a readily retrievable format.

**WHITING FORENSIC HOSPITAL**  
**OPERATIONAL PROCEDURE MANUAL**

<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.22:</b>	<b>Restrictions on the Use and Disclosure of Protected Health Information</b>
<b>Governing Body Approval:</b>	April 27, 2018
<b>REVISED:</b>	

**PURPOSE:** To inform Health Information Management (HIM) and clinical staff that the patient has the right to request restrictions on the uses and disclosures of his/her Protected Health Information (PHI) and that the request must be submitted by the patient or personal representative in writing.

**SCOPE:** All Clinical Staff and HIM

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) to respect the right of the patient who requests restrictions on the uses and disclosures of Protected Health Information (PHI). All requests for such restrictions shall be in writing.

***Definitions:***

1. ***Disclosure:*** The release, transfer, provision of access to, or the divulging in any other manner of information outside the agency holding the information.
2. ***Individually Identifiable Health Information:*** Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies

the individual, or (4) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Note: Individually identifiable health information is to be treated as protected health information.

3. Personal Representative: A person who has authority under applicable law to make decisions related to health care on behalf of a patient.
4. Protected Health Information (PHI): Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.
5. Use: With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

#### **PROCEDURE:**

1. Staff provides the patient with form WFH-523, Request for Restrictions of Protected Health Information, when the patient requests a restriction on the use and disclosure of his/her PHI.
2. Staff receiving the request submits the form to HIM for processing.
3. HIM forwards the request to the Attending Psychiatrist for a decision to allow or deny the restriction.
4. HIM staff informs the patient of the decision in writing within 30 days using WFH-523.
5. The original form WFH-523 is filed in the Correspondence section of the medical record.
6. If the hospital agrees to the requested restriction, HIM staff will not use or disclose PHI in violation of this restriction. Additionally, the HIM staff alerts others who have already received this information of the restriction.
7. WFH may terminate its agreement to a restriction if:
  - A. the patient agrees to or requests the termination in writing;
  - B. the patient orally agrees to the termination and the oral agreement is documented; or
  - C. WFH notifies the patient it is terminating the agreement and the termination is effective after the individual is informed.

8. If a restriction is denied, WFH notifies the patient in writing using WFH-523 and informs the patient of his/her right to appeal the denial to the WFH Privacy Officer.
9. If the patient chooses to appeal the denial, he/she completes the Request for Appeal of Denial form (WFH-666) which is sent to the Privacy Officer.
10. The Privacy Officer determines whether or not to uphold the denial and provides written notice to the patient within 30 days using WFH-666.
11. If the denial is upheld, the patient is informed of his/her right to a further review by the Office of Healthcare Information, using WFH-666, Request for Appeal of Denial.
12. HIM staff files the forms WFH-523 and WFH-666 in the Correspondence section of the medical record.
13. On an annual basis, HIM reviews denials on restrictions and verifies consistency and adherence with best practice standards.

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL**

<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.23:</b>	<b>Use and Disclosure of Protected Health Information Without Patient/Conservator Authorization</b>
<b>Governing Body Approval:</b>	June 7, 2018
<b>REVISED:</b>	

**PURPOSE:** To inform HIM and clinical staff of the recipients to whom Protected Health Information (PHI) may be disclosed without authorization, and for what purposes (*see specific definitions below*).

**SCOPE:** All Clinical Staff and HIM and Unit Clerk Staff

**POLICY:**

Purposes for which Protected Health Information (PHI) may be disclosed without authorization include:

1. Public Health activities and purposes;
2. addressing concerns about victims of abuse or neglect;
3. health oversight activities;
4. judicial or administrative proceedings, including hearings of the Psychiatric Security Review Board;
5. deceased individuals;
6. to avert a serious threat to health or safety of a person or the public;
7. specialized government functions;
8. shared government services; and
9. workforce member crime victims.
10. The purposes listed in CGS 52-146f

## Definitions:

1. Correctional Institutions: Any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody include juvenile offenders, adjudicated delinquents, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.
2. Disclosure: The release, transfer, provision of access to, or the divulging in any other manner of information outside the agency holding the information.
3. Health Oversight Agency: A governmental agency or authority, or a person or entity acting under a grant of authority from, or a contract with, such a public agency, including the employees or agents of the public agency, its contractors and those to whom it has granted authority, that is authorized by law to oversee the public or private health care system or government programs in which health information is necessary to determine eligibility or compliance.
4. Individually Identifiable Health Information – Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse, and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe the information can be used to identify the individual. Note: Individually identifiable health information is to be treated as protected health information.
5. Workforce Members – Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for the Agency, is under the direct control of the Agency, regardless of whether they are paid by the Agency.
6. Protected Health Information (PHI): Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.
7. Public Health Authority: A governmental agency or authority, or a person or entity acting under a grant of authority from or a contract with such a public agency, including the employees or agents of the public agency, its contractors and those to whom it has granted authority, that is responsible for public health matters as part of its official mandate.
8. Use: With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

## **PROCEDURE:**

### 1. Public Health Activities

WFH may disclose PHI for the following public health activities and purposes:

- A. A public health authority that is authorized by law to receive such information for the purpose of preventing or controlling disease, injury, or disability, including but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations and public health interventions, or at the direction of the public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority;
- B. A public health authority or other appropriate government authority authorized by law to receive reports of child abuse, neglect;
- C. A person subject to the jurisdiction of the Food and Drug Administration; or
- D. A person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if WFH or public health authority is authorized by law to notify such person as necessary in the conduct of a public health intervention or investigation.

### 2. Victims of Abuse or Neglect

WFH staff will disclose PHI as mandated by CGS 17a-101 through 17a-103c (for child victims), 17b-450 through 17b-454 (for elder abuse), and PA 18-86 Section 2 (for patients in a behavioral health facility). WFH may disclose PHI about individuals

as otherwise required by law, including laws that require the reporting of certain types of wounds or other physical injuries, or in compliance with a court order.

### 3. Health Oversight Activities

WFH may disclose PHI to a Health Oversight Agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight.

### 4. Judicial or Administrative Proceedings

WFH may disclose PHI in the course of any judicial or administrative proceedings in response to a Connecticut General Statute requiring a report or testimony, or in response to an order of a court or administrative tribunal. If responding to the latter, WFH discloses only the PHI expressly authorized by such order.

### 5. Deceased Individuals

- A. WFH may disclose PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- B. WFH may disclose PHI to funeral directors, as necessary, to carry out their duties with respect to the decedent. If necessary for funeral directors to carry out their duties, WFH

may disclose the PHI prior to, and in reasonable anticipation of, the individual's death.

- C. WFH may use or disclose PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

6. To Avert a Serious Threat to Health

- A. WFH is permitted to use and disclose PHI if WFH believe, in good faith, the use or disclosure:

- 1. is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or,

7. Specialized Government Functions

- A. WFH discloses PHI to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act (50 U.S.C. 401, *et seq.*) and implementing authority (e.g., Executive Order 12333).
- B. WFH discloses PHI to authorized federal officials for the provision of protective services to the President or other persons authorized by 18 U.S.C. 3056, or to foreign heads of state or other persons authorized by 22 U.S.C. 2709(a)(3), or to the conduct of investigations authorized by 18 U.S.C. 871 and 879.

8. Shared Government Services

DMHAS' State Administered General Assistance Program may disclose PHI relating to eligibility for or enrollment in the program, to another agency administering a government program providing public benefits, if the sharing of eligibility or enrollment information between the agencies, or the maintenance of such information in a single or combined data system accessible to the agencies, is required or expressly authorized by statute or regulation.

9. Workforce Member Crime Victims

WFH is not considered to have violated the rights of a patient if a member of its workforce, who is the victim of a criminal act, discloses PHI to a law enforcement official, provided that:

- A. the PHI disclosed is about the suspected perpetrator of the criminal act; and

- B. the PHI disclosed is limited to the following:

- 1. name and address;
- 2. ;
- 3. type of injury;
- 4. date and time of treatment;
- 5. date and time of death, if applicable; and
- 6. a description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars and tattoos.

**WHITING FORENSIC HOSPITAL**  
**OPERATIONAL PROCEDURE MANUAL**

<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.24:</b>	<b>Use and Disclosure of Protected Health Information, Minimum Necessary</b>
<b>Governing Body Approval:</b>	June 7, 2018
<b>REVISED:</b>	

**PURPOSE:** To inform staff that they need to make every effort to limit the use, disclosure and requests for patient Protected Health Information (PHI), to the minimum necessary in order to accomplish the intended purpose. The “Minimum Necessary Standard” applies to both external disclosures and internal communications of patient PHI.

**SCOPE:** All Clinical Staff and HIM

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) to make efforts that shall limit the use and disclosure of patient Protected Health Information (PHI) to the minimum necessary in order to accomplish the intended purpose. WFH shall apply the “Minimum Necessary Standard” to both external disclosures and internal communications of patient PHI.

***Definitions:***

1. ***Disclosure:*** The release, transfer, provision of access to, or the divulging in any other manner of information outside the agency holding the information.
2. ***Individually Identifiable Health Information:*** Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. **Note:** Individually identifiable health information is to be treated as protected health information.
3. ***Protected Health Information (PHI):*** Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health

care to an individual, or the past, present or future payment for health care provided to an individual.

4. Treatment, Payment, and Health Care Operations (TPO): Includes all the following:
  - A. Treatment – The provision, coordination, or management of health care and related services, consultation between providers relating to an individual, or referral of an individual to another provider for health care.
  - B. Payment – Activities undertaken to obtain or provide reimbursement for health care, including determinations of eligibility or coverage, billing, collections activities, medical necessity determinations and utilization review.
  - C. Health Care Operations – Includes functions such as quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, conducting or arranging for medical review, legal services and auditing functions, business planning and development, and general business and administrative activities.
5. Use: With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

## **PROCEDURE:**

1. External Disclosures
  - A. Whiting Forensic Hospital (WFH) utilizes criteria designed to limit the PHI disclosed to the information reasonably necessary to accomplish the intended purpose. Criteria includes the purpose for which the disclosure or use is requested, what should be disclosed, who is requesting disclosure, and how long a time period is granted for use of PHI.
  - B. WFH has designated the Director of Health Information Management/designee to oversee or review all requests on an individual basis in accordance with such criteria.
  - C. WFH limits requests for PHI from other facilities or covered entities to that which is reasonably necessary to accomplish the purpose for which the request is made.
2. Internal Communications
  - A. WFH does not permit individually identifiable health information to be displayed in common settings or public areas, such as on white boards or rosters in hallways where the public or other patients would have ready access.
  - B. WFH only permits oral communication in public areas that is necessary to carry out treatment, but encourages that this communication be kept to a minimum. WFH staff makes reasonable efforts to prevent others from intercepting PHI, in whatever medium (e.g. fax, written documents).
  - C. WFH identifies and makes reasonable efforts to limit access of those persons, or classes of persons in its workforce, who need access to PHI to carry out their duties and to identify the categories of PHI to which access is needed and any conditions appropriate to such access.
  - D. At WFH, there are various functions performed by multiple workforce members, with different job titles. In the performance of these functions, staff is provided with access to

only the minimum necessary PHI in order to fulfill their duties. For example, in the performance of one function, a workforce member is provided access to the entire medical record of an individual. In the performance of a second function, this same workforce member will only have access to a portion of the medical record. Please refer to the sample table below.

<b>Function</b>	<b>Access</b>
<p><u>Clinical Functions:</u> (Treatment)            Treatment Team: Physicians, Nursing Staff (APRN, RN, LPN), Psychologists, Social Workers, Clinical Case Managers, Unit Directors, Program Managers</p> <p>Pharmacists, Dietitians, Dental Staff, Physical Therapy, etc.</p>	<p>Access to the entire medical record of patients for whom direct care is provided or supervised.</p> <p>Access limited to portions of the medical record necessary to perform duties as determined using professional judgment and standards, up to and including the entire medical record.</p>
<p><u>Monitoring Activities:</u> (Health Care Operations)            Peer Review            Performance Improvement            Utilization Review/Management            Compliance Reviews</p>	<p>Access limited to the portion(s) of the medical record(s) necessary to accomplish the specific monitoring requirements.</p>
<p>Health Information Management</p>	<p>Access to portions of the medical record needed to perform the specific duties as relate to the record.</p>
<p>Disposition/Transfer/Referral Meetings</p>	<p>Access limited to the portions of the medical record that directly relate to the disposition planning.</p>
<p>Information Technology Staff</p>	<p>Access to databases and IT resources for systems management.</p>
<p>Billing</p>	<p>Access limited to the minimum necessary administrative, clinical and payment information provided from the medical record.</p>
<p>Students and Trainees (Health Care Operations)</p>	<p>Access to entire medical record of assigned patients.</p>

**WHITING FORENSIC HOSPITAL**  
**OPERATIONAL PROCEDURE MANUAL**

<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.25:</b>	<b>Disclosures to Personal Representatives</b>
<b>Governing Body Approval:</b>	June 7, 2018
<b>REVISED:</b>	

**PURPOSE:** To inform staff that if a person has the legal authority to act on behalf of a patient in making health care decisions or act on behalf of a deceased patient or estate, Whiting Forensic Hospital (WFH) shall treat such person as a personal representative with respect to the patient’s Protected Health Information (PHI).

**SCOPE:** All Clinical Staff, HIM and Unit Clerks

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) that if a person has the legal authority to act on behalf of a patient in making decisions related to healthcare, WFH shall treat such person as a personal representative with respect to the patient’s Protected Health Information (PHI).

If a person has the legal authority to act on behalf of a deceased patient or the patient’s estate, WFH shall treat such person as a personal representative with respect to the patient’s PHI.

***Definitions:***

1. ***Disclosure:*** The release, transfer, provision of access to, or the divulging in any other manner of information outside the agency holding the information.
2. ***Individually Identifiable Health Information:*** Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. ***Note:*** Individually identifiable health

information is to be treated as protected health information.

3. *Personal Representative*: A person who has authority under applicable law to make decisions related to health care on behalf of a patient.
4. *Protected Health Information (PHI)*: Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.

#### **PROCEDURE:**

1. HIM staff discloses PHI to a personal representative of a patient if such person has the legal authority to act on behalf of the patient. (See *Operational Procedure 9.21 Verification Requirements for Use and Disclosure*, for criteria to identify that a person has legal authority to act on behalf of a patient)
2. WFH may decline to treat a person as a personal representative of a patient if:
  - A. WFH has a reasonable belief that:
    1. the patient has been or may be subjected to abuse or neglect by such person; or
    2. treating such person as the personal representative could endanger the patient; and
  - B. WFH, in the exercise of professional judgment, decides that it is not in the best interest of the patient to treat the person as the patient's personal representative.

#### **Illustration/Example:**

*Example:* In a psychiatric hospital a legally appointed Conservator of Person of a patient requests disclosure of an evaluation from the patient's medical record. The conservator presents a copy of the legal document verifying their authority as a personal representative to the Medical Records Department, along with a release form. The Medical Records Department releases the record.

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<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.26:</b>	<b>Use and Disclosure of Protected Health Information for Research</b>
<b>Governing Body Approval:</b>	June 7, 2018
<b>REVISED:</b>	

**PURPOSE:** To inform all staff that Protected Health Information (PHI) can only be used for research purposes if certain criteria are met.

**SCOPE:** All Clinical Staff and HIM

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) to use or disclose Protected Health Information (PHI) for research purposes in full compliance with all applicable state and federal laws and regulations. The confidentiality rights of the patient are held in the highest regard by WFH at all times.

***Definitions:***

1. ***Disclosure:*** The release, transfer, provision of access to, or the divulging in any other manner of information outside the agency holding the information.
2. ***Individually Identifiable Health Information:*** Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. ***Note:*** Individually identifiable health information is to be treated as protected health information.
3. ***Protected Health Information (PHI):*** Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.

4. Use: With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

## **PROCEDURE:**

1. Whiting Forensic Hospital (WFH) may use or disclose PHI for research if at least one of the following criteria is met:
  - A. WFH obtains a signed authorization (WFH-184) from the patient. (*See Operational Procedure 9.19 Authorization for Use and Disclosure of Protected Health Information*)
  - B. WFH obtains documentation that an alteration to or waiver, in whole or in part, of the individual authorization has been approved by the Department of Mental Health and Addiction Services (DMHAS) Institutional Review Board (IRB).
  - C. WFH obtains from the researcher representation that:
    1. use or disclosure is sought solely to review PHI as necessary to prepare a research protocol or for similar purposes preparatory to research;
    2. no PHI is to be removed from WFH by the researcher in the course of the review; and
    3. the PHI for which use or access is sought is necessary for the research purposes.
  - D. WFH obtains from the researcher:
    1. representation that the use or disclosure is sought solely for research on the PHI of decedents;
    2. documentation, at the request of WFH, of the death of such individuals; and
    3. representation that the PHI for which use or disclosure is sought is necessary for the research purposes.
2. WFH may only permit use or disclosure based on documentation of approval of an alteration or waiver, which includes:
  - A. a statement identifying:
    1. the IRB;
    2. the date on which the alteration or waiver of authorization was reviewed and approved under either normal or expedited review procedures; and
    3. a signature by the chair/designee of the IRB.
  - B. a statement that the IRB has determined that the alteration to or waiver, in whole or in part, of authorization satisfies the following criteria:
    1. the use or disclosure of PHI involves no more than minimal risk to the individuals;
    2. the alteration or waiver will not adversely affect the privacy rights and the welfare of the individuals;
    3. the research could not practicably be conducted without the alteration or waiver;
    4. the research could not practicably be conducted without access to and use of the PHI;
    5. the privacy risks to individuals whose PHI is to be used or disclosed are reasonable in relation to the anticipated benefits if any to the individuals, and the importance of the

- knowledge that may reasonably be expected to result from the research;
6. there is an adequate plan to protect the identifiers from improper use and disclosure;
  7. there is an adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers, or such retention is otherwise required by law;
  8. there are adequate written assurances that the PHI will not be reused or disclosed to any other person or entity, for authorized oversight of the research project, or for other research for which the use or disclosure of PHI would be permitted; and
- C. a description of the PHI needed, including the use or access that has been determined to be necessary by the IRB.
3. The Hospital Research Committee ensures that the above documentation requirements are satisfied prior to permitting use and disclosure of PHI for research purposes.

**Illustrations/Examples:**

*Example:* A researcher requests identified data on individuals who have received services in the past but who are not currently available to sign a release form. Access may be granted if the IRB finds that such release of information is acceptable under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulation and 45 CFR 46.

**WHITING FORENSIC HOSPITAL**  
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<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.27:</b>	<b>De-Identification of Protected Health Information</b>
<b>Governing Body Approval:</b>	June 7, 2018
<b>REVISED:</b>	

**PURPOSE:** To inform Health Information Management (HIM), Information Technology (IT), Clinical, Performance Improvement (PI) and Utilization Review (UR) staff that in order to protect the patient’s rights to privacy, Protected Health Information (PHI), is de-identified as warranted by the request for disclosure.

**SCOPE:** HIM, IT, PI, and UR Staff

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) that in order to protect the patient’s rights to privacy, Protected Health Information (PHI) is de-identified as warranted by the request for disclosure.

***Definitions:***

1. ***Disclosure:*** The release, transfer, provision of access to, or the divulging in any other manner of information outside the agency holding the information.
2. ***Individually Identifiable Health Information:*** Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse, and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe the

information can be used to identify the individual. *Note:* Individually identifiable health information is to be treated as protected health information.

3. Protected Health Information (PHI): Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.
4. Treatment, Payment, and Health Care Operations (TPO): Includes all the following:
  - A. Treatment – The provision, coordination, or management of health care and related services, consultation between providers relating to an individual, or referral of an individual to another provider for health care.
  - B. Payment – Activities undertaken to obtain or provide reimbursement for health care, including determinations of eligibility or coverage, billing, collections activities, medical necessity determinations and utilization review.
  - C. Health Care Operations – Includes functions such as quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, conducting or arranging for medical review, legal services and auditing functions, business planning and development, and general business and administrative activities.
5. Use: With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

#### **PROCEDURE:**

1. Whiting Forensic Hospital (WFH) determines that health information is not individually identifiable only if:
  - A. a person with appropriate knowledge of, and experience with, generally accepted statistical and scientific principles determines that the risk is very small that the information could be identifiable and documents the methods and results of the analysis that justify such determinations; or,
  - B. the information identifiers of the patient or of relatives, employers or household members of the patient, are removed. These identifiers include:
    1. names;
    2. all geographic subdivisions including address and zip code;
    3. all dates, except year, including birth date, admission date, discharge date, date of death;
    4. telephone numbers;

5. fax numbers;
  6. electronic mail addresses;
  7. social security numbers;
  8. medical record numbers;
  9. health plan beneficiary numbers;
  10. account numbers;
  11. certificate/license numbers;
  12. vehicle identifiers and serial numbers, including license plate numbers;
  13. device identifiers and serial numbers;
  14. Web Universal Resource Locators (URL's);
  15. Internet Protocol (IP) address numbers;
  16. biometric identifiers, including finger and voice prints;
  17. full face photographic images and comparable images; and
  18. any other unique identifying number, characteristic, or code.
- C. WFH does not have actual knowledge that the information could be used alone or in combination with other information to identify a patient who is a subject of the information.
- D. WFH may assign a code or other means of record identification to allow information de-identified under this section to be re-identified by WFH, provided that:
1. the code or other means of record identification is not derived from or related to information about the individual and is not otherwise capable of being translated so as to identify the individual; and,
  2. WFH does not use or disclose the code or other means of record identification for any other purpose, and does not disclose the mechanism for re-identification.
2. WFH assigns the Director of Health Information Management as the individual responsible for determining that the information that is released complies with all aspects of this procedure.

### **Illustrations/Examples:**

**Example 1:** WFH receives a request for information on medication errors from the Office of the Commissioner (OOC) for performance improvement purposes. The Pharmacy, Nutrition and Therapeutics Committee, with assistance from Health Information Management, de-identifies the data requested prior to its submission and clears the data prior to its release with the individual responsible for compliance with this policy.

**Example 2:** WFH receives a request from a Yale University researcher who is conducting a study on the number of insanity acquittees per year with substance use disorders. WFH in turn requests from the assistance of the OOC, where the data is compiled, and all patient identifiable information is removed. A report is then submitted back to WFH with the aggregate data that was requested. This data is then forwarded to the Yale researcher.

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<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information/HIPAA
<b>PROCEDURE 9.28:</b>	<b>Limited Data Set</b>
<b>Governing Body Approval:</b>	June 7, 2018
<b>REVISED:</b>	

**PURPOSE:** To inform Health Information Management (HIM), Information Technology (IT), Clinical, Performance Improvement (PI) and Utilization Review (UR) staff that in order to protect the patient’s rights to privacy, Protected Health Information (PHI), which is used or disclosed for research purposes or health care operations (such as quality assurance reviews) is either de-identified or provided in a limited data set.

**SCOPE:** HIM, IT, PI and UR staff

**POLICY:**

It is the policy of Whiting Forensic Hospital (WFH) that in order to protect the patient’s rights to privacy, Protected Health Information (PHI) shall be de-identified. If de-identification is not practical, WFH may then use a Limited Data Set in the performance of research or health care operations (such as quality assurance reviews).

***Definitions:***

1. *Disclosure:* The release, transfer, provision of access to, or the divulging in any other manner of information outside the agency holding the information.
2. *Individually Identifiable Health Information:* Information that is a subset of health information, including demographic information collected from an individual, and that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or

condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (3) which identifies the individual, or (4) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Note: Individually identifiable health information is to be treated as protected health information.

3. Protected Health Information (PHI): Individually identifiable information relating to past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.
4. Treatment, Payment, and Health Care Operations (TPO): Includes all the following:
  - A. Treatment – The provision, coordination, or management of health care and related services, consultation between providers relating to an individual, or referral of an individual to another provider for health care.
  - B. Payment – Activities undertaken to obtain or provide reimbursement for health care, including determinations of eligibility or coverage, billing, collections activities, medical necessity determinations and utilization review.
  - C. Health Care Operations – Includes functions such as quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, conducting or arranging for medical review, legal services and auditing functions, business planning and development, and general business and administrative activities.
5. Use: With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

#### **PROCEDURE:**

1. When utilizing patient records (electronic or physical) for review of health care operations (such as quality assurance reviews) or research, Whiting Forensic Hospital (WFH) staff attempts to use de-identified information where possible. If this is not practical, then staff may use a Limited Data Set (LDS).
2. If a LDS is used, staff may not use the following PHI within the LDS:
  - A. names;
  - B. postal address information, other than town or city, state, and zip code;
  - C. telephone number;
  - D. fax numbers;
  - E. electronic mail addresses;
  - F. social security numbers;
  - G. medical record numbers;

- H. health plan beneficiary numbers;
  - I. account numbers;
  - J. certificate and/or license numbers;
  - K. vehicle identifiers and serial numbers, including license plate numbers;
  - L. device identifiers and serial numbers;
  - M. Web Universal Resource Locators (URL's);
  - N. Internet Protocol (IP) address numbers;
  - O. biometric identifiers, including finger and voice prints; or
  - P. full face photographic images and comparable images.
3. If a LDS cannot be used for a research project, the project itself needs to be approved by, and performed under, the DMHAS Institutional Review Board. (See *Operational Procedure 9.26 Use and Disclosure of Protected Health Information for Research*).
  4. If a LDS cannot be used for a review of health care operations, then authorized staff may use the full patient record (electronic or physical), but solely for the purpose of the review.

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<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information
<b>PROCEDURE: 9.29</b>	<b>Transporting Medical Records and Documents Containing Patient Protected Health Information</b>
<b>Governing Body Approval:</b>	June 7, 2018
<b>REVISED:</b>	

**PURPOSE:** To ensure all medical records and documents containing patient protected health information (PHI) are adequately secured to ensure patient information is not exposed to unauthorized individuals.

**SCOPE:** All Whiting Forensic Hospital (WFH) Employees

**POLICY:**

All WFH employees must properly secure medical records and other documents containing PHI when transporting records/documents on or off hospital grounds. Medical records and other documents are transported in a locked courier bag or locked tote box whenever they are taken out of a building. During transport the courier bag must be locked with the key removed. The key must be carried by the employee and may not be attached to the bag in any way.

**PROCEDURE:**

**MEDICAL RECORDS:** All WFH employees must properly secure medical records when transporting medical records out of the patient care buildings. Medical records are transported in a locked courier bag or locked tote box.

- **Large courier bags** are assigned to each patient unit for transporting medical records from patient buildings to locations on and off hospital grounds.
  - Each bag has a control number assigned to each unit. The courier bag must be signed out/returned when used to transport medical records. The bags will hold 2 medical record binders
- **Large tote boxes** may be obtained from the HIM office located in each patient building.

- Plastic tote boxes are used for larger volumes of records or documents needing to be transported from patient buildings to locations on and off hospital grounds.
- **Transporting Medical Records includes, but is not limited to:**
  - Transfers to another patient building on campus
  - PSRB hearings
  - Dental Clinic, Haviland Patient Health Clinic, Page Hall Physical Therapy Probate Court
- **Additional courier bags** and tote boxes may be signed out as needed from the HIM office located in each patient building.

**DOCUMENTS CONTAINING PATIENT HEALTH INFORMATION:** All WFH employees must properly secure documents/reports containing PHI when transporting documents on hospital grounds from one building to another and off hospital grounds. Documents containing PHI are transported in a locked courier bag or locked tote box.

- **Briefcase style courier bags** are assigned to each patient unit, WFH managers and other WFH personnel who routinely carry documents containing PHI on and off hospital grounds.
  - Each bag has a control number assigned to the unit or individual. The courier bag must be signed out/returned when used to transport documents containing PHI to/from the building.
- **Documents Containing PHI include, but are not limited to:**
  - Reports generated from WITS or other computer programs
    - Census logs/reports, incident reports, or any logs/reports containing patient names, MPI # or other PHI
  - Chart audits
  - Court applications/reports

**MOVEMENT OF LARGE QUANTITY OF RECORDS:** The movements of large quantities of medical records that cannot be secured using the courier bags or tote box must be approved by the HIM Supervisor, who is responsible for ensuring adequate protections are in place for transport.

**WHITING FORENSIC HOSPITAL**  
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<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information
<b>PROCEDURE 9.35:</b>	<b>Confidentiality of Patient Information Access to Patient Information by (Other) DMHAS Facilities</b>
<b>Governing Body Approval:</b>	June 7, 2018
<b>REVISED:</b>	

**PURPOSE:** To obtain/disclose patient health information (PHI) from/to other DMHAS treatment facilities when the requesting DMHAS facility cannot obtain written authorization from the patient when the patient is receiving active treatment at the requesting facility.

**SCOPE:** All Clinical Staff, HIM, and Unit Clerks

**POLICY:**

Patient medical records may be disclosed to any DMHAS treatment facility to which the patient is admitted for diagnosis or treatment if Whiting Forensic Hospital (WFH), in possession of the records, determines that the disclosure or transmission is needed to accomplish the objectives of diagnosis or treatment, in accordance with CGS 52-146f(1).

**PROCEDURE:**

**1. Disclosure Procedure:**

- A. Information is requested by the DMHAS treatment facility via telephone or written request.
  1. Verify that the patient is currently receiving treatment from the requesting DMHAS treatment facility.
  2. Search for the patient in the DMHAS Patient Information Computer System. Select the episode information to insure that the patient has been registered at the requesting facility.

- B. A signed consent form signed by the patient is NOT necessary when information has been identified by the requesting facility as needed to accomplish the objectives of diagnosis or treatment.
  - 1. The requesting treatment facility is asked to fax to WFH a written request for the information stating it is needed for diagnostic and/or treatment purposes.
  
- C. Information may be faxed if such information is identified as required immediately by the requesting facility. Other alternative forms of transmittal include:
  - 1. Faxing key documents and mail the remainder of the documentation
  - 2. Faxing key documents and utilizing an overnight mail service, such as Federal Express, for the remainder of the documentation
  - 3. Fax transmittal should contain only key documents such as the:
    - a. Admission Psychiatric Evaluation
    - b. Psychological Assessment
    - c. Psychosocial History and Assessment
    - d. Discharge Summary
  
- D. The patient shall be informed that the communications or records will be disclosed.

**Requests for Information from other DMHAS treatment facilities by WFH**

- A. A member of the treatment team contacts the other DMHAS facility to request the clinical record/information.
  - 1. If the DMHAS facility indicates that they will not disclose this information without the written authorization signed by the patient, the Director of Health Information Management is contacted immediately.
  - 2. The Director of HIM will contact the HIM Director of the treatment facility to obtain the requested documentation.

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURES MANUAL**

<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information
<b>PROCEDURE 9.36:</b>	<b>Confidentiality of Patient Information – Patient Requests to Examine Records - Inpatient Status</b>
<b>Governing Body Approval:</b>	June 7, 2018, October 20, 2020
<b>REVISED:</b>	September 10, 2020

**PURPOSE:** Under the authority of the Connecticut General Statutes and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 C.F.R. Parts 160 through 164), the Department of Mental Health and Addiction Services (DMHAS), has adopted regulations to establish the rights of patients who wish to examine their medical records.

**SCOPE:** All Clinical Staff, HIM and Office Assistant

**POLICY:**

It is the policy of the DMHAS that staff should make records available for inspection and comment by recipients of care unless the information in the records would create a reaction that would cause a substantial risk that the patient would inflict life-threatening injury to his/her self or to others or experience a severe deterioration in mental state. Information that would violate the confidentiality of another person is also protected. The department believes that allowing consumers to read their own records and discuss them with their clinicians reduces suspicion, creates opportunities for discussion between consumers and treaters, and increases consumer participation in treatment.

**PROCEDURE:**

**When a patient request to review their medical record:**

1. The patient completes the Medical Record Examination Request form (WFH-131). Upon completion, the completed forms are sent to Health Information Management (HIM) for processing.
2. HIM forwards the request to the appropriate Attending Psychiatrist for approval or denial of the request.
  - A. If the request to review the medical record is approved, HIM sends a Medical Record Examination form (WFH-131a) to the Head Nurse to schedule an appointment with the patient to review their medical record. A clinician must be with the patient at all times during the review to answer questions and to insure the safety of the medical record.

- B. If the request to review the medical record is denied, HIM notifies the patient of the Attending Psychiatrist's decision and advises the patient that they may name an alternate (physician) to review their request. (WFH-184d). Upon completion of the form, forward to HIM.
- C. HIM notifies the Alternate Physician of the patient's request for further consideration of their request to review their medical record. (WFH-184f).
- D. HIM notifies the patient (and Attending Psychiatrist) of the Alternate Physician's decision regarding access to their medical record. If access is denied, the patient is notified (WFH-184g) and is provided with information regarding further judicial relief.

The clinician assigned to review the medical record with the patient provides the patient with the following forms (information):

1. Request for Copy of Medical Record Documentation (WFH-151) and Authorization for Use and Disclosure of Protected Health Information (WFH-184) If the patient requests a copy of any documentation, forward the form to HIM for processing.

Processing by HIM includes:

- A. Obtaining the authorization for the release of information to the patient by the Attending Psychiatrist.
  - B. Obtaining the patients' signature when they are furnished with the requested documents.
2. Requests for Correction (WFH-RCP). If during the patients' review of the medical record they find what they believe to be an error in the information recorded, they have the right to request that the error be corrected (amended). Upon completion of the Request for Correction form, send to HIM for processing.

Processing by HIM includes:

- A. Notifying the appropriate Clinician of the request for correction of their documentation by the patient.
- B. Notifying the patient of the Clinician's decision regarding their request for correction (amendment).

### **INSTRUCTIONS FOR AMENDING DOCUMENTATION:**

Record the correction on the document in question, date and sign the entry. **DO NOT** cross out or otherwise obliterate the original entry.

*See Also: Operational Procedure 9.15 Access to Protected Health Information*

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL**

<b>SECTION II:</b>	ORGANIZATION FOCUSED FUNCTIONS
<b>CHAPTER 9:</b>	Management of Information
<b>PROCEDURE 9.38:</b>	<b>Confidentiality of Patient Information / Processing of Requests for Patient Information</b>
<b>Governing Body Approval:</b>	October 20, 2020, July 15, 2022
<b>REVISED:</b>	September 10, 2020, July 13, 2022

**PURPOSE:** To inform all Whiting Forensic Hospital (WFH) employees that all patient information is confidential and to provide Health Information Management (HIM), and Office Assistants as directed by HIM, instruction regarding processing of requests for patient information.

**SCOPE:** All Clinical Staff, HIM, and Office Assistant Staff

**POLICY:**

All information obtained and records prepared in the course of providing services to patients shall be confidential. Confidentiality of health information is protected under the following state and federal regulations:

Medical Information	<i>Section 4-104 of the Connecticut General Statutes</i>
Psychiatric Records	<i>Chapter 899 of the Connecticut General Statutes</i>
Substance Abuse Records	<i>42 CFR Part 2 of the Federal Regulations</i>
AIDS and/or HIV Related Information	<i>Chapter 368x of the C.G.S.</i>

In general, the above Statutes and Regulations state that medical, psychiatric, substance abuse or AIDS/HIV related information may not be released from patients' medical records without the informed written authorization of the patient.

Per DMHAS General Work Rule 17, employees shall comply with all State and Federal confidentiality laws and regulations and are prohibited from access, use or disclosure of service recipients' protected health information without proper authorization.

Requests for copies of patient information are processed by HIM. The Office Assistants under the direction of HIM may send copies of patient information as requested by the Social Worker for Discharge Planning purposes.

## **PROCEDURE:**

### 1. Confidentiality of Patient Information:

- A. Each patient has the right to privacy and confidentiality, and this right extends to the fact of hospitalization, except when hospitalization is ordered by a court or other judicial body and is a matter of public record.
- B. Confidentiality applies to the involuntary, as well as to the voluntary patient. Patient information may only be released in compliance with this policy and Connecticut General Statutes regarding court-committed or PSRB-committed patients.
- C. Any staff member who violates the confidentiality of a patient may be liable to a lawsuit for monetary damages and the breach of confidentiality could lead to termination of employment.

### 2. Documents Defined as Part of the Medical Record:

The Public Health Code for the State of Connecticut defines the parts of the Medical Records as, "*the clinical record of the care and treatment of the patient, and his response to same.*" Medical records are maintained separately from business and other administrative records:

- A. *Incident reports* are not filed in the patient's medical record and are NOT considered part of the medical record. Subpoenas received by HIM which include incident reports are to be referred to the Chief Executive Officer (CEO), Chief Medical Officer (CMO) or designee.
- B. *Documentation received from other providers of care* is considered part of the medical record, as they are relied upon in the diagnosis, treatment and/or care of the patient. This information is not released unless it is specified on the authorization form per re-disclosure policies outlined in Connecticut General Statute 52-146i and Federal Regulations 42 CFR Part 2.
- C. Information received at Whiting Forensic Hospital (WFH) *pertaining to treatment at another hospital during Hospital Leave Status*, are not released unless it is specified on the authorization form per re-disclosure policies outlined in Connecticut General Statute 52-146i and Federal Regulations 42 CFR Part 2.
- D. Other information received at WFH, which does *not involve the diagnosis, treatment and/or care of the patient*, are not released. Persons requesting such information are referred to such other agencies.
- E. *HIV/AIDS Testing* is not part of the medical record if testing was resulting from a "significant exposure." When a physician obtains voluntary consent to testing after an occupational exposure, or when involuntary testing is authorized, as provided in section 19a-582(e)(5) of the C.G.S., no record of the existence or results of the HIV-related test will appear in the person's medical record or other records unless the test result is relevant to the medical care the person is receiving at that time, or the person makes a specific

written request that the test result be recorded. Access to these records shall be limited to the physician or to persons designated by the CEO or COPS of WFH.

- F. *Legal documents* pertaining to the patient's legal status, to include Court Reports, may be released if specified on the authorization to release information form, per re-disclosure policies.
- G. *A WFH patient's writings that are disclosed to the treatment team, such as journal entries or letters*, are considered part of the medical record but will not be released to third parties unless authorized by the patient or his/her representative.

### 3. Written Authorization to Release Patient Information:

- A. No information shall be released or shared without a proper authorization to release or share information.
  - 1. The signature of the person authorizing a release of information must be legible, must be signed in ink and dated. If a signature is in doubt or is not verifiable, the requestor may be notified to furnish a notarization with the signature before information may be released. No photocopied signatures are accepted. Signatures recorded as "X" require a witness signature.
  - 2. Authorizations received by fax will be honored, and the signature will be considered an original signature.
  - 3. Authorizations to release or share information must be a permanent part of the patient's medical record.
  - 4. Form WFH-184 is used for securing or releasing information to/from other hospitals/clinics/agencies/individuals regarding medical, psychiatric, alcohol and/or drug diagnoses and treatment and confidential HIV related information.
  - 5. The only exception to the above pertains to after-hours discharges, in which case a WFH-184 is not required for the release of the W-10 and WFH-2.

### 4. Persons Who May Authorize the Use and Disclosure of Patient Health Information (PHI):

- A. The patient:
  - 1. An involuntary patient, as well as a voluntary patient, may give or refuse to give an authorization. Court-committed patients may also give or refuse authorization, except to the Superior Court and/or PSRB as required by statute.
  - 2. Any competent patient 18 years of age or over may give WFH the authority to seek, release, or share information.
  - 3. If WFH seeks the patient's authorization, care must be taken to ensure that the patient is competent and arrived at an informed consent at the time the authorization is given.
- B. Legal Guardian/Conservator/Executor or Administrator of Estate/Next-of-Kin:
  - 1. The duly appointed legal guardian or conservator of an incapacitated patient may authorize WFH to seek, release, or share information. Documentation attesting their authority must accompany any such authorization.

- a. Patients who have a conservator of person may authorize the use and disclosure of PHI without the written authorization of the conservator when it is necessary to facilitate the obtaining of PHI or the disclosure of PHI. The patient must have a basic understanding of hospital's need to seek or disclose his/her PHI.
2. The duly appointed Executor or Administrator of an estate or next-of-kin, of a deceased patient may authorize WFH to release information. The patient's death certificate, next-of-kin birth certificate, and documentation attesting their authority must accompany any such authorization.

C. Whiting Forensic Hospital:

1. WFH may release information without an authorization from the patient who is incapacitated in the opinion of a qualified psychiatrist and for whom a legal guardian has not been appointed and there is no known next of kin. The release of information must be in the best interest of the patient. Such verbal or written information may be disclosed only:
  - a. in communication between qualified mental health professionals in provision of services or appropriate referrals, or,
  - b. to the extent necessary to make claims on behalf of a patient for aid, insurance, or medical assistance to which he/she may be entitled.
5. Disclosure of Patient Information – General Statement of Policy:
  - A. All written requests to WFH to release information shall be referred to HIM for processing to ensure that all requests are processed according to existing regulations/policies.
  - B. If a request is defective in any way, HIM shall return it to the requestor with an explanation and request for correction.
  - C. All requests of an unusual nature shall be referred to the CEO or CMO of WFH.
  - D. HIM shall determine whether it or a more appropriate unit (e.g., a treatment team, Patient's Accounts) shall respond to the request.
  - E. HIM shall have final responsibility for reviewing all information to be released, to protect confidentiality, and to guard against releasing information about other patients, family members, relatives, etc., or records from other agencies.

6. Confidentiality of Specific Health Information:

A. Psychiatric Health Records:

Psychiatric health records are considered privileged communications and are thus protected under Chapter 899 of the Connecticut General Statutes. C.G.S. 52-146d et seq. states that the protected communications include all "oral and written communications and records thereof relating to diagnosis and treatment of a patient's mental condition between the patient and a psychiatrist, or between a member of the patient's family and a psychiatrist, or between any such persons and a person participating under the supervision of a psychiatrist in the accomplishment of the objectives of diagnoses and treatment, wherever made." This privilege applies to civil and criminal actions, juvenile, probate, commitment

and arbitration proceedings, proceedings preliminary to such actions or proceedings, and legislative and administrative proceedings.

B. Drug and Alcohol Abuse Treatment Records:

Substance abuse records are governed by federal and state statutes and regulations.

7. Confidentiality Statements:

A. All written communications or records regarding a patient (current/former) in this facility, which are disclosed to another person or agency, shall bear the following statement(s):

*"NOTE: Confidentiality of psychiatric, drug and/or alcohol abuse and HIV records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization as provided under Connecticut General Statutes, Chapter 899c and sections 19a-581 through 590, and Federal Regulations 42 CFR 2. These laws prohibit you from making any further disclosure without specific written consent of the person to whom it pertains. A general authorization for the release of information is NOT sufficient for this purpose."*

B. The following statement is added to the cover-letter for releases of information to attorneys:

“We are disclosing this information to you under Connecticut General Statutes. Under these statutes, you may not re-disclose the information contained therein to the patient without express authorization from this hospital or the patient's physician as provided in Section 4-194 of the Connecticut General Statutes.”

8. Required Elements for an Authorization to Release Patient Information:

- A. The purpose of the request.
- B. The specific information being requested.
- C. The name and address of the organization or individual requesting the information.
- D. The date the authorization was signed.
- E. A notice that authorization is valid only for a specified period of time.
- F. See also Operational Procedure Manual – Policy 9/HIPAA

9. Copying of Medical Record Documentation:

A. If a patient or WFH Staff request that copies from the patient's record be sent to outside agencies, hospitals, or individuals, a team member is responsible for obtaining the patient's authorization (WFH-184). The authorization form is sent to HIM for processing. HIM staff and the Office Assistants, as instructed by HIM, are the only WFH employees to reproduce any portion of the medical record for correspondence purposes.

B. Whenever information is released, the authorization to release information shall be placed in the patient's record. This shall include a statement on:

- a. The information released.

- b. The date released.
- c. The initials(s) of the HIM staff or Office Assistant who released the information.

C. Information regarding the release of patient information which includes where the information was sent, itemization of information sent, date request received and date processed is documented and maintained by HIM staff.

10. Review of Medical Records by Non-WFH Employees – *No Copies Furnished:*

- A. When a request to review (no copies requested) a patient record is received, which has been authorized by the patient, the requestor may review the record on the unit or may review the record in HIM Office.
- B. In the event that the record is of a patient who has been discharged (or expired), the record is reviewed by the requestor in HIM.
- C. Record reviews of active patients in the Whiting Forensic Hospital takes place in the HIM office or other designated location.

11. Oral Disclosures of Information:

Section 52-146(I) of the Connecticut General Statutes states that in cases where the disclosure of psychiatric information is made orally, the recipient of the information must be informed that such information is governed by the provisions of Chapter 899 of the Connecticut General Statutes.

12. Release of Information to Courts:

A. Subpoena Duces Tecum:

- 1. The subpoena provision in the Connecticut General Statutes 4-104 does NOT apply to psychiatric or substance abuse records.
- 2. It is required that an authorization be obtained from a patient whose records have been subpoenaed before disclosure whether the patient is named as a part to the lawsuit or not. If the patient or his/her attorney refuses to authorize the disclosure of the health record, the information may not be released. No information may be produced pursuant to a subpoena without valid written authorization from the patient (or legal guardian, conservator or executor of their estate). See Also Operational Manual Chapter 9; Procedure 9.4 Subpoena of Medical Records.

B. Commitment Proceedings and Appointment of a Conservator - Probate Court:

- a. In the instances where a patient is in our hospital and the court hearing is related to their legal status with WFH, a court order will not be required in order to have our staff or medical record present in court.
- b. For Probate Court proceedings for appointment of a conservator, authorization from the patient or a court order will not be required in order to have our staff or the medical record present in court as outlined in C.G.S. 152-146f (4).

13. Telephone Inquiries:

- A. The fact of hospitalization is confidential and shall not be revealed, nor shall any information be released over the phone.
- B. When a caller wishes to talk with a patient, the caller shall not be informed whether or not the person is a patient. The caller shall be informed that if the person is a patient, he/she will be notified and may return their call.

14. Visitors:

The fact of hospitalization is confidential and shall not be revealed, nor shall any information be released to a visitor requesting to see a patient. The visitor is to be referred to the Nursing Supervisor.

15. Family Members of Patients:

No information on current patients is to be released by anyone, except the appropriate treating staff, without the written authorization of the patient. The patient must be informed that information appropriate to the treatment needs of the patient will be sought from and/or shared with family members. If the patient requests that the family members not be informed of the hospitalization, and it is essential that family members be informed or information be sought from them, the patient must be informed of the essential nature of the need and his/her cooperation solicited. If the patient absolutely refuses, his/her wish must be honored.

16. News Media:

All requests by News Media for patient-specific information is referred to the CEO or CMO of WFH.

17. WFH Staff:

- A. No staff member may have access to patients' records unless the staff member has a bona fide treatment responsibility, interest in the furtherance of the patients' treatment goals, or as directed by the CEO or CMO.
- B. Treatment staff or HIM has the right to deny access to a patient's record if not satisfied with the staff member's responsibility or interest in the matter. The staff member is referred to the CEO or CMO.

18. State Collection Services and the Department of Income Maintenance:

The patient's name, address, and fees for service may be disclosed, under the provisions of Connecticut General Statutes, Section 17b-225 to the State Collection Services, as well as treatment information (e.g., diagnoses, dates and duration of treatment, discharge summary). This statute also covers matters concerning financial assistance to patients by the State Department of Income Maintenance.

19. Disability Rights Connecticut (DRCT):

- A. DRCT may review medical records when the patient or their conservator has signed a release of information or when the DRCT determines there is probable cause to believe that the patient is being abused or neglected, or DRCT has received a complaint of abuse or neglect.

20. Case Managers:

The authorization for Mental Health Case Managers to review the patient's medical record is obtained when the patient signs the Consent for Treatment form upon admission to WFH. Requests for copies of medical record documentation are processed by HIM with the patient's written authorization (WFH-184).

21. Medical Examiner:

Information requested by a properly identified medical examiner, in the case of a patient's death, may be released without written authorization.

22. Release of Information – Legal Issues:

A. Law Enforcement Agencies:

- 1. Information regarding treatment rendered at WFH may be given to clinical staff engaged in diagnosis or treatment of the patient without the patient's authorization (as per CGS 52-146f (1)) when the patient is in the custody of Law Enforcement Agencies (i.e., jail, prison, police lockup, or other detention facility). HIM returns the call from the Law Enforcement Agency to verify their identification.
- 2. Medical records or other patient information will not be released to law enforcement personnel without the patient's written authorization. In the absence of statutory

authority, court order, search warrant, etc., a police agency has no authority to examine a medical record.

3. Crimes committed on the WFH premises or against WFH employees may be reported to law enforcement personnel. The circumstances of the incident, the patient's name, address, and the patient's last known whereabouts are the ONLY information to be released. Information from the patient's medical record may NOT be released.
4. Suspected child abuse and neglect may be reported, but only the minimum necessary information to complete the report shall be released. (See Procedure 9.23 Use and Disclosure of Protected Health Information Without Patient/Conservator Authorization.)

B. Attorneys Appointed to Represent Involuntary Patients - Commitment Proceedings by the Probate Court:

- a. As a patient's representative, an attorney has the right to communicate with staff and to review the patient's record as outlined in C.G.S. 52-146f.
- b. The attorney must furnish the court order or written authorization from the patient to the Nursing Supervisor.

C. Psychiatrist or Other Professional Person Appointed to Evaluate Patients:

- a. Per C.G.S. 52-146f (4), an outside psychiatrist or other professional person appointed by the court to evaluate a patient has the right to review the patient's record.
- b. The outside psychiatrist or other professional person must furnish the court order to the Nursing Supervisor.
- c. The patient's record is reviewed in the CEO's Office or other designated area, in the presence of treatment or administrative staff.
- d. Copies of the medical record must be furnished upon request. After the court order has been verified by Health Information Management, copies are provided as requested.

23. Treatment Facilities:

Other Department of Mental Health Facilities/Crisis Intervention Programs Funded by DMHAS:

C.G.S. 17a-451(t) states the commissioner of mental health may direct "clinical staff at department of mental health facilities or in crisis intervention programs funded by the department who are providing treatment to a patient to request disclosure of the patient's record of previous treatment in order to accomplish the objectives of diagnosis or treatment of the

patient. If the clinical staff in possession of the requested record determines that disclosure would assist the accomplishment of the objectives of diagnosis or treatment, the record may be disclosed to the requesting clinical staff without patient authorization. Records disclosed shall be limited to records maintained at department facilities or crisis intervention programs funded by the department."

24. Social Agencies Other Treatment Facilities:

- A. Current Patients - *See # 25 below*
- B. Discharged Patients - No information is to be released except upon the receipt of a written, duly executed authorization to release information.

25. Sharing/Releasing Information – Current Inpatient:

A. Mental Health Centers or Clinics:

- a. Information is shared by treatment teams or other appropriate professional staff only and applies only to current patients on whom there is joint activity; admission to WFH through a Center or Clinic; patient referral by WFH to a Center or Clinic for continuing or follow-up care or treatment; etc. The treating teams honors the request.
- b. The call is transferred to the team, and verbal information is given by only a qualified staff person. A qualified staff person may include the attending psychiatrist, psychologist, social worker, unit director, or other staff involved with treatment of the patient and development of the treatment plan. Requests for written information are processed with the patient's authorization (WFH-184) by the Unit Clerk or HIM Staff.
- c. The patient must be informed that there will be sharing of information between the two facilities.
- d. Information disclosed must be documented in the medical record.

B. Agencies or Individuals Involved with Current Patients:

- a. The treatment teams or other appropriate professional staff may share verbal information with agencies (welfare departments, courts, etc.) or individuals (physicians, attorneys, probation officers, etc.) involved with current patients. Requests for written information are processed with the patient's authorization (WFH-184) by HIM.
- b. The information must be pertinent and specific, and its purpose must be the furtherance of the patient's treatment goals.
- c. The patient must be informed that there will be a sharing of information.
- d. Any sharing of information must be documented in the patient's record.

26. Facilities Where Patients Are Placed:

- A. The treatment teams or other appropriate professional staff, only, may share verbal information with facilities (e.g., group homes and other supervised residential settings) where patients may be placed for follow-up care and/or treatment. Requests for written information are processed with the patients' authorization (WFH-184) HIM Staff.
  - a) The information must be pertinent and specific, and its purpose must be the furtherance of the patient's treatment goals.
  - b) The patient must be informed that there will be a sharing of information.
- B. Nursing Homes, Acute Care Hospitals, or Other Hospitals (Direct Transfer or Medical Discharge Acute Care MD/AC Status):
  - a. Per Federal and State regulations, pertinent medical/psychiatric information is sent with the patient (or sent as soon as possible) upon direct transfer to a nursing home, an acute care hospital, or other medical or psychiatric (inpatient) hospital without written authorization from the patient. The discharge summary is sent as soon as it is completed.

27. Requests from Patients (former or Active) to Inspect or Receive Copies of their Medical Record:

A. Active Patients: - Treatment Plans:

Treatment Plan - In compliance with The Joint Commission (TJC) Standards, the patient is to participate in the development of their treatment plan, and such participation is to be documented in the medical record. As appropriate, the patient reviews and signs the treatment plan with a member of the Treatment Team to indicate their participation. The patient may receive a copy of the Treatment Plan. No written authorization is required.

B. Discharged Patients:

- a. The Supervisor of HIM is responsible for responding to all requests for patient access to records for discharged patients.
- b. All requests for copies of medical records **MUST** be in writing (WFH-184)
- c. Except for requests from Active Patients for copies of current Treatment Plans, the Supervisor of HIM asks the patient the purpose of the request. HIM offers to send the record directly to the individual/agency the copy is needed for.

1. If the patient still requests a copy, their request is referred to a psychiatrist for approval/denial of their request.

## 28. Exceptions for Releasing Information Without Written Authorization:

### A. Psychiatric or Medical Emergencies:

- a) Phone requests for information are honored in the case of psychiatric or medical emergencies to facilitate immediate and effective treatment of the patient.
- b) Such release of information is only to a professional person or another hospital and only in cases where a patient under their immediate care is in an emergency situation. Verification must be made of the professional person or hospital by returning the telephone call.
- c) Information is released when a psychiatrist determines that there is imminent risk of danger to self/others or when it is necessary to disclose for the purpose of admitting the patient to a mental health facility.
- d) Per C.G.S. 52-146f (2), this disclosure is permissible only in order to effect immediate hospitalization of the patient, and not for any other purpose (e.g., informing police of possible criminal actions of the patient, etc.).
- e) For current patients, the treating teams honors the request. The call is transferred to the team, and information is given by only a qualified staff person. A qualified staff person may include the attending psychiatrist, psychologist, social worker, unit director, or other staff involved with treatment of the patient and development of the treatment plan.
- f) For discharged patients, HIM honors the request or may call upon the treatment team to respond to the request as above.

### B. Information Exchange Between Mental Health Centers/Clinics, Medical or Psychiatric Hospitals and WFH for Discharged Patients:

- a. Information may be shared between Mental Health Centers/Clinics, Medical or Psychiatric Hospitals, and WFH when a patient is being transferred from one of these Mental Health facilities to another for continued care.
- b. In order to exchange written information, the signature of the patient must be obtained (WFH-184), and the request is processed by HIM. The Discharge Summary is copied and sent as soon as it is completed.
- c. Qualified Services Organization Agreements:

A qualified services organization agreement means a person who provides services such as bill collecting, laboratory analysis, or medical or other professional services for which they have entered into a written agreement with WFH.

29. Regulatory Agencies, Research Facilities, DMHAS, and WFH Administration:

A. Conduct of Research, Gathering Statistical Data, Education (C.G.S. 52-146g):

For research requests, see Procedure 9.26 Use and Disclosure of Protected Health Information for Research. Members of the Utilization Review Committee, Quality Assurance/Improvement Committees, Medical Record Committee or professional staff performing medical evaluation studies (to include Infection Control Studies, Death Review etc.) may review medical records which are determined to be necessary for these individuals to perform their duties as part of the peer review process. Written authorization is not necessary.

B. TJC and Department of Public Health:

- a. Surveyors of TJC and DPH may review medical records for accreditation or certification purposes without the authorization of the patient. These surveyors abide by our WFH/DMHAS confidentiality policies.

D. Exposure Evaluation Group:

Disclosure of confidential HIV-related information may be revealed to WFH health care or other workers who in the course of their occupational duties have had a significant exposure to HIV infection, provided the criteria outlined in Connecticut General Statutes 19a-581 through 590 are met. All such disclosures are made by the Chairman of the "Exposure Evaluation Group" or his designee.

30. Confidentiality of Substance Abuse Information

A. Confidentiality of Alcohol and Drug Abuse patient records is defined in 42 CFR Part 2 of the Federal Regulations. The regulations permit disclosure without patient authorization if the disclosure is:

- a) to medical personnel to meet any individual's bona fide medical emergency;
- b) authorization to qualified personnel for research, audit, or program evaluation. Qualified personnel may not include patient identifying information in any report or otherwise disclose patient identities except back to the program which was the source of the information;
- c) pursuant to a court order after the court has made a finding that "good cause" exists.
- d) required to fulfill reporting obligations to the PSRB and/or Superior Court as mandated by Connecticut General Statutes.

- B. Information may be released with the written authorization of the patient (WFH-184) which specifies that drug/alcohol information is being released. If the form received, for WFH to release substance abuse information, does not specify that drug/alcohol abuse information may be disclosed, the authorization form is returned to the sender with a copy of the confidentiality statement as outlined in 42 CFR Part 2 of the Federal Regulations.

31. Disclosure of AIDS and/or HIV Related Information:

- A. The confidentiality of AIDS and/or HIV related information is protected under C.G.S. Chapter 368x. Information may not be released without the patient's written authorization (WFH-184) for disclosure of confidential HIV related information which is signed by the protected individual or a person authorized to authorization to health care for the individual which is dated and specifies to whom disclosure is authorized, the purpose for such disclosure and the time period during which the release is to be effective. A general authorization for the release of medical or other information is NOT a release of confidential HIV related information.
- B. Conditions under Which HIV Related Information May Be Disclosed:
  - a. No person who obtains confidential HIV related information may disclose or be compelled to disclose such information except for the following:
    1. the protected individual or his legal guardian
    2. any person who secures a release of confidential HIV related information
    3. a federal, state or local health officer when such disclosure is mandated or authorized by federal or state law
    4. a health care provider or health facility when knowledge of the HIV related information is necessary to provide appropriate care or treatment to the protected individual or a child of the individual and when confidential HIV related information is already recorded in a medical chart or record and a health care provider has access to such record for the purpose of providing medical care to the protected individual
    5. a medical examiner to assist in determining the cause or circumstances of death
    6. health facility staff committees or accreditation or oversight review organizations which are conducting program monitoring, program evaluation or service reviews
    7. a health care provider or other person in cases where such provider or person in the course of his occupational duties has had a significant exposure to HIV infection, provided the criteria outlined in C.G.S. 19a-583 are met
    8. employees of hospitals for mental illness operated by the department of mental health if the infection control committee of the hospital determines that the behavior of the patient poses a significant risk of transmission to another patient of the hospital
    9. any person allowed access to such information by a court order which is issued in compliance with provisions outlined in C.G.S. 19a-582

10. life and health insurers, government payers and health care centers and their affiliates, reinsurer, and contractors, except agents and brokers, in connection with underwriting and claim activity for life, health, and disability benefits
11. any health care provider specifically designated by the protected individual to receive such information received by a life or health insurer or health care center pursuant to an application for life, health or disability insurance.

B. Disclosures to Known Partner(s):

- a. A physician may disclose confidential HIV-related information to a known partner of a protected individual if both the partner and the protected individual are under the physician's care or to a public health officer for the purpose of informing or warning partners of the protected individual that they may have been exposed to the HIV virus under conditions outlined in C.G.S. 19a-584. The physician may also warn or inform a partner at the request of the protected individual as outlined in Chapter 368x of the Connecticut General Statutes.
- b. The physician or public health officer shall have no obligation to warn or inform, identify, or locate any partner.

C. Notation of Disclosures:

- a. Disclosures made to the below-listed persons/agencies do not need to be noted in the medical record:
  1. a federal, state, or local health officer when such disclosure is mandated or authorized by federal or state law
  2. persons reviewing information or records in the ordinary course of ensuring that a health facility is in compliance with applicable quality care standards or any other authorized program evaluation
  3. program monitoring or service review
- b. ALL other disclosures, oral and written, must be noted in the medical record or with any record of an HIV-related test result of a protected individual, who shall be informed of such disclosures upon request; provided for disclosures made to governmental agents requiring information necessary for payments to be made on behalf of patients or clients pursuant to contract law, such notation need only be entered at the time the disclosure is first made.

D. Disclosure of Confidential HIV-Related Information to a Health Care or Other Worker Pursuant to a "Significant Exposure"

Disclosure of confidential HIV related information may be revealed to WFH health care or other workers who in the course of their occupational duties have had a significant exposure to HIV infection, provided the criteria outlined in C.G.S. 19a-583 is met. All

such disclosures are made by the Chair of the exposure evaluation group or his/her designee. The exposure evaluation group shall be an ad hoc group assigned by the CMO.

E. Disclosures to Mental Health Centers, Clinics, Medical/Psychiatric Hospitals, Nursing Homes, Group Homes, Boarding Homes, Family Care Homes, or Other Treatment Facilities

- a. Confidential HIV-related information may only be disclosed to a health care provider or health facility without the patient's authorization when knowledge of the HIV - related information is necessary to provide appropriate care or treatment to the protected individual. This may only be determined by a physician.
- b. A notation of the disclosure is made by the physician in the patient's medical record.

F. To Courts, Administrative Agencies via Subpoena Duces Tecum

The subpoena provision in the Connecticut General Statutes 4-104 does NOT apply to confidential HIV-related information. When a record is subpoenaed that contains confidential HIV-related information, the facility must request either a court order or authorization of the patient prior to release of the record, or certified true copy thereof.

**WHITING FORENSIC HOSPITAL  
OPERATIONAL PROCEDURE MANUAL**

<b>SECTION II:</b>	<b>ORGANIZATION FOCUSED FUNCTIONS</b>
<b>CHAPTER 9:</b>	Management of Information
<b>PROCEDURE 9.44:</b>	<b>Electronic Monitoring/Surveillance System</b>
<b>Governing Body Approval:</b>	July 18, 2018
<b>REVISED:</b>	July 30, 2018

**PURPOSE:** Establish a uniform administrative procedure addressing the use of Electronic Monitoring/ Surveillance Systems at Whiting Forensic Hospital (WFH). Electronic Monitoring/ Surveillance System encompass all equipment used to record visual occurrences on the grounds of WFH.

An Electronic Monitoring/Surveillance System provides oversight of areas in the physical plant of the hospital that cannot always be monitored with constant observation. The Electronic Monitoring/Surveillance System aids in monitoring the provision of services and identifying and evaluating unusual event(s) for the purpose of validating events, documenting occurrences, education/training of WFH staff, and for the prevention of future events which may compromise the safety of staff and clients.

**SCOPE:** All WFH staff; volunteers and contractors

**POLICY:**

Pursuant to Conn. Gen. Stat. Sec. 31-48d, an Act Requiring Notice to Employees of Electronic Monitoring/Surveillance System by Employers, Department of Mental Health and Addiction Services (DMHAS) and WFH must provide employees written notice of the types of electronic monitoring/surveillance system that may be used. “Electronic Monitoring/Surveillance System” is defined by the Act as “the collection of information on an employer’s premises concerning employees’ activities or communications by any means other than direct observation, including the use of a computer, telephone, wire, radio, camera, electromagnetic, photo electronic or photo-optical systems, but not including the collection of information (a) for security purposes in common areas of the employer’s premises which are held out for use by the public, or (b) which is prohibited under state or federal law.”

DMHAS and WFH seek to provide clients with professional treatment while rendering care and services, and to provide for the safety and protection of clients and staff. DMHAS and WFH have a zero tolerance approach to patient abuse and workplace violence.

Electronic Monitoring/Surveillance Systems can greatly improve the security of staff and patients alike. In order to be effective, the system needs to be properly maintained and monitored on a regular basis so that safety threats can be accurately assessed.

## **PROCEDURE:**

- I. Employees may be subject to electronic monitoring or video recording (visual images only) while in State facilities like WFH and other locations where State business is conducted. Notwithstanding, employees will not be subject to electronic monitoring or recording in areas designed for employees' health or personal comfort, or for safeguarding their possessions, such as rest rooms, locker rooms or lounges.
- II. Employees' activities involving State computer equipment and computer and/or electronic documents, data, communications and video, including but not limited to e-mail and internet usage, may be monitored, recorded and reviewed.

### **III. Operation of Surveillance Systems**

- A. Any technical issue related to the electronic monitoring surveillance system will be reported to DMHAS Police immediately, so that the issue can be correctly routed.
- B. Surveillance video shall be maintained on a DVR or a server in a secure area and stored for a period of not less than 30 days before they are overwritten. Surveillance video will be maintained longer than 30 days if they contain images that DMHAS and WFH deem critical to inquiries of a serious nature, (i.e., video records related to accidents must be maintained for 10 years). If DMHAS and WFH reasonably anticipate litigation relating to images contained in video, then videos shall not be destroyed. All other surveillance video images will be overwritten after 30 days, (See State Agencies' Records Retention/Disposition Schedule S1: Administrative Records [Revised 06/2009]).
- C. The surveillance system shall be in operation 24 hours a day, 7 days a week, and in accordance with required maintenance.
- D. All cameras in patient care areas are monitored 24 hours a day, 7 days a week by designated security personnel, who will report immediately any inappropriate or suspicious activity to the agency police, Nurse Supervisor and/or Manager on Duty.
- E. Periodically, the manager on duty shall view surveillance videos of areas considered high risk, high volume or prone to problems. The manager on duty shall also perform routine, random review of surveillance video of all patient care areas.
- F. In addition, the Manager On Duty and Nurse Supervisor will review the surveillance videos following every episode of restraint, seclusion, secure guided escort, or psychiatric emergency ('code') on the units. Any staff person involved in the code, along with the Unit Director (UD), may view the tape at the discretion of the Manager on Duty. It is the Manager on Duty's responsibility to review these episodes to ensure that staff interventions were carried out appropriately. The

manager on Duty will refer any problems identified to the CEO and Chief Medical Officer.

- G. If no work rule violation is observed and no MHAS-20 appears to be warranted, the Manager on Duty or the Nurse Supervisor will attempt to inform the staff involved in the code of this observation during the same shift, if possible. The Manager on Duty or the COO/designee will notify the UD of this observation within 2 business days. The UD will notify all staff involved in the code within an additional 2 business days. Additional information or a subsequent complaint may result in further investigation.
- H. Surveillance video deemed by a reviewer to reflect a possible work rule violation will be brought to the attention of the Manager on Duty, who will notify the Chief Executive Officer or designee. The CEO and other authorized individuals will view the video. If the CEO determines that the image rises to the level of a possible allegation, he/she will notify the Office of Labor Relations (OLR). Where criminal charges may be possible, the CEO will also notify the Chief of the DMHAS Police,. Per DMHAS procedure, an Alleged Policy/Work Rule Violation MHAS-20 report may be filed if deemed necessary as outlined in DMHAS AC 230.D19.
- I. Video found to be of a concern which may serve as the basis for disciplinary and/or legal actions shall be retained and secured until a formal determination is made as to the disposition of the incident in question.
- J. Video images captured on video recording devices will not be used as the sole grounds for termination or discipline of an employee. In concert with *Operational Procedure 8.34 Investigation of Alleged Violations of DMHAS Policies, Procedures, Regulations or Work Rules* a thorough investigation will be conducted. The video image constitutes only one aspect of the investigatory process.
- K. The CEO or his/her designee reserves the right to save any tape believed to be useful as a training tool.
- L. Ordinarily, electronic monitoring devices shall not be placed in patient private care areas such as bedrooms, bathrooms or shower rooms. Exceptions may occur with the proper approvals from the patient or conservator for the safety or wellbeing of the patient. In addition, this must be in the form of a physician's order, added to the patient's treatment plan, and informed consent must be obtained either from the patient or from the patient's conservator if one is appointed. This consent will be documented on Form 806a Video Monitoring Surveillance Agreement. Form 806 Private Room Video Surveillance must also be completed by the attending psychiatrist, unit director, medical director and CEO (or their designees), and then filed in the legal section of the medical record.

- M. All staff who are presently employed or patients receiving services within facilities or, where applicable, the patient's legal conservators are to receive notification and general information about the presence of Electronic Monitoring/Surveillance System.
- N. Written consent is required from each patient when images or videos containing patients will be used for external purposes (in which the public will see and/or hear them). (*See Operational Procedure 1.20 Recording and Filming of Patients*).
- O. The system shall be under the operation and direction of the hospital CEO or his/ her designee(s) who will have "Confidential Agent" status.

#### **IV. Promulgation of the procedure on the Video Surveillance System**

- A. Signs will be prominently posted in all building entrances. This notice shall be posted in a conspicuous place which is readily available for viewing by all: "Premises under video surveillance, electronic surveillance systems are in use in this area." (Also posted signs are in Spanish.)
- B. All patients, or their conservators, are notified in writing of the presence of video surveillance and recording systems. This notification will include information about the purpose and locations of such video surveillance cameras and assurances articulated that no video camera will be located in areas of personal privacy, including bathrooms and shower areas, unless specific permission is granted under Section III.L above. On occasion a hallway camera may capture a view of a portion of a bedroom. To ensure privacy patients are advised to close their bedroom doors whenever privacy is desired. The only exception regarding private room surveillance is described in Section III. L of this policy (see above). This information is incorporated in the Treatment Permission form (WFH-657).