



Patient Records
Electronic Access
Playbook



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**THIS AMA® PATIENT RECORDS
ELECTRONIC ACCESS PLAYBOOK**
represents information believed to be current
best practices, but it is not intended as legal,
financial, medical, or consulting advice.

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Introduction

This Playbook focuses on dispelling myths around HIPAA and helping physicians and their practices understand their obligations to provide patients with access to their health information.

Introduction to the Patient Electronic Access Records Playbook

WHAT IS THE PATIENT RECORDS ELECTRONIC ACCESS PLAYBOOK?

The Playbook is an educational and reference manual designed for medical professionals who are involved in patient health record sharing. It compiles the legal requirements that staff must follow for patient record sharing, as well as guidance and best practices for staff to make compliance more efficient in day-to-day operations.

Patients have a right to access their medical records. It is critical that practices help provide patients with their own health information, not only because it's the law but also because it is the right thing to do.



Who is the Playbook for?

This Playbook is intended for medical professionals who have a role—major or minor—in responding to and fulfilling requests to share patient health records. While responsibilities vary widely across practices, this may include receptionists, office managers, medical records personnel, and—to varying degree—health care providers, such as medical assistants and physicians.

Why should I use the Playbook?

The laws governing patient health data and how it can be shared are notoriously complex. Learning and implementing HIPAA (the Health Insurance Portability and Accountability Act) can be challenging for practices—a challenge that's become greater within digital ecosystems. To help make your job easier, the American Medical Association (AMA) has compiled all of the legal materials into a single document and organized it with the needs of medical administration staff in mind.

When should I use the Playbook?

The Playbook is intended to serve multiple needs for readers: an educational source for new employee training, a reference manual for checking rules in uncertain situations, and/or an operations handbook for more efficiently integrating these record-sharing requirements into the day-to-day operation of the workplace.



The Benefits of Patient Electronic Access to Health Information

Imagine a day when a new patient begins with your practice, and you immediately have access to all of their medical information.

Medication history ... problem list ... allergies ... claims history ... even past diagnostic scans. This information is not delivered to you in a pile of papers or a large PDF that gets added to your electronic health record (EHR) as an attachment. Rather, this information is fully organized in your EHR as if you entered it yourself, but indicating the source of each data point. The information is even supplemented with multiple blood pressure readings over the last year and how much exercise the patient is regularly getting.

On this day, you will be able to provide better care to the patient and at a lower cost.

We may not be there yet, but we are moving toward this day.

It starts with providing the patient with access to his or her own information. Not in a disorganized pile of papers, nor in a 500-page PDF, but rather in a standardized format that allows the patient to collect their EHR and claims information from multiple sources, supplement it with information from personal devices, such as fitness trackers, and deliver it to you in a way that your information systems can understand.

However, we can only get to that day if everyone is working together ... health plans, patients, other health care providers, and — most importantly — you.



Electronic Patient Access Is a Right

Not only is electronic patient access a step toward better care and lower costs, but it is also every patient's right.

Federal and state laws provide patients the right to obtain access to much of their health information. In particular, the federal medical privacy law, commonly known as HIPAA, provides a patient the right to obtain an electronic copy of their medical record in the patient's preferred form and format, as long as your practice is technically able to do so.

Personal representatives, family members, and other caregivers also play a big role in helping patients access their records. Throughout this Playbook, where you see discussions of patient access, remember that patients often rely on caregivers to help them with access, and you should respect a patient's desire for you to share their records with their care team on their behalf.



Understanding the Legal Requirements: HIPAA & Patient Access Laws

This second part of the Playbook focuses on understanding the legal requirements surrounding patient electronic access, including when patients direct that access be granted to a third party, such as a caregiver or attorney.



Legal Complexity
and the Challenge
Facing Medical
Office Staff



Historically, these legal requirements have been a source of significant confusion among patients, providers, and third parties.

Does the patient's access right extend to third parties, such as attorneys, acting on the patient's behalf? Do I need to purchase new technology or pay additional fees to my vendors? What if I don't think the access is in the patient's best interest?

Navigating the laws to understand a provider's responsibilities in this area is a challenge for a seasoned privacy attorney, let alone a medical practice focused first and foremost on delivering patient care.

This section is intended to help you better understand the rules for what you can and can't share, with whom, and in what ways.

The Different Laws Behind Patient Access Rules



Physicians have to comply with a multitude of laws governing patient access to health information, and these laws vary significantly.

The laws form a puzzle, and it is important to understand how each piece fits together. The puzzle includes HIPAA, state laws, the Promoting Interoperability Programs, aka PI (formerly known as the Electronic Health Record Incentive Payment Programs or “Meaningful Use”), and the federal law governing substance use disorder treatment records. There are also federal regulations prohibiting what’s known as “information blocking.”

While the Playbook will detail how each of these laws impact the patient’s right to access, this first section explains how they fit together.



HIPAA

The first piece of the puzzle is the federal medical privacy law commonly known as HIPAA.¹

It is best to think of HIPAA as a floor, with other laws providing greater rights. HIPAA provides patients a right to access most of their health information, limits how much the patient can be charged for access, and provides deadlines for providing access.

Combating “Information Blocking” through Apps

Federal regulation prohibits medical providers and EHR vendors from standing in the way of patients receiving their own health information, a process known as “information blocking”. In particular, patients have the right to request access to their records using a smartphone app of their choosing. Your EHR will have what’s called an application programming interface, or API, that allows a patient’s app to connect to the EHR and download their health information. As a general rule, you must facilitate a patient’s desire to connect their app to your EHR.



STATE LAWS

On top of HIPAA are state laws. If your state law provides a greater right of access to a patient, then you must comply with both HIPAA and the state law’s additional obligations.

If your state law makes it harder for a patient to obtain access to health information, then the portion of state law making access more difficult will not apply. When considering HIPAA and state law, always put yourself in the patient’s shoes and determine which gives the patient more access to the patient’s information. You must comply with whichever law gives the patient more access.



INTEROPERABILITY REQUIREMENTS

Next up are the Promoting Interoperability (PI) Programs, which arose from the EHR Incentive Payment Programs that required “meaningful use” of EHR technology.

These Programs impact your Medicare and Medicaid reimbursement levels. The Programs include patient engagement requirements that are very different from HIPAA. You need to comply with both the Program’s requirements and HIPAA if you wish to maximize your Medicare and Medicaid payments.



SPECIAL REQUIREMENTS AROUND USE DISORDERS

Finally, there is a federal rule governing certain programs that hold themselves out as providing treatment, diagnosis, or referral for treatment for substance use disorders.

It is important to know whether this rule applies to your practice. This rule requires a special consent form if a patient directs that a copy of substance use disorder information go to a third party, such as a caregiver or attorney. Unlike under HIPAA, a patient must also sign a consent form to share substance use disorder information for treatment and payment purposes.

1. What: Amount & Type of Information



HIPAA provides a patient the right to access health information about the patient that is maintained in a “designated record set.”ⁱⁱ



KEY TERM: DESIGNATED RECORD SET

This includes the medical record, billing records, and any other information that is used to make decisions about the patient. It is not limited to information in the EHR. It does not include copies of health information that are solely used for the benefit of your practice but do not impact the patient’s care or financial obligations. For example, a copy of the medical record that is used in a peer review process to improve care going forward would not be part of the designated record set.

Few patients have ever asked for a copy of their “designated record set,” however. They more often ask for a copy of their medical records. It is fine to provide only the information requested.

- **If the patient only asks for a copy of her medical record**, then you do not also have to provide her with a copy of her billing records if these are kept outside of the medical record.
- **In contrast, if the patient asks for “all information” that you have about her**, then you must at least provide all information in the designated record set. You are permitted, but not required, to provide additional health information about the patient (such as information in a quality improvement program) that falls outside of the designated record set.



PRO TIP:

The designated record set includes information that you add to the medical record that originates from other health care providers. You cannot deny access to health information in your records on the grounds that someone else created it.

If you participate in one or more electronic health information exchange networks, then you may have access to other health care providers' medical records. These records do not become part of the designated record set simply because you have access to them or view them. They only become part of your designated record set if you add them to your own EHR. Best practice, however, is to add to your own medical record any information that you view and rely upon through electronic health information exchange (and then provide it to the patient if the patient requests a copy of her medical record).



STATE LAW

State laws differ on what information is subject to the right of access.

For example, California law provides access to “patient records;”ⁱⁱⁱ Texas law provides access to electronic health records;^{iv} and Florida law governs “copies of all reports and records relating to examination or treatment” of the patient.^v In general, state laws are generally more focused on clinical records, while HIPAA’s “designated record set” includes billing records too.

When a state law provides greater access rights than HIPAA, it may be with respect to a smaller amount of information. For example, if your state law provides that a patient may receive a copy of the “medical record” within 15 days, then this means you must provide a copy of the medical record within 15 days under state law. You then must provide the remainder of the designated record set (such as billing records) within 30 days (with a 30-day extension available) under HIPAA if the patient’s request encompasses both medical and billing records.



INTEROPERABILITY

The PI Programs include certification criteria that specify what information must be made available to patients through the EHR.



This primarily consists of the “Common Clinical Data Set,” or CCDS for short. The CCDS includes:

1. Patient name
2. Sex
3. Date of birth
4. Race
5. Ethnicity
6. Preferred language
7. Smoking status
8. Problems
9. Medications
10. Medication allergies
11. Laboratory tests
12. Laboratory values/results
13. Vital signs
14. Care plan fields, including goals and instructions
15. Procedures
16. Care team members
17. Immunizations
18. Unique device identifiers for a patient’s implantable devices
19. Assessment and plan of treatment
20. Goals
21. Health concerns^{vii}

Additionally, the PI Programs require that the EHR provide the patient with the provider’s name and office contact information (only for patient visits to ambulatory settings), laboratory test reports, and diagnostic image reports. Any certified EHR technology should make this information available through its patient portal feature.



PRO TIP:

Talk to your vendor to ensure that your EHR makes available to patients the CCDS and other requirements from the PI Programs. Also, make sure that you understand and can explain to your patients what information is included in the CCDS. For example, since the CCDS does not include everything in the patient’s designated record set, you should ensure that patients know they can still ask you for information that isn’t available on the EHR’s patient portal. Make sure that all of the practice’s staff knows how to help patients and/or their caregiver(s) access their portal.

1. WHAT ●

2. HOW ●

3. WHO ●

4. WHEN ●

5. WHEN NOT ●

6. HOW MUCH ●

FAQS



I have a patient portal. Doesn’t that make me HIPAA compliant?

Not necessarily. Under HIPAA, patients have the right to receive more information than is available in the patient portal and through alternative means, such as email, through an app, or on a CD or USB drive.



What do I need to include in a request for records? What about a request for “a list of the patient’s medical records disclosure”?

You need to include what they asked for, to the extent the information is contained within the “designated record set.” This includes medical and billing records and any other record that is used to make decisions about the patient. The term does not include business records that solely relate to the practice.



What do I do if the patient requests the diagnostic imaging tests, such as MRI scans?

If the images are in your system, and you are relying on them for diagnosis and treatment decisions, you must produce them to the patient if requested to do so. If you are relying on a link to another health care provider’s systems, then you can direct the patient to the other health care provider for the information. However, please note that, even where you are not the originator of the image, if it is in your system, you must produce it.

2. How: Forms and Formats for Sharing Records









HIPAA

HIPAA requires you to provide a patient with access to the designated record set in the form and format that the patient requests, if you are able to do so.

The form of access can include inspection (if the patient does not need to retain a copy or does not want to pay for a copy), access through paper records, or access through electronic records. It can include physical media, such as a CD or USB drive, or electronic transmission such as email. Format can include a searchable Portable Document Format (PDF) file, graphical

files (such as JPG or TIF), or a health-care-specific format such as a Clinical Document Architecture (CDA). Some formats may be far better for providing access to images, such as X-rays, with optimal resolution. Other formats may be better for organizing large amounts of information in a way that the patient and other health care providers will best be able to leverage, such as a CDA.

FORM OF ACCESS TYPES	CD	USB	Electronic Transmission	PDF	JPG/TIF	CDA
						

HIPAA only requires that you produce a requested form and format if it is readily producible.

This means that you do not need to purchase new technology to accommodate a patient's request if they want their records in a way that you do not have available already. You do not need to pay thousands of dollars to your EHR vendor for a new feature. However, you must know what formats your EHR technology is able to readily produce. For example, if a patient requests a copy of a medical record in CDA format and your EHR is able to save a patient file in this format, then you cannot provide the patient with paper copies or a PDF simply because you are unfamiliar with the requested format.

Sometimes providing health information in the patient's requested form and format will require some extra time and effort but is readily producible in that form and format. For example, information may be readily available to the patient through a patient portal, but the patient would like you to email the information instead. In such a case, you must provide the information in the patient's requested form and format, meaning that you must email the patient.



PRO TIP:

If your practice has conducted a security risk assessment and determined that you generally should only send encrypted email, but the patient requests that you send their medical record through unencrypted email, then you should notify the patient that there is some risk that the information may be viewed by unauthorized persons while transmitted across the internet. If the patient is fine with the risk, then you must accommodate the patient's request and send the information via unencrypted email. You should document in your records that you informed the patient of the risk and the patient accepted (or this can be part of your record request form, such as the Sample Patient Access Request Form provided in Appendix D).

1. WHAT ●

2. HOW ●

3. WHO ●

4. WHEN ●

5. WHEN NOT ●

6. HOW MUCH ●



STATE LAW

Most state laws do not provide patients with specific rights with respect to the form or format of access. Accordingly, you are generally fine if you comply with HIPAA and provide a patient with the patient's records in the requested form and format, if the records are readily producible in that form and format. If your state does have special laws around form and format of access, be sure that your practice is familiar with them and accommodates the patient's requests accordingly.



Appendix D



INTEROPERABILITY



The PI Programs require that the patient be able to view the above information online, download the information in human-readable format and in the CDA format, and transmit the information to a third party through email transmission to any email address and through secure messaging.

The PI Programs also now require that the information is accessible to third-party apps through an Application Programming Interface, or “API.” An API is a standardized method for two applications to talk to each other, such as when a tax preparation application is able to connect to a bank’s records. Certified EHR technology must include an API and documentation that allows third-party developers to configure their software to work with the API. This way, third-party apps can pull information from the EHR.

If you have EHR technology that is certified to the 2015 Edition of the certification criteria, then it should have all of these capabilities built in.



Do I need to buy any new technology or pay any fees to my EHR vendor based on a patient's request?

No. While you are required to provide patient records in the format specified by the patient, HIPAA only requires you to do so if the form and format are readily producible. You do not need to purchase new technology to accommodate a patient's request. You also do not need to pay thousands of dollars to your EHR vendor for a new feature, but you must know what formats your EHR technology is able to readily produce.



Do I have to provide the records electronically if they want it that way?

HIPAA provides that they are entitled to an electronic copy. However, if the records are stored in a manner that is not electronic (such as in paper), you are not required to procure hardware or software to convert the paper records into electronic records. If you already have a scanner or some other mechanisms to allow the conversion, or if the records are already stored electronically, you must provide the records in electronic form if requested by the patient to do so.



Do I have to comply with a patient's request that I email records?

Email is often not encrypted and can be intercepted; however, you cannot require that a patient use an alternative if that patient is comfortable with email's risk. In this case, give the patient a basic warning related to email risks, and obtain a verbal or written confirmation from the patient that the patient is aware of the risk and still wants to receive the records via email.



Do I have to use the USB drive provided by my patient?

Under the HIPAA Security Rule, you should conduct a risk analysis that identifies the risks of connecting foreign USB drives to your systems. It is advisable to be cautious about using a USB drive that is foreign to your systems. In most cases, plugging an unfamiliar USB drive into one of your computers is not a good idea because the patient may unwittingly be passing along malware. If you determine that the risk is too high, then you should work with the patient to identify an alternative way to obtain the patient's records or provide the records to the patient using a USB drive that your practice has purchased.

The World of Apps

APIs and Patient Apps

The PI Programs now require certified EHR technology to include APIs that allow for secure communications between apps. When you complete your taxes online, an API may allow your online tax software to seamlessly pull information from multiple bank accounts after you share your bank accounts' credentials. In health care, the similar promise of APIs is that a patient app will be able to seamlessly pull medical information from numerous health care providers' EHR systems through APIs.

APIs can also allow for automated transmission into EHRs. For example, a patient may use a smart watch to track their fitness and vital signs and various applications on their cellphones to track health-related activities like their nutrition and medication refills. If all these mechanisms utilize API technology, the patient will be able to condense all of this data in to one location through a data aggregator application that also uses an API. From the point of view of a physician, this data can be useful in diagnosing an ailment, monitoring treatment effects, and tailoring recommendations to fit the lifestyle of the patient.

What is FHIR?

Fast Healthcare Interoperability Resources (FHIR) standardizes the electronic exchange of health care information. FHIR helps apps and other software communicate over APIs. Previously, connecting EHRs to other systems was cumbersome, often requiring

expensive integration fees. With FHIR, different EHRs and apps will have a common API language, eliminating the need for expensive integration processes.

Privacy and Security of Patient Apps

One significant concern with patient apps is the privacy and security of such apps. Is the app developer selling the patient's health information? Will the patient's information be encrypted? What if the patient's mobile device is lost or stolen? Is the health care provider liable for sharing information with an unsecured app?

If a patient requests that you share information through an app, you are required to do so under HIPAA if you have the technology to do so. Your EHR's API should allow the app to connect and receive information securely. You are not responsible for whether the app is a "good one," including whether it has appropriate privacy and security in place. If the patient's information is breached once stored within the app, you are not responsible.

Nevertheless, it is a good idea to educate your patients about app privacy and security. Encourage them to check the privacy policy before downloading a health app to make sure that their information will not be misused. Suggest that they password protect their phone if they are going to store medical information on it. Remember, unlike a stolen credit card number, medical information cannot be changed. In today's world, health data privacy should be top of mind.



FAQS



The patient wants me to send her medical information to an app, but my EHR does not appear to support or be compatible with these apps. Do I need to send the record to her app?

There are applications that manage personal health records (PHR) for the consumer by collating information from various health providers, and that can allow sharing of information. The government is pushing to make it easier for the patient to be able to use such apps. If your EHR is certified to the “2015 Edition,” then it should include API features that allow third-party apps to obtain medical information from your EHR. There should be minimal, if any, action needed on your part for information to be available through your EHR to patients’ apps.

3. Who: Patient Requests and Involvement of Third Parties

Direct Requests from Patients

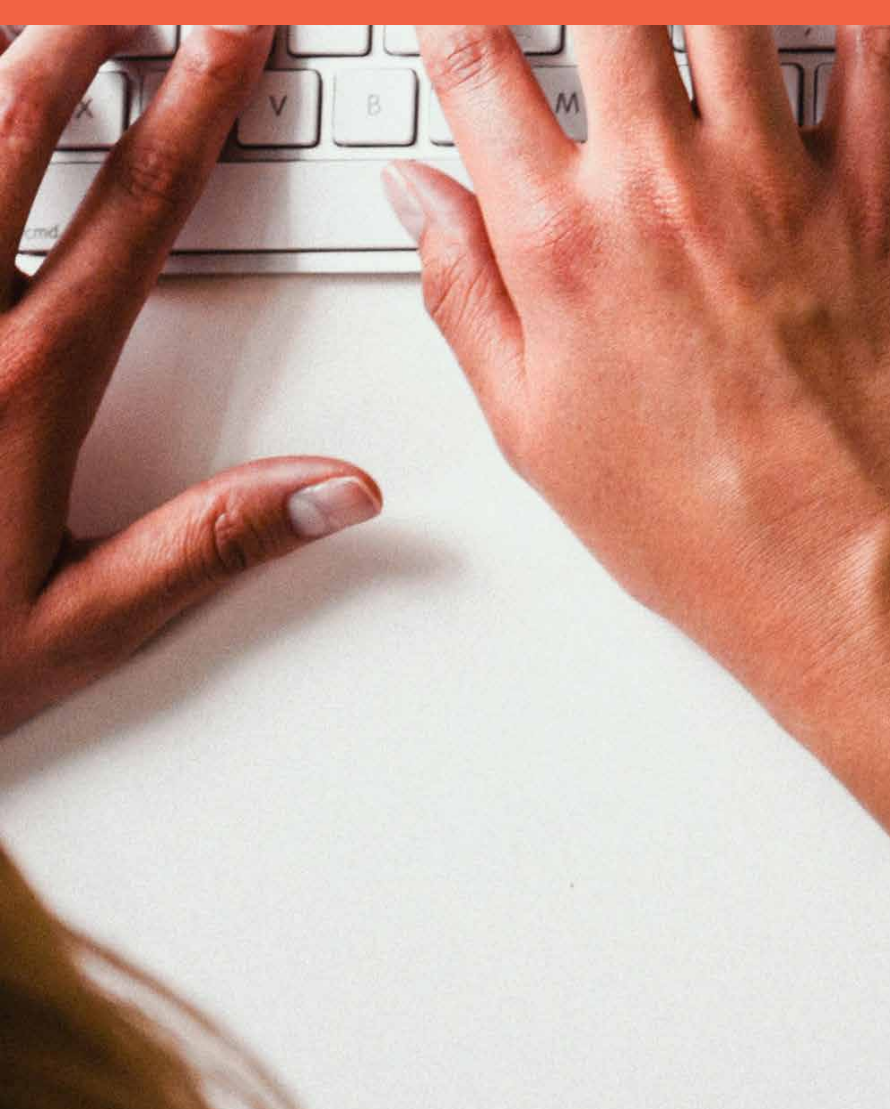
HIPAA

HIPAA requires you to respond to every single patient request in the time and manner dictated by the regulations.



Each failure to provide timely access in accordance with HIPAA can be penalized by the Office for Civil Rights, which enforces HIPAA. While many people focus on the aspects of HIPAA that require medical practices to keep information secure and private (which is important!), HIPAA also is very clear that patients have a right to access their own information, so a practice that does not facilitate that access violates the law. More importantly, patients rely on

you to provide them with access to their records to empower them to coordinate their own care. They may need records to share with specialists, if they are moving, or if they are seeking additional treatment options. It is also important to provide access to any caregivers that a patient has directed you to share information with. Caregivers help to ensure that patients get the treatment and services they need.



1. WHAT ●

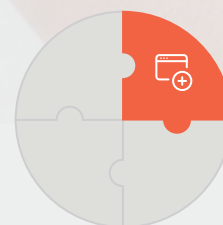
2. HOW ●

3. WHO ●

4. WHEN ●

5. WHEN NOT ●

6. HOW MUCH ●



STATE LAW

Like HIPAA and in contrast to the Programs, state laws generally require you to respond to 100% of patient requests in the time and manner dictated by state law.

INTEROPERABILITY

The patient's information must be available to the patient to view, download, or transmit in the EHR's patient portal or access through an API within four business days of the information being available to the clinician.^{viii} Make sure you know how to grant a patient access to their portal whenever they ask. All certified EHRs should have the capability to allow patients and their caregivers to view, download, and transmit their records. If you have any questions about how your patient portal works, talk to your EHR vendor.

Requests Originating from Third Parties

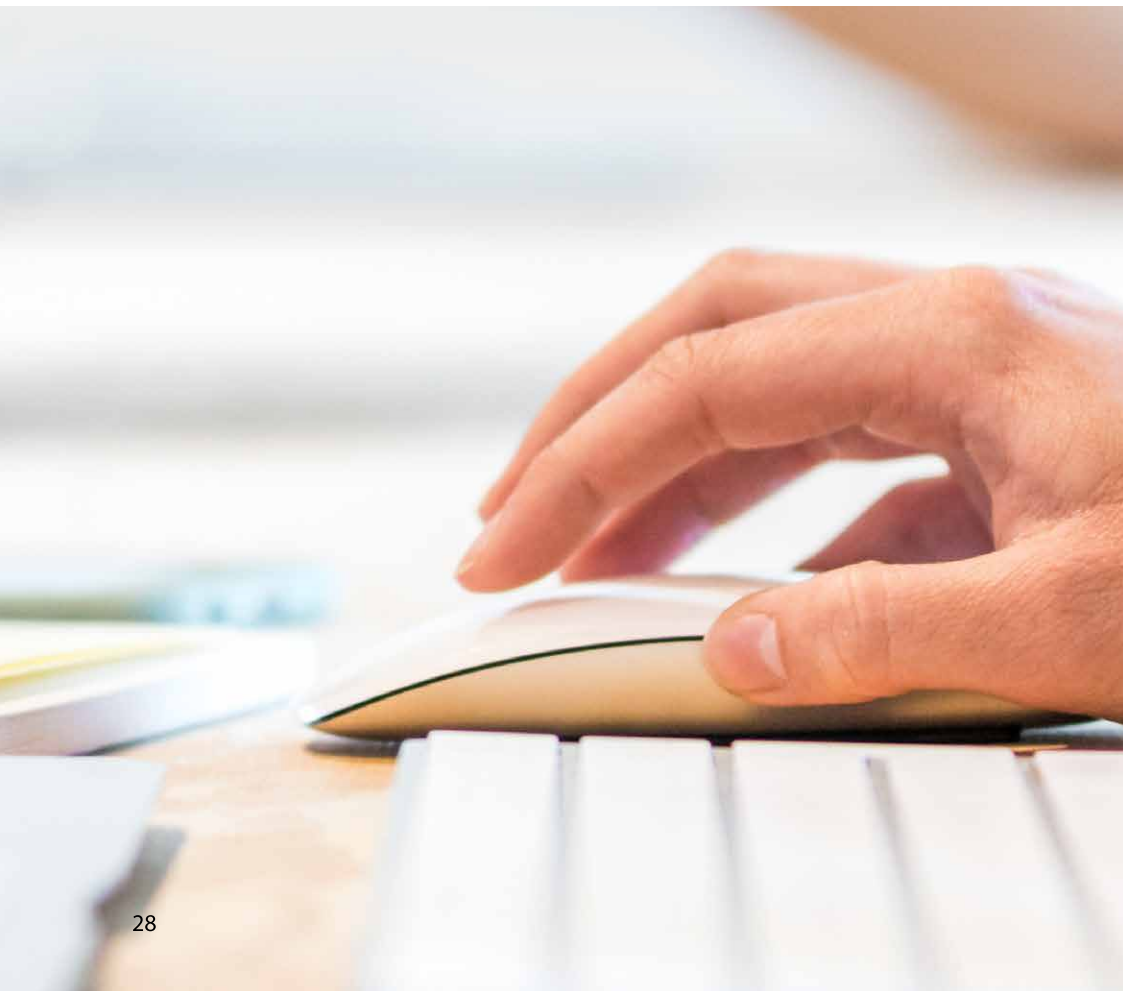
HIPAA



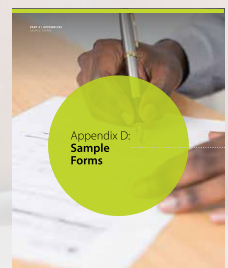
Unlike when a request for records comes from a patient or their designated representative, if a request comes from, and is at the direction of, a third party, then the request does not fall under the patient's right of access under HIPAA.

For example, if a life insurance company seeks a copy of an individual's medical records for the purpose of approving a life insurance application, then this is a third-party request, and it is not subject to the HIPAA right of access. Instead, you must receive a HIPAA-compliant authorization to make the disclosure.

A HIPAA-compliant authorization must include certain elements that are not appropriate for a request that comes from the patient such as an expiration date or certain statements, such as that the information will no longer be subject to HIPAA. An example of an authorization is included in Appendix D.



Appendix B



Appendix D

There are many differences between third-party requests that require a HIPAA-compliant authorization and requests that are from or at the direction of the patient.

For more information on personal representatives and caregivers, as well as requests from third parties, see Appendix B.

1. WHAT ●

2. HOW ●

3. WHO ●

4. WHEN ●

5. WHEN NOT ●

6. HOW MUCH ●

	PATIENT REQUEST	THIRD-PARTY REQUEST
DISCRETION	No , you are required to provide the requested records unless HIPAA provides grounds for denying some of the request (such as access to psychotherapy notes).	Yes , you have discretion to decide whether to disclose the requested information.
TIMING	You must respond within 30 days , with a 30-day extension available. Note that if the patient is requesting access to a patient portal or is using an app to retrieve their records from your EHR, they should be given almost instantaneous or very prompt electronic access.	HIPAA does not have a required time frame to respond.
FORM	Request does not need to be in writing unless the patient requests that you send a copy to a third party. (A sample form is included in Appendix D.)	A HIPAA-compliant authorization, with specific elements and statements, is required. (A sample form is included in Appendix D.)
CHARGES	You may only charge up to a reasonable and cost-based fee. If you are granting electronic access, there should be no reason to charge a fee, unless you pass on the cost of the electronic media (such as if you provide the patient with a USB drive). Patients should never be charged fees to access their portal.	You can charge any amount set forth under state law. If state law is silent, then you may only charge a reasonable, cost-based fee to cover the cost of preparation and transmittal (unless the authorization indicates that you will receive remuneration in exchange for disclosing the patient's information).

Remember, patients often rely on personal representatives, family members, and other caregivers to help them with access to their records. You should respect a patient's desire for you to share their records with their care team on their behalf.



STATE LAW

Remember that HIPAA is a “floor” with respect to patient rights, so if a state law is more restrictive than HIPAA, you must follow HIPAA instead of the state law.

Conversely, if the state law provides a patient with additional rights, you must follow the state law.

If you receive a request from the patient and state law makes it harder for the patient to get their information than HIPAA does, then follow HIPAA.

For example, California law generally requires that disclosures of medical information to third parties must be based on the patient’s consent, and the consent must be in 14-point font.^{xiii} If a patient submits a written request to send a copy of the medical record to a third party, then you

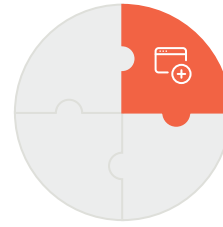
must do so in order to comply with HIPAA. You cannot deny the request because it does not use 14-point font. Similarly, if a state has additional restrictions on disclosures of sensitive information, such as HIV test results or substance use disorder records, then you should follow HIPAA rather than these state laws if the request is from the patient.

In contrast, if the state provides patients with additional ways to access their information, then you have to follow the state law.

For example, if a third party requests medical records and has a HIPAA-compliant authorization signed by the patient, HIPAA gives you discretion as to whether or not to disclose the requested information to the third party. But some state laws require you to provide the requested information. In that case, you must comply with both the state law (by providing the access) and HIPAA (making sure that the authorization form complies with all of HIPAA’s requirements).

INTEROPERABILITY

The PI Programs require practices to provide patients, or the patient’s authorized representative(s), timely access to health information through the EHR’s view, download, and transmit and API functionalities.



1. WHAT ●

2. HOW ●

3. WHO ●

4. WHEN ●

5. WHEN NOT ●

6. HOW MUCH ●

A “patient’s authorized representative” under the PI Programs is the same as the patient’s personal representative under HIPAA, such as the parent of a minor or a legal guardian.

While a patient can provide access to the EHR’s health information to a third party who is not the patient’s authorized representative (such as a caregiver), this will not count for purposes of satisfying the Programs’

requirements. Note that while the Programs technically only require practices to provide access to at least one patient or authorized representative, practices should make portal access available to all of their patients — not only does your EHR come with this functionality, but it’s the right thing to do. There is no reason to limit access to the bare minimum required by the Programs.

FAQS



Am I required to provide a copy of a patient’s medical record?

Yes, if the request comes directly from the patient or their personal representative (such as a parent for a minor patient), you must provide the record under HIPAA and other state laws.



Can I require that a person appear in person when they make a request for records? How do I verify a patient’s identity?

It is important to verify the identity of the patient, particularly where it is an individual that you do not know. Identification, however, should not become an unreasonable obstacle to the patient accessing medical records. You may not require an in-person verification when you receive a request for records. You should, however, still seek to verify the patient’s identity, such as by obtaining information that is not publicly known (such as the last four digits of the patient’s Social Security number) or having the patient transmit a copy of a government ID.

4. When: Timing for Records Fulfillment Requests



HIPAA

HIPAA provides you up to 30 calendar days to supply a patient with access to his or her designated record set.

You may extend this period by up to an additional 30 days, for a total period of 60 days, but you must notify the patient within the initial 30 days of the reasons for the delay and the date by which you will provide the access. For example:

We received your January 1, 2020, request for a copy of your records. Because your records are stored off-site, and we have been delayed in obtaining these records from the off-site storage facility due to the recent blizzard, we will not be able to provide you the requested copy until March 2, 2020. We will send the records earlier if at all possible.

While HIPAA provides up to a 30-day extension, we recommend providing access within the initial 30-day period whenever possible.

Your patients may be eager to receive their records for any number of reasons, including needing to schedule additional appointments with specialists. Try to let your patients and their caregivers know when you have received their record request and, if possible, an estimated timeline for when they can expect to receive the records. This type of communication can help to relieve significant anxiety and improve trust and communication between the practice and your patients. It can also help eliminate redundancy and inefficiency while improving patient safety and outcomes. Also consider implementing a system allowing patients to flag emergency requests versus those that are more routine.



PRO TIP:

Remember that if the patient is requesting access to a patient portal or is using an app to connect to your EHR, they should be given almost instantaneous or very prompt electronic access.



STATE LAW

Many states have more stringent timing requirements than HIPAA. For example, Texas provides for access to the electronic health record within 15 business days^x and California provides a right to inspect records within five business days.^{xi}

If a state law does not provide a deadline or provides a greater amount of time than under HIPAA, then you must comply with HIPAA (providing access within 30 days, with a 30-day extension available).



INTEROPERABILITY

The patient's information must be available to the patient to view, download, or transmit or access through an API within four business days of the information being available to the clinician.^{xii}

1. WHAT ●

2. HOW ●

3. WHO ●

4. WHEN ●

5. WHEN NOT ●

6. HOW MUCH ●

FAQS



How much time do I have to respond to a patient's request for their records?

Under HIPAA, you have 30 days to comply with the request. You are permitted to grant yourself an additional 30-day extension (only once), but you must notify the patient of this extension within the initial 30 days. This means you have a maximum of 60 days to comply with a request. That being said, you should still look at the rules for the specific state(s) in which you practice because many states have more restrictive time frames with which you must comply.

5. When Not: Denial of Record Request Access



HIPAA

HIPAA provides very limited grounds for denying access. You may deny access to protected health information because:

- × The information is in psychotherapy notes (notes from a mental health professional regarding a counseling session that are for the mental health professional's personal recollection and are kept outside of the medical record);
- × The information was created in reasonable anticipation of a civil, administrative, or criminal action or proceeding;
- × The requested information is outside the designated record set; or
- × The health information was obtained from someone other than a health care provider under a promise of confidentiality and providing access would be reasonably likely to reveal the source of the information (such as: "Don't tell my husband, because I know he is embarrassed by it, but the other day he forgot my name. I think his dementia is getting much worse.").
- × There are also grounds for denial if you are part of or acting on behalf of a correctional institution or a federal agency or if the requested health information is part of an ongoing research study.

HIPAA also allows you to deny access for the following reasons, but the patient may request an appeal to a licensed health care professional who was not involved in the original denial decision:

- × A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person (it is not enough to believe that the access will cause purely emotional harm to the patient or be detrimental to treatment);
- × The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person (substantial emotional harm to the other person referenced in the health information would be sufficient); or
- × The request for access is made by the individual's personal representative (such as a parent, guardian, or a person with health care power of attorney) and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

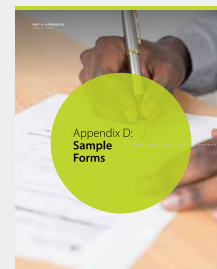
If access is denied for one of the above three reasons and the patient requests an appeal, then the reviewing licensed health care professional can be from within or outside of your organization.

You may only deny access to the portion of the record that meets the above criteria.

For example, if a 100-page medical record includes a mental health diagnosis on one page that a licensed health care professional has determined is reasonably likely to cause the individual to harm himself or another person (such as a staff member), then you can deny access to the portion of the medical record with the mental health diagnosis but must provide timely access to the other 99 pages (and even the remainder of the page with the redacted mental health diagnosis).

Your denial must be in writing within 30 days of the request for access (or 60 days if you timely inform the patient of the need for a 30-day extension) and must inform the patient of the right to have the denial reviewed by a licensed health care professional who was not involved in the denial decision. We include a sample denial notice in Appendix D.

- 1. WHAT ●
- 2. HOW ●
- 3. WHO ●
- 4. WHEN ●
- 5. WHEN NOT ●**
- 6. HOW MUCH ●



Appendix D



STATE LAW

State laws vary on whether they allow you to deny access in certain circumstances, such as where you believe that access may cause physical harm.

If state law does not provide for denying access, then it provides greater access rights than HIPAA. This means that you may not deny access in accordance with HIPAA, since the state law does not similarly provide a basis for denying access.

If state law provides you with greater discretion than HIPAA to deny access to medical records, then you must comply with HIPAA. For example, if state law permits you to deny a patient's request for access anytime you believe that such denial is in the best interest of the patient, then HIPAA provides a greater right of access and you must comply with HIPAA. You would only be able to deny access if, for example, you reasonably believe that providing access would lead to physical harm to the patient or another person. You would have to otherwise provide access, even if you do not believe it is in the patient's best interest.

Some state laws may provide additional rights when access is denied. For example, a state law may provide that when you deny access, you must provide a copy of the records to the patient's choice of physician instead. If a state law provides such a right, then you must follow the state law.

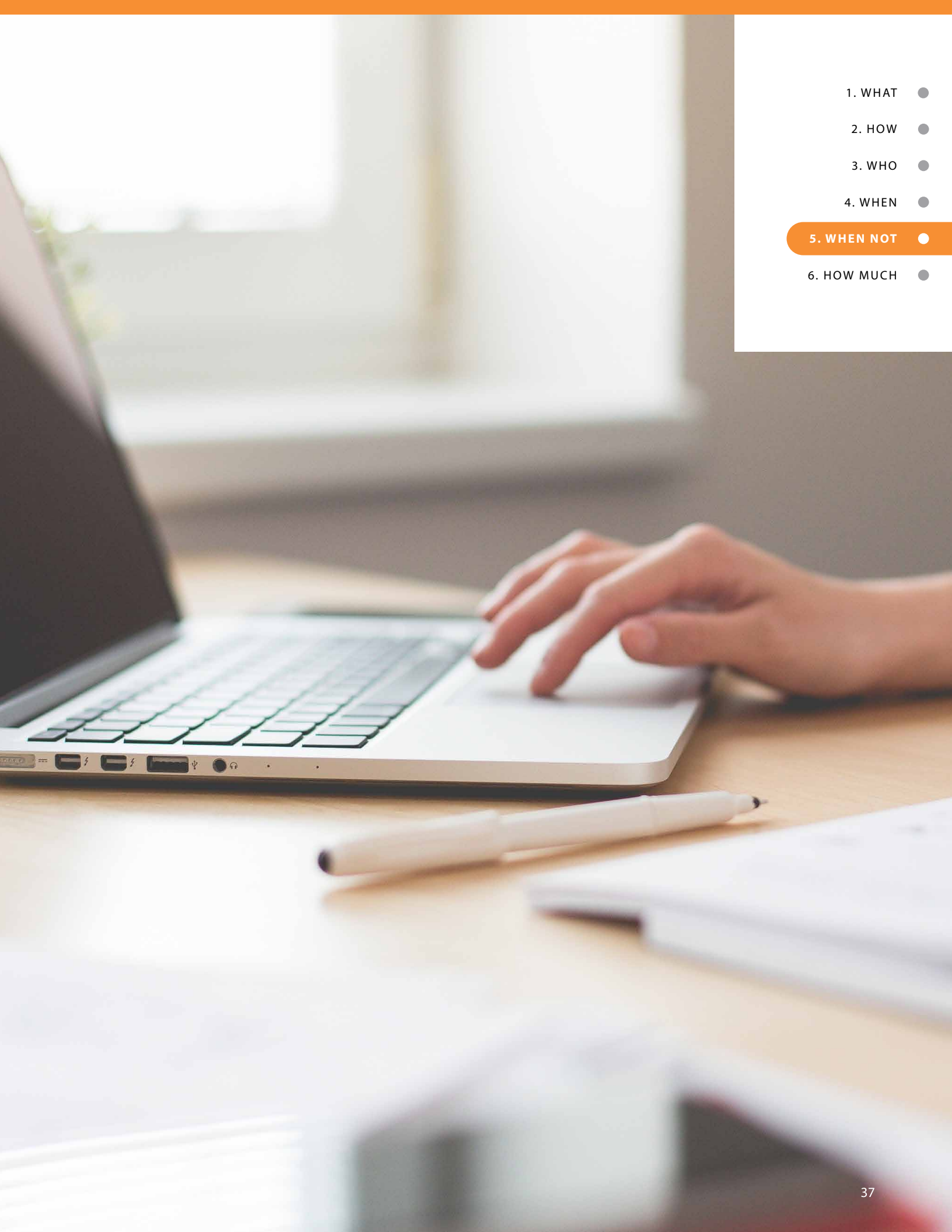


INTEROPERABILITY

The PI Programs permit clinicians to deny patients access to their health information, as long as the clinician provides at least one patient with timely access to the patient's information.

For example, if under HIPAA, you determine that a patient should not receive access to the patient's medical information because it is reasonably likely to cause physical harm, then this patient should not be counted as the one unique patient who was provided timely access to health information.





1. WHAT ●

2. HOW ●

3. WHO ●

4. WHEN ●

5. WHEN NOT ●

6. HOW MUCH ●

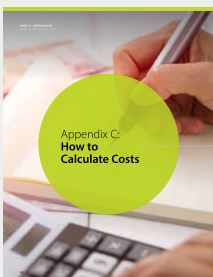
6. How Much: Permissible Charges for Record Requests

If the patient requests access (either directly or directs a third party to forward the patient's request), then you may only charge a reasonable and cost-based fee for the access. If the patient requests to inspect her records, then you may not charge a fee.

Reasonableness

If state law sets a limit on fees, then this amount is considered "reasonable" and you cannot exceed this amount. You are still limited to your costs, however. For example, if state law provides that you can charge \$0.75 per page, but your actual copying costs for paper copies is \$0.12 per page, then you may only charge \$0.12 per page. If state law is silent, then reasonableness would be based on a comparison to your peers. For example, if your costs are triple that of other similar providers (because highly paid staff are doing the copying or you are delivering copies through an expensive courier service), then a patient can claim that your costs are unreasonable and violate HIPAA.

To learn more about costs allowed for paper copies and electronic copies, see Appendix C.



Appendix C

- 1. WHAT ●
- 2. HOW ●
- 3. WHO ●
- 4. WHEN ●
- 5. WHEN NOT ●

6. HOW MUCH ●

Providing access to your patients' records should not be viewed as a revenue-generating opportunity.



STATE LAW

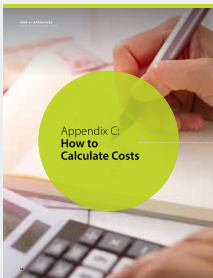
Most states set limits on what amount can be charged to patients for their medical records.

As discussed previously, you may only charge the lesser of this amount or your actual copying costs. A Table of Allowable Fees by State is included in Appendix C.



INTEROPERABILITY

While the PI Programs do not address charges to patients, under HIPAA, a physician cannot charge a patient for access to health information through the EHR's patient portal, since there is no associated copying cost to the practice.



Appendix C



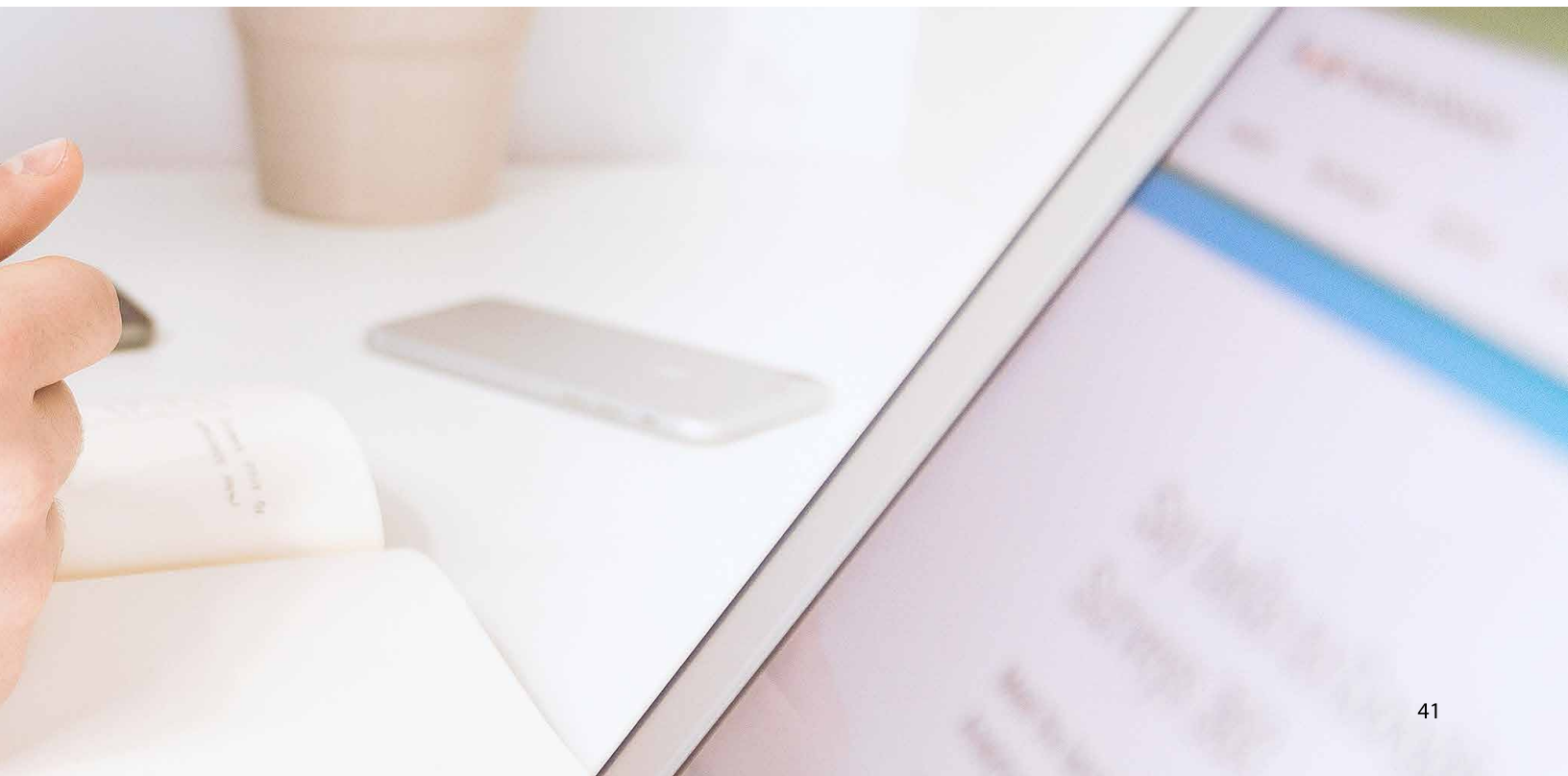
Can I charge for paper records? How about other electronic media, e.g., a CD?

Under HIPAA, you are allowed to charge the lesser of either a “reasonable” fee as defined under state law or the actual costs to you of copying the records. Your copying costs may include employee wages associated with copying time, the cost of supplies, the cost of the media (e.g., the CD cost), and postage. You should avoid charging a retrieval and review fee or a fee associated with the electronic maintenance of the records.



My state has a law stating how much patients can be charged. Can I charge this to my patients?

HIPAA permits you to charge “reasonable” and “cost-based fees” for records. If the state law sets a limit on fees, then this amount is considered “reasonable” and you cannot exceed this amount. However, you are still limited to your costs, and so you cannot charge the higher state fee schedule amount if your actual cost is less than the statutory amount.



Confidentiality of Substance Use Disorder Patient Records



If you are part of a federally assisted substance use disorder treatment program, then some of your records may be subject to the “Part 2 Rule.”

(This is the law’s nickname because it is found at Part 2 of Title 42 of the Code of Federal Regulations.)

If you are subject to the Part 2 Rule, then special protections will apply to any records that identify someone as having or having had a substance use disorder.

The Part 2 Rule does not provide patients with a right of access to their information but fully permits clinicians to disclose health information to the patient.

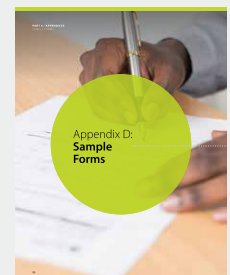
If the Part 2 Rule applies to you, then any disclosure of information to a third party that identifies a patient as having a substance use disorder will require a special consent form.

This would include if you are part of a facility that specializes in substance use disorder treatment, part of a unit of a general medical facility that holds itself out as providing substance use disorder treatment, or if you are part of a general medical facility or practice and you primarily provide substance use disorder treatment. In contrast, the Part 2 Rule likely does not apply if you only occasionally provide substance use disorder treatment to patients and are not part of a specialized facility or unit.

If you only provide substance use disorder services, then any records that indicate you treated an individual will be subject to the Part 2 Rule (and also HIPAA and applicable state law). If you provide a range of services, then the Part 2 Rule will only apply to the portions of records that identify the patient as having or having had a substance use disorder. HIPAA and applicable state law will apply to the remainder of the records.

The HIPAA right of access will still apply. Accordingly, if a patient asks to receive a copy of his or her medical records and these medical records include information subject to the Part 2 Rule, then it is sufficient to follow HIPAA and any state law that provides additional access rights.

This is true even if the patient is the one requesting the disclosure to the third party. For example, if the Part 2 Rule applies to you and a patient requests that you send the patient’s full medical record to a third party, then HIPAA will require you to grant the request (unless one of the limited grounds for denying access under HIPAA applies), but you will need to have the patient sign a consent that complies with the Part 2 Rule to include the portion of the record that identifies a substance use disorder. An example of such a consent is included in Appendix D.



Appendix D

Scenario 1 – Entire Facility Qualifies as a Part 2 Program



- Facility or practice is not focused on general medical care.
- Facility or practice is focused on a medical specialty, such as addiction treatment or behavioral health.
- Facility or practice holds itself out (such as on its website or in marketing materials) as providing substance use disorder diagnosis, treatment, or referral for treatment. It can also hold itself out as providing other services.
- The Part 2 Rule applies to entire facility or practice.
- Part 2 records will be those records that identify someone as having a substance use disorder. Identifying that someone received services from the facility or practice, without more, is not subject to the Part 2 Rule if facility or practice provides other services too.
- Example: A health care practice that focuses exclusively on a range of behavioral health issues, including addiction treatment, and markets addiction treatment services on its website and brochures.

Scenario 2 – One or More Units Qualify as Part 2 Programs

- Part of a general medical facility, such as a general acute care hospital or a primary care practice.
- Includes a specialty unit, such as an inpatient psychiatric unit, an addiction treatment center, or a behavioral health clinic.
- The specific unit holds itself out (such as on its website or in marketing materials) as providing substance use disorder diagnosis, treatment, or referral for treatment. It can also hold itself out as providing other services.
- The Part 2 Rule applies only to specific unit, not the entire facility or practice.
- Part 2 records will be those records that identify someone as having a substance use disorder. Identifying that someone received services from the unit, without more, is not subject to the Part 2 Rule if the unit also provides services other than substance use disorder services.
- Example: A general acute care hospital maintains an addiction treatment unit, which is listed on the hospital's website.



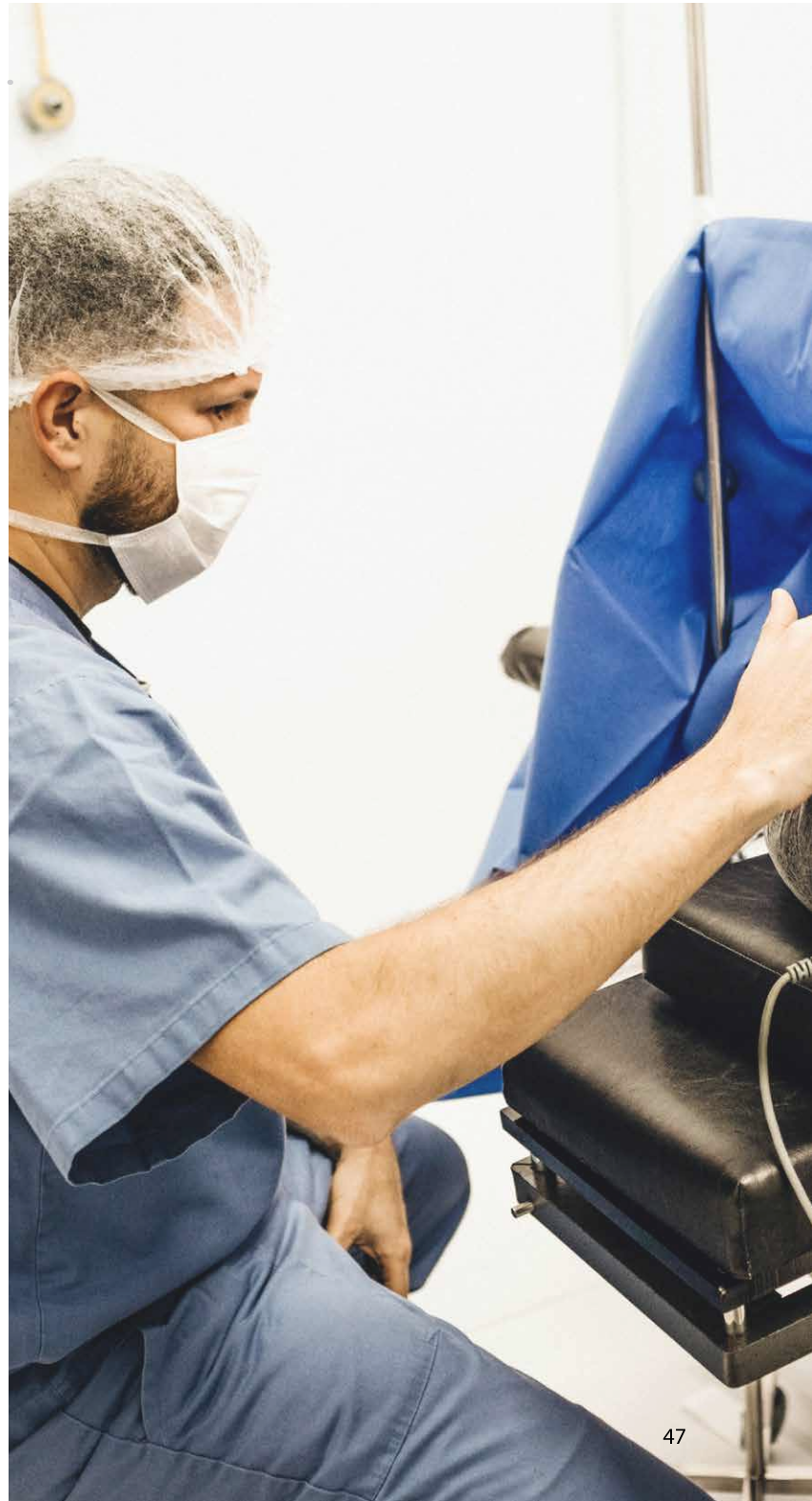
Scenario 3 – One or More Persons Qualify as Part 2 Programs



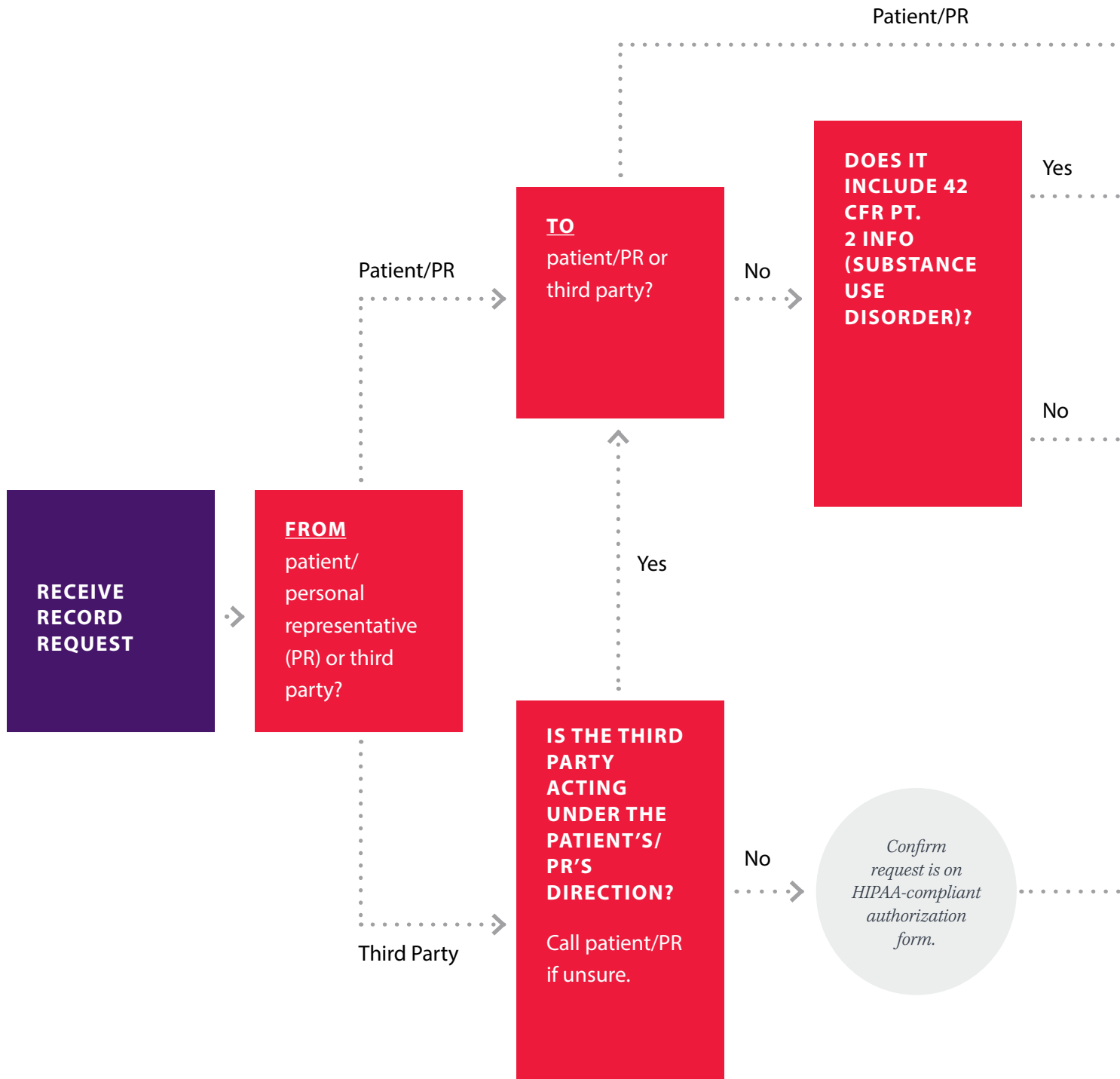
- Medical personnel or other staff at a general medical facility, such as a general acute care hospital or a primary care practice.
- Not part of a specialty unit that itself qualifies as a Part 2 Program (see Scenario 2).
- The person's primary function is providing substance use disorder diagnosis, treatment, or referral for treatment and is identified publicly as doing so.
- The Part 2 Rule applies to the specific persons, not a unit or the entire facility or practice.
- Part 2 records will be those records that identify someone as having a substance use disorder. Identifying that someone received services from the person who qualifies as a Part 2 Program will constitute Part 2 records if person only provides substance use disorder treatment or records indicate receipt of substance use disorder treatment.
- Example: A 15-physician primary care practice includes two physicians and a nurse practitioner who each spend the majority (more than 50%) of their time providing substance use disorder services. Their website profiles identify that they specialize in this area. Those three staff will each qualify as Part 2 Programs. Another physician provides substance use disorder services 25% of her time and is identified as specializing in this area. This physician is not subject to the Part 2 Rule because substance use services are not her primary function.

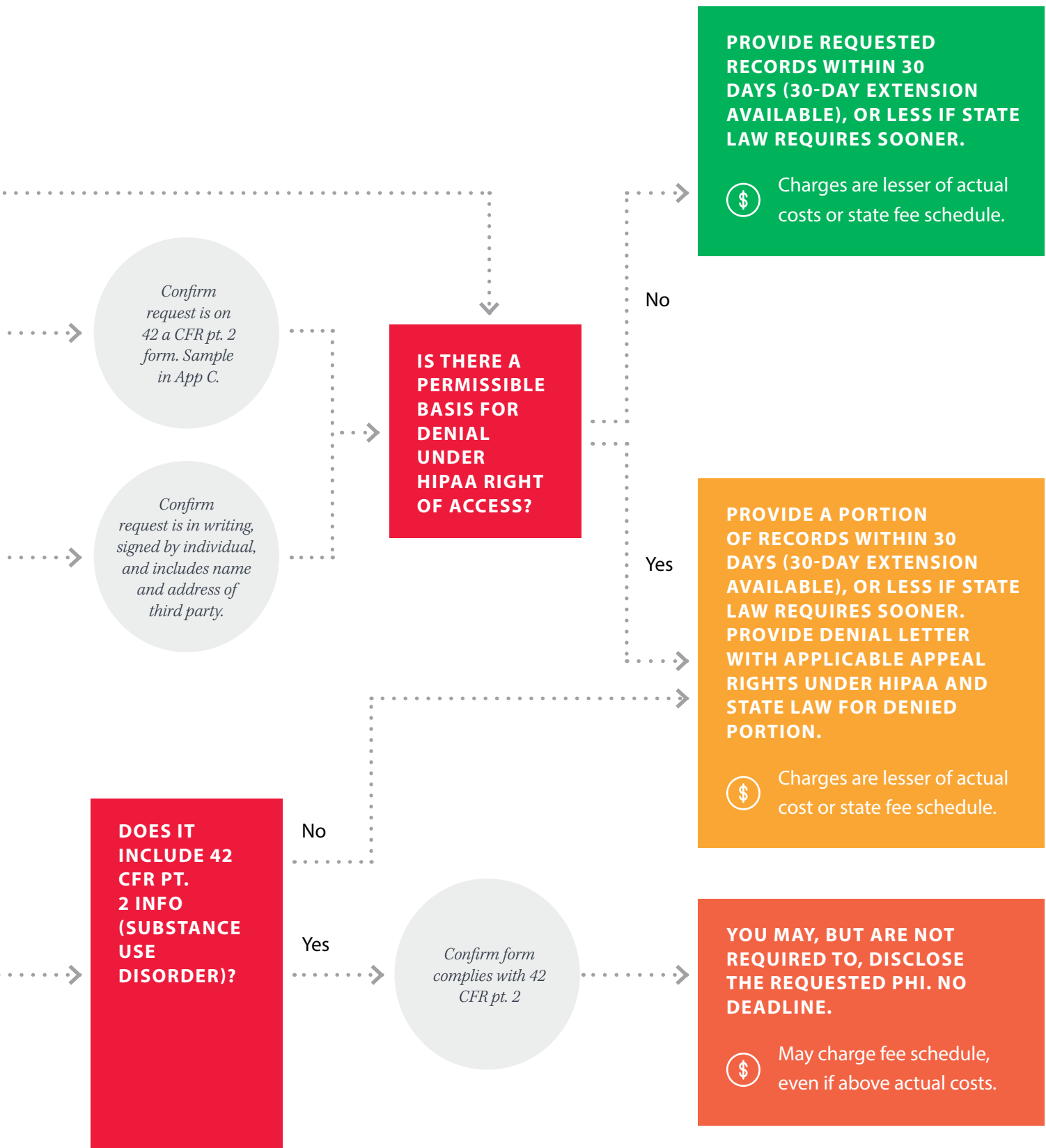
Scenario 4 – Part 2 Rule Does Not Apply

- Medical personnel or other staff at a general medical facility, such as a general acute care hospital or a primary care practice.
- Not part of a specialty unit that itself qualifies as a Part 2 Program (see Scenario 2).
- The medical staff sometimes diagnoses, treats, or refers substance use disorders. No medical staff spends more than 50% of their time providing substance use disorder services.
- Neither the facility nor any of its staff will be subject to the Part 2 Rule.
- Example: A doctor occasionally (less than 10% of his time) diagnoses his patients with substance use disorders and refers them to an addiction treatment center. Even though the medical records sometimes include information about substance use disorders, they are not subject to the Part 2 Rule.



Patient Records Request Flowchart







Putting It Into Practice: Operationalizing Records Access Fulfillment

Now that you understand the complicated sets of laws that apply to patients' access to their health information, let's talk about how to put all of this into practice.

Approaches to Integrating Legal Compliance with the Operations and Patient Mission of Your Practice

This section offers guidelines for operationalizing patient access laws into the day-to-day operation of your practice.

While office processes, staff structures, and technological capabilities vary widely, the following set of steps should make the fulfillment of patient record requests clearer and more efficient.

1. Get to Know Your EHR's Capabilities
2. Key Points to Remember
3. Promote Greater Use of Electronic Records Among Patients



1. Get to Know Your EHR's Capabilities

The first step to operationalizing patient electronic access is understanding the capabilities of your EHR technology.

If your EHR is properly certified, then it should have certain minimum capabilities. But those capabilities won't do you much good if you are not familiar with them.

Your EHR vendor should be a partner in understanding how to use the EHR to improve patient engagement. Consider contacting your vendor and asking for a tour of its patient engagement features.

Some questions to answer with respect to your EHR:

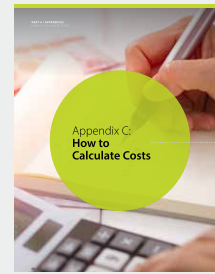
- How can patients view, download, and transmit the "Common Clinical Data Set"? This should be through some sort of patient portal.
- Is the EHR's API operational so that third-party apps can connect?
- To what physical electronic media can the EHR save? CD? USB drive? How do we do so?
- In what formats can the EHR save? PDF (both graphical and searchable)? JPG? TIF? Microsoft Word?

- Can the EHR save patient records in the Clinical Data Architecture (CDA) format? How do we do so?
- Can all EHR information about a patient (not just the Common Clinical Data Set) get sent securely through a secure message?
- Can all EHR information about a patient get sent through unencrypted email?
- Can EHR information get securely sent through the Direct Message protocol? This is a secure email format that goes to an address with "direct" in the domain, such as john.doe@direct.PHRvendor.com. There may be some initial setup the first time the EHR is set up to send Direct Messages to a particular company's app. Is any setup required to send Direct Messages to a new domain? Is there any fee for such a setup?
- Can some patient information get marked so that it will not be accessible to the patient where denial of access is permitted under HIPAA? How do we do so?

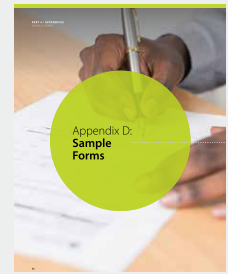
2. Key Points to Remember

It is critical that your office remember the following key points:

- Patients have a **right** to view or obtain a copy of their medical and billing information.
- There are limitations to what and how much can be charged for patients' records. Providing access to your patients' records should not be viewed as a revenue-generating opportunity. Electronic access, in particular, should be available for little or no cost. More information can be found in Appendix C.
- Patients are not required to use the patient portal and can obtain copies of their medical information through alternative means.
- If a patient requests a copy of medical information, have the patient fill out a patient request form. A sample form is included in Appendix D.
- A patient's access cannot be denied simply because the practice believes that access is not in the patient's best interest.
- A patient can receive her medical records through unencrypted email if warned of the risk of unauthorized access in transit.
- If a request comes from a third party and does not appear that it is at the patient's direction, then a HIPAA-compliant authorization form is required. A sample authorization form is included in Appendix D. If you are unsure whether a third-party request is at the patient's direction or the third-party's direction, then we recommend contacting the patient to confirm that the request is at their direction.
- If a patient would like a copy of their medical record sent to a third party, they have a right to have the practice do so.
- Your patients may be eager to receive their records for any number of reasons, including needing to schedule additional appointments with specialists. Try to let your patients and their caregivers know when you have received their record request and, if possible, an estimated timeline for when they can expect to receive the records. This type of communication can help to relieve significant anxiety and improve trust and communication between the practice and your patients. It can also help eliminate redundancy and inefficiency while improving patient safety and outcomes. Also consider implementing a system allowing patients to flag emergency requests versus those that are more routine.
- Remember that many patients are sick and have asked family members or other caregivers to help them access their records. Try to work with these caregivers to provide access in accordance with the patient's wishes. You can always call the patient if you need to double-check about whether to give the caregiver a record.



Appendix C



Appendix D

3. Promote Greater Use of Electronic Records Among Patients

If you have taken the steps described above, you should now understand how a patient can access his or her information, determined the appropriate amounts that can be charged and forms that should be used, and educated your workflow. Is that enough?

If you really want to improve patient outcomes, consider going further. How can you promote patient access in a manner that improves the health of your patients?

Here are a few steps that you can take to use patient engagement to improve care:

NEW PATIENTS

Provide new patients with information about how they can obtain their medical information from past health care providers and health plans, and then share it with you in a format that works with your EHR system, such as in a CCD format. For example, when new patients make an initial appointment, you can send a fact sheet encouraging them to obtain past medical records in a CCD format and forward it to you. This way, you can begin your treatment relationship with the most information possible.

ENCOURAGE CHECKING THE MEDICAL RECORD

For existing patients, encourage them to check their medical information before each appointment. Mistakes do happen, and sometimes the patient is in the best position to find and alert the physician of errors in the medical record.

Additionally, at the end of each appointment, encourage the patient to log in to the patient portal to view their information.

FAMILIARIZE YOURSELF WITH APPS

There are thousands of health apps, and you cannot become familiar with each one. But spend some time browsing app stores or speaking with peers about apps to identify ones that may be particularly helpful to your patients. For example, maybe many of your patients would benefit from an app that provides medication reminders or helps track cholesterol levels over time. You may only see a patient once a year, but a few helpful app recommendations can help manage the patient's health the other 364 days.

In particular, if your patient has complex medical issues that involve multiple health care providers, consider whether there are apps that you can recommend to help the patient access multiple EHRs and maintain a single repository of medical information.

In a few years, "prescribing" an app may be as commonplace and helpful as prescribing medicine.


ENCOURAGE THE PATIENT TO TAKE CHARGE OF THEIR HEALTH

Most importantly, encourage each patient to use apps and access to health information to become an active champion of his or her health. Patients can better manage their health by understanding and managing all of their health information.



Part 4 /

Appendices



Appendix A:
**Frequently
Asked Questions**



I have a patient portal. Doesn't that make me HIPAA compliant?

Not necessarily. Under HIPAA, patients have the right to receive more information than is available in the patient portal and through alternative means, such as email or on a CD or USB drive.



Do I need to buy any new technology or pay any fees to my EHR vendor based on a patient's request?

No. While you are required to provide patient records in the format specified by the patient, HIPAA only requires you to do so if the form and format are readily producible. You do not need to purchase new technology to accommodate a patient's request. You also do not need to pay thousands of dollars to your EHR vendor for a new feature, but you must know what formats your EHR technology is able to readily produce.



Do I have to pay my EHR vendor each time a patient wants me to connect to a new app?

No. The Promoting Interoperability Programs require certified EHR technology to include APIs that allow for secure communications between apps, allowing third parties to connect to the EHR without you having to pay a fee.



My state has a law stating how much patients can be charged. Can I charge this to my patients?

HIPAA permits you to charge "reasonable" and "cost-based fees" for records. If the state law sets a limit on fees, then this amount is considered "reasonable" and you cannot exceed this amount. However, you are still limited to your costs, and so you cannot charge the higher state fee schedule amount if your actual cost is less than the statutory amount.



Am I required to provide a copy of a patient's medical record?

Yes, if the request comes directly from the patient or their personal representative (such as a parent for a minor patient), you must provide the record under HIPAA and other state laws.



Do I have to provide the records electronically if they want it that way?

HIPAA provides that they are entitled to an electronic copy. However, if the records are stored in a manner that is not electronic (such as in paper), you are not required to procure hardware or software to convert the paper records into electronic records. If you already have a scanner or some other mechanisms to allow the conversion, or if the records are already stored electronically, you must provide the records in electronic form if requested by the patient to do so.



Do I have to use the USB drive provided by my patient?

Under the HIPAA Security Rule, you should conduct a risk analysis that identifies the risks of connecting foreign USB drives to your systems. It is advisable to be cautious about using a USB drive that is foreign to your systems. In most cases, plugging an unfamiliar USB drive into one of your computers is not a good idea because the patient may unwittingly be passing along malware. If you determine that the risk is too high, then you should work with the patient to identify an alternative way to obtain the patient's records.



How much time do I have to respond to a patient's request for their records?

Under HIPAA, you have 30 days to comply with the request. You are permitted to grant yourself an additional 30-day extension (only once), but you must notify the patient of this extension within the initial 30 days. This means you have a maximum of 60 days to comply with a request. That being said, you should still look at the rules for the specific state(s) in which you practice because many states have more restrictive time frames with which you must comply.



Do I have to comply with a patient's request that I email records?

Email is often not encrypted and can be intercepted; however, you cannot require that a patient use an alternative if that patient is comfortable with email's risk. In this case, give the patient a basic warning related to email risks, and obtain a verbal or written confirmation from the patient that the patient is aware of the risk and still wants to receive the records via email.



Can I require that a person appear in person when they make a request for records? How do I verify a patient's identity?

It is important to verify the identity of the patient, particularly where it is an individual that you do not know. Identification, however, should not become an unreasonable obstacle to the patient accessing medical records. You may not require an in-person verification when you receive a request for records. You should, however, still seek to verify the patient's identity, such as by obtaining information that is not publicly known (such as the last four digits of the patient's Social Security number) or having the patient transmit a copy of a government ID.



Can I charge for paper records? How about other electronic media, e.g., a CD?

Under HIPAA, you are allowed to charge the lesser of either a "reasonable" fee as defined under state law or the actual costs to you of copying the records. Your copying costs may include employee wages associated with copying time, the cost of supplies, the cost of the media (e.g., the CD cost), and postage. You should avoid charging a retrieval and review fee or a fee associated with the electronic maintenance of the records.



What do I need to include in a request for records? What about a request for “a list of the patient’s medical records disclosure”?

You need to include what they asked for, to the extent the information is contained within the “designated record set.” This includes medical and billing records and any other record that is used to make decisions about the patient. The term does not include business records that solely relate to the practice. Further, under HIPAA, there is a provision called the “accounting of disclosures.” This is a list of how health information has been disclosed outside of the organization and covers items like when you have to disclose information to public health authorities or law enforcement. There are regulatory exceptions for disclosures for treatment, payment, and health care operations.



How do I find out what other methods are available for my EHR vendor to produce records?

If your EHR is certified EHR technology (i.e., it has been certified for use under what previously was called the “meaningful use” programs), then it will have a view/download/transmit function (a patient portal), which permits patients to remotely obtain certain information without having to contact your staff. The EHR will probably also allow for secure “Direct Messaging” and creation of a PDF, which can be printed or sent using encryption technology. It may also allow documents to be saved in the CDA format, which is a format specifically created for health information. Contact your EHR vendor to find out all their capabilities.



What do I do if the patient requests the diagnostic imaging tests, such as MRI scans?

If the images are in your system, and you are relying on them for diagnosis and treatment decisions, you must produce them to the patient if requested to do so. If you are relying on a link to another health care provider’s systems, then you can direct the patient to the other health care provider for the information. However, please note that, even where you are not the originator of the image, if it is in your system, you must produce it.




How do I know if it is safe for patient records to be available through the EHR portal? Does a certification mean that the EHR is HIPAA compliant?

No, EHR certification does not mean that the EHR is HIPAA compliant. Software cannot be HIPAA compliant but can support a health care provider's HIPAA compliance. For example, your EHR's patient portal likely has password protection and other security features that support your HIPAA compliance. But it falls to you to include the EHR software in your information security "risk analysis" and identify potential security risks. This does not mean you have to review software coding, but you should discuss with your EHR vendor what the company does to identify security vulnerabilities in the patient portal, such as whether an independent third party has assessed the vendor's systems for security flaws. You can also ask if there are security features that you are responsible for turning on.



The patient wants me to send her medical information to an app, but my EHR does not appear to support or be compatible with this app. Do I need to send the record to her app?

There are applications that manage personal health records (PHR) for the consumer by collating information from various health providers, and that can allow sharing of information. The government is pushing to make it easier for the patient to be able to use such apps. If your EHR is certified to the "2015 Edition," then it should include API features that allow third-party apps to obtain medical information from your EHR. There should be minimal, if any, action needed on your part for information to be available through your EHR to patients' apps.



Appendix B:
**Additional
Resources**

Individuals Rights under HIPAA to Access their Health Information, U.S. Department of Health & Human Services Office for Civil Rights,

<https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html>

Patient Engagement Playbook, U.S. Department of Health and Human Services Office of the National Coordinator for Health IT,

<https://www.healthit.gov/playbook/pe/>

An Individual's Right to Access and Obtain Their Health Information Under HIPAA, Medscape,

https://www.medscape.org/viewarticle/876110?src=acdmpt_ocr-hhs_876110

(eligible for CME credit)

Patient Engagement Toolkit, American Health Information Management Association,

<http://bok.ahima.org/PdfView?oid=301404>

Resources for Patients and Practices from the National Partnership for Women and Families:

GetMyHealthData.org

What Is Patient Engagement? (Patient Engagement Toolkit), Health Information and Management Systems Society,

<https://www.himss.org/library/patient-engagement-toolkit>

2015 Edition Base EHR Definition - Certification Criteria Required to Satisfy the Definition,

https://www.healthit.gov/sites/default/files/2015edition_base_ehr_definition_ml_11-4-15.pdf

How do I select a vendor?

<https://www.healthit.gov/faq/how-do-i-select-vendor>

The future of Healthcare 2018,

https://www.thedoctors.com/contentassets/23c0cee958364c6582d4ba95afa47fcc/tdc_the-future-of-healthcare-survey-2018.pdf

Introduction to CDA and C-CDA (HIMSS 2016),

<https://www.hl7.org/documentcenter/public/calendarofevents/himss/2016/Introduction%20to%20Clinical%20Document%20Architecture%20%28CDA%29%20and%20Consolidated%20CDA%20%28C-CDA%29.pdf>

Additional resources on personal representatives, caregivers, and requests from third parties

If someone has the legal authority to make health care decisions on behalf of the patient, such as a parent of an unemancipated minor or a legal guardian of an incompetent adult, then this person is considered a “personal representative” of the patient and stands in the patient’s shoes for purposes of HIPAA.

A request from a personal representative should be treated as a request from the patient rather than as a request from a third party. Accordingly, a HIPAA-compliant authorization is not needed for a request from a personal representative.

Although a request from a third party requires a HIPAA-compliant authorization, a request from a patient (or personal representative) that requests that you send the information to a third party should be treated as a patient request.

Accordingly, a HIPAA-compliant authorization is not required or appropriate. Rather, HIPAA only requires that the patient’s request is in writing, provides the name and address of the third party, and is signed by the patient. As with other patient requests, you must respond within 30 days (with a 30-day extension available if needed), and charges are limited to a reasonable and cost-based amount, even though the records are going to a third party.

- One of the more confusing situations is when the request is delivered by a third party who claims that they are acting on behalf of the patient. The requestor may claim that it is a patient request and that you may only charge your copying costs

(rather than the amount set forth under state law). If the third party is merely forwarding the patient’s request at the patient’s direction, then you should treat the request as a patient request. For example, if a patient tells a caregiver to get a copy of the patient’s records, then this should be treated as a patient request, even if the written request is delivered by the caregiver and directs that the records be provided to the caregiver.

- In contrast, if it does not look like the third party is acting at the patient’s direction but merely obtained the patient’s signature on a form, then this should be treated as a third-party request and a HIPAA-compliant authorization is required.

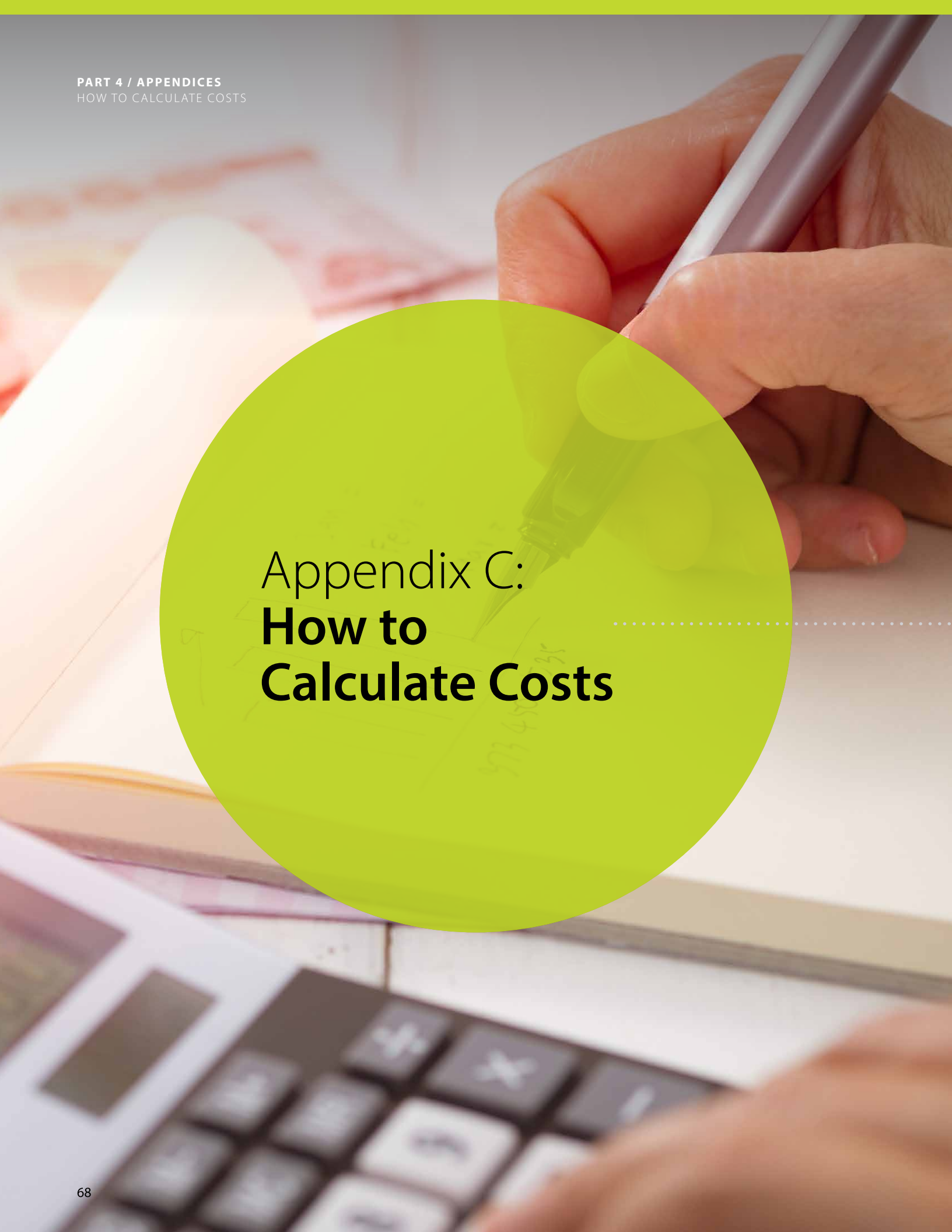
Sometimes, the only way to tell whether the request is truly at the patient’s direction is to contact the patient and confirm.

For example, you could contact the patient and indicate:

Hi, I’m calling from Dr. Lancaster’s office. I received a form from Andrew Roberts indicating that you would like us to send your complete medical records to Mr. Roberts. Because the privacy of your information is very important to us, we just want to verify your request. Do you recall completing that form, and can you confirm that you would like us to provide your entire medical record to Mr. Roberts?

A verification process like this can be burdensome, but it will help ensure that the patient really does want their medical records shared and minimize risks to your practice.





Appendix C:
**How to
Calculate Costs**

Additional resources on cost and price calculations

State Fee Schedule

First, identify the maximum charges under state law for your state. This Playbook includes a chart of allowable fees by jurisdiction in Appendix D.

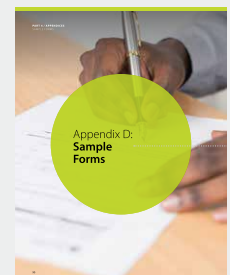
Charges for Paper Records

If the patient requests paper copies, then you may charge for your labor, supplies, and postage, either based on: (a) the actual cost of each patient's request; or (b) the average costs. Your labor costs are limited to copying time, such as time that an employee spends at a copying machine making the copies. It may not include costs associated with retrieving the patient's records, reviewing the request, collating the records, or conducting quality review. You can calculate your labor costs by multiplying the time it takes to make the copies by the staff member's cost (such as hourly wage, adjusted for the additional cost of any employee benefits). The cost of supplies can include the cost of paper, ink, and packaging.

It likely will not be feasible to separately calculate the cost of each request. This would involve timing how long it takes to respond to each request. Instead, it is preferable to base your charges on your average costs. This can be done by conducting a time study (such as over a day or a week, depending on how regularly you receive patient access requests) in which you record the time it takes for your staff to complete a number of copying jobs for patient record requests, and then divide this cost by the total number of pages of those requests.

The U.S. Department of Health and Human Services Office for Civil Rights (OCR), the agency that administers and primarily enforces HIPAA, has indicated that it expects that any health care provider can substantiate the copying costs that it is charging. We include a sample spreadsheet for calculating your costs of paper records in Appendix D.

You can calculate the cost of materials per page by taking the cost of paper (e.g., how much you pay for a ream or box of paper) and dividing it by the number of pages. You can add the cost of ink by dividing the cost you pay for a toner cartridge by the number of pages printed per toner cartridge. You can either track the number of pages printed per cartridge, or you can go to the manufacturer's website and find their guidelines on how many pages are expected per cartridge. For example, if a ream of paper costs \$6.00 and has 500 pages, then the cost of paper per page



Appendix D

Additional resources on cost and price calculations (continued)

is \$0.012 per page. If a toner cartridge is \$55 and the manufacturer indicates it yields up to 2,600 pages, then the cost of ink would be \$0.021 per page. The combined material cost per page would be \$0.033 per page.

You can calculate labor costs per page by conducting a time study. Choose a time period in which you handle a number of patient copy requests. For example, if you average one patient request a day, then you may wish to choose a week for your time study. Track the amount of time that staff spends copying during this time period. Do not include other time, such as time reviewing requests, retrieving records, or performing a quality review of the completed copies. Multiply the amount of time spent copying by the total hourly wage of the employee(s), and then divide by the total number of pages copied.

The total hourly wage can include an adjustment for benefits. For example, an employee is paid \$18 per hour. The employee also receives one week vacation per year (valued at \$720 based on \$18 per hour), three sick days (\$432), and \$5,000 in employer-contributed health insurance premiums. The benefits are worth a total of \$6,152. Assuming a standard work year of 2,080 hours, this comes out to \$2.96 per hour. This can be added to the \$18 per hour in this example, for a total wage cost of \$20.96 per hour.

If the time study found that employees spent four hours copying and copied 700 pages, then this would lead to four hours times \$20.96 per hour, divided by 700 pages, or \$0.12 per page for labor.

You can then charge for paper records based on the cost of materials (\$0.033 per page in this example),

labor (\$0.12 per page in this example), and any costs for shipping (such as the cost of the box and postage).

If you have outsourced release of information to a vendor, you can ask your vendor for a copy of their cost calculations.

Charges for Scanned Records

If a patient requests an electronic copy of records that was maintained in paper form, then you can charge for the cost of scanning. This can be calculated for each patient request, or you can conduct a time study and calculate an average cost of scanned documents on a per-page basis. We include a sample spreadsheet for calculating your costs of electronic records that were maintained in paper in Appendix C.

To calculate labor, you can perform a time study to determine the cost of scanning documents on a per-page basis. You can calculate this by timing how long it takes to scan patient records, multiply by the total hourly wage (including the cost of employee benefits, as discussed above), and then dividing by the number of scanned pages. For example, if it takes three hours to scan 400 pages, then it would be three times \$20.96 per hour divided by 400 (\$0.16 per page).

You can charge for any physical electronic media (such as a CD or USB drive), the time it takes to save to the media, and the cost of postage and shipping materials. If the electronic copy is transmitted through email or secure messaging, then the only cost would be the labor cost or scanning.

Charges for Electronic Copies

Electronic copies will frequently cost you significantly less than paper copies. You may charge for labor, supplies (such as a CD or USB drive and packaging), and postage (if the patient requests you to mail a CD, for example). You may calculate your costs based on: (a) the actual cost of each patient request; (b) the average costs; or (c) an all-inclusive, flat fee of up to \$6.50.^{xiv}

Labor - Your labor costs are limited to copying time, such as time spent saving the records to a USB drive, burning a CD, or sending an email. This will likely be a small amount of time and, therefore, negligible cost. If you save records to a USB drive, there likely is minimal, if any, labor cost. As with paper records, you may not include time spent reviewing the request, organizing the response, or conducting quality assurance.

Supplies - You can also determine your cost for electronic media, such as your cost per CD or USB drive. There should be no charge for supplies associated with email or secure message.

Postage - You can charge for shipping and postage costs.

Average Cost - If you choose to calculate an average cost, then you can perform a time study to determine the average time to burn records to a CD. A worksheet is included in Appendix C.

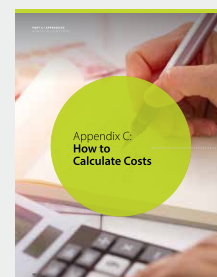
\$6.50 Cap - The \$6.50 amount is only a cap if the records are stored electronically, the patient requests an electronic copy, and you choose to go with an all-inclusive, flat fee. If you calculate that the costs of a particular request or the average costs of electronic copies are more than \$6.50, then you can charge the greater amount. You would need to be able to provide documentation justifying this higher cost. We include a sample spreadsheet for calculating your costs of electronic records in Appendix C.

For example, a patient requests an electronic copy of records that predate your conversion to an EHR. The records are in paper format. The patient would

like you to save the electronic copy to CD and send the CD via two-day delivery. You have a time study that calculated that the cost of labor of scanning documents is \$0.02 per page, and the average labor cost of saving records to CD is \$0.14. The requested document is 300 pages. You purchase CDs and padded CD mailers in bulk for \$0.19 per CD and \$0.30 per mailer. In this example, you can charge \$6 for the labor cost of scanning the pages, \$0.14 for the labor of saving the document to CD, \$0.19 for the CD itself, \$0.30 for the padded CD mailer, and \$6.70 for the shipping via two-day delivery. Accordingly, you can charge \$13.33 for this copy. You are not limited to \$6.50 because: (a) the records were not stored electronically, so the \$6.50 is not applicable; and (b) even if applicable, you are allowed to charge actual or average costs, rather than the flat fee.

List Your Charges (Optional)

While not required, the U.S. Department of Health and Human Services Office for Civil Rights, which administers and enforces HIPAA, suggests listing your copying charges on your website so that patients can understand the different options and the costs of each choice.



Appendix C

Sample Time Study for Calculating Costs of Electronic Copies

The cost of materials and labor can be calculated using the charts below, while shipping costs will be determined based on the chosen method of transmittal (e.g., a commercial carrier like FedEx, a government entity like the U.S. Postal Service, or even a personal messenger).

Cost of Materials

1. Cost of paper
(such as a ream or case of paper)

2. Total number of pages

3. Cost of paper per page
(Line 1 divided by Line 2)

4. Cost of inkjet or toner cartridge

5. Number of pages per inkjet or toner cartridge (manufacturer's guidance on pages per cartridge can be used)

6. Cost of ink per page
(Line 4 divided by Line 5)

7. Average cost of materials per page
(Line 3 plus Line 6)

Cost of Labor

8. Hourly wage of employee performing copying

9. Cost of employee benefits: annual value of paid vacation time of employee performing copying
(hourly wage times number of vacation days times 8 hours per day)

10. Cost of employee benefits: annual value of paid sick leave of employee performing copying
(hourly wage times number of paid sick days times 8 hours per day)

11. Cost of employee benefits: annual value of employer-paid health insurance premiums of employee performing copying

12. Cost of employee benefits: annual value of any other employee benefits of employee performing copying

13. Total annual cost of employee benefits
(Line 9 plus Line 10 plus Line 11 plus Line 12)

Cost of Labor

14. Hourly cost of employee benefits

(assuming 52 workweeks and 40 hours per workweek, for a total of 2,080 hours per year, divide Line 13 by 2,080)

15. Total hourly wage of employee performing copying

(Line 8 plus Line 14)

16. Total time spent copying during time study in hours

(time study should be a period of time that includes multiple patient requests for paper copies, such as a one-week time study if the practice averages one patient request a day, or a one-day time study if the practice receives a significant number of patient requests for paper copies per day)

17. Total labor cost of copying for time study

(Line 15 times Line 16)

18. Total number of pages copied during time study

19. Average cost of labor per page

(Line 17 divided by Line 18)

Total Cost of Paper Copy

20. Total number of pages

21. Total cost of materials

(Line 7 times Line 20)

22. Total cost of labor

(Line 19 times Line 20)

23. Cost of shipping materials, if shipped

24. Cost of postage, if shipped

25. Total cost of paper copy

(Line 21 plus Line 22 plus Line 23 plus Line 24)

Sample Time Study for Calculating Costs of Electronic Copies

(For information originally
maintained on paper)

The cost of labor can be calculated using the charts below, while shipping costs will be determined based on the chosen method of transmittal (e.g., a commercial carrier like FedEx, a government entity like the U.S. Postal Service, or even a personal messenger).

Cost of Labor (Scanning)

1. Hourly wage of employee performing scanning

2. Cost of employee benefits: annual value of paid vacation time of employee performing scanning
(hourly wage times number of vacation days times 8 hours per day)

3. Cost of employee benefits: annual value of paid sick leave of employee performing scanning
(hourly wage times number of paid sick days times 8 hours per day)

4. Cost of employee benefits: annual value of employer-paid health insurance premiums of employee performing scanning

5. Cost of employee benefits: annual value of any other employee benefits of employee performing scanning

6. Total annual cost of employee benefits (Line 2 plus Line 3 plus Line 4 plus Line 5)

7. Hourly cost of employee benefits
(assuming 52 workweeks and 40 hours per workweek, for a total of 2,080 hours per year, divide Line 6 by 2,080)

8. Total hourly wage of employee performing scanning (Line 1 plus Line 7)

9. Total time spent scanning during time study in hours
(time study should be a period of time that includes multiple patient requests for scanned copies, if feasible)

10. Total labor cost of scanning for time study (Line 8 times Line 9)

11. Total number of pages scanned during time study

12. Average cost of labor per page (Line 10 divided by Line 11)

**Cost of Labor
(if burning records to CD
takes significant time)**

13. Average time in hours spent burning patient records to a CD

14. Average labor cost of CD burning
(Line 8 times Line 13)

Total Cost of Scanned Electronic Copy

15. Average cost of labor for scanning per page (Line 12)

16. Total number of scanned pages

17. Total cost of labor for scanning (Line 15 times Line 16)

18. Total labor cost of CD burning, if patient requests CD
(Line 14)

19. Cost of CD or USB drive, if patient requests electronic copy on CD or USB drive

20. Cost of shipping materials (such as padded CD mailer), if patient requests mailing of electronic media

21. Cost of postage, if patient requests mailing of electronic media

22. Total cost of scanned electronic copy
(Line 17 plus Line 18 plus Line 19 plus Line 20 plus Line 21)

Sample Time Study for Calculating Costs of Electronic Copies

To calculate the cost of reproducing records already stored in electronic media, either charge a flat fee of \$6.50, or use the following formula.

Cost of Labor (if burning records to CD takes significant time)

1. Hourly wage of employee performing CD burning

2. Cost of employee benefits: annual value of paid vacation time of employee performing CD burning
(hourly wage times number of vacation days times 8 hours per day)

3. Cost of employee benefits: annual value of paid sick leave of employee performing CD burning
(hourly wage times number of paid sick days times 8 hours per day)

4. Cost of employee benefits: annual value of employer-paid health insurance premiums of employee performing CD burning

5. Cost of employee benefits: annual value of any other employee benefits of employee performing CD burning

6. Total annual cost of employee benefits
(Line 2 plus Line 3 plus Line 4 plus Line 5)

7. Hourly cost of employee benefits
(assuming 52 workweeks and 40 hours per workweek, for a total of 2,080 hours per year, divide Line 6 by 2,080)

8. Total hourly wage of employee performing CD burning
(Line 1 plus Line 7)

9. Average time spent burning patient records to a CD

10. Average labor cost of CD burning
(Line 8 times Line 9)

Total Cost of Electronic Copy

11. Total labor cost of CD burning, if patient requests CD

(Line 10)

12. Cost of CD or USB drive, if patient requests electronic copy on CD or USB drive

13. Cost of shipping materials (such as padded CD mailer), if patient requests mailing of electronic media

14. Cost of postage, if patient requests mailing of electronic media

15. Total cost of electronic copy

(Line 11 plus Line 12 plus Line 13 plus Line 14)

Table of Allowable Fees by State

Medical Records Request Fees

Chart is current as of December 31, 2018. Please refer to the specific statute for current cost.

STATE	STATUTE	COST
Alabama	Code of Alabama § 12-21-6.1	<ul style="list-style-type: none"> • \$1 per page for the first 25 pages • 50¢ per page for each additional page • A \$5 search fee • The cost of shipping • The cost to reproduce special records like X-rays
Alaska	No state limit.	
Arizona	Arizona Revised Statutes § 12-2295.	Reasonable fee for the production of the records
Arkansas	Arkansas Code § 16-46-106.	<ul style="list-style-type: none"> • 50¢ per page for the first 25 pages, • 25¢ per page for each additional page and a \$15 labor charge • Cost of any required postage can also be charged • “Reasonable fees” can be charged for retrieval of records stored off-site and for narrative medical reports
California	California Health & Safety Code, Division 106, Chapter 1, § 123110.	<ul style="list-style-type: none"> • Reasonable, cost-based fee, including labor for copying, supplies for creating a paper copy of electronic media, postage, and, if agreed to by patient, preparing an explanation or summary • Additionally, fee is not to exceed 25¢ per page for paper copies • 50¢ per page from microfilm • No charge permitted for first copy if records are needed to support a claim or appeal regarding eligibility for a public benefit program

Colorado	Colorado Revised Statutes § 25-1-801.	<ul style="list-style-type: none"> • Determined based on HIPAA • “Reasonable fees” defined as: <ul style="list-style-type: none"> • \$18.53 for the first 10 pages • 85¢ per page for the next 30 pages • 57¢ per page for each additional page • Microfilm cost \$1.50 per page • Radiographic studies cost the actual cost of reproduction for each radiograph copy • The cost of shipping and postage • Any electronic media costs • Any applicable taxes • A \$10 fee for certification of the medical records, if requested
Connecticut	Connecticut General Statutes § 20-7c(d).	No charge for medical records requested by a patient, patient’s attorney, or authorized representative “for the purpose of supporting a claim or appeal under any provision of the Social Security Act”
Delaware	Delaware Administrative Code, Title 24, Division 1700, § 16.0.	<ul style="list-style-type: none"> • \$2 per page for the first 10 pages • \$1 per page for pages 11–20 • 90¢ per page for pages 21–60 • 50¢ per page for pages 61 and above • Actual cost of reproduction special records like radiology films, models, photographs, or fetal monitoring strips • The cost of shipping and postage
District of Columbia	D.C. Municipal Regulations § 17-4612.2.	“A reasonable fee for duplicating records”

Florida	Florida Statutes, Title XXIX, Chapter 395, § 3025 Florida Administrative Code § 64B8-10.003. .	<ul style="list-style-type: none">• Hospitals:<ul style="list-style-type: none">• \$1 per page, plus sales tax and actual postage• Non-paper records (such as microfiche) charge not to exceed \$2• Up to \$1 may be charged for each year of requested records, except for records maintained at any licensed facility that primarily provides psychiatric care, or to records of treatment for any mental or emotional condition, or records of substance abuse• Doctors:<ul style="list-style-type: none">• \$1 per page for the first 25 pages• 25¢ for each additional page• The actual cost of reproduction for X-rays and other special kinds of records
Georgia	Official Georgia Code Annotated § 31-33-3, Georgia Dep't of Community Health	<ul style="list-style-type: none">• \$25.88 for search, retrieval, and administrative costs• 97¢ per page for the first 20 pages• 83¢ per page for pages 21–100• 66¢ per page for pages in excess of 100• Full reasonable cost of reproduction for records that are not in paper form, such as radiology films
Hawaii	Hawaii Revised Statutes § 622-57(g).	"Reasonable costs"
Idaho	No state limit.	

Illinois	<p>Illinois Compiled Statutes, Chapter 735, § 5/8-2001(d)</p> <p>State of Illinois Comptroller, Copying Fees Adjustments.</p>	<ul style="list-style-type: none"> • For paper copies: <ul style="list-style-type: none"> • \$1.05 per page for the first 25 pages • 70¢ per page for pages 26–50 • 35¢ per page for pages in excess of 50 • A \$27.91 handling charge • The actual postage or shipping costs • \$1.74 per page for microfiche or microfilm is “the reasonable cost of all duplication of record material or information that cannot routinely be copied or duplicated on a standard commercial photocopy machine such as X-ray films or pictures.” • For electronic copies, records “retrieved from a scanning, digital imaging, electronic information or other digital format in an electronic document,” the cost is 50% of the per-page charge for paper copies
Indiana	<p>Indiana Administrative Code, Title 760, Article 1, Rule 71, § 3</p>	<ul style="list-style-type: none"> • 1 per page for the first 10 pages • 50¢ per page for pages 11–50 • 25¢ per page for pages 51 and higher • The cost of shipping and postage • \$20 labor fee, so long as the first 10 pages are free • \$10 additional if the records are to be provided within two working days • \$20 for certified records
Iowa	<p>Iowa Administrative Code § 876.8.9</p> <p>Iowa Code § 622.10(6).</p>	<ul style="list-style-type: none"> • “The actual cost of production” for producing patient records or images, which cannot “exceed the rates established by the workers’ compensation commissioner for copies of records in workers’ compensation cases” of: <ul style="list-style-type: none"> • \$20 for pages 1–20 • \$20 plus \$1 per page for 21–30 pages • \$30 plus 50¢ per page for 31–100 pages • \$65 plus 25¢ per page for 101–200 pages • \$90 plus 10¢ per page for more than 200 pages • The cost of postage • \$10 for certified records
Kansas	<p>No state limit.</p>	

Kentucky	Kentucky Revised Statutes § 422.317	<ul style="list-style-type: none">• First copy is free• \$1 per page may be charged “for furnishing a second copy of the patient’s medical record upon request either by the patient or the patient’s attorney or the patient’s authorized representative.”
Louisiana	Louisiana Revised Statutes § 40:1165.1	<ul style="list-style-type: none">• For paper records:<ul style="list-style-type: none">• \$1 per page for the first 25 pages• 50¢ per page for pages 26–300• 25¢ per page for pages 301 and higher• A handling charge not to exceed \$25 for hospitals, nursing homes, and other health care providers• Cost of actual postage• For electronic copy of electronic records, same as paper records capped at \$100 plus postage• For electronic copy of mix of electronic and paper records, same as paper records but the costs associated with the portion maintained electronically is capped at \$100
Maine	Maine Revised Statutes, Title 22, Subtitle 2, Part 4, Chapter 401, § 1711-A.	<ul style="list-style-type: none">• Hospitals:<ul style="list-style-type: none">• For paper copies<ul style="list-style-type: none">• \$5 for the first page• 45¢ for each additional page• Maximum of \$250 for the entire medical record• For electronic copies, “reasonable actual costs of staff time to create or copy the medical record and the costs of necessary supplies and postage,” not to exceed \$150• Doctors:<ul style="list-style-type: none">• For paper copies<ul style="list-style-type: none">• \$5 for the first page• 45¢ for each additional page• Maximum of \$250 for the entire treatment record or medical report• For electronic copies, “reasonable actual costs of staff time to create or copy the treatment record or medical report and the costs of necessary supplies and postage,” not to exceed \$150

Maryland	Code of Maryland, Health – General § 4-304(c)(3)	<ul style="list-style-type: none"> • For paper copies <ul style="list-style-type: none"> • 76¢ per page plus the actual cost for postage and handling • \$22.88 retrieval and preparation fee (subject to HIPAA) • For electronic copies <ul style="list-style-type: none"> • 57¢ per page plus the actual cost for postage and handling • \$22.88 retrieval and preparation fee (subject to HIPAA)
Massachusetts	Massachusetts General Laws, Chapter 111, § 70 Code of Massachusetts Regulations, Title 243, § 2.07(13)(d)	No charge for medical records requested by “any applicant, beneficiary or individual representing said applicant or beneficiary if the record is requested for the purpose of supporting a claim or appeal under any provision of the Social Security Act”
Michigan	Michigan Compiled Laws § 333.26269.	<ul style="list-style-type: none"> • One free copy of a patient’s medical records for “a medically indigent individual” • Additional or other requests: <ul style="list-style-type: none"> • \$24.48 per request plus • \$1.22 per page for the first 20 pages • 61¢ per page for pages 21–50 and • 24¢ per page for pages 51 or more <p>*No initial fee for a patient’s own medical records</p>

Minnesota	Minnesota Statutes § 144.292, subdivision 6, paragraph (d).	<ul style="list-style-type: none"> • \$10 retrieval fee only for “copies of records requested by a patient or the patient’s authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act.” For further appeals, “a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided.” • No fee for “a person who is receiving public assistance, who is represented by an attorney on behalf of a civil legal services program or a volunteer attorney program based on indigency.”
Mississippi	Mississippi Code Annotated § 11-1-52(1)	<ul style="list-style-type: none"> • \$20 total for pages 1–20 • \$1 per page for the next 80 pages • 50¢ per page for any additional pages • 0% of the total charges for postage and handling • Extra \$15 for retrieval of records stored off-site
Missouri	Missouri Revised Statutes § 191.227.	<ul style="list-style-type: none"> • For paper copies <ul style="list-style-type: none"> • \$25.51 search and retrieval fee plus • 59¢ per page • Extra \$23.88 for retrieval of records stored off-site • Packaging and delivery costs • A \$2 notary fee is applicable • For electronic copies <ul style="list-style-type: none"> • \$25.51 search and retrieval fee plus • 59¢ per page or \$111.79 total, whichever is less • Packaging and delivery costs • A \$2 notary fee is applicable
Montana	Montana Code Annotated § 50-16-540	<ul style="list-style-type: none"> • \$15 administrative fee for searching and handling plus • 50¢ per page for paper copies
Nebraska	Nebraska Revised Statute § 71-8405	No charge for records for use in supporting an application for disability benefits or an appeal relating to the denial of such benefits under Title II, Title XVI, or Title XVIII of the Social Security Act.

Nevada	Nevada Revised Statutes § 629.061(5)	<ul style="list-style-type: none"> • One free copy for records “necessary to support a claim or appeal under any provision of the Social Security Act... if the request is accompanied by documentation of the claim or appeal.” • For additional copies, 60¢ per page plus • “A reasonable cost for copies of x-ray photographs and other health care records produced by similar processes”
New Hampshire	New Hampshire Revised Statutes, Title XXX, § 332-I:1	<ul style="list-style-type: none"> • \$15 total for the first 30 pages or 50¢ per page, whichever is greater • A “reasonable cost” for providing special records like “filmed records,” including radiograms, X-rays, and sonograms
New Jersey	New Jersey Administrative Code § 8:43G-15.3(d) New Jersey Administrative Code § 13:35-6.5(c).	<ul style="list-style-type: none"> • Hospital: <ul style="list-style-type: none"> • \$10 search fee per request plus • \$1 per page or \$100 per record for the first 100 pages • 25¢ per page for additional pages up to a maximum of \$200 for the entire record • Shipping and postage costs • Doctors: <ul style="list-style-type: none"> • \$1 per page or \$100 for the entire record, whichever is less • \$10 to cover shipping, postage, and retrieval costs if the record is less than 10 pages • Cost of duplication for special records like X-rays or “any other material within a patient record which cannot be routinely copied or duplicated on a commercial photocopy machine” plus • An administrative fee of the lesser of \$10 or 10% of the cost of reproduction
New Mexico	New Mexico Administrative Code § 7.1.10.10	<ul style="list-style-type: none"> • \$2 per page for the first 10 (one-sided) pages • 20¢ per page for each additional page
New York	New York Public Health Law § 17	No charge if requested “for the purpose of supporting an application, claim or appeal for any government benefit or program...”

North Carolina	North Carolina General Statutes § 90-411	<ul style="list-style-type: none"> • 75¢ per page for the first 25 pages • 50¢ per page for pages 26–100 • 25¢ per page for each page over 100 • Minimum fee of \$10
North Dakota	North Dakota Century Code § 23-12-14.2	<ul style="list-style-type: none"> • For paper copies <ul style="list-style-type: none"> • \$20 total for the first 25 pages • 75¢ per page for each additional page • For electronic copies <ul style="list-style-type: none"> • 30 total for the first 25 pages • 25¢ per page for each additional page
Ohio	Ohio Revised Code § 3701.741(C)(1)(e).	One free copy plus one free copy of any updated records to a patient or his/her representative “if the medical record is necessary to support a claim under Title II or Title XVI of the Social Security Act”
Oklahoma	Oklahoma Statutes § 76-19(A)(2).	<ul style="list-style-type: none"> • For paper copies <ul style="list-style-type: none"> • 50¢ per page • \$5 each for special records like X-rays or other photographs, images, or pathology slides • For attorneys, an additional \$10 base fee is permitted, plus postage or delivery fees • For electronic copies <ul style="list-style-type: none"> • 30¢ per page plus delivery fees, not to exceed \$200
Oregon	Oregon Revised Statutes § 192.576	One free copy for a patient or his/her attorney or representative if records fall within the period from the date of the alleged onset of disability to the date of the administrative hearing to support an appeal of the denial of Social Security disability benefits
Pennsylvania	Pennsylvania Consolidated Statutes, Title 42, Chapter 1, § 6152.1	<p>Effective January 1, 2020</p> <p>\$29.19 flat fee for production of records “requested for the purpose of supporting a claim or appeal under any provision of the Social Security Act”</p>
Puerto Rico	No limit specified.	

Rhode Island	Rhode Island General Laws § 23-17-19.1(16).	No charges for a patient or his/her attorney or representative if “necessary for the purposes of supporting an appeal under any provision of the Social Security Act”
South Carolina	South Carolina Code of Laws § 44-7-325	<ul style="list-style-type: none"> • 68¢ per page for the first 30 pages • 52¢ per page for each additional page • Clerical fee of up to \$26.30 for searching and handling • Postage • Sales tax • Cap of \$157.80 (including search and retrieval fee) for copying costs for electronic copies, plus postage and sales tax • Actual cost for reproduction of X-rays • No charge for copies for a health care provider for continuing medical care
South Dakota	No state limit.	
Tennessee	Tennessee Code Annotated § 63-2-102 Tennessee Code Annotated § 68-11-304.	<ul style="list-style-type: none"> • Hospital: <ul style="list-style-type: none"> • No charge for medical records for an “indigent person” to support a claim or appeal under any provision of the Social Security Act or patients represented by organizations that provide legal assistance to the indigent, or attorneys with an affiliated pro bono program • For non-indigent patients: <ul style="list-style-type: none"> • \$18 fee, which includes the first 5 pages • 85¢ for pages 6–50 • 60¢ per page for pages 51–250 • 35¢ per page for subsequent pages • \$20 for each certified record • Doctors: <ul style="list-style-type: none"> • \$20 total for records 5 pages or less • 50¢ per page for each page over the first 5 pages • The actual cost of mailing • \$20 for certified records

Texas	Texas Health & Safety Code § 161.202	One free copy if requested by a patient, former patient, or his/her attorney or representative for use in supporting an application for or appeal of disability benefits under Title II, Title XVI, or Title XVIII of the Social Security Act
Utah	Utah Code § 78B-5-618.	<ul style="list-style-type: none"> • For paper copies <ul style="list-style-type: none"> • \$21.16 search fee per request plus • 53¢ per page for the first 40 pages • 32¢ per page for each additional page • The cost of postage and any applicable sales tax • For electronic copies <ul style="list-style-type: none"> • 26.5¢ per page for the first 30 pages • 16¢ per page for each additional page
Vermont	Vermont Statutes Annotated, Title 18, § 9419(a)	No charge if “requested to support a claim or an appeal under any provision of the Social Security Act”
Virginia	Code of Virginia § 32.1-127.1:03 Code of Virginia § 8.01-413	<p>A reasonable cost-based fee, which shall include only the cost of supplies for and labor of copying the requested information, postage when the individual requests that such information be mailed, and preparation of an explanation or summary of such information as agreed to by the individual</p> <p>If requested by an attorney:</p> <ul style="list-style-type: none"> • Paper copies <ul style="list-style-type: none"> • 50¢ per page for the first 50 pages • 25¢ per page for each additional page • \$1 per page for hard copies from microfiche • \$20 clerical fee for search and handling • Postage • Shipping costs • Electronic copies <ul style="list-style-type: none"> • 37¢ per page for the first 50 pages • 18¢ per page for each additional page • \$20 clerical fee for search and handling • Postage • Shipping costs • Limited to \$150 total

Washington	<p>Revised Code of Washington § 70.02.010(37)</p> <p>Revised Code of Washington § 70.02.030(2)(b).</p>	<ul style="list-style-type: none"> • 65¢ per page for the first 30 pages • 50¢ per page for each additional page • \$15 clerical fee • One free copy of a patient’s medical records every two years “if the patient is appealing the denial of” SSI or Social Security disability benefits, requested by a patient or his/her “personal representative”
West Virginia	<p>West Virginia Code § 16-29-2.</p>	<ul style="list-style-type: none"> • One free copy of a patient’s medical records for an “indigent person” Social Security Act claims or appeal • Additional patient requests or requests by non-indigents, “a fee consistent with HIPAA... plus any applicable taxes”
Wisconsin	<p>Wisconsin Statutes § 146.83(1f)(am).</p>	<p>Charges cannot exceed the “amount that the federal Social Security Administration reimburses the department for copies of patient health care records” for records to be used in the appealing of a denial of a Social Security disability insurance or Supplemental Security Income claim</p>
Wyoming	<p>Wyoming Administrative Rules, Board of Medicine, Chapter 3: Practice of Medicine, § 4(e).</p>	<p>“Reasonable charges, and charge a patient for the actual costs incurred in responding to a patient’s request” for medical records, including “the cost of copies, clerical staff time and the physician’s time in reviewing and summarizing the records and/or x-rays and diagnostic records, if necessary.”</p>



Appendix D:
**Sample
Forms**

PATIENT RECORD REQUEST FORM

You have the right to inspect and obtain a copy of your medical and billing records that we maintain. If you request copies of your records, we will notify you of any charge.

Patient Information: (Individual whose information will be released)

Name:

(First, Middle, Last)

Date of Birth:

(Month/Day/Year)

Address:

(Street, City, State, Zip Code)

Description of requested records:

Records requested from:

(Date)

to

(Date)

Please indicate whether you want to inspect your records or obtain a copy of your records:

- Inspect Obtain a copy on:
- CD
 - USB Drive
 - Paper records
 - Secure message (will require a login)
 - Unencrypted email (By choosing this option, you understand that there is a risk that the requested information could be viewed by an unauthorized person when transmitted over the internet)
 - Other preferred form and format:

If you are requesting to obtain a copy:

- For pickup
- Mail to the following physical address:

Name

Street

City

State

Zip Code

- Email or send secure message to the following email address: _____

Print Name:

Relationship (if authorized representative of patient):

Signature:

Date:

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the patient (e.g., Health Care Power of Attorney).

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize the use and disclosure of my health information as described below:

1. This authorization applies to the following information:

- Entire Medical Record
 - All Billing Records
 - Other (please specify):
-

Time Period: From _____ to _____

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my health information:

- All past, current, and future health care providers
 - The following health care providers (please specify):
-

3. I authorize the following persons (or class of persons) to receive my health information *[name or describe specifically]*:

4. Purpose of proposed use or disclosure (for example, "marketing purposes"):

5. This authorization expires *[Insert a date or event on which the authorization will expire.]*:

REFUSAL TO SIGN:

You may refuse to sign this authorization. We may not condition treatment, payment, enrollment, or eligibility for benefits on your providing or refusing to provide this authorization.

REDISCLASURE:

If you have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.

REVOCATION:

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to _____. You may deliver your revocation by any means you choose (e.g., personally or by mail), but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this authorization.

AUTHORIZATION

I understand and agree to the foregoing:

Sign:

Date:

Print name of patient:

If you are signing as the patient's representative:

Print your name:

Describe your authority:

AUTHORIZATION FOR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS

I request the disclosure of my substance use disorder treatment information as described below:

1. This authorization applies to the following information:

- All substance use disorder treatment information
- Only a portion of my substance use disorder treatment information (please specify):

Time Period: From _____ to _____

2. I authorize the following substance use disorder treatment program(s) to make the disclosure of my substance use disorder treatment information:

3. I authorize the following persons to receive my health information [Unless disclosure is to a treating provider or third-party payer, the specific name of an individual is required].

4. Purpose of proposed use or disclosure:

At patient's request

5. This authorization expires [Insert a date or event on which the authorization will expire]:

REVOCAATION:

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to _____. You may deliver your revocation by any means you choose (e.g., personally or by mail), but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this authorization.

AUTHORIZATION

I understand and agree to the foregoing:

Sign: _____

Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____

REQUEST FOR ACCESS - NOTICE OF DENIAL LETTER

<Date>

<Name and Address of Requester>

Dear <____>:

We have received and reviewed your request for a copy of your health information record dated ____.

Unfortunately, we cannot honor all or part of your request because:

- The requested information falls outside of the “designated record set,” meaning that it is not used to make decisions about you (not reviewable)
- The requested information is contained in psychotherapy notes, which are personal notes of a mental health professional (not reviewable)
- The requested information was compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding (not reviewable)
- The requested information was created or obtained in the course of research that includes treatment, and you previously agreed that access to information would be suspended until completion of the research (not reviewable)
- The requested information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information (not reviewable)
- A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of you or another person (reviewable)
- The requested information makes reference to another person (other than a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person (reviewable)
- The request for access is made by the patient’s personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the patient or another person (reviewable)

If the above basis for denying you access to your health information is identified as “(reviewable),” then you have the right to request review of the decision by a licensed health care professional who we designate and who did not participate in the original decision to deny access. You may request such a review by contacting <insert name/title of person> at our office at <insert telephone number and address>.

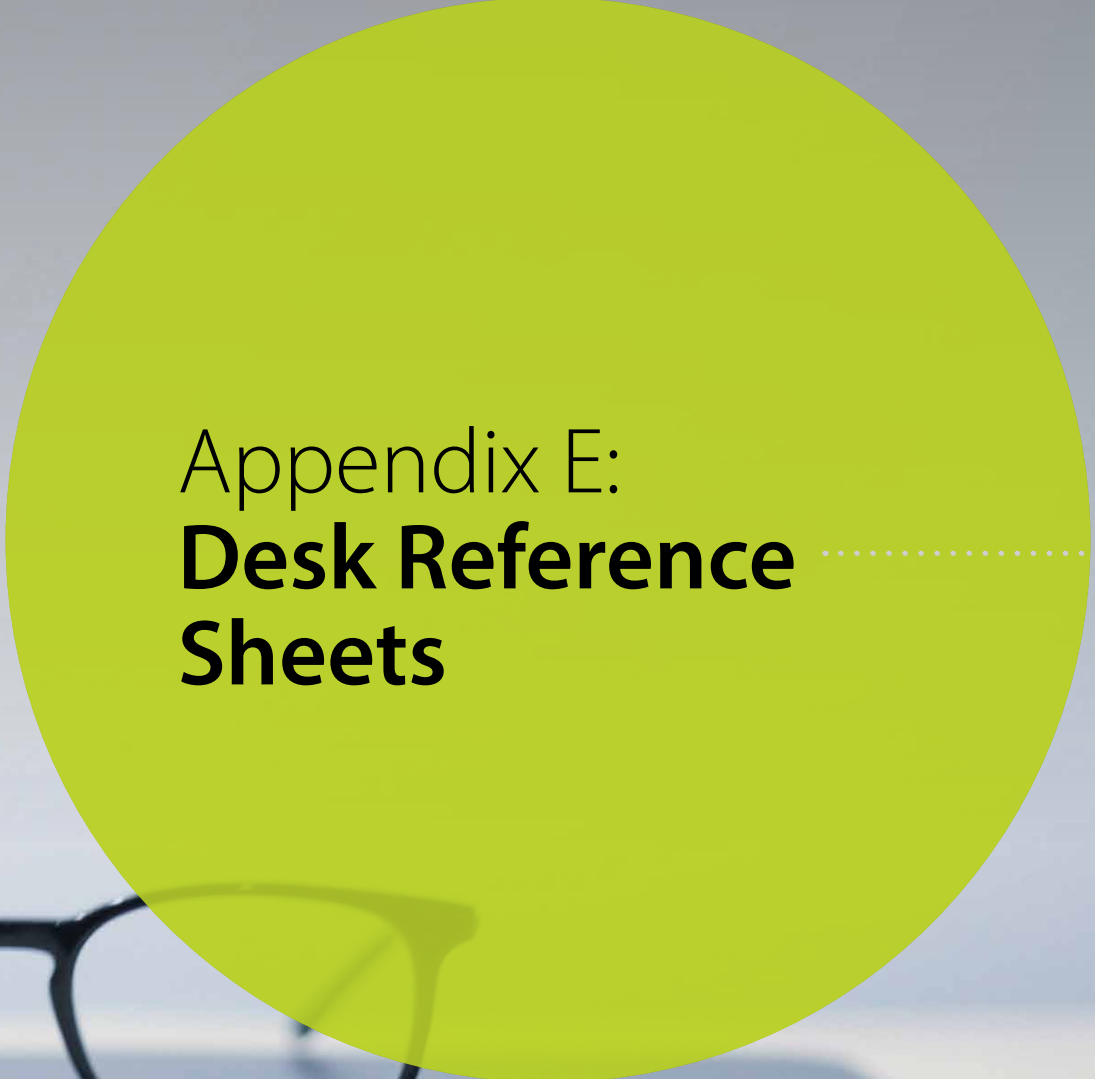
This denial applies to ALL or PART of the information you requested. If we are denying only part of your request, you will be given access to the remaining information after we have excluded the parts which are inaccessible for you.

If you believe your privacy rights have been violated, you may deliver a written complaint to <insert name/title of person> at our office at <insert telephone number and address>. You may also file a complaint with the Secretary of Health and Human Services. We respect your right to file a complaint with us or with the Secretary of Health and Human Services. If you choose to take this action, no one will retaliate or take action against you for filing a complaint.

Sincerely,

<insert name/title of person>

- ⁱ The Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1320d to 1320d-9, and its implementing regulations at 45 C.F.R. parts 160 to 164 (collectively, "HIPAA").
- ⁱⁱ 45 C.F.R. § 164.524.
- ⁱⁱⁱ Cal. Health and Safety Code § 123110.
- ^{iv} Tex. Health and Safety Code § 181.102.
- ^v Flor. Stat. § 456.057(6).
- ^{vi} 45 C.F.R. § 170.315(e)(1).
- ^{vii} 45 C.F.R. § 170.202.
- ^{viii} Merit-Based Incentive Payment System (MIPS) Advancing Care Information Performance Category Measure 2018 Performance Period: Patient Electronic Access, Centers for Medicare & Medicaid Services, https://qpp.cms.gov/docs/pi_specifications/Measure%20Specifications/2018.MIPS%20ACI%20Measure_Provide%20Patient%20Access.pdf.
- ^{ix} Cal. Civ. Code § 56.11.
- ^x Tex. Health and Safety Code § 181.102.
- ^{xi} Cal. Health and Safety Code § 123110.
- ^{xii} Merit-Based Incentive Payment System (MIPS) Advancing Care Information Performance Category Measure 2018 Performance Period: Patient Electronic Access, Centers for Medicare & Medicaid Services, https://qpp.cms.gov/docs/pi_specifications/Measure%20Specifications/2018.MIPS%20ACI%20Measure_Provide%20Patient%20Access.pdf.
- ^{xiii} Cal. Civ. Code § 56.11.
- ^{xiv} Individuals Rights under HIPAA to Access their Health Information, U.S. Department of Health & Human Services Office for Civil Rights, <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html>.



Appendix E:
**Desk Reference
Sheets**

Key Points to Remember

It is critical that your office remember the following key points:

- Patients have a **right** to view or obtain a copy of their medical and billing information.

- There are limitations to what and how much can be charged for patients' records. Providing access to your patients' records should not be viewed as a revenue-generating opportunity. Electronic access, in particular, should be available for little or no cost. More information can be found in Appendix C.

- Patients are not required to use the patient portal and can obtain copies of their medical information through alternative means.

- If a patient requests a copy of medical information, have the patient fill out a patient request form. A sample form is included in Appendix D.

- A patient's access cannot be denied simply because the practice believes that access is not in the patient's best interest.

- A patient can receive her medical records through unencrypted email if warned of the risk of unauthorized access in transit.

- If a request comes from a third party and does not appear that it is at the patient's direction, then a HIPAA-compliant authorization form is required. A sample authorization form is included in Appendix D. If you are unsure whether a third-party request is at the patient's direction or the third-party's direction, then we recommend contacting the patient to confirm that the request is at their direction.

- If a patient would like a copy of their medical record sent to a third party, they have a right to have the practice do so.

- Your patients may be eager to receive their records for any number of reasons, including needing to schedule additional appointments with specialists. Try to let your patients and their caregivers know when you have received their record request and, if possible, an estimated timeline for when they can expect to receive the records. This type of communication can help to relieve significant anxiety and improve trust and communication between the practice and your patients. It can also help eliminate redundancy and inefficiency while improving patient safety and outcomes. Also consider implementing a system allowing patients to flag emergency requests versus those that are more routine.

- Remember that many patients are sick and have asked family members or other caregivers to help them access their records. Try to work with these caregivers to provide access in accordance with the patient's wishes. You can always call the patient if you need to double-check about whether to give the caregiver a record.





Patient Records Request Flowchart

