

RECORDS AND FORMS MANAGEMENT 5.0

Clinical Records -- 5.1

Release of Medical Information Outside the Health Department -- 5.1.c

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Signature:



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APPLICABILITY

This policy applies to Local Health Department, Regional and Central Office personnel.

PURPOSE

To facilitate patient management while protecting the confidentiality of all patients.

DEFINITIONS

A medical record is defined as all records kept electronically or on paper, printed forms, cards, tape, flash drives, disk, or any other information storage/transmitting media devices of medical histories, reports and summaries, diagnoses, prognoses, records of treatment and medication ordered and given, X-ray and radiology interpretations, physical therapy charts, notes, lab reports, and dental records.

POLICY

In general, written authorization must be obtained from the patient, the patient's parent, guardian, or legal representative to disclose information from a medical record to entities other than health departments in the state of Tennessee. The Department of Children's Services qualifies as the guardian of a minor if the minor is in its custody.

Verbal authorization is acceptable when obtained from the individual patient requesting his/her own medical records.

Medical records of deceased individuals are still subject to protection under HIPAA for 50 years after the date of death. Releases are permitted to coroners and medical examiners upon receipt of a written request indicating the information is necessary to carry out their duties. Written authorization must be obtained for releases to individuals who have been involved in the care or the payment for care of the individual before death, at the request of the next of kin, and at the request of the legal representative of the deceased individual.

Please note that some disclosures do not require an authorization, and other disclosures can only be authorized by the patient himself/herself.

A. Disclosures that do not require authorization

Authorization from the patient or the patient's parent, guardian, or legal representative is not required to disclose medical records pursuant to the following requests:

- Requests from medical personnel to protect the health or life of the patient in an emergency
- Requests from other healthcare providers or healthcare organizations in order to treat the patient or to continue the care of the patient
- Requests from public health agencies for purposes of preventing, treating, or controlling disease or for conducting public health surveillance activities
- Requests issued via a valid subpoena, court order, or other legal request approved by the Office of General Counsel
- Requests from a patient's health plan for payment or the plan's Health Plan Employer Data and Information Set (HEDIS) purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan

B. Disclosures that can only be authorized by the patient

Certain types of information contained in a medical record are subject to enhanced privacy protections under state and federal law. Unless a disclosure request falls under section A, the patient himself/herself must authorize the release of the following records:

STD (including HIV) Records

Any STD/HIV information in a patient's medical record can only be disclosed pursuant to a request under Section A or a written authorization from the patient specifying the release of STD/HIV information. Parents, guardians, and legal representatives cannot access these records or authorize their disclosure on behalf of the patient.

Family Planning and Prenatal Records of Minors (patients under the age of 18 years)

If a minor has consented to family planning and prenatal services, then parents and/or legal guardians cannot access these records or authorize their disclosure without the minor's consent. These records can be disclosed pursuant to a request under Section A. For adults, family planning records should be treated as regular medical records.

PROCEDURE

The procedure to be followed in releasing medical information is guided by the type of information to be released; the agency or individual to whom information is to be released; and the circumstances under which the release of information occurs.

To release medical information about a patient, proper authorization (whether written or verbal) must be obtained with the above stated exceptions. The [Release of Medical Record Information, PH-1778](#), or the [TDH Referral Form, PH-2126](#), (recommended in those cases where the health department expects to receive health related information back from the treating physician/agency) may be used for written authorization purposes.

All forms of written authorization are to become part of the patient's medical record. All verbal authorizations are to be documented in the patient's medical record. When obtaining verbal authorization, appropriate verifications must be taken to ensure proper identity of the patient (verify with Social Security Number and Date of Birth).

Faxing of medical records is an acceptable procedure when the required authorization for release (as specified in this policy) is obtained and when the recipient fax number is verified prior to transmitting information.

Medical records may be released upon receipt of a subpoena or court order. Prior to responding to the subpoena or court order, health department staff must contact the Office of General Counsel. See [Policy 3.13](#) for further information on an employee's responsibility related to a subpoena or court order.

Patients who enroll in TDH care coordination programs are informed of the need to share specific types of information with other agencies and health providers prior to agreeing to enroll in those programs and must sign a program specific enrollment and/or release form. These forms serve as written authorization; therefore, the Release of Medical Record Information, PH-1778, or TDH Referral Form, PH-2126, need not be used for these patients.

NECESSARY FORMS

1. [Release of Medical Record Information, PH-1778](#)
2. [TDH Referral Form, PH-2126](#)

REFERENCE DOCUMENTS

1. [T.C.A. § 68-10-113](#)
2. [T.C.A. § 38-7-117](#)
3. 42 C.F.R. § 164.502
4. 42 C.F.R. § 164.512
5. 45 C.F.R. § 160.203
6. 45 C.F.R. § 164.510

OFFICE OF PRIMARY RESPONSIBILITY

Office of the Medical Director, Community Health Services, (615)253-3407

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- Epidemiological activities are addressed by the Communicable Disease laws and regulations and, therefore, are not covered under this policy.
 - Immunization information is addressed by program rules and, therefore, is not covered under this policy. See [Policy 5.1.d](#) for information on the release of immunization information.