

RECORDS AND FORMS MANAGEMENT 5.0

Confidentiality -- 5.2

Patient Access to Personal Medical Records -- 5.2.b

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Date Last

Revised:

Signature:

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POLICY

All patients shall have access to the information in their personal medical record, in accordance with the "Client Access to Records Act."

APPLICABILITY

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

PURPOSE

To guarantee a patient access to his/her personal health information.

PROCEDURE

Except as otherwise provided by law or subpoena, personnel shall furnish to a patient or a patient's authorized representative a copy of such patient's medical record within ten working days of a written request by the patient or authorized representative. Failure to comply with the ten day timeframe can result in disciplinary actions against the licensed provider by the Board of Medical Examiners.

The staff member responsible for maintaining the medical record system in each facility is responsible for screening and confirming the identity of each patient who requests a copy of their medical record or requests to see information in their personal medical record. Once the identity of the patient is confirmed, medical personnel must be present while the patient is viewing the record or notified before a copy is made and given to the

patient. If, however, the patient requests to see or obtain a copy of their immunization record, medical personnel do not need to be present or notified.

If medical personnel are not available, or if there is a question as to the patient's identity, the health department may have a period of up to ten working days to respond to the patient's request. If such a situation occurs and is not satisfactory to the patient, or if any other problem is involved with the request, the Regional Office should be contacted for direction in managing the request.

All instances of record access or copying, except for internal routing purposes and audits, must be documented and attached to or stored in the patient's medical record. Documentation should consist of the date of access and the patient's purpose for accessing the record.

REFERENCE DOCUMENT

[T.C.A. 63-2-101](#)

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OFFICE OF PRIMARY RESPONSIBILITY

Office of the Director, Bureau of Health Services, (615)741-7305