Policy & Procedure

Life Science RDD Services	**FUNCTION**
HIPAA / PRIVACY **DESIGNATED RECORD SET**	**NUMBER**
	PRIOR ISSUE
	EFFECTIVE DATE 12/13/18

PURPOSE

To describe the documents that comprise the Designated Record Set.

POLICY

The HIPAA Privacy Rule requires that patients be permitted to request access and amendment to their Protected Health Information ("PHI") that is maintained in a Designated Record Set. This policy documents the contents of the Designated Record Set.

PROCEDURE

1. The Designated Record Set is a group of records maintained by or for the Facility that consists of the Medical Records and billing records about a patient and is used, in whole or in part, by or for the Facility to make decisions about the patient. The term *record* means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for the Facility.
2. The Facility maintains the following as the Designated Record Set:
   a. The patient's Medical Record,
   b. The patient's Business Office File, and
   c. The patient's Personal Health Records.
3. The Patient Medical Record includes, at a minimum, the following:

- Activity documentation
- Admission/readmission documentation
- Advance directives
- Assessments, flow sheets
- Care plan
- Informed consent
- History and physical exams and other related hospital records
- Minimum Data Set
- Medication and treatment records
- Nursing documentation/progress notes
- Nutritional services documentation
- Physician and professional consultant progress notes
- Physician's orders
- Reports from lab, x-ray and other diagnostic tests
- Face sheet

a. Excluded from the Medical Record are source data, including photographs, films, monitoring strips, videotapes, slides, worksheets and daily communication sheets, and shadow files or charts, unless such data is used to make decisions related to the patient's care.

b. If records from other providers are used by the Facility to make decisions related to the care and treatment of the patient, then these records are considered part of the Designated Record Set as well as the Medical Record, e.g., history and physical, discharge summary and labs from previous acute care hospitalization.

4. The Patient's Business Office File includes, at a minimum, the following:

- Admission documents
- Acknowledgement of receipt of the Facility's *Notice of Privacy Practices*
- Correspondence relating to coverage and payment from insurance companies, health plans, Medicare, Medicaid and other payor sources
- Patient claim information, including claim, remittance, eligibility response, and claim status response
- Statements of account balance
- Collection activity documents and correspondence

5. Personal Health Records consist of the patient's personal health information provided to the Facility by the patient. If such records are used by the Facility to make health care related decisions, provide care services, or document observations, actions or instructions, then the records will be considered part of the Designated Record Set.

6. The following are excluded from the Designated Record Set: Administrative data, such as audit trails, appointment schedules and practice guidelines that do not imbed PHI. Also excluded are incident reports, quality assurance data, vital certificate worksheets, and derived data such as accreditation reports, anonymous patient data for research purposes, public health records and statistical reports.

7. The Designated Record Set is to be retained according to state and federal regulations and following Facility or company retention procedures.