Background

Individuals have the right to inspect, obtain a copy, and request amendments to protected health information (PHI) about themselves. PHI includes medical record and billing information maintained in a “designated record-set.” An individual has the right to access the designated record set as long as it is maintained. The purpose of this policy is to identify those records that comprise the designated record set.

Definitions

- Designated record set: a designated record set is a group of records consisting of one or more of the following types of information about individuals:
  - Medical and billing records,
  - Information about health plan enrollment, payment, claims adjudication, and case or medical management record systems, and
  - Other information used to make healthcare decisions.

- Protected Health Information (PHI): Protected health information is a subset of individually identifiable health information maintained in health records and/or other clinical documentation in either paper-based or electronic format.

Policy

At UW Medicine, designated record sets are maintained by the particular entity that provides medical treatment to the individual. The entity controls access to the designated record set. The entity retrieves information from the designated record set by utilizing the name, identifying number, symbol, or other identifier-assigned to the individual. The record and data are the property of UW Medicine entities. UW Medicine classifies designated record sets as follows:
I. Legal Medical Record includes:
   • Documentation of UW Medicine healthcare services provided to an individual (e.g. healthcare professional's documentation, discharge summaries, orders, assessments, consultation reports, care plans, consents, advance directives, etc.);
   • Individually identifiable data, in any medium, collected or directly used in and/or documenting healthcare or health status. This includes paper-based medical records, imaged records and enterprise electronic medical records;
   • Healthcare records from all UW Medicine settings, including inpatient and ambulatory areas; and
   • Healthcare records that UW Medicine has accepted from other healthcare professionals.

II. Billing Record includes:
   • Patient-identifiable claims,
   • Other patient identifiable data used for payment purposes, and
   • UW Medicine supporting documentation for the reimbursement of services provided to the patient.

III. Exclusions to the Designated Record Set:
   The designated record set excludes records that do not pertain to medical treatment, billing, insurance coverage, payment, or claim adjudication, and are not otherwise used to make decisions about the individual. Examples of excluded records include:
   • “Shadow” records. Files maintained by clinicians that contain only copies of information otherwise located in the designated record set. Shadow records contain no new or original documents and are maintained merely for the convenience of clinicians.
   • Quality Improvement. Risk management records, quality assessment and improvement records, and peer review records that are used for operational analyses and not for making decisions about patients.
   • Psychotherapy Notes. Psychotherapy notes are notes, recorded in any medium, by a behavioral health professional, 1) analyzing or detailing the explicit contents of conversation during a private counseling session or a group, joint, or family counseling session, and 2) that are separated from the rest of the individual’s medical record. Examples of Psychotherapy Notes include documentation of intimate personal content, details of fantasies and dreams, process interactions, sensitive information about other individuals in the patient’s life, or the behavioral healthcare professional's personal reactions, hypotheses, or speculations as a result of a patient or group interaction. (Also see UW Medicine Privacy Policy: PP17-Psychotherapy Notes Management.)
• Source systems’ data. Data from non-electronic medical record systems other than what is extracted to create interpretations or summarizations that are maintained in the Legal Medical Record or Billing Record and to make healthcare decisions.

References

• 45 CFR Part 160 and 164; Sections 164.501; 164.524(a), (b), (c), (e); 164.526(a), (b), (c), (d), (e)

Cross References

• UW Medicine Health Information Management Policy 1 – Definition, Retention and Disclosure of the Legal Medical Record.

Approvals

_________________________________________________ __________________________
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Additional Contacts

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