**PURPOSE**

To describe the documents that comprise the Designated Record Set.

**POLICY**

The HIPAA Privacy Rule gives individuals the right to inspect, amend, and obtain copies of 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 [COVERED ENTITY] that consists of the medical records, billing records, and any other records that are used in whole or in part by or for [COVERED ENTITY] to make decisions about any individuals, whether or not the records have been used to make a decision about the particular individual requesting access. The term record means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for [COVERED ENTITY]. Records that are otherwise included within the definition of the Designated Record Set but that are maintained by a Business Associate are also part of the Designated Record Set.
2. An individual’s medical record, in any medium, includes:
	1. Documentation by health care professionals while providing patient care services, for reviewing patient data, research or clinical trials, and documenting observations, actions, or instructions.
		1. Examples of these documents include but are not limited to: care plans, progress notes, consents, consultation reports, immunization records, medication orders, nursing assessments, patient submitted documents, telephone consultations, lab orders/reports, etc.
	2. Records received from other institutions that are incorporated into the Designated Record Set.
	3. External records, which are records that were not created by [COVERED ENTITY] or that did not originate at [COVERED ENTITY], are considered part of the Designated Record Set if they are used by [COVERED ENTITY] to make decisions related to the care and treatment of the individual.
3. Examples of Records Included in the Designated Record Set include:
	1. History and Physical examinations and reports
	2. Orders
	3. Progress notes
	4. Laboratory reports
	5. Consultation reports
	6. Psychosocial history reports
	7. Photographs or videos
	8. Authorizations and consents, including research consents related to health care treatment decisions
	9. Inpatient and Outpatient records
	10. Emergency Department records
	11. X-rays, Imagining and Radiology reports, films, digital copies of films
	12. Pathology reports and slides
	13. Procedure and Operative reports
	14. Vital signs
	15. Psychiatric Assessments and Evaluations
	16. Billing records
	17. Remittance advice
	18. Case management records
	19. Other records that are used to make health care decisions about the patient (e.g., other diagnostic tests and results; interpretive reports)
4. The following are excluded from the Designated Record Set, even if they include PHI, because they are not used to make health care decisions about individuals. Accordingly, individuals do ***not*** have a right to access these records for any purpose(s):

* 1. Administrative data, such as audit trails, appointment schedules, and practice guidelines that do not imbed PHI.
	2. 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.
	3. Health information that is not used to make decisions about the patient such as data collected and maintained for research, peer review, or performance improvement purposes; appointment and surgery schedules, birth and death registers, and surgery registers.
	4. Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g(a)(4)(B)(iv) such as immunization records.
	5. Employer Records held by a health plan or health care provider in its role as employer, such as pre-employment physicals, workers’ compensation related documentation, results of HIV and TB tests.
	6. Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or other legal proceeding.
	7. Other Documents such as guardianship documents and adoption documents that include identifying information of birth parents.
	8. Psychotherapy notes, defined in the Federal Privacy Rule 42 CFR §164.501 as: notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and are separated from the rest of the patient’s medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
1. The Designated Record Set is to be retained according to state and federal regulations and [COVERED ENTITY] retention procedures.