OVERVIEW OF THE MANAGEMENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

When persons enter Department of Mental Health (DMH) system of care through the HIPAA Privacy Notice and the Consent for Services, we pledge to them that only in very specific situations, most of which require their authorization, do we disclose information about them, the fact that they are being seen, or any information regarding their treatment with the Department. Staff of the Department, upon employment and annually, sign an oath of confidentiality pledging not to disclose PHI except as authorized or permitted by federal or state law. Those staff who have access to the Department data system sign an additional oath pledging not to disclose PHI. These activities signify the importance the Department and the public place on the confidential maintenance of PHI.

Living up to our pledge is a daily challenge because the Department is such a large and complex organization and PHI, in various forms, can be found in every area of Department operations. The two documents in this Chapter of the **Clinic Operations Manual,** are designed to provide basic information to clinic managers regarding the management and disclosure of PHI and assist them in dealing with the daily challenges of appropriate management and disclosure. The **HIPAA Privacy Guidelines** contains the federal privacy rules with which the Department must manage its PHI. These privacy rules were implemented by the Department in April, 2003. Its implications are broad and reach to each area of the Department that maintains PHI. The **Clinical Records Guidelines** deals with more specific and practical issues of which managers must be aware if they are to be responsive to the pledge we make to our clients by maintaining confidential operations. Client clinical record and information shall be disclosed only as specified in the Department of Mental Health **Clinical Records Guidelines and HIPAA Privacy Guidelines** or as directed by the Department Medical Record Director or HIPAA Privacy Officer or Department management or Counsel.

It is our hope that these materials will provide valuable information and support managers in maintaining appropriate diligence. In addition, there are a variety of resources in the Department as noted on the next page that are available to assist you with questions or help you work through appropriate disclosure procedures in accord with the type of request.

WHO TO CONTACT WHEN YOU HAVE QUESTIONS

For questions regarding the:

- content of the **Clinical Records Guidelines**
- management of clinical records
- ensuring that authorization contains core elements
- disclosure of information/PHI from the clinical record, except for client access

contact:

Charles Onunkwo, MHA, RHIT
Health Information Management Asst. Director
Los Angeles County Department of Mental Health
Administrative Operations – Quality Assurance
695 South Vermont Avenue, 15th Floor
Los Angeles, CA 90005
Telephone: (213) 251-6722
Facsimile: (213) 739-6298
E-mail: COnunkwo@dmh.lacounty.gov

For questions regarding the:

- content of the **HIPAA Privacy Guidelines**
- management of disclosure of PHI not related to the clinical record
- form only — Use and Disclosure of Protected Health Information
- client access
- situations in which refusing to disclose records or PHI is being considered
- situations in which PHI may have been improperly released

contact:

Ginger Fong
HIPAA Privacy Officer
Los Angeles County Department of Mental Health
695 South Vermont Avenue
Los Angeles, CA 90005
Telephone: (213) 251-6428
E-mail: GFong@dmh.lacounty.gov

For disclosure to the media, contact:

Mimi Martinez McKay
Deputy Director, Strategic Communications
Los Angeles County Department of Mental Health
550 S. Vermont Avenue, 11th Floor
Los Angeles, CA 90020
Telephone: (213) 738-2862
E-mail: MMMcKay@dmh.lacounty.gov

For de-identified data, that is, data that does not include the disclosure of PHI, contact:

John Ortega
Chief Information Office — Bureau
Los Angeles County Department of Mental Health
695 S. Vermont Avenue, 6th Floor
Los Angeles, CA 90005
Telephone: (213) 251-6424
E-mail: JOrtega@dmh.lacounty.gov

Contents

INTRODUCTION

The purpose of these Guidelines is to provide sufficient background information and specific procedures for proper record-keeping and disclosure of Protected Health Information (PHI). Although addressed primarily to record keepers, it is designed to be equally useful to other Department of Mental Health (DMH) staff that may have questions regarding DMH record keeping procedures. When disclosing information from client records and/or PHI, directly-operated programs must comply with the California State Welfare and Institutions Code (WIC) 5328, the Confidentiality of Medical Information Act (CMIA), and Federal Laws such as the Health Insurance Portability and Accountability Act (HIPAA). These Guidelines as well as the HIPAA Privacy Guidelines summarize these applicable laws and provide compliant Department maintenance and disclosure procedures. It is not expected that the information in these Guidelines will address all situations to which record-keepers or program managers may need to be responsive, but it is expected that these Guidelines will be used as a first guide to managing records and the proper disclosure of information. Should consultation be needed, Department staff is available as noted in the Overview.

CHAPTER 1. PURPOSE, CONTENT, OWNERSHIP AND MAINTENANCE OF MENTAL HEALTH CLINICAL RECORDS

PURPOSE OF MENTAL HEALTH CLINICAL RECORDS

The purpose of the mental health clinical record is to:

1. Serve as a basis for evaluating and planning the client's individual treatment and care and to monitor the client's mental health care over time;
2. Provide a means of communication and continuity of care between all service delivery staff and other mental health care providers involved in the care of a client;
3. Furnish documentary evidence of the course of the client's illness and/or conditions;
4. Serve as a basis for analysis, study and evaluation of the quality of care rendered;
5. Assist in protecting the legal interest of the client, facility/program and/or therapist;
6. Provide clinical data for use in research and training/education;
7. Provide a linkage between past and current services to the same client;
8. Provide the basis for appropriate utilization review and quality of care evaluations; and
9. Document services for cost audits and provide for accurate and timely claims review and payment.

CONTENT OF MENTAL HEALTH CLINICAL RECORDS

The content of a mental health clinical record shall include complete, accurate and current documentation of any and all information that identifies the client, justifies the diagnosis and condition of the client, and documents the treatment provided. The documents maintained in DMH clinical records are not considered "Psychotherapy notes." Information acquired in the delivery of services, including assessment activities, **shall not** be kept separate or apart from the clinical record.

To ensure that all records reflect the above content and purposes, each facility/program shall conduct periodic record reviews to determine "proper content" of each individual clinical record.

The mental **health** clinical record is a legal document that will almost certainly be examined by other authorized persons, often as part of a court proceeding. The following are standards (do's and don'ts) for record documentation:

Do's

- **Do make** sure that all entries are signed;
- Do make sure that all entries are legible to someone other than the writer;
- Do make sure that all entries are dated the date the service was provided. If the entry is made on a date other than the service date, the date the note was written should be documented in the body of the note;
- Do use black ink to make written entries;

Don'ts

- Don't use white out or an eraser. If a mistake is made, draw a single line through the entry and write "mistaken entry" rather than error. (The word error could seem to indicate that a mistake in care was made rather than in the documentation.) Write the correct entry as close to the mistaken entry as possible, and date and sign with your first initial, last name and title;
- Don't leave empty lines or spaces between entries. Mark through all empty lines;
- Don't name a second client. Use initials or refer to a second client as "brother", "cousin", etc.;
- Don't record staff conflicts, disagreements, or staffing problems.

Patient Identification (I.D.) Number

A unique number is generated by the Integrated Behavioral Health Information System (IBHIS) and allows for the collection, storage, and retrieval of data on every individual who has received services anywhere in the County Mental Health Department System of Care.

OWNERSHIP OF MENTAL HEALTH CLINICAL RECORDS AND RELATED RESPONSIBILITIES

The Los Angeles County Department of Mental Health is the owner of the mental health clinical records of those persons who receive services at any of its directly-operated clinics. All mental health clinical records shall be considered the sole property of the Department. The Department and its staff are charged by law with the protection and safe-keeping of the information in the record. Any disclosure of information from these clinical records must be in the best interest of the client and in accord with existing Federal, State and County laws and regulations and Department procedures.

The Department Custodian of Records (Health Information Management Director) shall act for the Director of the Department of Mental Health in interpreting all mental health clinical record State laws and Department policies and procedures and assisting County directly-operated programs in fulfilling their record keeping and disclosure of protected health information responsibilities.

MAINTENANCE OF MENTAL HEALTH CLINICAL RECORDS

Each program shall ensure all clinical records are securely maintained in locked files. All files and record rooms shall be kept locked in the absence of authorized staff. Clinical records shall be safeguarded against loss, defacement, tampering, or use by unauthorized persons.

Keeper of Records

Each site of the Department of Mental Health directly-operated programs shall designate a "Keeper of Records" who may also serve other programs at the same location. Programs within a site that are administratively distinct may each have their own Keeper.

Each Keeper of Records shall be involved in **ALL** requests for protected health information and/or copies of clinical records to ensure that compliance with Department of Mental Health policies for the disclosure is appropriately followed and that, when appropriate, there is documentation in the record's "Accounting Tracking Sheet."

"Request Log for Protected Health Information (PHI)"

In addition to the "Accounting Tracking Sheet form", Keepers of Records shall maintain a "Request Log for Protected Health Information (PHI)" **(Appendix 01)** containing the following elements:

1. Name of the client and IBHIS number for whom the information is being requested;
2. Name of the requesting party/Telephone Number;

3. Date received; By whom (initials);
4. Type of request;
5. Due date of request, if any;
6. Processing Fee and amount, if any;
7. Disposition/Comments.

"Request Log for Protected Health Information (PHI)" shall be checked, updated daily, and kept secure in a designated area in the chart file room.

Accessibility of Clinical Records

Mental health clinical records shall be maintained and made available upon request by the following:

- As requested by physician or case manager involved with the client's care and treatment;
- Any authorized staff, agent or employee of DMH Administration (i.e. Risk Management, HIPAA Privacy Officer or Medical Records Director);
- As part of an approved DMH Committee for Human Research (CHR) protocol that involves mental health clinical record review;
- Any other authorized person by law to make such a request (i.e. regulatory agency such as Licensing Boards/State Medi-Cal Fraud); Department of Homeland Security/United States Secret Service).

Mental health clinical records shall not be removed from the facility jurisdiction except upon request by the following:

- As requested by a legal mandate, i.e., court order, subpoena, statute, regulatory agency such as Licensing Boards/State Medi-Cal Fraud)
- As requested by the DMH Risk Manager
- As requested by the HIPAA Privacy Officer
- As requested/approved by the Director of Medical Records

The Medical Records Director shall be notified of any removal of original mental health clinical records from the facility's premises.

Off-site Storage

Off-site archive storage of mental health clinical records shall be arranged through the Office of the Medical Records Director to ensure appropriate security, retention and destruction. (See Chapter 5)

Authority: Los Angeles Department of Mental Health, Policy No. 104.1 based on Title XXII, California Code of Regulations, Section 71551(b); Health Insurance Portability and Accountability Act (HIPAA)

CHAPTER 2. SITUATIONS NOT REQUIRING CLIENT AUTHORIZATION AND RESPONSE PROCEDURES

DISCLOSURES WITHOUT A REQUEST AND NOT REQUIRING AUTHORIZATION

In most situations in which protected health information (PHI) is released without the client's authorization, the disclosure is prompted by a request. In a very few situations, disclosure can be made in the absence of a request. These situations are:

1. For health care operations, such as making or confirming appointments - See **HIPAA Privacy Guidelines**
2. For notification of law enforcement of persons who are at risk of being victims of violence — See DMH Policy 202.2 Duty to Warn and Protect Third Parties in Response to a Client Threat [The Tarasoff Decision and WIC 5328(r)]
3. When submitting child or elder abuse reports — See DMH policies 202.8 and 202.9 respectively
4. For disaster relief purposes in emergency situations - See **HIPAA Privacy Guidelines**

REQUESTED DISCLOSURES NOT REQUIRING A WRITTEN AUTHORIZATION

Requests for protected health information must be accompanied by a valid authorization or a court order except in the situations noted in this Chapter. Even in these situations, a written request is preferred. Even most urgent situations allow for obtaining a faxed or e-mailed request. However, requiring a written request in the following situations shall never delay or obstruct the disclosure of needed information as long as the identity of the requestor has been verified. Note that most of these requests require some declaration of the intent of use or need for the requested information.

1. **Request from any Provider who is Responsible for a Person's Health or Mental Health Care** [HIPAA Privacy rules & WIC 5328(a)] **or for Conservatorship Proceedings** [WIC 5328(a)]
   Copies of client's records and/or protected health information may be shared among professionals providing care to a client or when requested for conservatorship proceedings. Before information is released, verify that the requestor is indeed a current provider of health/mental health services. A written declaration by the provider is preferred, but in emergency situations a return phone call may be the best possible verification. See Chapter 4 for record preparation instructions.

2. **Request from a Person who is a Member of an Emergency Response Team for HIV/AIDS Disclosure**
   The request must be in writing and must include the team/agency of which she/he is a member, the date of the incident, and the reason why she/he may be concerned regarding the possibility of HIV/AIDS exposure. Only the minimum necessary regarding the provider's knowledge of HIV/AIDS information may be disclosed without client authorization. (Ryan White Comprehensive AIDS Resources Emergency Act of 1990 [P.L. 101-381; 42 U.S.C. Sec. 201] and [WIC 5328(s)]).

3. **Request from Governmental Law Enforcement Agencies, Including the Department of Homeland Security United States Secret Service** WIC 5328(g)
   The request must be in writing and may only be granted when the stated disclosure is for the purpose of the protection of federal and state public officials and their families. Clinical records and/or any information in the clinical records may be accessed by these authorities.

4. **Request for Submission of a Client PHI for Benefit Establishment**
   A request to the extent necessary for a recipient to make a claim or for a claim to be made on behalf of a recipient for aid, insurance, or medical assistance to which he or she may be entitled. WIC 5328(c)

5. **Request for Verification of a Claim by Payer** (HIPAA Privacy Notice)

6. **Deposition Subpoena from Worker's Compensation Appeals Board for (1) Appearance; (2) Production of Records; or (3) Both** (See sample subpoena **Appendix 02-a and 02-b).**
   The Workers' Compensation Appeals Board is considered to be an administrative judicial authority which exercises all judicial powers vested in it by the Labor Code, and as such acts in the same manner as a court of law. As long as DMH records requested are to be sent directly to the Worker's Compensation Appeals Board Court, authorization is not required. However, no disclosure can be made to or ordered by an attorney, a notary public, hearing officer, or other quasi-judicial body without client authorization or court order. Any subpoena duces tecum/deposition subpoena received from the Worker's Compensation Appeals Board that orders the records to be sent to the attorney's office or to a photocopy company requires a court order or an authorization. See Chapter 4 for record preparation instructions.

7. **Request for Records or Appearance or Both by Court Order**
   Since the court has the final word, the custodian of records or his/her designee shall always obey a court order. If there is some question concerning its legality, Counsel should be consulted through the Medical Records Director. A court order is an order signed by a judge for testimony, clinical records and/or protected health information. Requests from courts for the disclosure of protected health

information being sent directly to the court do not require an authorization. [WIC 5328(f)] See Chapter 4 for record preparation instructions.

8. Request from Attorney When Client's Impairment Prohibits Ability to Sign
A request from client's attorney in any and all proceedings when a client's impairment prohibits his/her ability to sign an authorization, and the facility staff, upon satisfying themselves of the identity of the attorney and of the fact that the attorney does represent the client's interests, may disclose client's PHI. WIC 5328(j) See Chapter 4 for record preparation instructions.

SITUATIONS THAT REQUIRE CONSULTATION PRIOR TO DISCLOSURE OF PHI WITHOUT CLIENT AUTHORIZATION

1. **Search Warrant** (See sample Search Warrant — **Appendix 03-a and 03-b).**
It is imperative that any staff presented with a search warrant, before allowing entry to a facility or any records, immediately transmit the warrant to program management who in turn shall immediately contact his/her Deputy Director for interface with County Counsel**.**

2. **Investigative Subpoena/Subpoena Duces Tecum** (See sample investigative subpoena duces tecum with required Affidavit **Appendix 04-a and 04-b).**
In general, investigative subpoenas received from most licensing boards, commissions or administrative agencies **do not** require a court order or an authorization for testimony/clinical record information to be brought to a board, commission or administrative agency pursuant to an investigative subpoena issued in accord with State code. Consultation shall be obtained from the Medical Records Director prior to disclosure.

3. **Request from Persons Serving on a Multidisciplinary Elder or Dependent Abuse Team**
The Medical Records Director should be consulted to determine whether or not the team and the requestor meet the requirements of State Codes. If they do, in accord with WIC 5328(u), PHI that is relevant to the prevention, identification, management, or treatment of an elder or dependent adult may be disclosed without authorization.

CHAPTER 3. REQUESTS REQUIRING AUTHORIZATION OR COURT ORDER

Although there are some situations in this Chapter in which consultation from the Medical Records Director is required, please note that consultation is available for any questions a program manager or keeper of records may have regarding any of these issues.

DISCLOSURES BY VERBAL AGREEMENT

In limited circumstances clients can give their verbal approval for release of their PHI:

- By request of the client for the involvement of a relative or close friend in his/her care. Verbal authorization does not extend to the relative or close friend having direct access or copies of the clinical record. The extent of the approved disclosure must be specific and documented in the clinical record's progress notes.
- With permission of the client when involvement in their care is requested by a relative or close friend. Verbal authorization does not extend to the relative or close friend having direct access to or copies of the clinical record. The extent of the approved disclosure must be specific and documented in the clinical record's progress notes.

REQUEST FROM A CLIENT FOR ACCESS TO HIS/HER CLINICAL RECORD

When the federal HIPAA Privacy rules became effective in April 2003, they superseded all California State law on client access. All instructions and forms for responding to a client's request for access to his/her clinical records can be found in the **HIPAA Privacy Guidelines** and associated Department policies and procedures. The HIPAA Privacy Officer should be consulted on any questions related to client access to records.

REQUESTS AND SUBPOENAS TO BE FORWARDED TO THE MEDICAL RECORDS DIRECTOR FOR RESPONSE

These types of requests and subpoenas are not unusual, but are governed by overlapping rules that ordinarily require special handling. For this reason, the Department has determined that they are best managed by the Medical Records Director.

- Request from a friend or relative of a Deceased Client
- Request from the County Coroner’s Office
- Out-of-State Subpoena

REQUESTS REQUIRING AUTHORIZATION OR COURT ORDER AND RESPONSE TYPES

Most federal and State laws governing mental health records are built on the premise that all mental health information should be confidential unless specifically exempted by law. In California, WIC 5328, et.al., covers all allowed exemptions and, in some instances, specifically requires an authorization. The following list is not all inclusive, but is comprised of the most common types of requests and those that are specifically covered by WIC either by inclusion or exclusion. All requests, except those listed in Chapter 2, require either client authorization or court order.

- Request from Client or Opposing Attorney
- Request from The Social Security Administration office — (See **Appendix 05)** for authorization that accompanies SSA request
- Request from County Patients' Rights Advocates — Required by WIC Code 5328(m).
- Request from School Psychologist
- Requests from Deputy Public Defender/Deputy District Attorney/County Counsel
- Request from the LA County Civil Service Commission
- Requests from the State Department of Labor/State Department of Corrections

SUBPOENAS REQUIRING AUTHORIZATION OR COURT ORDER AND RESPONSE IN THE ABSENCE OF EITHER

Subpoenas ordering appearance, records, or both to court

- **Civil Subpoena for Personal Appearance at Trial or Hearing** (See sample subpoena **Appendix 06)**
  *** Note** that Personal subpoenas addressed specifically to an individual employee of the Department should only be accepted by the person to whom the subpoena is addressed.

- **Civil Subpoena (Duces Tecum) for Personal Appearance and Production of Documents, Electronically Stored Information, and Things at Trial or Hearing and Declaration** (See sample subpoena **Appendix 07)**

- **Order to Attend Court or Provide Documents: Subpoena/Subpoena Duces Tecum (Criminal and Juvenile)** (See sample subpoena **Appendix 08)**

Follow the instructions "Appearing in Court as a Witness" (See **Appendix 09)** and read the appropriate court statement. (See **Appendices 10 and 11)**

If the request is for records, a copy of the record must be taken to the court. See Chapter 4 for record preparation instructions.

Subpoena Duces Tecum for delivery to other than a court

A letter must be sent returning the subpoena stating that an authorization or court order is required before records can be disclosed. The Department authorization should accompany the letter. (See **Appendix 12)**

Deposition Subpoena for appearance, clinical records, or both

- **Deposition Subpoena for Production of Business Records** (See sample **Appendix 13)**
- **Deposition Subpoena for Personal Appearance** (See sample **Appendix 14)**
- **Deposition Subpoena for Personal Appearance and Production of Documents and Things** (See sample **Appendix 15)**

If a deposition subpoena orders an appearance at or a deposition subpoena orders records to be delivered to an attorney's office, a photocopy company, or anywhere other than a court of law, a telephone call shall be made to the party requesting the records giving him/her notice that in the absence of a court order or a valid authorization, DMH requests to be excused from appearing, since DMH would not be able to disclose PHI protected under WIC 5328(f). A letter of response documenting this conversation, returning the deposition subpoena and attaching the Department's authorization is required. (See **Appendix 16** for sample letter "Excuse from Deposition.")

If after notifying the requesting party that mental health information is protected under WIC 5328(f) and the requesting party refuses to excuse DMH staff from appearing/bringing records, then, an appearance must be made as ordered for DMH staff to read the appropriate statement (see **Appendices 10 and 11)** and to go on record that the Department is prohibited from releasing pursuant to a subpoena except to a court. In this situation, copies of records should not be taken to the deposition.

If a deposition subpoena orders an appearance before a judge or orders records to a court, then the appropriate court statement regarding a subpoena must be read in court. (See **Appendices 10 and 11).** When records have been subpoenaed copies of records should be prepared as described in Chapter 4 and taken to court should the judge order their disclosure.

Subpoena (Deposition) for Billing and or Payment Records

If the subpoena is not accompanied by an authorization or a court order, then it must be returned. (See sample **Appendix 13)**

If the subpoena is accompanied by a valid authorization or court order fax, the subpoena and authorization/court order must be sent to the Financial Services Bureau within 2 days of receipt with a transmittal letter (See transmittal letter in **Appendix 17).** Copies of requested billing and or payment record information will be obtained by Financial Services staff and returned to the program contact for disclosure to the requesting party.

CHAPTER 4. ACCEPTANCE AND RESPONSE PROCEDURES FOR REQUESTS AND SUBPOENAS

In limited situations, HIPAA allows for refusing to disclose all or some requested information. The Department HIPPA Privacy Officer MUST always be consulted before refusing to disclose information.

See **Appendix 18** for a decision tree covering the procedures in this Chapter.

RECEIVING REQUESTS AND REVIEWING SUBPOENAS PRIOR TO ACCEPTANCE

Verbal and Telephone Requests

Immediate determination must be made regarding whether or not an authorization is required. If an authorization is required, the requestor should be given appropriate instructions for making a written request with a valid authorization. If authorization is not required, after confirming the identity of the caller or source of the call, the requested information shall be disclosed and documentation of the disclosure noted in the Correspondence Section of the clinical record.

Written Requests

Written requests for records usually come by mail and **MUST** be responded to within ten (10) business day of the receipt of the request. In situations where more time is required, arrangements shall be made with the requesting party for an extension of time within which to respond. Arrangements shall be documented and kept together with the original request.

Subpoenas

Requests and subpoenas must be served during normal working hours and should Only be accepted by one of the following personnel:

- Designated Keeper of Records
- Program Director or his/her designee
- Personal subpoenas by the individual being served.

Prior to acceptance of a subpoena, advise the process server that before s/he leaves you must examine the subpoena to ascertain the following:

1. The name of the defendant

Any claim/summons/other notice in which DMH is named as a defendant shall NOT be accepted by an employee, even if an employee is named on

the claim/summons/other notice along with the Department. Instead, take these steps:

a. Notify the clinic manager,
b. Obtain information regarding the subpoena, such as the case name, court, legal counsel and counsel's telephone number,
c. Provide the server with the attached "Statement of Non-Acceptance" indicating that employees of Department of Mental Health are not authorized to accept claims or other notices of intent to commence legal action against the Department (See **Appendix 19),** and
d. Immediately provide the case information to the DMH Clinical Risk Manager.

A subpoena naming the County of Los Angeles as the defendant can be accepted by a DMH employee but shall be immediately reported to the Medical Records Director then processed as usual.

2. The document is an order addressed to the LA County Department of Mental Health or the Custodian/Keeper of Records,
3. The name, address and telephone number of the person initiating the subpoena is stated,
4. The date, time and place of the hearing/deposition is stated and the date has not passed,
5. The signature of the person issuing the subpoena appears on the subpoena,
6. That if applicable, the requirements of Section 1985.3 of the Civil Code have been met and having attached to the subpoena,
7. An affidavit which contains a description of "good cause" for production of the records described in the subpoena; specifies the exact records to be produced; fully details the relevance of the records requested to the issues involved in the case; and states that the witness has the desired records in his/her possession or under his/her control. (CCP 1985),
8. A Certification of the Notice to Patient. Exceptions:
    - Criminal or Administrative agency proceedings,
    - Subpoena(s) issued by Local and State courts or State Bar of California,
    - Subpoena(s) issued by Federal or out-of-state Courts,
    - Subpoena(s) for non-identifiable patient information

If the subpoena is found to be appropriate, complete, and in order, it should be accepted, signed for, and date/time stamped. (CCP 1985 & 1985.5) If the subpoena is found not to be appropriate or complete, it must be returned to the server with a verbal explanation for the refusal to accept. If the server refuses to wait for the review of the subpoena, the subpoena should be handled like a document received via mail.

Subpoenas MUST be responded to within the time limits set within the subpoena. Ten (10) working days are supposed to be allowed, but often subpoenas come with less than the required ten days. Notify the Medical Records Director immediately if the due date does not give sufficient time for a response.

WRITTEN AUTHORIZATION

All requests for protected health information discussed in Chapter 3 require a valid HIPAA compliant authorization. All future references in this Chapter to an "authorization" shall refer to a valid HIPAA compliant authorization. Use of the Department's approved "Use/Disclosure of Protected Health Information (PHI) Requiring Authorization" form is required whenever an authorization is originated within a directly-operated program. It is preferred regardless of the origin of the request, but other formats are acceptable as long as they contain the minimum core elements. Anyone signing an authorization other than the client (parent, guardian, or conservator) must present proof of their legal authority.

Core Elements of a HIPAA Compliant Authorization

The Authorization for Request or Use/Disclosure of Protected Health Information must contain:

- a **description** of the information to be used or disclosed;
- the **name of the person** or organization that will receive the protected health information;
- the **date** the authorization expires;
- a statement of the client's **right to revoke** the authorization in writing, including the exceptions to this right and how to revoke the authorization. (A client may revoke an authorization at any time except to the extent that the **DMH** has taken action before the date of revocation.);
- a statement that the information used or disclosed may be subject **to re-disclosure** by the recipient, if the recipient is not subject to HIPAA (Please refer to current Confidentiality Statements that are part of all DMH clinical forms); the client's **signature and the date** (If the signature is the client's personal representative, a description of the person's authority to act for the client); a statement that we **will not condition** treatment, payment, or eligibility for benefits on the client's providing authorization;
- a **description of each purpose** of the requested use or disclosure; and
- a statement that the client **may refuse** to sign.

Verification Procedures

Upon receipt of an authorization, staff must:

- Ensure all required core elements are included.
  Verify the signature of the client or personal representative using any available signature information. When a signature is not available, use other means of identification such as a copy of a Driver’s License. Minors, who have consented to and are receiving services based on the completion of the Department's "Consent of Minor" form, are the only persons who may authorize access to their protected health information.

Invalid Authorizations and Response

An Authorization is not valid if it:

- is missing any of the core elements,
- has expired,
- was not filled out completely,
- has been revoked,
- was improperly combined with another document, or
- contains information known to be false, such as a non-matching signature.

Please consult with the Medical Records Director if there are questions or concerns regarding the validity of an Authorization.

Requests or subpoenas with invalid authorizations shall be returned to the requestor with the original request/subpoena. (See sample letter **Appendix 20** which states that information cannot be released without a valid authorization.) A copy of the request/subpoena shall be filed in the Correspondence Section of the clinical record with the response letter.

In those situations, in which the subpoena orders the record and/or appearance to the court, the subpoena must be processed as described in the section entitled "Preparing a Record for Court in the Absence of an Authorization."

PROCESSING A REQUEST OR AN ACCEPTED SUBPOENA WITH A VALID AUTHORIZATION WITH THE EXCEPTION OF COURT ORDER

All subpoenas and court orders for client's mental health clinical records and protected health information served and received at a **DMH** directly-operated program shall be brought to the attention of the facility's Clinic Manager, logged in at the clinic's "Request Log for Protected Health Information (PHI)" form **(Appendix 01).** Those subpoenas/and court orders brought to the attention of the Medical Records Director (Custodian of Records) for consultation shall be brought to her attention as soon as possible or **no later than one (1) business day** following receipt of the subpoena/court order.

Client Search

If after searching your files, it is determined the person was never seen, the record was destroyed, or the record cannot be located, send the response letter in **Appendix 21.** If you are unable to locate the records, contact the Director of Medical Records immediately and continue to search for at least 30 days. If they are not found within that timeframe, the therapist must provide a reconstructed copy of the original record.

Reviewing the Record

Notify the responsible physician and/or therapist that a subpoena has been received and that it requires review for disclosure. Only information that is specifically noted in the authorization shall be disclosed. If substance use/abuse or HIV/ARC information or test results are included in the clinical record and the authorization does not specifically allow for the disclosure of this information, this information must be redacted from the clinical record. See DMH Policy 500.1, Section 4.13 for disclosing of HIV/AIDS.

Preparing a Record for Disclosure

1. For disclosure to any requestor other than a court

    a. Make a copy of those records identified by the reviewer as stipulated within the subpoena, stamping those sheets not already containing the confidentiality statement with a confidentiality stamp.
    b. Mail copies of the record in an envelope stamped "confidential" by certified mail return receipt requested.

2. From the Court/Worker's Compensation Appeals Board:
   take the following steps:

    a. Make a copy of those records identified by the reviewer as stipulated within the subpoena, stamping those sheets not already containing the confidentiality statement with a confidentiality stamp.
    b. Attach the completed "Declaration of Keeper of Records" to the copied record (see **Appendix 22).**
    c. Make an inner envelope (see **Appendix 23-a)** that is to be sealed after the copied record is placed inside. Stamp "Confidential."
    d. Make an outer envelope (see **Appendix 23-b)** Stamp "Confidential." If records are to be mailed to court, they should mail by certified mail. See **(Appendix 24).**
    e. Call the attorney and ask to be placed "on call."
    f. When called, take the copied record to Court.

3. From the court for the original record

   First, telephone the party issuing the subpoena and request that the facility/program be allowed to produce a copy of the record. If agreed, follow steps outlined above for preparing a copy for the court. If there is a refusal to accept a copy, take the following steps:

    a. Remove all information not requested including correspondence.
    b. In chronological order (using a pencil) number each page of record not excluded in "a" above in the lower right hand corner. This allows for an accurate count of pages sent to court.

c. Photocopy the numbered pages which will be retained at the facility/program to be used while the original is in court.
d. Complete a "Declaration of the Custodian of Records". (See **Appendix 22)** and attach to record.
e. Complete two copies of the "Stipulation to Return Records to Facility" (See **Appendix 24-a)** and attach them to the record. Place the original "Letter to Court Regarding Stipulation to Return Records to Facility" (See **Appendix 24-b**) on top of the Stipulation.
f. On hearing date take the original record to court.
g. If the judge orders the record disclosed, have court clerk assist you in obtaining the judge's signature on the "Stipulation." Each attorney, i.e., the plaintiff's and defendant's MUST also sign each of these forms. Both originals are left in court with the original record(s), the copies are returned to program and shall be included in the copy of the record.
h. The Keeper of Records should make contact with the court until the original record is returned.

PREPARING A RECORD FOR COURT IN THE ABSENCE OF AN AUTHORIZATION

1. Make a copy of those records identified by the reviewer as stipulated within the subpoena, stamping those sheets not already containing the confidentiality statement with a confidentiality stamp.
2. Attach the completed "Declaration of the Custodian of Records" to the copied record (see **Appendix 22).**
3. Make an inner envelope (see **Appendix 23-a)** that is to be sealed after the copied record is placed inside. Stamp "Confidential."
4. Make an outer envelope (see **Appendix 23-b)** Stamp "Confidential." If records are to be mailed to court, they should mail by certified mail. See **(Appendix 24).**
5. Call the attorney and ask to be placed "on call" and notify him/her of the need to read a "Court Statement' to obtain a court order in the absence of an authorization. (See **Appendix 10 and 11)**
6. When called, take the copied record to Court and follow the court instructions.
7. The judge will decide whether or not disclosure is appropriate to the case. If the judge decides disclosure is appropriate, s/he should sign the "Order for the Production of Psychiatric Records." (See **Appendix 29).** Present two copies of this form and request a "conformed copy" of the form indicating the name of the judge signing it and the date of the Order. Upon receipt of the order, the copied records may be remanded to the court. This Order should be placed in the client's original mental health record. In the event the judge orders disclosure but does not sign the Order, the record must still be disclosed.

CHAPTER 5. PURGING, RETENTION, AND DESTRUCTION OF CLINICAL RECORDS AND OTHER PROTECTED HEALTH INFORMATION

PURGE REPORT

Clinical records shall be purged for destruction annually through the use of the Purge Report. This report contains an alphabetical listing of names of clients according to their discharge dates for adults and year of destruction for children. Clinical records may be purged, boxed, and transferred to an archives storage area three (3) years after the client's discharge date. Purge Reports for archiving or destruction may be requested and obtained through the Medical Records Director. (See Appendix 30 for Purge Report Instructions)

RETENTION GUIDELINES

Mental Health Clinical Records:

- Clinical records, of all minors (0-17 years of age) including those who are legally emancipated, shall be retained safely until their twenty-fifth (25th) birthday;
- Clinical records of adult clients shall be retained safely for a minimum of **ten (10)** years following their most current date of discharge;
- Clinical records, of adult and minor clients which have audits or legal actions pending, shall be retained until the issues have been settled, regardless of the Department's prescribed retention period.
- All documents created and scanned into the EHR after the implementation of the EHR shall be destroyed immediately upon confirmation that the document(s) were correctly scanned into IBHIS, our EHR system.

Retention for other types of PHI, including logs, shall be for the same duration as the clinical record, depending on whether the client is an adult or a minor. [Examples of other types of PHI are as follows]:

- All Non-Open PHI files containing PHI where no DMH record was opened;(202.38 *Non-Open Protected Health Information (PHI) File)*
- Information on emergency contacts on persons for whom a clinical record was not opened;
- All information related to the application/screening of a person when the person does not become a client;
- Community Outreach Services (COS) forms;
- Telephone contacts documented on Triage forms which do not result in an open record;
- Referrals received by DMH which do not result in an open record;
- DMH Response letters where "no record" was found;
- Suspected Child Abuse Reports which are stored separate from the clinical record in a notebook/file folder in the file room in a locked drawer, in a locked cabinet in the Program Head/Manager's Office, Administrative Files, or a designated locked File Room Security Shelf with limited accessibility only to the

Program Head/Manager and his/her designee; (202.08 *Reporting Suspected Child Abuse and Neglect)*

- Units of Service Logs or clients' NCR claiming information sheets;
- Client Sign-In Logs;

A client's Financial Folder should be "drop filed" into the client's clinical record upon discharge so that it will be retained for the same duration as the clinical record.

Exceptions:

- Medi-Cal Administrative Activities (MAA) forms must be kept for a period no less than seven (7) years for the purpose of audits.
- Clinical pharmaceutical records (prescriptions) must be kept for a period of three (3) years from the client's date of service [(2ICFR § 1304.04(h)].

PURGING FOR STORAGE AND RETRIEVAL

Storage

Los Angeles County maintains an Archive Center in the sub-basement of the Hall of Administration. In accord with a clinic's clinical record room capacity, clinical records may be purged, boxed, and transferred to this archives storage area three (3) years after the client's discharge date. They will be maintained in the Archive Center through their date of destruction.

Records must be purged for storage using the Department Purge Report. This Report contains an alphabetical listing of names of clients according to their discharge dates for adults and year of destruction for children. Purge Reports for archiving or destruction may be requested and obtained through the Office of the Medical Records Director. See **Appendix 29** for Purge Report Instructions.

An Archive Records Deposit Receipt form **(**see **Appendix 30)** will be issued to each program in return for their boxed records that are transferred to the Los Angeles County Archives Center.

Retrieval

Retrieval requests of archived clinical records must be requested via a Fax that contains the following information:

- client's name and date of birth
- IS number
- archive box number
- the purpose for the record request, and
- the date records are needed.

When records are retrieved and ready for pick up, the requestor will be notified. When the records are picked up, the Fax sheet will be signed as a receipt by the individual picking up the records. If the retrieved records are not reactivated, the records shall be returned to the Office of the Medical Records Director as soon as the requested purpose for the records has been accomplished.

DESTRUCTION

When clinical records are maintained on site up to their legal retention date, the clinic's records shall be purged annually for records that can be destroyed. These records will be identified and boxed through the use of the Purge Report, but may not be destroyed without the approval of the Medical Records Director. (See **Appendix 31** for Special Request form to be used for clinical records destruction.) Arrangements will be made with a shredding contractor for pickup and destruction of clinical records through the Office of the Medical Records Director.

The Office of the Medical Records Director will oversee the destruction of records stored in Archives in accord with their destruction date.

APPENDICES – QUICK REFERENCE

Appendix **No.**

GLOSSARY OF TERMS

ARCHIVES

Archives is a storage area where clinical records are kept, usually three years from clients' discharge dates, for the remainder of their retention period until their date of destruction. DMH utilizes the Los Angeles County Archives Center (Hall of Administration) through the Chief Administrative Office and other directly-operated on-site archive storage areas such as the Service Area 8 Archive Center.

CIVIL SUBPOENA

A civil subpoena is issued in a lawsuit between two parties in which either an injunction or damages are usually sought.

COURT ORDER

A court order is a decision issued by a court which can be a single command, for example, ordering a witness to appear in court to testify or to bring records to court.

CRIMINAL SUBPOENA

A criminal subpoena is issued in a proceeding by the government against a private citizen alleging the violation of a law and seeking a penalty or punishment.

DECLARATION (ACCOMPANYING THE RECORDS)

The Keeper of Records who prepares the records/PHI for disclosure must complete and sign a declaration attesting to certain criteria. A completed and signed declaration must accompany disclosed records/PHI to court.

DEPOSITION

A deposition is an examination of a witness by an attorney before a notary public. The testimony of the witness is recorded by a court reporter and is later made available for admission into evidence in a hearing.

DEPOSITION SUBPOENA

A deposition subpoena requires a non-party to provide copies of business records to, or appear, before a subpoenaing party. A deposition subpoena differs from a subpoena duces tecum in that production of and testimony regarding records revolve around the informal discovery process before trial, rather than around a court hearing incident to a subpoena duces tecum.

FEDERAL SUBPOENA

A federal subpoena is governed by federal laws, e.g., Federal District Court Federal Trade Commission.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA is a federal law that is designed to protect privacy of identifiable client information, provide for the electronic and physical security of health and client protected health information, and simplify billing and other electronic transactions through the use of standard transactions and code sets (billing codes).

INVESTIGATIVE SUBPOENA

An investigative subpoena is issued by a government agency that has authority to conduct an investigation within its area of jurisdiction.

ISSUANCE AND SERVICE OF SUBPOENA DUCES TECUM

Issuance and service of a subpoena duces tecum means that a subpoena, a subpoena duces tecum, or a deposition subpoena are issued by an officer of the court or an attorney of record in the case and served on a named individual, department or office.

KEEPER OF RECORDS

The responsible person for handling all requests for disclosure of clinical record and/or PHI and ensuring compliance with DMH policies for disclosure.

PURGING OF RECORDS

Purging is a term used for “cleaning out” chart files of clinical records belonging to clients who have been discharged for three (3) years or more.

REQUEST LOG FOR PROTECTION HEALTH INFORMATION (PHI)

The Request Log for Protection Health Information (PHI) form is a daily log maintained by the Keepers of Records for the purpose of documenting relevant information to all requests for disclosure of clinical records and/or PHI.

STATE SUBPOENA

A state subpoena is governed by state laws, e.g., local Superior Court, California Medical Board.

SUBPOENA

A subpoena is a legal document commanding a specific person to appear at a certain time and place to give testimony or to produce documents upon a certain matter.

SUBPOENA DUCES TECUM

A subpoena duces tecum orders the person subpoenaed to produce records or documents under his/her control at a specified time and place. It may also require the person to accompany the records and testify as a witness.

WITNESS

A witness is an individual who gives testimony or, in the case of a subpoena duces tecum, produces documents upon a certain matter.

WORKER'S COMPENSATION APPEALS BOARD

The Worker's Compensation Appeals Board is an administrative judicial authority which exercises all judicial powers vested in it by the Labor Code, and as such acts in the same manner as a court of law.