SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Release of Patient Health Information Related to an Insurance/Compensation Claim
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/675
DATE OF PUBLICATION	April 2024
RISK RATING	Medium
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standard: Standard NS1.16
REVIEW DATE	April 2027
FORMER REFERENCE(S)	N/A
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Clinical Governance and Medical Services
AUTHOR	Health Records and Medico-Legal Committee
POSITION RESPONSIBLE FOR THE DOCUMENT	Chair, Health Records and Medico-Legal Committee
FUNCTIONAL GROUP(S)	Finance Records Management – Health
KEY TERMS	Release of Information, ROI, Medico-Legal, Insurance, Insurers, Compensation, Privacy, Confidentiality, Requests for Information, Consent, Medical Records
SUMMARY	Outlines requirements and procedures regarding the release of patient health information by Finance staff in relation to insurance/compensation claims.

Release of Patient Health Information Related to an Insurance/Compensation Claim

SESLHDPR/675

1. PROCEDURE STATEMENT

This procedure describes the legislative requirement of all staff within SESLHD under the *Health Records and Information Privacy Act (2002) (HRIPA)*, with particular focus on the release of information by staff in response to a request to support the payment of an insurance or compensation claim.

2. BACKGROUND

Definitions:

Attendance:	The period of admission to discharge a patient attends a facility to receive treatment (includes inpatient, outpatient, and community)
Authorised Representative:	The *Health Records and Information Privacy Act 2002* sets out the list of people who can be an authorised representative. They are: • someone who has an enduring power of attorney for the individual • a guardian as defined in the *Guardianship Act 1987* • if the individual is a child under 18, a person who has parental responsibility for them. The *Act* defines this as "all the duties, powers, responsibility and authority which, by law, parents have in relation to their children" • any other person who is authorised by law to act for or represent the person (including an executor or administrator of a deceased estate) • a "person responsible" under Section 33A of the *Guardianship Act*.
Client/patient:	any person to whom a health care provider owes a duty of care in respect of provision of health care services.
Confidentiality:	the restriction of access to information, and the control of the use and release of personal information, in order to protect patient privacy.
Electronic Health Record:	Includes all electronic health record systems such as eMR Cerner, eMaternity, eRIC, MOSAIQ, ARIA, or any other electronic medical record application/system.
Health Information:	(a) personal information that is information or an opinion about: (i) the physical or mental health or a disability (at any time) of an individual, or (ii) an individual's express wishes about the future provision of health services to him or her, or (iii) a health service provided, or to be provided, to an individual, or (b) other personal information collected to provide, or in providing, a health service, or (c) other personal information about an individual collected in connection with the donation, or intended donation, of an individual's body parts, organs or body substances, or (d) other personal information that is genetic information about an

	individual arising from a health service provided to the individual in a form that is or could be predictive of the health (at any time) of the individual or of any sibling, relative or descendant of the individual, or (e) healthcare identifiers, but does not include health information, or a class of health information or health information contained in a class of documents, that is prescribed as exempt health information for the purposes of the HRIP Act generally or for the purposes of specified provisions of the HRIP Act.
Health Record:	A documented account, whether in hard copy or electronic form, of a client/patient's health, illness, and treatment during each visit or stay at a public health organisation. Note: holds the same meaning as "health care record", "medical record", "clinical record", "clinical notes", "patient record", "patient notes", "patient file", etc.
HIM:	Health Information Manager
HPP:	Health Privacy Principle under the *Health Records and Information Privacy Act 2002*
MRM:	Medical Record Manager
Sensitive Information:	Information that is potentially stigmatising to the client/patient and therefore should be treated with particular care. Examples of sensitive information include HIV/AIDS, sexual assault, sexual health, drug & alcohol, aboriginal health, adoption, genetics, organ/tissue donor identification, third party information, and child protection (including Risk of Significant Harm Reports).
Third Party:	A person involved in the disclosure of personal health information, being neither the individual who is subject of the information to be disclosed, nor that individual's health care provider at the time the disclosure occurs. Note: does not include "hearsay" recounted from an individual – only covers confirmable and specific information.

3. RESPONSIBILITIES

3.1 All Employees will:

- Adhere to procedures within this policy and the references relating to release of health information
- Forward requests for health information to the Health Information Unit unless part of an area approved to release health information.

3.2 Private Patient Liaison Officers (PPLO) will:

- Adhere to procedures within this policy and the references relating to release of health information.

3.3 Finance Officers will:

- Adhere to procedures within this policy and the references relating to release of health information
- Ensure appropriate records are kept of all requests and responses.

3.4 Line Managers will:

- Promptly respond to any notifications of issues or concerns with the access or release of information
- Ensure all staff have completed relevant training and are familiar with this procedure prior to being tasked with the release of health information.
- Ensure appropriate records are kept of all requests and responses and assist in the auditing process.

3.5 District Managers/Service Managers will:

- Promptly respond to any escalated notifications of issues or concerns with the access or release of information.

3.6 Health Information Managers/Medical Record Managers will:

- Perform yearly audits on the release of information by departments outside of the Health Information Unit (HIU)
- Provide ongoing support for staff members with queries or issues
- Provide clinical information in a timely manner when requested by departments outside of the HIU.

3.7 Medical/Clinical staff will:

- Not release information for insurance purposes but forward requests to Health Information Unit, Finance, or PPLO.

4. PROCEDURE

Consent

Consent is an important element in healthcare provision and dealing with health privacy issues. Consent must be informed, reasonable specific, freely given, and timely. For further information see Section 5.4.1 of the Privacy Manual for Health Information.

Consent must be sought from someone who has capacity to consent. Refer to Section 5.5 of the Privacy Manual for Health Information for tests for capacity.

Where the patient is less than 14 years of age, consent may be given by a parent or legal guardian. Where the patient is between 14 and 16 years of age, the young person is generally able to consent and effort should be made to seek the consent of both patient and parent or legal guardian where this is reasonable. Where the patient is 16 years of age or over, they should generally be capable of consenting for themselves. Refer to Section 5.5.2 of the Privacy Manual for Health Information for more information.

When a person lacks the capacity to consent (or is deceased), an authorised representative is able to make decisions relating to access to or disclosure of health information on the client/patient's behalf. Refer to the hierarchy for appointing 'authorised representative' in Section 5.6 in the Privacy Manual for Health Information.

Where the request is made for information related to an insurance or compensation claim, a photocopy of the relevant form (HC21 Private Health Insurance Claim form, Inpatient Election Form for Medicare Eligible Patients and Inpatient Declaration for Overseas Visitors Form), signed and dated by the client/patient (or authorised representative), containing consent to disclosure, is sufficient authority for the release of the relevant discharge summary, operation report or Emergency Department (ED) Triage Note. If further information is requested, only relevant sections of the patient's health record which relate to the claim may be provided. Patient consent is required for disclosure of additional health records.

Safeguards when delivering and transmitting information

Requirements necessary to maintain secure delivery will vary depending on the medium of transmission of the information. Refer to Section 9.2.4 of the Privacy Manual for Health Information for guidelines on how to deliver information via facsimile, mail and email securely.

4.1 Receiving a request for patient health information

1. A written request is received from a health fund or insurance company on organisational letterhead or with an adequate corporate signature from a verifiable organisational fax or email.
2. Review the request and check the following:
   2.1. There is sufficient identifiable information (e.g. name, DOB, date of attendance, address, etc) to locate the patient.
   2.2. The request clearly identifies the type of information requested (e.g. discharge summary or copy of clinical notes).
   2.3. The request clearly identifies the date of the attendance/encounter relevant to the claim.
   2.4. The requested information is required to support the payment of an insurance or compensation claim with the Hospital.

4.2 Request for Discharge Summary, Operation Report, and/or ED Triage Clinical Notes

1. Retrieve insurance or compensation claim form (HC21 Private Health Insurance Claim form, Inpatient Election Form for Medicare Eligible Patients and Inpatient Declaration for Overseas Visitors Form) relating to the patient.
   1.1. Ensure that the claim form relates to the relevant health fund and encounter.
   1.2. Identify if consent has been provided for disclosure to release information.
2. Search for the patient using the MRN on PowerChart (for further guidance on how to use PowerChart refer to the PowerChart Admin Reference Guides.)
3. Enter access reason in eMR as per “Powerchart – Adding eMR Chart Access By Reason QRG” (Appendix 2) (i.e. “Access for finance purposes”)
4. Find the document in eMR – the preferred method is to click on the “Clinical Notes” tab, sort by encounter, and search for the discharge summary, operation report, ED notes, or other specifically requested documentation. Ensure that it relates to the correct encounter
5. Review the documentation and identify if the requested information is sensitive. Sensitive information is:
   - HIV/AIDs information
   - Sexual assault notes
   - Sexual health notes
   - Drug and Alcohol notes
   - Child Protection
   - Third Party information (i.e. information relating to another person)
   - Aboriginal health notes

- Adoption notes
- Genetics notes
- Organ / Tissue Donor Identification.

If unsure about whether documentation contains any of the above, contact site HIM/MRM for guidance.

N.B if the information is sensitive you cannot release the information without obtaining further specific consent from the client/patient or redacting the sensitive information (and any related treatment – such as medications). The state form SMR020.080 – Consent to Release Health Information to Non-Health Agencies may be used for this purpose.

6. Provide the documentation to the requesting health fund

Requirements necessary to maintain secure delivery will vary depending on the medium of transmission of the information. Refer to Section 9.2.4 of the Privacy Manual for Health Information for guidelines on how to deliver information via facsimile, mail and email securely.

6.1. Facsimile

6.1.1. Complete all fields on the authorised fax cover sheet

6.1.2. Carefully check the fax number against the requestor's contact details

6.1.3. Fax the document

6.1.4. Obtain the fax transmission report from the fax machine and verify that the information was faxed successfully.

6.2. Mail/Courier

6.2.1. Mark the envelope as "Confidential"

6.2.2. Mark the envelope for the "Attention" of the requestor

6.2.3. Carefully write the address ensuring that it is complete and correct

6.2.4. Place the document in the envelope

6.2.5. Seal the envelope ensuring that it is secure and non-transparent.

6.3. Email

Note: Ministry of Health does not consider email a secure method of transmission and it should be avoided where possible. If necessary, please follow the steps below

6.3.1. Print the document to PDF or scan and save the document in pdf format

6.3.2. Password protect the document using a randomly generated password or phrase (do not use something that could be guessed such as "MRN-NAME")

6.3.3. Reply to original email

Note: Review cc's before you send to ensure information is only being sent to the requesting person

6.3.4. Attach password protected document to email and send

6.3.5. Phone, SMS, or fax requestor to inform them of the password (do NOT send the password/phrase via the same method as the document).

6.4. Secure Messaging System/Portal

6.4.1. Scan, print to PDF, or print to file as PDF

6.4.2. Log-in to secure messaging system/portal, ensuring that it is the correct portal and the website is secure (i.e. HTTPS)

6.4.3. Send/upload documentation

6.4.4. Record receipt/verification number provided.

7. Document the release of information in eMR

7.1. Create an "Admin Note" against the patient and encounter you have logged in against and include:

7.1.1. Date of request

7.1.2. Who requested the information

7.1.3. Date of response

7.1.4. Information provided

7.1.5. Mode of provision (email, fax, secure portal, etc)

7.1.6. Receipt/verification/tracking number information as relevant

NOTE: Ensure you are in the correct "encounter"

7.2. Scan and attach any paperwork to the note type (incl. consent, written request, etc).

4.3 Clinical Notes relating to the Claim

Requests for more information than would be expected from the Discharge Summary, Operation Report, or other single documents. To ensure provision of a complete health record, PPLOs are not expected to complete these requests.

1. Finance staff should retrieve insurance or compensation claim form (HC21 Private Health Insurance Claim form, Inpatient Election Form for Medicare Eligible Patients and Inpatient Declaration for Overseas Visitors Form) relating to the patient.

2. Forward the request and a copy of the signed insurance or compensation claim form to the respective facility Medico-legal Manager/Health Information Manager to process unless the request is for Mental Health records – see point 4.

3. The site will process the request for information under their medico-legal processes and inform the finance officer when complete. Each site will aim to have these requests processed within five business days.

4. For requests for Mental Health information requests should be forwarded to the Mental Health Revenue Manager. They will ensure that 3rd party information is redacted, specific consent has been received and justification for the request has been received.

   Note: This step must be followed as the health record within SESLHD is hybrid in nature and eMR alone will not produce a complete copy of the health record.

4.4 Additional Clinical Notes outside of the attendance

Requests for information or full records that do not relate to the specific attendance for which the HC21 was signed. These requests require additional consent and the PPLOs are not expected to complete them.

1. Forward the request and a copy of the signed insurance or compensation claim form to the respective facility Medico-legal Manager/Health Information Manager to process.

2. The site will process the request for information under their medico-legal processes and inform the finance officer when complete.

   Note: This step must be followed as the health record within SESLHD is hybrid in nature and eMR alone will not produce a complete copy of the health record.

5. DOCUMENTATION

Completion of:

HETI Privacy Module 1 (Course Code 39966648)
HETI Privacy Module 2 (Course Code COM938)
Powerchart training

Admin Note QRG

6. AUDIT

Yearly audits are to be conducted by the Health Information Unit to ensure that Finance are receiving valid requests and are processing these in accordance with this procedure. The audit results to be presented at the SESLHD Health Records and Medico-Legal Committee and District Revenue Committee.

A list of requests and responses can be obtained by running an audit on "Admin Note Types" in eMR report PC109.

Any issues are discussed and escalated to the relevant manager.

7. REFERENCES

Legislation

Health Records and Information Privacy Act 2002 No 71

NSW Health Policies

NSW Health Policy Manual Privacy Manual for Health Information (2015)
NSW Health Consent to Medical and Healthcare Treatment Manual (2020)

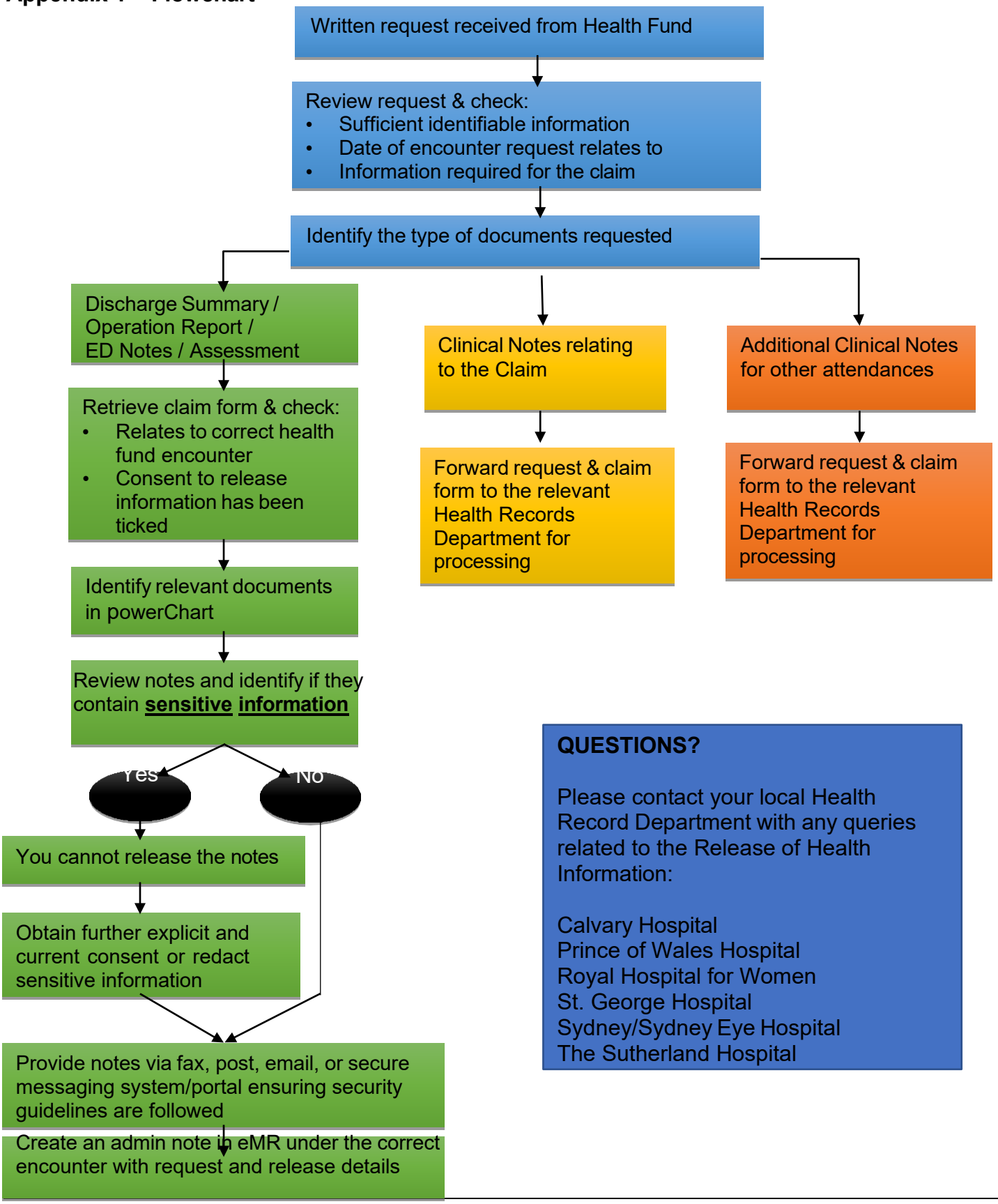
SESLHD Policies and Procedures

SESLHDPR/292 - Hybrid Health Care Record Procedure

8. VERSION AND APPROVAL HISTORY

Date	Version No.	Author and approval notes
Sep 2019	DRAFT	Margaret Suda A/Manager, Health Records, POWH
July 2020	DRAFT	Draft review and approved SESLHD Health Records & Medico Legal Committee
August 2020	DRAFT	Draft for comment period.
October 2020	DRAFT	Processed by Executive Services.
November 2020	1	Approved by Corporate Executive Council. Published by Executive Services.
4 April 2024	1.1	Minor review. Added a point 4 – regarding mental health information request, redaction of 3rd party information and use of consent. Added Admin Note QRG in Section 5. Updated links.

Appendix 1 – Flowchart



QUESTIONS?

Please contact your local Health Record Department with any queries related to the Release of Health Information:

Calvary Hospital
Prince of Wales Hospital
Royal Hospital for Women
St. George Hospital
Sydney/Sydney Eye Hospital
The Sutherland Hospital

Appendix 2 – Powerchart – Adding eMR Chart Accessed by Reason QRG

Health
South Eastern Sydney
Local Health District

PowerChart

eMR Quick Reference Guide

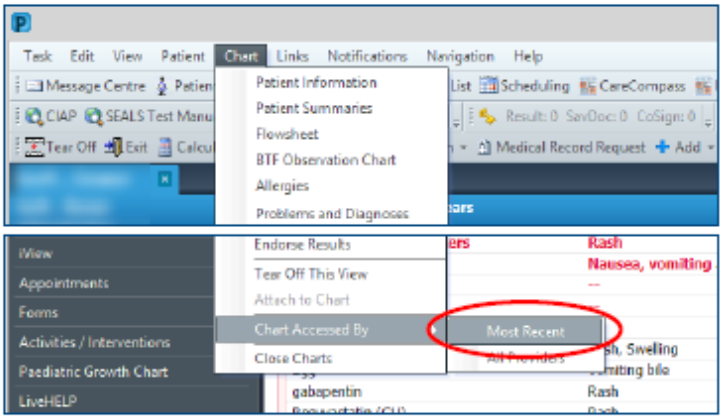
Health
Illawarra Shoalhaven
Local Health District

Powerchart: Adding eMR Chart Accessed By Reason

ntroduction

This Electronic Medical Record (eMR) Quick Reference Guide (QRG) is to show how to add a reason for accessing a patient's chart/Electronic Medical Record.

a. Click the Chart menu and select Chart Accessed By and then Most Recent as shown below.



b. The Chart Access log will display with your name and position shown below in provider name column. Click into the Comment field and enter your reason for access. Click Save and Close.