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Policy Memorandum¹

This Policy Memorandum Issuance #16-11-011

Effective Date: Upon Issuance Expiration Date Upon Reissuance of IMPP² (required)

_____ Addresses subject matter for which an IMPP will be forthcoming and assigned to Chapter(s) _____ of the IMPP manual.

X _____ Amends or modifies existing IMPP(s) # 05-107 INFORMATION TECHNOLOGY AND RECORDS: Confidentiality/Release of Medical and Mental Health Information

_____ Elaborates on the contents of IMPP(s) # _____

_____ Is for Staff Only X _____ Is for Both Staff and Offenders

This policy memorandum is being issued to replace Attachment A - Correct Care Solutions (CCS) Authorization for Release of Health Information, Form #05-107-001 with a new Attachment A - Corizon Health Authorization for Release of Protected Health Information, Form #CS1602.

The new Attachment A, Form #CS162 shall supersede the previous Attachment A, Form #05-107-001 and it shall not longer be used.

Secretary of Corrections

Date: 11/16/16

¹ Note: To keep your IMPP Manual current, please place this Policy Memorandum in your manual at the appropriate location. If the memorandum addresses subject matter for which an IMPP will be forthcoming, place this issuance before the first IMPP in the Chapter indicated. If the memorandum addresses an existing IMPP, the issuance should be placed in front of the existing policy. If this memorandum is for both staff and offenders, it shall be immediately posted.

² Unless another Policy Memorandum or IMPP on this subject is issued, the requirements contained herein have no force and effect after the indicated expiration date.



Authorization for Release of Protected Health Information

Pursuant to 45 CFR Parts 160 & 164 (HIPAA) & 42 CFR Part 2 (Drug & Alcohol Abuse Law)

Send records from: Name/Facility: _____ Address: _____ Phone: _____ Fax: _____ Attention: _____ Date of Service: _____	Send records to: Name/Facility: _____ Address: _____ Phone: _____ Fax: _____ Attention: _____
DEMOGRAPHICS	
Patient Name: _____	ID Number: _____
Alias: _____	Date of Birth: _____
Social Security Number: _____	
INFORMATION REQUESTED	
I hereby authorize the above named provider to release the following confidential information to the person or entity named above: <i>(Initial on lines provided if required)</i>	
<input type="checkbox"/> Physician/Provider's summary of diagnosis, medications, treatments, prognosis and recent care	
<input type="checkbox"/> Recent hospitalization	<input type="checkbox"/> Discharge summary
<input type="checkbox"/> Mental Health treatment	<input type="checkbox"/> Immunization history
<input type="checkbox"/> Substance Abuse treatment	<input type="checkbox"/> Dental records
<input type="checkbox"/> HIV/AIDS results	<input type="checkbox"/> STD results
<input type="checkbox"/> All records	_____
<input type="checkbox"/> Other records (specify): _____	
Purpose of disclosure: _____	
CONSENT FOR RELEASE	
I, or my authorized representative, request the disclosure of my protected health information as set forth on this form. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that:	
1) The information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), alcohol and drug abuse, or mental health treatment, only if I have placed my initials on the appropriate items listed above.	
2) I understand that signing this authorization is voluntary. My treatment or payment for my treatment will not be conditioned upon my authorization of this disclosure.	
3) I have a right to revoke this authorization at any time by writing to the health care provider listed above, except to the extent information has been released in reliance upon this authorization.	
4) I understand that information disclosed pursuant to the authorization may be re-disclosed by the recipient and no longer protected by the federal privacy regulations.	
This authorization shall be in force and in effect until ____ / ____ / ____ ; or until two (2) years from date of execution, at which time this authorization expires.	
_____ Patient's Signature	_____ Date/Time
_____ Witness Signature	_____ Date/Time



Autorización para la Divulgación de Información Médica Protegida
De acuerdo con el Título 45 del CFR, Partes 160 y 164 (HIPAA) y con el Título 42 del CFR, Parte 2
(Ley sobre abuso de drogas y alcohol)

Expedientes enviados de: Nombre/centro: _____ Dirección: _____ Teléfono: _____ Fax: _____ Atención: _____ Fecha del servicio: _____	Expedientes enviados a: Nombre/centro: _____ Dirección: _____ Teléfono: _____ Fax: _____ Atención: _____
DEMOGRAFÍA	
Nombre del paciente: _____	Número del preso: _____
Alias: _____	Fecha de nacimiento: _____
Número de Seguro Social: _____	
INFORMACIÓN SOLICITADA	
Por medio del presente documento doy mi autorización al proveedor antes mencionado para divulgar la siguiente información confidencial a la persona o entidad anterior: <i>(Poner las iniciales en las líneas proporcionadas, si se requiere)</i>	
<input type="checkbox"/> Resumen del diagnóstico, medicamento, tratamientos, pronósticos y atención reciente del médico/proveedor <input type="checkbox"/> Hospitalización reciente <input type="checkbox"/> Tratamiento para salud mental _____ <input type="checkbox"/> Tratamiento para abuso de sustancias _____ <input type="checkbox"/> Otros expedientes (especifique): _____	
<input type="checkbox"/> Resumen del alta <input type="checkbox"/> Historial de vacunación <input type="checkbox"/> Expedientes odontológicos	
<input type="checkbox"/> Resultados del VIH/SIDA _____ <input type="checkbox"/> Resultados de ETS _____ <input type="checkbox"/> Todos los expedientes	
CONSENTIMIENTO PARA LA DIVULGACIÓN	
Yo, o mi representante autorizado, solicitamos la divulgación de mi información médica protegida como se establece en este formulario. En cumplimiento con la Ley de Responsabilidad y Portabilidad de Seguros Médicos de 1996 (<i>Health Insurance Portability and Accountability Act</i> , o HIPAA). Entiendo que:	
1) La información entregada o liberada puede incluir información relacionada con enfermedades de transmisión sexual (ETS), Síndrome de Inmunodeficiencia Adquirida (SIDA), Virus de Inmunodeficiencia Humana (VIH), tratamiento para salud mental o contra el abuso de drogas y alcohol, únicamente si coloqué mis iniciales en las casillas correspondientes anteriores.	
2) Comprendo que la firma de esta autorización es un acto voluntario. Mi tratamiento o el pago por mi tratamiento no estará condicionado por mi autorización de esta divulgación.	
3) Tengo el derecho de revocar esta autorización en cualquier momento por escrito al proveedor de atención médica mencionado anteriormente, con excepción de la información que ya se haya divulgado conforme a esta autorización.	
4) Comprendo que el receptor de la información divulgada de acuerdo con la autorización puede volver a divulgarla y en este caso, la información ya no quedará protegida por los reglamentos de privacidad federales.	
Esta autorización permanecerá en vigor hasta el ____ / ____ / ____; o hasta dos (2) años después de la fecha de firma. Al final de dicho período expirará esta autorización.	
Todas las casillas en este formulario han sido completadas por mí y todas mis preguntas fueron respondidas.	
_____ Firma del paciente	_____ Fecha/Hora
_____ Firma del testigo	_____ Fecha/Hora

KANSAS DEPARTMENT OF CORRECTIONS

	INTERNAL MANAGEMENT POLICY AND PROCEDURE	SECTION NUMBER 05-107	PAGE NUMBER 1 of 4
		SUBJECT: INFORMATION TECHNOLOGY AND RECORDS: Confidentiality/Release of Medical and Mental Health Information	
Approved By:  Secretary of Corrections		Original Date Issued: 07-23-84	Current Amendment Effective: 11-13-09
		Replaces Amendment Issued: 06-26-06	
Reissued By:  Policy & Procedure Coordinator		The substantive content of this IMPP has been reissued as per the appropriate provisions of IMPP 01-101. The only modifications within the reissue of this document concern technical revisions of a non substantive nature. Date Reissued: 01-07-11	

POLICY

All medical and mental health records are confidential and shall be handled in accordance with State and federal statutes and regulations regarding confidentiality and privacy. (ACO 2-4E-01; ACI 3-4330, 3-4377; NCCHC P-61) The policies of the Departmental Health Authority, as approved by the Department, shall control access to medical and mental health records and information and indicate the procedures for maintenance and safekeeping of health records. (ACI 3-4330, 3-4376; NCCHC P-60) Health records shall be maintained under secure conditions in the health care unit. (NCCHC P-61) Confidential information shall be provided to departmental staff and other care providers, as determined necessary by the Health Authority, to protect the welfare of the inmate and/or staff, or, in the interest of facility operations. (ACI 3-4330, 3-4377; NCCHC P-61, P-62) The release of confidential medical and mental health care information shall require appropriate written consent, and shall be accomplished only within the appropriate policies and procedures of both this document and IMPP 05-105.

DEFINITIONS

Departmental Health Authority: The medical director of the agency or organization responsible for the provision of health care services for the Kansas Department of Corrections.

Facility Health Authority: The physician or health administrator responsible for the provision of health care services at a facility. The Facility Health Authority works under the direction of the Departmental Health Authority.

Health Record: Medical and mental health information maintained and secured by the health care provider and contained in the form of electronic / paper media.

Electronic Medical Record: Reflects all medical, mental health, dental, and psychiatric orders and treatments provided, including consultations and X-ray films stored electronically in the electronic medical records system.

PROCEDURES

I. Access to Health Records

- A. Access to health records shall be limited to properly authorized personnel having a demonstrated need for access to these records as determined by the warden and the Departmental Health Authority's policy. (ACI 3-4330, 3-4377; NCCHC P-61)

1. In order to preserve the health and safety of correctional staff, the inmate, and other inmates, strictly on a need to know basis, the Facility Health Authority shall share information with staff about inmates with: (NCCHC P-62)
 - a. Chronic conditions (e.g., diabetes and epilepsy);
 - b. Mental instabilities (e.g., psychoses and suicidal ideation);
 - c. Physical limitations; and/or,
 - d. Prescribed medications with potential side effects.
2. The Facility Health Authority shall provide pertinent information in writing regarding an inmate's health status/medications to parole staff immediately prior to an inmate's release on parole or post-release supervision.

II. Release of Health Information

- A. Federal Alcohol and Drug Abuse Regulations pertaining to confidentiality shall be adhered to whenever any information from an inmate's health record is provided, including alcohol and drug abuse programs.
- B. Records received from non-KDOC health care agencies, to facilitate the treatment of an inmate, shall not be released to a third party agency or individual.
 1. The source of such information may be made available for release to a third party.
- C. Confidential information shall be disclosed if the Facility Health Authority determines such disclosure is necessary to protect against the following:
 1. Suicide;
 2. Communicable disease;
 3. Injury to self or others; and/or,
 4. A threat to the safety and security of the facility.

III. Release of Information: Written Authorization (ACI 3-4330, 3-4378)

- A. When releasing information from the health record, original materials shall not be removed/released from the facility.
- B. Prior to releasing health information, KDOC officials shall have in their possession one of the following:
 1. A properly executed Department of Corrections Consent for Release of Confidential Medical Information Form, Attachment A;
 - a. The consent for release of information shall:
 - (1) Be signed by the inmate (ACI 3-4330, 3-4378; NCCHC P-62), parent, guardian or legal representative;
 - (2) Specify information that is authorized to be released;
 - (3) Include date treatment began; and,

- (4) Indicate length of time the release of information is in effect.
- b. The original of all release of information requests shall be placed in the inmate's medical file.
2. A Court Order; or,
3. A subpoena accompanied by executed KDOC Consent for Release of Confidential Medical Information, Court Order, or (if applicable) a statement from the inmate's attorney indicating that the inmate has put his/her medical condition into issue by filing a law suit.

IV. Release of Information: Without Written Authorization

- A. Release of the RDU Evaluation Report shall be limited to those parties and agencies identified in KSA 75-5266 and IMPP 05-101.
- B. A summary of psychiatric, or psychological, and social work information shall be released only when deemed appropriate by the Facility Health Authority or designee.
- C. Information concerning reportable diseases shall be released to local and State health departments in accordance with State statutes.
- D. Medical and mental health status reports shall be provided by the Facility Health Authority, or designee, to:
 1. The warden when questions arise pertaining to transfer, classification, or change of treatment;
 2. The Secretary, warden, or designees for purposes of monitoring and evaluating the delivery of medical and mental health services;
 3. Outside physicians in an emergency, surgical, or treatment situation for the purpose of continuity of care;
 4. Parole services, when an inmate is released from a facility;
 5. Other KDOC facilities when an inmate is being transferred inter-facility; and,
 6. A person with legal power of attorney for the inmate's health care.
- E. The facility staff shall be responsible for processing any requests or the release of information if the inmate's records are still within their control. In cases where inmate files are no longer at the facility, the Central Office Records Administrator shall be responsible for processing any release of information.

V. Use of Health Records in Research Projects (ACO 2-1F-15)

- A. The use of medical and/or mental health records for approved evaluation and research projects may be granted if:
 1. The requirements of IMPP 06-101, Research and Evaluation Activities, are met; and,
 2. The identity of the inmates or release of such information would not have a direct adverse effect on the inmates involved.

NOTE: The policy and procedures set forth herein are intended to establish directives and guidelines for staff and offenders and those entities who are contractually bound to adhere to them. They are not intended to establish State created liberty interests for employees or offenders, or an independent duty owed by the

Department of Corrections to either employees, offenders, or third parties. Similarly, those references to the standards of various accrediting entities as may be contained within this document are included solely to manifest the commonality of purpose and direction as shared by the content of the document and the content of the referenced standards. Any such references within this document neither imply accredited status by a Departmental facility or organizational unit, nor indicate compliance with the standards so cited. The policy and procedures contained within this document are considered to be compliant with all applicable Federal statutes and/or regulatory requirements. This policy and procedure is not intended to establish or create new constitutional rights or to enlarge or expand upon existing constitutional rights or duties.

REPORTS REQUIRED

None.

REFERENCES

KSA 75-5266
IMPP 05-101, 06-101
ACO 2-4E-01
ACI 3-4377, 3-4378
NCCHC P-60, 61, 62

ATTACHMENTS

Attachment A – Consent for Release of Confidential Medical Information, 1 page

