Applicability: _ ADULT Operations Only _ JUVENILE Operations Only X DEPARTMENT-WIDE

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HEALTH CARE SERVICES: Confidentiality and Release of Medical and Behavioral Health Information

Original Date Issued: 08-16-22 Replaces IMPP Issued: N/A CURRENT EFFECTIVE DATE: 08-16-22

Approved By:  , **Secretary** **Next Scheduled Review:** 11/2025

POLICY

All health records and information about the resident's health status is confidential and is to be handled in accordance with State and Federal statutes and regulations regarding confidentiality and privacy. The policies of the contracted vendor as approved by the Department and Director of Health Care Compliance are to define control and access procedures to health records and health information as well as procedures for maintenance and safekeeping of health records.

DEFINITIONS

Director of Health Care Compliance: This position acts as the administrative health authority for the Department. This position manages health care systems, directs the health care services model, and has final approval on all policies and procedures in the health care system.

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

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

Health Services Administrator (H.S.A.): The individual responsible for ensuring the organization and delivery of all levels of quality accessible health services in the facility. The H.S.A. works under the direction of the Regional Medical Director clinically and the Regional Vice President or designee administratively.

PROCEDURES

I. Access to Health Records

A. Access to health records is to be limited to properly authorized personnel having a demonstrated need for access to these records as determined by the contracted vendor and Departmental policies as approved by the Director of Health Care Compliance, the KDOC Chief Information Officer, and/or the Secretary of Corrections or his/her designee. The contracted health services vendor is to maintain documentation that health care staff receive instruction in maintaining confidentiality.

1. Access to health records and health information at the site level is controlled by the Health Services Administrator as the responsible health authority. The H.S.A. shares with the Warden/Superintendent information as needed regarding a resident's medical management.

2. Only information that is necessary to preserve the health and safety of a resident, other residents, volunteers/visitors, or correctional staff is to be provided. Examples include:

a. Chronic conditions (e.g., diabetes, seizure disorder),

b. Mental instabilities (e.g., psychoses, suicidal ideation),

c. Physical limitations; and or,

d. Potential for serious medication side effects.

3. The Health Services Administrator is to ensure pertinent written information is provided regarding a resident's health status/medications to discharge planners and parole staff prior to a resident's release on parole or post-release supervision.

II. Release of Health Information

A. Federal Alcohol and Drug Abuse Regulations pertaining to confidentiality are to be adhered to whenever any information from a resident'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 a resident, are not to 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 is to be disclosed if the Health Services Administrator 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

A. When releasing information from the health record, original materials are not to be removed/released.

B. Prior to releasing health information, KDOC officials are to 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-English or B-Spanish);

a. The consent for release of information is to:

(1) Be signed by the resident, 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 is to be scanned into the resident's electronic medical record.

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 resident's attorney indicating that the resident 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 is to be limited to those parties and agencies identified in KSA 75-5266 and IMPP 05-101D.

B. A summary of psychiatric, or psychological, and social work information is to be released only when deemed appropriate by the Regional Medical Director or designee.

C. Information concerning reportable diseases is to be released to local and State health departments in accordance with State statutes.

D. Medical and behavioral health status reports are to be provided by the Health Services Administrator, or designee, to:

1. The Warden/Superintendent when questions arise pertaining to transfer, classification, or change of treatment;

2. The Secretary, Warden/Superintendent, 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/Conditional Release services, when a resident is released from a facility;

5. Other KDOC facilities when a resident is being transferred inter-facility; and,

6. A person with legal power of attorney for the resident's health care.

E. The Central Office Records Administrator is to be responsible for processing any release of information.

V. Use of Health Records in Research Projects

A. The use of medical and/or behavioral health records for approved evaluation and research projects may be granted if:

1. The requirements of IMPP 06-101D, Research and Evaluation Activities, are met; and,

2. The identity of the residents or release of such information would not have a direct adverse effect on the residents involved.

NOTE: The policy and procedures set forth herein are intended to establish directives and guidelines for staff, residents and offenders and those entities that are contractually bound to adhere to them. They are not intended to establish State created liberty interests for employees, residents or offenders, or an independent duty owed by the Department of Corrections to employees, residents, 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 intended to be compliant with all applicable statutes and/or regulatory requirements of the Federal Government and the state of Kansas. This policy and procedure are not intended to establish or create new constitutional rights or to enlarge or expand upon existing constitutional rights or duties.

REPORTS

None.

REFERENCES

KSA 75-5266
IMPP 05-101D, 06-101D
ACA 5-ACI-6C-03 (Ref. 4-4396)
ACI 3-4220; 3-4378
ACO 2-1F-15
NCCHC P-A-08; P-62

HISTORY

08-16-22 Original

ATTACHMENTS

Attachments	Title of Attachments	Page Total
A	Consent for Release of Confidential Medical Information English	1 page
B	Consent for Release of Confidential Medical Information Spanish	1 page

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AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Patient Name	Date	
SSN#	ID#	DOB
Current Institution		
Last Home Address		

I understand that by signing this form, I am giving healthcare staff at this facility permission to access my prior healthcare records from the agencies listed below and to share information about my health condition and/or treatment with staff of the agencies listed below. I also give permission for the staff of this facility and the agencies listed below to discuss confidential information about my health condition and/or treatment.

The information to be released between the date of _____ and the date of _____ includes:

- ☐ Admission Summary
- ☐ Discharge Summary
- ☐ Inpatient MH/Psychiatric
- ☐ Emergency Room Treatment
- ☐ Other:
- ☐ X-ray Reports
- ☐ Lab Reports
- ☐ Treatment Plans
- ☐ Current Medications
- ☐ Operative Reports
- ☐ HIV Status & Treatment
- ☐ Outpatient MH/Psychiatric
- ☐ Other:
- ☐ Sexually Transmitted Diseases
- ☐ History of Medications
- ☐ Substance Abuse Treatment

I understand that this information may include all or any part of the records of my treatment for HIV, sexually transmitted diseases, psychiatric illness, alcohol and/or substance abuse treatment and other mental health issues. The information received or distributed will be used only for my treatment. Further disclosure of this information without my specific written authorization or as otherwise permitted by law is legally prohibited. I understand that I am not required to sign this authorization for the release of healthcare information in order to receive healthcare or treatment.

I authorize the healthcare staff at this facility to request information from and/or release information to following community agencies:

1.
2.
3.

This authorization will remain valid for 180 days from the date of my signature unless I revoke the authorization in writing.

PATIENT SIGNATURE: _____ DATE: _____

HEALTHCARE STAFF SIGNATURE: _____CONTACT NUMBER: _____

Information to be sent to/from:

AUTORIZACIÓN PARA LA DIVULGACIÓN DE INFORMACIÓN DE ATENCIÓN MÉDICA

Nombre del paciente	Fecha	
Núm. de Seguro Social	Núm. de identificación	Fecha de nacimiento
Institución actual		
Última dirección residencial		

Entiendo que al firmar este formulario le doy permiso al personal de atención médica de esta institución a acceder a mis expedientes médicos anteriores de las agencias enumeradas abajo y a compartir información sobre mi padecimiento y/o tratamiento con el personal de las agencias enumeradas abajo. También le doy permiso al personal de esta institución y a las agencias enumeradas abajo para hablar sobre información confidencial acerca de mi padecimiento y/o tratamiento.

La información que será divulgada entre la fecha del _____ y la fecha del _____ incluye:

- ☐ Resumen del ingreso
- ☐ Resumen del alta
- ☐ Salud mental/psiquiátrica como paciente internado
- ☐ Tratamiento en la sala de emergencias
- ☐ Otra:
- ☐ Informes de rayos X
- ☐ Informes laboratorio
- ☐ Planes de tratamiento
- ☐ Medicamentos actuales
- ☐ Informes quirúrgicos
- ☐ Estado VIH y tratamiento
- ☐ Salud mental/ psiquiátrica en consulta externa
- ☐ Otra:
- ☐ Enfermedades venéreas
- ☐ Historial de medicamentos
- ☐ Tratamiento del abuso de sustancias

Entiendo que esta información puede incluir todos o cualquier parte de los expedientes de mi tratamiento para el VIH, enfermedades venéreas, enfermedades psiquiátricas, tratamiento del abuso de alcohol y/o sustancias y otros problemas de salud mental. La información recibida o distribuida será utilizada solo para mi tratamiento. La divulgación adicional de esta información sin mi autorización escrita específica, o como lo permite la ley de otra manera, está legalmente prohibida. Entiendo que no estoy obligado a firmar esta autorización para la divulgación de la información de atención médica para recibir atención médica o tratamiento.

Autorizo al personal de atención médica de esta institución a solicitar información de y/o divulgar información a las siguientes agencias comunitarias:

1.
2.
3.

Esta autorización permanecerá válida por 180 días a partir de la fecha de mi firma a menos que revoque la autorización por escrito.

FIRMA DEL PACIENTE: _____ FECHA: _____

FIRMA DEL PERSONAL DE ATENCIÓN MÉDICA: _____ NÚM. DE CONTACTO: _____

La información debe enviarse a/provenir de: