SECTION 2: HEALTH INFORMATION MANAGEMENT

2.1. General Policies

POLICY:

1. Maintenance and Ownership of Healthcare Records and UF’s Commitment:
   a. Health and financial records created as a result of patient care encounters in any University of Florida (UF) patient care area, including faculty practice clinics in Gainesville, Jacksonville, and outlying areas, the Student Health Care Center, and the Counseling and Wellness Center, are the property of UF, even though components of the records may be shared with the UF Health Shands HealthCare System (Shands).
   b. A health record shall be maintained for every individual who is evaluated or treated as a patient in any UF patient care area. Currently, UF’s health records are considered hybrid records, consisting of both electronic and paper documentation.
   c. Information recorded in UF’s healthcare and patient financial records ultimately belongs to the patients about whom it is recorded. UF is committed to protecting the confidentiality of all patient information it receives, creates, maintains, and transmits in any format.

2. Use and Disclosure of Protected Health Information (PHI): Individually identifiable health information created, received, maintained, or transmitted by UF in any format may only be used and disclosed in accordance with federal and state laws and UF’s policies and procedures or with the approval of the Chief Privacy Officer. See SECTION 3: Uses and Disclosures of PHI: General Rules.

3. Removal of Patient Related Information: Patient information, whether original or copied, in paper or electronic formats, that is generated or received for the care of patients by UF, may NOT be removed from the premises of UF or Shands by anyone, except upon receipt of a court order, subpoena duces tecum, or written departmental administrative approval.

4. Health Information Custodians:
   a. Either the UF Health Shands Health Information Management (HIM) Director or the Clinic Manager act as the officially designated Custodian for Health Information Records in all formats for UF in all locations.
   b. Any issues with UF records related to patients’ rights (i.e., requests for copies, amendments, restrictions, etc.) or other requests for copies or information are managed by designated UF Health HIM personnel.
   c. Questions about custodianship should be directed to either UF Health Shands HIM or the appropriate clinic.

5. Health Information Management Personnel:
   a. Each patient care area and department that creates, receives, maintains, uses, and/or discloses PHI in any format must designate at least one staff member to manage the health information and patient records for that area.
b. The staff member is not required to be solely dedicated to the management of health information, but must be specifically trained and responsible for maintaining the confidentiality, security, and accessibility of patients’ information.

DEFINITIONS

1. **Active/Inactive Records**: Active healthcare records are those currently being used for ongoing patient care, payment, litigation, or research activities. Inactive records are those for patients who have not received healthcare, made payments for care, or been involved in litigation or research for a designated period of time.

2. **Designated Record Set**: A defined group of health and billing records that contain PHI.

3. **Legal Health Record (LHR)**: A formally defined legal business record, made by a healthcare organization, in the routine course of business at or near the time that events occurred. The legal health record is a subset of the entire patient database, and identifies what information constitutes the official business record of an organization for evidentiary purposes.
   a. The legal health record is comprised of individually identifiable data, recorded in any medium, collected from multiple disciplines, and used by healthcare professionals while providing patient care or services, reviewing patient data, or documenting observations, actions, or instructions.
   b. Documentation may include personal identification information, diagnoses, treatments, services provided, and payment for services. Documentation may also include copies of records, created elsewhere, that are considered relevant to decisions made about care or services provided at UF.
   c. Components of the legal health record may physically exist in separate and multiple paper-based files or electronic/computer-based databases; these components would be compiled and released upon receipt of a legally authorized request.

4. **Primary Records**: Original documentation created and maintained in any format as a direct result of a patient or client encounter in any of UF’s healthcare facilities, including faculty practice clinics and student health clinics. Paper Primary records are usually maintained in and/or by the entity where the care or service was provided. Primary records also include any original documents that are not reproducible elsewhere, such as older records being retained in off-site storage.

5. **Shadow Records**: Paper copies of primary records that are temporarily kept separately from the primary record, usually for the convenience of health care providers or their staff. Shadow records should not be created in areas where electronic records are available.

   NOTE: Paper records that were created and maintained in UF clinics are not shadow records, even though they may include documents shared with other parts of UF and Shands.

PRIVACY REQUIREMENTS

1. **Using and Disclosing Health Information**: Individually identifiable health information created, received, maintained, or transmitted by UF may only be used and disclosed in accordance with UF’s policies and procedures or with the approval of the Chief Privacy Officer.

2. **Authorizations**: A complete and valid HIPAA Authorization is required for disclosures of PHI for purposes not related to treatment, health care operations, or as otherwise required by law, including:
   a. To patients or their legal representatives (See also SECTION 4: Patient’s Rights - Access to Health Records).
b. To third parties, including healthcare professionals who do not have a treating relationship with the patient (See also SECTION 3: Uses and Disclosures of PHI - Authorizations).

c. To researchers (See also SECTION 3: Uses and Disclosures of PHI - Research).

3. **Security of Active Records:** All patient records in all formats must be stored so that they are available for use, but also physically and technologically secure. Information and records must be protected from unauthorized access, physical damage by fire, water, insects, pests, temperature, and humidity, and other reasonably foreseeable hazards.

**GENERAL PROCEDURES**

1. **Health Record Integrity and Chronology:** Double check to be sure paper documents are filed in the correct patient’s record in chronological order and that electronic information and scanned/imaged documents are being entered in the correct encounter record for the correct patient.

2. **Authorized Disclosure/Release of Health Information:** Route all requests related to disclosure of PHI to the designated record manager for the primary record. Only authorized personnel who have been appropriately trained should disclose patient information in response to requests (See also SECTION 3: Uses and Disclosures of PHI General Rules).

3. **Specific Procedures:** Refer to your college, department or unit policies and procedures developed for specific Health Information Management issues, especially as related to electronic health records.

4. **Disaster Preparations:** Refer to your facility’s Disaster Manual for protection of non-electronic records during potentially damaging situations. Refer to UF’s Information Security Guidelines and your unit’s Information Security Manager for protection of electronic records.

**REFERENCES**

1. HIPAA: 45 CFR §164.501 - Definitions; §164.502 - Use and Disclosure
2. Florida Statues: 456.057 - Ownership and Control of Patient Records

**EXHIBITS**

1. Table: The Designated Record Set
2. UF Privacy Office HIPAA authorization forms available at, [http://privacy.ufl.edu/uf-health-privacy/forms/](http://privacy.ufl.edu/uf-health-privacy/forms/)
### Table: The Designated Record Set

<table>
<thead>
<tr>
<th><strong>Included in the Designated Record Set</strong></th>
<th><strong>Examples</strong></th>
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| Health records created, received, maintained, or transmitted by healthcare providers in UF’s health care components. | • The content of any paper-based and/or electronic patient health record held by UF;  
• UF Student Health Records, except immunization records. |
| Billing records created, maintained, or transmitted by health care providers in UF’s health care components. | • The content of any paper-based healthcare account record held by UF;  
• Any patient account data in a computerized scheduling system, or electronic billing and accounting system. |
| Other records used to make health care decisions about the individual. | • A clinical report generated by a hospital physician and subsequently incorporated into a UF patient health record;  
• Copies of reports generated by other UF providers and used to make decisions about the individual, even when kept in shadow charts. |
| Records maintained by a business associate that meet the definition of designated record set that are not duplicates of records maintained by the covered entity. | • Records maintained by record storage companies that have agreed to manage release of information rather than returning the records to the covered entity to respond. |
| Source data interpreted or summarized in the individual’s medical or health record. | • Interpretations of Pathology slides;  
• Interpretations of Diagnostic films;  
• Interpretations derived from Electrocardiogram tracings. |

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<th><strong>Not in the Designated Record Set</strong></th>
<th><strong>Examples:</strong></th>
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| Health information generated, collected, or maintained for purposes that do not include decision-making about the individual. (Copies of patient records from other providers that were not used to make health care decisions about the patient, if retained, are available for inspection only, not copying) | • Data collected and maintained for research, peer review (QA/QI); or performance/outcomes improvement purposes;  
• Appointment and surgery schedules;  
• Diagnostic or operative indexes;  
• Duplicate copies of information that may also be located in the individual’s official health or billing record. |
| Psychotherapy notes. | • The notes of a mental health professional about counseling sessions that are maintained separate and apart from the regular health record. |
| Information compiled in anticipation of, or for use in a civil, criminal, or administrative action or proceeding. | • Notes taken during a meeting with our attorneys about a pending lawsuit. |
| CLIA Documents | • Requisitions for laboratory tests;  
• Duplicate lab results when the originals are filed in the individual’s primary health record. |
| Employer records when patient is a UF / UFP / UFJHI / UFJPI / SHCC employee. | • Pre-employment physicals and employee health records (immunization, PPD, etc.) maintained in Human Resources files.  
• The results of HIV tests maintained by the infectious disease control nurse on employees who have suffered needle stick injuries on the job. |
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<tr>
<th>Business associate records that duplicate information maintained by the covered entity.</th>
<th>• Transcribed operative reports transmitted to the covered entity.</th>
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<tbody>
<tr>
<td>FERPA Student Health Records</td>
<td>• Immunization Records</td>
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<tr>
<td>UAA Student Athlete Records</td>
<td>• Pre-Participation Physicals, drug-testing and immunization records, insurance info, diagnostic test results, progress notes, rehab notes, physician dictations, healthcare referrals and notes</td>
</tr>
<tr>
<td>Source Data (Available for copying or inspection upon the specific request of the patient)</td>
<td>• Pathology slides</td>
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<td>• Diagnostic films</td>
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<td>• Electrocardiogram tracings from which interpretations are derived</td>
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