

A GUIDE TO RELEASE OF INFORMATION FOR PROVIDERS

Omaha Release of Information Office (136D4)– Room 1409

Ext. 3164, 3996 or 3589

Supervisor, Release of Information (136D) – Room B617

Ext. 3427

DO's

1. **At this point in time the following information can be released to the patient without a written consent or involvement of Release of Information personnel:**
 - You may verbally provide any information the patient needs or wants to know regarding his/her condition and the results of any test or procedures.
 - You may verbally provide any instructions and/or orders that the patient needs to follow after his/her hospitalization or clinic visit. This information can also be shared with a caregiver (such as a wife or nursing home caring for the patient) consistent with good medical-ethical practices.
 - You may give the patient a copy of a lab test, radiology report, pathology report etc., if it is given during the course of the visit and is part of providing patient education or explaining care to the patient. (For example, a Coumadin Clinic where the provider prints a graph of 6 months worth of tests to show the patient how his levels have decreased over a period of time or a follow-up appointment after a stress test to discuss the results and determine future action). You may also call or send the patient a copy of test results when they become available, even if it is a few days after the visit.
 - You may send letters to the patient regarding his/her medical condition, need for follow-up, etc. A copy should be maintained for the patient's record. If the patient has specified that he has a confidential mailing address any letters must be sent to that address. Send your letters to patients through the Release of Information department so that they can ensure that it is sent to the appropriate address.
 - You may give the patient any information regarding his condition or treatment over the phone. But if the patient is calling you, **you must be very sure that it is actually the patient that you are speaking with.** The best way to do this is to call the patient back at the home or work phone number listed in his/her records.
 - You may provide the patient a printout or list of his/her medications such as can be provided using the options RX Information Profile, ACTIVE RX'S DISPLAY [PSZZACT], or the Active Prescriptions under the Reports tab in CPRS.
 - If you are discussing the patient's treatment in the presence of a third party, you must make sure that you have the consent of the patient to do so. You are strongly encouraged to document this approval in the medical record.
2. The two-part NCR **RETURN TO WORK** form can be used. The patient does sign this copy and this does constitute consent. However, physicians can complete this form and give it to the patient right at the time of the visit. The carbon copy needs to be sent to the Release of Information office so that an accounting can be maintained as required by the Privacy Act.
3. **FORM COMPLETION** --When Release of Information staff requests that a form be completed or an opinion be given, Providers can assume that all necessary consents and disclaimers have been obtained and that the forms must be dealt with. **VHA policy requires that VHA health care providers, when requested, provide descriptive statements and opinions for VA patients with respect to patients' medical condition, employability, and degree of disability. These forms must be completed as soon as possible and as completely as possible. The completed forms must be returned to the Release of Information office and not given directly to the patient.** This must be done so that an accounting can be maintained, a disclaimer signed, and a copy of the completed form made for the record, as required by the Privacy Act.

4. **EXAMINATIONS IN ORDER TO PROVIDE OPINIONS**--If a patient requests an examination in order to complete a form or provide an opinion, this must be done. The exception to this rule is exams for the Social Security Administration. PROVIDERS MAY COMPLETE FORMS, PREPARE LETTERS, OR MAKE STATEMENTS IN THE MEDICAL RECORD FOR THE SOCIAL SECURITY ADMINISTRATION IF THEY CAN DO SO BASED ON THEIR PERSONAL KNOWLEDGE OF THE PATIENT AND/OR A REVIEW OF THE RECORDS. **HOWEVER, NO SPECIAL EXAMINATION MAY BE DONE SOLELY TO COMPLETE SOCIAL SECURITY FORMS.**
5. **OPINIONS REGARDING SERVICE CONNECTION**--If requested by a patient, providers are required to provide an opinion in the medical record regarding the relationship of the patient's medical condition as it relates to his/her military service. *A note in the medical record containing a statement such as, "in my medical opinion the currently existing medical condition is 'related to,' 'possibly related to,' or 'at least as likely as not related to' an injury, disease, or event occurring during the veteran's military service" constitutes a sufficient supportive statement. The injury, disease, or event can be something described by the veteran or shown in other records, but should be identified as such by the physician in the physician's statement. A statement to the effect of, "I am unable to determine whether a relationship exists" between the present disability and a described injury, disease, or event occurring during military service, is also acceptable.*

NOTE: In all instances involving VA determinations of disability or service connection mentioned in items 3, 4 & 5 above, **the veteran is required to sign a disclaimer** that states: "I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions." **For this reason it is essential that no completed form or notes with a medical opinion of disability or service connection be given directly to the veteran. He/she must be sent to the Release of Information office listed above before this information is released.** Security bags are available in each clinic area for the veteran to transport the notes or forms to the Release of Information office.

6. **NON-VA Providers**—You may release verbal information (not including information pertaining to treatment for Drug Abuse, Alcohol Abuse, HIV/AIDS, or Sickle Cell Anemia) to a non-VA health care provider for treatment purposes. You may release records (not including information pertaining to treatment for Drug Abuse, Alcohol Abuse, HIV/AIDS, or Sickle Cell Anemia) to a non-VA health care provider for treatment purposes upon receipt of a written (or FAXED) request. **If you are releasing records a written request from the non-VA provider is required.** Any records released to a non-VA provider do constitute a disclosure. Therefore you need to inform the Release of Information Office and send the written request when you provide records to non-VA providers, so that a record of this disclosure can be maintained as required by HIPAA and the Privacy Act. If you need to release either verbal information or records pertaining to alcohol abuse, drug abuse, sickle cell anemia or HIV/AIDS, contact the Release of Information office before any information is released and they will guide you through the correct processes.
7. Do call Release of Information or the HIMS Supervisor at the numbers listed at the top of this document if you have any questions regarding Release of Information.
8. Do call the Privacy Officer, Miriam Chapman ext. 3427 if you have questions or concerns regarding Privacy Issues or witness any violations of privacy at our facility.

DON'TS

1. Don't give patients copies of **past** electronic or hard copy medical records that are not required during the course of the patient's current visit as part of providing instruction, education, or determining the course of treatment. This is a violation of the Privacy Act. If patients need copies from their **past** records they should be referred to Release of Information. This includes progress notes, lab, radiology and pathology reports, discharge summaries, operation reports etc.

2. Don't complete a form that the patient brings in and just hand it back to him/her. You may complete the form, but make sure that the patient and the form get to Release of Information so that a consent can be obtained, a copy made for the record, a disclaimer obtained if necessary, and an accounting maintained.
3. Do not refer patients to the Compensation and Pension office if they are requesting a disability evaluation for any purpose that is not related to VA disabilities. Non-VA disability opinions should be provided by the Primary Care physician with referrals to other providers if necessary.
4. **DO NOT RESPOND TO ANY SUBPOENA OR COURT ORDER OR LETTER FROM AN ATTORNEY SENT DIRECTLY TO YOU.** Take any subpoena or court order or attorney letter you receive to Release of Information **IMMEDIATELY**. They will check with the Regional Counsel if necessary, and provide you with guidance and information on how to proceed.
5. Do not communicate confidential patient information using e-mail systems other than the internal VistA e-mail. You may not communicate confidential patient information in OUTLOOK. This applies to communications with the patients or other providers. E-mail systems other than VistA are not secure.
6. If you call a patient do not leave any medical information other than an appointment date and time on an answering machine or voice mail.