

Minnesota Sex Offender Program

Policy:	106.300	Title: Health Information Record Designation
Issue Date:	5/6/14	
Effective Date:	5/6/14	

AUTHORITY: [45 CFR Parts 160 and 164](#) - Health Insurance Portability and Accountability Act
Minn. Stat. §§[13.02](#); [13.03](#); [13.04](#); [13.384](#) (Data Privacy)
Minn. Stat. §[254A.09](#) (Confidentiality of Records)
Minn. Rule [4642.1000](#) (Individual Permanent Medical Record)

PURPOSE: To identify the client record types of the Minnesota Sex Offender Program (MSOP) Health Information Management Services (HIMS), for business and legal purposes and to ensure the integrity of the records are maintained to support business and legal needs.

APPLICABILITY: Minnesota Sex Offender Program (MSOP), program-wide

POLICY: HIMS will create and maintain records serving a primary intended purpose of clinical and client care use, and also serving the business and legal needs of MSOP.

DEFINITIONS:

Designated Record Set – a private, comprehensive document created in the course of client care from admission through discharge. The MSOP Designated Record Set includes the sex offender treatment records, medical records, billing records, victim notification record, confidential record, and those records used to make medical and treatment decisions about the client.

Hybrid Record – an identification of the record during the transition to the electronic legal record causing part of the record to be on paper and part of the record to be in electronic form.

Legal health record – a hybrid record subset of the entire client database and electronic document storage, serving as the legal business record for the organization and released upon request. The legal health record support the decisions made in a client’s care, supports the revenue sought from third-party payers, and documents the services provided as legal testimony regarding the client’s illness or injury, response to treatment, and caregiver decisions. The legal record includes:

Medical Record – documentation, in any medium, of an individual’s physical health and healthcare services.

Treatment Record – information, in any medium, used for or documented about an individual’s behavioral health and sex offender treatment.

PROCEDURES:

A. Designated Record Set

1. Inclusion

The designated record set includes:

- a) the legal health record (see Procedure B, below);

- b) information regarding reimbursement for services or billing;
- c) records of another facility used in whole or in part by MSOP to make decisions about individuals;
- d) administrative records such as authorizations for release of any types of information, certification of records, release of information logs, consents or agreements; and
- e) correspondence documents.

2. Exclusion

The designated record set excludes the following which may have specific data classification as private or confidential:

- a) client-identifiable administrative data used for administrative, regulatory or healthcare operations including, but not limited to, court exhibits, court documents not pertaining to treatment of the client, record reviews, duty to warn, victim notification, incident reports, grievances, investigative information, property management, programming documentation, security documentation, accreditation or licensing reports;
- b) aggregated, summary, or non-client identifiable data;
- c) notes maintained separately from the legal health record;
- d) information created in research studies to which the client has temporarily waived rights to access;
- e) records destroyed based on retention schedule or rendered unusable due to fire, flood, damage, or other circumstances;
- f) information subject to a legal privilege; and
- g) source data including, but not limited to, images, raw test data, videos, electrocardiograms (EKGs), x-rays, etc.

3. Disclosure

Designated staff will only disclose information from the designated record set upon specific order. The information is not released when the “medical record” is requested, subpoenaed, or court ordered unless specified.

4. Access

HIMS staff store, maintain and collect information for the designated record set in hybrid records with access based on roles and responsibility.

B. Legal Health Record

The legal health record includes individually-identifiable information documented regarding the observations, actions, or instructions related to treatment and healthcare of the MSOP clients.

1. Inclusion
The legal health record includes the medical record and the treatment record information designated on the appropriate record guidelines (attached). (See also MSOP Policy 500.190, "Health Information Management Services.")
2. Exclusion
The legal health record excludes reports or information not made or kept in the regular course of treatment or healthcare such as files, records or reports from other agencies.
3. Disclosure
HIMS staff will only disclose information from the legal health record needed to fulfill the intent of the request and will exclude information determined to not be included in the legal health record.
4. Access
HIMS staff will collect, maintain and store information for the legal health record in a hybrid record with access based on roles and responsibility.

C. Medium

The designated record set is comprised of documentation physically existing in separate and multiple paper or electronic-based forms.

1. Staff may refer to the documents in electronic document storage. Staff will not print documents stored in the MSOP designated portion of the electronic document storage. HIMS staff and/or the electronic document management services (EDMS) staff will retain and manage any original hard-copy documents per MSOP Policy 106.200, "MSOP Records Management and Retention."
2. Staff will not print copies of these documents unless it is needed for an emergency situation or printed under MSOP Policy 500.192, "Data Request and Copy Costs."
3. Staff will refer any requests for release of information from the designated record set to the HIMS staff.

REVIEW: Annually

REFERENCES: MSOP Policy 500.192, "Data Request and Copy Costs"
MSOP Policy 500.190, "Health Information Management Services"
MSOP Policy 106.200, "MSOP Records Management and Retention"

SUPERSESSION: MSOP Policy 500.190, "Health Information Management Services (HIMS)," Section C.6., 9/6/11.
All facility policies, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

ATTACHMENTS: Filing Guidelines – Medical Record (500.190D)
Filing Guidelines – Treatment Record (500.190G)
Filing Guidelines – DOC Site (500.190H)
Filing Guidelines – Health Services Record 500.190I

/s/

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