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The Voice of 16,000 Michigan Physicians

MEDICAL RECORDS GUIDE *for* **PHYSICIAN PRACTICES**

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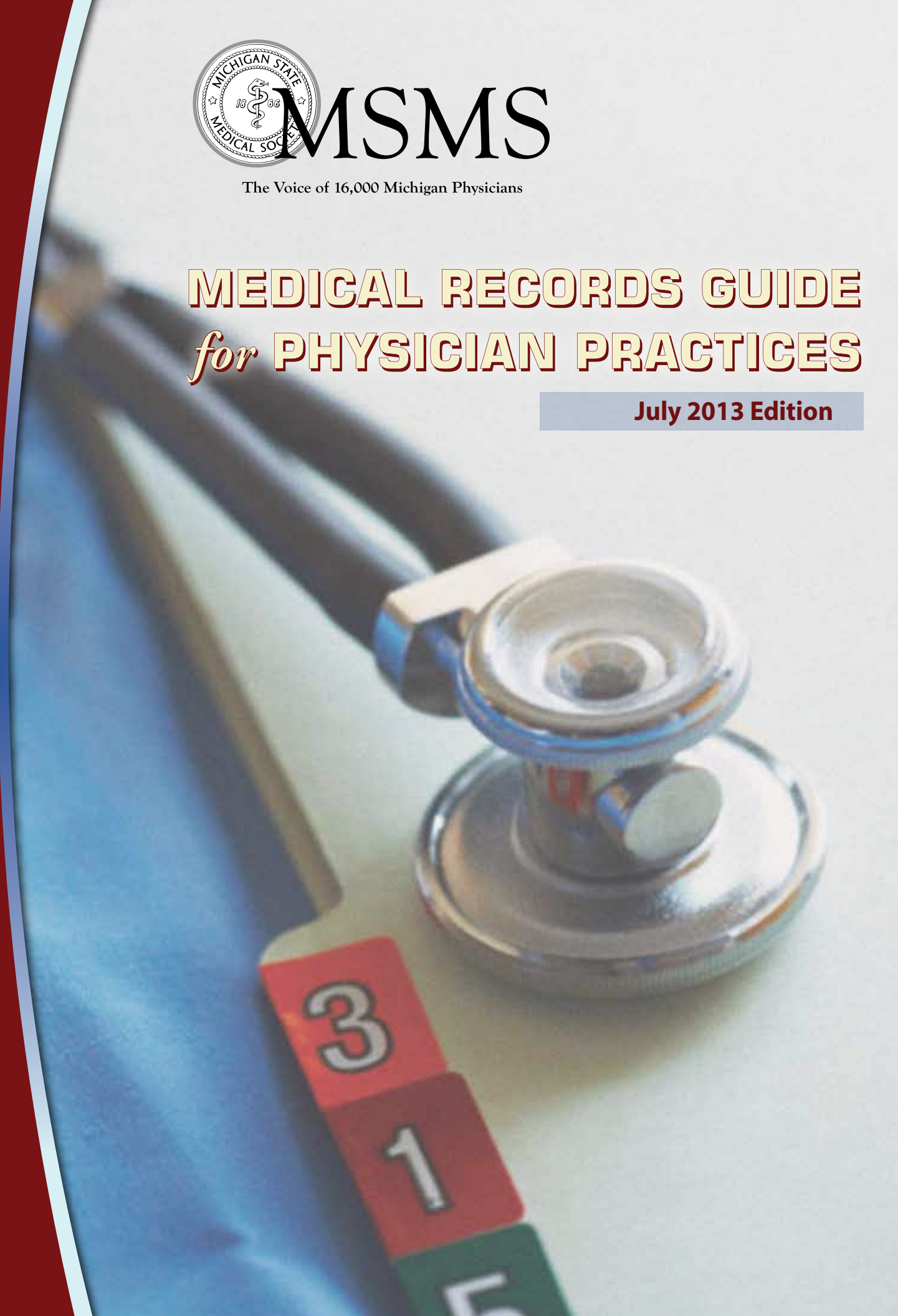


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ABBREVIATIONS

The following abbreviations have been used throughout this booklet:

- MMRAA – Michigan Medical Records Access Act – MCL §333.26261 *et seq.*
- HIPAA – Health Insurance Portability and Accountability Act
(Privacy Rule Provisions – 42 USCS §1320d)
- MCL – Michigan Compiled Laws
- NCQA – National Committee for Quality Assurance
- USCS – United States Code Service
- HHS – US Department of Health and Human Services
- CFR – Code of Federal Regulations



CHAPTER 1

OWNERSHIP OF MEDICAL RECORDS

1.1 DOES THE PATIENT OWN THE MEDICAL RECORD?

A medical record (i.e., the physical media on which clinical data is recorded, such as paper, electronic media, x-ray film, etc.) is owned by the provider who furnished the medical services to the patient, absent an agreement to the contrary. This legal principle was first recognized by the Michigan Supreme Court's opinion in *McGarry vs. J.A. Mercier Co.*, 272 Mich. 501 (1935). Subsequently, Michigan's Attorney General reaffirmed this principle, as well as the patient's right to access and copy the medical record during the provider's normal business hours long before the enactment of HIPAA's privacy rule. See Mich. Op. Att'y Gen. No. 5125 (May 30, 1978).

1.2 WHO IS THE PROVIDER OF MEDICAL SERVICES IF I AM EMPLOYED BY A HOSPITAL, A PC OR PLC?

If a physician is practicing other than as an unincorporated sole proprietor, the medical records are normally owned by the physician's employer (i.e. the PC, PLC, clinic, hospital or other facility), absent a contrary agreement. An employed physician provides his/her services through the employer/entity which is normally the provider for purposes of ownership of medical records.

1.3 WHAT IF I AM ONE OF THE OWNERS OF A MEDICAL PRACTICE ORGANIZED AS A PC OR PLC?

The PC or PLC remains the owner of the medical records, absent an agreement to the contrary. Your dual status as an owner and employee of the PC or PLC does not, in and of itself, shift ownership of the medical records to you individually.

1.4 IF I LEAVE MY EMPLOYMENT WITH A PC or PLC, CAN I TAKE MEDICAL RECORDS WITH ME?

Unless there is an agreement between you and the PC or PLC allowing to you do so, you will not be legally entitled to take medical records with you. However (as is discussed in more detail in CHAPTER 3), patients always have the right to access and copy their medical records. If you are departing to be employed at another PC or PLC, patients you have seen may request a copy of their medical records and provide them to you for their continued treatment with you at the new location. If you are not contractually prohibited from doing so by a covenant-not-to-compete or similar agreement with the PC or PLC you left, then the patient will have the records and will be able to be treated by you at your new practice.

1.5 MUST I ALLOW PATIENTS ACCESS TO AND PROVIDE A COPY OF THEIR MEDICAL RECORD EVEN THOUGH THE PATIENT DOES NOT OWN THE MEDICAL RECORD?

Yes. Both the MMRAA and HIPAA's Privacy Rule require that patients be provided access to their medical records. However, this right of access should not be confused with ownership. Upon a proper request (see CHAPTER 3) and payment of the required fee (see CHAPTER 9), a patient has the right only to a copy of their medical record.

1.6 IF A PHYSICIAN IS CREDENTIALLED BY AND CONTRACTED WITH A HOSPITAL, BUT IS ACTUALLY AN EMPLOYED PHYSICIAN OF ANOTHER HOSPITAL, TO WHOM DO THE CHARTS BELONG?

The paper or electronic media on which medical records are recorded is normally the property of the organization which owns and operates the medical practice or clinic where patients receive services, absent a contrary agreement. In the above example, the hospital which has credentialed and contracted with the physician is furnishing medical care to patients and presumably owns the medical records, absent a contrary agreement with the hospital which employs the physician. HIPAA and the Michigan Medical Records Access Act do not regulate ownership rights to medical records. In addition, MCL §333.16213, which imposes a general seven-year record retention requirement on Michigan licensed health professionals and facilities, expressly states that it shall not “be construed to create or change the ownership rights to any medical records.”



CHAPTER 2

WHAT TO INCLUDE IN AND HOW TO CHANGE A MEDICAL RECORD

2.1 WHAT INFORMATION DOES THE LAW REQUIRE TO BE INCLUDED IN A MEDICAL RECORD?

There is very little law dictating specifically what must be included in a medical record. For licensing purposes, MCL §333.16213 requires that all Michigan licensed physicians must “keep and maintain a record for each patient for whom he or she has provided medical services, including a full complete record of tests and examinations performed, observations made, and treatments provided.” There is no other Michigan statute specifically addressing the general content of a medical record. In addition, non-statutory legal standards also guide the content of medical records. For example, from a billing and reimbursement perspective, medical records must document that medical services were furnished as billed and coded.

From a professional liability standpoint, physicians must make note of all the information necessary to enable them to diagnose and treat their patients in accordance with the standard of care. The specific categories of information necessary to be included in a medical record to ensure proper diagnosis and treatment at times will be the same for all patients; (e.g., relevant history, physical examination findings, diagnosis, etc.). Typically, patient-specific information will vary on a case by case basis. In addition, the patient’s informed consent needs to be documented or evidenced in the medical record.

The NCQA in its Surveyor Guidelines for Accreditation of Managed Care Organizations has included the following comprehensive list of content guidelines for medical records (consider using this list as your guide):

1. Each page in the record contains the patient’s name or ID number.
2. Personal/biographical data include the address, employer, home and work telephone numbers, and marital status.
3. All entries in the medical record contain author identification.
4. All entries are dated.
5. The record is legible by someone other than the writer. A second surveyor examines any record judged to be illegible by one physician surveyor.
6. Significant illness and medical conditions are indicated on the problem list.
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
9. For patients 14 years and older, there are appropriate notations concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance abuse history).
10. The history and physical records contain appropriate subjective and objective information pertinent to the patient’s presenting complaints.
11. Laboratory and other studies are ordered, as appropriate.
12. Working diagnoses are consistent with findings.
13. Treatment plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time or return is noted in weeks, months, or as needed.
15. Unresolved problems from previous office visits are addressed in subsequent visits.

16. Review for under and/or over-utilization of consultants.
17. If a consultation is requested, is there a note from the consultant in the record?
18. Consultation, lab, and imaging reports filed in the chart are initialed by the primary care physician to signify review. If the reports are presented electronically, or by some other method, there is also representation of physician review, consultation, and abnormal lab and imaging study results that have an explicit notation in the record regarding follow-up plans.
19. There is no evidence that the patient was placed at inappropriate risk by a diagnostic or therapeutic problem.
20. An immunization record has been initiated for children, or an appropriate history has been made in the medical record for adults.
21. There is evidence that preventative screening and services are offered in accordance with the organization's practice guidelines.

2.2 SHOULD NON-CLINICAL INFORMATION (E.G., BILLING RECORDS) BE FILED SEPARATELY?

Yes. Information that does not directly relate to the diagnosis and treatment of a patient should be filed separately, apart from the medical record. Billing records, insurer correspondence, etc. are not needed for you to properly diagnosis and treat the patient and therefore should be kept in a separate file. However, any such individually identifiable information maintained in a separate file remains subject to HIPAA's privacy and security standards.

2.3 ARE RECORDS THAT I RECEIVE FROM OTHER SOURCES (E.G., OTHER PHYSICIANS, A HOSPITAL OR CLINIC) CONSIDERED A PART OF MY MEDICAL RECORD?

Yes. Presumably you obtained or were given these other records to assist you in the diagnosis and treatment of the patient. These records obtained from other sources therefore become a part of your medical record. When someone requests a copy of a medical record (see CHAPTER 3 and CHAPTER 4), their right to inspect and copy extends to any documents and other items contained in the requested medical record, even though some of these documents and other items were not created on the order of the physician to whom the request is directed. Under HIPAA, individually identifiable health information specifically includes information that is *received* by a health care provider and that relates to the past, present, or future physical or mental health, condition of or care provided to an identified individual.

2.4 HOW DO I CORRECT MISTAKES DISCOVERED IN A MEDICAL RECORD?

You should adopt a uniform method for making corrections to your medical records. Corrections should be made so that the portion of the record being corrected remains legible and does not conceal or alter the prior entries—see Question 2.6, below. Make a single line through the erroneous information only. Do not completely cover or render the erroneous entry unreadable (e.g., by using liquid paper or black permanent marker). Insert the correct information in the margin and initial and date the correct entry. If a large amount of information is to be corrected, consider attaching an addendum on a new page and signing and dating it.

For Medicare purposes, amendments, corrections, addenda or delayed entries in paper or electronic records must: (1) clearly and permanently identify any amendment, correction or delayed entry as such; (2) clearly indicate the date and author of any amendment, correction or delayed entry; and (3) not delete but instead clearly identify all original content. Medicare auditors are under instructions not to consider any entries that do not comply with these principles, even if such exclusion would lead to a claim denial. For example, they may not consider undated or unsigned entries handwritten in the margin of a document.

2.5 SHOULD I INCLUDE MY MENTAL IMPRESSIONS OF THE PATIENT, WHAT I THINK REGARDING THEIR LIFESTYLE CHOICES, THEIR INABILITY TO FOLLOW MY TREATMENT DIRECTIVES, ETC.?

Only include in the medical record that information necessary to enable you diagnose and treat the patient in accordance with the standard of care. If your “impressions” are not necessary, do not include them in the medical record. Always keep in mind the right of others to access the medical record (CHAPTER 4). Remember that what you include may be viewed by others. If the entry bears a direct relationship to the diagnosis and treatment of the patient, you cannot be criticized for including the information.

2.6 IS IT A CRIME TO FALSIFY A MEDICAL RECORD?

Physicians and others who intentionally, willfully or recklessly place, or cause to be placed, misleading or inaccurate information in a medical record, knowing that the information is misleading or inaccurate, are committing a crime (MCL §750.492a). This includes placing misleading or inaccurate information for the purpose of concealing responsibility for a patient's injury, illness or death. However, it is permissible to supplement information or to correct an error in a patient's medical record or chart in a manner that reasonably discloses that the supplementation or correction was performed and that does not conceal or alter prior entries.



CHAPTER 3

WHEN ACCESS TO MEDICAL RECORDS IS SOUGHT BY PATIENTS

3.1 DO PATIENTS ALWAYS HAVE THE RIGHT TO ACCESS THEIR MEDICAL RECORD?

Pursuant to both the MMRAA and HIPAA's Privacy Rule, patients and their authorized representatives (see Question 3.3) have a right to examine and obtain a copy of their medical record.

The MMRAA contains a detailed procedure for responding to a patient's (or their authorized representative's) request to examine or obtain a copy. First, a written request must be provided to you that is signed and dated not more than 60 days before being provided. You then have the obligation to do one or more of the following, as promptly as required under the circumstances, but not later than 30 days after receipt of the written request (60 days if the record is stored offsite):

- (i) Either make the medical record available for inspection and copying at your office during regular business hours or provide the copy as directed in the written request.
- (ii) Inform the person requesting the records that the medical record does not exist or cannot be found.
- (iii) If you have contracted with another person or medical records company to maintain your medical records, transmit a retrieval request to the person or medical records company maintaining the medical records. You must then either retrieve the medical record and follow the steps in subdivision (i) above or require the contracted entity maintaining the medical records to comply with subdivision (i) above.
- (iv) If the medical record is no longer in your possession and you do not have a contract with a person or medical records company to maintain the requested medical record, inform the person requesting the record of the name and address, if known, of the person or entity that maintains the medical record.
- (v) Provide the person requesting the record a clear statement supporting your determination that providing access to the medical record is likely to have an adverse effect on the patient or yourself and that you will agree to provide access to another physician, health facility or the patient's or authorized representative's legal counsel.
- (vi) Provide the person requesting the record with a written denial if some or all of the information in the medical record was obtained by you pursuant to a confidentiality agreement and granting access would violate that agreement.
- (vii) Take reasonable steps to verify the identity of the person making the request to examine or obtain a copy of the medical record.

If you are unable to comply with the request within the required 30 day time period (60 days if the records are stored offsite), provide a written statement indicating the reasons for the delay and extend the response time for **no more than an additional 30 days**.

3.2 ARE THERE EXCEPTIONS ALLOWING ME TO DENY A PATIENT OR AN AUTHORIZED REPRESENTATIVE ACCESS TO A MEDICAL RECORD?

The right of a patient or his or her authorized representative to examine or obtain the patient's medical record under MMRAA and HIPAA's Privacy Rule is subject to exceptions. For example, MMRAA provides generally that the right to examine or obtain copies is subject to exceptions provided by law or regulation. Common exceptions to the general right of access for patients and their authorized representatives under HIPAA Privacy Rule §164.524 are for "psychotherapy notes;" information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administration action or proceeding; and information that is maintained by you subject to or that is exempt from disclosure pursuant to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a. Additional circumstances in which HIPAA Privacy Rule §164.524 permits access to be denied include when a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person. Denial on this basis is subject to review.

3.3 WHO ARE AUTHORIZED REPRESENTATIVES AND WHEN MUST I GRANT THEM ACCESS TO A PATIENT'S MEDICAL RECORD?

Under the MMRAA, an "authorized representative" is any of the following:

- (i) A person empowered by the patient by explicit written authorization to act on the patient's behalf to access, disclose, or consent to the disclosure of the patient's medical record, in accordance with the MMRAA.
- (ii) If the patient is deceased, any of the following:
 - (A) His or her personal representative.
 - (B) His or her heirs at law including, but not limited to, his or her spouse.
 - (C) The beneficiary of the patient's life insurance policy, to the extent provided by MCL §600.2157.
- (iii) For the purpose of obtaining a copy of an autopsy report regarding a deceased patient, any of the following:
 - (A) The deceased patient's heirs at law including, but not limited to, the deceased patient's spouse.
 - (B) The deceased patient's personal representative.
 - (C) The beneficiary of the deceased patient's life insurance policy, to the extent provided by MCL §600.2157.

3.4 CAN I CHARGE A FEE AND INSIST ON PAYMENT IN ADVANCE BEFORE PROVIDING A COPY OF THE MEDICAL RECORD?

Yes. You may charge a fee for production of a copy. The determination of the specific fee is discussed in CHAPTER 9. The MMRAA allows you to refuse to retrieve the medical record or copy it until the applicable fee is paid. The only exception applies when the patient is a "medically indigent individual" as defined in MCL §400.106 (i.e., individuals receiving family independence program benefits or supplemental security income pursuant to the Social Security Act) in the circumstances discussed in Question 9.1.



3.5 WHAT IF THE PATIENT IS A CHILD? WHO HAS A RIGHT OF ACCESS TO A CHILD'S MEDICAL RECORDS?

The MMRAA defines “patient” as including a minor child’s parent, legal guardian or a person acting in loco parentis. Therefore, these persons are entitled to access a minor child’s medical records the same as if they were the patient. You should always obtain reasonable assurances that you are dealing with a proper guardian (e.g., insist on receiving a copy of the court order appointing the person guardian, etc.) or that the person is acting in loco parentis (i.e., someone who has assumed the obligations of a parent with respect to the child patient—typically a residential institution such as a boarding school).

Under the MMRAA, an important exception exists to the right of a parent, guardian and those acting in loco parentis to access a minor child’s medical records. If the minor lawfully obtained health care without the consent or notification of a parent, guardian, or other person acting in loco parentis, the MMRAA provides that the minor has the exclusive right to exercise the rights of a patient under the Act with respect to those medical records relating to that care. However, the statutes governing consent by minors typically provide that information related to the treatment and care which a minor alone was permitted to consent to may be given to or withheld from the parent, spouse, putative father (in the case of pregnancy), guardian or person in loco parentis when determined medically necessary by the treating physician. Further, the statutes governing consent by minors without parental notification do not obligate physicians to furnish care solely on the basis of a minor’s consent.

Often, this is an issue relative to pregnancy/prenatal care, which is addressed below. Treatment for venereal disease or HIV (MCL §333.5127), outpatient mental health (MCL §330.1707) and substance abuse (MCLA §333.6121) are subject to similar standards which should be consulted on a case-by-case basis. Organizations which accept Title X federal funding for family planning services are normally barred by federal rules from disclosing information without the minor-patient’s consent. However, physicians in private practice typically do not accept federal Title X funding for family planning services and are not subject to such rules.

MCL§333.9132 provides that if a minor consents to the provision of prenatal and pregnancy related health care, or to the provision of health care for a child of the minor, by a licensed health facility or agency or a licensed health professional, the consent shall be valid and binding as if the minor had achieved the age of majority. The consent is not subject to later disaffirmance by reason of minority. The consent of any other person, including the putative father of the child or a spouse, parent, guardian, or person in loco parentis, is not necessary to authorize the provision of health care to a minor or to a child of a minor. “Health care” means only treatment or services intended to maintain the life and improve the health of both the minor and the minor’s child or fetus.

MCL§333.9132 does not legally obligate physicians to furnish care consented to only by the minor-patient. However, the statute provides that before furnishing health care to a minor pursuant to its terms, a health facility or agency or a health professional must inform the minor that the putative father of the child or the minor’s spouse, parent, guardian, or person in loco parentis may be notified as specified below. Further, at the initial visit to the health facility or health professional, permission shall be requested of the minor to contact the minor’s parents for any additional medical information which may be necessary or helpful to the provision of proper health care. For medical reasons, the treating physician, and on the advice and direction of the treating physician, a member of the medical staff of a health facility or agency or other health professional may, but is not obligated to, inform the putative father of the child or the spouse, parent, guardian, or person in loco parentis as to the health care given or needed. The information may be given to or withheld from these persons without consent of the minor and notwithstanding the express refusal of the minor to the providing of the information.

3.6 WHAT IF THE PATIENT IS A CHILD WHOSE PARENTS ARE DIVORCED?

MCL§722.30 provides that a parent shall not be denied access to records or information concerning his or her child because the parent is not the child’s custodial parent, unless the parent is prohibited from having access to the records or information by a court order. See also the answer to Question 4.1(C).

3.7 DO I HAVE TO PREPARE A SUMMARY OF A MEDICAL RECORD IF REQUESTED TO DO SO BY THE PATIENT?

No, you are not obligated to prepare a summary of a medical record if requested to do so by the patient. If you elect to prepare a summary at the patient's request, you may require the patient to agree in advance to the fee, if any, that you will charge for furnishing the summary. You are permitted to charge a fee for preparation of a summary of the medical record, which is in addition to the fee you are entitled to charge for producing a copy of the medical record (see Chapter 9).

On a related point, HIPAA does not permit you to furnish a summary of a medical record, in lieu of providing access to the record when requested by the patient, unless the patient agrees in advance to a summary and agrees in advance to pay the fee you will charge for providing the summary.

3.8 MAY I WITHHOLD MEDICAL RECORDS REQUESTED BY A PATIENT IF MY FEES, A DEDUCTIBLE OR COPAY IS PAST DUE?

No. Neither the HIPAA Privacy Rule nor the MMRAA permits you to withhold medical records until a past due balance is paid. However, you may insist that the patient prepay the appropriate copying fee and the fee charged for preparation of a summary of the medical record (see CHAPTER 9).

3.9 MAY I INQUIRE AS TO THE PURPOSE OF A REQUEST FOR MEDICAL RECORDS?

No. MMRAA prohibits a health care provider or health facility that receives a request for a medical record from inquiring as to the purpose of the request.

3.10 ARE THERE ANY RESTRICTIONS ON A WORKER'S COMPENSATION PATIENT BEING ABLE TO OBTAIN A COPY OF HIS/HER MEDICAL RECORD.

Employees are permitted to obtain copies of their medical records. Michigan's Worker's Compensation Health Care Services Rules specifically states that nothing in the Rules precludes an employee from requesting medical records and reports related to a specific date of injury. Rule 418.10114(1).

Rule 418.10118(1) provides that a practitioner, facility, or health care organization shall, at the request of the carrier, the carrier's agent, the employee, or the employee's agent, furnish copies of the case record for a particular covered injury or illness to the carrier, the carrier's agent, the employee, or the employee's agent. The "case record" is defined as the complete health care record which is maintained by a carrier and which pertains to a covered injury or illness that occurs on a specific date. Rule 418.10108(i). The maximum fee for providing copies is \$0.45 per page, plus the actual cost of mailing. In addition, an administration charge for the staff's time to retrieve and copy the records is payable as follows: 0-15 minutes \$2.50, and \$2.50 for each additional 15 minute increment. The party who requests the records is responsible to pay the copying charges.



CHAPTER 4

WHEN ACCESS TO MEDICAL RECORDS IS SOUGHT BY SOMEONE OTHER THAN THE PATIENT

4.1 WHO BESIDES PATIENTS AND THEIR AUTHORIZED REPRESENTATIVES MAY ACCESS MEDICAL RECORDS?

In addition to patients and authorized representatives (discussed in CHAPTER 3), certain other parties may seek access to medical records. Depending on who these parties are and the circumstances causing them to seek access you may have to grant them access. The following is a summary of the most common requestors of medical records and what is required for them to be granted access:

- A. Family Members/Caregivers. I have many elderly patients who are brought to the office by a son or daughter. I know that the son or daughter routinely cares for the patient in addition to transporting the patient to and from my office. May I allow access to the patient's medical record to their caregivers?**

The most conservative thing for you to do in this situation is to obtain the patient's written authorization to disclose his/her medical information to the caregiver. Although HIPAA's privacy rule generally provides that the patient's "personal representative" must be treated the same as the patient, the MMRAA is more restrictive and requires that a personal representative must be empowered by the patient's explicit written authorization. Both HIPAA's Privacy Rule and applicable Michigan law would allow the caregiver access to the information for treatment purposes if an authorization has been obtained. Additionally, access would be permitted in the absence of an authorization if the caregiver is a court-appointed legal guardian.

- B. Patient Advocates. If my patient has given his wife a health care power of attorney, may I disclose the patient's medical record information to her?**

Yes. HIPAA's Privacy Rule (see HHS Frequently Asked Questions dated December 3, 2002) allows access to a person who has been granted a health care power of attorney by the patient.

- C. Divorced Parents. I have a minor patient whose parents are divorced. The child's mother is the custodial parent and usually brings the child to the office. Now the child's father is calling asking detailed questions regarding the child's medical care. Must I grant the father access to the information?**

Yes. MCL §722.30 provides that a parent shall not be denied access to records or information concerning his or her child because the parent is not the child's custodial parent, unless the parent is prohibited from having access to the records or information by a court order. For this purpose, "records or information" includes, but is not limited to, medical, dental and school records, day care provider's records, and notification of meetings regarding the child's education.

- D. Personal Representative/Executor of a Deceased Patient's Estate. Who is entitled to access of the medical records of a deceased patient?**

If the patient is deceased, the MMRAA provides that any of the following are entitled to access the records: the patient's personal representative; the patient's heirs at law (including but not limited to, his or her spouse); and the beneficiary of the patient's life in policy, to the extent provided by MCL §600.2157. See Question 3.3.

E. Attorneys.

- (i) **When You Are Being Sued for Malpractice.** A patient is suing me for malpractice. Do I need permission from the patient to grant access to her medical records to my attorney, expert witness, and others assisting me in my defense of the malpractice claim?

No. For HIPAA purposes, these disclosures are for your own health care operations and do not require an authorization. However, you must enter into a HIPAA-compliant business associate agreement with your defense attorney. Additionally, for physician/patient privilege purposes under Michigan law, MCL §600.2912f, provides that the patient is deemed to have waived, for purposes of that claim, the statutory physician/patient privilege by giving the pre-suit notification.

- (ii) **Patient Is Suing Another Physician.** My patient is suing another physician for malpractice. I have received a request from the defendant physician's attorney for copies of the patient's medical records. This attorney has also requested a meeting to discuss the patient's condition. Can I provide the information and speak with the physician's defense attorney without first obtaining permission from the patient?

In order to comply with both Michigan law and HIPAA, the physician's defense attorney must provide to you either: (1) the patient's authorization; (2) a court order (not just a "naked subpoena" discussed below); or (3) a written statement from the physician's defense attorney and accompanying documentation that he/she has notified or made a good faith attempt to notify the patient that his/her medical record information has been requested, including the legal basis for the request and sufficient information to permit the patient to raise an objection to a court or an administrative tribunal and assurance that the time to raise such objections has lapsed without any objections being filed or a court or administrative tribunal has resolved the objections allowing access.

- (iii) **Subpoenas.** Is a subpoena a court order requiring that access be given?

Not necessarily for purposes of HIPAA. For purposes of giving access to medical records and information in the absence of a patient's HIPAA-compliant authorization when otherwise required, HIPAA treats a subpoena as a court order only if it has been signed by a judge or a magistrate of a court of competent jurisdiction. For HIPAA purposes, a subpoena signed by an attorney is not a court order. While medical records and information should not be released pursuant to a "naked subpoena" (one not signed by a judge or magistrate or accompanied by the patient's authorization) other than in the circumstances described in response to Question 4.1E(ii), the subpoena cannot be ignored and must be responded to in a timely manner. Contact the attorney issuing the subpoena and ask for the patient's written authorization or a court order, or contact your own attorney.

- F. Insurers and Other Third Party Payers.** Can medical record information be released to insurance companies and other third parties paying for my services?

HIPAA permits you to use a patient's medical record information for treatment, payment and health care operations purposes as provided in your Notice of Privacy Practices, without first obtaining the patient's signed authorization. "Payment" includes any activity undertaken by you to obtain reimbursement for providing your services to the patient. Your required Notice of Privacy Practices should include a statement to this effect. You are required to make a good faith effort to obtain the patient's written acknowledgement that the individual received the privacy notice.

G. Agencies or Department of the State of Michigan or the Federal Government. Does HIPAA's Privacy Rule prevent me from providing access to patients' medical records to the State of Michigan and/or the federal government when required by a specific statute, administrative rule, etc.?

No. Section 164.512 of the HIPAA Privacy Rule allows you to make disclosures required by applicable law, administrative rule, etc. without the authorization of the patient. Chapter 5 contains a list of Michigan statutes pursuant to which such access must be provided or disclosures made.

4.2 THE WIFE OF A DECEASED PATIENT REQUESTS HIS MEDICAL RECORD. THEY WERE SEPARATED AND THE DECEASED PATIENT HAD WRITTEN INSTRUCTIONS NOT TO PROVIDE INFORMATION TO HIS WIFE. WHAT IS THE PRACTICE TO DO?

Michigan's Medical Records Access Act (MMRAA), MCL §333.26261 *et seq.*, does not address this specific question, nor has it been addressed by any published Michigan court opinions. However, it is important first to understand that Michigan does not recognize a "legal separation," although by statute it does recognize a legal action for separate maintenance. Actions for separate maintenance are not common. They typically have been pursued by couples for whom divorce is objectionable on religious grounds or for one spouse to maintain coverage under the other's health insurance plan (assuming that the plan does not treat separate maintenance as having the same effect as divorce). Like a judgment of divorce, a judgment of separate maintenance may provide for a division of assets, allocation of debts, and child and spousal support. Although a judgment of separate maintenance legally separates the couple, they legally remain married. While both spouses are living, neither can remarry unless they bring a new legal action for divorce and a judgment of divorce is entered by the court.

Whenever anyone seeks medical records under the MMRAA on the basis that he or she is the patient's surviving spouse, and is not a court-appointed personal representative of the deceased patient's estate, it is reasonable for a medical practice to require the surviving spouse to furnish documentation establishing that when the patient died, he or she was married to the patient, that a legal action for divorce or separate maintenance was not pending, and that a judgment of divorce or separate maintenance had not been entered by a court of competent jurisdiction. The documentation could include a true copy of the couple's marriage license and an affidavit or notarized statement signed by the surviving spouse under oath.

Assuming that when the patient died no such legal actions were pending and no such judgments had been entered by a court, the couple was legally married when the patient died, even if not living together (i.e., "separated"). The surviving spouse would qualify as the patient's "authorized representative" eligible to obtain the medical records under the MMRAA. The MMRAA does not enumerate any exceptions to the authority of a surviving spouse to access medical records, such as if the records contain instructions written by a deceased patient not to provide information to the spouse.

If an action for divorce or separate maintenance was pending when the patient died, or if a judgment of separate maintenance had been entered by the court, further investigation would be warranted, before deciding whether the surviving spouse may obtain the records. For example, if the parties were pursuing an action for divorce or separate maintenance and one spouse died before the judgment was duly entered by the court, the parties remained legally married when the patient died, even if the judge had indicated prospectively that a judgment would be granted. In this instance, the court records may need to be reviewed to confirm that a judgment had not been entered before the patient's death. If a judgment of separate maintenance had been entered by the court before the patient died, it would need to be reviewed to determine whether or not it extinguished the legal rights of the spouse as a "surviving spouse" for purposes of the MMRAA.

If a judgment of divorce had been entered by the court before the patient died, the survivor would not qualify as a "surviving spouse" under the MMRAA and would not be entitled to the medical records on this basis.

CHAPTER 5

DISCLOSURES OF MEDICAL RECORD INFORMATION REQUIRED BY MICHIGAN LAW

5.1 WHAT ARE THE SITUATIONS THAT I MIGHT ENCOUNTER REQUIRING DISCLOSURE OF MEDICAL RECORD INFORMATION TO AGENCIES OR DEPARTMENTS OF THE STATE OF MICHIGAN OR THE FEDERAL GOVERNMENT?

The following is a general list of the most common situations requiring such a disclosure. The statutory reference has been included. The specific information that is required to be disclosed and what conditions, if any, must first be fulfilled will vary depending on the specific statute involved. Use this list as a guide to alert yourself to the situations requiring disclosure. Consult the statute itself or your personal attorney to ascertain the content of the disclosure and what you must do, if anything, prior to making the disclosure.

- Child Abuse [MCL §722.623];
- Adult Abuse [MCL §400.11a.];
- Nursing Home Abuse [MCL §333.21771];
- Mental Health Patient Abuse [MCL §330.1723];
- HIV/AIDS – Report to Health Department or Other Health Care Provider [MCL §333.5131 (5)(a)];
- HIV/AIDS – Disclosure to Contact Person [MCL §333.5131(5)(b)];
- Emergency Patient/Infectious Agent [MCL §333.20191];
- Deceased Patient/Infectious Agent [MCL §333.2843b];
- HIV Infection [MCL §333.5114];
- Wounds Caused by Violence [MCL §750.411];
- Report of Asphyxia [MCL §750.411c.];
- Minor/Prenatal Care [MCL §333.9132];
- Minor/Venereal Disease/HIV [MCL §333.5127];
- Minor/Substance Abuse Treatment [MCL §333.6121];
- Minor/Mental Health Treatment [MCL §330.1707];
- Licensing Board [MCL §333.16244];
- Abortions [MCL §333.2835(2)];
- Birth Defects [MCL §333.5721];
- Occupational Disease [MCL §333.5611]



CHAPTER 6

RETENTION OF MEDICAL RECORDS

6.1 HOW LONG DO I HAVE TO KEEP MY MEDICAL RECORDS?

For Michigan health professional licensing purposes, MCL §333.16213 requires that you keep your medical records for **a minimum of seven years** from the date of service to which the record pertains unless a longer period of time is required by another federal or Michigan law or regulation or by generally accepted standards of medical practice. MCL §333.16644, which applies only to dental records and requires them to be maintained for ten years from the date of service, is an example of a statute requiring a longer retention period.

6.2 CAN I DESTROY A RECORD LESS THAN SEVEN YEARS OLD IF THE PATIENT IS DECEASED?

Yes, but only if you first comply with the provisions of MCL §333.16213, which require written notice to and written authorization from the patient's authorized representative (e.g., a personal representative, etc.) (see Question 6.5).

6.3 CAN I DESTROY A MEDICAL RECORD THAT IS MORE THAN 7 YEARS OLD? IS PATIENT NOTIFICATION AND/OR CONSENT REQUIRED?

MCL §333.16213(4) states that medical records required to be maintained per MCL §333.16213(1) may be destroyed or otherwise disposed of after being maintained for 7 years from the date of service. Patient notification and/or consent is not required. Compliance with MCL §333.16213, which is required for Michigan health professional licensing purposes, is only one of various factors which should be considered before medical records are destroyed, when destruction is not prohibited by law. For example, one factor to assess before destroying records is whether any longer retention period is required by federal or state laws and regulations or by generally accepted standards of medical practice. See Questions 6.1 and 6.4.

6.4 ARE THERE FEDERAL STATUTES THAT REQUIRE RECORDS TO BE KEPT LONGER THAN SEVEN YEARS? ARE THERE OTHER REASONS WHY I WOULD KEEP MEDICAL RECORDS MORE THAN SEVEN YEARS?

FDA-certified mammography facilities are required to retain mammograms and associated records no less than ten years provided no additional mammograms are performed (21 CFR §900.12(c)(4)). Federal regulations require physicians and other providers participating in Medicare Advantage plans to retain medical records, financial records and source reports for 10 years. Any retention periods imposed by managed care contracts must be considered.

The statute of limitations on potential medical malpractice claims should be considered before destroying any medical record. You do not want to be in a position of having to defend a medical malpractice claim without the medical records that are the subject of the claim.

Competent Adult Patients. The statute of limitations applicable to a competent adult patient is two years from the date of service or within six months after the patient discovers or should have discovered the existence of the claim, whichever is later, but in no event later than 6 years from the date of the act or omission. While the 6 year cap does not apply to claims which have been fraudulently concealed or to claims for injury to a reproductive organ resulting in the inability to procreate, such claims must still be commenced within two years from the date of service or within the six month discovery period, whichever is later. The statute of limitations on most medical malpractice claims of competent adult patients should expire within the seven year mandatory retention period required by Michigan law.

Minor Patients. The determination of the medical malpractice statute of limitations on a claim of a minor patient is different. Generally, if the claim occurred prior to the minor's eighth birthday, the claim must be filed prior to the child's tenth birthday or within the statute of limitations for a competent adult patient, described above, whichever is later. If the claim accrues after the child's eighth birthday, the child is

subject to the statute of limitations applicable to competent adult patients, described above, unless the injury is to the minor's reproductive system. If the injury is to the minor's reproductive system and the child is less than thirteen years old, the statute of limitations continues until the minor is fifteen years old or until the adult statute of limitations would have expired, whichever is later. If a minor with an injury to the reproductive system is more than thirteen years old at the time the claim accrued, then the adult statute of limitations applies.

As you can see, determination of the statute of limitations applicable to medical malpractice claims of minors can be significantly longer than seven years and can be complex to determine. Prior to destroying any medical records of a patient who was a minor at the time the service was rendered you should consult with your attorney and malpractice insurance carrier. The Doctors Company recommends that physicians retain medical records for at least 10 years after the last visit for adult patients and up to age 28 for minors, or 10 years after the patient reaches majority.

6.5 WHAT IF THE PATIENT CONSENTS TO MY DESTRUCTION OF HIS/HER MEDICAL RECORD? DOES THE LAW STILL REQUIRE ME TO RETAIN THE RECORD FOR A MINIMUM OF SEVEN YEARS?

No. MCL §333.16213(1)(a)-(b) allows you to destroy medical records that are less than seven years old if you both: (1) send a written notice to the patient that you are about to destroy their medical record, offer the patient the opportunity to request a copy of the record and request the patient's written authorization to destroy the medical record; and (2) receive written authorization from the patient or the patient's authorized representative. Authorized representatives include the patient's legally appointed guardian, parents, or a person acting in loco parentis.

6.6 DOES THE LAW REQUIRE SPECIFIC METHODS OF STORAGE OF MEDICAL RECORDS?

MCL §333.16213(1) provides only that medical records be maintained in such a manner as to protect their integrity, to ensure their confidentiality and proper use, and to ensure accessibility and availability to patients or patient's authorized representatives as required by law. MCL §333.16213(3) allows you to contract with another health care provider, a health facility or agency, or medical records company to "protect, maintain and provide access to your medical records if you do not have room in your own office." "Medical Records Company" is defined by MCL §333.16213(7)(b) as a person who contracts for or agrees to protect, maintain and provide access to medical records. Any records storage company with which you have a contract potentially could serve as a medical records company for storage purposes.

6.7 SHOULD I RETAIN MEDICAL RECORDS LONGER THAN SEVEN YEARS FOR PAYOR AUDIT PURPOSES?

You should review your payor contracts to see if you have agreed to maintain medical records longer than seven years. If so, you must comply with your contractual obligation and retain the records for the required period. In addition, you should take into consideration related laws when establishing your minimum retention period. For example, under the federal False Claims Act, actions may be brought for up to ten years following the date of payment by a federal health care program such as Medicare. It is possible, therefore, that destroying records after seven years could leave you without needed information to respond to claims based on Medicare and other federal health care program payments.

6.8 ARE IMMUNIZATIONS AN EXCEPTION TO THE SEVEN-YEAR REQUIREMENT? IS THERE ANOTHER STATUTORY PROVISION THAT REQUIRES THEM TO BE RETAINED LONGER?

Immunizations are subject to the minimum seven-year record retention requirement of MCL §333.16213 and not to any longer retention period. Michigan does not impose specific retention periods for immunization records, either by statute or administrative rule. Similarly, the National Vaccine Injury Compensation Act (42 U.S.C. §300aa-10 *et seq.*) and accompanying regulations (42 C.F.R. §100.1 *et seq.*) do not specify retention periods for the administration of vaccines covered by the Act. However, some may wish to retain immunization records for at least 10 years from the date administered, as a best practice. The American

Medical Association's guidance is to always retain immunization records (see Question 6.9). Please also refer to Questions 6.4 and 6.7 regarding statute of limitation and paper audit considerations.

Although not establishing specific retention periods, the National Vaccine Injury Compensation Act imposes record keeping requirements. The Act requires that each health care provider who administers a vaccine listed in the Vaccine Injury Table (42 C.F.R. §100.3) to any person is required to record in such person's permanent medical record (or in a permanent office log or file to which a legal representative shall have access upon request) (1) the date of administration of the vaccine; (2) the vaccine manufacturer and lot number of the vaccine; (3) the name and address and, if appropriate, the title of the health care provider administering the vaccine; (4) the edition (date of publication) of the Centers for Disease Control and Prevention ("CDC") Vaccine Information Statement ("VIS") provided the parent or legal representatives of any child or to any other individual to whom such provider intends to administer such vaccine and the date provided; and (5) and any other identifying information on the vaccine required by government regulations.

6.9 WHAT ETHICAL CONSIDERATIONS DO I NEED TO BE AWARE OF RELATIVE TO THE RETENTION OF MEDICAL RECORDS?

American Medical Association ethics opinion 7.05 provides that physicians have an obligation to retain patient records which may reasonably be of value to a patient. The opinion establishes *guidelines* to assist physicians in meeting their ethical and legal obligations. The guidelines include the following:

1. Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time.
2. Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity.
3. Immunization records should always be kept.

Similar to this *Medical Records Guide*, the AMA ethics opinion advises physicians to check state law for minimum retention periods and to maintain records for at least the length of time of the applicable statute of limitations.



CHAPTER 7

DESTRUCTION OF MEDICAL RECORDS

7.1 WHEN CAN I DESTROY MY MEDICAL RECORDS?

Refer to CHAPTER 6 on retention of medical records. You must ensure that you comply with the law and retain your medical records for the required time period (generally seven years). Please also refer to Questions 6.4 and 6.7 regarding the statute of limitations on medical malpractice claims and payor contract and health plan audits, respectively. These may reasonably cause you to retain your medical records for longer than the law requires.

Assuming that the applicable retention period required by law has expired, and you have consulted with your personal attorney and malpractice insurance carrier and determined that the records will no longer be necessary for the care and treatment of the patient or audit, you are free to destroy the medical record.

7.2 HOW SHOULD THE DESTRUCTION BE ACCOMPLISHED?

MCL §333.16213(4) allows medical records to be destroyed by shredding, incinerating, electronically deleting or in another “manner that ensures continued confidentiality of the patient’s health care information and any other personal information relating to the patient.” Obviously, you must ensure the continued confidentiality of the information contained in the medical record during its destruction. Do not simply set them outside your office for trash pick up.



CHAPTER 8

DISPOSITION OF MEDICAL RECORDS UPON THE SALE OR CLOSURE OF YOUR PRACTICE, YOUR RETIREMENT OR OTHER CESSATION OF YOUR PRACTICE

8.1 IF I SELL MY PRACTICE CAN I JUST TRANSFER THE RECORDS TO THE BUYER? IF I RETIRE CAN I SIMPLY TRANSFER THE RECORDS TO MY PATIENTS' NEW PHYSICIANS? IF I SIMPLY CLOSE MY PRACTICE AND MOVE OUT OF TOWN, WHAT AM I LEGALLY REQUIRED TO DO WITH MY MEDICAL RECORDS?

MCL §333.16213(3) contains specific requirements applicable to you when you sell or close your practice, retire from practice, or otherwise cease to practice. This law requires you not to abandon medical records which you are required to maintain for the minimum seven year retention period. Instead, you must:

1. Send a written notice to the Michigan Department of Licensing and Regulatory Affairs, Health Professions Division (P.O. Box 30670, Lansing, MI 48909) specifying who will have custody of your medical records and how a patient may request access to or copies of his/her medical record; and
2. Transfer the medical records to any of the following:
 - (i) a successor physician;
 - (ii) if requested by the patient, to the patient or a specific health facility or agency or other health care provider; or
 - (iii) a health care provider, a health facility or agency or a medical records company with which you have contracted.

Physicians need to have the right to continue to access medical records following their transfer. For example, to defend a malpractice claim or post-payments audit. If a practice is sold, the continued right of access is typically documented by contractual agreement between the selling and purchasing physicians. If a practice is closed, physicians typically will furnish copies of the medical records to the patients and will retain the original records until such time as they may be destroyed.

8.2 CAN I JUST DESTROY THE RECORDS IF I AM NOT SELLING MY PRACTICE AND/OR I HAVE GIVEN PATIENTS ADEQUATE NOTICE OF MY CLOSURE OF THE PRACTICE AND THEY HAVE ALL MOVED TO OTHER PHYSICIANS?

MCL §333.16213(3)(b) allows you to destroy, upon your retirement or the closure of the practice, medical records that are less than seven years old, but only if you first send a written notice to the last known address of each patient and you receive written authorization from the patient to destroy his/her medical record. This notice must provide the patient with thirty days to request a copy of his/her record or to designate where the patient would like the medical record transferred. If the patient fails to request a copy or transfer of his or her medical records or to provide you with written authorization for the destruction, you may not destroy those records that are less than seven years old. You may destroy those records that are seven years old or older without notice to or consent from patients (see Questions 6.1–6.5).



CHAPTER 9

CHARGING FEES FOR COPYING AND PREPARING A SUMMARY OF A MEDICAL RECORD

9.1 WHAT CAN I CHARGE FOR COPYING A MEDICAL RECORD?

HIPAA's Privacy Rule does not specify actual dollar amounts that you may charge. Instead, HIPAA states that you are permitted to charge "a reasonable, cost based fee," which includes the cost of copying (including the cost of supplies and the labor of copying), postage (when the patient has requested the copy to be mailed) and the cost of preparing an explanation or summary (if requested and agreed to by the individual making the request).

The MMRAA, unlike HIPAA, places specific caps on fees for copies. These fees are adjusted on an annual basis by the Michigan State Treasurer to reflect changes in the Detroit Consumer Price Index. The fees as of February 8, 2013, are:

- \$1.16 per page for the first 20 pages, \$0.58 per page for pages 21 through 50, and \$0.23 per page for pages 51 and over.
- In addition to these per page charges, you are allowed to impose an initial fee of \$23.32 per request for a copy if someone other than the patient himself/herself (i.e., an authorized representative) makes the request.

In addition, the MMRAA permits you to charge (a) any actual costs incurred in retrieving medical records that are seven years old or older and not maintained or accessible on-site, (b) if the medical record is in some form or medium other than paper, the actual cost of preparing a duplicate, and (c) any postage or shipping costs incurred by the health care provider, health facility, or medical records company in providing the copies.

The MMRAA requires you to waive all fees for a medically indigent individual, limited to one set of copies. Any additional requests for the same records from you are subject to the fee provisions. You may require the patient or his or her authorized representative to provide proof that the patient is medically indigent (see Question 3.4).

Neither HHS nor any court has ruled whether the fee provisions of the HIPAA Privacy Rule or MMRAA should be followed. Until there is such a ruling, it is suggested that MMRAA should be followed.

The Worker's Compensation program has its own fee schedule applicable to medical records relating to a specific work-related condition, treatment and request for payment of that treatment. See Mich Admin R 418.10118, which can be obtained at www.michigan.gov/documents/wca/wca_hcs_08_Rules_225656_7.pdf. The fee schedule should be checked for annual updates.

9.2 WHAT IF PARTS OF THE MEDICAL RECORD ARE IN A FORM OR MEDIUM OTHER THAN PAPER (E.G., X-RAYS)?

The MMRAA allows you to charge the actual cost of preparing a duplicate.

9.3 SOME OF MY OLDER RECORDS ARE STORED OFFSITE. THE STORAGE COMPANY CHARGES ME A FEE TO RETRIEVE THESE RECORDS AND DELIVER THEM TO MY OFFICE. IS THE PATIENT RESPONSIBLE FOR PAYING THIS FEE?

Only if the records that are retrieved are more than seven years old. You may not pass this fee on to the patient if the records are less than seven years old.

9.4 CAN I INSIST THAT THESE FEES BE PAID IN ADVANCE?

Yes.

9.5 WHAT CAN I CHARGE FOR PREPARING A SUMMARY OF THE MEDICAL RECORD?

HIPAA's Privacy Rule does not specify the actual dollar amount that you may charge for preparing a summary of a medical record. HIPAA permits you to charge "a reasonable, cost based fee" as described above. You may charge a fee for preparation of a summary, which is in addition to the other permitted charges described in Question 9.1. A suggested practice is for you to set a reasonable hourly rate, notify the individual of the total estimated charge, and obtain in advance his or her written agreement to pay the fee. Depending on the circumstances, it may be reasonable for you to require payment in advance of your preparation of the summary (see Question 3.6).

9.6. WHAT FEES MAY BE CHARGED FOR ELECTRONIC COPIES OF MEDICAL RECORDS? CAN THE MICHIGAN PER PAGE FEE BE USED AS A GUIDE?

The final HIPAA rules published on January 25, 2013 have specific provisions addressing permitted charges for copies of electronic medical records. The Michigan per page fee chargeable for paper copies cannot be used as a guide for electronic copies of records.

Amendments to §164.524(c)(4) of the HIPAA privacy rule provide that if an individual requests a copy of protected health information or agrees to a summary or explanation of such information, the covered entity may impose a reasonable, cost-based fee, provided that the fee includes only the cost of: (i) labor for copying the protected health information requested by the individual, whether in paper or electronic form; (ii) supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (iii) preparing an explanation or summary of the protected health information, if agreed to by the individual. Although the amendments to §164.524(c)(4) technically become effective on September 23, 2013, covered entities should follow them now, because §13405(e)(2) of the HITECH Act, effective February 10, 2010, provides that a covered entity may not charge more than its labor costs in responding to the request for a copy of copy (or summary or explanation) of protected health information from an electronic health record in electronic form.

The government has clarified a number of related points (78 Fed. Reg. 5556, 5636 Jan. 25, 2013):

- Labor costs included in a reasonable cost-based fee could include skilled technical staff time spent to create and copy the electronic file, such as compiling, extracting, scanning and burning protected health information to media, and distributing the media. This could also include the time spent preparing an explanation or summary of the protected health information, if appropriate.
- Although the proposed rule indicated that a covered entity could charge for the actual labor costs associated with the retrieval of electronic information, the government did not adopt this in the final rule. Under the final rule, a covered entity may not charge a retrieval fee, whether a standard retrieval fee or one based on actual retrieval costs.
- Fees associated with maintaining systems and recouping capital for data access, storage and infrastructure are not considered reasonable, cost-based fees, and may not be included under the final rule.
- Covered entities are not required to obtain new types of technology needed to comply with specific individual requests, and therefore the cost of obtaining such new technologies is not a permissible fee to include in supply costs.
- A covered entity is permitted to charge for postage if an individual requests that it transmit portable media containing an electronic copy through mail or a courier (e.g., if the individual requests that the covered entity save protected health information to a CD and then mail the CD to a designee).



The Voice of 16,000 Michigan Physicians

120 West Saginaw Street
East Lansing, MI 48823
(517) 337-1351
Fax (517) 337-2490
www.msms.org
msms@msms.org