LINCOLN COMMUNITY HEALTH CENTER, INC.

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SUBJECT: Designated Record Set

APPROVAL DATE: 02/2020

REVISION DATE:

REVIEW DATE: 04/2022

PURPOSE:

To describe the documents that comprise the Designated Record Set.

PROCEDURE STATEMENT:

HIPAA Regulations require that patients have a right to access and amend their Protected Health Information (PHI) that is maintained in a Designated Record Set. This procedure documents the contents of the Designated Record Set only applies to Lincoln Community Health Center (LCHC).

DEFINITIONS:

The **Designated Record Set** is a group of records maintained by or for LCHC that consists of the Medical and Billing records about a patient and are used, in whole or in part, by or for LCHC to make decisions about the patient. The term "Record" means any item, collection, or grouping of information that includes PHI that has been used for treatment, which is maintained by or for LCHC.

The **Personal Health Record** is a group of records that the patient has brought to LCHC from another health care facility.

PROCEDURE:

1. LCHC maintains the following as the Designated Record Set:
   - The Patient's Health Record
   - The Patient's Billing Office File

2. The Patient's Health Record includes, at a minimum, the following:
   - Advance directives
   - Assessments, flow sheets
   - Care plan
   - Face Sheet (Registration Information)
   - Informed consent
   - History and physical exams and other related clinic records
   - Medication and treatment records
   - Nursing documentation/progress notes
   - Nutritional services documentation
   - Physician and professional consultant progress notes
   - Physician's orders
   - Rehabilitative and restorative therapy records

- Reports from lab, x-ray and other diagnostic tests
- Social service documentation

3. The Patient's Finance Office File includes, at a minimum, the following:
   - Admission documents
   - Acknowledgement of receipt of the LCHC's *Notice of Privacy Practices*
   - Correspondence relating to coverage and payment from insurance companies, health plans, Medicare, Medicaid and other payer sources
   - Patient claim information, including claim, remittance, eligibility response, and claim status response
   - Statements of account balance
   - Collection activity documents and correspondence
4. Personal Health Records consist of the patient's personal health information provided to LCHC by the Patient. If such records are used by LCHC to make health care related decisions, provide care services, or document observations, actions, or instructions, then the records will be considered part of the Designated Record Set.
5. The following are excluded from the Designated Record Set:
   - Administrative data, such as audit trails, appointment schedules and practice guidelines that do not include PHI.
   - Also excluded are incident reports, quality assurance data, vital certificate worksheets, and derived data such as accreditation reports, anonymous patient data for research purposes, public health records and statistical reports.
   - Records created by and for another medical facility independent of LCHC.
6. The Designated Record Set is to be retained according to state and federal regulations and following LCHC's retention procedures.

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APPROVED BY: Dr. Juliana Hodges Dr. Juliana Hodges cn=Dr. Juliana Hodges, o=Lincoln Community Health Center, ou=QI & RM Director, email=juliana.hodges@duke.edu, c=US 2022.06.06 12:47:47 -04'00' **DATE:** 06/06/2022
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