



DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

SUBJECT: CLIENTS RIGHT TO ACCESS PROTECTED HEALTH INFORMATION	POLICY NO. 500.3	EFFECTIVE DATE 04/14/03	PAGE 1 of 7
APPROVED BY:  Director	SUPERSEDES	ORIGINAL ISSUE DATE	DISTRIBUTION LEVEL(S) 1

PURPOSE

- 1.1 To establish a Department of Mental Health (DMH) policy and procedure to ensure clients or clients' personal representatives the right to access Protected Health Information (PHI) contained within their mental health record.

POLICY

- 2.1 A client has the right to access his/her PHI in all but a limited number of circumstances, which include information compiled in anticipation of or use in a civil, criminal or administrative action or proceeding.
- 2.2 Any current or former adult client, any minor client authorized by law to consent to treatment and any client's legally authorized personal representative has the right to inspect and receive copies of his/her PHI contained in his/her mental health record upon presenting the treatment provider with a signed **Request for Access to Health Information** form (Attachment I).
- 2.3 If a minor client is legally authorized to consent to the treatment, only the minor client may sign a Request for Access to Health Information form. The decision should be based on whether the minor could have consented to the treatment, not whether the minor was the one who actually gave the consent. Otherwise, the request form must be signed by the minor's parent, guardian or personal representative. Cal. Health & Safety Code § 123110(a).
- 2.4 If a personal representative makes a request for access on behalf of the client, he/she must provide the appropriate proof of legal identification as outlined in the Verification of Identity and Authority policy/procedure. Upon verification of the personal representative's identity, the treatment provider must also ensure that the level of access does not exceed what has been provided by the supporting legal documentation, such as a limited power of attorney.
- 2.5 If DMH does not maintain the PHI that is the subject of the client's request for access, and DMH knows where the requested information is maintained, DMH must inform the client where to direct the request for access.
- 2.6 DMH directly operated facilities/programs must comply with this policy/procedure.
- 2.7 Contract agencies must have policies and procedures that comply with the authorities cited at the end of this policy. They may adopt DMH's policy/procedure.



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DEFINITIONS

- 3.1 **“Personal Representative”** means:
- 3.1.1 The guardian or conservator of an adult client.
 - 3.1.2 A parent or guardian of a minor who is a client.
 - 3.1.3 The executor or administrator of the estate of a person who has died.
- 3.2 **“Minor”** means:
- 3.2.1 Under California law a minor is a person under the age of 18. (Cal. Family Code § 6500)
 - 3.2.2 Under California law, an emancipated minor is considered to be an adult for the purpose of consenting to medical care. An emancipated is a minor who comes within any of the following categories.
 - 3.2.2.1 Emancipated by court order: Minors 14 years of age or older may petition a state court for emancipation (Cal. Family Code §§ 7002(c), 7120).
 - 3.2.2.2 Minors on active duty with U.S. Armed Forces regardless of age. (Cal. Family Code § 7002(b))
 - 3.2.2.3 Married or formerly married. (Cal. Family Code § 7002(a))
 - 3.2.3 Under California Law a self-sufficient minor is a minor 15 years of age or older who is living separate and apart from his/her parents or legal guardian; and manages his/her own financial affairs, regardless of the source of income. (Cal Family Code § 6922)
 - 3.2.3.1 A self-sufficient minor may consent to his/her own medical care without parental consent.
- 3.3 **“Mental Health Record”** means a patient record stored in any form or medium (e.g., electronic or paper) relating to evaluation or treatment of a behavioral disorder. (Cal. Health & Safety Code §§ 123105(b), (d))
- 3.4 **“Protected Health Information”** (PHI) means individually identifiable information about a client’s physical or mental health, the receipt of health care or payment for that care.



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- 3.5 “Access” means to inspect and copy or arrange for copying PHI maintained by DMH or DMH’s business associates.
- 3.6 As of April 16, 2002, documentation that originated from other agencies and is filed in the DMH record is considered to be part of the DMH official record.

PROCEDURE

- 4.1 If the signed Request for Access to Health Information form is submitted in person, DMH must provide a signed copy to the requestor.
- 4.2 If DMH grants the request, in whole or in part, it must provide the client notification of the acceptance by using the **Letter Responding to Client’s Request for Access to Health Information** (Attachment II) and provide to the client details on how to access the requested PHI, in accordance with this Policy.
- 4.3 DMH must arrange with the client/representative for a convenient time and place to inspect or obtain a copy of the client’s mental health record. The inspection must take place during business hours. If requested, DMH may alternatively provide a copy through the mail or fax.
- 4.4 If the medical record is maintained at more than one location, DMH need only produce the PHI once in response to a request for access.
- 4.5 Requests for inspection shall be honored within five (5) working days after receipt of a signed Request for Access to Health Information form.
- 4.6 Requested copies shall be provided at the time of inspection or mailed within fifteen (15) days after receiving the signed form, depending on the decision made by the treatment provider.
- 4.7 The treatment provider may provide a written summary of the mental health record or an explanation of the PHI to which access has been provided if the client agrees in advance to receive such a summary or explanation.
- 4.7.1 A reasonable fee may be charged for the summary or explanation provided the client agrees to such fees in advance.
- 4.8 Upon receipt of the request, the treatment provider or Program Head shall be responsible for establishing the identity of the requestor by following the procedures outlined in the Verification of Identity and Authority policy and procedure. Difficulty in establishing identity shall not intentionally be used to delay or hinder authorized access.



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- 4.8.1 In the absence of the therapist of record, the facility director or the Program Head shall establish the identity of the requestor and designate a competent professional to act on the client's request for access to records.
- 4.8.2 The primary therapist (or designee), attending psychiatrist and/or program director shall be responsible for reviewing the record for completeness and making the decision to:
 - 4.8.2.1 Approve the request for access to the PHI; or
 - 4.8.2.2 Exclude PHI to which access is denied based on reasons set forth in this policy, and give the client access to any other PHI requested; or
 - 4.8.2.3 Deny the request for access.
- 4.9 The parent, guardian or conservator of a minor shall not be entitled to inspect or obtain copies of the minor's records:
 - 4.9.1 If the treatment provider is unable to verify the identity and relationship of the requestor due to the lack of a valid picture identification and/or supporting documentation.
- 4.10 DMH may deny a client/representative access to PHI without providing an opportunity for review when:
 - 4.10.1 An exception detailed in this policy statement exists;
 - 4.10.2 DMH is acting under the direction of a correctional institution and the inmate's request to obtain a copy of the PHI would jeopardize the health, safety, security, custody or rehabilitation of the client or other inmates, or the safety of any officer, employee or other person at the correctional institution, or a person responsible for transporting the inmate;
 - 4.10.3 The client agreed to temporary denial of access when consenting to participate in research that includes treatment and the research is not yet complete;\
 - 4.10.4 The PHI was obtained from someone other than a health care provider under a promise of confidentiality and access would likely reveal the source of the information.
- 4.11 DMH may deny a client/representative access, provided that the client is given a right to have such denials reviewed under the following circumstances:
 - 4.11.1 The treatment provider or other licensed health care professional has determined, in the exercise of professional judgment, that the access is likely to endanger the life or physical safety of the client.



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- 4.11.2 The PHI makes reference to another person (not including treatment provider) and a licensed health care provider, exercising professional judgment, determines that the access requested is reasonably likely to cause harm to the person referenced.
- 4.11.3 The request for access is made by the personal representative, and the treatment provider or other licensed health care professional has determined, in the exercise of professional judgment, that access is likely to cause substantial harm to the client or another person.
- 4.12 If DMH denies access, in whole or in part, to PHI, it must, to the extent possible, give the client access to any other PHI requested, after excluding the PHI to which it denied access.
- 4.13 The treatment provider shall inform the patient in writing of the denial of access, using the Letter Responding to Client's Request for Access to Health Information.
- 4.13.1 The Letter Responding to Client's Request for Access to Health Information must contain:
- 4.13.1.1 The basis for the denial;
- 4.13.1.2 A statement of the client's review rights, including a description of how the client may exercise such review rights;
- 4.13.1.3 A description of how the client may complain to DMH or to the United States Department of Health and Human Services.
- 4.13.2 If access is denied, the **Request for Review of Denial of Access** form (Attachment III) shall be included with the Letter Responding to Client's Request for Access to Health Information.
- 4.14 A copy of the Letter Responding to Client's Request for Access to Health Information shall be placed in the client's mental health record.
- 4.15 If the client requests a review of a denial, where the grounds for denial are subject to review, the client must submit a Request for Review of Denial of Access form.
- 4.15.1 Upon receipt of a Request for Review of Denial of Access, a licensed health care professional designated by DMH, who was not directly involved in the decision to deny access, will review the case.



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- 4.15.2 Within five (5) working days, the licensed health care professional must determine whether or not to deny the request access based on this policy, and notify the DMH Program Head or the manager involved in the denial of access, Patients' Rights and the designated representative of the DMH Privacy Officer of the final decision. (See Policy and Procedure –HIPAA Complaint Process)
- 4.15.3 The DMH Privacy Officer or his/her designee must provide written notice within two (2) additional working days to the client/representative of the findings of the review, using the ***Letter of Response to Client's Request for Review of Denial of Health Information*** (Attachment IV).
- 4.15.4 A copy of the final review letter will be sent to the Chief Information Privacy Officer (CIPO) and placed in the client's mental health record along with a copy of the client's written Request for Review of Denial of Access.
- 4.15.5 If the client requests a review of a denial, where the grounds for denial are not subject to review, no further action by the treatment team is required.
- 4.16 The client or personal representative is allowed to have one other individual accompany him/her during the inspection of mental health records.
- 4.17 DMH may charge a reasonable fee for copies of a client's PHI at a charge of 25 cents per page for paper or fax copies; 50 cents per page for copies from microfilm.
- 4.18 All requests, decisions or information relating to client/representative access to mental health records shall become part of the clinical record.

DOCUMENT RETENTION

- 4.19 This policy and procedure and associated forms will be retained for a period of at least seven (7) years from the date of its creation or the date when it was last in effect, whichever is later.

AUTHORITY

Cal. Family Code §§ 6500, 6922, 7002, 7120
 Cal. Health & Safety Code §§ 123100 *et seq.* (to the extent that State law is not preempted by HIPAA)
 HIPAA, 45 CFR, § 164.524



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ATTACHMENTS

Attachment I	Request for Access to Health Information form
Attachment II	Letter Responding to Client's Request for Access to Health Information
Attachment III	Request for Review of Denial of Access
Attachment IV	Letter of Response to Client's Request for Review of Denial of Health Information

CLIENT'S REQUEST FOR ACCESS TO HEALTH INFORMATION

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client

Birth Date of Client

MIS #

Street Address

City, State, Zip

REQUEST TO ACCESS AND INSPECT MY HEALTH INFORMATION ONSITE

REQUEST DMH SEND A COPY OF MY REQUESTED HEALTH INFORMATION TO:

Name

FAX Number (include area code)

Street Address

City, State, Zip Code

INFORMATION TO BE ACCESSED, COPIED OR INSPECTED:

INSPECTION PERIOD: I request information regarding the following time period:

FROM ____/____/____ **TO** ____/____/____
Month Day Year Month Day Year

REQUEST SUMMARY OF REQUESTED HEALTH INFORMATION

COPY FEES: DMH MAY CHARGE YOU FOR MAKING COPIES OF YOUR HEALTH INFORMATION. THE ASSOCIATED FEES MAY BE 25 CENTS PER PAGE FOR PAPER OR FAX COPY; 50 CENTS PER PAGE FOR MICROFILM.

YOUR RIGHTS REGARDING THIS REQUEST TO ACCESS:

Right to Receive a Copy of This Request - I understand that I must be provided with a signed copy of the form.

Right to Request Review of Denial of Access- I understand that DMH may deny my request to access my health information, in whole or in part. If I am denied access, I may request a review of their decision by submitting a *Request for Review of Denial of Access*. In most circumstances, DMH will then designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of your request.

CLIENT’S REQUEST FOR ACCESS TO HEALTH INFORMATION
COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (“LACDMH”)

SIGNATURE OF CLIENT: _____

OR

SIGNATURE OF PERSONAL REPRESENTATIVE:

If signed by other than client, state relationship and authority to do so:

DATE: ____/____/____
Month Day Year

FORM(S) OF IDENTIFICATION PROVIDED:

___ State Driver’s License _____

___ State Identification Card _____

___ Birth Certificate _____

___ Military ID _____

___ Other (Provide details) _____

FACILITY: _____

PRACTITIONER: _____

DATE: ____/____/____
Month Day Year

For more information about your health privacy rights, ask the Treatment Team for a copy of our **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at <http://www.dmh.co.la.ca.us/> or by sending a written request to:

Patient’s Rights Office
Los Angeles County Department of Mental Health
550 S. Vermont Ave., 5th Floor
Los Angeles CA 90020

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.



DEPARTMENT OF MENTAL HEALTH

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

LETTER RESPONDING TO CLIENT'S REQUEST FOR ACCESS TO HEALTH INFORMATION

Date of Birth:
MIS #:

Dear

Thank you for submitting your **Request for Access to Health Information**. Your request was forwarded to the responsible practitioner for review.

We received your written request, stamped on _____, to access your protected health information. We have determined that:

- Your request has been accepted, and the information is included with this notice. The cost for this service is \$ _____, based on a charge of 25 cents per page, and a bill will be sent to you home of record.
- Your request has been accepted, and the following appointment time has been scheduled to for your records review:
 - Date:
 - Time:
 - Location:

If you have any questions or need to reschedule, please contact the Treatment Team or call us at
- We will grant your request to access, but only in part (see below regarding the reason for partial denial). We will provide access to the following health information:



DEPARTMENT OF MENTAL HEALTH

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

REASON FOR DENIAL (IF APPLICABLE)

Your request to access your protected health information is denied because:

- You are not authorized access to the health information.
- We are not permitted to release health information regarding information compiled in anticipation of or use in a civil, criminal, or administrative action or proceeding. **This denial is not subject to the right to review.**
- You did not provide all the information we need to complete your request. Please complete the highlighted items identified and return it to us.
- You were unable to provide satisfactory personal identification to access your own information.
- You were unable to provide satisfactory personal identification as proof of status as a patient's representative (parent, guardian or conservator).
- Other:

If we denied your request to access, you have the right to require LACDMH to permit inspection by, or provide copies to, a licensed mental health professional designated by you with your written authorization. If you want to exercise this right, please contact your Treatment Team.

Request for Review of Denial of Access (IF APPLICABLE)

If we denied your request to access your protected health information, in whole or in part, you may submit a ***Request for Review of Denial of Access***, included with this letter. After completing the form, return it to the Treatment Team or mail it to:

**Los Angeles County Department of Mental Health (LACDMH)
Patient's Rights Division
550 South Vermont Avenue
Los Angeles, CA 90020**



DEPARTMENT OF MENTAL HEALTH

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

You also have the option to complain to either the County's Privacy Official or to the federal government. To file a complaint with Los Angeles County, contact:

**Los Angeles County Chief Information Office
Chief Information Privacy Officer
500 West Temple Street, Suite 493
Los Angeles, CA 90012
(213) 974-2164
Email: CIP0@cio.co.la.ca.us**

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

{Name}
Program / Unit Manager
Department of Mental Health
Los Angeles County

CLIENT’S REQUEST FOR REVIEW OF DENIAL OF ACCESS

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH (“LACDMH”)

CLIENT:

Name of Client

Date of Birth

MIS #

Street Address

City, State, Zip

I am requesting a review of denial of access to my protected health information.

LACDMH will designate a licensed health care professional, who was not involved in the decision to deny access, to review the determination. We will notify you in writing of the determination of the reviewing health care professional. LACDMH must adhere to the determination of the reviewing professional.



Signature of Client / Personal Representative

Date

If signed by other than the client, state relationship and authority to do so: _____

Facility

Practitioner

Date

For more information about your health privacy rights, ask the Treatment Team for a copy of our **Notice of Privacy Practices**. You may also obtain a copy by visiting our website at <http://www.dmh.co.la.ca.us/> or by sending a written request to:

**Patient’s Rights Office
Los Angeles County Department of Mental Health
550 S. Vermont Ave., 5th Floor
Los Angeles CA 90020**

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.



DEPARTMENT OF MENTAL HEALTH

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

FINAL LETTER OF RESPONSE TO CLIENT'S REQUEST FOR REVIEW OF DENIAL OF ACCESS TO HEALTH INFORMATION

Date of Birth:
MIS #:

Dear

We have completed a separate, independent review of your initial **Request for Access to Health Information** in response to your **Request for Review of Denial for Access**. We have determined that:

- Your request has been accepted, and the information is included with this notice. The cost for this service is \$ _____, based on a charge of 25 cents per page, and a bill will be sent to your home of record.
- Your request has been accepted, and the following appointment time has been scheduled for your records review:
 - Date:
 - Time:
 - Location:*If you have any questions or need to reschedule, please contact the Treatment Team or call us at*
- We will grant your request to access, but only in part (see below regarding the reason for partial denial). We will provide access to the following health information:

REASON FOR DENIAL (IF APPLICABLE)

Your request to access your protected health information is denied because:

- You are not authorized access to the health information.



DEPARTMENT OF MENTAL HEALTH

Patient's Right Division
550 S. Vermont Ave., 5th Floor
Los Angeles, CA 90020

Other:

FINAL DENIAL (IF APPLICABLE)

If your request has been denied, either partially or in whole, after submitting a **Request for Review of Denial for Access**, we would like to remind you that you, as stated in the Notice of Privacy Practices, that you have the option to complain to either the County's Privacy Official or to the federal government. To file a complaint with Los Angeles County, contact:

**Los Angeles County Chief Information Office
Chief Information Privacy Officer
500 West Temple Street, Suite 493
Los Angeles, CA 90012
(213) 974-2164
Email: CIPO@cio.co.la.ca.us**

To file a complaint with the Federal Government, contact:

**Region IX, Office for Civil Rights,
US Department of Health and Human Services
50 United Nations Plaza-Room 322
San Francisco, CA 94102
Voice Phone (415) 437-8310
FAX (415) 437-8329
TDD (415) 437-8311**

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your healthcare needs.

Sincerely,

Department of Mental Health
Los Angeles County