



OFFICE OF THE OHIO PUBLIC DEFENDER

Understanding and Obtaining Medical Records

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www.opd.ohio.gov



Why Medical Records Matter:

- Documentation about drug use from an accepted, expert source
- Expert opinion(s) on appropriate treatment options
- Historical perspective of client condition(s)
- Useful when opposing charges and crafting compelling sentencing arguments
- Much less expensive than hiring an expert
- Help create a complete picture of client for the adjudicator





Obtaining Medical Records





Obtaining Medical Records - HIPAA



- *Physical* Conditions, Treatment, Records
- *Mental Health* Conditions, Treatment, Records
- *Substance Abuse* Conditions, Treatment, Records

- Health Insurance Portability and Accountability Act of 1996
- Governs access to who can look at and receive protected health information (PHI)
- Attorneys are considered “business associates of covered entities”
- Requires WRITTEN PERMISSION for a “covered entity” to view protected health information
- Lays out requirements of releases of information



Obtaining Medical Records: Making Sure Your Release of Information is HIPAA Compliant

ROI MUST INCLUDE:


- Identifying information of individual
- Description of the information that will be used/disclosed
- Purpose for which information will be disclosed
- Name of person/entity to whom information will be disclosed
- Expiration Date/Event
- Dated signature of individual

MUST ALSO INCLUDE ADVISORY STATEMENTS OF:

- Individual's right to revoke authorization
- Any exceptions to right to revoke authorization
- How the authorization can be revoked
- Potential for information to be redisclosed by recipient



Obtaining Medical Records: Sample HIPAA Compliant Release of Information

 Office of the Ohio Public Defender
250 East Broad Street, Suite 1400
Columbus, Ohio 43215 www.opd.ohio.gov
(614) 468-5394
Fax (614) 728-3670

TIMOTHY YOUNG
State Public Defender

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: _____ Re: _____
DOB: _____
SSN: _____
Date: _____

I authorize the use or disclosure of my health information as described below. The above-listed individual or organization is authorized to make the disclosure.

The type and amount of information to be used or disclosed is as follows:

<input type="checkbox"/> Problem list	<input type="checkbox"/> Laboratory results from _____ to _____
<input type="checkbox"/> Medication list	<input type="checkbox"/> X-ray and imaging reports from _____ to _____
<input type="checkbox"/> List of allergies	<input type="checkbox"/> Consultation reports from _____ to _____
<input type="checkbox"/> Emergency room records	<input type="checkbox"/> Drug and alcohol treatment
<input type="checkbox"/> Immunization record	<input type="checkbox"/> Psychotherapy records/mental health records
<input type="checkbox"/> Mental Health Assessment (MHA)	<input type="checkbox"/> All discharge summaries and admission records
<input type="checkbox"/> Outpatient Notes (OPN)	<input type="checkbox"/> All history & physical information
<input type="checkbox"/> Medication Progress Notes (MPN)	<input type="checkbox"/> Entire Record
	<input type="checkbox"/> Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

This information may be disclosed to and used by the following individual or organization:
Name: Office of the Ohio Public Defender
Address: 250 East Broad Street, Suite 1400, Columbus, Ohio 43215
For the purpose of legal representation in criminal case

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provided my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: August 31, 2013. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that the entity or person releasing records will not condition treatment, payment, enrollment, or eligibility for benefits on the execution of this Authorization. I understand that the information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164-524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my HIM director or privacy officer.

Releasee/Patient _____ Date _____
If Signed by Legal Representative, Relationship to Patient _____ Signature of Witness _____

#126087

Identifying Information of Individual

Description of Information to be Disclosed

Purpose of Disclosure

Expiration of Authorization

Name of person/entity to whom information will be disclosed

Advisory Statements

Individual Signature and Date

www.opd.ohio.gov





Obtaining Medical Records: Provider-Specific HIPAA Releases of Information

While a ROI that includes all HIPAA-required elements is technically sufficient to obtain records, many providers/entities require you to use ROIs specific to only them.

Examples include:

The Ohio State University

The Cleveland Clinic

Nationwide Children's Hospital

Southeast Mental Health Services

Equitas

ODRC



If you're not sure if a provide requires a specific ROI, call and ask!
This will save you a lot of time and frustration in the long run.



Obtaining Medical Records: Record Selection

On every ROI, there is a section that looks something like this:

The type and amount of information to be used or disclosed is as follows: ___ Entire Record

- | | | | |
|-----|---------------------------------|-----|---|
| ___ | Problem list | ___ | Laboratory results from _____ to _____ |
| ___ | Medication list | ___ | X-ray and imaging reports from _____ to _____ |
| ___ | List of allergies | ___ | Consultation reports from _____ to _____ |
| ___ | Emergency room records | ___ | Drug and alcohol treatment |
| ___ | Immunization record | ___ | Psychotherapy records/mental health records |
| ___ | Mental Health Assessment (MHA) | ___ | All discharge summaries and admission records |
| ___ | Outpatient Notes (OPN) | ___ | All history & physical information |
| ___ | Medication Progress Notes (MPN) | ___ | Other: _____ |



Obtaining Medical Records: Record Selection

Best practice for PHYSICAL HEALTH RECORDS is to select “ENTIRE RECORD” and narrow your timeframe to TEN YEARS

The type and amount of information to be used or disclosed is as follows: Entire Record **2011 – PRESENT**

- | | |
|--|--|
| <input type="checkbox"/> Problem list | <input type="checkbox"/> Laboratory results from _____ to _____ |
| <input type="checkbox"/> Medication list | <input type="checkbox"/> X-ray and imaging reports from _____ to _____ |
| <input type="checkbox"/> List of allergies | <input type="checkbox"/> Consultation reports from _____ to _____ |
| <input type="checkbox"/> Emergency room records | <input type="checkbox"/> Drug and alcohol treatment |
| <input type="checkbox"/> Immunization record | <input type="checkbox"/> Psychotherapy records/mental health records |
| <input type="checkbox"/> Mental Health Assessment (MHA) | <input type="checkbox"/> All discharge summaries and admission records |
| <input type="checkbox"/> Outpatient Notes (OPN) | <input type="checkbox"/> All history & physical information |
| <input type="checkbox"/> Medication Progress Notes (MPN) | <input type="checkbox"/> Other: _____ |



Obtaining Medical Records: Record Selection

Best practice for MENTAL HEALTH AND SUBSTANCE ABUSE RECORDS is to select “ENTIRE RECORD” AND SELECT THE FOLLOWING:

The type and amount of information to be used or disclosed is as follows: Entire Record

- | | | | |
|-------------------------------------|---------------------------------|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Problem list | <input type="checkbox"/> | Laboratory results from _____ to _____ |
| <input checked="" type="checkbox"/> | Medication list | <input type="checkbox"/> | X-ray and imaging reports from _____ to _____ |
| <input type="checkbox"/> | List of allergies | <input type="checkbox"/> | Consultation reports from _____ to _____ |
| <input type="checkbox"/> | Emergency room records | <input checked="" type="checkbox"/> | Drug and alcohol treatment |
| <input checked="" type="checkbox"/> | Immunization record | <input checked="" type="checkbox"/> | Psychotherapy records/mental health records |
| <input checked="" type="checkbox"/> | Mental Health Assessment (MHA) | <input checked="" type="checkbox"/> | All discharge summaries and admission records |
| <input checked="" type="checkbox"/> | Outpatient Notes (OPN) | <input type="checkbox"/> | All history & physical information |
| <input checked="" type="checkbox"/> | Medication Progress Notes (MPN) | <input type="checkbox"/> | Other: _____ |



Understanding Medical Records





Understanding Medical Records: Discharge Summary

A *discharge summary* includes the following information:

1. Reason for Care

2. Primary Diagnoses

3. Procedures/Treatment Provided

4. Patient's Discharge Condition

5. Patient Instructions

6. Signature of Treatment Provider

Exam: Ms. Nesmith presents as sad looking, guarded, communicative, well groomed, normal weight, and looks unhappy. Her speech is mumbled, slow, slurred, and soft. There is no difficulty naming objects or repeating phrases. Sad demeanor reveals underlying depressed mood. Affect is appropriate, full range, and congruent with mood. There are no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. Associations are intact, thinking is logical, and thought content appears appropriate. Suicidal ideas or intentions are denied. Homicidal ideas or intentions are denied. Cognitive functioning and fund of knowledge are intact and age appropriate. Short- and long-term memory are intact, as is ability to abstract and do arithmetic calculations. This patient is fully oriented. Insight into problems appears fair. Judgment appears fair. There are no signs of anxiety. She is easily distracted. Ms. Nesmith made poor eye contact during the examination.

Diagnoses: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Adjustment disorder with depressed mood, F43.21 (ICD-10) (Active)
R/O Major depressive disorder, single episode, moderate, F32.1 (ICD-10) (Active)

Instructions / Recommendations / Plan:

A clinic or outpatient treatment setting is recommended because client is impaired to the degree that there is relatively moderate interference with occupational functioning. Attend one group once per week. Cognitive Behavioral Therapy: 1x week □for 6 months.

Return 1 week, or earlier if needed.

90791 Psych Diagnostic Interview



Understanding Medical Records: Discharge Summary

Benefits of DISCHARGE SUMMARIES

Provides you a quick snapshot of:

- Diagnoses
- Treatment Dates
- Treatment Plan
- Presenting history for current problem

Downsides of DISCHARGE SUMMARIES

Does not:

- Go into detail for each diagnosis
- Provide day-by-day treatment explanations
- Provide information on medication/treatment compliance
- Provide long-term history of client

Need to dive deeper into the record for these things!



Understanding Medical Records: Diagnoses

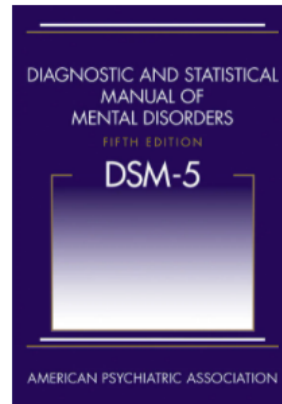
Common Diagnostic Terminology in Records Relating to Substance Abuse Disorders/Mental Health

Active/Current	Client currently meets diagnostic criteria
Inactive	This diagnosis has resolved for Client
In remission	Client still holds diagnosis, but is not experiencing symptoms
R/O	“Rule Out” - Client appears to meet diagnostic criteria for this condition, but further assessment should be completed
NOS	“Not Otherwise Specified” – Used to note the presence of a condition where symptoms presented are sufficient to make a general diagnosis, but not a specific one
Malingering	Client is exaggerating symptoms
Feigning	Client is making up symptoms
MAT	“Medication-Assisted Treatment” – a form of treatment that uses medication to treat substance abuse disorders, sustain recovery, and prevent overdose
AOD	“Alcohol and Other Drugs”



Understanding Medical Records: DSM-5/ICD-10

The DSM-5 is the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders



ICD-10 = Codes for
Billing Purposes!

- The MOST COMMON diagnostic system for psychiatric and substance abuse disorders in the U.S.
- Published by the American Psychiatric Association
- Each diagnosis has a list of criteria and a corresponding code
- Excellent resource to learn more about diagnoses listed in records



Understanding Medical Records: DSM-V/ICD-10

Common DSM-V Diagnoses and Codes in Records Relating to Substance Abuse Disorders

Alcohol Use Disorder	F10.10; F10.20
Opioid Use Disorder	F11.10; F11.20
Opioid Withdrawal	F11.23
Unspecified Opioid-Related Disorder	F11.99
Cocaine Use Disorder	F14.10; F14.20
Cannabis Use Disorder	F12.10; F12.20
Amphetamine Use Disorder	F15.10; F15.20

Note that records PRIOR to 2013 use the DSM-IV and DSM-IV-TR which are coded differently!



Understanding Medical Records: DSM-V/ICD-10

Common DSM-V/ICD-10 Diagnoses and Codes in Records Relating to Substance Use Disorders

Major Depressive Disorder	F32.0 – F33.9
Persistent Depressive Disorder	F34.1
PTSD	F43.10
Generalized Anxiety Disorder	F41.1
Bipolar I Disorder	F31.0 – F31.78
Bipolar II Disorder	F31.81
Schizophrenia Disorder	F20.9
Schizoaffective Disorder	F25.0; F25.1

Note that records PRIOR to 2013 use the DSM-IV and DSM-IV-TR which are coded differently!



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Helpful Resources

To look up diagnostic codes:

<https://www.icd10data.com/ICD10CM/Index/D>

Information about the DSM-V, including up-to-date changes:

<https://www.psychiatry.org/psychiatrists/practice/dsm>





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QUESTIONS?

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