

MEDICAL RECORDS GUIDE

for Physician Practices

JUNE 2022 EDITION ◀

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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	U.S. Department of Health and Human Services
CFR	Code of Federal Regulation

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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 and the MMRAA. See Mich. Op. Att'y Gen. No. 5125 (May 30, 1978).

1.2 WHO IS THE OWNER OF THE MEDICAL RECORD 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 an agreement to the contrary. An employed physician generally provides his/her services through the employer/entity which is normally the provider for purposes of determining 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. A physician's dual status as an owner and employee of the PC or PLC does not, by itself, shift ownership of the medical records to the physician 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 you to 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. In addition, regulations on "information blocking" (the "Information Blocking Rule") issued by the HHS Office of the National Coordinator for Health Information Technology ("ONC") prohibit physicians and other health care providers from engaging in conduct or practices that they know are unreasonable and likely to interfere with the access, exchange or use of electronic health information.

However, this right of access should not be confused with ownership. Upon a proper request (see CHAPTER 3) and payment of the required fee (if applicable, see CHAPTER 9), a patient has the right only to access to and/or 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."

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What to include in and how to change a medical record

COMPREHENSIVE LIST OF CONTENT GUIDELINES FOR MEDICAL RECORDS

The following list of general guidelines should be followed when completing a medical record.

- Ensure medical record entries are clear and readable. If possible, dictate all long entries that require more than brief or routine annotations.
- Include a detailed and accurate medical history, physical findings, differential diagnoses, treatment plan, care rendered, advice given, and all other matters pertinent to the patient's medical course.
- Exercise caution when using templates or check boxes within an electronic medical record. While most insurers do not prohibit the use of templates or check boxes, physicians should ensure that the template selected allows for a full and complete collection of information to demonstrate applicable coverage and coding criteria are met.
- Documentation for each encounter should be specific to that encounter—electronic entries carried forward from a previous visit should be reviewed, updated and edited as necessary to ensure the entries are accurate and current.
- Do not copy entries from patient to patient. This could risk the medical record's integrity.
- Never squeeze words into a line or leave blank spaces. Draw diagonal lines through all blank spaces after an entry.
- Never erase, write over, try to ink out, or use whiteout on an entry. In case of error, draw a single line through the incorrect entry, and write the date, the time, and your initials in the margin. To correct an error when using electronic medical records, add an addendum or note identifying the error and related correction.
- Never add anything to an original record unless you write a separately dated and signed note. The patient, a third-party payer, or a plaintiff's attorney may have obtained a copy of the original records.
- Always indicate the date and time of an entry. Ensure each page includes the patient's name and that each progress note is accompanied by the date and time. Make certain all entries are initialed or signed.
- Avoid personal abbreviations, ditto marks, or initials. Use only standard and accepted medical abbreviations.
- Do not use lengthy, self-serving entries. These may appear defensive in nature when explaining a complication or medical catastrophe.
- Do not use the patient's record as a place to record confidential communications between you and your professional liability insurance carrier or your attorney—or to criticize another caregiver.
- Always keep a record of when and by whom your medical record is photocopied. For electronic medical records, ensure that your EMR system has an audit feature which can identify who accesses, prints or takes other action regarding a medical record and when.
- Each medical record should contain:
 - *Results of a patient's physical examination, specifically noting the absence of abnormality.*
 - *Patient history, a list of all medications with particular emphasis on current medications, to include over-the-counter drugs and supplements and any allergies or drug sensitivities.*
 - *Specific notation on the patient's experience, if any, with drug or alcohol abuse and family or emotional problems.*
 - *Progress notes, entered after each office visit, about any change in status. (If negative, your follow-up should be indicated).*
 - *Signed and witnessed consent forms for special procedures or surgery.*
 - *Documentation of compliance with certain laws (e.g., information regarding review of MAPS, signed Start Talking Consent form, etc.)*
 - *Patient informed consent and response to medication or procedures.*
 - *Patient failure to follow advice or to keep appointments and any refusal to cooperate. (Log missed appointments and follow-up telephone calls and letters.)*
 - *All significant laboratory, drug screening or imaging reports and the dates when they were ordered and read.*
 - *Copies or records of instructions of any kind (including diet) and directions given to the family.*
 - *Records of consultations with other physicians and their written or oral response, with the dates and times.*
 - *Thorough documentation of any patient's grievance, including the date and time.*

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.” Although there are some laws which require certain documentation under specific circumstances (such as documenting in the medical record a patient’s response regarding other controlled substances the patient may be using before prescribing controlled substances under MCL §333.7303a), 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 list of general guidelines shown on page 2 should be followed when completing a medical record.

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 diagnose 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 IS INFORMATION STORED IN OTHER FORMATS (I.E. VIDEO, X-RAY FILMS, ECGS, FETAL MONITOR STRIPS, PHOTOS, ETC.) A PART OF THE MEDICAL RECORD?

Yes. Any and all data collected as part of the diagnosis or treatment of a patient is a part of the medical record.

2.5 IF A PATIENT BRINGS A MEDICAL RECORD FROM ANOTHER PHYSICIAN TO ME, AM I REQUIRED TO INCLUDE IT IN MY MEDICAL RECORD?

Not necessarily. You should extract only the portions of the other record you determine are necessary for your diagnosis/treatment of the patient. This retained information becomes a part of your medical record. If, instead, you retain the entire record brought by the patient that entire record becomes a part of your medical record.

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

You should adopt a uniform method for making corrections to your medical records, whether electronically or on paper. Corrections should be made so that the portion of the record being corrected remains legible and does not conceal or alter the prior entries. For paper medical records, 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.

2.7 HOW DO I MAKE CORRECTIONS IN AN ELECTRONIC MEDICAL RECORD?

When selecting an EMR System you should make sure it allows error correction without overwriting the erroneous entry. The following are additional features you should make sure:

- The system has the ability to track corrections or changes once the original entry has been entered or authenticated.
- When correcting or making a change to an entry, the:
 - Original entry is viewable,
 - Current date and time are entered,
 - Person making the change is identified, and
 - Reason for the change or correction is noted.
- If a hard copy is printed from the EMR, it has also been corrected.
- The system offers the ability to suppress viewing errors, but it ensures that flags notify others of any corrections.
- The location of the error points to the correction.

2.8 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 to 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.

2.9 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.

2.10 MUST I REVIEW IMAGING, LABORATORY AND CONSULTANT’S REPORTS PRIOR TO INCLUDING THEM IN A PATIENT’S MEDICAL RECORD?

If the reports qualify as electronic health information, the Information Blocking Rule makes clear that a physician cannot routinely time-delay the availability of information requested by a patient unless an exception or exclusion applies. According to an ONC Frequently Asked Question, it would likely be considered an interference for purposes of information blocking if a health care provider established an organizational policy that, for example, imposed delays on the release of lab results for any period of time in order to allow an ordering clinician to review the results or in order to personally inform the patient of the results before a patient can electronically access such results (see also 85 FR 25842 specifying that such a practice does not qualify for the “Preventing Harm” Exception).

However, the Information Blocking Rule does not prohibit taking necessary steps with respect to documents or other information which are not yet finalized (e.g., laboratory results which are pending confirmation or otherwise not yet considered by the hospital reliable for purposes of clinical decision making, or a clinical note that a physician has begun to draft but cannot finalize until he or she receives confirmed laboratory or pathology results.

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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. In addition, the Information Blocking Rule prohibits physicians and other health care providers from engaging in conduct or practices that they know are unreasonably and likely to interfere with the access, exchange or use of electronic health information.

The MMRAA contains a detailed procedure for responding to a patient's (or their authorized representative's) request to examine or obtain a copy of a medical record. 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):

- 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.
- Inform the person requesting the records that the medical record does not exist or cannot be found.
- 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.
- 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.

- If you determine that disclosure of the requested medical record is likely to have an adverse effect on the patient, you must provide the person requesting the record a clear statement supporting your determination and provide the medical record to another health care provider, health facility or legal counsel designated by the patient or his or her authorized representative.
- If some or all of the information in the medical record was obtained from someone other than a health care provider or health facility under a confidentiality agreement, you may provide a written denial if access to the medical record would be reasonably likely to reveal the source of the information.
- Take reasonable steps to verify the identity of the person making the request to examine or obtain a copy of the medical record.

Similarly, under the HIPAA Privacy Rule, a Covered Entity must provide an individual with access to PHI in the form and format requested no later than 30 days after receipt of the request. If you are unable to comply with the request within the required time period, HIPAA and the MMRAA require that you provide a written statement indicating the reasons for the delay and extend the response time for no more than an additional 30 days.

However, for purposes of the Information Blocking Rule, ONC has clarified that the fact that a physician meets its obligations under another applicable law (such as fulfilling the request for electronic health information, or "EHI" within the maximum allotted time allowed under HIPAA or the MMRAA) will not automatically demonstrate that the physician's practice does not constitute Information Blocking under the Information Blocking Provisions. For example, if a physician who could more promptly fulfill a request for EHI chooses instead to engage in a practice that delays fulfilling the request, such practice could constitute impermissible Information Blocking, even if the request is fulfilled in accordance with HIPAA and the MMRAA. Physicians should thus use reasonable efforts to fulfill requests as soon as practicable.

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, 45 CFR §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.

However, consideration should be given as to whether denial of access to an electronic medical record is unreasonable and constitutes information blocking under the Information Blocking Rule.

Generally, EHI which is subject to the Information Blocking Rule must be shared upon request by a patient or other authorized requestor, unless an exclusion or an exception under the Information Block Rule applies. For example, psychotherapy notes, as well as information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, are excluded from the definition of EHI and are not subject to the Information Blocking Rule.

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:

- 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.

- If the patient is deceased, any of the following:
 - His or her personal representative (to verify someone is a personal representative you should insist on a copy of "Letters of Authority" issued by a probate court).
 - The patient's heirs at law. These are the persons who would inherit the patient's property if he/she died without a Will. (i.e. in most cases the patient's spouse and if none it will be the patient's surviving children).
 - The beneficiary of the patient's life insurance policy only in the event necessary to provide information to an insurer to obtain life insurance benefits
- For the purpose of obtaining a copy of an autopsy report regarding a deceased patient, any of the following:
 - The deceased patient's heirs at law including, but not limited to, the deceased patient's spouse.
 - The deceased patient's personal representative.
 - The beneficiary of the deceased patient's life insurance policy but only to the extent necessary to provide information to an insurer to obtain life insurance benefits.

The MMRAA treats a patient's appointed guardian, and a minor patient's parent, guardian or person acting in loco parentis the same as the patient (subject to limited exceptions). See also Question 3.5.

Similarly, under the HIPAA Privacy Rule, Covered Entities must treat "personal representatives" the same as the individual patient for purposes of HIPAA and access to the patient's medical record. A personal representative includes (1) a person with authority to act on behalf of an adult or emancipated minor in making decisions related to health care, (2) a parent, guardian or other person acting in loco parentis if the patient is a minor, subject to certain exceptions, or (3) a person with authority to act on behalf of a deceased patient or his or her estate, subject to limited exceptions.

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. The MMRAA requires you to take reasonable steps to verify 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 use disorder (MCL §330.1264) 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 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, the patient must also 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 FOR SERVICES RENDERED, SUCH AS A DEDUCTIBLE OR COPAY, ARE 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?

Michigan's Worker's Compensation Health Care Services Rules specifically provide that patients have access to medical records and reports related to a specific work place injury. Mich Admin Code R. 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. Mich Admin Code R 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. The copying charge for each x-ray film requested by a worker's compensation carrier or its agent is \$15.00 which includes mailing and handling.

When there is doubt whether a request is in connection with a worker's compensation case, you should have your attorney contact the patient's attorney or otherwise verify a case is pending with the court or tribunal.

3.11 A PATIENT HAS REQUESTED AN ELECTRONIC COPY OF THEIR MEDICAL RECORD, BUT I ONLY MAINTAIN PAPER MEDICAL RECORDS. AM I REQUIRED TO PROVIDE AN ELECTRONIC COPY OF THE PATIENT'S MEDICAL RECORD?

The HIPAA Privacy Rule requires you to provide an individual with access to his or her medical record in the form and format requested by the individual, but only if it is readily producible in such form and format. If the medical record is not readily producible in the form and format requested, you must provide the medical record in a readable hard copy form or such other form and format as agreed to by you and the individual. If the copy is readily producible electronically but not in the specific format requested, you may offer the individual the copy in an alternative readable electronic format.

You are not required to purchase a scanner or other device to create electronic medical records (see HHS Frequently Asked Question 2055 dated June 24, 2016).

3.12 ARE MY PROGRESS NOTES A PART OF THE MEDICAL RECORD THAT PATIENTS HAVE ACCESS TO?

Yes. Progress notes should be entered in the medical record after each visit. These entries are a part of the medical record and subject to the patient's right of access.

3.13 WHAT SHOULD I DO IF SOMEONE SEEKING ACCESS TO A DECEASED PATIENT'S MEDICAL RECORD IS CLAIMING TO BE AN AUTHORIZED REPRESENTATIVE OR AN HEIR AT LAW?

The MMRAA and HIPAA Privacy Rule require you to take reasonable steps to verify the identity of the individual making the request and authority to access PHI. The person claiming to be a personal or authorized representative should be able to provide appropriate documentation, such as a copy of "Letters of Authority" issued by a probate court. It may be more difficult to verify an heir at law. Most often this will be the spouse or child of the deceased patient. If you do not know the person to be the spouse or child of your deceased patient, do not release the medical record without being presented with documentation reasonably establishing their identity and relationship to the patient. What this will be will have to be determined on a case-by-case basis. You should consult with your attorney.

3.14 WHAT DO I DO IF A REQUEST FOR A PATIENT'S RECORDS IS MADE BY A GOVERNMENTAL AUTHORITY WITHOUT A PATIENT AUTHORIZATION?

See Chapter 5 for a list of Michigan Statutes authorizing or requiring disclosure of medical record information without patient authorization. When in doubt whether a statute applies, or if disclosure is permitted, you should contact your attorney.

04

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. If a practice has reasonably verified the child's father's identity, the practice should not deny access to the records absent the practice's receipt of a court order instructing otherwise.

D. Personal Representative/Executor of a Deceased Patient's Estate

Who is entitled to access of the medical records of a deceased patient?

See Question 3.3. 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; and the beneficiary of the patient's life in policy to the extent necessary to provide information to an insurer to obtain life insurance benefits.

E. Attorneys

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 should 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.

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 written 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. See 45 CFR §164.512(e).

Subpoenas.

Is a subpoena a court order requiring that access be given?

A subpoena that is not either: (1) signed by a judge or magistrate; or (2) accompanied by a court order or a HIPAA compliant authorization signed by the patient, must only be complied with if it is issued in connection with a patient's malpractice case against another physician (as described in Question 4.1E.(ii)). When unclear, contact the attorney issuing the subpoena and ask for the patient's written authorization or a court order, or contact your own attorney to determine what the case is about or otherwise determine whether the subpoena must be complied with.

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 disclose 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 pa-

tient 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.

05

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, non-exhaustive 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/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];
- ◆ Communicable Disease [Mich Admin Code R. 325.173];
- ◆ HHS HIPAA Compliance [45 CFR 164.502]

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 requires 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 SEVEN 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 seven 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 multiple various factors which should be considered before medical records are destroyed, even 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 ten 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 six years from the date of the act or omission. While the six-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 ten years after the last visit for adult patients and up to age 28 for minors, or ten 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. However, even if you are permitted by law to destroy the medical record, consideration should be given to your risk exposure if you proceed with such destruction, such as being unable to defend a malpractice claim or post-payor audit.

6.6 DOES THE LAW REQUIRE SPECIFIC METHODS OF STORAGE OF MEDICAL RECORDS? MAY MEDICAL RECORDS BE STORED OUTSIDE MY OFFICE?

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. Similarly, the HIPAA Security Rule sets forth physical, administrative and technical safeguards for the storage and protection of electronic protected health information. 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. If you decide to move records outside your office for storage (in addition to insuring the privacy of the information) you must maintain the safety of the record (there must be adequate protection from fire, flood, theft, etc.) and their accessibility (i.e. they must remain available for copying).

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 (AMA Principals of Medical Ethics 3.3.1(i)). Keep in mind the statute of limitations and the possibility of an audit (see Questions 6.4 and 6.7) prior to destroying these records.

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?

The AMA Principals of Medical Ethics Section 3.3.1 provides that medical considerations should be used to determine how long to keep medical records and that you should retain information that another physician seeing the patient for the first time could be reasonably expected to need or want to know, including:

- Immunization records, which should be kept indefinitely; and
- Records of significant health events or conditions and interventions that could be expected to have a bearing on the patient's future health needs, such as records of chemotherapy.

6.10 CAN I SCAN AND SAVE MY EXISTING PAPER MEDICAL RECORDS IN ELECTRONIC FORM?

Yes, but your obligation to maintain the privacy, safety and accessibility (see Question 6.6) of the record remain the same. Be aware that electronic records must be encrypted while they are stored and during transit. Prior to destroying the paper records, you should carefully review the electronic version to make sure it is complete and readable.

6.11 SHOULD I MAINTAIN A BACK UP COPY OF MY ELECTRONIC RECORDS?

Yes. Both a copy of the EMR Software itself and your electronic medical records should be maintained on a disk, cloud or other medium at an offsite location. You should have a process in place to do this routinely each day.

6.12 CAN I GIVE A PATIENT HIS/HER ORIGINAL MEDICAL RECORD?

You could, but this is not generally recommended. You do not want to be without the record in a third-party billing audit, a malpractice suit, a licensing action or other situations where your medical record would be necessary for your defense. Giving the record away also means you lose control of its contents (i.e. the patient may make alterations, destroy the record, etc.). The best practice would be to provide a copy only and retain the originals.

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 for most records). 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.” 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 pickup. Electronic destruction may be the most difficult to accomplish. It must be done in such a way that the information cannot be reconstructed or retrieved.

- Laser discs within a hard drive should be destroyed by pulverizing.
- Magnetic degaussing may be used for data stored on microchips or other magnetic medium.
- DVDs should be destroyed by shredding or cutting.
- Magnetic tapes should be destroyed by demagnetizing.

7.3 CAN I HIRE A THIRD PARTY TO HANDLE MY DOCUMENT AND/OR ELECTRONIC RECORD DESTRUCTION?

Yes. You must have a Business Associate Agreement in place with this third party that meets all of HIPAA’s requirements. This Agreement should also include:

- The destruction method to be used.
- The time between your disclosure and the destruction.
- The business associates’ safeguards against breaches.
- Indemnification if a breach occurs.
- Require the third party business associate to maintain liability insurance.

7.4 AM I REQUIRED TO MAINTAIN A MEDICAL RECORD DESTRUCTION LOG?

There is no Michigan or federal requirement that you document the destruction of medical records. However, it is considered a best practice that you maintain a permanent medical record destruction log which reasonably identifies the destroyed medical records and verifies that the medical records have been properly destroyed. The medical record destruction log should include a description of the destroyed medical records, the date and method of destruction, a statement that the medical records were destroyed during the normal course of business, and the name and signature of the person or company destroying the medical records.

7.5 CAN A MEDICAL RECORD BE THINNED BY DESTROYING THOSE PARTS THAT ARE MORE THAN SEVEN YEARS OLD?

Yes, but consider the statute of limitations for medical malpractice claims, the possibility of third-party audits and other potential risk exposures (Questions 6.4 and 6.7) first.

08

Disposition of medical records upon the sale or closure of practice, retirement, or other cessation of 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 (or longer period if required by other state or federal law). Instead, you must:

- Send a written notice to the Michigan Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing (P.O. Box 30670, Lansing, MI 48170 or through your MiPLUS account) 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
- Transfer the medical records to any of the following:
 - a successor physician;
 - if requested by the patient, to the patient or a specific health facility or agency or other health care provider; or
 - a health care provider, a health facility or agency or a medical records company with which you have contracted.

Physicians should make sure they have the continuing right to access medical records following their transfer. This would be necessary to defend a malpractice claim, licensing investigation or in a post-payment audit. If a practice is sold, the continued right of access is typically documented in the sale agreement between the selling and purchasing physicians. This agreement should state that the selling physician has a continuing right to access the records and that the purchasing physician will retain the records for an

agreed upon amount of time. 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. Custodial agreements for storage of medical records should include the following:

- The medical records will be retained until the physician arranges for their destruction.
- No one can access the information contained in the medical records without a signed release from the patient or an authorized representative or a properly executed subpoena or court order.
- The physician and the custodian will notify each other if either changes their address or phone number.
- The terms apply to all persons in the custodian's employment and facility.
- Copies of medical records will be released to a person designated by the patient only with the patient's written authorization.
- The custodian will comply with state and federal laws governing medical record confidentiality, access, disclosure, and charges for copies of the records.
- Language that addresses the safety of and continued access to the records by the physician.



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 (consider the statute of limitations prior to any destruction of medical records. See Question 6.4). 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).

8.3 DO I HAVE TO TRANSFER MY MEDICAL RECORDS TO ANOTHER PARTY WHEN I CEASE PRACTICING OR CAN I JUST KEEP THEM WITH ME?

You may keep the medical records with you. There is no law requiring you to transfer them to another party. If you decide to keep medical records with you, you will be obligated to maintain the patient's privacy, the safety of the medical records and to maintain accessibility to them (see Question 6.6).

8.4 MUST I NOTIFY PATIENTS WHERE THEIR MEDICAL RECORDS ARE BEING STORED OR HAVE BEEN TRANSFERRED?

No. However, it is best practice to notify patients that your practice will be closing and to give them the option to have their records transferred to a physician they designate. This notice should be accompanied by an authorization for the patient's use. If patients do not respond (and your medical records are not being transferred as part of a sale of your practice) you must maintain custody of your medical records, maintain patient privacy, safeguard the records and ensure accessibility as discussed in Questions 6.6 and 8.3.



09

Charging fees for copying and preparing a summary of a medical record

9.1 WHAT CAN I CHARGE FOR COPYING A MEDICAL RECORD?

Paper Records – HIPAA requires you to make a reasonable determination of your actual, reasonable cost of producing the copy. If this amount is less than the MMRAA fee, you may charge only the actual cost you determined. If the MMRAA fee is less, you may only charge the amount permitted under the MMRAA.

Electronic Records – HIPAA allows you to charge an amount you determine to be your actual cost of producing the copy in the form and format agreed to by you and the patient, subject to the limitations set forth below. Alternatively, you may charge a flat-fee of \$6.50.

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 is limited to the cost of copying (including the cost of supplies and the labor of copying, whether in paper or electronic form), 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 in advance 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 April 12, 2021 are:

- \$1.28 per page for the first 20 pages, \$0.64 per page for pages 21 through 50, and \$0.26 per page for pages 51 and over.
- In addition to these per-page charges, you are allowed to impose an initial fee of \$25.64 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).

HHS has taken the position (see HHS Frequently Asked Question 2031 dated June 24, 2016) that costs not permitted by the HIPAA Privacy Rule may not be charged to individuals even if the costs are authorized by State law. Your fee for providing an individual with a copy of his or her medical record must be reasonable in addition to cost-based, and there may be circumstances where the State-authorized fee is not reasonable, even if the State-authorized fee covers permitted labor, supply and postage costs. For example, the MMRAA fee schedule may be higher than your costs to provide the copy of the medical record. While the MMRAA may be considered as a guide, you should not charge the maximum permitted copy fees under the MMRAA unless such fees reflect your reasonable costs for copying a medical record. Notwithstanding, in response to a 2020 federal court decision, HHS issued a notice clarifying that the HIPAA Privacy Rule's fee limitations only apply to patient requests for their own medical records, and does not apply to a patient's request to transmit records to a third party, such as a law firm. In these circumstances, it is appropriate to apply the MMRAA fee schedule. See also Question 9.8.

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 Code R 418.10118. The fee schedule under this administrative rule should be checked for annual updates.

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

The MMRAA allows you to charge the actual cost of preparing a duplicate. If the X-Rays can be readily produced in the form and format requested by the patient (e.g., electronic copy), an individual is entitled to access them in such form and format, but you may still charge a reasonable, cost-based fee for such request as discussed in Question 9.1. It is advisable to discuss any unique situations in advance with the requestor and associated costs before proceeding to make copies and/or incurring costs.

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?

No. Although these fees are permitted by the MMRAA if the records are more than 7 years old, to the extent fees imposed by an offsite storage company are inconsistent with the fees permitted by HIPAA described in Question 9.1, HIPAA would likely preempt the MMRAA and thus, you could not pass the fee onto the patient.

9.4 MUST I NOTIFY PATIENTS WHAT THE FEE WILL BE IN ADVANCE? CAN I INSIST THAT THESE COPY FEES BE PAID IN ADVANCE?

Yes. You must notify patients in advance what the fee will be and you may insist on payment upfront. The MMRAA expressly permits practices to refuse to copy all or part of a medical record for a patient or his or her authorized representative until the applicable fee is paid. In addition, HHS' recent Proposal for Rulemaking confirms that the HIPAA Privacy Rule does not prohibit practices from requiring individuals to pay a fee for copies of PHI upfront before receiving such copies.

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 (HIPAA requires the individual's advance agreement to the fees imposed for the summary or explanation). 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 HIPAA Privacy Rule has 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.

Section 164.524(c)(4) of the HIPAA Privacy Rule provides 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; (iii) postage, when the individual has requested the copy, or the summary or explanation be mailed, and (iv) preparing an explanation or summary of the protected health information, if agreed to by the individual. In addition, Section 13405(e) (2) of the HITECH Act provides that a covered entity may not charge more than its labor costs in responding to the request for a 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.

- A covered entity may not charge a search and retrieval fee, whether a standard retrieval fee or one based on actual searching and retrieval costs.
- Fees associated with maintaining systems and recouping capital for data access, storage and infrastructure are not
- 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).

As an alternative option to calculating actual or average permitted costs for requests for electronic copies of a medical record that is maintained electronically, you may elect to charge a flat fee not to exceed \$6.50, inclusive of all labor, supplies and any applicable postage (see HHS Frequently Asked Question 2029 dated June 24, 2016).

9.7. MAY I CHARGE A FEE TO ALLOW A PATIENT ACCESS BY VIEWING INFORMATION ON MY EHR?

No. The HIPAA Privacy Rule at 45 CFE 164.524(c)(4) permits a covered entity to charge a reasonable, cost-based fee that covers only certain limited labor, supply, and postage costs that may apply in providing the patient with a copy of their medical record in the form and format requested or agreed to by the individual. When a patient only wants to view information or access it via the View, Download, and Transmit functionality of your EMR there are no labor costs and no costs for supplies to enable such access. Therefore, you may not charge a fee.

9.8 WILL CHARGING A FEE VIOLATE THE INFORMATION BLOCKING RULE?

Not necessarily. The Fee Exception under the Information Blocking Rule allows physicians and other “actors” to charge fee for accessing EHI, provided that the fee is (1) based on objective and verifiable criteria, uniformly applied for similarly situated people/requests; (2) reasonably related to the actor’s costs; (3) reasonably allocated among all similarly situated people, and (4) based on costs not already recovered for the same instance of the service to a provider or third party.

In addition, the fee must not be based on:

- Competitive considerations;
- Sales, profit, revenue or other value that the requestor or other party may derive from the access, exchange or use of the EHI;
- Costs that an actor incurs because it designed or implemented health IT in non-standard ways (unless the requestor agreed to the fee associated with such implementation);
- Costs associated with intangible assets other than actual development and acquisition costs;
- Opportunity costs unrelated to the access, exchange or use of EHI; or
- Any costs leading to the creation of intellectual property if the actor charges a royalty for that intellectual property under the Licensing Exception and the royalty includes development costs of creating that intellectual property.
- To be eligible under the Fee Exception, an actor may not charge any of the following fees:
- Fees prohibited under the HIPAA Privacy Rule for individuals’ requests for access to their protected health information;
- Fees based in any way on the electronic access of an individual’s EHI by the individual, the individual’s personal representatives or others designated by the individual. The Information Blocking Rule defines “electronic access” as “an internet-based method that makes EHI available at the time the EHI is requested and where no manual effort is required to fulfill the request.”
- Fees to export EHI to switch health IT or provide EHI to patients, if done through a capability certified to the final rule’s EHI export health IT certification criterion at 45 CFR § 170.315(b)(10) (Certified EHI Export Capability); and
- Fees to export or convert data from an EHR system, unless the parties agreed to the fee in writing at the time the EHR system was acquired.

Even if the fee imposed by a practice fails to meet the Fee Exception criteria, this does not mean that the practice has violated the Information Blocking Rule, unless the practice knows the fee charged or its conduct related to the fee imposed is unreasonable and likely to interfere with the access, exchange and use of EHI.

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