Releasing Records from Other Providers

by Barry S. Herrin, JD, FACHE

Question: Should organizations include records of other providers when responding to a release of information?

Answer: Yes. There are three reasons this is so.

First, there is no law or regulation that generally prohibits the redisclosure of information received from another provider other than records of drug or alcohol abuse testing and treatment under 42 CFR Part 2 and perhaps under state Medicaid subrogation statutes.

Second, if an organization uses information from an outside source to manage, treat, diagnose, or develop a plan of care for a patient and that information is not in the organization's legal health record, its record does not tell the whole story of care. HIM professionals have this problem with present on admission indicators, medical necessity denials of reimbursement, and other places.

Third, and most importantly, external measurements of admissibility, evidence, authentication, and truthfulness really do not mean anything in the context of defining what the business record of a healthcare provider is. No one person in any healthcare facility—certainly not the HIM director—can truthfully say that all of the information in any legal health record is objectively true, because no one person created the record. The entire record is nothing but a compilation of information from disparate sources of uncertain veracity.

However, everyone acts as if the information is true based on the premise that nobody would deliberately include untruthful information. That is what makes the issue of external records so thorny.

Physician offices routinely include lab studies done by outside labs and radiological interpretations done by hospitals in their records. They release these records all the time. There is no difference between a hospital's original records and those that hospitals receive from physicians or other providers.

Different release of information requirements apply to unsolicited information, information that arrives postdischarge, and systems in which nobody can tell what external information was reviewed. However, those are vastly different questions from "Should we routinely exclude from our legal health record every external document?"

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