Team Name: Health Information Services Team Lead: Regional Privacy & Access Officer Approved by: VP - Corporate Services	Reference Number: ORG.1411.PL.102 Program Area: Health Information Services Policy Section: Privacy & Access
Issue Date: April 8 2015 Review Date: Revision Date: February 1, 2017	Subject: Access, Disclosure and Correction to the Clinical Record under The Mental Health Act

POLICY SUBJECT:
Access, Disclosure and Correction to the Clinical Record under The Mental Health Act

PURPOSE:
1. To manage Individuals requests to examine (view) and receive a copy of their Personal Health Information.

2. To Maintain and protect the interests of the Trustee of Personal Health Information including its property right to the Record, regardless of media (electronic, paper or digital image).

BOARD POLICY REFERENCE:
Executive Limitation (EL-2) Treatment of Clients

POLICY:
1. The provision of *The Mental Health Act*, (Manitoba) takes precedence over any conflicting provisions in *The Personal Health Information Act* (Manitoba) ("PHIA").

2. Southern Health-Santé Sud may charge a fee for access to and disclosure of information within the clinical record in accordance with the ORG.1411.PL.502.SD.02 Access/Disclosure/Release of Personal Health Information Fee Schedule. The fee may be waived at the discretion of the Medical Director/delegate.

3. The delegate (e.g. attending psychiatrist) can respond to requests from inpatients under his/her care, in consultation with the Medical Director's office.

4. **Access to the Clinical Record:**
   4.1 The patient has the right, on request, to examine and receive a copy of his/her clinical record maintained by a psychiatric facility.

   4.2 The request to examine and receive copies of the patient's information must be made in writing to the Medical Director of the psychiatric facility.

4.3 The Medical Director/delegate responds to the request within seven days of receipt of the request and advises the patient that his/her request has been either approved or referred to the review board.

4.4 If the Medical Director wishes to refuse access to all or part of the clinical record, he or she shall, within seven days after receiving the request, apply to the Review Board for an order permitting all or part of the clinical record to be withheld.

4.5 After reviewing the clinical record the review board may order the Medical Director to permit the patient/alternate to examine and receive a copy of the entire record or the review board may order that certain information be severed from the record permitting the patient/alternate to examine or copy the remainder of the clinical record.

5. **Correction to the Clinical Record:**

5.1 A patient/alternate may make a request in writing to the Medical Director to correct personal health information recorded and maintained in the patient's clinical record.

5.2 No fee is charged for a request for and/or correction to a clinical record.

6. **Disclosure of the Clinical Record:**

6.1 Information maintained in a clinical record is only disclosed with the patient/alternate's consent or where permitted under *The Mental Health Act* as outlined below.

6.2 Every disclosure of information is limited to the minimum amount of information necessary to accomplish the purpose for which the information is disclosed.

6.3 The Medical Director/delegate may disclose information maintained in a clinical record without the patient's consent or consent on the patient's behalf only if the disclosure is restricted to the following circumstances:

6.3.1 To a person on the staff of the facility or a student directly involved in the patient's care, for the purpose of assessing or treating the patient;

6.3.2 To the Medical Director of another facility or other health facility currently involved in the patient's direct care, on that person's written request;

6.3.3 To a person who is providing health care to the patient, to the extent necessary to provide that care, unless the patient, while competent, has instructed the Medical Director not to make the disclosure;

6.3.4 To the person authorized to make treatment decisions on the patient's behalf under, for the sole purpose of making treatment decisions on the patient's behalf;

6.3.5 To any person, if the Medical Director reasonably believes that the disclosure is necessary to prevent or lessen a serious and immediate threat to the mental or physical health or the safety of the patient or another person;

6.3.6 To the Review Board for the purpose of a hearing;

6.3.7 To the Chief Provincial Psychiatrist for the purpose of carrying out his or her duties under *The Mental Health Act*;

6.3.8 To a Review Board established or designated for Manitoba under Part XX.1 of the *Criminal Code* (Canada);

6.3.9 To a person for research purposes in accordance with the Research Approval Process policy;

6.3.10 Required for the planning, delivery, evaluation or monitoring of a program that relates to providing health care to the patient or the payment for health care;

6.3.11 Required for the purpose of peer review by the standards committee of the facility, or to a medical staff committee established to study or evaluate medical practice in the facility;

6.3.12 Required by a critical incident review committee established under Part 4.1 of *The Regional Health Authorities Act*;

6.3.13 To a body with statutory responsibility for the discipline of members of a health profession or for the quality or standards of professional services provided by members of a health profession;

6.3.14 To the executor or administrator of a deceased patient's estate, or

6.3.15 To a relative of the patient if the Medical Director is of the opinion that disclosure would not be an unreasonable invasion of the deceased patient's privacy and would not endanger the mental or physical health of another person;

6.3.16 To a lawyer acting on behalf of the facility or on behalf of a person on the staff of the facility.

6.4 Disclosure under a subpoena or court order

6.4.1 The Medical Director discloses information in a patient's clinical record when required to do so by a subpoena, order or direction of a court, unless a written statement has been received from the patient's attending physician that the disclosure of the information could reasonably be expected to endanger the mental or physical health or the safety of the patient or another person;

6.4.2 Further to receiving the written statement the court will hold a hearing, which may include an examination of the clinical record, to determine if the disclosure of the information could reasonably be expected to endanger the mental or physical health or the safety of the patient or another person;

6.4.3 The Medical Director will respond further to the outcome of the hearing as follows:

6.4.3.1 Information is not disclosed where the decision is not to order disclosure of the information; or

6.4.3.2 Discloses the information where the court has determined that it is essential in the interests of justice.

DEFINITIONS:

1. **Alternate Decision Maker (Alternate):** Is a person who has decision-making capacity and is willing to make decisions on behalf of a patient who does not have the capacity to make a decision. An Alternate may be legally authorized (e.g. health care proxy or committee) or may be a person designated (e.g. family member) in the absence of a legally authorized individual. For psychiatric facilities this would refer to "Person Authorized to Make Treatment Decisions".

2. **Clinical Record:** The clinical record compiled and maintained in a designated Psychiatric Facility for the observation, assessment, diagnosis and treatment of persons who suffer from mental disorders.

3. **Delegate:** A person or persons delegated by the Medical Director to process requests for access to, correction or disclosure of information within the clinical record.

4. **Medical Director:** The psychiatrist responsible for the provision and direction of psychiatric services for a designated psychiatric facility. The Medical Director may delegate any of the medical director's powers, duties or functions under *The Mental Health Act*.

5. **Patient:** A person who is or has been admitted to a Psychiatric Facility as an in-patient, or is/was attending as an outpatient for diagnosis and treatment.

6. **Psychiatric Facility:** A place designated in the regulations of *The Mental Health Act* as a facility for the observation, assessment, diagnosis and treatment of persons who suffer from mental disorders.

7. **Review Board**: The Mental Health Review board established pursuant to *The Mental Health Act.*

PROCEDURE:

Procedure for Access to the Clinical Record:

The Medical Director and/or Delegate:

1. Receives the request from the patient/alternate who would like to examine and/or receive copies of the clinical record.

2. Requests that the patient/alternate provide a completed ORG.1411.PL.101.FORM.01 Request to Access Personal Health Information form or another form of written request.

3. Reviews the clinical record and determines what information may be released, or

4. Applies to the Review Board, within seven days after receiving the request, if he/she wishes to refuse access to all or part of the clinical record.

5. Responds, in writing, to the patient/alternate's request within seven days of receipt of the request and advises the patient that his/her request has been either approved or referred to the review board.

6. Arranges to meet and/or provide copies of the clinical record to the patient/alternate and advises of any orders or stipulations for the patient's access to the clinical record.

The Delegate:

1. Advises the patient/alternate, in writing, of the approval/refusal to view the clinical record and the estimated costs to examine and receive copies of the clinical record.

2. Advises the patient/alternate of the estimated cost to examine and receive copies of the clinical record after a request has been granted.

3. Arranges with the patient/alternate to examine the clinical record and/or to obtain copies of the clinical record.

4. Records in the clinical record what information has been provided, the date and to whom.

5. Files the completed form and any correspondence in the patient health record.

6. Arranges for appropriate staff to be available to provide explanation of terms, codes or abbreviations used in the clinical record.

Procedure for Correction to the Clinical Record

The Medical Director and/or delegate:

1. Receives the request for a correction to the clinical record from a patient/alternate.

2. Requests that the patient/alternate provide a completed ORG.1411.PL.104.FORM.01 Request to Correct Personal Health Information form or another form of written request.

3. As promptly as required in the circumstances, but no later than 30 days after receiving the request:

    (a) Makes the correction by adding the information to the record in such a manner that it will be read with and form part of the record or be cross-referenced to it;

    (b) Informs the patient/alternate that the record no longer exists or cannot be found;

    (c) Informs the patient/alternate of the name and address of the facility that maintains the requested information;

    (d) Advise the patient/alternate of the refusal to correct the record as requested, the reason for the refusal, and the patient/alternate's right to add a statement of disagreement to the record.

4. Where a correction has been refused:

    (a) Permits the patient/alternate to file a concise statement of disagreement stating the correction requested and the reason for the correction;

    (b) Add the statement to the clinical record in such a manner that it will be read with, and form part of the clinical record or adequately cross referenced to it.

5. Notifies, where practical, any other person or organization to whom the clinical record has been disclosed during the year before the correction was requested about the correction or statement of disagreement and provides a copy.

6. Files the completed form and any correspondence in the patient health record.

Procedure for Disclosure of Information

The Medical Director or delegate:

1. Upon receipt of a written request for the disclosure of personal health information and where it has been determined that consent is required:

   (a) Completes the Consent to Disclose Personal Health Information form where the Medical Director is consenting on the patient's behalf, noting under Part 3 of the form the authority to act on behalf of the individual as Section 36 (2) of *The Mental Health Act*.

   (b) Obtains a signed ORG.1411.PL.502.FORM.01 Consent to Disclose Personal Health Information from the patient/alternate, if another valid consent has not been provided.

   (c) Where a written consent has been provided, reviews the consent to ensure it includes:

   - the name and date of birth of the individual
   - the date of the signature within one year
   - the name of the facility/department/program that is authorized to disclose the information
   - the purpose for the request
   - the date(s) care provided and specific information required
   - the signature of the individual

   Where the above criteria for a valid consent have not been met, the patient/alternate may be contacted to verify the information.

   (d) Obtain the original consent. Where the original is not accessible, contact the patient/alternate directly to verify their consent and document verification on the consent copy.

2. Records in the clinical record where verbal consent is obtained and the circumstances mandating the verbal consent.

3. Verifies the authority to disclose information without consent, prior to disclosing information.

4. Records in the clinical record any disclosure of information including, but not limited to, what information was disclosed, the date and to whom.

5. Processes the request for disclosure of information.

6. Files the consent in the patient health record.

SUPPORTING DOCUMENTS:
ORG.1411.PL.101.FORM.01 Request to Access Personal Health Information Form
ORG.1411.PL.101.FORM.01.F Request to Access Personal Health Information-French.
ORG.1411.PL.104.FORM.01 Request to Correct Personal Health Information.
ORG.1411.PL.502.FORM.01 Consent to Disclose Personal Health Information Form
ORG.1411.PL.502.FORM.01.F Consent to Disclose Personal Health Information Form-French
ORG.1411.PL.502.SD.06 Access/Disclosure/Release of Personal Health Information Fee Schedule

REFERENCES:
The Mental Health Act, Part 5 – Information and Records