GENERAL DISTRIBUTION

WEST VIRGINIA DIVISION OF CORRECTIONS & REHABILITATION	**NUMBER:**	**142.01**
	DATE:	**26 July 2021**
	SUBJECT:	**RELEASE OF INMATE/OFFENDER HEALTHCARE RECORDS**

POLICY DIRECTIVE

PURPOSE:

To maintain the confidentiality of inmate/offender healthcare records and provide a mechanism for the release of healthcare records in accordance with state code.

REFERENCE:

WV Code §§16-29-1 and 16-29-2 (as amended during the 2021 regular session of the Legislature); Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Title 42: Public Health, Part 2 – Confidentiality of Substance Abuse Patient Records (42 CFR Part 2).

RESPONSIBILITY:

No additional written instructions on this subject are required.

CANCELLATION:

Any previous written instruction on the subject.

APPLICABILITY:

All facilities and work units within the Division of Corrections and Rehabilitation that house or supervise adult inmates/offenders. This Policy is available for general distribution and is to be made available for inmate/offender review.

DEFINITIONS:

Disclose: To communicate, transmit, or in any way convey information to any individual or entity in writing, verbally, or other form. Sharing healthcare records between separate

DCR facilities or work units is not considered disclosure when the information is necessary in the legitimate performance of assigned duties.

Healthcare Record: For the purpose of this Policy, includes medical information recorded in any form of medium that is created or received by a health care provider, health care facility, health plan, public health authority that relates to the past, present or future physical or mental health of the person, or the provision of health care to the person. This includes records related to alcohol and drug abuse and substance abuse treatment programs.

POLICY:

I. No healthcare records pertaining to any inmate/offender, including records of mental health and/or substance abuse treatment, shall be released, or otherwise provided to any person(s) except as provided herein.

   A. Complete healthcare records, including mental health records and substance abuse treatment, can be provided to outside medical or mental health providers; the Social Security Administration; correctional facilities in other jurisdictions; and/or entities in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all applicable federal and state laws.

   B. Any inmate wishing to have a copy of his/her healthcare record as maintained by the facility healthcare provider may request the same from the healthcare administrator at his/her facility. All written requests will be kept on file in the medical department.

      1. However, should this request involve pending litigation, a copy of the request shall be forwarded by the Superintendent/designee through the chain of command to the appropriate Assistant Commissioner.

      2. No request for healthcare records shall be honored unless the inmate agrees to pay all reasonable expenses incurred in preparing the summary of the requested records, the cost of copying the records, and any other reasonable expenses as established by the healthcare provider consistent with state code.

      3. In the case of an inmate receiving treatment for psychiatric or psychological problems, the inmate shall only be authorized to receive a summary of the psychiatric or psychological records, and such records shall not be made available to the inmate or his/her authorized agent until the treatment program has terminated and the inmate has discharged all his/her sentences.

   C. Requests made to Parole Officers for information shall be referred to his/her Regional Director.

   D. Any inmate/offender wishing to have a copy of his/her records related to alcohol and drug abuse and/or substance abuse treatment programs may request the same.

E. Provided that pursuant to an order of any court of competent jurisdiction, based upon a finding that the information is sufficiently relevant to a proceeding before the court to outweigh the importance of maintaining confidentiality of records, records for psychiatric or psychological treatment may be released to an inmate's counsel or as provided in the court order. All records released pursuant to this section shall be clearly marked as confidential records potentially disruptive to the treatment of the inmate if disclosed to the inmate and will be considered contraband if found in the possession of any inmate.

F. Furnishing a copy or summary of the reports of x-ray examinations, electrocardiograms, and other diagnostic procedures shall satisfy a request for healthcare records.

G. Whenever an individual other than the inmate/offender, such as a friend or family member, legal guardian, conservator, executor, and/or administrator requests information pertaining to treatment or healthcare of an inmate/offender, including psychological or psychiatric treatment, no such information shall be provided unless the inmate/offender has first executed an Authorization for Release of Health Information (**Attachment #1**). Requested information pertaining to psychological or psychiatric treatment shall be dealt with as stipulated above.

H. If a subpoena is served on the facility/work unit or the agency to produce such records, a copy of the subpoena shall be forwarded by the Superintendent/Director/designee through the chain of command to the appropriate Assistant Commissioner.

I. If an inmate/offender is deceased and is therefore unable to execute an appropriate release, such release shall be executed by the inmate's/offender's personal representative/executor/administrator upon such person tendering proof of their appointment as the personal representative. Such proof shall be provided in the form of a letter of administration and/or Certificate of Appointment from a county clerk's office with such documents having a raised seal of the county clerk.

J. No telephone inquiries pertaining to health records shall be responded to except to advise the caller to direct such inquiries to the Office of the Commissioner in writing.

K. This policy and all such requests for information pertaining to inmate/offender healthcare shall be construed in favor of inmate/offender privacy.

II. Information concerning the treatment needs of an inmate/offender may be disclosed to parties who will be providing professional services to that inmate/offender only after an Authorization for Release of Health Information (**Attachment #1**) has been completed and signed by the inmate/offender.

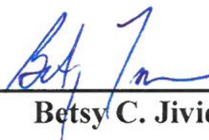
A. The Authorization will be effective for sixty (60) days from the date it is signed.

B. The inmate/offender may withdraw the Authorization in writing at any time. Revocation of this Authorization will not impact any action taken in reliance on this Authorization prior to receipt of written revocation.

C. Completed forms will be scanned into OIS Documents Management.

ATTACHMENT(S):

#1 Authorization for Release of Health Information (3 pages)

APPROVED SIGNATURE:  7-9-21

Betsy C. Jividen, Commissioner **Date**

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name: ______________________________________ SSN: ____________________

Date of Birth: ________________________________ OID No. __________________

I hereby authorize _________________________ (medical provider) at ___________________________ (facility) to release copies of the portions of my health care records described below to ____ [insert name of person or organization to receive records] or his/her designee.

Specific Information Covered by this Authorization

THE FOLLOWING INFORMATION IS SPECIALLY PROTECTED BY FEDERAL AND STATE LAWS. IF ANY OF THIS INFORMATION APPLIES TO YOU, PLEASE INDICATE ANY OR ALL OF THE INFORMATION YOU WOULD LIKE TO MAKE SUBJECT TO THIS AUTHORIZATION:

( ) Alcohol/Drug Abuse Records ***** Complete Page 2***
*( ) Mental Health Records** _____ *Initials*
**Excluding Psychotherapy Notes.*
( ) HIV Related Info. _____ *Initials*

( ) Discharge Summary ____ Initials
( ) History/Physical Info. ____ Initials
( ) Laboratory Studies ____ Initials
( ) X-ray Reports ____ Initials
( ) Operative Reports ____ Initials
( ) Pathology Reports ____ Initials

Date(s) of Service and/or medical information specific to this request:

____

This Authorization will expire sixty (60) days from the date that I sign it. I understand that I may revoke this Authorization, in writing, at any time. I also understand that my revocation of this Authorization will not impact any action taken in reliance on this Authorization prior to [medical vendor's] receipt of my written revocation.

I understand the nature of this Authorization.

I understand that my treatment, payment, enrollment in any health plan, or eligibility for benefits or accommodation may not be, and are not, conditioned upon my agreeing to sign this authorization.

______________________________ ____________________
Signature Date

If this Authorization authorizes the release of Mental Health Records or HIV-related information, the following statement must be included with the information being released:
This information has been disclosed to you from records whose confidentiality is protected by Federal and State laws. These laws prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the patient to whom it pertains or is otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL SUBSTANCE USE DISORDER ("SUD") PATIENT RECORDS

Name: ______________________________________ SSN: ____________________

Date of Birth: ________________________________ OID No. __________________

I hereby authorize ____________________________________ [insert name] at ____________________ (facility/work unit) to disclose the following information relevant to my treatment and case management plan (*initial*):

___ Course and results of treatment

___ Attendance in treatment

___ Substance use history

___ Diagnostic summary and diagnosis

___ Medical history / treatment

___ Drug / Alcohol test results

___ Biopsychosocial assessments

___ Evaluations and recommendations

___ Treatment plans

___ Disciplinary records

___ Legal history

___ Discharge summary

___ Social / Family history

___ Eligibility

___ Psychiatric Evaluation / Treatment

___ Verbal Exchange of information

To ____ [insert name of person or organization to receive records] or his/her designee.

I understand that my substance abuse disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance abuse disorder patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will automatically expire in 60 days from the date that I sign it. I also understand that my revocation of the Authorization will not impact any action taken in reliance on this Authorization prior to [medical vendor] receipt of my written revocation.

I understand that my treatment may not be conditioned on my agreement to sign this Authorization. I also understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the person(s) listed above and may no longer be protected.

I understand I have the right to receive a list of entities to which my patient identifying Part 2 information has been disclosed; all requests must be submitted in writing. ________ (initial)

I understand the nature of this authorization. I have signed this Authorization voluntarily.

I understand I have the ability to obtain a copy of this form upon release or request.

____ ______________________________

Signature Date

Notice to Recipient:

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or otherwise permitted by 42 CFR Part 1. General Authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

In addition to the above, the records from which this information has been disclosed are protected by other applicable Federal and State Laws which prohibit you from making any further disclosure of this information unless expressly permitted by the written authorization of the patient or is otherwise permitted by law.