

Sample Definitions for Discussion Patient Consent Subgroup Meeting October 26, 2006

Definitions of “health record” and related terms

Health Information from HIPAA 45 CFR 160.103

Health information means any information, whether oral or recorded in any form or medium, that:

- (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
- (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Health Record Information from Minn. Stat. 72A.491, Subd. 10

"Health record information" means personal information that:

- (1) relates to an individual's physical or mental condition, health history, or health treatment; and
- (2) is obtained from a health professional or health care institution, from the individual, or from the individual's spouse, parent, legal guardian, or other person.

Medical Data from Minn. Stat. 13.384, subd. 1(a)

"Medical data" means data collected because an individual was or is a patient or client of a hospital, nursing home, medical center, clinic, health or nursing agency operated by a state agency or political subdivision including business and financial records, data provided by private health care facilities, and data provided by or about relatives of the individual.

Individual Permanent Medical Record from Minn. Rules 4642.1000

A patient's *individual permanent medical record* must consist of all of the following elements of the hospital record which are applicable to that patient.

A. Identification data which includes the patient's name, address, date of birth, sex, and if available, the patient's social security number.

B. Medical history which includes details of the present illness, the chief complaint, relevant social and family history, and provisional diagnosis. For obstetrical patients, the

medical history shall include prenatal information when available. For newborns, a birth history consisting of a physical examination report and delivery record as it pertains to the newborn must be included.

C. A physical examination report.

D. A report of operations which includes the preoperative diagnosis, the names of all surgeons and assistants, the anesthetic agent, a description of the specimens removed with pathological findings, a description of the surgical findings, the technical procedures used, and the postoperative diagnosis.

E. A discharge summary which includes the reason for hospitalization, summary of clinical observations, procedures performed, treatment rendered, significant findings (for example, pertinent laboratory, X-ray, and test results), and condition at discharge. For newborns or others for whom no discharge summary is available, a final progress note must be included.

F. Autopsy findings.

Health Record (for supervised living facilities) from Minn. Rules 4665.4100

Basic health information to be maintained in each resident's *health record* shall include:

A. identifying information: name, previous address, date of admission and discharge, person to contact in an emergency;

B. the physician responsible for his/her medical care as designated by the resident or guardian;

C. the name of the resident's dentist as designated by the resident, parent, or guardian; dates of dental examinations and treatments; special instructions for care and oral hygiene as recommended;

D. adverse reactions to drugs recorded and prominently posted as a precaution;

E. where professional therapy services are provided to the resident, regular notations regarding the resident's progress in such therapies;

F. dates and descriptions of all illnesses, accidents, treatments thereof, and immunizations, including examinations required in parts 4665.3300 to 4665.4000;

G. summary of hospitalizations, to include recommendations for follow-up and treatment; and

H. where the resident is being treated through a special diet, a copy of the diet, length of time to be used, prescription signed by the supervising physician, and the dates of review of the diet.

Iowa

"*Protected health information*" means information that contains a subject's medical information, including past, present, or future treatment and payment information. "Protected health information" is a composite of multiple fields that grouped together give detailed accumulative information about a subject's health. When joined together in an accessible record set, the following three distinct areas of health-care-processing file information constitute protected health information:

1. Information that identifies the subject.
2. Medical information describing condition, treatment, or health care.
3. Health care provider information

Indiana

"*Health record*", "*hospital record*", or "*medical record*" means written or printed information possessed by a provider (as defined in IC 16-18-2-295) concerning any diagnosis, treatment, or prognosis of the patient, unless otherwise defined. Except as otherwise provided, the terms include mental health records and drug and alcohol abuse records

Ohio

"*Medical record*" means any document or combination of documents, except births, deaths, and the fact of admission to or discharge from a hospital, that pertains to the medical history, diagnosis, prognosis, or medical condition of a patient and that is generated and maintained in the process of medical treatment.

"*Medical record*" means the personal information that relates to an individual's physical or mental condition, medical history, or medical treatment.

"*Medical record information*" means personal information that relates to an individual's physical or mental condition, medical history, or medical treatment and that is obtained from a medical professional or medical care institution, from the individual, or from the individual's spouse, parent, or legal guardian.

New Jersey

"*Medical-record information*" means personal information which:

- (1) Relates to an individual's physical or mental condition, medical history or medical treatment, and
- (2) Is obtained from a medical professional or medical-care institution, from the individual, or from the individual's spouse, parent or legal guardian.

Definitions of “emergency”

Emergency Care from Minn. Rules 4685.0100, Subpart 5, (A)

"*Emergency care*" means medically necessary care which is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the enrollee in serious jeopardy.

New Jersey

"*Emergency care*" means immediate treatment provided in response to a sudden, acute and unanticipated medical crisis in order to avoid injury, impairment or death.

Indiana, adapted from IC 16-34-2-1.2

"*Medical emergency*" occurs when immediate medical care is needed to prevent death or a substantial and irreversible impairment of a major bodily function.

Ohio

"*Medical emergency*" means an unforeseen event affecting an individual in such a manner that a need for immediate care is created.

Definition of “record locator service”

Record Locator Service

"*Record locator service*" means an electronic index which contains patient demographic data and information indicating providers maintaining health records for the patients included in the index.

"*Record locator service*" means a database that contains demographic data for patients that is linked to the providers where medical records for those patients are maintained.

"*Record locator service*" means a method for locating patient medical records at participating providers by using demographic data for the patient.

Note: If the RLS will be operated by government, the Legislature will need to enact a data classification and authorize data sharing.

Definition of “demographic data”

Demographic Data

"*Demographic data*" means patient's name, address, date of birth, gender, parent's or guardian's name, and other non-clinical data which can be used to uniquely identify a patient. Other identifiers to add-in, driver's license number or government issued identification card number.

“Demographic data” means patient identifying information including name, address, date of birth, and gender. If the patient is a minor, demographic data also includes the names of the patient’s parents or guardians.

“Demographic data” means those data elements that will uniquely identify a patient for purposes of a provider’s medical records system or for purposes of a record locator service. Demographic data include the patient’s name, address, date of birth, gender and any identifying number assigned by the record locator service. If the patient is a minor, demographic data also includes the names of the patient’s parents or guardians.