

This document is intended as a reference only. Any questions/concerns should be directed to the Health Records Department.

CONTROL AND SECURITY OF HEALTH INFORMATION

PC-C-010

POLICY

The health record is the property of the Regional Health Authority and it is maintained for the benefit of the patient, the physician and the Regional Health Authority. It is the responsibility of the Regional Health Authority to safeguard the information against loss, tampering and unwarranted access or use by unauthorized persons. **Regardless of the medium, health records shall be kept secure and not left unattended in areas access to unauthorized individuals.**

Under the Hospital Act in New Brunswick, the Chief Executive Officer of the Regional Health Authority is responsible for the safekeeping of all patient records which are confidential except as set out below. **All information leaving the Regional Health Authority, based on the contents of the health record, is controlled by the Regional Director of Health Records. No information should be released from any department or clinic except as outlined herein.**

The Right to Information Act in New Brunswick DOES NOT APPLY to personal health information.

PROCEDURE

The original health record may not be removed from the Regional Health Authority except upon the order of a court of competent jurisdiction or in response to a search warrant. In certain circumstances, where home visits are provided, the original chart may accompany the physician or Health Care Professional on the visit (e.g. Albert County Hospital clinic patients and Extra Mural Program patient charts). The chart must be returned to the facility following treatment.

The chart may accompany a patient transported to the George Dumont Hospital for continuation of care while still an inpatient in our Regional Health Authority. The chart must be immediately returned upon completion of this visit.

Copies of information from the health record can be released upon a written request signed by the patient. There are very few situations in which information can be released without the patient's authorization and these are described in later sections. Information in the health record which does not originate in South-East Regional Health Authority will be released upon patient authorization as it is to be considered part of the health record.

Consents For Release of Information

Every authorization must be a handwritten original. In an emergency, a faxed authorization is accepted but it must be followed later by the original signed form.

To be valid, an authorization for release of medical information must contain: (1) name of individual at the institution who is to receive the information, (2) the date, (3) name of hospital, (4) full name of patient, (5) date of birth, (6) date(s) of hospitalization in question, (7) signature of patient and (8) signature of witness. The authorization form signed by the patient must specify the particular episode of hospitalization in question or must specify "all hospital records". The patient has the right to exclude certain information from being released. The patient's signature should be compared with a signature on the chart. If there is any concern about the authorization, contact the patient by telephone to confirm his/her intention.

If the patient is 14-16 years of age and is requesting information, he can write the consent if, in the opinion of an attending doctor and supported by written opinion of one other doctor, the minor is capable of understanding the nature and consequences of a medical treatment. This statement would have to be in the clinical record before a patient who is 14-16 years old would be allowed to sign an authorization to release information from his/her record.

The Regional Health Authority record contains information collected during all hospitalizations, Emergency Department visits, selected clinic visits, etc., and information that may have been obtained from another hospital or physician's office.

(9) Consents are valid for 60 days from the date of signing. (Note: This is not supported by law)

In the event that the patient cannot sign the consent (e.g., death) and if there is an executor of the estate, he/she has signing authority but must provide **proof that he/she is the executor**. If there is no executor, consents must be signed by the next of kin. **Next of kin line of succession is: 1) spouse, 2) all adult children, 3) both parents, 4) all siblings.** Consents signed by Family and Community Services social worker-guardians must be accompanied by **proof of guardianship. Authorizations signed by common-law spouses are not valid.** Depending on age, authorization signed by parent is appropriate (see also Fax Policy re receipt of authorization via fax - pg. 12.20).

For consents in cases of "Joint Custody": A father has the same rights as a mother if he is married to the child's mother or has been granted joint custody. **The agreement outlining rights of the joint custody must be shown before consent is accepted.** Usually one parent is listed as the primary custodian and that person has signing authority. (This does not apply to birth information. The mother's consent is required here.)

(Psychiatric Unit patients who are unable to consent - see Mental Health Act for directions on who can consent on their behalf.)

Transferal of Records

In health clinics, patients may request that copies of their records be forwarded to another physician. The patient should be told to **complete a written request (authorization) for copies to be sent to the new physician**. A charge is normal in these cases (see fee schedule)

Release

The Health Records Department has the authority to release information from the health record in accordance with the following:

I TO THE PATIENT

The health record is the property of the Regional Health Authority and is maintained for the benefit of the patient, the physician and the Regional Health Authority. Under Regulations of the Hospital Act of the Province of New Brunswick, the patient's record may be disclosed by providing a copy to any person upon written request, signed by the patient, including the patient himself. The South-East Regional Health Authority and its Medical Staff support the principle of patients having access to their own health record information.

When a patient asks to see or obtain a copy of his/her own record or any part thereof, including records kept in other departments such as Medical Imaging, Social Work and Physiotherapy:

1. All requests for access should be directed to the Health Records Dept. or in a Health Centre, to the appropriate physician's secretary **for discussion with the physician**. The request must contain sufficient information to positively identify the person authorizing release of the record and to ensure that the correct record is being released.
 - 1.1. Health Records personnel will inquire as to the reason for the request as the patient may be interested in only a specific piece of information (e.g., blood transfusion information yes/no, name of anesthetist, etc.). In such instances, information may be given without written authorization and without following section 2 below. Health Records personnel may respond to telephone inquiries of this nature after validating that the person requesting the information is entitled to receive it. In addition, Emergency Department records of assault, etc., are usually required by the police or to take to court. Patients can be given copies of these on the authorization of the Director of Health Records or a designate.
 - 1.2. A minor whose consent to treatment/surgery has been accepted may request and receive access. For other minors, authorization must be obtained from a parent or legal guardian.
 - 1.3. For patients known to be mentally incompetent, a legal guardian must authorize release of information.

- 1.4. In order for information to be released to next of kin of a minor under protective custody, a court order is required.
2. When a patient asks to see or obtain a copy of his/her own chart:
 - 2.1. The patient will complete a written request and pay a \$10 search fee. There is a waiting period of five working days.
 - 2.2. The attending physician will be notified. Patient Access is legislated under the Hospital Act in the Province of New Brunswick and includes access to all information in the file regardless of origin.
 - 2.3. Access to any psychiatric information requires that the psychiatrist first review the file (see 4.)
 - 2.4. The Regional Health Authority recommends that the physician sit with the patient to provide interpretation of hospital procedures and medical terminology. In the absence of the physician, a health record professional may sit with the patient; however, the health record professional will not attempt to interpret or explain any of the chart contents or hospital procedures. Patients reviewing original records must always be supervised and must not have the opportunity to alter, deface or remove any part of the health record.
 - 2.5. A patient may append a written, signed, dated and witnessed statement to the health record.
 - 2.6. Copies of the record will be provided to the patient. The first 3 pages at no charge. Additional pages are \$1 each.
3. When a patient requests access to his hospital chart while still in the hospital:
 - 3.1. The nurse manager will notify the attending physician. If he does not wish to sit with the patient to review the record in order to provide interpretation, the patient will be given access to the chart with the nurse manager in attendance.
 - 3.2. If the attending physician is not available, the nurse manager will contact the Chief of Staff or Chief of the appropriate Medical Staff Department. If an inpatient requests copies, this must be handled in Health Records. There is a \$10 search fee **(included up to three pages)**.
4. Procedure to follow for access to psychiatric records:
 - 4.1. Patient access to psychiatric records while an in-patient:
 - Patient access to psychiatric records will be at the discretion of the psychiatrist.
 - The treating psychiatrist will review the chart and determine if anything needs to be withheld.

- If anything needs to be withheld, the Administrative Director of the Psychiatry Program, within 7 days after the person asks to examine the clinical record, will file an application in the prescribed form with the Chairman of the Review Board as per sub-section 16.1(3) of the Mental Health Act.
 - The patient will be contacted by the psychiatrist to explain what is taking place and the reason for the delay.
 - Communication with the patient is the responsibility of the psychiatrist.
- 4.2. Patient access following discharge will be handled the same as any routine patient access request:
- The right of the patient to access his/her patient record is referred to in the Mental Health Act and in the Hospital Act of the province.
- 4.3 All other access to psychiatric records:
- Any other access to psychiatric records will conform to the applicable section on releasing health records found in this policy.

II TO PHYSICIANS IN SOUTH-EAST REGIONAL HEALTH AUTHORITY

Any physician on the staff of the South-East Regional Health Authority who has attended or is attending a patient may have access to the record without further authority. In addition, copies of that record may be made available to the attending physician. It is the responsibility of the physician to ensure that copies of the record or parts thereof which are in his possession are not improperly used.

Patients in a subsequent illness attended by another physician in the same hospital - If the patient has been admitted to the hospital, copies of the previous discharge summaries and patient records are sent to the nursing unit to aid in the treatment of the patient. Members of the Medical Staff may freely consult such records as pertain to their work.

When a physician dictates a report, a copy of that report will be forwarded to other physicians as directed. A copy of the Emergency Record is sent to referring/attending physicians.

Members of the Medical Staff may freely consult such records as pertain to their work in research, teaching or education of others. These records are to be used as impersonal documents and the collected data benefits all.

Medical staff and hospital staff: Patient Access Procedure is followed.

III TO PHYSICIANS OUTSIDE SOUTH-EAST REGIONAL HEALTH AUTHORITY

A physician outside our Regional Health Authority who requires information on a patient shall show proof that he is the attending physician of the patient. Such proof shall normally be in the form of a written authorization for the release of information signed by the patient but may be at the direction of the patient's physician in South-East Regional Health Authority or may be a faxed request on doctor's office letterhead. In an emergency situation, information is to be released on verbal request alone. This is to be followed by written request.

IV TO COLLEGE OF PHYSICIANS AND SURGEONS

An original dated authorization is required. Forward copy of request and original chart to Risk Manager and she will notify Chief of Staff. Notify attending physician upon release of information.

V TO ADMINISTRATOR OF ANOTHER HOSPITAL OR NURSING HOME OR DESIGNATE

When a patient is discharged to a nursing home or transferred to another hospital, a continuity of care record and other pertinent information is sent with the patient.

When another hospital requests information, it is assumed this is required for the proper care, diagnosis and treatment of the patient and may be released without a written authorization of the patient. To fulfill the requirements of the Hospital Act, a written request is required. Information may be forwarded prior to receipt of written request in an emergency situation.

Cancer Research Centres

No written authorization is required for information requested from Canadian Cancer Treatment/Research Centres. **A request in writing is required.**

The Laboratory Department routinely releases copies of autopsies and tissue reports positive for malignancy, to the Saint John Regional Hospital for tumor registry. Original slides and sections are not to be released.

Release of Preadmission Test Results

- It is the responsibility of the hospital departments performing the preadmission tests, i.e., Lab, Medical Imaging and Electrodiagnostic Services to FAX or send by mail the preadmission test results to the appropriate hospital as listed on the requisitions.
- In the event that a patient scheduled for surgery at The Moncton Hospital has preadmission tests performed at another hospital, the test results may be forwarded by another hospital directly to the Admitting Department and vice-versa.

VI TO LAWYERS

The lawyer must present original written authorization which has been signed by the patient, dated and witnessed not older than 60 days. Only material from the specific hospitalization requested should be released. The attending physician is notified as a courtesy. The lawyer, if he desires, may come to the Regional Health Authority to view the specific records. A Health Record professional must be present with the lawyer while the record is being reviewed.

Executors of an estate or their legal representatives, in as much as they are supposedly acting in the best interest of the deceased, should be allowed access to any information from the record, if this becomes necessary for the performance of their duties, providing they present proof of their authority. A written authorization is required under the Hospital Act.

Medical-legal services as well as third party examinations and special forms completed by physicians in clinics - it is recommended that **an original written authorization** be required prior to releasing patient information (see NBMS fee schedule for charges).

Request for information from the Hospital's legal representative is referred to the Manager of Patient Safety and Risk. Correspondence is to be filed in the Risk Management files and not on the Health Record.

VII LAW ENFORCEMENT AGENCIES (EG., R.C.M.P.)

A law enforcement agency does not have authority to obtain medical information on a patient unless it presents the written authorization of the patient or a subpoena or search warrant.

The hospital can verify to police that a person, named by the police was a patient on a specific date and time without written patient authorization. However the hospital cannot verify for what condition the patient was treated without a patient authorization or court order.

Similarly, the hospital can verify to police that a person(s) with a specific condition specified by police, was treated on a specific date and time.

The hospital CANNOT provide addresses or birth dates of patients to police without proper authorization.

Gunshot wounds and stabbings are considered reportable incidents and as such are reported to the police. Once the RCMP member responds to the call, he/she will act according to the requirement of the law (See Section 4009, "Release of Patient Information Policing Authorities", Hospital Services Bulletin).

If suspected illegal drugs are found, they are confiscated and locked in the narcotic cupboard. The RCMP are notified and will arrive to pick them up. The name of the patient may be disclosed to the RCMP officer (see Schedule B, Section 3.4 (a), (b) of the Protection of Personal Information Act).

NOTE: Please see Administration Manual, [PC-G-085 Requests for Police Interviews with Patients](#) for instructions regarding police requesting interviews with patients.

VIII TO THIRD PARTY PAYERS

All requests for information from insurance companies require an original signed and dated authorization from the patient.

When Veteran Affairs Canada request a summary - A photocopy of the discharge summary is sent. No authorization is needed but a **written request** is required.

Upon the request of a bona fide representative of the **WHSCC**, information may be released without the authorization of the patient but a **written request** is required. Copies may be sent to WHSCC if specified in writing or dictation by a physician. Otherwise, the request is to be signed by one of the Regional Directors of WHSCC. These may be faxed to WHSCC.

WHSCC sometimes requests that Physiotherapy and Occupational Therapy forward monthly updates on each patient. Each chart must contain an authorization allowing the RHA to routinely forward these monthly updates to WHSCC.

IX OTHER REQUESTS

Request for Copy of Autopsy

Release of post-mortem findings are handled the same as all other requests for release of information. (Try to defer to physician for interpretation.) Note that in Coroner's cases, the hospital does not have the authority to release autopsy results.

Inquiries should be referred to the Regional Coroner's Office, Province of New Brunswick, P.O. Box 5001, Moncton, NB, E1C 843 (telephone: 856-2315). Coroner's autopsy results, if on file, may be released to another Health Records Dept. if requested.

Request from Coroner

According to Coroner's Act, coroners may have access to patient information without authorization.

Request from the Minister of Health

Upon the request of the Minister of Health of the province or his/her designate (e.g., Deputy Minister) - Information may be released without an authorization.

Request from Board of Trustees Member

Access to health records is subject to regulation of the Hospital Act. **The patient's written authorization is required** for access to health records by a member of the Board of Trustees.

X **STATUTORY REPORTING OF PATIENTS AND MEDICAL INFORMATION TO AUTHORITIES OUTSIDE OF THE HOSPITAL**

- a. When patients with certain infections and venereal diseases are treated at the hospital, a report must be sent to the District Medical Health Officer by Infection Control.
- b. Certain deaths require notification of the coroner.
- c. A case where child abuse is suspected must be reported to Family and Community Services.
- d. Death certificates reporting the cause of death must be reported by a physician to the Registrar General of Vital Statistics (Vital Statistics Regulations under the Health Act).
- e. Birth certificates and notification of Live Birth forms must be completed by the Hospital and forwarded to Vital Statistics.
- f. Demographic information on therapeutic abortions without specific patient identification is provided to Statistics Canada. No patient identification is included in this report.
- g. The Mental Health Act contains various situations where information is reviewed by a Patient Advocate, Tribunal and Review Board (see Mental Health Act).

XI **VOLUNTARY REPORTING**

- a. Health and Welfare Canada report of an adverse reaction or event suspected due to drugs, vaccines, cosmetics or food products - Under patient identification, the Hospital case number should be used rather than the patient's name.
- b. Health and Welfare Canada report of a poisoning or suspected toxic exposure - Under patient information, the Hospital case number or the emergency room number should be used or it should be left blank.
- c. The following cases are considered reportable incidents (by nursing) and as such are reported to the police (i.e. names and dates):
 - gunshot wounds
 - stabbings

XII **RELEASE OF NON-MEDICAL INFORMATION (PLEASE NOTE: DO NOT RELEASE STAFF NAMES TO INSURANCE COMPANIES, LAWYERS, ETC.; EX: AMBULANCE DRIVERS, NURSES, ETC.)**

To the patient or next of kin - If a patient calls requesting dates of admission, discharge, name of surgeon, anesthetist or other non-medical information, **verify telephone number and return the call to the patient with the information.**

NOTE: Watch for husbands requesting information re: wife, especially maternity and/or therapeutic abortions.

Telephone Company, florists or other public service – The Health Record Department will relay the message to the patient and/or family on the company's behalf.

Other Requests - Requests for non-medical information will be handled on an individual basis.

XIII TO FAMILY AND COMMUNITY SERVICES

- A request under Section 5.11.1(3) of the Family Services Act accompanied by a completed request form attesting that the Social Worker has requested and has been unable to secure parental (or significant other) consent, information may be released.
- Upon request for information on a minor from a Social Worker, Family and Community Services, proof of guardianship must be provided along with a signed authorization from the guardian prior to release of information.
- **Birth information on babies placed for adoption** with the Family and Community Services **is provided** routinely by this hospital.

XIV TO OTHER SERHA FACILITIES (including: Community Mental Health, Addiction Services, Public Health, Sackville Memorial Hospital, Albert Community Health and Wellness Centre, Extra Mural Program, Health Services Center Rexton, Katherine Wright Family Wellness Center, Port Elgin Health Center and Petitticodiac Health Center).

The procedure for release of information is as follows:

- Requires written request from the facility
- Request may be mailed or faxed to the Health Record Department
- Information may be released based on request
- If a facility **phones** indicating it is an emergency and they need information faxed immediately the information may be faxed to them.
 - Call the facility, verify their fax number and ask that they immediately retrieve the information from their fax machine upon receipt
 - Ask the facility to forward a written request to the Health Record Department
 - Fax the requested information and record in detail what you have sent on the request.

XV RELEASE OF INFORMATION PURSUANT TO THE FAMILY SERVICES ACT

- When a request is made from the Family and Community Services for health information on a reported case of suspected child abuse, **an authorization form should be completed by the requesting Social Worker (should be signed by Supervisor).**
- The authorization form is entitled "Family and Community Services Request for Release of Information" must be signed by the social worker and his/her immediate supervisor.
- The authorization can be a faxed copy in the event that the information is requested on an urgent or emergency basis. In this instance, the original authorization should be forwarded to Health Records as soon as possible.
- Upon receipt of the authorization (faxed or original), the requested information should be released by Health Records to the Family and Community Services.
- Out-of-province requests for child abuse information should be referred to Screening and Information, Family and Community Services.(856-2400).

XVI **RELEASE OF INFORMATION TO PATIENT ADVOCATE APPOINTED UNDER MENTAL HEALTH ACT.**

The patient advocate (for patients with involuntary admissions) **has the right of access to records** through the authority of the Mental Health Act.

XVII **INFORMATION TO CIHI**

Patient Information is transmitted electronically or on paper to CIHI without specific patient authorization but within a contract between the Department of Health and CIHI which provides regulation of access, release, handling, security and destruction of identifiable patient information. Patient identification is by unique identification number only.

XVIII **PERSONS SEEKING INFORMATION CONCERNING ADOPTION**

Since there is no authorization provided by the mother for the release of information from her records, the privacy of the mother must be protected and **no information can be released.** Refer persons requesting information on either mothers or babies to Post Adoption Registry Service, P.O. Box 6000, Fredericton, NB E3B 5H1. This service will contact the hospital with a form to be completed and returned to them, supplying medical information to adoptees (telephone: (506)453-2949).

XIX PERSONS SEEKING INFORMATION CONCERNING BIRTH

Prior to 1982 newborn charts in the Moncton facility were stored with the mother's charts under the mothers' unique I.D. Requests to verify information from these charts, such as date and hour of birth require **authorization from the mother or legal guardian**. If a mother presents proper I.D., she may have access to birth info. In the case where the mother is deceased, this fact must be stated in writing the request. The requested information can then be released. Access to information by alleged "father" requires authorization signed by mother (refer to Patient Access Policy 12.3.1).

XX RELEASE OF INFORMATION FROM DEPARTMENTS OTHER THAN HEALTH RECORDS

Medical Imaging Department

This Department has the authority to release information from its files within the terms of the policy on Control of Health Information.

Legal requests are handled by the Health Records Dept.

Radiology images are hospital property; they must be kept available for clinical comparison on subsequent examinations and are therefore not normally released. On specific request the films may be loaned to a qualified medical practitioner responsible for the care or evaluation of the patient. Refer any other request to Administration.

Social Work and Psychology

Information requests directed to Social Work and Psychology are to be referred to the Health Records Department accompanied by a copy of the information requested.

Pain Clinic

Requests for information are handled by the Health Record Department.

Other Diagnostic Services

Information requests directed to diagnostic departments are to be referred to the Health Record Department, accompanied by a copy of the information requested.

Laboratory

Hospital slides and sections from autopsies are not released except under search warrant or subpoena.

Nursing

All requests for written information are to be directed to the Health Records Department. Press inquiries are handled in the Nursing Office.

Press/Media

All inquires are handled by the Director or Community Relations and Development

Rehabilitation Services

Medical information requests directed to Rehabilitation Services are to be referred to the Health Records Department accompanied by a copy of the information requested.

O.T. & Physio.

All requests must have original authorizations when releasing medical information. **Information should only be faxed if urgent or in an emergency.** Information required to obtain rehabilitation estimates can be sent by the therapist or designate providing there is a written patient authorization (Rehab authorization) filed on the chart (e.g. specs to suppliers).

Emergency Department

Written information requests directed to the Emergency Department are to be referred to the Health Records Department. See also #5 Control of Health Record information to Law Enforcement Agencies.

XXI INCIDENT REPORT AND OTHER ADMINISTRATIVE REPORTS

The incident report is an investigative report prepared for the purpose of being submitted to a solicitor for advice and, as such, is privileged from disclosure. (Amendment to Evidence Act.) **Incident reports are not part of the Health Record and are not copied in response to information requests. Infection Control/Drug Abuser Alerts Reports are working documents and are not to be disclosed by copy or patient access.**

XXII ACCEPTING A SUBPOENA OR SUMMONS

1. There are two kinds of subpoenas or summons: One subpoena requires only the presence in the court of the person served. The other subpoena, "duces tecum", requires the presence of the person and the records in the court. **The person serving the subpoena has no right to access the records and the Regional Health Authority's "Control of Health Record Information" policy remains in effect except that the records will be produced at the time and place designated by the subpoena.**

- a. While the server is still present, check for the name and phone number of the attorney responsible for the subpoena. Check the docket number of the case and location of the courtroom.
 - b. Check immediately to see if person has been an inpatient or treated in the Emergency Department.
 - c. Collect material requested in subpoena.
 - d. Notify the attending physician. Notify Risk Management.
 - e. Without the written authorization of the patient, subpoenaed records are not to be made available for review by the lawyers of either side prior to being entered as evidence.
2. Out-of-Province Subpoena: It is the Hospital's solicitor's advice that we comply with requests if it appears in the best interest of the patient. However, he feels that we are not legally bound to do so. In the event that it does not appear to be in the best interest of the patient, please consult with him.
- Note:** In most cases, it is sufficient to copy and send chart and not appear in person with the record.

XXIII SEARCH WARRANTS

On presentation of a search warrant signed by a judge of the Provincial Court of New Brunswick:

- a. Note documents, etc., requested and retrieve same.
- b. Make photocopies and give copies to officer. If copies are unacceptable you may be required to produce originals and leave copies in our files.
- c. Record name and address of person accepting material and the date.
- d. Advise attending physician.

Laboratory Response to a Warrant to Search

In all cases, when presented with a warrant to search for laboratory specimens and/or records pertaining to testing of said specimens, the following procedure should be followed:

1. Where Records of Testing are Requested: **The officer presenting with the warrant should be directed to the Health Records Department. They will be responsible for the issuing of any official records of testing from the hospital.** If there is a request for a specimen which accompanies the request for records, the Health Records Department will direct the individual to the laboratory and we will provide the specimen if it is still in our possession.

Note: In cases where a specimen is requested, please direct the officer to the Laboratory Director who will release the specimen, if he is available.

- The copy of the warrant to search will be retained on the patient's chart in the Health Records Department.

2. Where Specimens of Blood Only are Requested:

- The laboratory will provide the specimen. Documentation should be made of the request, specimen which was issued, date of issuance and individual to which it was released.
- The original copy of the warrant to search should be directed to the Health Records Department along with documentation of release of specimen so that both may be retained on the patient's chart. If there is no chart, one must be opened by the Health Records Department.

XXIV **STUDIES AND RESEARCH**

Internal

Medical Records will be available for clinical studies provided that such studies are approved by the Medical Director and the Research Ethics Committee.

External Studies

Each study (or research) shall include a written policy designed to protect the confidentiality of the data collected. All such studies shall be approved by the Research Ethics Committee. Reports and/or publication of findings shall contain no identifying information.

XXV **RELEASE OF INFORMATION BY FAX**

See [Security of Transmission of Health Information \(AD-F-030\)](#)

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Revised by Risk Management
Reviewed and Revised by Health Records Department

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