SECTION 11: MEDICAL RECORDS

11.0 Consent for Treatment

Consent for treatment must be given at the initial office visit. This is accomplished by the beneficiary, parent or guardian signing a consent form. This form must be maintained in the beneficiary's medical record. Refer to the end of this section for a sample of Consent for Treatment form. This form allows free exchange of information between the provider and the Fresno County mental health clinical staff. Provider may copy the language used in this form.

Minors, in certain circumstances, have the right to access confidential services without parental consent, therefore minors are authorized to sign the Consent form for any confidential services and/or information regarding medical treatment specific to those confidential services. In certain circumstances, records and information are not to be released to parent(s) without the minor's authorization. (A sample Authorization form is provided at the end of this section. Please also refer to the summary of Legal Consent Requirements for Medical Treatment of Minors, also provided at the end of this section.)

11.1 Medication Consent

The Fresno County Mental Health Plan (FCMHP) requires providers to obtain a Medication Consent when medications are prescribed. The beneficiary, or legal guardian, must sign the Medication Consent form when starting a new medication, and whenever a change in medication class or addition of new class of psychotropics occurs (e.g., addition of antidepressant to medication regime, change from antidepressant to anti-psychotic medication, etc.) This form must be available in the beneficiary's primary language if beneficiary is monolingual. The consent must be kept in the medical record at all times.

11.2 Release of Medical Records and Distribution

The privacy of the beneficiary's protected health information (PHI) must be maintained. Information will be used and disclosed in accordance with the California Medical Information Act, Welfare and Institutions Code Section 5328 – 5328.9, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. An authorization must be obtained

before a beneficiary's PHI can be used or disclosed for purposes other than treatment, payment, healthcare operations, or as required or permitted by law.

Historically, such a document has been referred to as a signed "release". Under HIPAA, the correct term is "authorization".

For example, authorizations are required for marketing, underwriting, and in some cases, research. Under HIPAA, a covered entity must seek authorization for EVERY separate occasion.

A copy of the authorization form should be given to the beneficiary or person providing the authorization, and the original authorization form should be filed in the beneficiary's medical record.

Records received from other health care providers about the beneficiary should be filed in the medical record. Such records may be released only by proper authorization of the beneficiary or legal representative.

Authorizations must:

1. Be given in writing.
2. Be linked to a specific purpose.
3. Be signed by the individual.
4. Identify the people who might use the PHI, or to whom it might be disclosed.
5. Set an expiration date or event beyond which the authorization ceases to be valid. If a date or event is not specified, then typically the authorization is valid for one year.

With a subpoena, an officer of the Federal, State, or municipal court can access a beneficiary's records. Agencies such as the FDA or other authorities that comply with reporting requirements in Title 17 of the California Code of Regulations must also be granted access to confidential information.

Beneficiary's records must be available to FCMHP staff, and the California Department of Health Care Services, as defined in the Provider Agreement, for fiscal audits, program compliance and beneficiary complaints.

With limited exceptions, a beneficiary or personal representative has the right of access to inspect and obtain a copy of his/her own medical

records, including copies of medical records from other providers which are used in the evaluation and treatment of the beneficiary and contained in the provider's medical record. If the Provider does not maintain the requested protected health information and knows where the requested information is maintained, it must inform the beneficiary where to direct the request for access. The beneficiary must present identification when requesting a copy of his/her medical record.

Minors, in certain circumstances, have the right to access confidential services without parental consent. Therefore, medical records and/or information regarding medical treatment specific to those confidential services are not to be released to parent(s) without the minors' consent. Please refer to the summary of Legal Consent Requirements for Medical Treatment of Minors, provided at the end of this section.

Copies of the beneficiary's records are to be transferred to requesting providers upon the consent of the beneficiary. A sample Authorization is provided at the end of this section.

11.3 Medical Record Copy Charges

The provider may not bill the FCMHP for charges associated with copying of records. Beneficiaries may not be charged for copying of records unless the record is requested for personal use.

11.4 Availability of Medical Records at Each Encounter

Each providers' medical records system must allow for prompt retrieval of the medical records and must be available to the FCMHP at each encounter, for the purpose of review.

11.5 Security of Medical Records

The medical record must be secure and inaccessible to unauthorized access to prevent loss, tampering, and disclosure of information, alteration, or destruction of the record.

Information must be accessible only to:

(1) Authorized staff within the provider's office,
(2) The FCMHP staff with identification, or

(3) Persons authorized through a legal instrument (e.g., subpoena).

As per the Provider Agreement/Contract, provisions must be made for the FCMHP to have appropriate access to the beneficiary's medical records for purposes of quality and utilization review.

11.6 Storage and Maintenance

Medical records must be stored in one central medical records area and must be inaccessible (preferably locked) to unauthorized persons.

Inactive records must be accessible for a period of time which meets state and federal requirements, currently seven years, or to the age of majority for minors, whichever period is longer.

11.7 Department of Health Care Services (DHCS) Medical Records Standards

In addition to the standards identified above, the FCMHP monitors provider records against the following medical record standards:

- Each beneficiary must have a separate medical record.
- All pages in the record are filed chronologically.
- Each page in the record contains the beneficiary's name or I.D. number for identification.
- Personal, biological, and demographic data includes age, sex, address, telephone number, marital status and is updated as appropriate.
- A copy of the Consent for Treatment form is maintained in the medical record.
- All entries are signed and dated. The signature can be handwritten or completed electronically in accordance with FCMHP PPG 1.3.8G, "Electronic Signatures for Electronic Health Record Documentation". A copy of this policy is provided at the end of this section.

- The author of all entries is identified by name and title/licensure.
- The records are legible, documented accurately and in a timely manner.
- Allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies or NKA) is noted if the beneficiary has no allergies.
- Medical history, including serious accidents, operations, illnesses, is recorded and identified. For children, medical history also includes birth information and mother's prenatal care.
- Records must contain evidence that missed appointments are followed-up by contacting the beneficiary to reschedule the appointment.

11.8 Monitoring Procedures for Providers' Compliance with Medical Records Standards

The medical record review includes a review of a predetermined number of randomly selected medical records to assess the content, completion, and conformance to the FCMHP's Medical Records standards.

Any deficiencies that are identified will be communicated to the provider via a post-facility audit summary. Corrective actions must be instituted if standards are not met. The FCMHP may withhold payment if medical records do not conform to FCMHP standards.

11.9 Resources

If you have any questions regarding confidentiality, Authorizations or request for information, you may call the FCMHP's Medical Records division for assistance at 600-9032.

Other resources available are The California Hospital Association Consent Manual and The California Patient Privacy Manual. These can be obtained by calling the California Healthcare Association at (916) 443-7401 or via their website: http://www.calhospital.org/.

This page intentionally left blank

Section 11:

Medical Records

Forms and Attachments

This page intentionally left blank

Consent Requirements for
MEDICAL TREATMENT OF MINORS

IF MINOR IS:	*Is parental consent required?*	*Are parents responsible for costs? †*	*Is minor's consent sufficient?*	*May M.D. inform parents of treatment without minor's consent?*
Unmarried, no special circumstances	Yes	Yes	No	Yes
Unmarried, emergency care and parents not available [Business and Professions Code § 2397]	No	Yes	Yes, if capable	Yes
Married or previously married [Family Code § 7002]	No	No	Yes	No
Emancipated (declaration by court, identification card from DMV) [Family Code §§ 7002, 7050, 7140]	No	Probably Not[1]	Yes	No
Self-sufficient (15 or older, not living at home, manages own financial affairs) [Family Code § 6922]	No	No	Yes	[1]
Not married, care related to prevention or treatment of pregnancy, except sterilization [Family Code § 6925]	No	No	Yes	No
Not married, seeking abortion	No	No	Yes	No
Not married, pregnant, care not related to prevention or treatment of pregnancy and no other special circumstances	Yes	Yes	No	Yes
On active duty with Armed Forces [Family Code § 7002]	No	No	Yes	No
12 or older, care related to diagnosis or treatment of a communicable reportable disease or to prevention of an STD [Family Code § 6926]	No	No	Yes	No
12 or older, care for rape[1] [Family Code § 6927]	No	No	Yes	Yes, usually
Care for sexual assault[1] [Family Code § 6928]	No	No	Yes	Yes, usually
12 or older, care for alcohol or drug abuse[1] [Family Code § 6929]	No[2]	Only if parents are participating in counseling	Yes	Yes, usually
12 or older, care for mental health treatment, outpatient only[1] [Family Code § 6924; Health and Safety Code Section 124260]	No	Only if parents are participating in counseling	Yes	Yes, usually
17 or older, blood donation only [Health and Safety Code § 1607.5]	No	No	Yes	Probably not

[1] Special requirements or exceptions may apply. See *Chapter 2* of the *Consent Manual* or *Chapter 3* of *Minors & Health Care Law.*

[2] Parental consent *is* required for a minor's participation in replacement narcotic abuse treatment (such as methadone, LAAM or buprenorphine products) in a program licensed pursuant to Health and Safety Code Section 11875 (now codified at Section 11839 *et. seq.* [Family Code § 6929(e)]

Note: Notwithstanding the above information, a psychotherapist may not disclose mental health information to a parent who has lost physical custody of a child in a juvenile court dependency hearing unless the parent has obtained a court order granting access to the information.

† Reference: Welfare and Institutions Code Section 14010

Minors are defined as all persons under 18 years of age.

08/13

CALIFORNIA HOSPITAL ASSOCIATION

1215 K Street, Suite 800 • Sacramento, CA 95814 • (916) 443-7401 • www.calhospital.org

This page intentionally left blank

Department of Behavioral Health
Policy and Procedure Guide

Section No:	**2 - Mental Health**	**Effective Date: 11/01/10**
Chapter No:	**1 – General Administration**	**Revised Date:**
Item No.:	**8 - Medication Consent**	

POLICY: All adult comsumers/minors and their families will be informed of the recommended psychotropic medications prior to signing a Medication Consent form.

DEFINITION: Psychotropic medication or psychotropic drugs are those medications administered for the purpose of affecting the central nervous system to treat psychiatric disorders or illnesses. These medications include, but are not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-Parkinson agents, hypnotics, medications for dementia, and psycho stimulants, and medications used for side effects caused by psychotropic medications.

PURPOSE: To ensure that Informed Consents are obtained prior to the administration of medication with the exception of STAT / emergency medication and in compliance with State consent requirements.

REFERENCE: Welfare and Institutions Code sections 359.5 (d), 5325, 5326.2, 5326.3, 5326.5, 5327, 5332, Title 9, Section 850-857 2001; Rule 1432.5, W & I Code section 369.5; W & I Code Section 5350 and 369; Judicial Council Form JV-220 and Form JV-220A, Department of Behavioral Health Children Mental Health Policy and Procedure-Medication Services 4.14.

PROCEDURE:

I. Informed Consent from the adult consumer/parent/ legal guardian shall be acquired prior to the administration of medication prescribed by the psychiatrist. Such consumers shall be treated with psychotropic medications, only after having been informed of his or her right to accept or refuse such medications and have consented to the administration of such medication. The Informed Consent shall be signed by the adult consumer or a parent or legal guardian coming to the DBH/DCFS offices or, if they do not have transportation, then the consent will be faxed or delivered to them at their home for signature. An Informed Consent Form is attached (Attachment A).

A. In order to make an informed decision, the adult/parent/legal guardian is to be provided with sufficient information by the treating psychiatrist prescribing such medication, which shall include the following:

1. Their right to accept or refuse medication (California State law requirement).

2. Nature of the adult/minor consumer's target symptoms and/or mental condition for which the proposed medication(s) has been recommended.

3. Reasons for taking such medication including the likelihood of improving or not improving without such medication.

4. The right to withdraw previously given consent at any time by stating such intention to any member of the treating staff.

5. Reasonable alternative treatments, if any.

6. Type, frequency and amount (including the use of PRN orders) method (oral or injection) and expected duration of taking the medications.

7. Probable side effects of these medications commonly known to occur and any particular side effects likely to occur in this particular adult or child consumer.

8. Side effects may include persistent involuntary movements of the face, tongue or mouth and might at times include similar movements of the hands and feet and that these symptoms of Tardive Dyskinesia are potentially irreversible and may appear even after these medications have been discontinued.

9. Possible additional side effects which may occur to minors taking such medications beyond three months.

B. The prescribing psychiatrist shall ensure that an Informed Consent Form is signed by the adult/parent/legal guardian indicating that the aforementioned information (Sections 3A 1-9) have been discussed with the adult/parent/legal guardian.

1. If the adult/parent/legal guardian refuses to sign the Informed Form or refuses to take the medication, the psychiatrist shall place the unsigned form in the consumer's medical record together with an entry in the progress note indicating that the adult/parent/legal guardian does not agree to sign the form and/or the adult/minor refuses to take medication.

2. Note: No consent signature; No treatment; No exceptions.

3. The adult/parent/legal guardian may withdraw their consent to psychotropic medication at any time by stating such intention to the psychiatrist or nursing staff. The withdrawal of consent shall be noted immediately in the medical chart and appropriate medical staff, are to be notified as per protocol that the Medications Consent has been rescinded.

4. The following classifications of medications require Informed Consent: anti-anxiety agents, hypnotic agents, all classes of antidepressants including MAO inhibitors, neuroleptic agents, lithium carbonate, stimulants, side effect medications including Cogentin/Artane/Benadryl and all other medications which are being used for psychiatric purposes including, but not limited to, alpha agonists, beta blockers and anti-convulsants.

C. The following steps will be adhered to in completing the Medication Consent Form.

1. The form will be properly labeled with the adult/minor/parent's name and medical record number

2. The appropriate box will be checked for the category of each medication prescribed and the name of each medication, either brand or generic, will be written next to the applicable medication category.

3. Any medication that does not fall into one of the named categories will be listed on the line for "Other", also placing a check in the box next to "Other."

4. The patient's signature and the date of the signature must be recorded on the appropriate lines on the form.

II. If the consumer is a conservatee, then the consumer and conservator shall be informed of the proposed medication in the same manner as for consumers who are not conservatees (Section I. A&B above) except, after providing all required information to the consumer, the following must be completed:

A. The prescribing psychiatrist shall place the unsigned Informed Consent Form in the consumer's medical record and the Informed Consent form shall be signed by the conservator, or deputy of the conservator, indicating that the aforementioned information (Section I. A. 1-8) has been discussed with the consumer.

III. **This Section Applies Only To Minors:** If the minor is a dependent or ward of the Fresno County Superior Court – Juvenile Division, then designated licensed nursing staff shall secure the Judicial Council Form JV 220 for the prescribed medication from the Department of Behavioral Health – Children's Mental Health record or from the Child Protective Services or Social Worker in non-emergency situations.

A. The following shall occur if medication is being considered for the first time:

1. When the psychiatric assessment is completed and indicates the need for psychiatric medications to manage symptoms, the psychiatrist shall complete and sign the *Judicial Council Form JV-220.* The form shall be submitted to the designated nursing staff.

2. The designated nursing staff shall review the information to ensure that the *Judicial Council Form JV-220* meets the requirements, is legible and appropriately noted. The designated nursing staff shall contact the minor's respective social worker indicating that the psychiatrist is applying for authorization for psychotropic medications. It is the responsibility of the assigned Child Welfare Social Worker to complete the *Judicial Council Form* JV 220 and notify the attorneys of record and the parties to the proceeding prior to the submission of the application and make available a copy of *Opposition to Application for Order for Psychotropic Medication-Juvenile, Judicial Council Form JV-220A*, to those receiving notice.

B. The designated nursing staff shall submit the completed original copy of *Judicial Council Form JV-220* to the Fresno County Superior Court – Juvenile Division and a faxed copy to the DCFS Court Clerk and Superior Court Clerk. Then route a copy to the minor's social worker. A copy of *Judicial Council Form JV-220* shall be filed in the medical record.

C. The Fresno County Superior Court – Juvenile Division shall respond within 5 days upon receipt of the *Judicial Council Form JV-220.* Upon authorization or denial from the Fresno County Superior Court – Juvenile Division a copy of the Court Order section of the application shall be faxed to the designated nursing staff. The form shall be filed in the medical record.

D. The designated physician shall be notified of the authorization of the *Judicial Council Form JV-220* from the Fresno County Superior DCFS Court Clerk shall Court – Juvenile Division. The designated physician shall review the authorized Court Order for the approved medications. The physician shall write for the approved prescription. The designated medication clinic nursing staff shall call the minor's caretaker to pick up the prescription. At this time, a follow-up appointment shall be scheduled.

E. Modifications within the authorized range of dosage for an approved medication shall not require the submission of a new *Judicial Council Form JV-220* for authorization by the Fresno County Superior Court – Juvenile Division.

F. If medication is initiated at JJCS for a minor, then Policy and Procedure Medication Services 4.14 shall be followed.

G. In emergencies, psychotropic medications may be administered to a minor with or without consent by the parent/legal guardian or court authorization and same will be documented in the chart.

1. Medications shall be ordered only for circumstances, which appear to present an imminent danger to self and/or imminent danger to others. An emergency exists when a sudden marked change in the minor's condition requiring immediate action necessary for the preservation of the life or the prevention of bodily harm to the minor or others.

2. For a dependent minor or ward of the court the following will apply:

   a. An emergency situation occurs when a physician finds that the child requires psychotropic medication because of a mental condition and the purpose of the medication is to protect the life of the child or others, prevent serious harm to the child or others or to treat current or imminent substantial suffering and it is impractical to obtain prior authorization from the court. The Court authorization must be sought as soon as practical, but never more than two Court days after the emergency administration of the psychotropic medication.

   Judicial Council of California.www.courtinfo.ca.gov.
   Revised January 1, 2009. WIC && 369.5. 739.5.
   California rules of the Court, rule 5.640.

3. The *Notification of Emergency Administration of Psychotropic Medication* shall be completed as an **emergency or expedited JV 220** and filed in the medical record. Copies shall be sent to the Fresno County Superior Court – Juvenile Division.

4. Authorization for follow-up medication services shall be requested using the procedure for a dependent or ward of the Fresno County Superior Court – Juvenile Division in non-emergency situations.

5. For minors with parents or legal guardians the following shall be followed:

a. The parent/legal guardian shall be notified once the emergency is resolved. The designated nursing staff will inform the parent/legal guardian of the medication purpose, potential side effects and any other information pertinent to the minor's need for medication. Documentation shall be completed by the ordering physician and parents/legal guardian.

IV. **This Section Applies Only To Adult Consumers**: In emergencies, psychotropic medications may be administered to an adult consumer with or without consent by the consumer or by court authorization.

A. Medications shall be ordered on emergency basis only for circumstances posing imminent danger to self and/or imminent danger to others. An emergency exists when a sudden marked change in the consumer's condition occurs, requiring immediate action for the preservation of life or the prevention of serious bodily harm to the consumer or to others.

B. In emergency situations, such medications shall be limited to that which is required to treat the emergency condition and must be provided in ways that are least restrictive to the personal liberty of the consumer.

V. The Informed Consent process must be repeated, including Sections I and II above, in the following circumstances.

A. The consumer previously refused to accept the medication but subsequently agrees to accept the medication.

B. The medication has been discontinued and subsequently restarted after an interval of one year or more.

C. New information about the medication, such as side effects, risks, indications, or other significant information is recognized.

Submitted By: Joseph Almeida Jr, MD Signature	(Enter Date Here) Date 12/15/10
Division Manager Approval: Donna Taylor Signature	(Enter Date Here) Date 12/15/10
Director Approval: Donna Taylor Signature	(Enter Date Here) Date 12/15/10
Director Approval for Revision: Signature	(Enter Date Here) Date Revised

This page intentionally left blank

Fresno County Mental Health Services ATTACHMENT A

MEDICATIONS CONSENT FOR PATIENTS

This is to acknowledge that I have had a discussion with my/the conservatee's/my child's physician, concerning his/her prescription of the following checked medication(s) some of which may not have U.S. FDA approval for the use(s) discussed.

I have been informed of the alternatives, risks, benefits and side effects, some of which are listed below, for different medications. Not all known or potential side effects are listed. This consent is effective until revoked by the patient/parent/legal guardian/conservator.
I understand that I/the conservatee/my child should avoid alcohol while taking any medications. Drug-drug interaction can occur with over the counter medications.

☐ Antipsychotic_____
Some possible side effects: nausea, vomiting, dizziness, weight gain, increased blood sugar/lipids, diabetes, sedation, restlessness, tremor, stiff muscles, **Tardive Dyskinesia** (involuntary movements of face, mouth or head, neck, arms, hands and feet; are potentially irreversible and may appear even after these medications have been discontinued), seizures, sexual problems, **Neuroleptic malignant syndrome** (rare medical emergency marked by high fever, rigidity, delirium, circulatory and respiratory collapse), increased risks of stroke or cardiovascular accidents. Additionally for Clozapine: seizures; lowered white blood cell count leading to infections; and, rarely, damage to heart. **Black-Box warning for Dementia-related Psychosis and suicidality**.

☐ Anti-Extrapyramidal (EPS) Medications_____
Some possible side effects: for Cogentin, Artane and Benadryl etc: Blurred vision, tiredness, mental dulling, dizziness, trouble urinating, dry mouth, constipation etc.

☐ Antidepressant _____
Some possible side effects: nausea, vomiting, appetite/weight changes, headaches, dizziness, sedation, sleep disturbances, dry mouth, sexual/erectile problems, seizures, abnormal internal bleeding, Persistent Pulmonary Hypertension of the Newborn, Mania.
Especially in youth: Suicidal thoughts and behavior, mood changes, sleep disturbances, irritability, outbursts, hostility, and violence.

☐ Antianxiety/Hypnotic_____
Some possible side effects: drowsiness, trouble concentrating, confusion, clumsiness, dizziness, weakness, decreased reflexes, difficulty driving, operating machinery and loss of inhibition.

☐ Mood Stabilizer_____
Some possible side effects: nausea, vomiting, skin rash, weight gain, dizziness, confusion, tiredness and birth defects. Additionally for Depakote: liver/pancreas problems, ovarian problems, Teratogenicity; for Carbamazepine: **HLA-B* 1502 allele** testing in Asians, lowered blood count leading to infections; for Trileptal: possible serious rash, potential life-threatening. For Lamictal: serious skin rash, **Steven-Johnson Syndrome**, potential life-threatening. Some of these are antipsychotic medications or antiepileptic drugs.

☐ Lithium_____
Some possible side effects: nausea, vomiting, diarrhea, tiredness, mental dulling, confusion, weight gain, thirst, increased urination, tremors, acne, thyroid disorder and birth defects.

☐ ADHD Medications_____
Some possible side effects: loss of appetite, decreased growth, trouble sleeping, restlessness, nausea, changes in blood pressure/heartbeat. Additionally for Strattera: rare liver injury with possible jaundice (yellow skin and eyes) abdominal pain, itchy skin, flu, dark urine. Additionally for Adderall/Amphetamine salts: risk of sudden unexplained death, primarily with (undetected) underlying cardiac structural abnormalities. Additionally for Concerta/methylphenidate: psychotic behavior including visual hallucinations, suicidal ideation, aggression or violent behavior.

☐ Others_____

I understand that I have the right to refuse this/these medication(s) and that it/they cannot be administered to me/the conservatee/my child until I have spoken with my/the conservatee's/my child's physician and have given my consent to treatment with this/these medications. I may seek further information at any time that I wish, and I may withdraw my consent to treatment with the above medication(s) at any time by stating my intention to my/the conservatee's/my child's physician.

I certify with my signature that I have legal authority to sign this medication consent and that the relationship listed is valid and legal.

_____ _____ _____
Client/Parent/Guardian/Conservator Signature Legal Relationship Date

☐ ***I withdraw this consent***

NAME: _____

DMH #:_____

This page intentionally left blank

Section No.:	**1 -**	**Administration**	**Effective Date: 11.1.09**
Chapter No.:	**3 -**	**Compliance & Work Standards**	**Revised Date: 3.2.12**
Item No.:	**8G -**	**Electronic Signatures for Electronic Health Record Documentation**	

POLICY:

Fresno County Mental Health Plan (FCMHP) approves the use of electronic signatures to authenticate electronic health record documentation. The electronic signature shall have the full legal force and effect of the handwritten signature. FCMHP shall utilize electronic signature technology that meets Federal and State electronic signature requirements, complies with the Certification Commission for Healthcare Information Technology (CCHIT) certification criteria for electronic signature systems, and conforms to the electronic signature standards as set forth by the California Department of Mental Health (DMH). The electronic signature shall be unique to the signer, under the signer's sole control, capable of being verified and linked to the data so that the signature is invalidated if the data are changed.

FCMHP service provider staff and contractors authorized to document in the electronic health record system must agree to the terms of the use of an electronic signature. The Electronic Signature Agreement shall be signed and approved prior to the use of an electronic signature. Appropriate sanctions shall be applied for failure to comply with the terms of the agreement.

The accepted electronic signature for FCMHP electronic health record documentation is 'Electronically signed by' with the service provider's first and last name, username, applicable credential, and the date and time of the signature.

PURPOSE:

To ensure compliance with all applicable Federal and State requirements for electronic signature systems, and to ensure the appropriate use of electronic signatures by FCMHP service provider staff and contractors.

DEFINITIONS:

Electronic Signature – an electronic sound, symbol or process, attached to or logically associated with a contract or other record and executed or adopted by a person with the intent to sign the record.

15 United States Code Section 7006

Digital Signature – an electronic identifier, created by computer, intended by the party using it to have the same force and effect as the use of a manual signature. California Government Code Section 16.5(d)

Electronically Signed Record – a financial program, or medical record that is required to be signed under California or Federal law, California or Federal regulation, or organizational policy or procedure, and may be requested during an audit by a DMH auditor or a DMH audit contractor. California Department of Mental Health.

REFERENCES:

California Department of Mental Health Letter No.: 08-10, December 4, 2008
California Government Code Section 16.5
California Code of Regulations Section 22000 - 22005
California Government Code Section 6254
California Code of Regulations, Title 9, Division 1, Chapter 11, Medi-Cal Specialty Mental Health Services, Welfare and Institutions Code 5328
The Centers for Medicare and Medicaid Services (CMS) Interpretive Guidelines for Hospitals 482.24(c)
Jurisdiction One Medicare Advisory, June 2009 Issue, Medicare Part B Medical Records: Signature Requirements, Acceptable and Unacceptable Practices
HIPAA Security Rule 45 C.F.R. Part 164.312
Certification Commission for Healthcare Information Technology (CCHIT), Certification criteria: Security Access Control SC 01.01 – 01.06, Security Audit SC 02.01- 02.08, Security Authentication SC 03.01- 03.13
Fresno County Management Directive 2919, Sanction Policy
Fresno County Management Directive 2923, Authentication: Access Controls, and Security Management Processes

PROCEDURE:

I. Service Providers shall:
   A. Be trained for the proper access and use of the electronic health record system, including the use of an electronic signature.
   B. Read and sign the Electronic Signature Agreement (Attachment A), prior to the use of the electronic signature, and whenever name, job title, or certification changes, and follow all terms and conditions of the agreement.
   C. Protect personal electronic signature codes and/or passwords from unauthorized use.
   D. Notify immediate supervisor of problems with or suspected unauthorized use of the personal electronic signature, or of name or certification changes.
   E. Review electronic health record entries for completeness and accuracy prior to electronically signing.

II. Supervisors, Managers, and Contractors shall:
   A. Arrange for the training of service providers about the proper use of the electronic health record system, and the use of an electronic signature.
   B. Review the Electronic Signature Agreement with, and obtain signed Agreement from, each service provider prior to the use of an electronic signature, and whenever name, job title, or certification changes.

C. Forward signed Electronic Signature Agreements to the office of the Mental Health Director or designee for approval and signature.
D. Respond to identified problems with or suspected unauthorized use of an electronic signature. Request assistance of the Systems and Procedures Analyst as necessary to investigate and resolve the problem.
E. Monitor service provider staff compliance with the terms of the Electronic Signature Agreement. Provide appropriate retraining, counseling, and administer disciplinary sanctions in accordance with department and County policy for any staff that fail to comply.

III. Mental Health Director shall:
A. Complete and sign the County Mental Health Director's Electronic Signature Certification form (Attachment B), certifying that electronic systems used by the county's mental health operations, including contract provider systems, meet the standards, information security considerations, regulations and laws applicable to them.
B. Maintain the Director's Certification in the central file for Electronic Signature Agreements located in the Medical Records Coordinator's office.

IV. Mental Health Director or Designee shall:
A. Consider, approve, and sign the Electronic Signature Agreements submitted by authorized FCMHP service provider staff and contractors prior to utilizing electronic signatures.
B. Maintain the approved and signed Electronic Signature Agreements in the central file located in the Medical Records Coordinator's office.

V. Medical Records Coordinator shall:
A. Maintain a central file of Electronic Signature Agreements, and the Director's Certification.
B. Provide the Director's Electronic Signature Certification and the Electronic Signature Agreements to the DMH auditor at the time of an audit.
C. Coordinate with the Senior Systems and Procedures Analyst(s) or designee(s) responsible for the FCMHP's electronic health record system operations to provide electronically signed health records to the DMH auditor at the time of an audit, including the following:

1.) Physical access to electronic health record systems
2.) Adequate computer access to the electronic health records needed for the audit review
3.) System or network access to electronic records, including a user ID and password
4.) Access to printers and capability to print necessary documents
5.) Technical assistance as requested
6.) Complete and readable scanned documents, as needed.

D. The SPA's will not establish access to the electronic health record until they have verified that the electronic signature agreement has been properly executed.

Submitted By: Ruth Chavez Signature	Date 3/28/12
Division Manager Approval: Signature	Date 3/28/12
Director Approval: Donna Taylor Signature	3/28/12 Date

Fresno County Mental Health Plan
Electronic Signature Agreement

This Agreement governs the rights, duties, and responsibilities of authorized service providers of Fresno County Mental Health Plan (FCMHP) in the use of an electronic signature in the FCMHP electronic health record. The undersigned (I) understands that this Agreement describes my obligations to protect my electronic signature, and to notify appropriate authorities if it is stolen, lost, compromised, unaccounted for, or destroyed. I agree to the following terms and conditions:

I agree that my electronic signature will be valid until my name, job title, or certification changes or earlier if it is revoked or terminated per the terms of this agreement. The terms of this Agreement shall apply to each such renewal.

I will use my electronic signature\password to establish my identity and sign electronic health record documents and forms. I am solely responsible for protecting my electronic signature\password. I agree to keep my electronic signature\password secret and secure by taking reasonable security measures to prevent it from being lost, modified or otherwise compromised, and to prevent unauthorized disclosure of, access to, or use of it or of any media on which information about it is stored.

If I suspect or discover that my electronic signature\password has been or is in danger of being stolen, lost, disclosed, used by an unauthorized party, or otherwise compromised, then I will immediately notify the County Mental Health Director or his/her designee and request that my electronic signature be revoked and my password be reset. I will then immediately cease all use of any electronic signature until my password is reset. I understand that I may also request revocation at any time for any other reason.

If I have requested that my electronic signature be revoked, or I am notified that someone else has requested that my electronic signature be suspended or revoked due to suspicion that it has been or may be compromised or subjected to unauthorized use in any way, I will immediately cease using my electronic signature. I will also immediately cease using my electronic signature upon termination of employment or termination of this Agreement.

I further agree that, for purposes of authorizing and authenticating electronic health records, my electronic signature has the full force and effect of a signature affixed by hand to a paper document.

Requestor Signature _____ Date _____

Requestor Printed Name _____

Approver Signature _____ Date _____

Title _____

This page intentionally left blank

County of Fresno

RETURN TO TABLE OF CONTENTS

AUTHORIZATION FOR ACCESS, USE, AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____

Last 4 Digits of Social Security Number: _____ Record# _____

Access, Use, and Disclosure of Health Information

I authorize the access, use, or disclosure of the above named individual's health information, which may contain medical, mental health, or substance abuse history and treatment information, as follows:

Name of the organization or individual **authorized to access, use, or disclose** the information (information to be released from): _____

Address: _____

Name of the organization or individual **authorized to receive and use** the information (information to be released to): _____

Address: _____

The **type and amount of information** to be accessed, used, or disclosed is as follows:

- ☐ Diagnosis
- ☐ History & Physical
- ☐ Assessment
- ☐ Lab Report
- ☐ Medication Record
- ☐ Plan of Care
- ☐ Immunization Record
- ☐ Progress Note
- ☐ Other _____

Dates of information from: _____ to: _____

Exception or information I do not want disclosed: _____

This information will be used for the following **purpose:**

- ☐ Coordination/Continuity of Care
- ☐ Eligibility for Public Assistance
- ☐ Disability Claim
- ☐ Legal
- ☐ Social Security Appeal
- ☐ Other _____
- ☐ Insurance

Restrictions

California law does not allow the organization or individual receiving this information to access, use, or make further disclosure of my protected health information unless the organization or individual obtains another authorization from me or unless access, use, and disclosure is specifically required or permitted by law.

Rights

I understand that I have the following rights with respect to this Authorization:

1. I may refuse to sign this authorization.
2. I have a right to receive a copy of this authorization.
3. I may revoke this Authorization at any time by signing the revocation at the bottom of this form or by a written notice of revocation signed by me or on my behalf. I can mail it or personally deliver to the following address:

   _____

   I understand that the revocation will be effective upon receipt. I understand that the revocation will not apply to information that has already been released in response to this authorization.
4. I may not be required to sign this Authorization as a condition to obtaining treatment, payment, or my eligibility for benefits.
5. I am entitled to notice if Fresno County will access, use, or disclose the protected health information for marketing and receive payment for the access, use, or disclosure of my protected health information.
6. I understand that I may request a restriction or limitation on the protected health information to be accessed, used, or disclosed.
7. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by confidentiality laws including the Health Insurance Portability and Accountability Act (HIPAA).

Expiration

This Authorization will expire on: _____ If I do not specify an expiration date or event, this authorization will expire in **one year**.

Signature

I knowingly and voluntarily sign this authorization:

Signature _____ Date _____
Printed Name _____ Telephone Number _____

Address _____

If signed by someone other than client/consumer, state your legal relationship to the client/consumer: _____

Witness/Language Interpreter _____

☐ I revoke this authorization Signature: _____ Date _____