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). 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 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 their 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 their 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 attachment at the end of this section for a summary of the Legal Consent Requirements for Medical Treatment of Minors in Various Circumstances.

Copies of the beneficiary's records are to be transferred to requesting providers upon the consent of the beneficiary.

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 ease of identification.
- Personal, biological, and demographic data includes age, sex, address, telephone number, and marital status. This data should be updated as often 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".
- 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 Hospital Association at (916) 443-7401 or via their website: www.calhospital.org

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Section 11:

Medical Records

Forms and Attachments

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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 [Family Code § 6925]	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 4* 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.

03/17

CALIFORNIA HOSPITAL ASSOCIATION

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

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Section: Mental Health

Effective Date: 11/01/2010 **Revised Date:** 11/21/2018

Policy Title: Informed Medication Consent

Approved by: Dawan Utecht (Director of Behavioral Health), Elizabeth Vasquez (Compliance Officer), Lesby Flores (Division Manager - Children's)

POLICY: All clients (adults, parent/legal guardians of minors) will be informed about recommended psychotropic medications and sign an Informed Medication Consent form. Prescribers must inform the client/parent/legal guardian of the risks and benefits of the proposed medication treatment and the risks and benefits of alternative treatments, including absence of treatment. The proposed medication must be explained so that the client/parent/legal guardian understands and is able to make an informed decision.

PURPOSE: To comply with State consent requirements and ensure that clients are informed about medications that are being recommended for the treatment of mental illness prior to the administration of medication, with the exception of emergency medications.

REFERENCE: Welfare and Institutions Code, Sections 359.5 (d), 369, 369.5, 739.5, 5325, 5326.2, 5326.3, 5326.5, 5327, 5332, 5350; CCR Title 9, Section 850-857; California Rules of the Court, Rule 5.640. Rule 1432.5; Fresno County DBH Guidance Regarding Consent for Behavioral Health Treatment Services for Minor Clients, California Family Code, Section 6550-6552, MHSUDS Information Notice No: 17-040.

DEFINITIONS:

Psychotropic medications: Medications that are administered that affect 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.

Judicial Council Forms: Forms used to establish parent/guardianship rights to consent and to obtain authorization to administer psychotropic medication to a ward of the court. **These forms are to be used in conjunction with obtaining an Informed Medication Consent from the client (adults, parent/legal guardians of minors, minors).**

PROCEDURE:

I. The prescribing psychiatrist, physician assistant (PA) or nurse practitioner (NP) must ensure the Informed Medication Consent **(see Attachment 1 – Informed Medication Consent - English)** from the adult client or parent/legal guardian of a minor client is acquired prior to the administration of psychotropic medications. Clients will be treated with psychotropic medications after having been informed of his or her rights to accept or refuse such medications. The parent/legal guardian of a minor client must be informed of the benefits and risks of medication. **The Judicial Council forms (JV220) are not sufficient to ensure informed medication consent**.

II. Informed Medication Consent is signed by either an adult client or parent/legal guardian in person. If the client or parent/legal guardian is unable to sign in person an electronic copy or fax will be sufficient to be given for the client or parent/legal guardian along with written explanation of the right to refuse medication and advised of the risks and benefits of the medication. A completed sample Informed Medication Consent Form generated by the electronic medical record is shown in **Attachment 4 – Informed Medication Consent Multi-Language**.

A. In order to make an informed decision, the adult/parent/legal guardian/minor is to be provided with sufficient information by the treating psychiatrist/PA/NP 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 client's target symptoms and/or mental condition which the proposed medication(s) have been-recommended.
3. Reasons for taking such medication including the likelihood of improving or not improving without such medication.
4. The right to withdraw the 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 (such as 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 minor client.
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. These symptoms of Tardive Dyskinesia and others are

potentially irreversible side effects that may appear even after these medications have been discontinued.

9. Possible additional side effects which may occur to minors taking such medications beyond three (3) months.
10. Medication records should be reviewed and signed by client at least every 12 months for accurate medications, even if there are no changes.

B. The prescribing practitioner shall ensure that an Informed Medication Consent Form is signed by the adult/parent/legal guardian indicating that the aforementioned information **(Section II. A 1-10)** have been discussed with the adult/parent/legal guardian/minor.

C. If the adult/parent/legal guardian refuses to consent to medication, this information will be documented in the progress note.

D. If the client verbally agrees to take the medication, but declines to sign the consent, an entry will be made in the progress note stating the verbal agreement. Ongoing efforts should be made and documented at each subsequent visit to encourage client/parent/legal guardian to sign the consent.

1. 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 record and appropriate medical staff are to be notified.
2. The following classifications of medications require an Informed Medication Consent:
    a. Anti-anxiety agents;
    b. Hypnotic agents;
    c. All classes of antidepressants, including MAO inhibitors;
    d. Neuroleptic agents;
    e. Lithium carbonate;
    f. Extra pyramidal motor system side effect medications including Cogentin/Artane/Benadryl, and
    g. All other medications which are being used for psychiatric purposes including, but not limited to, alpha agonists, beta blockers and anticonvulsants.

E. The following steps will be adhered to in completing the Informed Medication Consent Form:

1. The form will be clearly/properly labeled with the adult/minor/parent/legal guardian name and client medical record number.
2. The appropriate section labeled medication will be used to document the category of each medication prescribed either brand or generic, and Type will be used to designate the type of family the medication belongs to (antidepressant, antipsychotic, etc.).
3. Any medication designated for "off label use" specifications can be listed on the line marked "Off label use" or placing a check in the box marked "Other".
4. The client/parent/legal guardian's signature and the date of the signature is recorded on the appropriate lines on the form.

III. **This Section Applies to Conserved Clients:** The client and conservator will be informed of the proposed medication in the same manner as for clients who are not conserved. The **exception** is that after providing all required information to the client, the following must be completed:

A. The prescribing practitioner (MD, PA, NP) will place the unsigned Informed Medication Consent form in the client's medical record to be signed by the conservator or deputy of the conservator as verification that the aforementioned information was discussed with the consumer.

B. The prescribing practitioner (MD, PA, NP) will document in the medical record the client's acceptance or refusal of medication or refusal to sign the informed medication consent.

C. This signed Informed Medication Consent is considered valid and verifies that all information has been discussed with the conserved client.

IV. **This Section Applies to Clients Using Caregiver's Affidavits:** The Caregiver's Affidavit **(see Attachment 5 – Caregiver Authorization Affidavit)** serves as a document giving an adult "qualified relative" authorization to consent for all mental health, medical treatment (including consent for administration of medications) and dental treatment for the entrusted care of the minor client**. Therefore, the "qualified relative" must sign the Informed Medication Consent form when it involves prescribing of medications**.

A. The "qualified relative" is defined in Consent for Treatment policy (2.1.19) under section Procedure subsection "C" Third Party. The Caregiver's Affidavit gives consent to medical, mental health and dental care of the minor. The Caregiver's Affidavit is placed in the client's file. The Affidavit ends when the parent/legal guardian returns to care for the minor and notifies treating staff member(s). The

affidavit is invalid after the provider receives notice that the minor no longer lives with this ("qualified relative") person.

V. **This Section Applies Only to Minors**: If the minor is a dependent of the Fresno County Superior Court – Juvenile Division, then designated licensed nursing staff will secure the Judicial Council Form JV-220 for the prescribed medication as well as the Informed Medication Consent Form. In lieu of JV-220 for counties that do not utilize court orders, other official documents approved by the Division Manager will be acceptable. **Please refer to Protocols Guide: How to Identify/Complete Appropriate Judicial Council Forms for a description on how to complete the JV-220 forms for wards of the court.**

A. In emergencies, psychotropic medications may be administered to a minor without consent by the parent/legal guardian, or court authorization.

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

B. For minors with parents or legal guardians: The parent/legal guardian will be notified once the emergency is resolve. 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.

VI. **This Section Applies Only to Adult Clients**: In emergencies, psychotropic medications may be administered to an adult client with or without consent by the client

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

VII. The Informed Medication Consent process must be repeated, including **Sections I and II** above, in the following circumstances:

A. The client 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 (1) year.

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

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 _____

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 I request a new electronic signature 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. I agree that my electronic signature will appear as follows:

Employee Signature _____ Date _____

Employee Printed:_____
First Name, Last Name, Relevant License or Job Title, Employee ID#

Supervisor's Signature _____ Date _____

Title _____

☐ New Employee (I.D.# to be entered by DBH Personnel within 2 weeks of hire date)

Original to be filed in Employee's DBH Personnel file

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