NYU Langone MEDICAL CENTER

Issuing Department: Internal Audit, Compliance, and Enterprise Risk Management

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Designated Record Set

Policy

Patients have the right to inspect, amend, and obtain copies of Protected Health Information ("PHI") that is contained within a Designated Record Set.

The Designated Record Set includes paper records and records contained in the official institutional electronic medical record and billing systems.

Records that otherwise meet the Designated Record Set definition but are held by a Medical Center Business Associate are also part of the Designated Record Set.

The Designated Record Set will be retained according to state and federal laws and regulations and in accordance with the Medical Center's Records Management Policy.

Workforce Members must pay particular attention to those records that are not included in the Designated Record Set and which are not available for patient inspection and amendment. Any questions regarding requests for those types of records should be referred to the Privacy Manager or the Office of Legal Counsel.

Examples of Records included in the Designated Record Set

- Inpatient and Outpatient records
- Day Surgery records
- Emergency Department records
- X-rays, Imagining and Radiology reports, films, digital copies of films
- Pathology reports and slides
- History and Physical examinations and reports
- Orders
- Progress notes
- Procedure and Operative reports
- Vital signs
- Psychiatric Assessments and Evaluations
- Laboratory reports
- Consultation reports
- Psychosocial history reports
- Photographs or videos

- Authorizations and consents, including research consents related to health care treatment decisions
- Billing records
- Remittance advice
- Case management records
- Other records that are used to make health care decisions about the patient (e.g., other diagnostic tests and results; interpretive reports)

Examples of Records not included in the Designated Record Set

The following are not part of the Designated Record set- even if they include PHI- because they are not used to make health care decisions about a patient. A patient **does not** have a right to access these records for any purpose.

- Quality Assessment records
- Credentialing records
- Peer Review files
- Research records (that are not used to make health care decisions about the patient)
- Incident report (e.g., reports regarding devices)
- Internal Grievance reports
- Information contained in employee records
- Information contained in the servers of a health information exchange in which the Medical Center participates that has not been integrated into a Designated Record Set
- Financial reports used for health care operations (e.g., inventory control or purchasing activities)
- Coding queries
- Internal Compliance reports and audits
- Administrative records
- Attorney-Client privileged records, or any other record that is subject to privilege under state and/or federal laws and regulations
- Public Health Records and Statistical Data
- Temporary Notes or Worksheets
- Any other record that is not used to make health care decisions about the patient
- External records (e.g., those provided from a previous physician)

Related Documents

Records Management Policy
Right to Inspect and Obtain PHI
Right to Request an Amendment

Legal Reference

45 C.F.R. §164.501
45 C.F.R. §164.524(a)
45 C.F.R. §164.526(a)

This version supersedes all previous Hospitals Center, School of Medicine, and/or Medical Center policies.