Assignment 5.1

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Patients have the right to access their medical records regardless of the method of an encounter, including telehealth and telepsychiatry. They must have the ability to view or receive a copy of their medical information if requested. Fees for such access have limitations, and the facility should not think of this process as an opportunity to generate revenue. Patients should have electronic access for no cost or almost no cost. However, no requirement exists for patients to use this format. Patients have the right to obtain this information in a different format. A patient can receive his records through unencrypted email if he also receives a warning about the possibility of unauthorized access during the mailing process. The patient cannot be refused access because the facility has reason to believe it is against the patient's best interest. The patient also has the right for their information to be sent to a third party (Henry, 2020). EHR technology is an opportunity for telemedicine providers to engage their patients immediately. Patients using the EHR engage with it and their provider, involving them in their own medical care, which empowers the patient and improves their care (Rotenstein, 2020). Telemedicine and telepsychiatry providers should provide a patient portal and provide patients with their medical records in other mediums if requested.

Patient consent is not the consent form itself but is the patient's authorization for treatment. The best method to document a patient's informed consent is with a signed form. The form should contain the signature of either the patient or a personal representative of the patient. However, the doctor should still review all appropriate information about a treatment or procedure, the alternatives for the treatment or procedure, and all the associated risks with the patient. Then the doctor should document the encounter in detail in a physician's note in the patient's record. The notes might also include verbal consent. The physician's note will provide

the court with proof that the patient fully understood all information because the patient was provided all necessary information and that the information was reviewed with the patient by the doctor rather than just given a form to sign. Although a physician's note is recommended, a signed form is still needed because the law requires it. The form might be more detailed than the physician's note, and a signed form is concrete proof of consent. The physician should include documentation and notes about a verbal exchange but should not solely rely on it (Hammaker, 2020, p. 67-68).

References

Hammaker, D. K. (2020). *Health Records and the Law*. (5th ed.). Burlington, MA: Jones & Bartlett Learning.

Henry, T.A. (2020, March 9). 10 tips to give patients electronic access to their medical records. *AMA.* https://www.ama-assn.org/practice-management/hipaa/10-tips-give-patients-electronic-access-their-medical-records

Rotenstein, L. S. and Friedman, L. S. (2020, Nov 20). The Pitfalls of Telehealth — and How to Avoid Them. *Harvard Business Review.* https://hbr.org/2020/11/the-pitfalls-of-telehealth-and-how-to-avoid-them