STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH

Effective Date: April 6, 1995

COMMISSIONER'S POLICY STATEMENT NO. 74

REQUESTS TO EXAMINE RECORDS

Under authority of Connecticut General Statutes §4-190 through 4-197 (the Personal Data Act), the Department of Mental Health has adopted regulations to establish the rights of persons who wish to examine departmental records concerning them (Section 17a-451(c)). This policy is intended to provide guidance to Department of Mental Health staff who receive such requests. To ensure equal treatment, Department of Mental Health financed care providers will also adhere to this policy.

It is the policy of the Department of Mental Health that staff should make records available for inspection and comment by recipients of care unless such disclosure would be medically harmful to the patient or would constitute an invasion of privacy of another person or would violate an assurance of confidentiality furnished to another person as described in Connecticut General Statutes 17a-548 (b) and Commissioner's Policy Statement No. 7. The Department believes that allowing consumers to read their own records and discuss them with their clinicians reduces suspicion, creates opportunities for discussion between consumers and treaters, and increases consumer participation in treatment.

A. COVERED SERVICE PROVIDERS

1. All Department of Mental Health facilities or programs that provide direct services to mentally ill persons shall make available the inspection procedures outlined below. Direct service DMH grantee agencies will also be covered except that an agency whose annual DMH funding does not exceed $25,000 is exempt from this policy so long as it provides a mechanism for the inspection of records. The Commissioner may grant any facility or program authorization to use another inspection procedure provided that such Commissioner finds that the alternative procedure is at least equal in effectiveness and timeliness.

B. INFORMATION DISTRIBUTION

1. Every DMH facility and every covered grantee shall develop and put into place a mechanism for informing consumers about their rights under this policy.

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C. REQUESTS FOR INSPECTION

1. Any person who believes that any facility of the Department of Mental Health or any covered grantee has medical, psychiatric or psychological records concerning that person may request an opportunity to examine some or all of such records.

2. The request shall be made in writing to the Director of the facility or program or a person designated by the Director to receive such requests. Upon request, any clinical staff member shall assist in the preparation and delivery of such a written request.

3. Within four (4) business days of receipt of a written request for inspection of the records, the Director or designee shall respond in writing, outlining the procedures available for review of the records.

4. As soon as possible, but in any case no later than ten (10) business days (for active records) or thirty (30) business days (for archived records) from the date of the request, the records shall be made available for inspection except as provided in Section D. For consumers in active treatment, a treating clinician designated by the facility shall review the record with the consumer in order to answer clinical questions, explain technical issues and jargon, and further the therapeutic dialogue. For consumers who have been discharged, the clinician shall be available to the consumer for joint review.

D. Exceptions to Inspection

1. If there exists information in the record which was provided under an assurance of confidentiality, such information may be withheld.

2. Information in a record which describes personal data about another person shall be withheld.

3. If, in the opinion of a physician, certain information in a record would be medically harmful to the consumer, that information may be withheld. Such a determination shall be made on an individual basis and shall be documented in writing with a statement of the reasons for the determination. The consumer may permit a qualified medical doctor of his/ her choosing to review the record. If that doctor determines that the record should be released to the consumer it shall be released. If that doctor agrees that the record should not be released, it will not be released and the consumer will be advised of the judicial relief provided under the Personal Data Act.

E. CONTESTING THE CONTENT OF RECORDS

1. Any person who believes that the facility or program is maintaining inaccurate, incomplete or irrelevant personal data concerning him/her may file a written request for correction of said data with the facility or program director.

2. Within thirty (30) days of receipt of such request, the facility or program shall give written notice to the person that it will make the requested correction, or if not, give the reason for its denial.

3. Following such denial, the person may add to the record a statement setting forth what that person believes to be an accurate, complete and relevant version of the personal data in question. Such statements shall become a permanent part of the record and shall be disclosed to any individual, agency or organization to which the disputed personal data is disclosed.

F. COPIES

1. A person may request copies of any or all of his/her record. The first twenty five (25) pages of such copy requested per year shall be provided without charge. As per Department of Mental Health procedure AC200 D13, dated 12/18/89, the facility or program may charge a fee not to exceed .25¢ per page for additional copies, plus a search fee charge of $3.00. Such fee may be waived.

2. Copies shall be furnished in accordance with the clinical review procedures detailed above in Section C-4. Copies will be made as soon as possible but in any case no later than ten (10) business days (for active records) or thirty (30) business days (for archived records).

G. RECORDING

1. To insure the appropriate handling of the medical record, and in order to comply with the Connecticut General Statutes 4-193(c), records shall only be copied by authorized Medical records staff of the facility. The facility will establish procedures whereby staff will be assigned to make authorized copies and record all instances of access and/or disclosure.

H. FACILITY PROCEDURES

1. Each facility will establish procedures necessary to implement this policy.

Albert J. Solnit, M.D.
Commissioner