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 medical and billing records, and other records that are used in whole or in part by or for NYU Langone Health to make decisions about individuals. This includes records that are used to make decisions about any individuals, whether or not the records have been used to make a decision about the particular individual requesting access. This includes both paper and electronic records and systems.

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

Information in a Designated Record Set will be retained according to state and federal laws and regulations and in accordance with NYU Langone Health' s Records Retention Policies.

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 Officer 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, telephone encounters)

Note on External Records

External records are those records which were not created by or originated at NYU Langone Health. For example, records (notes, reports) patients bring from a non-NYU Langone Health physician. If external records are used to make health care decisions about a patient, then those records are part of the Designated Record Set.

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
- 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 NYU Langone Health 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, audits, and logs
- 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
- Laboratory results from a test performed at a laboratory not certified to perform such test(s) under the Clinical Laboratory Evaluation Program (CLEP) or the Clinical Laboratory Improvement Amendments (CLIA)
- Any other record that is not used to make health care decisions about the patient

Research Records

Research records that are not used or are not available (to the treating provider) to make health care decisions about a patient are not part of the Designated Record Set. Records contained in an electronic medical record will be presumed to be available for use in making decisions about a patient, and therefore included in the Designated Record Set. Records that are maintained by but separate from other NYU Langone Health records which are not generally accessible by Workforce Members for purposes unrelated to Research, are not part of the Designated Record Set.

Some records are considered for Treatment and Research, such as documentation related to a clinical procedure or other service, even if the activity was undertaken for Research purposes only, and therefore are part of the Designated Record Set.

During the course of a Research study, the right to access Research records otherwise contained in the Designated Record Set may be suspended provided the patient agrees to such restriction (at NYU Langone Health, this is included in the standard Research Informed Consent document for the specific study). The right of access is reinstated upon the completion of the Research study.

Related Documents

All HIPAA Privacy Policies and Procedures
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 NYU Langone Health (as defined in this Policy) previous policies, including but not limited to NYU Hospitals Center, New York University School of Medicine, Lutheran Medical Center, and Winthrop University Hospital.