Section: Medical Records
Policy: Maintenance & Access to Clinical Records
Policy No.: MR 01
Effective: 12/19/1984
Revised/Approved: 03/28/2017

POLICY: It is the policy of Community Counseling Services that the Medical Records Department will establish a single case record for each individual receiving services (A/D Prevention, C&E services, Family Support/Education excluded), maintain clinical records of individuals receiving services in a secure location in each facility, restrict access to clinical records of individuals receiving services to those persons who have a specific need for the record, and maintain an indexing system that allows for locating the medical record of a particular individual receiving services whenever the records are removed from the central files. For policy purposes, the terms "clinical record", "medical record", and "case file" are used interchangeably.

PURPOSE: To ensure that clinical records of individuals receiving services are secure and can be easily located/accessed when necessary.

PROCEDURE: All open medical records of individuals receiving services will be maintained by the medical records department of the county in which the individual receiving services is served. Closed medical records will be stored in their original, hard copy form for a minimum of one (1) year. Closed files will be stored as follows:

In Starkville: Choctaw, Oktibbeha, Webster, Winston Counties
In Columbus: Clay, Lowndes, Noxubee Counties

After one (1) year, the file will be stored on compact disk and/or digital storage. After the record is stored on compact disk and/or digital storage, the original medical record will be shredded/destroyed.

Storage of clinical records: All records of individuals receiving services are to be kept in cabinets in an area of the facility which is designated for medical records and which are locked when records are not in use. Access to clinical records of individuals receiving services shall be restricted to Office Manager/Medical Records Technicians (OMO/MR Technician), treatment team member involved in the treatment and/or consultation of an individual receiving services, and supervisory/ administrative personnel for the purposes of quality assurance and/or consultation with service providers regarding treatment. A listing of those persons authorized to access medical records of individuals receiving services shall be prominently posted in the designated medical records area. Each clinical record of an individual receiving services shall be clearly labeled with the name and assigned case number of the individual receiving services and marked "Confidential". Clinical records shall be stored in numerical order by the individual(s) designated as responsible for the medical records department in each facility.

Procedure for requesting clinical records: The service provider/supervisor will request the medical records files that are needed by submitting a list, in writing, to the medical records department. The OM/MR Technician will locate and remove from the

cabinets the medical record file(s) which has/have been requested. The OM/MR Technician will place the record(s) in the staff member's basket in the medical records library or a secure designated area. The OM/MR Technician will keep the list of records that were requested by the staff member. Clinical records are to be returned by the end of each work day to be stored in the secure, designated medical records area. When the record(s) is/are returned to the medical records department, the OM/MR Technician will indicate on the list that the files have been returned. The OM/MR Technician is responsible for filing the record(s) into the appropriate cabinet(s). If a file is not returned by 4:30 of the day the file was checked out, the service provider will be contacted and instructed to return the file to the medical records facility. All records which leave the medical records department for any reason should be checked out by the above procedure. If the service provider does not return the record according to the procedures indicated, the County Administrator/Supervisor shall be notified.

Removal of Clinical Record from the facility: Approval by the medical records department is required to remove a record from the facility for any reason. Medical records may be removed from the facility under the following circumstances; 1) The individual receiving services is receiving treatment (i.e., medical services) or emergency services in a Community Counseling Services facility other than where his/her record is stored; 2) The individual receiving services has moved and will be served in another county served by Community Counseling Services; 3) The record is required by supervisory/administrative personnel for quality assurance or consultation regarding treatment, 4) The case of the individual receiving services has been closed and the file must go to a central storage location for closed cases as designated (see MR 06: Discharge Procedures for Closure of Medical Records); 5) The record has been requested as part of an audit by an appropriate credentialing/licensing agency that has authority to have access to the record. Medical records which leave the facility in which they are stored may only be transported by interoffice mail courier (inside the mail bag in an envelope stamped "confidential" and locked in the vehicle during transport) or by a service provider who has been given authority to remove the file from the facility for one of the reasons indicated above (inside in an envelope marked "Confidential", locked in the vehicle/trunk during transport).

Access after-hours to medical records in an emergency situation: Requests after hours for medical records by emergency staff shall be directed to the appropriate County Administrator/Supervisor. The County Administrator/Supervisor or his/her designee will travel to the nearest office to which he/she has access and obtain the needed information from computer records if possible. If the needed information is not contained in the computer record, the County Administrator/Supervisor or his/her designee shall travel to the office where the medical record is located, access the medical record, obtain the necessary information, and relay it to the professional dealing with the emergency, taking appropriate measures to verify the individual requesting the information has a right to the information. A key to the medical records office in each county office shall be kept on site in a secure location known only to medical records personnel and the County Administrator/Supervisor so that records may be obtained whenever necessary.

Mississippi Operational Standards addressed: Rule 16.8A-C, 16.7D,E

Section: Medical Records
Policy: Calculating Charges for Records Released
Policy No: MR 02
Effective: 03/30/1995
Revised/Approved: 10/01/2005

POLICY: It is the policy of Community Counseling Services to charge a standard fee for records that are released.

PURPOSE: To reimburse Community Counseling Services for the expense and time that is required to locate, retrieve, copy, and mail medical records to the requesting party.

PROCEDURE: The individual requesting records is charged a fee of $20.00 for each record that is copied up to 20 pages. The requester will be charged $.50 for each page that exceeds 20 pages.

Example: If the medical records technician copies a record for an individual receiving services and the record is 50 pages, the medical records technician would calculate the charges as follows:

$20.00 for copying the record	20.00
30 pages at $.50 a copy	15.00
TOTAL =	35.00

Exceptions to charges: Other mental health facilities, hospitals, and/or another service provider which will deliver continuing **mental health care** will not be charged if they are specifically the entity requesting the records. If the individual receiving services requests the chart on behalf of another provider, the individual receiving services will be charged according to the process identified in this policy.

Section: Medical Records
Policy: Service Termination and Provider Termination
Policy No: MR 03
Effective: 01/01/1997
Revised/Approved: 03/28/2017

POLICY: It is the policy of Community Counseling Services that all individuals receiving services shall be terminated from a program/service when the individual no longer wishes to participate or continue in the program/service, ceases attending/participating in a service/program, or can no longer benefit from the program/service. It is also the policy of CCS to discharge all individuals receiving services from Community Counseling Services when the individual no longer wishes to receive any service from CCS and/or there is no longer a need for any service provided by the agency. Should an individual receiving services fail to request discharge, but cease participation in any service, the primary service provider shall formally discharge the individual in a timely fashion. All cases of all individuals receiving services shall be reviewed and staffed before provider discharge.

PURPOSE: To establish a method and criteria for termination from programs/services and CCS provider discharge. To ensure a timely closure and thorough review of the chart of an individual receiving services before closure of his/her case. To ensure that no individual's enrollment in a service program or in the agency as a whole remain open unnecessarily beyond ninety (90) days following the last service received by the individual, and that discharge occurs if the individual receiving services has not received services in twelve (12) months. For substance use disorders services, the individual must be discharged when no contacts are recorded for ninety (90) days.

Termination and discharge are two unique terms and actions. Termination is the action utilized and documented to discontinue a service and/or program within CCS. Discharge is the action utilized and documented to signify that an individual is no longer receiving services through CCS.

PROCEDURE: It shall be the responsibility of the County Administrators to ensure that termination/discharge is accomplished in a professional manner and with the well-being of the individual receiving services as the primary goal.

Service/Program Termination/Provider Discharge: Should an individual receiving services state that he or she wishes to have one or more service(s) discontinued or that he/she wishes to discontinue participation in one or more program(s), the service provider(s) or program manager(s) as appropriate, shall meet with the individual to determine the reason for the request that the service/program be discontinued. If the individual has accomplished his/her goals for participation in the service/program, the individual will be consulted and if he/she is in agreement, the individual will be formally terminated (according to procedures detailed below) from the service(s)/program(s). It will also be determined at this time if the individual should be discharged from all CCS services due to completion of treatment goals. If the individual has not accomplished his/her goals, the service provider and/or program manager (as appropriate) shall gather information as to the why the individual wants

the service/program discontinued and provide information/advantages of continued participation. As reflected in his/her client's rights, the individual has the right to refuse treatment/services. If the individual expresses his/her intention to discontinue participation, he/she will be formally terminated (according to procedures detailed below) from the service(s)/program(s) and if requested, discharged from all CCS services.

If an individual receiving services fails to return for three (3) consecutive appointments for services/program participation, the service provider shall attempt to contact to the individual to determine the reason for non-participation and be given a deadline for contacting the provider/agency regarding continuation of services/program. This may be done through telephone contact and/or written correspondence. All attempts shall be documented in the medical record. If the individual fails to respond within the timeframe identified, his/her case will be presented at the next regularly scheduled meeting of the appropriate treatment team. The treatment team will make a decision regarding whether or not to terminate the individual's participation in the service/program and what action is to be taken if the participation is not to be terminated. If the decision is for termination, the individual will be formally terminated from the service/program (according to procedures detailed below). The case will also be reviewed at this time to determine if the individual receiving services should be discharged from all CCS services.

Service Termination/Discharge Procedures: All recommendations for service terminations/provider discharge shall be made during a regular staffing session of the interdisciplinary treatment team so that no individual will be discharged/terminated who is still receiving services, and so that no individual receiving services will be discharged/terminated who has a marked need for services to be continued. Documentation of service/program termination and/or provider discharge of an individual receiving services shall be completed within 5 days of the decision/request to terminate a service/participation in a program and/or discharge from all CCS services. The Service Termination/Change Form and the Provider Discharge Summary as applicable shall be completed as outlined in the DMH Record Guide. At a minimum, reason for service termination/provider discharge, assessment of progress towards objectives/goals outlined on the ISP, and service termination/discharge instructions given to the individual or their guardian/legal representative must be documented.

Individuals receiving services who fail to return for ninety (90) days shall have their cases presented to the treatment team by the Manager of the Record at the next regularly scheduled staffing for a decision on whether or not to close the individual's case or what actions shall be taken if the case is not to be closed. If the decision of the treatment team is to continue to try to engage the individual receiving services in treatment, the Manager of the Record and a service provider in each area of recommended treatment shall make every effort to encourage the individual receiving services to participate in treatment and shall document those efforts in the appropriate section of the individual's chart. Should efforts be unsuccessful, the case shall be presented to the treatment team at the end of each ninety (90) day period for further deliberations. In all instances, an individual's case shall not remain open more than twelve (12) months from the date of the individual's last service from the

agency. For substance use disorders services records, the case must be closed when no contacts are recorded for ninety (90) days.

Service Termination/Change details: If an individual is being terminated from a given service or program, the service provider responsible for that service or program shall complete the Service Termination/Change form. If it has been determined/recommended that the individual begin receiving another service within the agency, this should be reflected as such on the Termination/Change Form and the referring staff member is responsible for notifying the staff member/program who will be providing the new service. Should an individual remain in a given program but move from one county to another, the Service Termination/Change form, along with other necessary documentation, shall be completed reflecting the change and transferring the case to the appropriate staff member in the other county. Once approved, the chart of the individual receiving services shall be sent to the medical records of the receiving county in accordance with policy MR 01. Prior to filing the Service Termination/Change form, the Medical Records department is responsible for entering the service termination/change into the computer system.

Provider Discharge details: If an individual is being discharged from all CCS Services, it is the responsibility of the assigned therapist to complete the Provider Discharge form. If the therapist or "Manager of the Record" is no longer employed at Community Counseling Services, the County Administrator/Supervisor will complete the discharge paperwork or will appoint a staff member to complete the termination paperwork. The completed Provider Discharge form shall be sent to the medical records department. Once received, the chart will be reviewed for closure by the medical records department and the Provider Discharge form will be filed in the chart on top of the most recent progress note. If chart deficiencies are notes, the medical records department will notify the responsible staff member so deficiencies can be corrected prior to closure. The Medical Records department is responsible for entering the provider discharge into the computer system prior to filing the Provider Discharge form. The chart will be filed in accordance to policy MR 01.

Community Living: Individuals living in community settings where they have signed a lease and pay rent cannot be discharged or terminated from the service in a manner that is not in full compliance with the terms of the lease/rental agreement. In addition, the community living service providers must take steps to find alternative living arrangements appropriate for the individual. Those arrangements shall be designed to mitigate the likelihood that the individual will be homeless as a result of being discharged or terminated from the community living program.

Mississippi Operational Standards addressed: 16.3A-D, F

Section: Medical Records
Policy: Comparing Case Notes and Service Logs
Policy No: MR 04
Effective: 03/30/1995
Revised/Approved: 03/28/2017

POLICY: It is the policy of Community Counseling Services to compare all case notes to correspond with the services indicated on the service logs for the day that the service was provided. For policy purposes, the terms “case note” and “progress note are used interchangeably.

PURPOSE: To ensure that services billed correspond to the information that is documented in the medical record.

PROCEDURE:
Daily Service Log/Progress Notes: The service provider is responsible for attaching his/her case notes for the day to the original daily service log. The intake assessment serves as the “progress note” for intakes. The pre-evaluation screening form serves as the “progress note” for pre-evaluation screenings. At the end of the day, the service provider places his/her service log and attached case notes into the service log basket located in the Medical Records Department. Once the service log/progress notes are submitted, the OM/MR Technician compares the service log and the case notes ensuring there is a note for each service log entry for direct individual service. The designated staff member checks to ensure the name and case number corresponds and that the name, case number, service code, minutes, and date on the case note are the same on the service log. The OM/MR Technician also verifies the notes are signed, including the service provider’s credentials. For provisionally certified therapists, the progress note must be signed off by a certified or independently licensed master’s level clinician. If all of the information is correct, the service log is sent to data entry and case notes are placed in the "To Be Filed" basket in the Medical Records Department. If any of the information on the case notes does not correspond with the service log, the notes and the service log are returned to the service provider for correction with an expectation that the returned/corrected log is returned to medical records as soon as possible. When both service log and case notes are complete and correct, a check mark is entered in the appropriate block on the Service Log Check-Off Sheet.

Weekly Service Logs/Progress Notes: For day treatment and psychosocial rehabilitation programs, week ending progress notes shall be submitted with weekly service logs at the end of the day on Friday. If the end of the month falls on a day other than Friday, the week ending log and corresponding note for that week should be submitted on the last working day of the month. The designated staff member checks to ensure the total number of minutes billed for the day are the same on the weekly note and on the weekly service log, that the notes are complete, and signed with credentials. For bachelor degreed staff who are completing weekly progress notes, the note must be signed off by a certified or independently licensed master’s level clinician. If all of the information is correct, the weekly service log is sent to data entry and case notes are placed in the "To Be Filed" basket in the Medical Records Department. If there are any discrepancies between the week ending log and the

weekly progress notes submitted, the weekly note and service log are returned to the service provider for correction. The service provider is expected to submit the returned/corrected log to medical records as soon as possible.

General:
If any notes and/or logs (daily or weekly) are not submitted in accordance with the established time lines, this shall be reflected on the Service Log Check-Off Sheet and the County Administrator/Supervisor shall be notified. No services logs should be accepted by the Medical Records Department that does not have corresponding progress notes for services provided.

Section: Medical Records
Policy: Confidentiality/Consent to Release/Obtain Information
Policy No.: MR 05
Effective: 11/01/1992
Revised/Approved: 03/28/2017

POLICY: It is the policy of Community Counseling Services that all information regarding individuals receiving services be considered strictly confidential and privileged unless there is evidence that harm may come to an individual receiving services or other person, an individual receiving services has signed a release authorizing the release of specified information, upon order of a court of competent jurisdiction, or upon request by medical personnel in a medical emergency. Community Counseling Services shall process requests for information regarding individuals receiving services in a manner which ensures the preservation of the confidentiality of individuals receiving services.

It is the policy of Community Counseling Services that any breeches in confidentiality should be reported to the Executive Director or his/her designee.

It is the policy of Community Counseling Services that all information regarding its internal operations are confidential, unless keeping information confidential would be legally indefensible.

PURPOSE: To conform to all applicable state and federal laws and to ensure that persons receiving services from Community Counseling Services can be confident that information obtained in the course of providing mental health services shall be maintained in a confidential manner at all times and shall not be open to public inspection. Information may be disclosed outside of Community Counseling Services only in the circumstances and under the conditions set forth in CCS' Policy and Procedure Manual.

PROCEDURE: It is the responsibility of the Executive Director to ensure that all CCS personnel maintain the confidentiality rights of individuals they serve at all times across situations and locations, such as in waiting areas to which the public has access, while speaking on the telephone, or in conversing with colleagues. CCS maintains policies and procedures related to the compilation, storage, and dissemination of individual case records/client information to ensure an individual's right to privacy and maintain the confidentiality of individuals' records and information. All newly employed staff members and volunteers are responsible for reviewing this policy, being familiar with its contents, and understanding their responsibilities as outlined. Employees/volunteers will sign indicating they have received a CCS Handbook and Resource Guide at orientation, as well as, their responsibility to read and review the material presented in the handbook and the information contained within. Employees will also successfully complete Relias Learning courses related to HIPAA and Confidentiality with documentation of completion maintained in each employees personnel file. All provisions of this Policy shall be observed at all times by all Community Counseling Services personnel.

General Information: It is the policy of Community Counseling Services that all information regarding individuals receiving services will be held in the strictest confidence. No information of any kind will be released to any external persons or agencies, by any staff member, without proper authorization from the individual receiving services and/or his/her legal guardian. Such confidential information includes not acknowledging that a person of a particular name or description is or has been receiving services from the program/agency. Written consent of the individual receiving services or his/her legal guardian is required before information can be released to any third party, including the Department of Human Services. Service providers must request written consent to release information from individuals eighteen (18) years and older which will allow the provider(s) to involve the family in the individual's treatment. Such releases must be requested before information can be released. All releases must be updated prior to the expiration date reflected on the Consent to Release Information, but at a minimum annually.

Only members of the Medical Records staff may distribute records to staff members and procedures are described below. These procedures ensure that only those who have a specific need for the record have access to it. Access to the case record by staff members other than the individual's direct service providers will be limited to Quality Assurance and to supervisory staff when warranted.

Confidentiality will be maintained in regard to individuals receiving services, their contracts, their records, and internal operations of Community Counseling Services, including those individuals receiving alcohol and other drug disorders services, in accordance with applicable federal regulations. Individuals receiving services are not to be identified nor discussed with individuals, groups, or agencies not directly affiliated with Community Counseling Services, including spouses, relatives, and friends of staff members and individuals receiving services. To maintain confidentiality, it is important that neither the names nor identifying data of individuals receiving services are discussed between or among staff members in public or quasi-public places such as restaurants, hallways, or in public areas of Community Counseling Services.

Internal operations of Community Counseling Services are considered confidential. This does not mean the agency operates in secrecy. As a public agency, Community Counseling Services complies fully with all provisions of the Freedom of Information Act. However, certain issues, such as employment, salary, interpersonal relations, etc., are not to be discussed outside of Community Counseling Services. Mechanisms to assure communication and for resolving problems are available through training and supervisory channels. Discussion of services should be in general terms or specific therapeutic terms that can be understood by the general public. Examples of cases may be used only if the identity of the individual receiving services cannot be determined from the case example cited.

Any request for information that may be of a confidential nature should be handled with an explanation that the information is confidential and cannot be released without the permission of the individual receiving services or upon receipt of a court order from a court of competent jurisdiction. Difficulties that may arise should be referred up the supervisory channel.

Medical Records Requests: The medical record is the property of Community Counseling Services. The information in the record is the property of the individual receiving services. All requests for information regarding individuals receiving services should be forwarded to the medical records department. A Consent to Release/Obtain Information which addressed all information to be released will be filed in the medical record of the individual receiving services. All Consents to Release/Obtain Information should be completed fully in accordance with the instructions outlined in the DMH Record Guide before a release can be honored. Incomplete consent forms are considered invalid. When copies of records are released, a notation will be made in the file stating the date that the records were released, the type of information that was released, and to whom the copies were sent. When records are released the following disclosure statement is attached: "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose."

Procedure for release of information with written consent:

1. The chart of the individual receiving services, including those individuals receiving alcohol and other drug disorder services, in accordance with federal regulations, is to be removed from open or closed files.
2. The OM/MR Technician will check the chart to ensure that the Consent to Release/Obtain Information form is completed fully and current and will verify that the signature is authentic by comparing it to other signatures in the file. A completed release must include all information as outlined in the DMH Record Guide. Reference the end of this policy for items which must be included in accordance with 45 CFR 164.508.
3. The requester is to be contacted for a proper consent form if the information required in 45 CFR 164.508 is not present.
4. The OM/MR Technician is to contact the individual receiving services if the request for records is made by anyone other than the individual receiving services or guardian.
5. There will be a waiting period of up to five (5) working days from the time that information is requested and the time that the records are mailed or can be picked up by the recipient. This waiting period will be used to verify proper authorization.
6. The chart is to be reviewed to ensure that there are no deficiencies.
7. Copies are to be made of the information that is requested on the release form.
8. A copy of the disclosure statement shall be attached to the copies of the record.
9. The original consent to release information form is to be filed in the C&E section of the chart and a copy of the release is sent to the requester, along with the records that are released.
10. A notation is made in the file of the date that the copies were made and the type of information disclosed and sent to the requester and shall include the name of the staff member processing the request.
11. The copies of the records are mailed to the requester by certified mail when appropriate. The envelope shall be stamped with the "confidential" stamp.

12. The "Procedure for Calculating Charges for Released Records" is to be followed to determine the fee for copying the chart.

Procedure for release of information directly to the individual receiving services and/or parent/legal guardian for minors: If the individual receiving services and/or his/her parent/legal guardian (for minors) requests that the records be released to him/herself, the therapist or County Administrator/Supervisor must be notified so that a clinical review of the chart may be made to ensure that there is no information which would be detrimental to the well-being of the recipient or others. If the individual receiving services is to receive the information, no copy of the record may be permitted to leave the premises until the individual and/or parent/legal guardian (for minors) reviews the record with the primary therapist or County Administrator/Supervisor so that questions may be answered and necessary clarifications made. If the individual and/or parent/legal guardian (for minors) requests his/her records for a third party such as a physician or attorney, he/she will be encouraged to permit Community Counseling Services to send the information directly to the third party to ensure the integrity of the information being disclosed. Unless the records are sent to another treatment facility for continuing care, there will be a charge for copying records as per Policy #MR 02, "Calculating Charges for Records Released".

Procedure for release of information without written consent in case of a medical emergency: When a verbal request is received to release information in case of medical emergency, if time permits, the medical records technician will:

- Contact the County Administrator/Supervisor for guidance/support
- Contact the service provider(s) of the individual receiving services to determine if they are aware of the situation, including those individuals receiving alcohol and other drug disorder services, in accordance with federal regulations.

Information required to deal with medical emergencies is given by telephone to the medical/treatment facility when warranted to ensure the safety and well-being of the individual receiving services. If a question persists about the legitimacy of the request, the OM/MR technician will consult with the County Administrator/Supervisor before disclosing the information. If necessary to determine legitimacy, the OM/MR Technician will call back to the medical/treating facility (to verify the legitimacy of the request) and will give the information needed to deal with the emergency by telephone. In all situations, an entry is made in the medical record of the individual receiving services which includes the nature of the emergency, the date and time of the disclosure, the information which was disclosed, to whom the information was disclosed and the reason for disclosure, and the signature, credential(s) and title of the individual disclosing the information.

Procedure for release of information without written consent pursuant to a court order (not a subpoena), to be carried out by medical records personnel:

1. The individual receiving services is notified of the court order requiring release of information.
2. The requested information is checked for completeness, and copied.
3. An affidavit is prepared, signed and notarized, confirming that a) the information being released applies to the individual receiving services, listing

him/her by name and case number, and b) is a true and complete copy of the information requested by the court order
4. The original affidavit and the requested information are mailed to the court.
5. A copy of the affidavit and the court order are placed in the file of the individual receiving services, along with a notation containing the date and time of the disclosure, the information which was disclosed, to whom the information was disclosed and the reason for disclosure, and the name, credential, and title as well as the signature of the individual disclosing the information

How to Respond to a Subpoena or a Subpoena duces tecum: A subpoena is **not** a court order and requires a properly completed written release of information form. If a subpoena is received which is not accompanied by a written release form, the issuing attorney should be called and informed of the necessity for a release of information form or a court order in accordance with state statute. Specifically,

§ 41-21-97. Confidentiality of hospital records and information; exceptions:
The hospital records of and information pertaining to patients at treatment facilities or patients being treated by physicians, psychologists or licensed master social workers shall be confidential and shall be released only: (a) upon written authorization of the patient; (b) upon order of a court of competent jurisdiction; (c) when necessary for the continued treatment of a patient; (d) when, in the opinion of the director, release is necessary for the determination of eligibility for benefits, compliance with statutory reporting requirements, or other lawful purpose; or (e) when the patient has communicated to the treating physician, psychologist or master social worker an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims, and then the treating physician, psychologist or master social worker may communicate the threat only to the potential victim or victims, a law enforcement agency, or he parent or guardian of a minor who is identified as a potential victim.

Release of information at the discretion of the holder of the record: Information may be released at the discretion of the holder of the record under the following circumstances:

- As necessary for the purpose of outside research, evaluation, accreditation, or statistical compilations, provided that the person who is the subject of the information will not be identified from the disclosure information
- To providers of mental or other health services or a public agency when there is a compelling need for disclosure based upon a substantial probability of harm to the recipient or other persons.

Other pertinent information:

- Information cannot be re-disclosed. This includes any information received by another entity or person that is maintained in the C&E section. Community Counseling Services can release only information that is generated within this agency.
- When responding to a request to disclose information, only the least amount of information should be disclosed to comply with the consent.

- Any attorney must have a written consent signed by the individual receiving services before he/she can access/receive records of the individual receiving services.
- For minor, a release form must be obtained to disclose information to any other person than the biological parent and/or legal guardian. In situations where there is a legal guardian appointed, proof of guardianship/court documents must be maintained in the file.
- Once an individual reaches the age of 18, he/she must give consent to communicate with any person, including family members.
- Only the written results of any testing are to be released. The raw data of any testing may not be released.
- When there is any question regarding the appropriateness of the release of information, the individual designated by the Executive Director shall be consulted.
- When there is concern about the well-being/safety of the individual receiving services as a result of disclosing information requested, the employee will consult with his/her immediate supervisor and/or a member of the Executive Leadership Team prior to disclosure of information and references policy EI 03: Managing Ethical Dilemmas.
- Written consent of the individual receiving services or his/her parent/guardian, when appropriate, is required prior to the release of identifying information regarding an individual receiving services to a third-party payer.
- Community Counseling Services personnel must maintain the confidentiality rights of all persons they serve at all times, across situations and locations. Identifiable information regarding individuals receiving services shall not be discussed in waiting areas, speaking on the telephone, or conversing with colleagues, except behind closed doors.
- When an individual receiving services is deceased, state and federal regulations must be complied with regarding requests for records.
- In the case of community living or residential facilities, the program must obtain written consent from the resident or legal representative prior to acknowledging his/her presence in the facility to visitors or to callers and ensure that such consents are contained in the medical record of the individual receiving services.
- No program shall release records of an individual receiving services for review to a state or federal reviewer other than Department of Mental Health staff members without a written statement indicating the purpose of the review, staff to conduct the review, that reviewer(s) is/are bound by applicable regulations regarding confidentiality and all others that apply, and the reviewer(s)' signature(s) is received, including date signed.

Mississippi Operational Standards addressed: 16.7A-C, F

45 CFR 164.508

General Authorization content: The rule states that a valid authorization must be in plain language and contain at least the following core elements:

- A specific and meaningful description of the information to be used or disclosed
- The name or other specific identification of the person(s) or class of persons authorized to use or disclose the information
- The name or other specific identification of the person(s) or class of persons to whom the covered entity may make the use or disclosure
- A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is sufficient when an individual initiates the authorization and does not provide a statement of the purpose
- An expiration date or event that relates to the individual or the purpose of the use or disclosure. For research purposes only – The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure for research, including for the creation and maintenance of a research database or repository
- Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of the representative's authority to act for the individual must be provided

In addition to the core elements, the rule states that a valid authorization must include:

1. A statement of the individual's right to revoke the authorization, in writing, and either:
- A reference to the revocation right and procedures described in the notice, or
- A statement about the exceptions to the right to revoke, and a description of how the individual may revoke the authorization

Exceptions to the right to revoke include situations in which the covered entity has already taken action in reliance on the authorization, or the authorization was obtained as a condition of obtaining insurance coverage.

2. A statement about the ability or inability of the covered entity to condition treatment, payment, enrollment, or eligibility for benefits on the authorization:
- The covered entity must state that it may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization, or
- The covered entity must describe the consequences of a refusal to sign an authorization when the covered entity conditions research-related treatment, enrollment or eligibility for benefits, or the provision of healthcare, solely for the purpose of creating protected health information for a third party on obtaining an authorization

3. A statement that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by the rule.

Section: Medical Records
Policy: Documentation of Medical Records
Policy No.: MR 06
Effective: 12/13/1994
Revised/Approved: 03/28/2017

POLICY: It is the policy of Community Counseling Services that all information pertaining to the treatment of an individual receiving services will be maintained in the medical record of the individual receiving services. The medical record for all individuals receiving services should be completed so that all records meet Department of Mental Health's Operational Standards and the requirements outlined in the Department of Mental Health's Record Guide. Programs must ensure that all forms include the areas reflected in the DMH Record Guide. Items specifically customized for a program's in-house procedures may be added to the forms as needed.

PURPOSE: To ensure uniformity in the medical records by listing forms which should be used and a brief description of how they are to be used.

PROCEDURE:
General Information: The forms outlined in the DMH Record Guide for Mental Health, Intellectual and Developmental Disabilities, and Substance Use Disorders Community Service Providers should be used to comply with the DMH Operational Standards. Forms can be modified, customized, or items added to meet the individual needs of the agency and/or program, but nothing can be removed from a DMH form. All entries in case records must be in permanent form (ink), accurate, legible, dated, signed and including the credentials of the staff member making the entry. If an item is not applicable, N/A = Not Applicable should be noted. If an item is applicable, but there is no information to list in a specific blank (i.e., medications), "none reported" should be reflected. No information in an individual's record shall contain the name or other identifiable information of another individual receiving services.

Changes are to be made so that original information is clearly visible (i.e., by marking a single line through changed information) and dated and initialed by the staff member making changes. Correction fluid, erasing or totally marking out original information is not permissible. There may be no blank spaces on any completed form. Late entries to the record are to be avoided if at all possible. Late entries, however, must also be documented as soon as possible. Late entries shall be identified as a "late entry". The date and time when the entry is actually made must be included. Events described in the late entry must include the actual date and time (if available) that the event occurred.

A record must be maintained for all individuals served by the program and must contain the following information as applicable to program/service. The DMH/CCS Record Guide (2017) should be referenced for specific information regarding each form and the requirements/timelines for completion.

All Records

- Face Sheet
- Consent to Receive Services/Acknowledgement of Grievance/Rights of Individuals Receiving Services
- Grievance/Complaint Notice
- Consent to Release/Obtain Information
- Signature on File
- Medication/Emergency Contact Information
- Initial Assessment
- Trauma History
- Individual Service Plan

As Applicable

- Individual Crisis Support Plan
- Recovery Support Plan
- Progress Notes (daily, weekly)
- Periodic Staffing/Review of the ISP
- Substance Use Disorder Specific Assessment
- Initial Assessment and Crisis Contact Summary
- Medical Examination (Supervised Living/Residential)
- Documentation of Healthcare Provider Visit (Supervised Living)
- Self-Administration Medication Log (Supervised Living/Residential)
- Telephone/Visitation Agreement (Supervised Living/Residential)
- Service Termination/Change Summary
- Provider Discharge Summary
- Individual Recovery Action Plan (PSR)
- Youth/Adult Pre-Evaluation Screening
- Wraparound Facilitation Individual Support Plan (Wraparound)

IDD Services (As applicable)

- IDD Plan of Services and Supports
- IDD Activity Support Plan
- IDD Service Note
- IDD Weekly Service Note
- ID/DD Waiver/IDD CSP Service Authorization
- ID/DD Waiver Home and Community Supports Service Agreement
- IDD Employment Profile
- ID/DD Waiver Job Discovery Profile

Substance Use Services

- Risk Assessment Interview for TB/HIV/STD
- Educational Activities for TB/HIV/STD
- HIV Opt out Form
- Substance Use Disorder Transfer/Termination Form

Additional information:

- For individuals who have a legal guardian/conservator appointed by a court of competent jurisdiction, copies of the court order
- Any evaluations and diagnostic assessments

The clinical record will be organized into specific sections for ease of access and to have a defined order for chart documentation. The following outlines the sections for MH/Substance Use records and ID/DD records.

Order of the Clinical Record for Mental Health/Substance Use:

- Medical: Medication/Emergency Contact Information, nursing/doctor notes, medical exam, documentation of healthcare provider visit, self-administration medication observation log
- Progress Note: therapy progress notes, initial assessment and crisis contact summary, initial assessment, substance use disorder specific assessment
- Psychosocial Rehabilitation: IRAP Plan, PSR weekly progress note
- Day Treatment: Weekly progress notes, monthly day treatment progress note
- Consultation and Evaluation: Trauma History, Consent to Release/Obtain Information, Assessment information/data, telephone/visitation agreement, Search & Seizure Report, Pre-evaluation Screening, miscellaneous
- Targeted Case Management: Progress Notes
- Peer Support: Progress Notes
- Staffing and Treatment Plan/ISP: Individual Service Plan, Recovery Support Plan, Individual Crisis Support Plan, Periodic Staffing/Review of ISP
- Client ID: Rights of IRS, Consent to Receive Services, Acknowledgement of Grievance, Face Sheet
- Community Support Services: Progress Note

Order of the Clinical Record for Intellectual and Developmental Disabilities (as applicable to program)

- Section I: Face Sheet, Access sheet, Medication/Emergency Contact Information, Rights of IRS, Consent to Receive Services, Eligibility Certificate, Signature on File, Copy of Insurance Cards
- Section II: Intake and History, Social History, Evaluation Data, Medical Examination Report, Assessment of Intellectual/Adaptive Functioning, Other Pertinent Reports
- Section III: Service Authorizations, IDD Plan of Services and Supports, IDD Activity Plan
- Section IV: IDD Service Note and Weekly Service Note, Monthly Attendance Logs, Medicaid Claims Forms
- Section V: Serious Incident Reports, Provider Discharge Summary, Termination/Change Summary
- Section VI: Consent to Release/Obtain Information, Acknowledgement of Grievance, Waivers, Miscellaneous

Other: In addition to applicable standards, programs certified and/or funded by DMH must comply with any additional specifications set forth in individual program grants/contracts and with the requirements outlined in the DMH Record Guide. In

addition, providers must maintain current and accurate data for submission, within established time frames, according to DMH Manual of Uniform Data Standards.

Mississippi Operational Standards addressed: Rule 2.5D,E 16.8D-F

Section:	Medical Records
Policy:	Filing Case Notes/Medical Record Documentation
Policy No:	MR 07
Effective:	03/30/1995
Revised/Approved:	03/28/2017

POLICY: It is the policy of Community Counseling Services that the medical records department files all documentation in the medical record.

PURPOSE: To ensure consistency in the filing of documentation.

PROCEDURE: The Office Manager/Medical Records Technician will locate the proper chart, using the name and case number (if available) of the individual receiving services. In situations where the case number is not provided, other identifying information, such as social security number or date of birth, will be used to ensure documentation is filed in the correct medical record. The OM/MR Technician will determine in which section the information should be filed. For progress notes, the service code listed on the note and/or the service provided will determine what section the progress note should be filed in. Each note shall be reviewed for a date, service provided, time, and signature with appropriate credentials before filing. If the note is deficient in any of these areas, the note is to be returned to the service provider for completion.

Section: Medical Records
Policy: Maintaining Signatures on Individual Service Plans
Policy No: MR 08
Effective: 10/31/1995
Revised/Approved: 03/28/2017

POLICY: In accordance with DMH Record Guide and Division of Medicaid's Administrative Rule #206, all services must be included on the individual service plan (ISP) and must be approved by a licensed independent practitioner in accordance with the appropriate scope of practice. These practitioners include a Mississippi licensed Physician who holds a specialty in psychiatry, a Mississippi licensed physician with minimum of five (5) years' experience in mental health, a Mississippi licensed Psychologist, a Mississippi Licensed Certified Social Worker (LCSW), a Mississippi Licensed Professional Counselor (LPC), a Mississippi Licensed Marriage and Family Therapist (LMFT), a Psychiatric Mental Health Nurse Practitioner under an approved protocol, or a Physician Assistant. It is the policy of Community Counseling Services that the individual service plan of each individual receiving services will be signed by an approved practitioner indicated above within thirty (30) days of intake and every year thereafter.

PURPOSE: To ensure that each initial and updated individual service plan is reviewed and signed by an approved practitioner.

PROCEDURE: The Medical Records department will be responsible for preparing/having ready all charts/ISP's to be signed by an approved practitioner the day before their next scheduled office visit/clinic.

New Admissions/Readmissions: Charts that are newly opened or reopened will be filed in the staffing drawer located in the medical records department until they are staffed. The OM/MR Technician will make available the charts that are needed for staffing. Once the individual service plan is staffed, it will be turned in to medical records. The OM/MR Technician will tab the individual services plans that need signed by an approved practitioner (see Policy Section). The charts that are tabbed will then be placed in a drawer designated for charts that need to be reviewed/signed.

Annual updates: A report of charts that are due for an annual recertification will be sent to the counselor of record, as well as, the County Administrator/Supervisor each month. Once the individual service plan is updated and staffed, it will be turned in to medical records. The OM/MR Technician will tab the individual services plans that need signed by an approved practitioner (see Policy Section). The charts that are tabbed will then be placed in a drawer designated for charts that need to be reviewed/signed.

Mississippi Operational Standards addressed: 16.9A,B; DMH Record Guide