

4A051, Module 4, Records Management



- ≡ Lesson 1: Release of Information and Health Insurance Portability and Accountability
- ≡ Lesson 2: Outpatient Health Records Management
- ≡ Lesson 3: Outpatient Health Records Duties
- ≡ Lesson 4: Service Treatment Record (STR)

Lesson 1: Release of Information and Health Insurance Portability and Accountability

Click the video below to continue our journey!



After completing this lesson, the student will be able to apply the release of information, health insurance portability, and accountability act (HIPAA) procedures, in accordance with (IAW) prescribed guidance and publications.





Fundamentals

HIPAA was enacted on August 21, 1996. The purpose of the Act is to improve the portability and continuity of health insurance coverage, improve access to long term care services and coverage, and to simplify the administration of healthcare. A primary component of HIPAA is the protection and privacy of individually identifiable health information. The HIPAA privacy rule governs this component and Department of Defense Manual (DoDM) 6025.18-R implements the requirements.



NOTE: HIPAA is covered under Public Law 104-191, 45 Code of Federal Regulations (CFR), parts 160 and 164.

***Some of the HIPAA privacy rules that you
will be involved with are:***

1

Use of information. Patient's protected health information can only be used for treatment, payment and health care operations without written authorization from the patient or other disclosures required by law.

2

Disclosure or release. Records can be disclosed for various reasons without authorization by the patient. Complying with a subpoena, court order, or public health requirement, as well as specific national security requirements are among the allowed disclosures.

3

Accounting of disclosure. The patient can request an accounting of every disclosure for the previous 6-year period back to 14 April 2003. This is limited to disclosures that are not part of treatment, payment, health care operations or disclosures authorized by the patient.

4

Restrictions on information. According to HIPAA and Military Health System (MHS) notice of privacy practices, a patient has the right to request restrictions of uses and disclosures of their medical or dental information. Requests for restrictions must be made in writing. If granted, the patient should be informed that the restriction is not permanent and only applies to the individual or military treatment facility (MTF) that grants the request for which it is requested and does not transfer to another individual or MTF.

Privacy Act



The Privacy Act

Fundamentals

The intent of the Privacy Act, established in 1974, is to protect personal information that can be used to distinguish or trace an individual's identity. This type of information is defined as personal information, which if lost, compromised or disclosed without authorization, could result in substantial harm, embarrassment, inconvenience, or unfairness to an individual. Some categories of personally identifiable information (PII), when maintained by the Department of the Air Force, are sensitive as stand-alone data elements.



The Privacy Act applies to all establishments, not just medical facilities. PII is the term used to identify this type of information.




Did you know?

It's important to distinguish the difference between personal health information (PHI) which is protected under HIPAA and PII which is protected under the Privacy Act. Both types of information are considered sensitive and should be protected from accidental release or hostile retrieval.

PHI may be a patient's social security number and the reason for appointment or diagnosis. PII may be the member's social security number (SSN) only. Both can be traced and identify a specific person, but only one set of data can give the viewer health information as well.

Now that you're familiar with the HIPAA and Privacy Act, let's discuss how it enables the DoD to protect medical records.

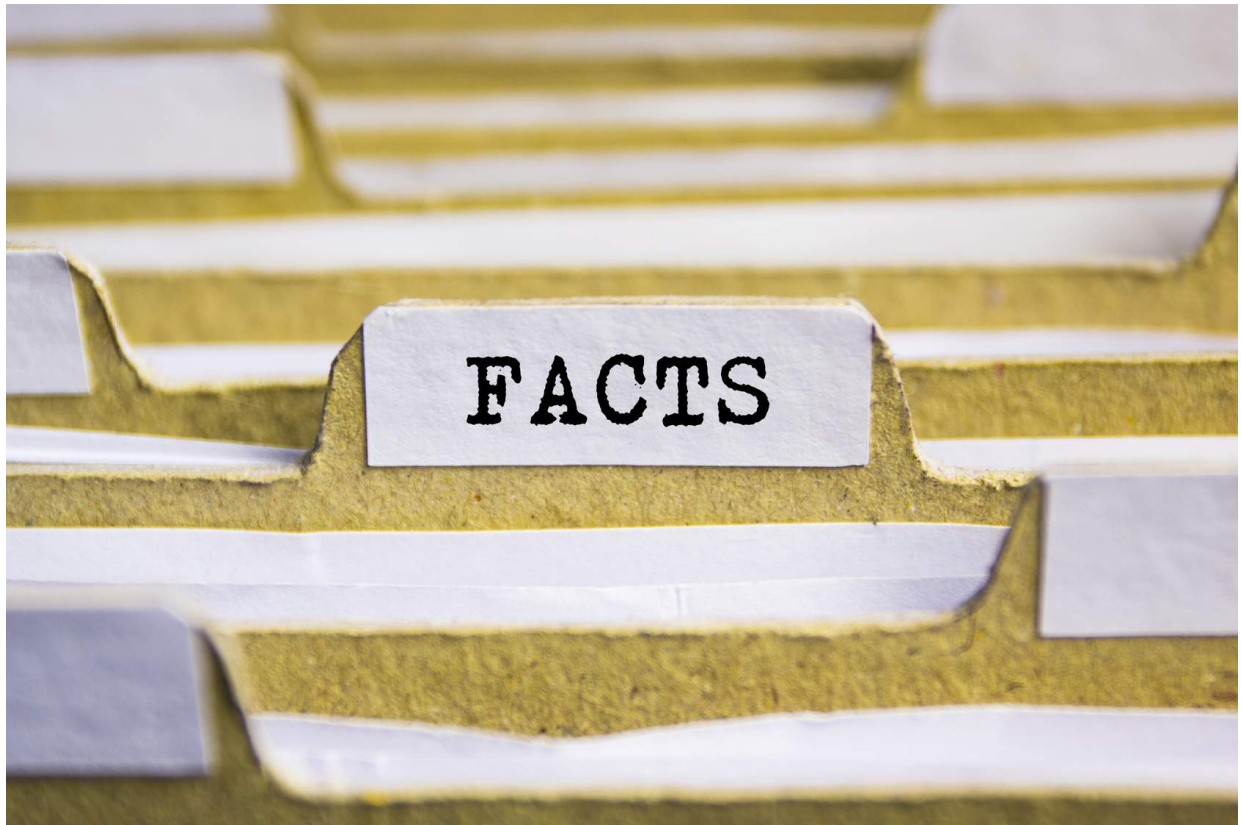


DoD Policy On Custody and Control of Medical Records

Did You Know?

- Beneficiary health records are the property of the United States Government.
- The information contained in the record belongs to the patient.
- Records are maintained in accordance with the Privacy Act and HIPAA.
- The patient has the right to the information in the record.

- Patients or their guardians may request a copy of the information in the record.





Hybrid Records

In the DoD, an outpatient record is considered "hybrid." This means that some records are kept as a hard copy, and the rest is on an electronic health record platform. For example, an active-duty member that entered the Air Force in 2006 would have started their career with a hard copy record which must be maintained, but after a certain point in their career the rest of their record would be solely electronic.

Hard Copies

You may notice in your MTF that most patients no longer have hard copy records, and if they do, the records aren't referenced. Although, we've come a long way in transitioning to electronic records, this does not remove the responsibility of maintaining the hard copy records for all patients. Your MTF will have a policy and process that prevents any patient from hand carrying their hard copy record.



When a patient moves to a new base or medical facility, it's the responsibility of the record room staff to mail the hard copy record to the new MTF.



Medical Record Copies

If a patient requests to remove the medical record from the medical facility, MTF personnel are required to inform the patient of the DoD policy **prohibiting** patients from hand-carrying their record(s). A patient may request *copies* of any necessary paperwork from the outpatient, inpatient, dental records, other paper or electronic health record required to ensure adequate medical reference and continuity of care between the MTF and the external provider or civilian medical facility.



NOTE: Copies are provided free of charge. However, unless specifically requested by either the referring or accepting physician, do *not* copy the *entire* medical or dental record.

Laws and Regulations

Another unique requirement of your position is understanding the release of information laws and regulations for outpatient records and other specialty clinic records. For instance, you may not be responsible for releasing mental health records, but you should be familiar so that you may inform a patient or third party of the correct process.



You may find that the outpatient records room becomes the main focal point for any release of information question!



Release of Information

Drug Abuse Offense and Treatment Act, and Comprehensive Alcohol Abuse Amendments

You must understand the laws governing these acts because they contain very specific instructions pertaining to the confidentiality of information in drug and alcohol abuse records. The drug and alcohol laws take precedence over other directives pertaining to access and release of medical information. Health records (inpatient and outpatient) that contain reference to drug or alcohol abuse or rehabilitation are reviewed by the Staff Judge Advocate (SJA) for a determination of releasability and for guidance on the nature of the reply.

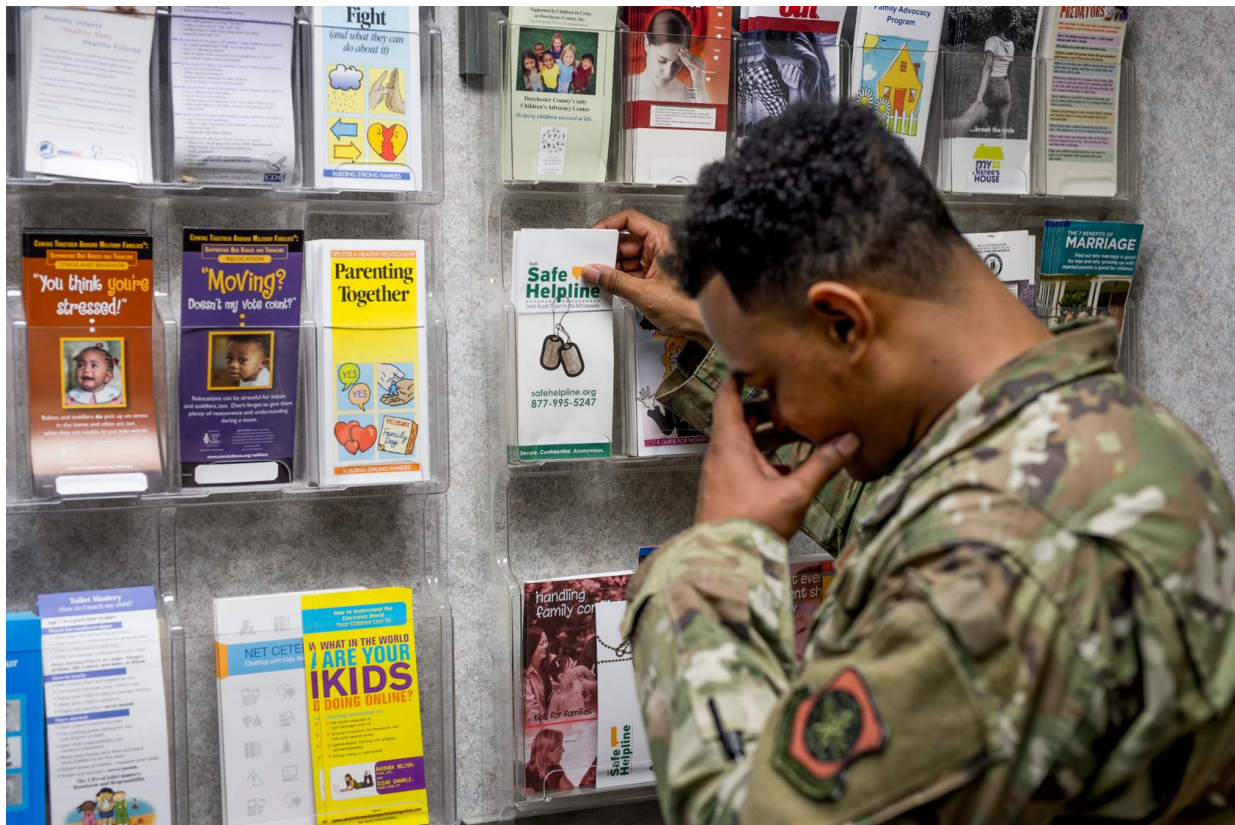
If it is determined that the record is not releasable under the drug and alcohol abuse acts, the requester is informed that release of the requested record is prohibited by law. If only a portion of the record is not releasable, the portion which can be released is provided, and the requester is informed that the records released are all that are allowed to be released under the law. The patient or their legal representative must give specific authorization in writing before information pertaining to drug and alcohol abuse or rehabilitation can be released from a health record.



Records that contain information from specialty clinics, such as mental health, are different standard records. However, there are some exceptions to restrictions.

Information in drug and alcohol abuse related records may be released under the following conditions:

- 1 Within the armed forces or between the Air Force and those components of the Veterans Administration furnishing health care to veterans.
- 2 To medical personnel to the extent necessary to meet a bona fide emergency.
- 3 To qualified persons for specific research, management, and financial audits or program evaluation.
- 4 By an appropriate court order of competent jurisdiction after application showing good cause. On the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, imposes appropriate safeguards against unauthorized disclosure.



Sensitive Medical Information

If a provider determines that direct disclosure to the patient could have an adverse effect on either the physical or mental health, safety, or welfare of the individual, or other persons with whom the patient may have contact, the disclosure will be made to a healthcare provider named by the individual, or to a person qualified to make psychiatric or mental health determinations. Healthcare providers may recommend ways of disclosing health records other than by direct patient access.

A healthcare provider may elect to disclose information on specific diagnoses of terminal illness or psychiatric conditions to a patient's designated representative, and not directly to the patient, with the patient's concurrence.

To protect the sensitive nature of the information, stamp records or documents “SENSITIVE MEDICAL INFORMATION” before release or referral outside the medical facility. Then, place them in a sealed envelope stamped “MEDICAL INFORMATION—FOR USE BY AUTHORIZED PERSONNEL ONLY.”



Click each tab below to learn more about safeguarding and releasing medical information.

Information in the health record is personal to the individual and must be safeguarded properly. Access to health records is restricted to authorized medical service personnel except in certain situations discussed in this lesson. Before releasing information to medical personnel, be sure their access to those records is authorized and necessary in the performance of their duties.

For instance, your suspicions should be aroused if an Airman from the medical equipment repair section requests a patient's medical record. If a request seems out of the ordinary or unrelated to the requester's normal duties, ask the person some questions and refer any suspicions you have to your supervisor.



Limit access to all open record storage areas and to electronic records to authorized personnel only. Authorized personnel are defined as personnel who, through a verification process, have presented a valid requirement to access said records. Personnel granted access must be fully aware of the requirements on safeguarding PHI maintained in the MTF.

Except under certain conditions, do not release information from medical records to any person or agency without the written consent of the person concerned (patient) or the patient’s legal representative. A spouse cannot sign to release information from their partner’s medical record. There are some specific exemptions, but most often patients who are 18 or older must sign their own request.



SAFEGUARDING AND RELEASING MEDICAL INFORMATION	SAFEGUARDING PRACTICES	RELEASING MEDICAL INFORMATION
<p>As you are aware by now, almost every activity in your career field has a set of procedures for you to follow. Releasing medical information is no exception. Because this is a very sensitive area, with implications for legal issues, you need to be very familiar with the guidelines.</p>		

There are some occurrences in which you are not required to have the patient's approval before releasing information. The three most common requests are continued treatment, payment for care, and healthcare operations. For instance, a primary care manager (PCM) in your facility may contact a local emergency room (ER) physician to transfer care of a patient. The PCM at your facility does not need to get approval from the patient prior to calling the ER physician and discussing continued care.



CONTINUE

If patients would like a copy of their medical information released, they need

**to complete a DD Form 2870,
*Authorization for Disclosure of Medical or
Dental Information.***

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION**PRIVACY ACT STATEMENT**

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.

AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.

PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.

ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.

DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.

This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)		5. TYPE OF TREATMENT (X one) <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT <input type="checkbox"/> BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO: (Name of Facility/TRICARE Health Plan)	
a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS (Street, City, State and ZIP Code)
c. TELEPHONE (Include Area Code)	d. FAX (Include Area Code)
7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable) <input type="checkbox"/> PERSONAL USE <input type="checkbox"/> CONTINUED MEDICAL CARE <input type="checkbox"/> SCHOOL <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> INSURANCE <input type="checkbox"/> RETIREMENT/SEPARATION <input type="checkbox"/> LEGAL	
8. INFORMATION TO BE RELEASED	
9. AUTHORIZATION START DATE (YYYYMMDD)	10. AUTHORIZATION EXPIRATION DATE (YYYYMMDD) <input type="checkbox"/> ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:

a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.

b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.

d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT (If applicable)	13. DATE (YYYYMMDD)
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SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

14. X IF APPLICABLE: <input type="checkbox"/> AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE (YYYYMMDD)
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE		SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:



There will be times that you receive a request that is not on the DD Form 2870, and that is okay if it meets the basic requirements listed in the table below:

Patient signature and date	Description of the information to be released	The name/organization authorized to release the information
Written in plain language	The name/organization	The individual's right to revoke the

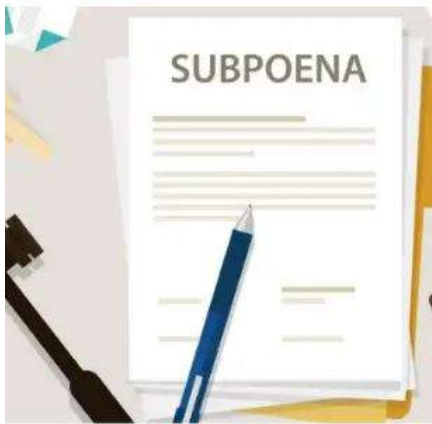
	authorized to make the request	authorization in writing
Purpose of the request	The name/organization where the information is going	An expiration date for the authorization

CONTINUE

Honoring Requests for Medical Information

When you receive a request for information, provide only enough information to accomplish the purpose for which the information is requested. For example, if an insurance company specifically requests information on an injury a patient received in a car accident two months ago, you may release their initial appointment notes and physical therapy, but not an appointment for a referral to a gastroenterologist. When information is released to a third party (such as insurance companies, civilian physicians, etc.), further release is not authorized without the consent of the patient, his or her legal representative, or the agency having records responsibility.

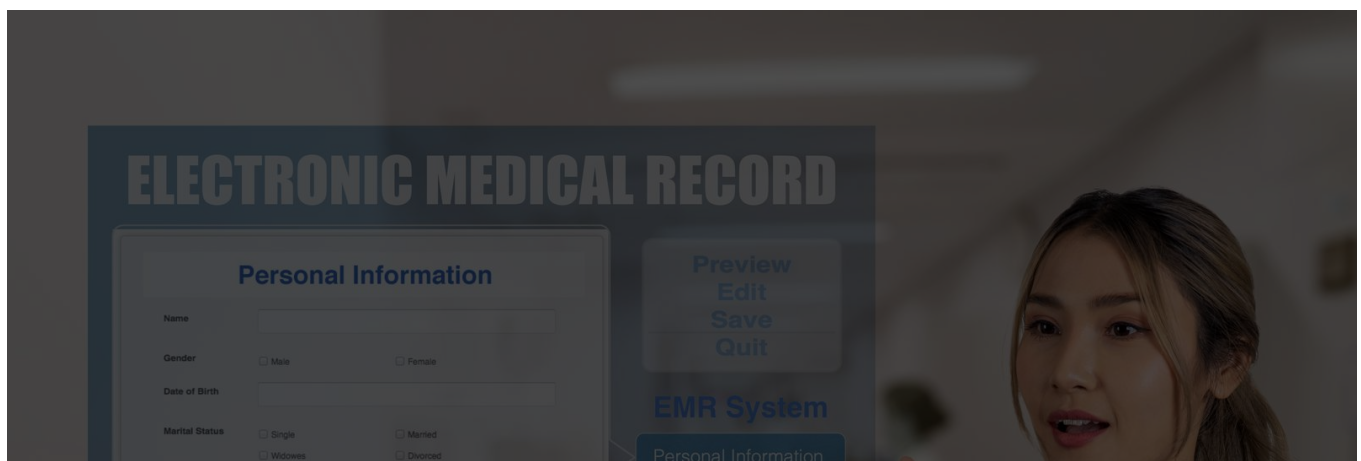
This is where it's important for you to understand the laws, policies, and procedures governing the maintenance use, and release of health records and medical documents. Often you will find that requests which require the patient's approval are sent to the records section with the necessary signatures, so you may release the medical information needed. However, if there is any doubt as to whether the requester has proper or legitimate need for the information, or does not provide a signed release, you will inform the requester that information is being withheld until written consent of the patient is furnished.



A medical patient may also be a member of the MTF workforce as active duty (AD), reservist, civilian, or contractor.



NOTE: MTF workforce members should not be accessing health record systems to obtain copies of their own medical records. They should request copies in the same manner as any other patient.





Release Medical Information Electronically

***The patient can elect to receive their records
by unencrypted/unsecured e-mail or to
another individual designated by the patient.***

Documentation of patient permission to send and receive medical information via electronic communication should be maintained in the medical records or tracked internally in a Release of Information tracking binder/spreadsheet for future requests. A patient may elect to receive their information via the DoD SAFE website (pictured below). You can access the site by visiting <https://safe.apps.mil/>. This site is DoD approved for transmittal of PII and PHI.

You will undoubtedly have to use a fax machine to transmit information to doctor offices within the area surrounding your facility. Although using a fax machine may seem like outdated technology, it's a secure way to send small packages of information until the MHS and civilian providers can transmit information in a different way. Your MTF will have fax coversheets to use on top of any medical documents before sending. This ensures proper information safeguarding on the receiver's end.

← → ↻ safe.apps.mil

This information system is approved for CUI and PII/PHI data

DoD SAFE

Logged on as user: GUIDRY
Email: @us.af.mil
Last Login:

Home Drop-Off Request a Drop-Off Pick-up Outbox Help Logout

< < Until further notice, recipients should utilize the 'Download All Files' or 'Download Selected Files' button to download files. > >
– Clicking the filename may result in an 'Invalid Response' error message. –
– Software Engineers are investigating the issue and once a fix action has been implemented, this banner will be removed. –

Announcements

New features in DoD SAFE 1.7 such as:

- Improved user guide now available directly on SAFE website.
- Expired drop-offs can be viewed.
- Subset of files in a drop-off can be downloaded in a zip.
- Selected recipients can be re-sent a drop-off.
- Drop-off screen UI enhancements to streamline file drop-off process.

Drop-off
Upload files to send to others

Request a Drop-off
Ask for files to be sent to you

Pick-Up
Download files sent to you

Outbox
View Drop-off details

Help
Get help using DoD SAFE

FAQ Quick Clicks

- How secure is DoD SAFE?
- Can SAFE be used for backup storage?
- What if my email address was recently changed and I am having issues logging into DoD SAFE?
- Why is my CAC not working?
- Why is my PIV not working?
- How do I send files?
- What kind of files can I send?
- How long are Drop-offs active?

**Send and receive up to CUI/PII/PHI files (up to 8 GB total)
using Department of Defense (DoD) Secure Access File Exchange (SAFE)**

Specific Requests and Laws Governing Requests

It is important to become familiar with some of the more common situations that may arise if/when you become responsible for the release of information at your MTF. If you work with release of information long enough, situations will arise that you have not yet encountered. Discuss the situation with your supervisor, or consult your HIPAA officer.

Complying with Air Force directives and laws are critically important!

Always remember to research the facts before you release medical information.



Click each tab below to learn more about unique request scenarios you may be faced with.

DoD Investigative Agencies —

If the information or access to health records is to be provided to nonmedical personnel with a proper and legitimate need, such as Air Force Office of Special Investigations (AFOSI) agents. Special agents are granted access to health records when proper identification is provided.

The agent must sign a dated statement which contains the information listed below:

- Identity of the patient whose record requires examination.
- Identity (file number) of the investigation.
- Certification by the agent that the information in the record is required for an official investigation.
- Identification of any copies of material furnished to or copied by the agent, and a signed receipt.

The request should be reviewed and approved by the HIPAA officer prior to disclosing any information; like all other requests, you will only release the requested information. Special agents should seek an interview with a health care provider when clarification or interpretation of medical documentation is necessary.

NOTE: Do not file the statement in the patient's health record. Maintain the statement in a separate folder in the general correspondence files until the investigation is concluded. At that time, annotate disclosure in the disclosure accounting system.

Although OSI has the right to seize government records for investigation, agents will not seize original medical records without SJA written approval. If such approval is received, copies of the seized records will be left with the medical facility. In all but very few exceptions, giving OSI a certified true copy of the original records will suffice.

Release to United States (US) Government Branches —

Due to the unique requirements in the military, patient's medical information may be disclosed to their leadership (first sergeant or commander). Consult with your HIPAA Officer before releasing information to any person within a patient's chain of command.

This information can be used for commanders to determine the individual's fitness for duty, fitness to perform any mission, joint medical surveillance, and reporting casualties. Information released must be balanced with the sensitive nature of PHI and will be limited to the minimum information necessary.

NOTE: Authorization by the individual or the opportunity to agree or object to the disclosure is not required.

Other Departments or Agencies —

Medical information is released upon request, to other departments and agencies, both federal and state, that have a proper and legitimate need for the information.

For example:

- Release protected health information to federal and state hospitals and prisons for further medical treatment of a person in their custody. Give the first sergeant or prisoner escort the original health records of active-duty members when processing a patient to go to a corrections facility.
- Release protected health information to the Occupational Safety and Health Administration (OSHA) to help detect, treat, and prevent occupational injuries and diseases.
- Release the protected health information of foreign military personnel to their appropriate foreign military authority.
- Release protected health information upon the request of medical research or scientific organizations or other qualified researchers when, in the opinion of the releasing authority, its release is legal and in the public interest. This also includes release of information to present or former members of the uniformed services who need it for private study or research to advance their professional standing. Where possible, de-identify the records by removing names and SSNs of individuals and other unnecessary demographic information. Counsel the researcher that the information must be held in confidence and that any published reports must not identify, in any way, the individuals whose health records were examined. Do not release the information when reproducing the information would be a burden or if it violates existing laws.

NOTE: All disclosures of information must be documented in the medical record or the automated disclosure tracking system.

CONTINUE

Knowledge Check. Input and submit your answer in response to the statement below.

Beneficiary health records are the property of the _____ while the information contained in the record belongs to the patient.

Type your answer here

SUBMIT

Knowledge Check. Select and submit the best option in response to the question below.

Which form is used to allow release of medical information?

-
- ☐ DD Form 988
 - ☐ Standard Form (SF) Form 570
 - ☐ Air Force (AF) Form 341
 - ☐ DD Form 2870

SUBMIT

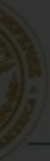
Knowledge Check. Select and submit the best option in response to the statement below.

Information or access to health records can be provided to nonmedical personnel with a proper and legitimate need, and when proper identification is provided.

- ☐ True
- ☐ False

SUBMIT

CONTINUE



U.S. Department of Defense
Military Health System

i DENTITY
AUTHENTICATI
SERVICES

Website has been Public Key Enabled

FOR DO NOTICE AND CONSENT BANNER

Processing a U.S. Government (USG) Information System (IS) that is provided for USG-authorized use only.

By using this IS (which includes any device attached to this IS), you consent to the following conditions:

USG routinely intercepts and monitors communications on this IS for purposes including, but not limited to, penetration testing, COMSEC monitoring, network operations, personnel misconduct (PM), law enforcement (LE), and counterintelligence (CI) investigations.

At any time, the USG may inspect and seize data stored on this IS.

Communications using, or data stored on, this IS are not private, are subject to routine monitoring, interception, and search, and may be disclosed or used for any USG purpose.

This IS includes security measures (e.g., authentication and access controls) to protect USG interests not for your personal benefit or privacy.

Notwithstanding the above, using this IS does not constitute consent to PM, LE or CI investigative searching or monitoring of the content of privileged communications, related to personal representation or services by attorneys, psychotherapists, or clergy, and their assistants. Such communications and work product are privileged. See User Agreement for details.

Protected Health Information Management Tool (PHIMT)



Accounting for Disclosure

A patient may request an accounting of every disclosure for the previous 6-year period. This does not include uses of PHI for treatment, payment, or healthcare operations. If you recall earlier in this lesson, we discussed HIPAA and factors to remember when releasing health information.

Some key points to keep in mind are:

- 1** When you receive a request for information, only provide enough information to satisfy the request.
 - 2** When in doubt, do not release any information until the patient's written consent is received.
 - 3** Patients or third parties may request to have documents sent electronically, you may only use approved modes of transmission.
-

If you're unsure of a request, discuss it with your HIPAA privacy officer or non-commissioned officer in charge (NCOIC).

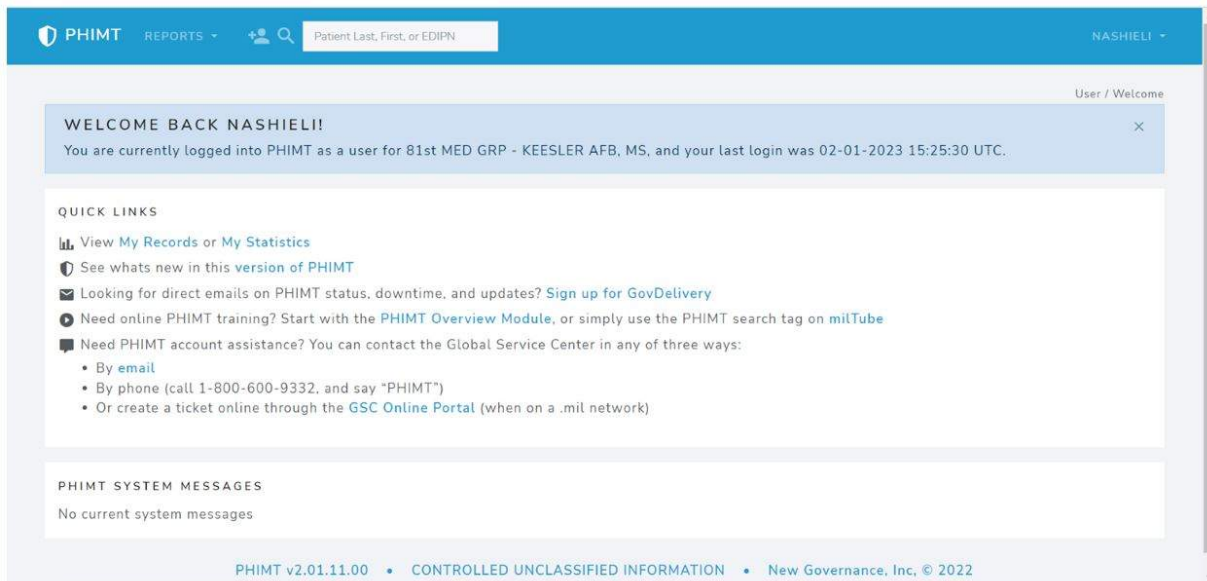
Unless you have been directed otherwise in accordance with local guidance, you should document all release of information in PHIMT.



Click the steps below required to enter a disclosure in PHIMT (*click the images to zoom*).

Step 1

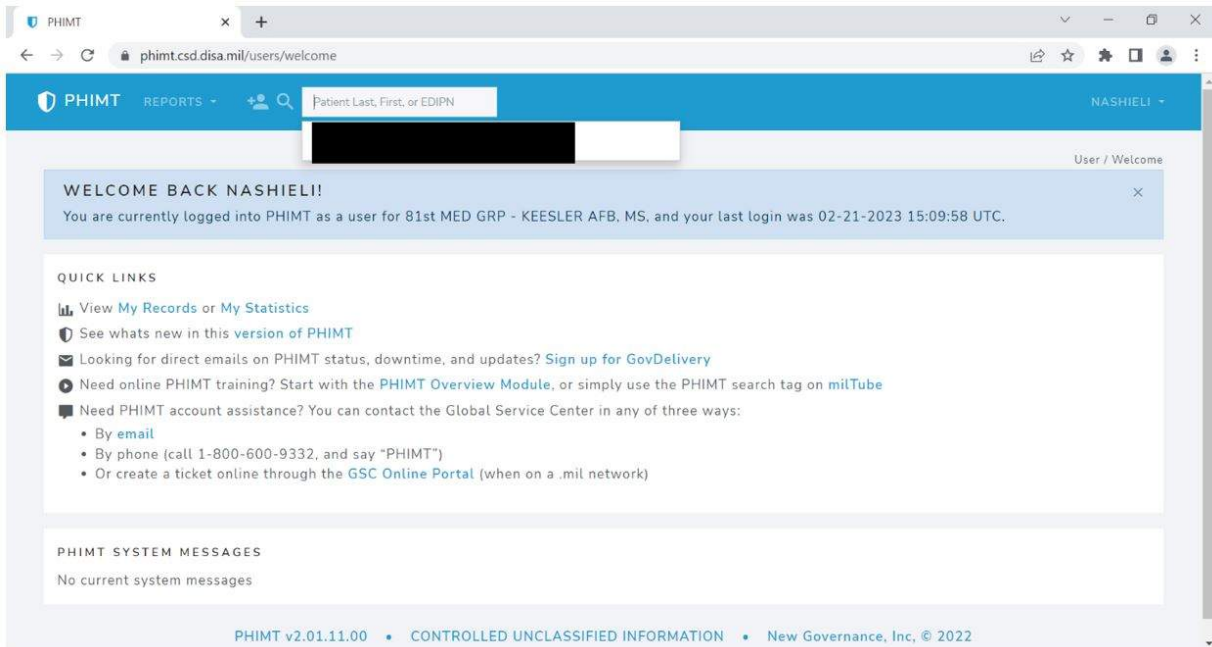
Log In



Log into your PHIMT account (phimt.csd.disa.mil).

Step 2

Enter Information



Enter in the patient information and search.

Step 3

Summary Screen

The screenshot displays the PHIMT Patient Summary interface. The browser address bar shows the URL: `phimt.csd.disa.mil/patients/94197b4cabef0164e053d631f70c3bc9/summary`. The page header includes the PHIMT logo, a "REPORTS" dropdown, a search bar with the text "Patient Last, First, or EDIPN", and a user profile icon labeled "NASHIELI".

The main content area is titled "PATIENT SUMMARY" and features a tabbed interface with the following tabs: "Releases", "Release Authorizations", "Accountings", "Restrictions", "Suspensions", "Complaints", and "Documents". The "Releases" tab is currently selected.

Below the tabs, there are two input fields: "Status" (with a dropdown menu showing "All") and "Recipient" (with a text input field labeled "Recipient Name").

The results section shows "Showing 0 Releases". Below this is a table with the following columns: "ACTIONS", "STATUS", "DATE", "TYPE", "RECIPIENT", "ORIGINATOR", and "ORGANIZATION". The table is currently empty, displaying "No Releases found".

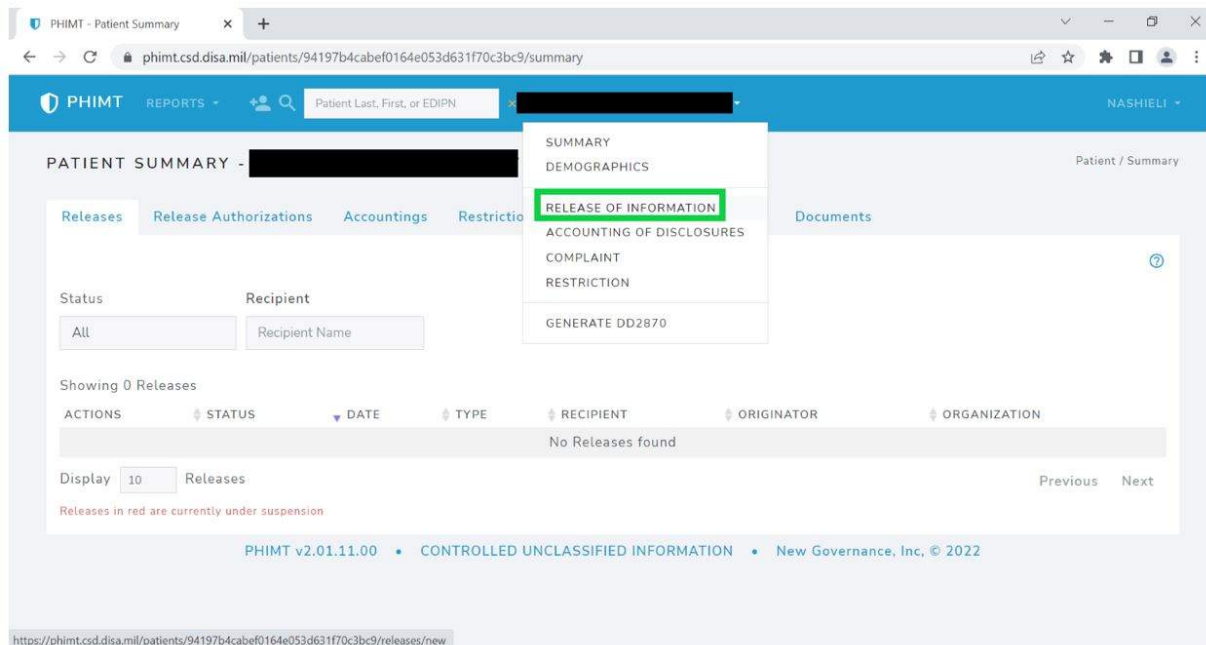
At the bottom of the results section, there is a "Display" dropdown set to "10" and a "Releases" label. To the right are "Previous" and "Next" navigation links. A small note at the bottom left states: "Releases in red are currently under suspension".

The footer contains the text: "PHIMT v2.01.11.00 • CONTROLLED UNCLASSIFIED INFORMATION • New Governance, Inc., © 2022".

After searching for the patient, the summary screen will be presented.

Step 4

Release of Information



Click on the drop-down menu next to the patient's name and select release of information.

Step 5

Reason for Release

PHIMT - Patient Release of Information

phimt.csd.disa.mil/patients/94197b4cabef0164e053d631f70c3bc9/releases/new

CREATE NEW PATIENT RELEASE OF INFORMATION

Patient / Release of Information

Release Timeline

RELEASE OF INFORMATION DETAILS

*Release Type

- About Decedents
- As Required by Law**
- Avert Serious Threats to Health or Safety
- Specialized Government Functions - Disclosures to Command Officials
- Judicial and Administrative Proceedings
- Cadaver Organ, Eye, or Tissue Donation Purposes
- Victims of Abuse, Neglect, or Domestic Violence
- Inmates in Correctional Institutions or in Custody
- Workers Compensation
- Research Purposes
- Public Health Activities
- Health Oversight Activities
- Specialized Government Functions - Other
- About Decedents
- Law Enforcement Purposes
- Specialized Government Function - Separation or Discharge from Military Service
- Treatment Purposes
- Legal
- Disability - VA
- Disability - Social Security Administration
- Disability - Commercial

SELECT RELEASE TYPE

on, determining a cause of death, or other duties as authorized by law.
cedent.
f Disclosures requests.

= more than once and recurring).

Choose the reason for release of information.

Step 6

Enter the Request Details

The screenshot shows a web browser window with the URL `phimt.csd.disa.mil/patients/94197b4cabef0164e053d631f70c3bc9/releases/new`. The form is titled "PHIMT - Patient Release of Information" and contains the following sections:

- *Origin Organization**: A text field containing "81st MED GRP - KEESLER AFB, MS". Below it is a small text label: "The hospital, clinic, etc. from which the release originates."
- *Release Frequency**: Two radio buttons. "Single Release" is selected. Below it is a small text label: "The frequency of the release (Single Release = only once, Multiple Releases for the Same Purpose = more than once and recurring)."
- *Request Format**: A dropdown menu is open, showing options: "Phone", "Postal Mail", "Commercial Carrier", "Secure Electronic", "Fax", "Paper", "In Person", and "Military Command Authority".
- *Request Date**: A date picker field showing "02-21-2023". Below it is a small text label: "The date of the request."
- *Delivery Date**: A date picker field showing "02-21-2023". Below it is a small text label: "The delivery date of the release data."
- Information Released**: A section with checkboxes for "Complete Health Record(s)", "Operative Reports(s)", "History and Physical Examination(s)", "Progress Note(s)", "Discharge Summary", "Consultation Report(s)", "Pathology Report(s)", and "Laboratory Test(s)". There is also an "Other:" label followed by a text area.
- Optional Comments or Notes**: A text area at the bottom of the form.

A small text label at the bottom of the "Information Released" section reads: "A description of the released PHI data. Select one or more checkboxes, and/or input an 'Other' description of the PHI data."

Enter in the request details, all data entry points with an asterisk are required.

Step 7

Enter the Request Details (continued)

The screenshot shows a web browser window with the URL phimt.csd.disa.mil/patients/94197b4cabef0164e053d631f70c3bc9/releases/new. The form is titled "PHIMT - Patient Release of Information" and is for a new release request.

***Origin Organization**
81st MED GRP - KEESLER AFB, MS
The hospital, clinic, etc. from which the release originates.

***Release Frequency**
☒ Single Release ☐ Multiple Releases for the Same Purpose
The frequency of the release (Single Release = only once, Multiple Releases for the Same Purpose = more than once and recurring).

***Request Format**
Paper
The format of the request.

***Request Date**
02-21-2023
The date of the request.

***Delivery Format**
A dropdown menu is open, showing options: Phone, Postal Mail, Commercial Carrier, Secure Electronic, Fax, Pickup, History and Physical Examination(s), and Progress Note(s).

***Delivery Date**
02-21-2023
The delivery date of the release data.

Information Released
A description of the released PHI data. Select one or more checkboxes, and/or input an "Other" description of the PHI data.

<input type="checkbox"/> Discharge Summary	Other: <input type="text"/>
<input type="checkbox"/> Consultation Report(s)	
<input type="checkbox"/> Pathology Report(s)	
<input type="checkbox"/> Laboratory Test(s)	

☐ History and Physical Examination(s)
☐ Progress Note(s)

Optional Comments or Notes

Enter in the request details, all data entry points with an asterisk are required.

Step 8

Enter the Request Details (continued)

PHIMT - Patient Release of Information

phimt.csd.disa.mil/patients/94197b4cabef0164e053d631f70c3bc9/releases/new

***Delivery Format**
Fax

***Delivery Date**
02-21-2023

The delivery format of the release data. The delivery date of the release data.

***Description of Protected Health Information Released**

☐ Complete Health Record(s)
☐ Operative Reports(s)
☐ History and Physical Examination(s)
☐ Progress Note(s)
☐ Discharge Summary
☐ Consultation Report(s)
☐ Pathology Report(s)
☒ Laboratory Test(s)

Other: RECENT LABWORK FROM 01JAN23-21FEB23

A description of the released PHI data. Select one or more checkboxes, and/or input an 'Other' description of the PHI data.

Optional Comments or Notes

Internal comments for this release. These are NOT included in any patient reports.

RECIPIENT DETAILS

Use the Current Patient or an Existing Recipient

CURRENT PATIENT RECIPIENT SEARCH CLEAR RECIPIENT FIELDS

Use the Current Patient button to select the current patient as the recipient, or use the Recipient Search button to find and reuse an existing recipient. For a new recipient, enter the recipient details in the fields below (including recipient name, type, contact name, phone, and address). Use the Clear Recipient Fields button to clear the recipient fields and start over.

Enter in the request details, all data entry points with an asterisk are required.

Step 9

Enter the Request Details (continued)

PHIMT - Patient Release of Information

phimt.csd.disa.mil/patients/94197b4cabef0164e053d631f70c3bc9/releases/new

***Delivery Format**
Fax
The delivery format of the release data.

***Delivery Date**
02-21-2023
The delivery date of the release data.

***Description of Protected Health Information Released**

☐ Complete Health Record(s)
☐ Operative Reports(s)
☐ History and Physical Examination(s)
☐ Progress Note(s)

☐ Discharge Summary
☐ Consultation Report(s)
☐ Pathology Report(s)
☒ Laboratory Test(s)

Other:
RECENT LABWORK FROM 01JAN23-21FEB23

A description of the released PHI data. Select one or more checkboxes, and/or input an 'Other' description of the PHI data.

Optional Comments or Notes
COMPLETED BY: A1C VAZQUEZ
Internal comments for this release. These are NOT included in any patient reports.

RECIPIENT DETAILS

Use the Current Patient or an Existing Recipient

CURRENT PATIENT RECIPIENT SEARCH CLEAR RECIPIENT FIELDS

Use the Current Patient button to select the current patient as the recipient, or use the Recipient Search button to find and reuse an existing recipient. For a new recipient, enter the recipient details in the fields below (including recipient name, type, contact name, phone, and address). Use the Clear Recipient Fields button to clear the recipient fields and start over.

Enter in the request details, all data entry points with an asterisk are required.

Step 10

Enter the Request Details (continued)

PHIMT - Patient Release of Information

phimt.csd.disa.mil/patients/94197b4cabef0164e053d631f70c3bc9/releases/new

Use the Current Patient button to select the current patient as the recipient, or use the Recipient Search button to find and reuse an existing recipient. For a new recipient, enter the recipient details in the fields below (including recipient name, type, contact name, phone, and address). Use the Clear Recipient Fields button to clear the recipient fields and start over.

***Recipient Name** ***Recipient Type**

MEMORIAL GULFPORT AT GULFPORT Civilian Hospital

The recipient of the patient's information. This is the name of the physician, facility, health plan or other third party that will receive the information. The type of recipient.

Recipient Contact **Recipient Email Address** **Recipient Phone**

DR. NASHIELI

Optional recipient email address.

228-376-4742

The full name of the contact person if the recipient is an organization, or if the contact person is different than the recipient e.g. John Doe, etc. Optional recipient phone number.

Recipient Address Line 1 **Recipient Address Line 2**

287 FISHER ST

The address of the recipient. An optional address line 2 for the recipient.

Recipient City **Recipient Country** **Recipient State** **Recipient Postal**

GULFPORT

Mississippi (MS)

39504

Military options also include APO, FPO, and DPO.

***Recipient Identity Verification** **Other:**

Enter in the request details, all data entry points with an asterisk are required.

Step 11

Save

The screenshot shows a web browser window with the URL `phimt.csd.disa.mil/patients/94197b4cabef0164e053d631f70c3bc9/releases/new`. The page title is "PHIMT - Patient Release of Information".

The main content area is divided into two sections:

- ASSOCIATED AUTHORIZATION (OPTIONAL)**: This section contains a table with headers: ACTIONS, TITLE, OWNER, and CREATED. Below the headers, it says "No Authorizations Found". To the left of the table is a dashed box with the text "Drop files here or click to upload".
- IMPROPER RELEASE (OPTIONAL)**: This section contains a paragraph of instructions: "Use 'Save as Complete' to complete and close this release. Alternatively use 'Save as Open' to save this release in your Record Report for later processing, or use 'Assign as Open to Another User' to assign this release to another user's Record Report for later processing. These last two options will save the release with an open (non-completed) status. 'Save as Void' should only be used if you want to cancel or void the release." Below this text are two buttons: "SAVE" and "Save as Complete".

At the bottom of the page, there is a footer with the text: "PHIMT v2.01.11.00 • CONTROLLED UNCLASSIFIED INFORMATION • New Governance, Inc. © 2022".

Lastly, you have the option of saving the original request for information in PHIMT.

CONTINUE

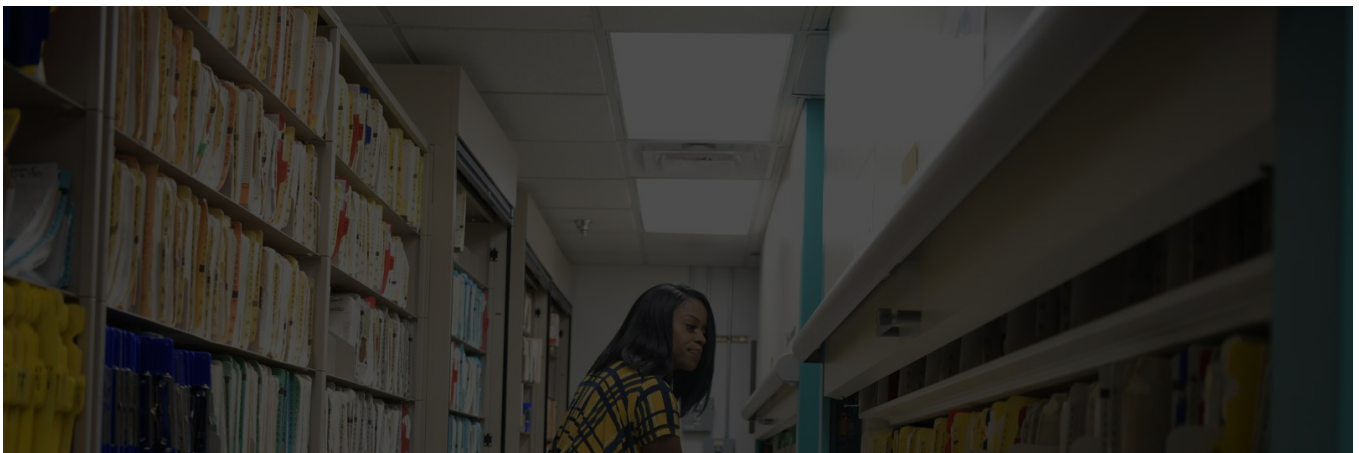
Knowledge Check. Select and submit the best option in response to the question below.

A patient may request an accounting of disclosure that includes how many years?

- ☐ 2 years
- ☐ 6 years
- ☐ 10 years
- ☐ 3 years

SUBMIT

CONTINUE





Sequestering Medical Records

What happens if an active-duty member passes away in your facility while undergoing surgery? What would be your responsibility if a well-known 4-Star general is admitted to your facility? You would need to consult with your supervisor or NCOIC to determine if the record should be sequestered. The MTF may sequester the original medical record (paper or electronic) depending on the scenario.

However, your MTF will have local operating instructions on how and when to sequester medical records. This policy is typically managed by the Quality Management Office and Chief of Medical Staff with guidance from the Medical Legal Consultant. Continuity of care and the safety of the patient whose record is being locked is a priority and must also be factored into the decision making.

Sequestering a record means limiting the availability and access to the medical record above and beyond the normal precautions.

Listed below are the specific situations that require a record be sequestered.

- 1** When an administrative claim or lawsuit against the government has been filed.
- 2** When a patient has tried to tamper, alter or illegally remove a record from the facility.
- 3** When a request is received from an attorney under circumstances indicating a claim or lawsuit is being considered.
- 4** When an Inspector General (IG), congressional inquiry or investigation has been initiated and when the medical record is relevant to an IG or congressional inquiry/ investigation.
- 5** When the record becomes relevant to an AFOSI. Annotate the sequestered record form with the AFOSI/Security Forces agent's name and case number for annual review process.

Now that you know some situations that would require a record to be sequestered, let's review the steps to sequester a medical record.

Step 1

Patients actively seen in your clinic

Let's start with sequestering paper medical records.

You will make a copy of the record, put all the documents in the correct 2100A with “Clinic Copy” in large block letters on the front. As new paperwork is generated the original documents will be filed in the sequestered record and copies will be put in the Clinic Copy on the shelf.

Create a “Clinic Copy” in Paper Record Tracking (PRT) as a unique record type for tracking purposes in the Medical Records Tracking module.

Step 2

Patients NOT actively seen in your clinic

If the patient is not actively being seen at your facility, you will remove the record to the identified secure location and place a charge out guide in place of the record. In the charge out guide place a coversheet stating the record is sequestered with a point of contact to direct questions to.

Place a cover sheet on the original medical record stating that the record has been sequestered.

Step 3

Justification

A separate file will be maintained on why the record is sequestered, the date sequestered, and review date (to determine continued sequestration).

Step 4

Annual Review

An annual review of sequestered records will be conducted to determine if the record is still required to be sequestered.

Step 5

Changes or Updates

If the patient moves, review the record to determine if sequestering is still applicable. If required, mail the record to the gaining MTF, include a cover letter stating that the record requires sequestering and circumstance.

Your facility will make a copy prior to mailing the record if scenarios 1, 3, 4, and 5 named above have occurred. The copy is maintained until the claim is resolved.

Step 6

Sequestering Electronic Health Records

Let's continue with sequestering electronic medical records.

Utilize your MTF's electronic health record to print all records for the patient. These records will be made available for continuity of care, if the patient is no longer being actively seen, the records will be placed in a locked location with limited access.

You or your NCOIC will send an encrypted e-mail to the following e-mail box:

dha.ncr.healthcare-ops.mbx.patient-admin-office@mail.mil.

The Defense Health Agency (DHA) Patient Administrative Department (PAD) will review the incident to determine if the individual's records and/or casualties' records should be sequestered and restricted from general view.

Summary



As you can see, the process for sequestering electronic health records is less involved than paper medical records. You will not be the one to make the decision on whether a record should be sequestered, but you will most likely be responsible for processing. Remember, you will be critical in protecting patient privacy.

CONTINUE

Knowledge Check. Select and submit the best options in response to the question below.

What two factors are a priority when making the decision to sequester a medical record?

- ☐ Who can see the record and limiting access
- ☐ Safety of a well-known patient and restricting access
- ☐ Continuity of care and safety of the patient
- ☐ Electronic health record and paper health record

SUBMIT

END OF LESSON

Lesson 2: Outpatient Health Records Management

After completing this lesson, the student will be able to maintain outpatient health records, IAW prescribed guidance and publications.

The primary purpose of the medical record is to document the course of a patient's illness and treatment during a particular period and during any subsequent periods as an inpatient or an outpatient.

The medical record serves as a:

- 1 Basis for the planning and evaluation of individual patient care
- 2 Communication link between the physician and other professionals contributing to the patient's care
- 3 Legal requirement imposed on hospitals and physicians

The best place to start our discussion is with the initial creation of the medical record and the types of entries used to identify the record.



Outpatient Medical Record

When we refer to the Outpatient Medical Record, it is important to note that this designated record set consists of not only the paper record, but *all* applicable outpatient electronic medical record data that provides a permanent record of a patient's medical care. Most of the outpatient electronic medical record information is maintained and documented in the DOD's approved Electronic Health Record (EHR); this system may vary depending on your location.

Until we transition to a completely electronic health record, the AFMS will continue to use a "hybrid" record consisting primarily of the EHR and including traditional paper-based records and forms to meet unique operational mission requirements. As EHRs are operational at all active duty MTFs, the combination of the electronic and the paper record constitute a complete health record for a beneficiary.



NOTE: The terms, "charge-out," "pull," or "checkout," refer to the removal of a paper medical record from the file.

Both the EHR and the paper record must be available for inspection, review, copying and disposition when required.

All outpatient records must contain enough information to (click each box):

☐

Identify the patient

☐

Support the diagnosis given by the health care providers
(practitioners)

☐

Justify the treatment

☐

Accurately document the results of care rendered

The visits a patient makes to your facility are documented on a variety of different forms that become part of this medical record.

CONTINUE

The text that follows takes you through the process of creating a medical record and how these forms become part of the outpatient health record.

There are only two types of Outpatient Records:

1

Service Treatment Records (STR)—the outpatient medical record and dental treatment record for a member of the United States military. It is made up of the patient's medical and dental encounters throughout the course of their military career.

2

Non-Service Treatment Records (NSTR)—outpatient medical records for patients in *ALL* other categories (dependents, civilians, foreign military, retirees, etc.).

The **outpatient medical record** is **vital** when it comes to patient **care**. The record holds the significant **health history** for that **patient**. It is **important** to keep the record **current** since you would not want to give a patient a **medication** that they are **allergic** to.

In this section, we will discuss how to build, and properly identify an outpatient medical record.




Air Force Form 2100A

This is a four-part folder and is the only Air Force Form in use as an outpatient health record “jacket.” The 2100A series folders are created for enlisted active-duty personnel at Lackland Air Force Base (AFB), TX. You may remember creating your own record during basic training. Active-duty officers will also have 2100A series folders, but the creation of their record will vary depending on their accession method.

These same folders are used for family members and other non-military patients, and are usually prepared during their first visit to an Air Force MTF. For retirees, these same folders are used, and should be prepared during their first visit to the MTF following their retirement.





Selecting the Form Number and Color of Outpatient Health Records

Creation of folders, arrangement of content and record filing methodology is consistent throughout Air Force MTFs. **There are 10 different colors of outpatient health records.** The different colors aid in filing and charging-out records.

It is important for you to know how to properly choose the correct folder in relation to the sponsor's social security number (SSN). As with all things military, there is a process involved in the selection of the correct folder for each patient.



Form Number Selection



Social Security Number (SSN)

The sponsor's SSN determines the Air Force Form 2100A series record you will use for the sponsor and their dependents. Each record cover contains a place to write the applicable SSN. It is of primary importance that the folder be properly numbered and then verified using Defense Enrollment Eligibility Reporting System (DEERS).

If a beneficiary has received medical care under a previous SSN; for instance, as a result of remarriage to another military sponsor, record forms filed under the former SSN should be consolidated under the current sponsor SSN. Once the patient has been registered in the appropriate EHR under the current sponsor's SSN, merge the old and new patient file. For future inquiries, a cross-reference from the old number to the new number should be indicated in the outpatient files as well as in the current automated system.

If a dependent spouse or child has received medical care under the SSN of a different sponsor (i.e. divorce, re-marriage to another sponsor), the record and forms filed under the former SSN should be consolidated and merged into a new record jacket reflecting

the new sponsor's SSN. If a beneficiary has received medical care under multiple SSNs as the result of dual eligibility status (i.e. a dependent spouse who is also an ARC member, or a retiree), then a cross-reference of the SSNs should be annotated on the outpatient record jacket to assist with identification. Dual status records maintenance will be discussed in further detail later in this section.



NOTE: The mix of dependent and active-duty record information cannot be merged.

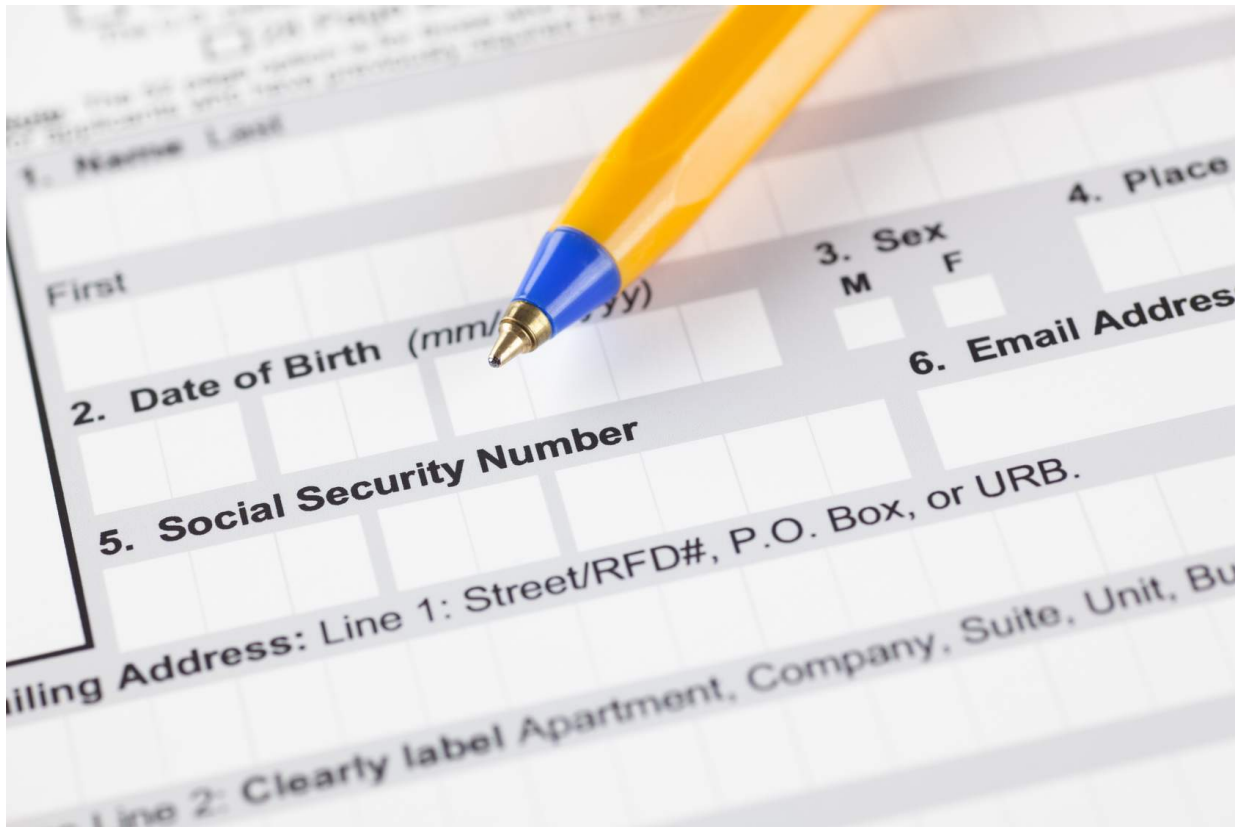
For example, if a dependent child joins the military and their dependent record must be retired, as discussed further in this chapter, and a brand-new medical record is created with none of the previous medical information transferred.

No Available Social Security Number

A pseudo-SSN is created for beneficiaries without an SSN. This process occurs in DEERS when the personnel technician issues an ID card or enrolls the beneficiary. Either one of these is generated:

- **Foreign Identification Number (FIN)**
- **Temporary Identification Number (TIN)**

If beneficiaries are not required to have an SSN, they are issued a FIN. Foreign national spouses who have been issued an Individual Taxpayer Identification Number (ITIN) by the Social Security Administration will be able to use that number.



When issuing an ID card, DEERS gives the personnel technician a choice to enter an SSN, FIN or TIN.



Click each tab below to learn more about FINs and TINs.

FIN

TIN

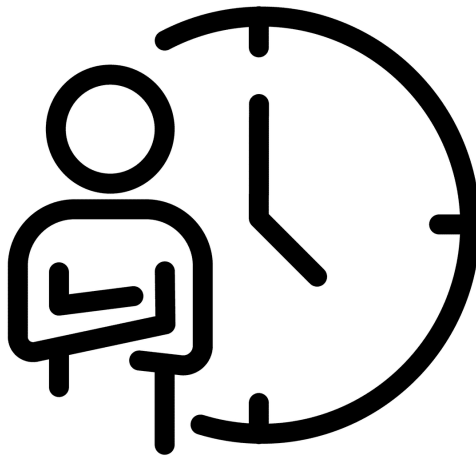
When FIN is selected, DEERS automatically assigns a 900–00–000F. This number is assigned to categories of eligible North Atlantic Treaty Organization (NATO) and non-NATO foreign military members, their family members, for foreign nationals employed in positions overseas that result in DOD benefits and entitlements, and for authorized non-US personnel who are not under our Social Security Administration System and will **not** receive an SSN.



FIN

TIN

A TIN is assigned and automatically generated by the DEERS (800–00–000D) for categories of beneficiaries who are **awaiting** an SSN (such as newborns) or for those who do not have an SSN. The TIN is used as a method to record the beneficiary as a potential patient on DEERS while awaiting an SSN. Foreign nationals who are the spouse of a US citizen will be issued a TIN if they are awaiting or will be receiving an SSN.



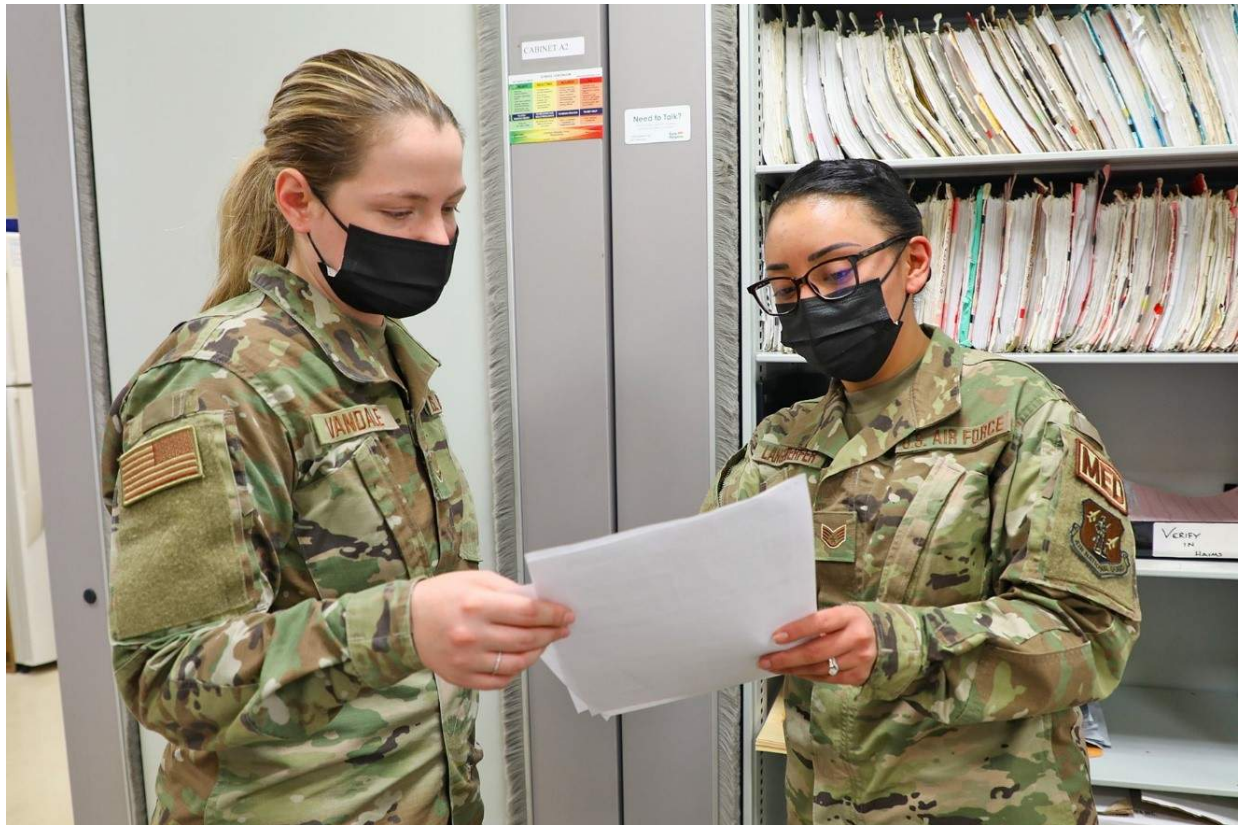
Color Selection

Select an **Air Force Form 2100A** series folder (whatever is on hand locally) according to the second to last digit of the sponsor's SSN. For example, if the SSN is 539–60–5427, the second to last digit is a “2.” This corresponds to a **yellow** Air Force Form 2100A.

The following table lists the range of SSN digits used to select a folder, the form number, and the color of the folder.

If the second to last SSN digit is:	Use Air Force Form	Color
00-09	2100A	Orange
10-19	2110A	Green
20-29	2120A	Yellow
30-39	2130A	Gray
40-49	2140A	Tan
50-59	2150A	Blue
60-69	2160A	White
70-79	2170A	Brown
80-89	2180A	Pink
90-99	2190A	Red

Over time, you will become acquainted with the folder color system and how to select the proper folder based on the SSN. Once you memorize this color-coding system, you can select the proper folder for the job in an instant.



***Here is a little word association sentence
that may help you memorize the different
colors in order:***

**Old George Yelled, "Grab That Big
Watermelon, Before Pa Returns!"**



CONTINUE

Let's now discuss preparing the folder.



Click the hot spots on the medical folder below to learn more about what each area is for.

0123456789R S

LAST NAME FIRST M.I.

1

PATIENT IDENTIFICATION

HEALTH RECORD

OUTPATIENT

Specify Service & Grade for Military & Retired Military Member

MILITARY _____

RETIRED MILITARY _____

NONMILITARY _____

SENSITIVE DUTIES PROGRAM (SDP)

FOOD HANDLER

PROPERTY OF US GOVERNMENT. POSSESSION BY INDIVIDUAL WITHOUT PROPER AUTHORIZATION IS PROHIBITED.

IF FOUND RETURN TO ANY US POST OFFICE POSTMASTER FORWARD TO HQ USAF/SG, BOLLING AFB DC 20332-6166

AF INT 2110A, 20040701 PREVIOUS EDITION WILL BE

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

R

S

Sponsor/Family Member Prefix

Family Member Prefix	Relationship Description
20	Sponsor
01-19	Sponsor's children
30	Sponsor's first spouse (current or former)
31-39	Each additional spouse (current or former)
40	Mother or Step-Mother of Sponsor
45	Father or Step-Father of Sponsor
50	Mother-in-Law of Sponsor
55	Father-in-Law of Sponsor
60-69	Other authorized dependents of Sponsor
90-95	Beneficiaries authorized by Statute
98	Civilian Emergency
99	All others, not elsewhere classified

Depending on the type of record you are creating, enter either sponsor's prefix, or the family member's prefix in the two circles immediately to the left of the SSN. On the family member's record, this prefix denotes the relationship of the member to the sponsor. Check the TRICARE DEERS website for the DEERS Dependent Suffix (DDS) for the patient or if not available, number in birth date order for family member children.

- Use black ink or a suitable marking device if black tape is not available. Stamp "FLY" in two-inch block letters in the upper left-hand corner of the front of the folder.

- Mark these folders with a strip of black tape on the side of the folder, extending from immediately below block to the bottom of the folder. If file cabinets are used, apply another strip of black tape to top of folder, immediately to the left of the last four digits of the SSN. Never cover the prefix or SSN.

0	1	2	3	4	5	6	7	8	9	R	S
LAST NAME				FIRST				M.I.			

+

HEALTH RECORD

OUTPATIENT

Specify Service & Grade for Military & Retired Military Member
MILITARY _____ ☐
RETIRED MILITARY _____ ☐
NONMILITARY _____ ☐

SENSITIVE DUTIES PROGRAM (SDP)	
FOOD HANDLER	

PATIENT IDENTIFICATION

PROPERTY OF US GOVERNMENT. POSSESSION BY INDIVIDUAL WITHOUT PROPER AUTHORIZATION IS PROHIBITED.

IF FOUND RETURN TO ANY US POST OFFICE, POSTMASTER FORWARD TO HQ USAF/SG, BOLLING AFB DC 20332-6168

AF INT 2110A, 20040701
PREVIOUS EDITION WILL BE USED

0
1
2
3
4
5
6
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R
S

Spouse Prefix Assignment

Assign the family member prefix “30” to the first spouse authorized care. If the member remarries due to spousal death, divorce, etc., assign the number “31” to the next authorized current spouse. Increase prefix numbers by 1 (e.g., 32, 33) for any additional dependent spouse authorized care. Only one current dependent spouse is authorized medical care.

<div style="display: flex; justify-content: space-between;"> LAST NAME FIRST M.I. </div>			<div style="display: flex; justify-content: space-around;"> 0123456789RS </div>																																		
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>HEALTH RECORD</p> <p>OUTPATIENT</p> </div> <div style="width: 65%;"> <p style="font-size: small;">Specify Service & Grade for Military & Retired Military Member</p> <p>MILITARY _____ <input type="checkbox"/></p> <p>RETIRED MILITARY _____ <input type="checkbox"/></p> <p>NONMILITARY _____ <input type="checkbox"/></p> </div> </div> <div style="margin-top: 10px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%;">SENSITIVE DUTIES PROGRAM (SDP)</td><td style="width: 50%;"></td></tr> <tr><td>FOOD HANDLER</td><td></td></tr> <tr><td> </td><td></td></tr> <tr><td> </td><td></td></tr> <tr><td> </td><td></td></tr> <tr><td> </td><td></td></tr> </table> </div>			SENSITIVE DUTIES PROGRAM (SDP)		FOOD HANDLER										<p>PATIENT IDENTIFICATION</p> <div style="border: 1px solid black; width: 100px; height: 50px; margin: 5px auto;"></div>		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>2006</td></tr> <tr><td>2007</td></tr> <tr><td>2008</td></tr> <tr><td>2009</td></tr> <tr><td>2010</td></tr> <tr><td>2011</td></tr> <tr><td>2012</td></tr> <tr><td>2013</td></tr> <tr><td>2014</td></tr> <tr><td>2015</td></tr> <tr><td>2016</td></tr> <tr><td>2017</td></tr> <tr><td>2018</td></tr> <tr><td>2019</td></tr> <tr><td>2020</td></tr> <tr><td>2021</td></tr> <tr><td>2022</td></tr> <tr><td>2023</td></tr> <tr><td>2024</td></tr> </table>		2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
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Sponsor's SSN

In the single space immediately to the right of the preprinted digit, located in the upper right-hand corner of the folder, place the last digit of the applicable SSN. In the seven spaces to the left of the preprinted digit, enter the remaining numbers of the SSN.

Remember, use ballpoint pen, felt-tip marker, or any other permanent means. Do **not** use a pencil! These nine numbers constitute the complete SSN of the sponsor.

The image shows a green outpatient record cover. At the top, there is a header with a row of boxes numbered 0 through 9, followed by 'R' and 'S'. Below this, there are fields for 'LAST NAME', 'FIRST', and 'M.I.'. To the right of these fields is a 'PATIENT IDENTIFICATION' block with a red circle containing a white plus sign. Below the identification block is a section for 'HEALTH RECORD OUTPATIENT' with a table for 'Specify Service & Grade for Military & Retired Military Member'. The table has three rows: 'MILITARY', 'RETIRED MILITARY', and 'NONMILITARY', each with a checkbox. To the right of this table is a vertical column of years from 2006 to 2024, with 'R' and 'S' at the bottom. Below the table is a section for 'SENSITIVE DUTIES PROGRAM (SDP)' with a table for 'FOOD HANDLER'. At the bottom, there is a green band with text: 'PROPERTY OF US GOVERNMENT. POSSESSION BY INDIVIDUAL WITHOUT PROPER AUTHORIZATION IS PROHIBITED.', 'IF FOUND RETURN TO ANY US POST OFFICE, POSTMASTER FORWARD TO HQ USAF/SG, BOLLING AFB DC 20332-6158', and 'AF INT 2110A, 20040701 PREVIOUS EDITION WILL BE USED'.

Patient Identification Block

The patient identification block is located on the upper right-hand corner of the outpatient record cover. Using a black pen or felt-tip marker enter the first name, middle initial, and last name of the patient. If you are handwriting this information, ensure it is legible. An emboss card or a label from the EHR may also be used. Today, HSMs will be using the functions featured in their base's EHR.

As stated earlier, automated records and printed labels for tracking patient medical records will be created when a patient is registered through the local EHR registration options, or a patient is admitted to the hospital.

An EHR record label consists of the following minimum patient identification:

- Patient's name.
- Family Medical Program (FMP).
- Sponsor's SSN.
- Record type.
- Volume number (used when a patient has more than one record volume).
- Record number.

- Status.
- Date of birth.
- MTF Defense Medical Information System (DMIS) ID or MTF code, name and location.
- Additional information at the discretion of the MTF.

When the label is printed, a bar code will also appear on the label that can be used by the appropriate equipment, to scan the patient information in the EHR. This label will be placed on the front cover in the patient identification block of the Air Force Form 2100A series health record.

LAST NAME			FIRST			M.I.			<div style="display: flex; justify-content: space-around; font-size: 0.8em;"> 0123456789RS </div>																																													
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Allergies

If the patient has a known allergy to medication(s), this information will be displayed prominently under the patient identification data on the right-hand side of the folder.



Right Side Blocking

Using black tape or black marker, block out the last character of the sponsor's SSN. Red tape or marker can be used to denote individuals assigned to the Sensitive Duties Program (SDP); green tape or marker may be used to denote individuals assigned to mobility positions.

If an individual is assigned to both SDP duties and mobility, SDP (red) will take priority. If an individual is removed from either of these programs, simply cover the previous marker or tape with black marker or tape.

Records maintained in aerospace medicine for flying personnel contain additional markings.

- Mark these folders with a strip of black tape on the side of the folder, extending from immediately below block to the bottom of the folder. If file cabinets are used, apply another strip of black tape to the top of the folder, immediately to the left of the last four digits of the SSN. Never cover the prefix or SSN.
- Use black ink or a suitable marking device if black tape is not available. Stamp "FLY" in two-inch block letters in the upper left-hand corner of the front of the folder.

LAST NAME		FIRST		M.I.		0 1 2 3 4 5 6 7 8 9 R S											
						1											
PATIENT IDENTIFICATION						0 1 2 3 4 5 6 7 8 9 R S											
						2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024											
HEALTH RECORD		Specify Service & Grade for Military & Retired Military Member															
OUTPATIENT		MILITARY _____ <input type="checkbox"/> RETIRED MILITARY _____ <input type="checkbox"/> NONMILITARY _____ <input type="checkbox"/>															
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<small>AF INT 2110A, 20040701</small> <small>PREVIOUS EDITION WILL BE USED</small>																	

Health Record Year

Mark through the current year of nonmilitary records with a felt-tip marker or pen to indicate the latest year non-active-duty patients were treated. Affix an Air Force Form 2700L, Year List Label for Air Force Form 2100, and Air Force Form 788, & Air Force Form 2100B Series, to extend the number of years and to extend the life of an outpatient record folder.

Do **not** accomplish a new Air Force Form 2100A series folder just to extend the year grid of a record.

LAST NAME			FIRST			M.I.			<div style="display: flex; justify-content: space-between;"> 0123456789RS </div>											
<div style="position: absolute; top: 10px; right: 10px; border: 1px solid black; padding: 5px;"> PATIENT IDENTIFICATION </div>									<div style="display: flex; justify-content: space-between;"> 0123456789RS </div>											
									<div style="display: flex; justify-content: space-between;"> 2006200720082009201020112012201320142015201620172018201920202021202220232024 </div>											

HEALTH RECORD

OUTPATIENT

Specify Service & Grade for Military & Retired Military Member

MILITARY _____ ☐

RETIRED MILITARY _____ ☐

NONMILITARY _____ ☐

SENSITIVE DUTIES PROGRAM (SDP)	
FOOD HANDLER	

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Army

This area is for Army use only.

<div style="display: flex; justify-content: space-between;"> LAST NAME FIRST M.I. </div>			<div style="display: flex; justify-content: space-around;"> 0123456789RS </div>																																												
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p style="text-align: center;">HEALTH RECORD</p> <p style="text-align: center;">OUTPATIENT</p> </div> <div style="width: 65%;"> <p style="text-align: center;">Specify Service & Grade for Military & Retired Military Member</p> <p>MILITARY _____ <input type="checkbox"/></p> <p>RETIRED MILITARY _____ <input type="checkbox"/></p> <p>NONMILITARY _____ <input type="checkbox"/></p> </div> </div> <div style="margin-top: 10px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">SENSITIVE DUTIES PROGRAM (SDP)</td> <td></td> </tr> <tr> <td>FOOD HANDLER</td> <td></td> </tr> <tr><td> </td><td></td></tr> <tr><td> </td><td></td></tr> <tr><td> </td><td></td></tr> <tr><td> </td><td></td></tr> <tr><td> </td><td></td></tr> </table> </div>			SENSITIVE DUTIES PROGRAM (SDP)		FOOD HANDLER												<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;">PATIENT IDENTIFICATION</div> <div style="display: flex;"> <div style="width: 15px; text-align: center; font-weight: bold;">0 1 2 3 4 5 6 7 8 9 R S</div> <div style="width: 100px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>2006</td></tr> <tr><td>2007</td></tr> <tr><td>2008</td></tr> <tr><td>2009</td></tr> <tr><td>2010</td></tr> <tr><td>2011</td></tr> <tr><td>2012</td></tr> <tr><td>2013</td></tr> <tr><td>2014</td></tr> <tr><td>2015</td></tr> <tr><td>2016</td></tr> <tr><td>2017</td></tr> <tr><td>2018</td></tr> <tr><td>2019</td></tr> <tr><td>2020</td></tr> <tr><td>2021</td></tr> <tr><td>2022</td></tr> <tr><td>2023</td></tr> <tr><td>2024</td></tr> </table> </div> </div>												2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
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MTF Identification

Identify the MTF having custodial responsibility for the outpatient record with a self-adhesive label affixed to the health record folder in the lower right-hand corner.

<div style="display: flex; justify-content: space-between;"> LAST NAME FIRST M.I. </div>			<div style="display: flex; justify-content: space-around;"> 0123456789RS </div>																							
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>HEALTH RECORD</p> <p>OUTPATIENT</p> </div> <div style="width: 60%;"> <p style="font-size: small;">Specify Service & Grade for Military & Retired Military Member</p> <p>MILITARY _____ + <input type="checkbox"/></p> <p>RETIRED MILITARY _____ <input type="checkbox"/></p> <p>NONMILITARY _____ <input type="checkbox"/></p> </div> </div>			<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">PATIENT IDENTIFICATION</div> <div style="display: flex; align-items: center;"> <div style="width: 15px; text-align: center; font-weight: bold;">0</div> <div style="width: 15px; text-align: center; font-weight: bold;">1</div> <div style="width: 15px; text-align: center; font-weight: bold;">2</div> <div style="width: 15px; text-align: center; font-weight: bold;">3</div> <div style="width: 15px; text-align: center; font-weight: bold;">4</div> <div style="width: 15px; text-align: center; font-weight: bold;">5</div> <div style="width: 15px; text-align: center; font-weight: bold;">6</div> <div style="width: 15px; text-align: center; font-weight: bold;">7</div> <div style="width: 15px; text-align: center; font-weight: bold;">8</div> <div style="width: 15px; text-align: center; font-weight: bold;">9</div> <div style="width: 15px; text-align: center; font-weight: bold;">R</div> <div style="width: 15px; text-align: center; font-weight: bold;">S</div> </div> <div style="display: flex; align-items: center;"> <div style="width: 15px; text-align: center; font-weight: bold;">2006</div> <div style="width: 15px; text-align: center; font-weight: bold;">2007</div> <div style="width: 15px; text-align: center; font-weight: bold;">2008</div> <div style="width: 15px; text-align: center; font-weight: bold;">2009</div> <div style="width: 15px; text-align: center; font-weight: bold;">2010</div> <div style="width: 15px; text-align: center; font-weight: bold;">2011</div> <div style="width: 15px; text-align: center; font-weight: bold;">2012</div> <div style="width: 15px; text-align: center; font-weight: bold;">2013</div> <div style="width: 15px; text-align: center; font-weight: bold;">2014</div> <div style="width: 15px; text-align: center; font-weight: bold;">2015</div> <div style="width: 15px; text-align: center; font-weight: bold;">2016</div> <div style="width: 15px; text-align: center; font-weight: bold;">2017</div> <div style="width: 15px; text-align: center; font-weight: bold;">2018</div> <div style="width: 15px; text-align: center; font-weight: bold;">2019</div> <div style="width: 15px; text-align: center; font-weight: bold;">2020</div> <div style="width: 15px; text-align: center; font-weight: bold;">2021</div> <div style="width: 15px; text-align: center; font-weight: bold;">2022</div> <div style="width: 15px; text-align: center; font-weight: bold;">2023</div> <div style="width: 15px; text-align: center; font-weight: bold;">2024</div> </div>																							
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Status

Indicate the patient's status in the box located in the center of the front cover of the record jacket. Enter the service and rank for extended active duty and retired personnel. Enter the country for non-US military personnel. Use pencil entries for items that change, such as rank. Blacken in the "military" block for active-duty military personnel. Enter an "R" in the military block for air reserve component (ARC) personnel not on active duty. For family members who are also members of an ARC, enter the family member's SSN here, as well as their status as a member of the Air Force Reserve or Air National Guard as appropriate. Blacken in the "Retired Military" block for retired personnel. Annotate the person's service and rank, which can be made in pen. Blacken in the "Nonmilitary" block for all others.

0 1 2 3 4 5 6 7 8 9 R S

LAST NAME FIRST M.I.

PATIENT IDENTIFICATION

HEALTH RECORD
OUTPATIENT

Specify Service & Grade for Military & Retired Military Member

MILITARY ☐
RETIRED MILITARY ☐
NONMILITARY ☐

SENSITIVE DUTIES PROGRAM (SDP)
FOOD HANDLER

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0 1 2 3 4 5 6 7 8 9 R S

Sensitive Duties Program/Food Handler

If the patient is a member of the personnel reliability program (PRP) program, stamp “PRP” in two-inch block letters on the left-hand side of the front of the folder.

If the person is a food handler, the Force Health Management section enters the date of the current food handler examination in pencil on the appropriate line of the preprinted format.



NOTE: All remaining areas on the Air Force Form 2100A are optional or as determined necessary by each MTF.

Once an FMP has been assigned to an individual, the number will not change if the patient is still associated with the same sponsor and SSN. When a military member marries a person with children, assign family member prefix numbers in sequence following

For example, typically an active-duty member with children will have FMPs assigned starting with 01 which is assigned to the eldest child. If the same active-duty member acquires more children through marriage or adoption, these children will be assigned FMPs sequentially

the last family member prefix already assigned to children of the sponsor (if any). Assign the oldest child the next number in numerical sequence.

after the FMPs already assigned regardless of the child's age. This means that once a FMP is assigned it should not be changed.

CONTINUE

Acknowledgement of Notice of Privacy Practices Procedures

HIPAA requires all patients to be informed of their rights regarding their protected health information. Each patient must receive the MHS Notice of Privacy Practices and acknowledgement of receipt must be documented in the outpatient record.

Medical records technicians and/or clinic check-in personnel check the back outside cover of outpatient health record to see if the acknowledgement label is present and signed. If none present, place the label centered near the bottom on the outside of the record. Ask the patient or their representative if they have received the MHS Notice of Privacy Practices in the mail and ask patient or representative to fill out the Name, Date, and FMP/SSN sections and sign the document. Have MHS Notice of Privacy Practices available to give to the patient if they did not receive or do not remember receiving it in the mail.

If the patient or their representative refuses to sign for any reason, fill in the date, patient name, FMP and SSN, check the block that the patient/representative declined to sign, and initial the label. Patients can also sign the Notice of Privacy Practices within the local EHR.

Here is an example of the receipt label.

**Acknowledgement of Military Health System
Notice of Privacy Practices**

The signature below only acknowledges receipt of the Military Health System Notice of Privacy Practices, effective date 14 April 2003.

Signature of Patient/Patient Representative date

Name of Patient/Representative relationship to patient (if applicable)

FMP/SSN: ____/____-____-____

☐ Patient/Representative declined to sign ____ MTF staff initials



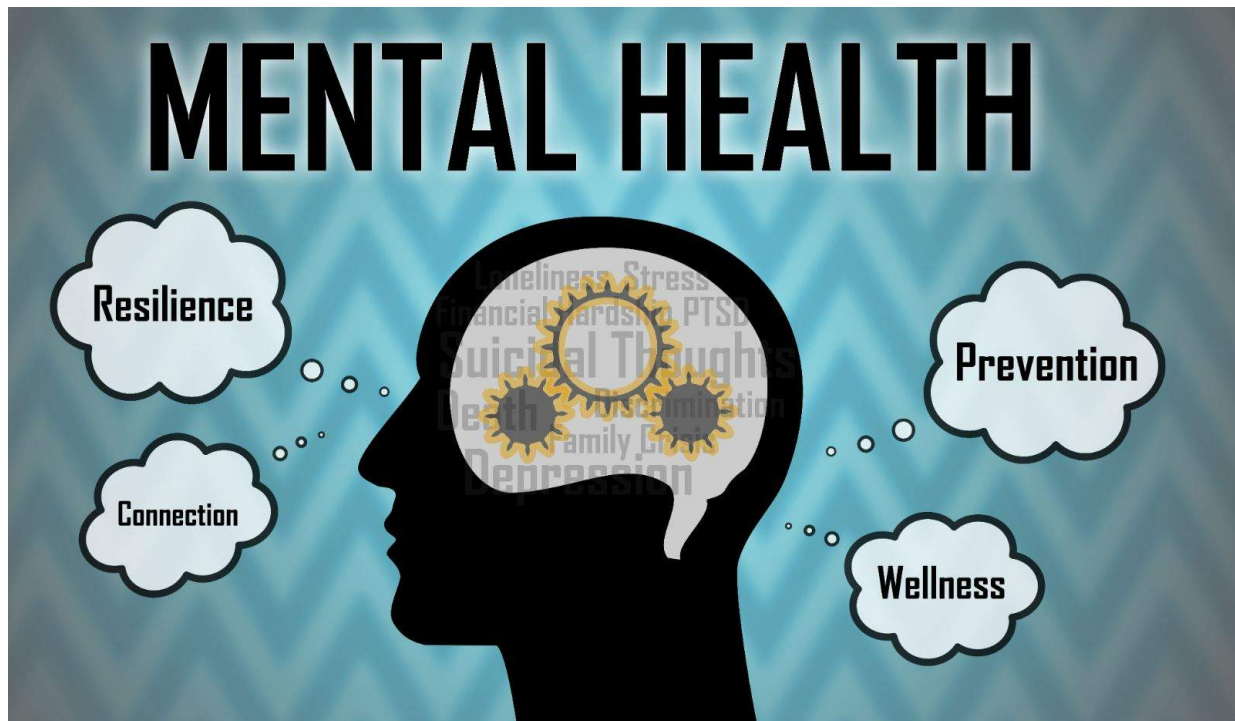
Click each tab below to learn more.

MENTAL HEALTH RECORDS

FAMILY ADVOCACY CLINIC

Mental health records are a separate category of records that contain detailed psychiatric notations of evaluations, consultations, tests, and treatment provided on an outpatient or inpatient status. Do not use AF Form 2100A series record jackets for records kept in the mental health clinic.

These records must be kept in properly secured files in the mental health clinic. See DAFI 44-172, Chapter 5, for details on mental health records and records management.



MENTAL HEALTH RECORDS

FAMILY ADVOCACY CLINIC

The Family Advocacy clinic or office maintains the original Family Advocacy Program (FAP) patient record. The FAP record contains detailed, confidential information regarding alleged or verified family maltreatment.

These files are separate from the outpatient record and are secured. Do not use the Air Force Form 2100A series records jackets.



CONTINUE

Knowledge Check. Select and submit the best option in response to the statement below.

If a beneficiary remarries another military member, you should not consolidate their record under the new sponsor social.

☐

True

☐

False

SUBMIT

CONTINUE

Outpatient Medical Record Maintenance



The maintenance of medical records includes *quality* and *security*. Click each tab below to learn more.

Quality



Quality ensures that the record jacket (if applicable) is clean, serviceable, and the contents are for the correct patient.

Security —

Security references the physical and electronic security of paper and electronic health records.

As a member of the outpatient records team, your *external* customers are the patients, and your *internal* customers are the staff of the medical facility.



Customer Satisfaction

Providing services that satisfy your customers does not happen by accident—it takes a lot of hard work, careful planning, listening to your customers, and teamwork. Doing something right the first time requires you to focus on what tasks you do (i.e., work processes).

Updating Records

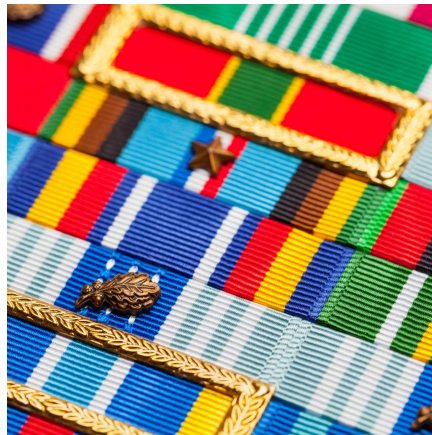
This involves different tasks, depending on what forms or other material you receive to post to the patient's file. Update the information on the outpatient record folder when changes in a patient's identification or status occur. Create a new record folder *only* when the existing folder no longer protects the contents of the record.

DO NOT add or remove from the list of sensitivities (allergies) identified on the cover of the medical record. If a new record folder is created, be sure to transfer all the sensitivity information (as well as all other information) from the previous folder to the new folder.



The patient's physician is responsible for making changes to the sensitivities list.

Some change examples include a name change due to marriage or divorce or a change in rank for an active-duty patient.



Withdrawing Documents

When material in an outpatient record is particularly relevant for further treatment of the patient as an inpatient, the material can be withdrawn and inserted in the inpatient record. Note the withdrawals on an Standard Form (SF) 600, *Medical Record—Chronological Record of Medical Care*. For example, a patient is

In this case, the entry on SF 600 reads “29 Jun 2010, consultation sheets, dated 16 and 17 May 2010, withdrawn and placed in the inpatient record on admission of this patient to the hospital for a partial gastrectomy. Thomas Edwards, A1C, USAF.” Anytime you remove a document, annotate the SF 600 with the reason

admitted to the hospital for surgery and relevant documents are removed from the outpatient file.

why you removed it and the new location of the document; then print your name and sign above it.

Filing Medical Documents

Prior to filing any medical documents in a paper or electronic health record, you must confirm that the document has the patient identifiers listed below.

- Patient's name
- Family member prefix
- Sponsor's SSN
- Facility providing treatment
- Name of the facility maintaining the records



NOTE: If the medical document does not have sufficient information to identify the patient, you may be asked to complete research and fill in the remaining minimum information required.

Adding Documents

Make sure all documents and forms are added to records immediately after receipt. Temporarily place documents and reports received while the record is charged out in the charge-out guide, which is filed in place of the record until it is returned.

MTFs will develop local policies and procedures to ensure complete cumulative test results are printed and inserted in the outpatient records upon referral of a patient to a

civilian provider for medical care, on permanent change of station (PCS) of individual, and in other appropriate instances where necessary. Your flight will have methods to ensure all test results (including archived results) are retrieved and filed when the record is retired to the National Personnel Records Center, the Department of Veterans Affairs, or the MTF deems it necessary for the record to contain the hard copy test results.

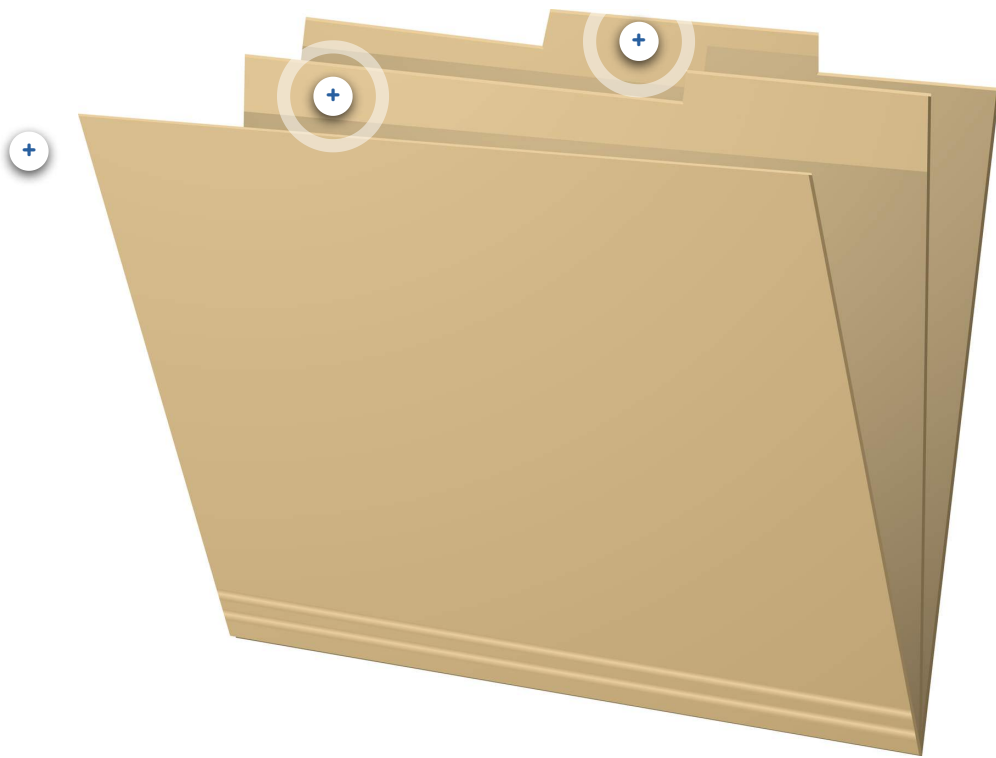
Distributing medical documentation to the appropriate section and in the right order will be covered next. Electronic records, unlike paper records, do not have multiple sections to file. We will go over the process for filing documents in the electronic health record later in this module.

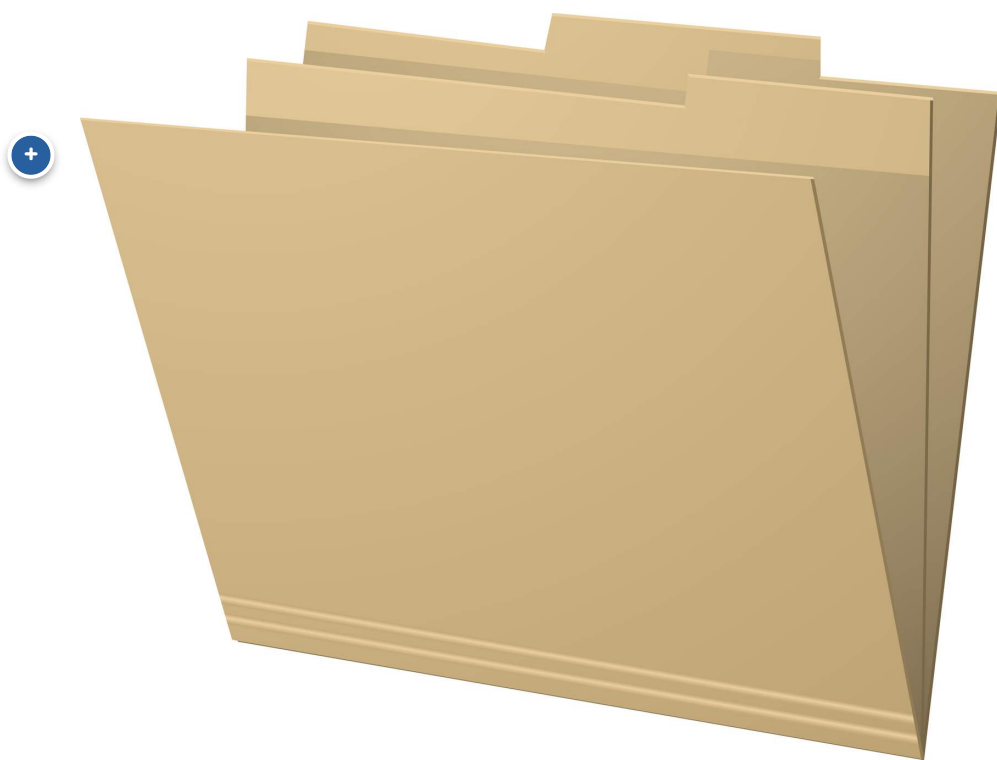
CONTINUE

Now let's look at the four-section filing arrangement in the Air Force Form 2100A series.



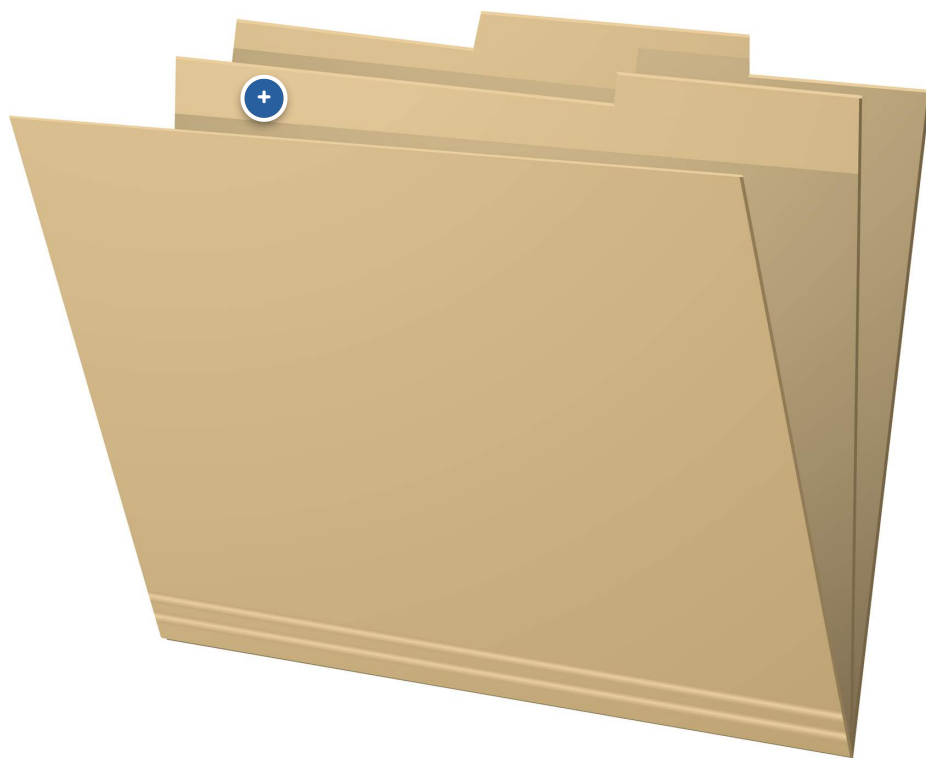
Click each hot spot below to learn about each section.





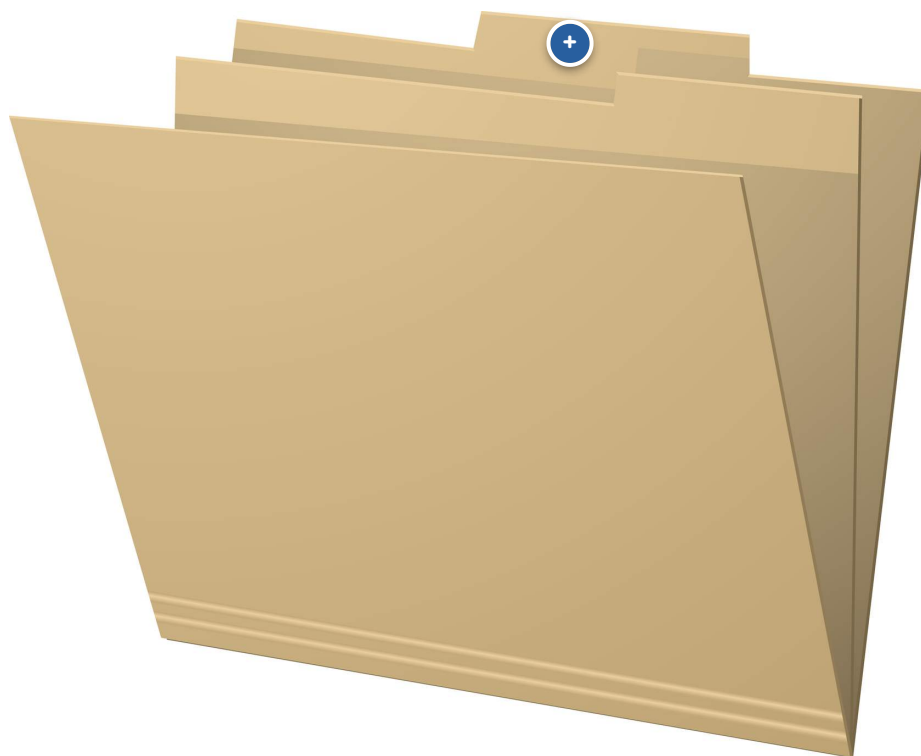
Section 1

Located on the left side of the folder immediately inside the front cover.



Sections 2 and 3

Located on the middle flap of the folder.



Section 4

Located inside the back cover.



Click each tab below to learn more about each section.

Section 1

Arrange forms in chronological sequence with the most recent action on top. The exception to this rule is the Air Force Form 1480A or DD Form 2766A, which will be the top form in section 1. File the following forms in order as listed after the Air Force Form 1480A or DD Form 2766. Previous versions of Air Force Form 1480A and DD Form 2766 will be filed after the current version, and on top of the rest of the paperwork in this section.

1. DD Form 2766C or Air Force Form 1480B, *Adult Preventive and Chronic Care Flowsheet—Continuation Sheet*.
2. DD Form 2795, *Pre-Deployment Health Assessment Questionnaire*.

3. DD Form 2796, *Post-Deployment Health Assessment*. File after the corresponding DD Form 2795.
4. DD Form 2844, *Medical Assessment Post-Deployment*. File after the corresponding DD Form 2795.
5. DD Form 2900, *Post-Deployment Health RE-Assessment*.
6. Air Force Form 1480, *Summary of Care*—original.
7. Air Force Form 3922, *Adult Preventive Care—Flow Sheet*—original.
8. Air Force Form 3923, *Child Preventive Care—Flow Sheets*—original.
9. DD 2569, *Third Party Collection Program—Insurance Information*—original. File here depending on local MTF policy. These forms are only valid for 1-year after the date signed, older forms may be removed.
10. Air Force Form 565, *Record of Inpatient Treatment or approved HER forms*.
 - a. The following are a listing of applicable inpatient forms that may be filed in Section 1.
 - a. Air Force Form 560, *Authorization and Treatment Statement* – original. Only necessary if admission was cancelled. Previously filed version will not be removed.
 - b. SF 502, *Medical Record, Narrative Summary* – copy of original.
 - c. SF 509, *Medical Record, Progress Notes* – copy of original when used as a final discharge note or discharge instruction.
 - d. SF 515, *Medical Record, Tissue Examination* – File a copy of original report if the procedure relates to inpatient care.
 - e. SF 516, *Medical Record, Operation Report* – File a copy of original report if the procedure relates to inpatient care.
 - f. OF 517, *Clinical Record, Anesthesia* – File a copy of original report if the procedure relates to inpatient care (if there was an anesthetic incident).
 - g. OF 522, *Medical Record, Request for Administration of Anesthesia and for Performance of Operations and Other Procedures* – Copy of all documentation relating to ambulatory surgery.

Section 2 —

Primarily, this section contains the documentation related to outpatient care received in the MTF or in a civilian medical facility. The forms are filed in the following order, from the top down:

1. Air Force Form 745, *Sensitive Duties Program Record Identifier*—This form is used to identify health records of patients in the Sensitive Duties Program. If used, it is the top form on the right side. Individuals may participate in more than one program. Facilities will circle the initials of the appropriate program on an Air Force Form 745 (*PRP and Presidential Support Program [PSP]*). Removal of the Air Force Form 745 depends on the number of programs with which the individual is associated.
2. Air Force Form 966, *Registry Record*—is placed on top of the right-hand documents and under Air Force Form 745, if used.
3. SF 600, *Medical Record*—Chronological Record of Medical Care, is filed in date order.
 - a. The following forms will be filed with the associated SF 600:
 - a. SF 558s, *Medical Record—Emergency Care and Treatment*, chronologically – Will be interfiled with SF 600s.
 - b. DD Form 2161, *Referral for Civilian Medical Care* – File on top of SF 600 to which it belongs.
 - c. SF 513, *Consultation Sheet* – File on top of SF 600 to which it belongs.
 - d. Air Force Form 1535, *Physical Therapy Consult* – File on top of SF 600 to which it belongs.
4. Air Force Form 1352, *Hyperbaric Patient Information and Therapy Record*—original if treatment was on an outpatient basis. File the most recent form on top of all others.
5. Air Force Form 1446, *Medical Examination, Flying Personnel*—signed original.
6. DD Form 2697, *Report of Medical Assessment*.
7. OF 178, *Certificate of Medical Examination* – applies to civilian employees only.
8. SF 88 or DD Form 2808, *Report of Medical Examination*—signed copy of each report. When DD Form 2161 or any other form is prepared in conjunction with the SF 88/DD 2808, it is filed with the SF 88/DD 2808.
9. SF 93, DD Form 2807-1, *Report of Medical History*—signed copy of each report. File civilian employee's SF 93/DD 2807-1 in his/her health record.
10. DD 2807-2, *Medical Prescreen of Report of Medical History*—signed copy of each report. File civilian employee's SF 93/DD 2807-1 in his/her health record.

Section 3

Except for forms related to inpatient care, (which we file in section 1), this section is much like the left side of the AF Form 2100 series folder. File the forms in the following order:

1. Air Force Form 348, *Line of Duty Determination*.
2. Air Force Form 422, *Physical Profile Serial Report* – filed chronologically with the most recent report on top.
3. Air Force 469, *Duty Limiting Condition Report* – most recent report only.
4. Prenatal Forms – Pre-natal forms will be maintained in the OB-GYN clinic until the mother delivers. If the mother delivers in a civilian facility the forms will be filed in the outpatient record.
5. SF 533, *Medical Record – Prenatal and Pregnancy* – If the mother did not deliver in the hospital, the record is filed as a whole package with all forms pertaining to prenatal treatment filed chronologically between the SF 533 and Air Force Form 3915.
6. Air Force Form 618, *Medical Board Report* – signed copy of original and associated documents.
7. DD Form 2992, *Medical Recommendation for Flying or Special Operational Duty*.
8. Air Force Form 1418, *Recommendation for Flying or Special Operational Duty – Dental*.
9. DD Form 2005 and Air Force Form 137, *Footprint Record*, directly above the Disclosure Accounting Record. Most 2100A series record jackets will have the Privacy Act Statement located on the outside cover on the back of the folder. Patients utilizing these jackets do not require a DD 2005 placed in section three.
10. All other forms not listed in Section 1, 2, and 4 – File all other forms, unless specifically designated elsewhere, in chronological order, with the most recent form or report on top. This may include consent forms or letters and copies of reports of care from civilian sources (reports from civilian sources should be reviewed by the military health care provider responsible for the patient's case prior to filing).
11. Disclosure Accounting Record – The purpose of the document is to maintain a record of patient information released. This document will contain the following information: patient name, requestor's name and address, nature of disclosure, individual's consent with a block for annotating "Yes, No or Not Required" and date of disclosure. Your MTF may have a local policy that tracks patient disclosures other than what is described above.

Section 4

This section is where most of the diagnostic test reports are filed. Arrange forms in the following order, from top to bottom, chronologically with the most recent report on the top of each group.

1. Laboratory forms are filed in chronological order with most current reports filed on top.
2. SF 601, *Health Record, Immunization Record*.
3. SF 602, *Health Record, Serology Record*.
4. SFs 519B, *Radiological Consultation Request Report* – filed in chronological order with most current reports filed on top.
5. OF 520, *Medical Record, Electrocardiograph (ECG) Record* – filed together in chronological order with the most recent on top; except when OFs 520 are attached documentation to other reports.
6. Air Force Form 1721, *Spectacle Prescription*.
7. DD Form 2215, *Reference Audiogram*.
8. DD Form 2216, *Hearing Conservation Data*.
9. Air Force Form 1671, *Detailed Hearing Conservation Data Follow-up*.
10. Air Force Form 190, *Occupational Illness/Injury Report*.
11. Air Force Form 1527, *History of Occupational Exposure to Ionizing Radiation*.
12. USAFSAM Form 1527-1, *Annual Report of Individual Exposure to Ionizing Radiation*.
13. USAFSAM Form 1527-2, *Cumulative Occupational Exposure History to Ionizing Radiation*.
14. Air Force Form 1753, *Hearing Conservation Examination*.
15. Air Force Form 2755, *Master Workplace Exposure Data Summary*.
16. Air Force Form 2769, *Supplemental Data Sheet* – this form is only used if the patient works with specific chemicals.
17. Air Force Form 895, *Annual Medical Certificate*.
18. Other diagnostic test reports are filed here and/or flat disc digital MEDIA not already stored in the patient's electronic health record.
19. Advanced directives (Self-Determination Acts, Living Wills, durable Power of Attorney forms, or organ donor forms) file behind all other test reports.

New folders are prepared for new patients or when the present folder no longer protects the contents.

What happens when you have several documents with the same date of treatment? (click each box)

☐

If there is no sequence to file the forms, look to see if there is a **time of treatment**. File the documents with the **latest time** on **top** of those with an earlier treatment time.

☐

You may receive three lab slips; for example, all of which were done on the same day. Most lab slips have a test **time** on them. This helps you arrange them on the lab display mount in the record.

☐

If there is no time on the document to help you, just file them **in any order** you feel is appropriate.

CONTINUE

Knowledge Check. Select and submit the best option in response to the question below.

Prior to filing any medical documents in a paper or electronic health record, you must confirm that the document has which patient identifiers?

- ☐ Patient's name; family member prefix; sponsor's SSN; facility providing treatment; name of facility maintaining records
- ☐ Patient's name; family member prefix; sponsor's SSN
- ☐ Patient's name and date of birth (DOB) only
- ☐ Patient's name and sponsor's SSN only

SUBMIT

Knowledge Check. Select and submit the best option in response to the statement below.

Medical documentation is arranged in chronological order in the paper health records. There are no exceptions to this rule.

☐

True

☐

False

SUBMIT

CONTINUE

A woman with dark hair, wearing black-rimmed glasses and a military camouflage uniform, is shown in profile, looking at a computer monitor. The background is slightly blurred, showing an office or clinical setting with a desk and some papers.

Outpatient Record Retirement



As You Can Imagine...

Consistently adding outpatient records to a facility will quickly create many records. To avoid overloading a records room, a records retirement will be accomplished. The step-by-step for this process will be discussed later in the lesson, first we'll go over some basic details so that you may familiarize yourself with the information.

As a Health Services Management Journeyman, you will play a crucial role in outpatient records retirement. It is an important process that involves more than just the task at hand.

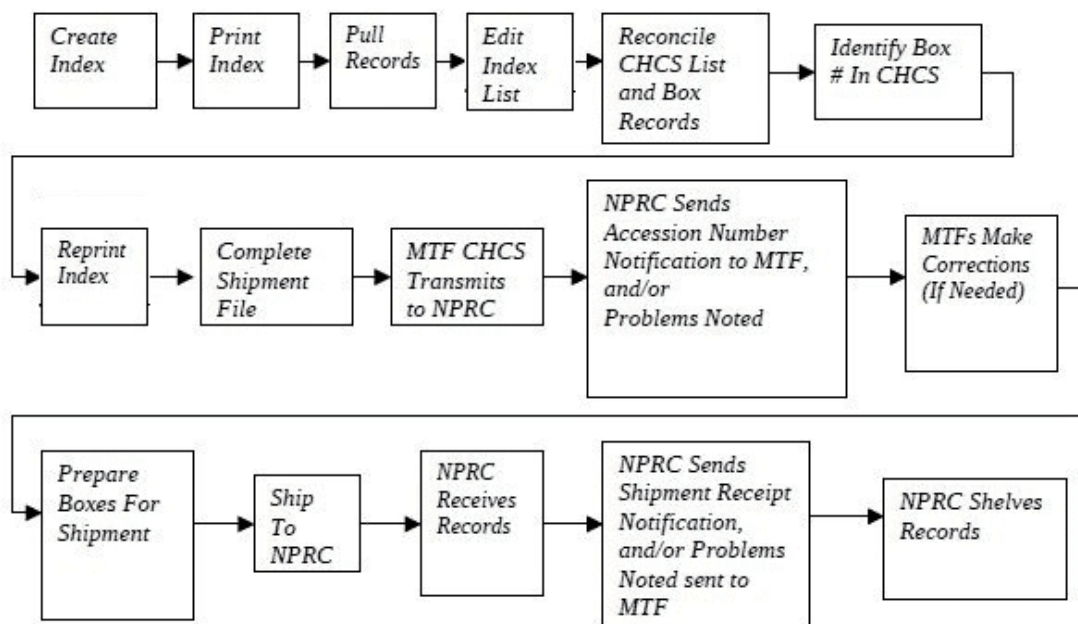
Records Eligible for Retirement

Non-military (including family members and retired personnel) records are referred to as Non-Service Treatment Records (NSTR). MTFs are required to at least annually (no later than the end of the same month from the previous year's record retirement), retire or purge outpatient medical records for family members and retired personnel to the National Personnel Records Center (NPRC). For example, if records were last retired in April 2019, the next records retirement process should be completed by 30 April 2020.

Records may be retired two years after the end of the calendar year of the last date of treatment. This will be determined by a review of the patient's appointment history in the electronic health record. Retire or purge records in accordance with Air Force Records Information System (AFRIMS) Records Disposition Schedule, Series 41, accessible via the Air Force Portal and the Medical Record Tracking, Retirement and Retrieval User Guide (MRTR2), available for download on the Air Force Medical Readiness Agency (AFMRA) Health Benefits Kx, which can be accessed here: <https://kx.health.mil/kj/kx2/HealthSvcsMgmtCFM/Pages/home.aspx>.

All MTFs will utilize the MRTR2 step-by-step guide to set up the CHCS record rooms, create pull lists of retirement eligible records, and to create the final shipment index. MTFs must create a records retirement list by using the Medical Records Menu to enter record selection criteria including record room, record type, and retirement year. A CHCS batch job selects the records and downloads the electronic list to a subfile for use specifically for the records retirement process. The subfile is the records retirement index file, which is printed and used as the pull list to retrieve the records eligible for retirement.

Below is the flow chart that outlines all the steps in the retirement process.



Read the scenario and click each step below to learn more.

Pulling Records and Editing Index List

Here's a scenario, your Lead Records Technician has been getting everyone ready for the annual records retirement. All the medics who have completed a record retirement previously are prepared for a lot of research, you're not sure what that will mean but you remember from your technical training and your career development courses (CDCs) that you know how to research loose medical documentation. You think "I've got a handle on this retirement thing," and you're ready to jump in!

Step 2

Index List

** Transfer/Retire **							
TERMINAL DIGIT From: 00 To: 09							
FMP/SSN	Patient Name	Record Type	Record Vol	PAT Last Pat CAT Activity	Box	Patient SSN	DOB
30/****_**_****	[REDACTED]	OUTPATIENT	V1	F48 21 Jul 1994			05 Sep 1959
01/****_**_****		OUTPATIENT	V1	A41 04 Feb 1994			29 Sep 1992
01/****_**_****		OUTPATIENT	V1	A41 28 Jan 1994			13 Mar 1978
30/****_**_****		OUTPATIENT	V1	F41 03 Dec 1993		****_**_****	21 Oct 1944
01/****_**_****		OUTPATIENT	V1	F41 20 May 1994			27 Apr 1993
30/****_**_****		OUTPATIENT	V1	F41 19 Jul 1994			01 Jan 1964
01/****_**_****		OUTPATIENT	V1	F43 15 Jun 1995		****_**_****	08 Nov 1974
30/****_**_****		OUTPATIENT	V1	F43 07 Jun 1996		****_**_****	10 Nov 1951
20/****_**_****		OUTPATIENT	V1	A31 24 Dec 1995		****_**_****	15 Sep 1956
99/****_**_****		OUTPATIENT	V1	K99 14 Feb 1996		****_**_****	31 Mar 1952
30/****_**_****		OUTPATIENT	V1	N41 17 Jan 1999		****_**_****	01 Oct 1972
30/****_**_****		OUTPATIENT	V1	N43 25 Jun 1999		****_**_****	05 May 1936
30/****_**_****		OUTPATIENT	V2	N43 25 Jun 1999		****_**_****	05 May 1936
30/****_**_****		OUTPATIENT	V3	N43 25 Jun 1999		****_**_****	05 May 1936
30/****_**_****		OUTPATIENT	V4	N43 25 Jun 1999		****_**_****	05 May 1936
30/****_**_****		OUTPATIENT	V1	F43 05 Sep 1995		****_**_****	12 Jan 1958
Press RETURN to continue or "A" to quit.							

Each MTF's record room will split their retirement index. The list will be in terminal digit order. An example index list is below. You may note that there's a column that states "Last Pat Activity", wouldn't that be enough to justify retiring the record? No, as HSMs who conduct our due diligence, we will research and verify before retiring a record.

Step 3

Record Pull



Once you receive your index list you will begin pulling records from the shelf and putting them in a box. You will pull and place records in the order listed on the index.

If you note a record on the list that is not on the shelf, annotate it and continue moving down the list.

Step 4

Research

Once all the records from your assigned index have been pulled, you will begin researching each record. Below are the basic steps you will take to research each record.

1. Search for the patient in the Armed Forces Longitudinal Technology (AHLTA) and review their previous history. If the patient has been seen in the past two years at your facility their record is returned to the shelf. Annotate this on your index list so the record can be removed from the index. If the patient HAS NOT been seen in the past two years at your facility continue to the next step.
 - If the patient has been seen in the past two years, but not at your facility, use the next step outlined below to assist you in determining where to send the record.
2. Use the CHCS/DEERS screen and Mini Registration to determine if the patient has a PCM assigned to your facility. The Defense Medical Information System (DMIS) code will assist you.
 - If the patient has your DMIS code, the DEERS screen shows INELIGIBLE for care AND the patient has not been seen for the past two years per AHLTA the record may be retired.
 - If the patient shows a DMIS code that does not match your facility, and they had appointments in their AHLTA previous encounters you will find the facility associated with the DMIS code reflecting in DEERS and mail the record.
3. Once you've determined that the record can be retired all the information in the electronic health record must be printed and added to the record. You will use AHLTA Web Print (AWP) to retrieve all the documents in AHLTA. Additionally, you will need to confirm that any laboratory or radiology report results from CHCS have also been printed and put in the record.
4. Prior to completing your research, you will verify that the label on the record jacket is clear, legible, and not torn or otherwise illegible. The same process is applied to the record jacket. If the record jacket is torn or unserviceable it must be replaced.

Step 5

Shipped Records List



Once all the records have been researched, the index list will be adjusted to reflect the records that will be shipped.

Step 6

New Index Created

A new index list will be printed, and this list must be reconciled against the records which are in the boxes. You and your team will ensure that the correct records are in the box, in the order displayed on the index list, and the boxes are labeled correctly (i.e., Box 1 of 27, Box 2 of 27, etc.) An example of the final index list is below. Note the box number on the right-hand side of the page.

Step 7

Final Index

Medical Records Transfer and Retire						
FMP/SSN	Patient Name	Record Type	Record Vol	PAT CAT	Last Pat Activity	Box#
30/****_****_****	[REDACTED]	OUTPATI	V1	F48	21 Jul 1994	1
01/****_****_****		OUTPATI	V1	A41	04 Feb 1994	1
01/****_****_****		OUTPATI	V1	A41	28 Jan 1994	1
30/****_****_****		OUTPATI	V1	F41	03 Dec 1993	1
01/****_****_****		OUTPATI	V1	F41	20 May 1994	1
30/****_****_****		OUTPATI	V1	F41	19 Jul 1994	1
01/****_****_****		OUTPATI	V1	F43	15 Jun 1995	1
30/****_****_****		OUTPATI	V1	F43	07 Jun 1996	1
20/****_****_****		OUTPATI	V1	A31	24 Dec 1995	1
99/****_****_****		OUTPATI	V1	K99	14 Feb 1996	1
30/****_****_****		OUTPATI	V1	N41	17 Jan 1999	2
30/****_****_****		OUTPATI	V1	N43	25 Jun 1999	2
30/****_****_****		OUTPATI	V2	N43	25 Jun 1999	2
30/****_****_****		OUTPATI	V3	N43	25 Jun 1999	2
+30/****_****_****		OUTPATI	V4	N43	25 Jun 1999	2
Find Mark pgDn update Help eXit						
Select an item to process.						

The final index list will be placed into the first box in front of the first record. After the boxes are sealed, the Logistics team will assist in mailing the boxes to the National Personnel Records Center.

Summary

This is a lot of information and can feel like a long process. Although it can be research intensive, have no fear because you will work with experts! Always look for the helpers, your NCOIC or supervisor will be there to assist as questions or unique situations arise. Also, don't forget the MRTR2 step-by-step guide. You will have all the tools needed to aid in a successful retirement!

CONTINUE

Knowledge Check. Select and submit the best option in response to the question below.

What type of records are eligible for retirement?

- ☐ All medical records
- ☐ Dependent records only
- ☐ Non-service treatment records

☐

Retiree records only

SUBMIT

Knowledge Check. Select and submit the best option in response to the question below.

What is the first step in the retirement process?

☐

Pull eligible medical records

☐

Print the index list

☐

Research medical records

☐

Adjust index list prior to shipping

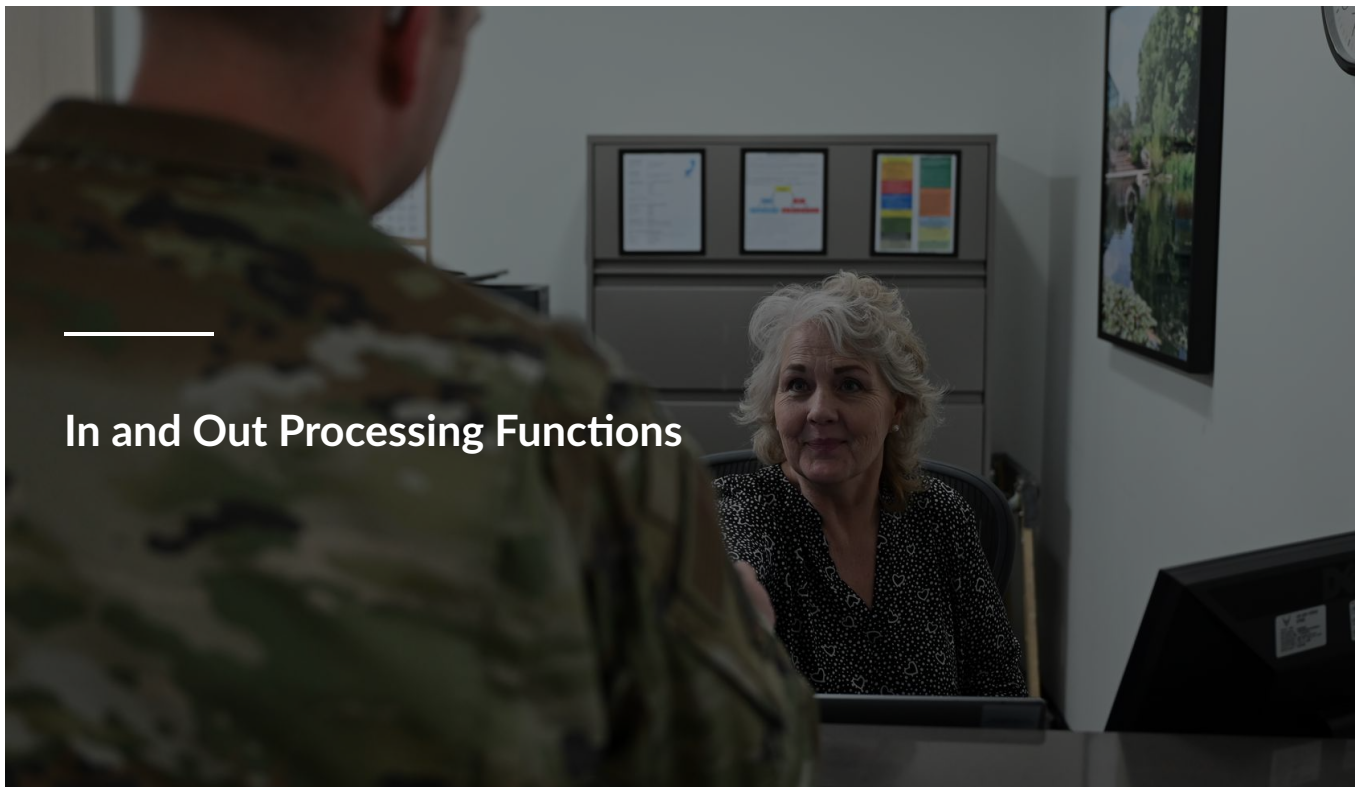
SUBMIT

END OF LESSON

Lesson 3: Outpatient Health Records Duties

After completing this lesson, the student will be able to perform outpatient health record duties, IAW prescribed guidance and publications.

In and Out Processing Functions



The Air Force has an established policy that all military service members will be made aware of their healthcare benefits as they move from one assignment to another. Specifically, members must be informed of:

- the scope of their benefits
- how to access healthcare in their local community
- how to access healthcare while away from home or enroute to a new duty station
- how to resolve problems related to medical care and access during this transitional period, should they arise

Additionally, medical in- and out-processing allows clinicians to review the patient's history and health status, verifying there are no significant medical or dental conditions.



TRICARE Operations and Patient Administration

As a 4A0, you may find yourself working in the TRICARE Operations and Patient Administration. This flight completes the majority of in and out processing for patients. Medical in processing will deliver a wealth of information to patients; but you're not expected to give the whole brief. However, you should have a basic understanding of the following topics:

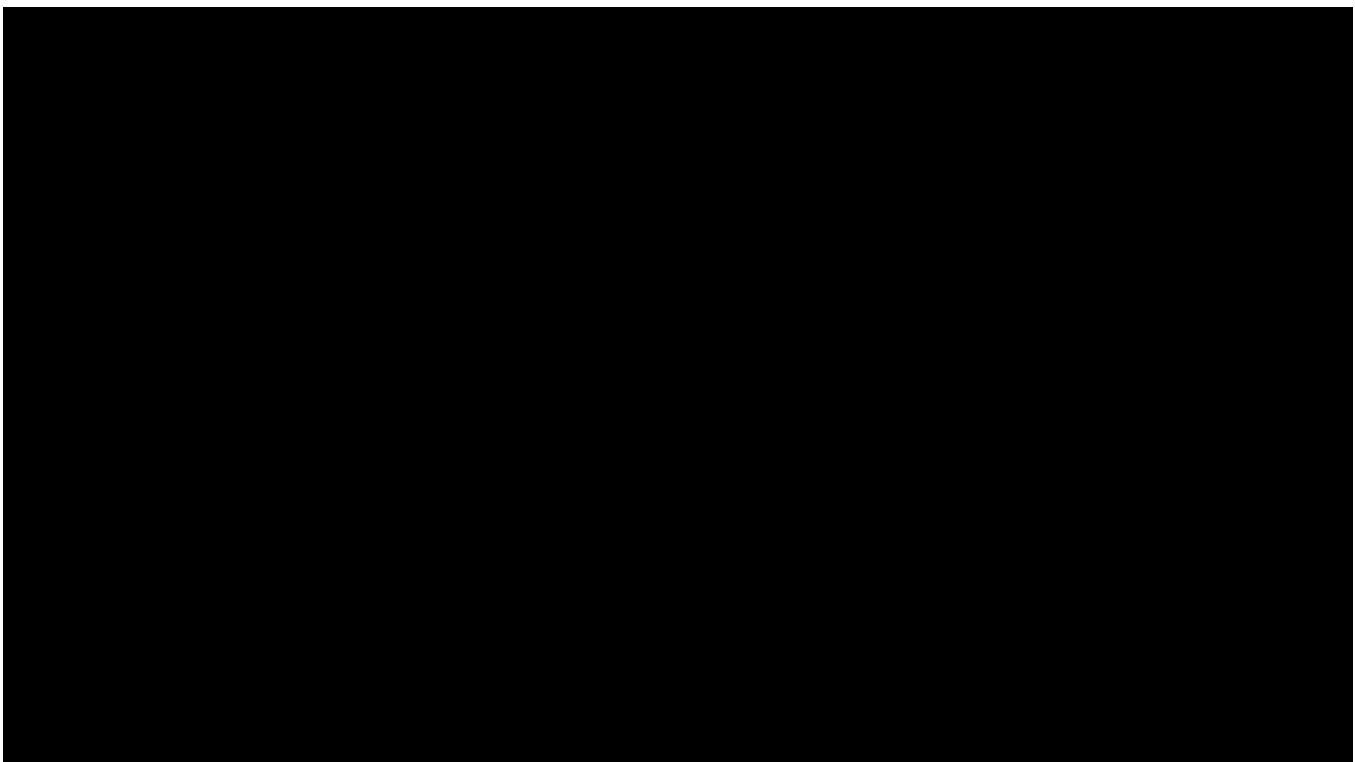
- TRICARE benefits and enrollment for your geographical area
- Demographic data collection (if required for your facility's electronic health record)
- Enrolling family members in the TRICARE Dental option
- Local point of contact for the Managed Care Support Contractor (MCSC)
- Contact information for the Beneficiary Counseling and Assistance Coordinator/Debt Collection Assistance Officer
- Local services available at your MTF
- DoD Custody and Control policy

- Secure message enrollment

The likelihood of an active-duty member hand carrying their medical records with them is small; however, should someone bring their record, collect and deliver it to the outpatient records room.



Click the video below to learn more about a newcomer's briefing.



If a member requests to carry their medical record, you will remind them of the DoD Custody and Control policy. Depending on the Electronic Health Record your facility has, you may need to confirm that ancillary test results (laboratory and radiology) are uploaded.

At a minimum, beneficiaries will be briefed on the following items:

- Scheduling appointments, obtaining prescriptions, and filing medical claims while in transit.
- Obtaining emergency care while in transit.
- Transferring and/or changing service member and dependent's PCM upon in processing at new MTF.

CONTINUE

Knowledge Check. Select and submit the best option in response to the statement below.

If a member requests to carry their medical record, you will remind them of the DoD Custody and Control policy. Depending on the Electronic Health Record your facility has, you may need to confirm that ancillary test results (laboratory and radiology) are uploaded.

☐

True

☐

False

SUBMIT

Knowledge Check. Input and submit your response into the statement below.

The Air Force has an established policy that all military service members will be made aware of their _____ as they move from one assignment to another.

Type your answer here

SUBMIT

CONTINUE



Perform Medical Record Tracking

Most MTFs no longer charge out records for appointments; however, as we transfer to a completely electronic system, you will still be responsible for tracking the paper records that remain. For instance, when an active-duty member and their family moves, you will have to transfer their record to the new facility. Once you've spent some time in your MTF, you will notice the transformation that is occurring throughout the Military Health System.

Due to the extensive amount of time it takes to produce and implement new processes, one MTF may be using a new system while another is still on the legacy system. For that reason, some processes will be described in both systems. There are multiple menu options to track records within CHCS, this lesson will go over the most direct route. Over time, you will develop your preferred method of tracking records within the system.

One change that has been occurring for years is moving medical records from paper to electronic.

The most common scenario in which you would need to track a record is when you can't find it on the shelf.

Tracking Medical Records, Legacy System

1

Use the CHCS/DEERS screen and Mini Registration to determine if the patient has a PCM assigned to your facility. The Defense Medical Information System (DMIS) code will assist you. If the

patient has your DMIS code, determine if the patient's medical records are maintained in a different record room.

2

If CHCS/DEERS gives your facility as a DMIS, go through the medical record menu, IN (Record Info), and RI (Record Inquiry). If no record is found, initiate a new record in CHCS and make a folder.

Tracking Medical Records, Paper Record Tracking (PRT) System

PRT is a “global” record tracking system. Once a record has been added or created in the system, anyone can view where the record is located.

1

Navigate to the RRT/RRM homepage.

2

Enter the PRT Record Number at the top of the screen manually or by scanning the barcode (if your MTF has the appropriate equipment).

3

Search for the record, once the results are displayed choose the patient you need.

4

Select Record Details to view the location for the patient's record. Below is an example of the Record Details screen.

RRT/RRM Homepage

PRT

RRT/RRM Homepage > Outpatient | Medical - OHTR (Civilian Employee Medical Folders (SF66D)) (397516)

Show all Records for this Patient

Edit Record Details

Charge-In Record

Sequester Record

Record Details

Patient Information

Label

Charge-Out Card

Temporary Movement Card

Retirement

Record History

Record Type

Outpatient

PRT Record Number

397516

Sponsor SSN

806416665

Volume

1

Record Subtype

Medical - OHTR (Civilian Employee Medical Folders (SF66D))

CHCS Record Number

FMP

20 | Sponsor

Home Location

zzzz | Fictional MTF 1 | Room #1 for test data | Outpatient

Record Status

Charged-Out

PATCAT

A11 | USA AD (OFF)

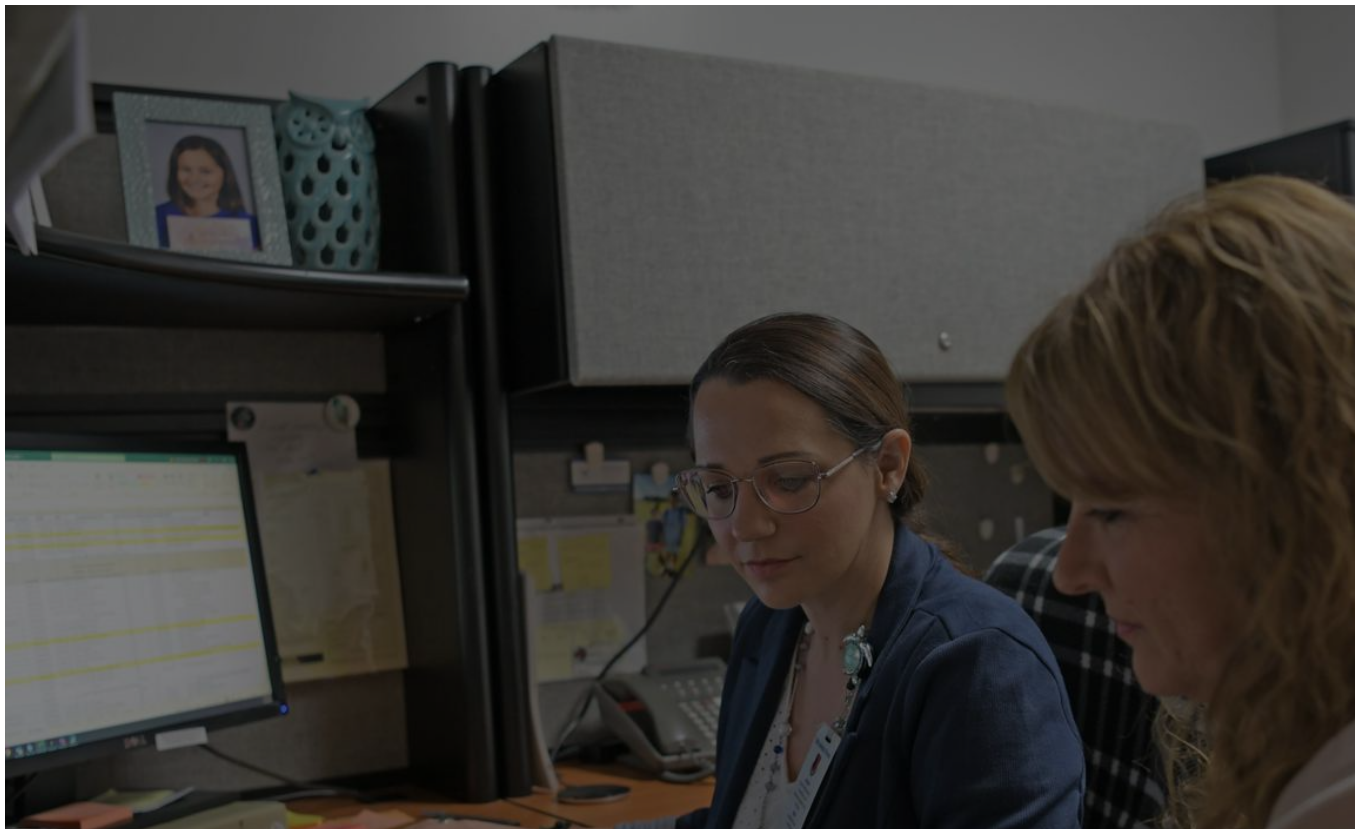
Current Location

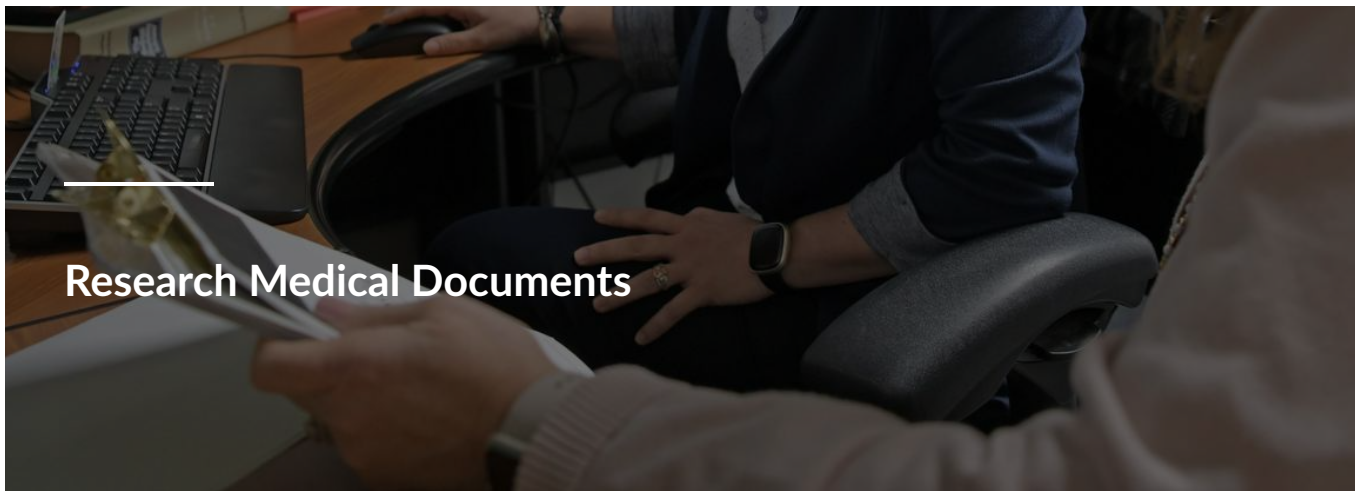
Borrower: ROBERT GRISSETT, Location: Fictional MTF 1

CHCS Home Location

PRT Location (see Home Location field)

Eligible For Retirement





Research Loose Medical Documentation in the Legacy System

Most MTFs no longer file documents in the hard copy record, instead these documents are scanned into the electronic health record. There are some exceptions such as patients on special status; for example, a pilot that is on fly status.

This more in-depth research is required if you've already conducted medical records tracking, or the record tracking mistakenly shows the record in your records room.

1

Use the CHCS/DEERS screen and Mini Registration to determine if the patient has a PCM assigned to your facility. Alternatively, you may use the General Inquiry of DEERS Internet website at <https://dwp.dmdc.osd.mil>. The sponsor's social security number is required to complete search.

2

If the patient is assigned to a different DMIS code than your facility, check your DMIS code book to find the location and mail the paperwork to that location. Print a copy of the DEERS CHCS screen to accompany the paperwork.

3

If the patient already has a medical record established, research the current location of that record. Using CHCS record menu, IN (Record Info), and TM (Trace Movement) should give you an indication of the current location.

4

If the patient has been identified through CHCS/DEERS as a reserve or guard member, search for their unit identification code (UIC). Confirmation of the exact MTF responsible for maintaining the beneficiary's health record(s) is required.

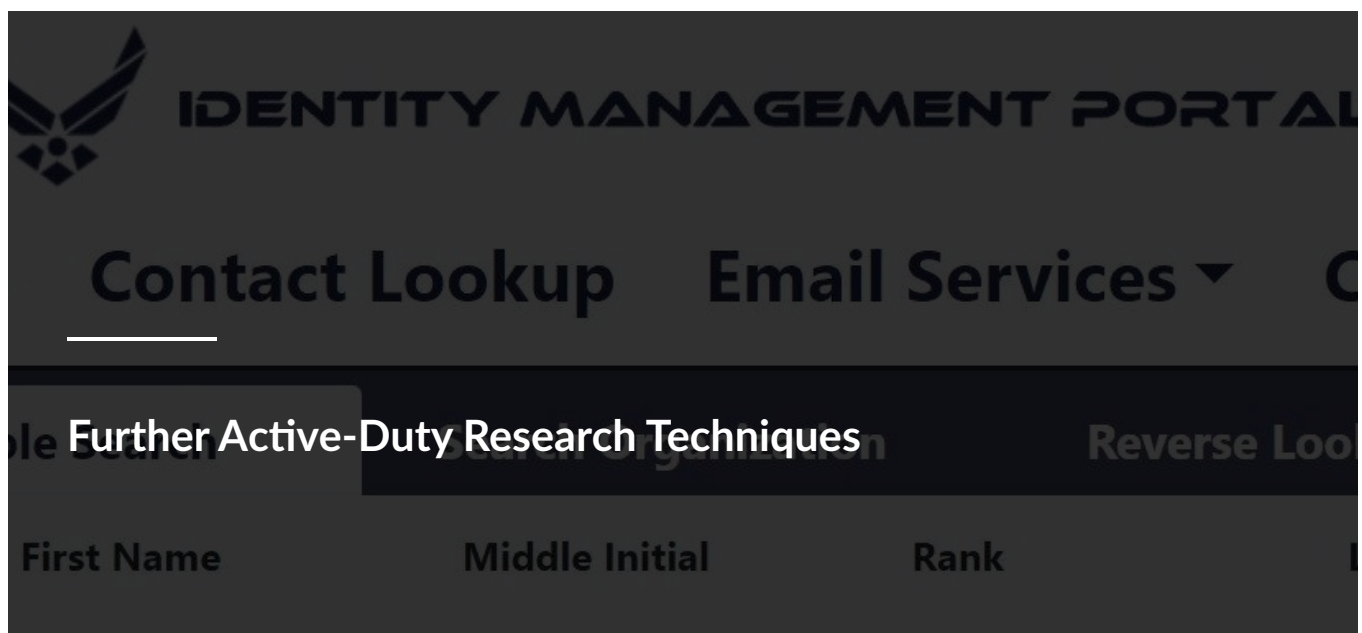


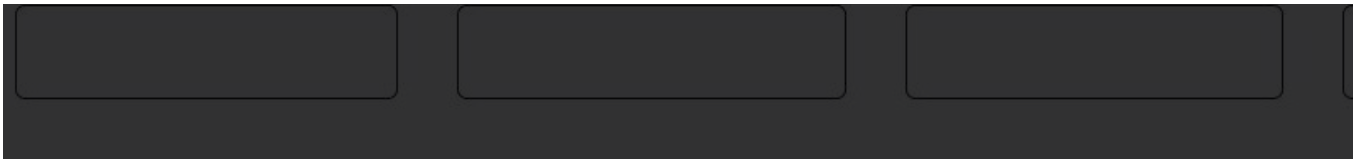
NOTE: The practice of blindly mailing medical documents or records to the MTF closest to where the beneficiary lives or works is prohibited.



FYI

The steps described earlier in this lesson for PRT will be the same steps used to search for a medical record in order to file loose documentation.





Below is a list of additional research techniques that can be used to identify the location of active-duty medical records.

1

When researching Air Force service member, access the Air Force Portal website's "White Pages" locator at <https://www.my.af.mil/>. Additionally, the Air Force global e-mail directory may be used as another alternative reference method.

2

Although not a medical record or MTF locator, the DefenseLink Internet website at <https://www.defense.gov/> may be of some limited use when researching an individual service member's duty address or duty contact information.

CONTINUE





Conduct Search for Misplaced Records

Before we discuss how to conduct a search for misplaced records, first we will review the most common scenarios in which a record may be “missing.”

- A health record is missing from the main record file with no documented borrower location or date.
- A health record is missing from the main record file with a documented borrow location and date, but the physical record has not returned to the main file following a period of 30 calendar days or more without a documented explanation.
- A health record is missing after a thorough investigation and search from the NCOIC or lead records room technician.



NOTE: Prior to determining that a record is lost, you must consult with your NCOIC or lead records room technician.



Once a record is deemed missing, follow these steps:

- 1** Identify a possible borrower charge-out location utilizing the CHCS medical records tracking module.
- 2** Utilize the PRT tracking steps discussed earlier in this lesson.
- 3** Each MTF staff member is required to search their immediate work area.
- 4** Check for misfiles everywhere in the record rooms. Send e-mails to other record room personnel to request records or medical

information.

5

Search provider offices and exam rooms; ensure the record hasn't been sent for a peer review or clinical review committee, meeting, or function. Contact the patient's previous bases.

6

Contact the patient to ensure they have not mistakenly kept their medical record.

The [TOPA Kx](#) website shown below has a directory for medical records representatives across the Air Force.

Newsfeed OneDrive Sites Amanda M Gilbert

Health Services Management CFM

DHA HEALTH.MIL TRICARE DHHQ

Search This Site...

Headquarters View Functional View MAICOMs & MTFs Restricted Access CAIB & IDS Find a Site Help

KxCP Sites to migrate to Azure GovCloud in spring 2023, click here for more information.

Site Documents Discussions Blog

4AO HSM Home AFMOA Admin Drive (Admin only) Site Metrics

4AO Health Services Management
"In Demand and Indispensable"

Tricare Operations & Patient Administration

HPM Directory TOPA FR Leadership Toolkit TRICARE Toolkits

*** New TOPA Leaders, please access the HPM Directory to update your MTF's TOPA Flight leadership contact information ***

TRICARE OPERATIONS	PATIENT ADMINISTRATION	TRAINING & GUIDANCE	POCs
AMTU	HIPAA	AFMS ACCESS IMPROVEMENT	MSgt Victoria Pierce
BCAC/DCAO	IDES	AIR FORCE MEDICAL SERVICE	TOPA Associate Career Field Manager
ENROLLMENT	MEDICAL RECORDS	APPOINTING INFORMATION SYSTEMS	210-292-4320 (DSN 554) victoria.pierce.mil@health.mil
PATIENT TRAVEL	PATIENT REGISTRATION	GROUP PRACTICE MANAGER (GPM)	MSgt Carmen Matta
REGION INFORMATION			Superintendent, Health

Often, the items listed above will enable you to locate a missing medical record. If you're still unable to locate a record, notify your HIPAA officer and NCOIC, or lead records technician to complete a non-availability letter (active duty only) and MTF verification checklist.

CONTINUE

Knowledge Check. Select and submit the best option in response to the question below.

What system is used as a “global” record tracking system?

- ☐ Composite Healthcare System (CHCS)
- ☐ Paper Record Tracking (PRT)
- ☐ Armed Forces Health Longitudinal Technology Application (AHLTA)
- ☐ Defense Enrollment Eligibility Report System (DEERS)

SUBMIT

Knowledge Check. Select and submit the best option in response to the statement below.

There are multiple ways beside the electronic health record system to search for active-duty records.

☐

True

☐

False

SUBMIT

Knowledge Check. Input and submit your response into the statement below.

The _____ website has a directory for medical records representatives across the Air Force.

Type your answer here

SUBMIT

CONTINUE

Electronic Health Record System

DEPARTMENT OF DEFENSE
MHS
GENESIS
MILITARY HEALTH SYSTEM

Since 2006, the AFMS has used AHLTA, the DoD's approved electronic health record (EHR) for the day-to-day outpatient care documentation processes. Until completely transitioned to an EHR, the AFMS will use a *hybrid* record consisting primarily of the electronic health record and include traditional paper-based records and forms to meet unique operational mission requirements. Most recently, the DoD has started transitioning to the Military Health System (MHS) Genesis. Your facility could be anywhere in the transition process, or still using the legacy system.

There could be a time when you see a full EHR transition; however, until that point, we are required to import documents.

Within your facility, you may note there are multiple EHRs that are used. Below is a list of some of the EHR systems you may encounter:

- AHLTA and CHCS – outpatient medical/dental care.
- Essentris – inpatient medical care.
- Composite Health Care System (CHCS) II-Theater (Armed Forces Health Longitudinal Technology Application-Theater (AHLTA-T)).
- Health Artifact and Image Management Solution (HAIMS) – enterprise-wide data sharing capability for all types of artifacts and images.

- MHS GENESIS – new electronic health record for MHS providing a single health and dental record for beneficiaries.

CONTINUE



Scan/Upload Artifacts and Images into Electronic Repository

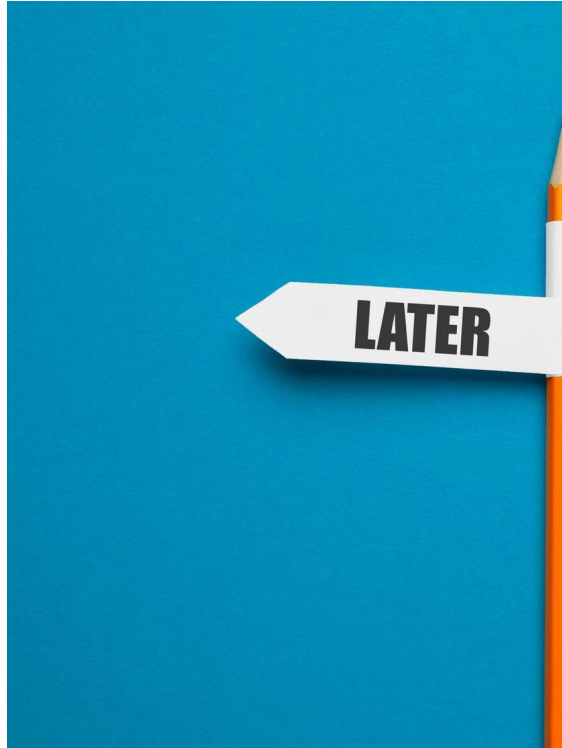
In this section, you will learn how to fill, scan, and upload new documents into the EHR and in the Health Artifact & Image Management Solution (HAIMS). There are two different paths to upload documents into a patient's record within HAIMS:

1. Scan a document then upload into HAIMS at a later time
2. Scan directly into HAIMS



Click through the steps below for each option.

Option 1-Scan and Upload Later



Step 2

Identify the Patient



Identify the patient and search for them within HAIMS

Step 3

Identify the Patient (continued)

The screenshot shows a web application interface for patient search. At the top, there is a navigation bar with buttons for 'Dashboard', 'Patient Search', 'Reports', and 'Bulk Scan'. On the right side of the navigation bar are buttons for 'Help' and 'My Settings'. Below the navigation bar, there is a status bar showing '<No Patient Selected>' and a 'quick search...' input field with a magnifying glass icon. The main section is titled 'Patient Search'. Inside this section, there is a form with several input fields. The 'Quick Search' field is highlighted with a blue border. Other fields include 'DoD ID', 'Last Name', 'First Name', 'DOB' (with a date picker icon), 'Gender' (a dropdown menu), 'Patient SSN', 'FMP', and 'Sponsor SSN'. At the bottom right of the form, there is a checkbox labeled 'Include DEERS' and two buttons: 'Search' and 'Clear'.

Dashboard Patient Search Reports Bulk Scan Help My Settings

<No Patient Selected> quick search... Q

Patient Search

Quick Search DoD ID

Last Name First Name DOB DD Mmm YYYY Gender

Patient SSN FMP Sponsor SSN

☐ Include DEERS Search Clear

Perform your search.

Step 4

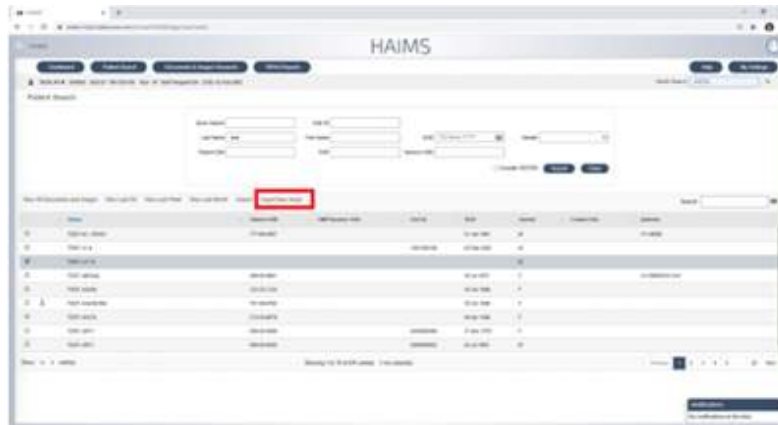
Select the Correct Patient

View All Documents and Images View Last (N) View Last Week View Last Month Search Import New Asset						
	Name	Patient SSN	FMP/Sponsor SSN	DoD Id	DOB	
<input checked="" type="checkbox"/>	ATEST, AMANDA	000-00-1101		1000799965	01 Jan 1940	
<input type="checkbox"/>	ATEST, ANNIE	111-11-1101			01 Jan 1940	

Once your results appear select the patient you require.

Step 5

Import



Once you've selected the patient, choose *Import New Asset*.

Step 6

Choose File

Acquire Asset - Import New

Select a File or Scan an Asset

☐ Browse and upload a file ☒ Scan and upload image

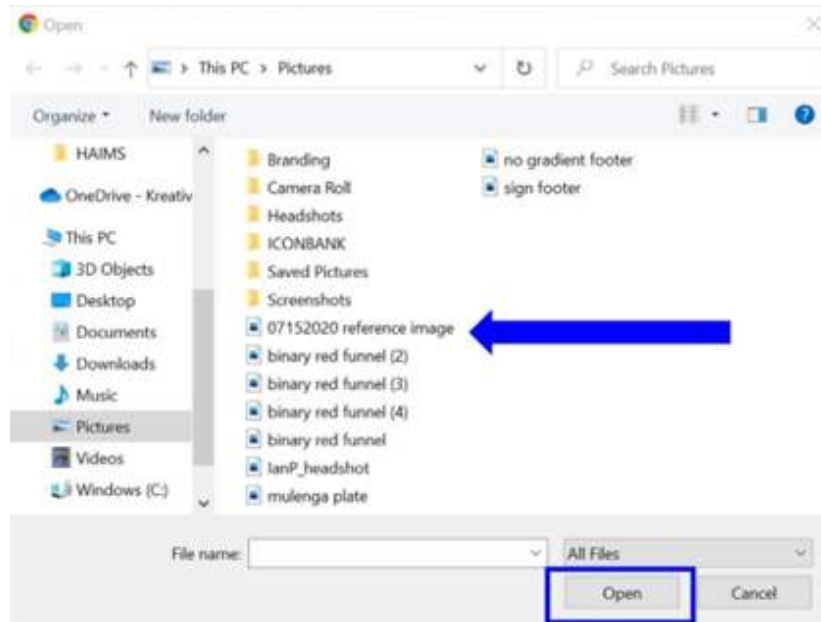
Scan

Cancel

A new dialogue box will open, choose whatever option pertains to your situation.

Step 7

Upload the File



Choose the appropriate file and click *Open*.

Step 8

Upload the File



Acquire Asset - Import New

Select a File or Scan an Asset

☒ Browse and upload a file ☐ Scan and upload image

Choose File 07152020 reference image.png

Examples of unsupported file extensions: .BAT, .DLL, .EXE, .VBS

Upload Cancel

You should now see your file ready to upload.

Step 9

Metadata

The screenshot shows a 'Metadata Form' with a tabbed interface. The 'Details' tab is active, displaying various input fields for document and organization information. The form is organized into sections: 'Details', 'DoD Organization', 'Non-DoD Organization', and 'DoD or Non-DoD Organization Address'. Each section contains specific fields with labels and icons for help or validation. At the bottom, there are four buttons: 'Cancel', 'Save and Close', 'Save and New', and 'Save From my Requests'.

Metadata Form

Details

Author Name (Full Name of document author or user selected)

Document Type

Date Document Created (DD-MM-YYYY)

Security

Urgency (Priority)

Word Count

Start and End Date

Document Title

Priority Setting

Urgency (Priority)

Document or Document

DoD Organization (Please select organization which the document has originally created)

Non-DoD Organization (Please select organization which the document has originally created)

Facility Name

Phone

DoD or Non-DoD Organization Address

Address

City/Province

Postal Code

State/Province

Country

Once you've selected upload, you will need to fill in metadata for the visit.

Step 10

Save and Close

Once you've filled in all information click *Save* and *Close*.

Option 2- Scan Direct to HAIMS



Step 2

Identify the Patient

The screenshot shows the 'Patient Search' section of a web application. At the top, there are navigation buttons: 'Dashboard', 'Patient Search' (active), 'Reports', and 'Bulk Scan'. On the right, there are 'Help' and 'My Settings' buttons. Below the navigation bar, a status bar shows '<No Patient Selected>' and a 'quick search...' input field with a magnifying glass icon. The main 'Patient Search' form contains several input fields: 'Quick Search' (highlighted with a blue box), 'DoD ID', 'Last Name', 'First Name', 'DOB' (with a date format 'DD Mmm YYYY' and a calendar icon), 'Gender' (a dropdown menu), 'Patient SSN', 'FMP', and 'Sponsor SSN'. At the bottom right of the form, there is a checkbox for 'Include DEERS' and two buttons: 'Search' and 'Clear'.

Identify the patient and search for them within HAIMS.

Step 3

Select Patient

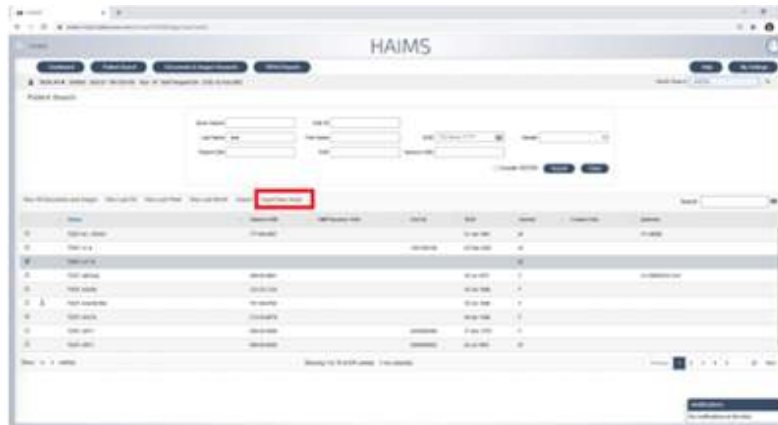
The screenshot displays a web application interface for patient search. At the top, there is a navigation bar with buttons for 'Dashboard', 'Patient Search' (which is highlighted), 'HIPAA Reports', 'Bulk Scan', 'Help', and 'My Settings'. Below the navigation bar, a status bar shows '<No Patient Selected>' and a 'quick search...' input field. The main section is titled 'Patient Search' and contains several input fields: 'Last Name' (with 'atest' entered), 'First Name', 'DOB' (with a date picker set to 'DD Mon YYYY'), 'Gender' (a dropdown menu set to 'Female'), 'Patient SSN', 'FMP', and 'Sponsor SSN'. There is also an 'Include DEERS' checkbox and 'Search' and 'Clear' buttons. Below the search filters is a table with columns: Name, Patient SSN, FMP/Sponsor SSN, DoD Id, DOB, Gender, Contact Info, and Address. The table contains two rows of data. At the bottom right, there is a 'Notifications' section that says 'No notifications at this time'.

	Name	Patient SSN	FMP/Sponsor SSN	DoD Id	DOB	Gender	Contact Info	Address
<input type="checkbox"/>	ATEST, AMANDA	000-00-1101		1000799965	01 Jan 1940	F		ATEST ADDRESS 123
<input type="checkbox"/>	ATEST, ANNIE	111-11-1101			01 Jan 1940	F		TEST ADDRESS 123

Once your results appear, select the patient you require.

Step 4

Import



Once you've selected the patient, choose *Import New Asset*.

Step 5

Scan and Upload

Acquire Asset - Import New

Select a File or Scan an Asset

☐ Browse and upload a file ☒ Scan and upload image

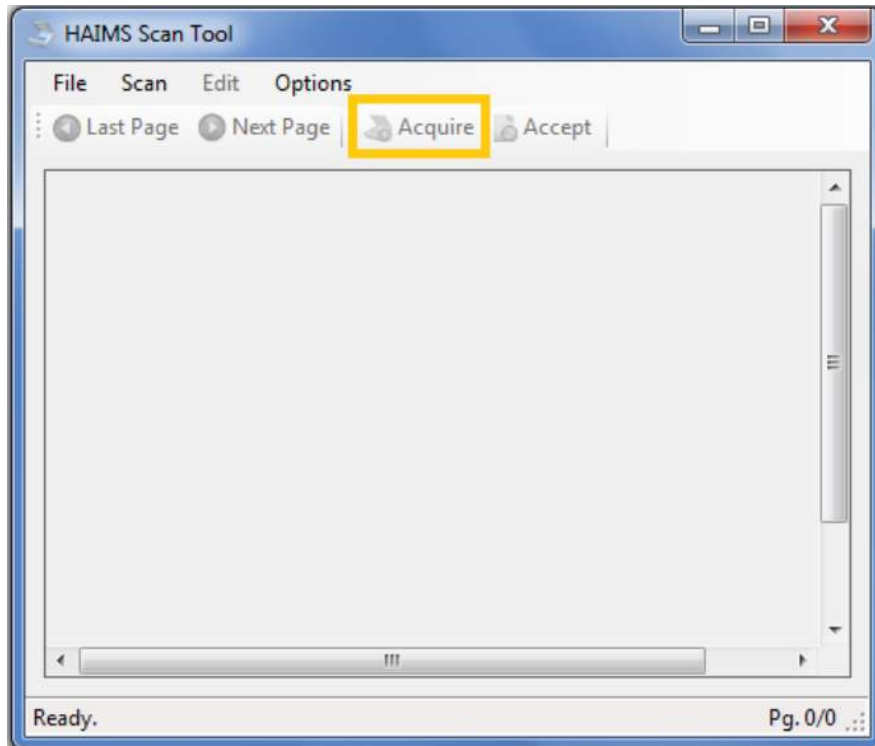
Scan

Cancel

A new dialogue box will open, choose *Scan and Upload Image*.

Step 6

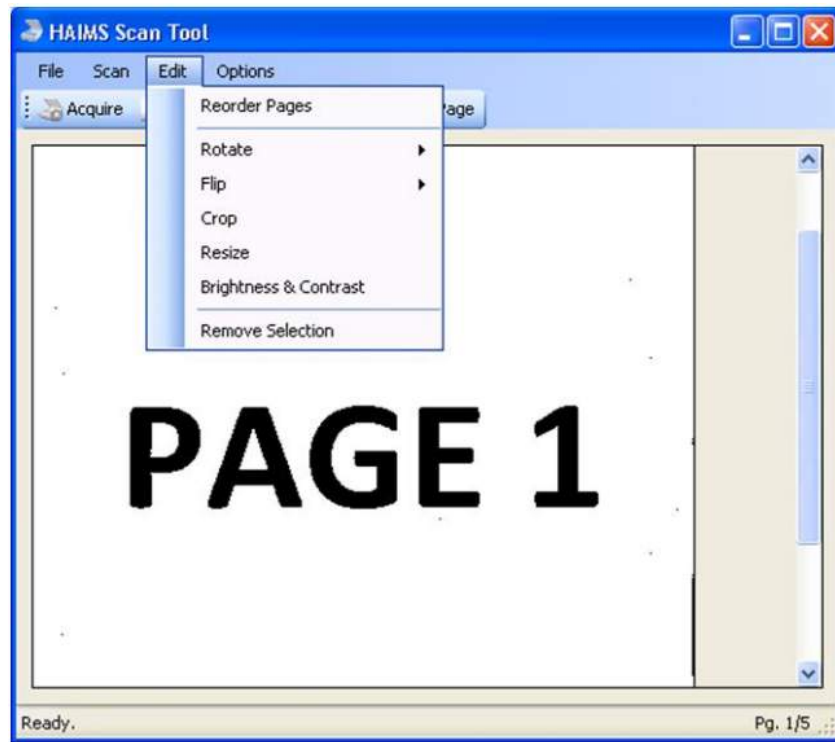
Acquire



The HAIMS scan tool will open, click *Acquire*.

Step 7

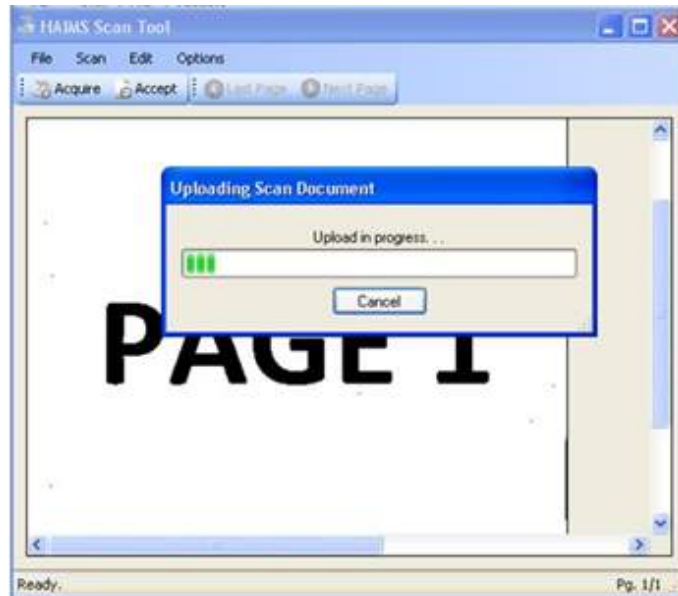
Accept



Once the document has been scanned it will appear in the HAIMS Scan Tool, once you've verified all pages have been scanned you may use the *Edit* function to make any necessary pages. After the document has been quality checked, click *Accept*.

Step 8

Upload in Progress



You should now see an upload in progress bar appear on your screen.

Step 9

Metadata



Once the document has been acquired in HAIMS, the document will appear on the left and the metadata will be on the right.


You can also upload into MHS Genesis, as shown in the steps below.

MHS Genesis

MILITARY HEALTH SYSTEM
MHS GENESIS

Need help with the
MHS GENESIS Patient Portal?

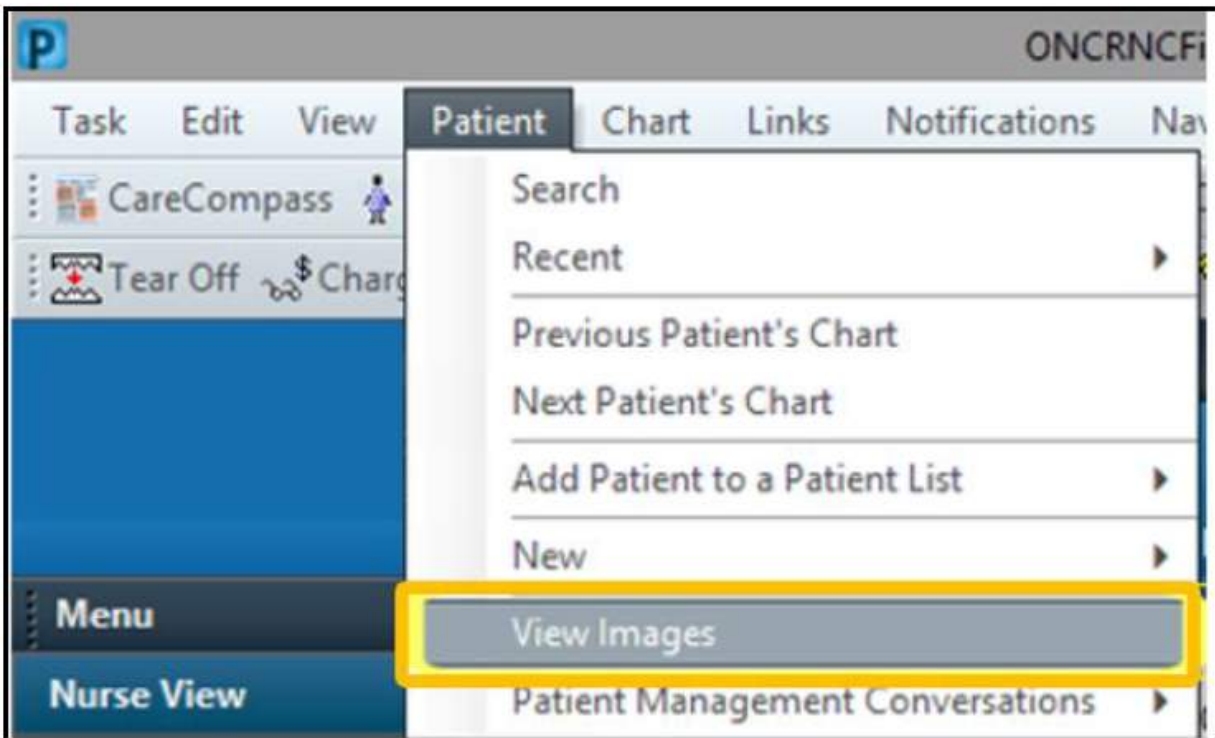
Please call
1-800-538-9552



For help with DS Logon, visit: <https://milconnect.dmdc.osd.mil>

Step 2

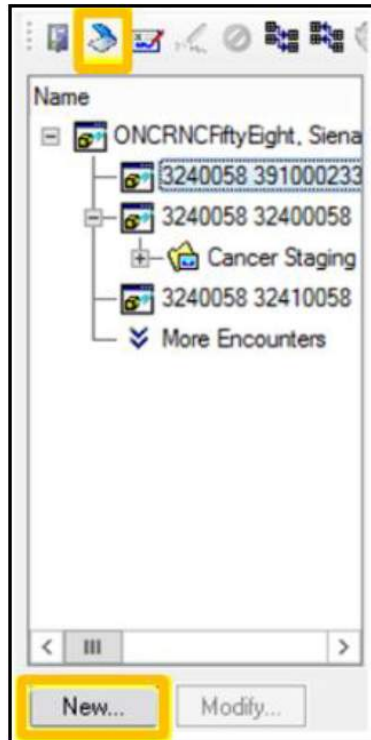
Select Patient



From PowerChart, open a patient's chart and select *Patient* from the menu bar, then select *View Images*.

Step 3

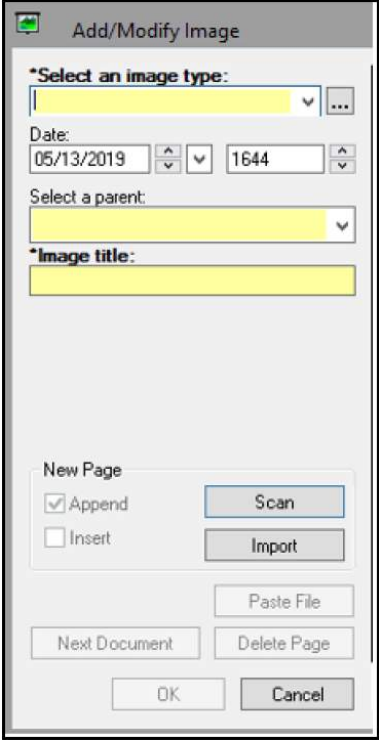
Add / Modify Image



Click either the *Scanner* icon or the *New* button at the bottom of the window. Both will open the *Add/Modify* image.

Step 4

Select Image / Load Document



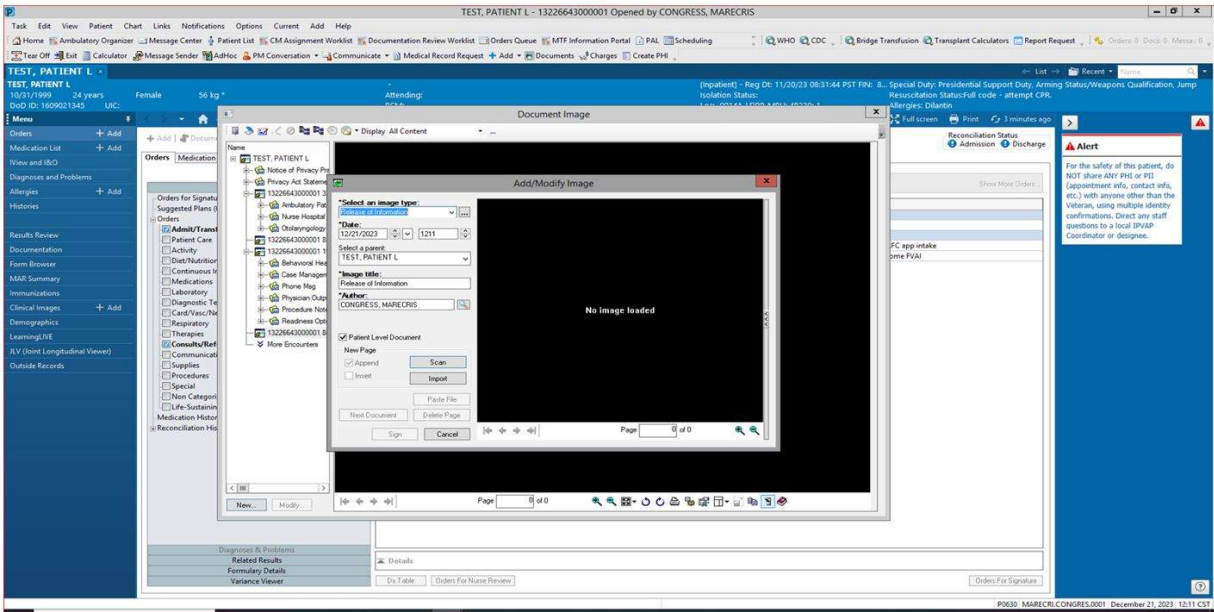
The screenshot shows a dialog box titled "Add/Modify Image". It contains the following fields and controls:

- *Select an image type:** A dropdown menu with a yellow background and a small "..." button to its right.
- Date:** Two date pickers. The first is set to "05/13/2019" and the second is set to "1644".
- Select a parent:** A dropdown menu with a yellow background.
- *Image title:** A text input field with a yellow background.
- New Page:** A section containing two checkboxes: "Append" (checked) and "Insert" (unchecked).
- Buttons:** "Scan" (blue), "Import" (grey), "Paste File" (grey), "Next Document" (grey), "Delete Page" (grey), "OK" (grey), and "Cancel" (grey).

Select the appropriate image type for the document that will be scanned by expanding the select an image type list. Load the document or documents into the scanner to be scanned and click scan in the *Add/Modify Image* window.

Step 5

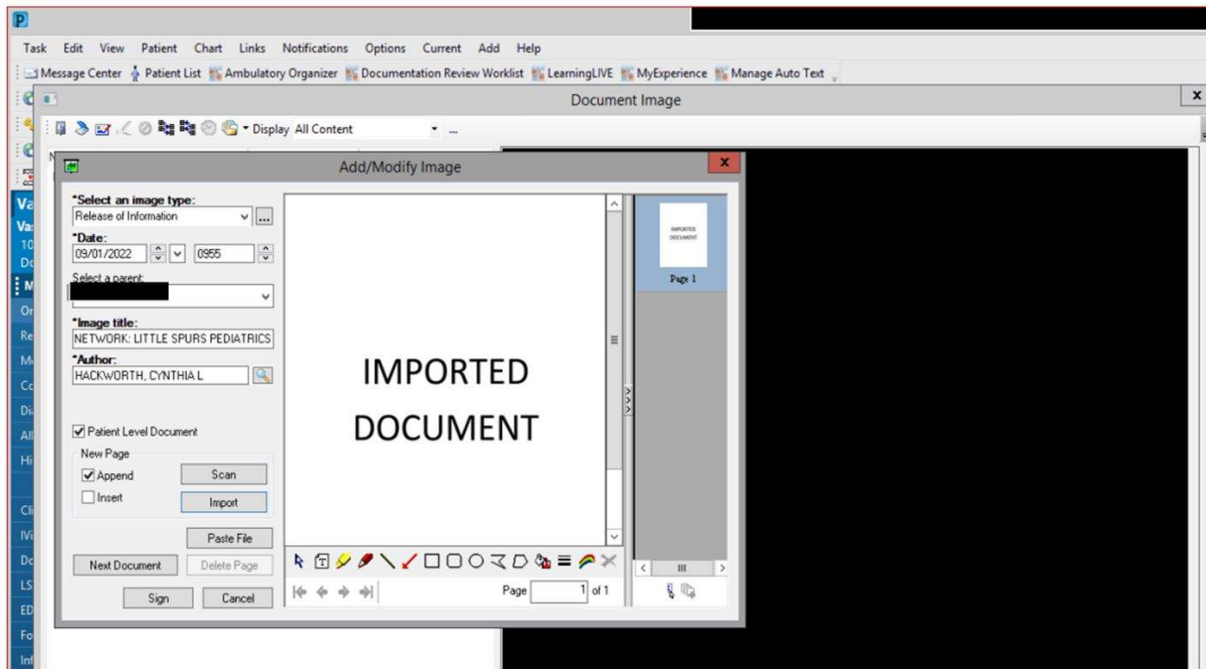
TWAIN



The Technology Without an Important Name (TWAIN) window will open. Select the scanner profile that will be used to scan. TWAIN window appearance will vary depending on the scanner model. Select the appropriate scanner profile then click **Scan**.

Step 6

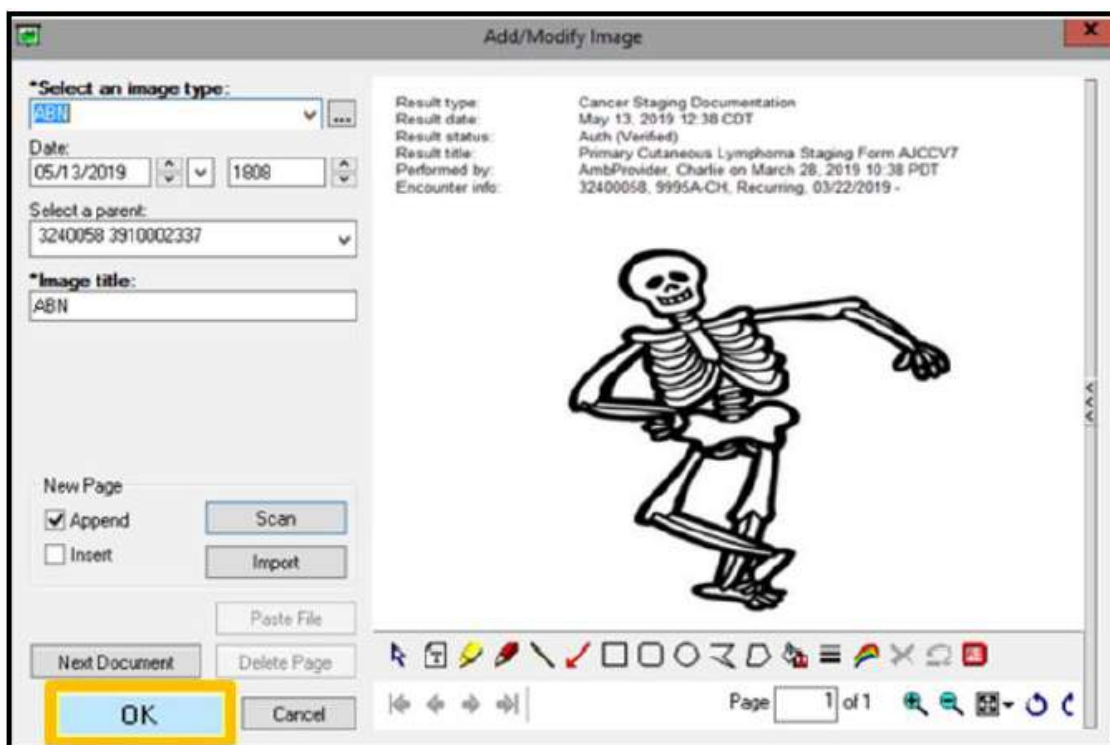
Close Window



Close the TWAIN window once all documents have been scanned.

Step 7

Save Document



The *Add/Modify Image* window will display with the image that was scanned. If no more documents need to be scanned, click **OK** to save the document.

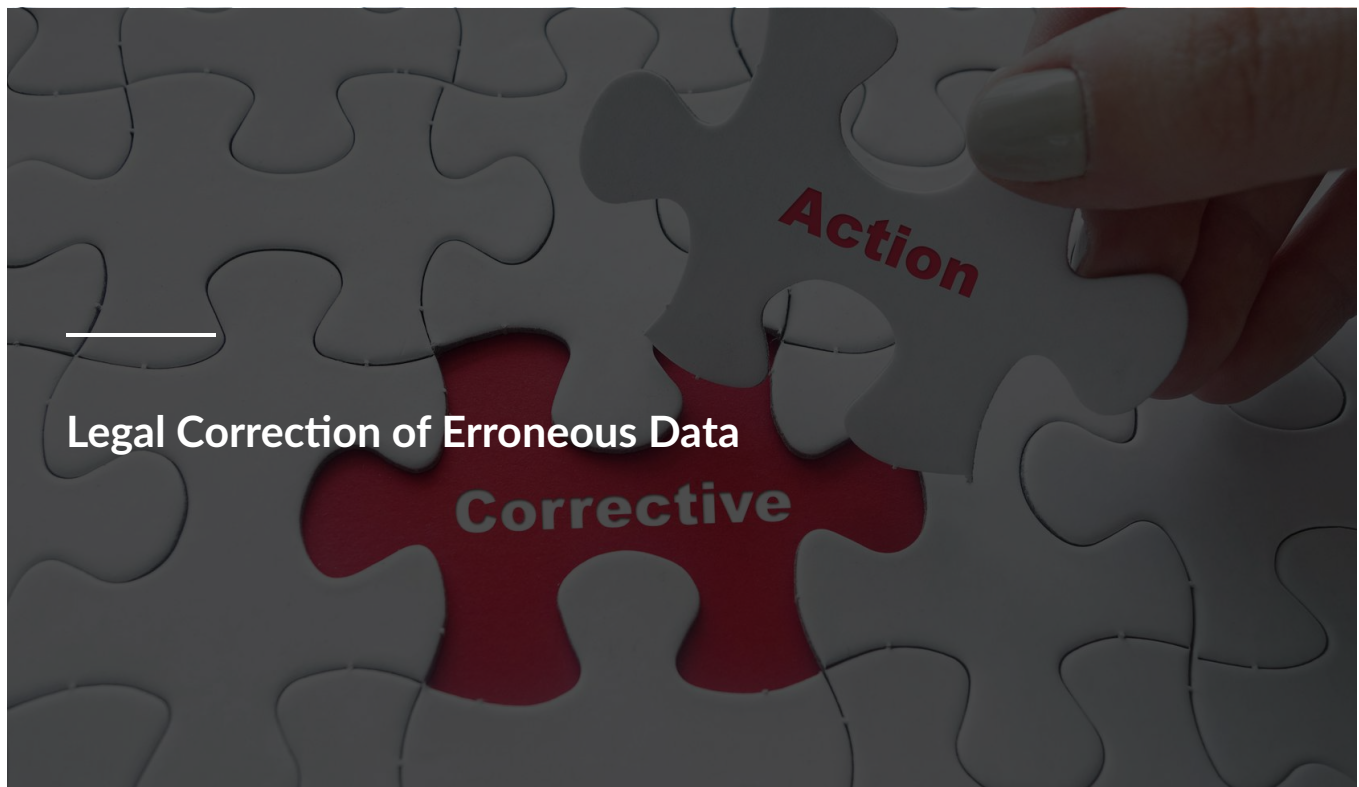
Repeat all prior steps to scan additional documents.

Step 8

Close Button



Once single document capture is complete, click the *Close* button and return to the patient's chart.



What happens if you find a document uploaded in the wrong record?



Mistakes Happen!

We're all human and mistakes happen, like discovering an incorrect file in a hard copy record. However, there is a way to correct this. If you discover a mistake, you will need to speak to your HIPAA privacy officer to request a legal correction. Your HIPAA privacy officer will most likely ask for basic data on the record, afterwards they will complete the process.

CONTINUE

Knowledge Check. Input and submit your response into the statement below.

Since _____ the AFMS has used AHLTA, the DoD's approved electronic health record for the day-to-day outpatient care documentation process.

Type your answer here

SUBMIT

END OF LESSON

Lesson 4: Service Treatment Record (STR)

After completing this lesson, the student will be able to perform service treatment record functions, IAW prescribed guidance and publications.

Health Record Disposition Processing

disposition

***There are two categories of health records:
The first category is the service treatment
record (STR) and the second category is the
non-service treatment record.***



Click each tab below to learn more.

STR

The outpatient medical record and dental treatment record for a member of the United States military. It is made up of the patient's medical and dental encounters incurred throughout the course of their military career.

The STR begins upon entry to active duty via the Military Entrance Processing Station (MEPS) intake physical, or commissioning physical, and *ends* upon discharge, retirement, separation, or death (if death occurred while on active duty).

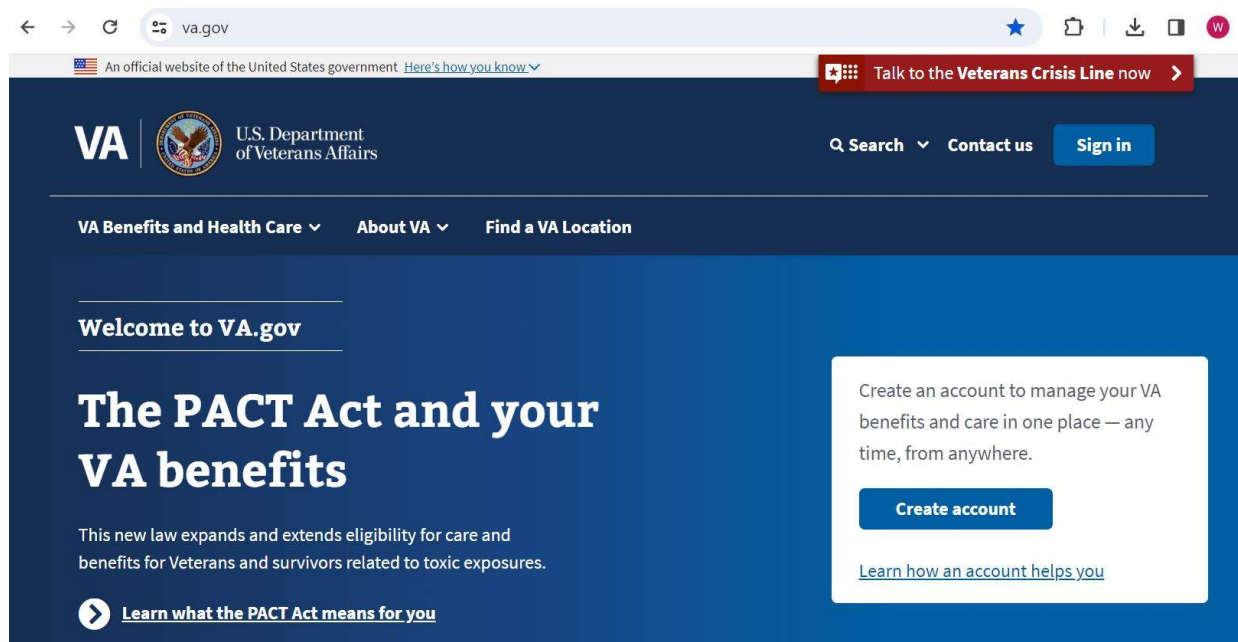


Non-STR —

Outpatient medical records for patients in all other categories (dependents, civilians, foreign military, retirees, etc.).



The STR process is mandated for all Air Force MTFs. This process requires that all Airmen retiring or separating from service will have their medical record mailed to a centralized STR cell in San Antonio, Texas.



You're the Key!

You play a key role in ensuring that America's veterans receive medical care. Record managers, as stewards of the Medical Corps and appointed maintainers of the medical/dental records, have an obligation to veterans – to ensure their complete STR is ready and available to the Veterans Affairs (VA) when the member chooses to file a claim.

While a claim can be initiated with a copy of the medical record, it is not official or complete without the *original* records. Without the original record, the member's claim will be left incomplete and unfiled, and the member will not receive their due compensation.

Active duty and Reserve component records disposition rules are subject to frequent

changes. For the latest information, proceed to the TOPA knowledge exchange (Kx) [website](#).



Click the steps below for general STR process instructions.

STR Process



The steps outlined in these slides are generalized instructions for the STR process. You should always consult your lead record technician or NCOIC prior to the start of a new process.

Step 2

Pulling the Loss Roster

You will be granted access to the Medical Records Management SharePoint site. On this site you will pull the loss roster for your base, at a minimum of monthly.

MTFs have a strict window in which records must be received by the STR processing center. Records can be mailed no earlier than the patient's retirement/separation date and no later than 30 days after the member's date of retirement/separation.

Step 3

Pulling the Record



Once a member has been identified on your MTF's loss roster, you will pull their record from the shelf.

You are required to work with the dental clinic. A complete record is a combination of medical and dental record.

Step 4

Transfer of a Record

Annotate the transfer of the record in your facility's current record tracking system.

Step 5

Copies

Place a copy of the member's orders in the record. Another copy of the orders will be placed in the charge out guide on the shelf.

Step 6

Staging Area

Place all STRs for the month in a separate staging area, remember these records must be kept in the same type of secure area as all other records. Put them in chronological order according to the loss roster.

Additional Documents

The following documents will need to be printed and added to the record as appropriate.

- Ancillary laboratory or radiology reports in CHCS.
- Clinical narrative summaries and operative reports from previous inpatient or ambulatory procedure visits.
- Medical Evaluation Board (MEB) actions.
- AHLTA web print.
- Civilian network provider reports (if not already documented).

Once records are complete in accordance with current standards, the records will be packaged and prepared to be mailed in either approved shipping boxes or envelopes.

Records will be mailed with a tracking number. The tracking number and loss listing will be kept in the outpatient records room (paper or electronically) for continuity and record keeping.

Step 8

Past Due or Missing Record



The STR processing center may contact you for a record that is past due. You will conduct a search for a misplaced record. If you and your team are unable to find the record, your HIPAA officer or NCOIC may deem the record lost.

This will require a non-availability letter and lost record checklist to be sent to the STR processing center. This might sound intimidating, but have no fear, you won't be responsible for doing this process on your own. Your lead records technician or NCOIC will be familiar with this process.

Step 9

Exceptions

Finally, as you're familiar with by now, there are exceptions to almost every rule. Below is a list of some situations that are exceptions to the STR process and will require you to consult with your NCOIC before proceeding.

- A service member's record is sequestered, or the member is deceased.
- A service member is killed in action.
- A service member is undergoing an appellate review (for punitive discharge or dismissal).
- A service member is a prisoner being transported to a correctional detention facility.
- A United States Air Force Academy cadet or airmen with less than 180 days of continued service.
- A service member of a NATO country.

CONTINUE

Knowledge Check. Select and submit the best option in response to the question below.

When does a service treatment record begin?

-
- ☐ When a member arrives at their first base
 - ☐ When a member signs their enlistment paperwork
 - ☐ When a member completes their Military Entrance Processing Station physical or commissioning physical
 - ☐ When a member graduates Basic Military Training or Officer Training School

SUBMIT

Knowledge Check. Select and submit the best option in response to the statement below.

Once a member's name appears on the loss roster, their record can be prepared and mailed immediately.

-
- ☐ True

☐

False

SUBMIT

END OF LESSON