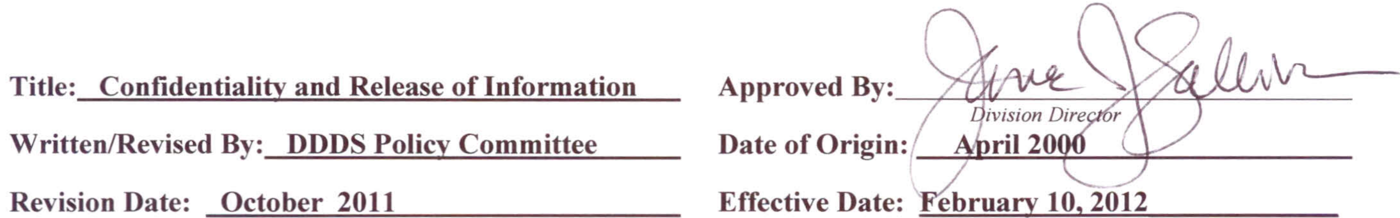
Delaware Health and Social Services
Division of Developmental Disabilities Services
Dover, Delaware



Title: Confidentiality and Release of Information
Approved By: Division Director
Written/Revised By: DDDS Policy Committee
Date of Origin: April 2000
Revision Date: October 2011
Effective Date: February 10, 2012

I. PURPOSE

To establish uniform standards and procedures relative to the protection and release of confidential information.

II. POLICY

It is the policy of the Division of Developmental Disabilities Services (DDDS) that confidential information be protected and safeguarded from loss, damage or inappropriate release.

III. APPLICATION

All DDDS employees, DDDS contractors and any person or entity who provides services, in any capacity.

IV. DEFINITIONS

A. Archived Information: Information that has been sent to the Health Information Management (HIM) Department.

B. Attending Physician: The physician designated by an individual or the individual's agent, surrogate or guardian to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility (DE Code, Title 16, §2501 (q)).

C. Breach of Confidentiality: Providing or allowing access to confidential information to a person who is not authorized to have that information within the scope of his/her job or without valid consent for release of that information. A breach of confidentiality may be intentional or unintentional. Examples of breach of confidentiality include, but are not limited to:
   1. Providing a copy of or electronic access to an individual's record (paper or electronic) without proper authorization or as permitted by this policy;
   2. Sharing confidential information with another person other than within the scope of job performance;
   3. Removing or allowing another to remove all or part of an individual's record (paper or electronic) or other confidential information;
   4. Failure to exercise due caution to prevent loss, damage, tampering, unauthorized access or unauthorized use or duplication of information contained in an individual's record (paper or electronic);
   5. Failure to exercise due caution to prevent conversation, sensitive discussion or casual review of information regarding an individual from being overheard/viewed by individuals without authorization to access such information.

IV. DEFINITIONS *(continued)*

D. Business Day: Monday through Friday, excluding holidays recognized by the State and declared State of Emergency Days.

E. Community Legal Aid Society, Inc. : also known as the Disability Law Program or CLASI

F. Confidential Information: Any item, collection or grouping of information which contains the name of an individual or an identifying number, symbol, or other identifying characteristics, or any unique grouping of information which makes the individual recognizable as if a name had been affixed. Examples of confidential information include information concerning an individual's diagnosis, care, treatment, level of function, prognosis, placement, financial status, psycho/social, psychological or medical history, and family information contained in the individual's record or in an electronic database; incident, injury and death reports, unit records, and assessments or files maintained by professional disciplines.

G. Consent: An agreement to an action that involves three elements which include: 1) the capacity to understand and make choices; 2) the information on which the consent decision is based (which shall be presented in terms understandable to the individual and/or surrogate); and 3) the voluntariness of the decision.

H. Current Information: Information that has not yet been purged from the Client Orient Record (COR) and sent to the HIM Department.

I. Health Care Provider: An individual licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession.

J. Health Information Management Department (HIM): The DDDS department that is responsible for safeguarding and filing of individual's personal information, release of information to authorized persons, maintaining accounting of release of information per HIPAA regulations and the administration of healthcare data collection systems.

K. Individual Data Form: an electronic form used within an individual's Therap Services electronic record, also known as IDF, that replaces the paper Social Assessment Update.

L. Public Record: Information of any kind, owned, made, used, retained, received, produced, composed, drafted or otherwise compiled or collected, by any public body, relating in any way to public business, or in any way of public interest, or in any way related to public purposes, regardless of the physical form or characteristic by which such information is stored, recorded or reproduced. Refer to 29 Del. C. § 10001 for more details.

M. Record- Compilation of information regarding a person served may be in two formats:
   a. Client Oriented Record (COR) and Program Book**:** the paper records that includes current information about a person served, on-going documentation of services and the person's plan of care (Essential Lifestyle Plan).
   b. THERAP: the electronic web based record that includes current information about a person served, on-going documentation of services and the person's plan of care (Essential Lifestyle Plan).

N. Release of Information: includes the lawful production of information, in any format.

O. Supervising Health Care Provider- The primary physician, or if there is no primary physician or the primary physician is not reasonably available, the health-care provider who has undertaken primary responsibility for an individual's health care.

P. Surrogate (known also as **Personal Representative** in HIPAA regulations and throughout this policy): A surrogate/Personal Representative may include the following individuals, in descending order of priority:
   1. A legal guardian of person or other legally recognized agent assigned to make decisions for an individual in that individual's best interest when he/she is not competent or unable to give informed consent;
   2. A person designated, in the presence of a witness, by a mentally competent individual receiving services to act as his/her surrogate and confirmed in writing in the individual's medical record, by the supervising health care provider and signed by the witness;
   3. In the absence of a personally designated surrogate or if the designee is not reasonably available or the individual receiving services has been determined by the attending physician to lack capacity, any member of the following classes of the individual's family who is reasonably available and recognized as such by the supervising health care provider, in the descending order of priority may act as a surrogate/personal representative for the purpose of requesting and receiving protected health information:
      a. The spouse, unless a petition for divorce has been filed;
      b. An adult child;
      c. A parent;
      d. An adult sibling;
      e. An adult grandchild;
      f. An adult niece or nephew.

      Individuals specified above are disqualified from acting as a surrogate if the individual receiving services has filed a petition for a Protection From Abuse against the individual or if the individual is the subject of a civil or criminal order prohibiting contact with the person receiving services.
   4. An adult who has exhibited special care and concern for the individual receiving services, who is familiar with his/her personal values and who is reasonably available may serve as a personal representative, **only in the absence of any of the aforementioned individuals, if they are appointed as legal guardian by the Court of Chancery.**

Q. Privacy/Complaints Officer: In accordance with 45 CFR Section 164.530 (a) (1) (ii), this designated individual shall receive complaints related to violation of the HIPAA Privacy Act and provide information about matters covered by the Notice of Health Information Practices.

R. Program Book: A book utilized primarily by direct support professionals that includes the person's Essential Lifestyle Plan, instructions for implementation of all supports and current data collection documents.

V. STANDARDS

A. Individuals receiving services by or through the Division of Developmental Disabilities Services shall have the right of privacy of information. A "Statement of Confidentiality of Information" shall be maintained in each individual's COR, Program Book and/or electronic record.

B. The medium on which data and information about a person is stored (paper, audio or computer-based) is the property of the Division of Developmental Disabilities Services and shall be maintained in secure, authorized locations in accordance with legal, accrediting, licensing, regulatory, and ethical standards.

C. The following parties shall have access to pertinent and confidential information from an individual's record if they have a need to know:
   1. Division of Developmental Disabilities Services staff (or contractual representative) responsible for the billing, planning, evaluation or implementation of the individual's treatment or programming;
   2. Consultants participating in the individual's care;
   3. Students in clinical affiliation;
   4. Other agencies providing active treatment services; and
   5. Representatives of Medicaid or Medicare and/or regulatory bodies whose access is authorized by conditions of program participation or Delaware Code.

D. Written authorization to release information shall not be required for access to or release of confidential information:
   1. To individuals receiving services who are legally able to give informed consent for disclosure of confidential information if released directly to the individual;
   2. In a bonafide emergency situation posing significant imminent risk to the individual receiving services;
   3. To Division of Developmental Disabilities Services staff responsible for the billing, planning, evaluation, or implementation of the individual's treatment or programming;
   4. To consultants, contracted service providers and students in clinical affiliation participating in the care or training of the individual;
   5. To representatives of fiscal intermediaries whose access is authorized by conditions of program participation (Medicaid, Medicare), regulatory agencies;
   6. To authorized State agencies investigating alleged rights violations or abuse, neglect, mistreatment, financial exploitation or significant injury of individuals served; and
   7. To DDDS Business Associates who have a treatment relationship with the individual receiving services.

E. Volunteers shall not have access to individuals' records unless otherwise authorized by virtue of their legal status.

F. Written authorization to release information shall be required for the disclosure of confidential information, via the use of the Surrogate/Personal Representative Request to Release Information form (exhibit D), Release of Information Authorization form (exhibit C), authorization submitted by the Disability Law Program of the Community Legal Aid Society, Inc (DLP/CLASI) or other HIPAA compliant authorization form. DDDS Case/Manager/Social Worker, Family Support Specialist or agency Program Coordinator:
   1. Completes bottom portion of form if using the Surrogate/Personal Representative Request to Release Information;
   2. Faxes any of the aforementioned authorizations to the DDDS Health Information Management Department (HIM) within one (1) working day of receiving completed form. Sends original authorization form to HIM within two (2) working days.

G. Information that includes identifying information or characteristics of an individual(s) other than the person for whom the release of information is authorized may **NOT** be released unless it is redacted. This applies to both paper and electronically stored information. This is in accordance with 45 CFR §164.514 (b) (2).

H. All written authorizations to release information shall expire one (1) year from the date they were signed, unless an earlier expiration date is designated, if the consent is rescinded or if the consent is no longer valid.

I. Individuals' legal guardian or recognized Surrogate/Personal Representative (and his/her contact information) shall be documented on the Social Assessment and Social Assessment Update located in the COR or Individual Data Form (IDF) and Emergency Data Form (EDF), both in the THERAP record. This information shall be immediately updated by the DDDS Social Worker/Case Manager or agency Program Coordinator, as applicable, when changes occur.

J. The determination of a Surrogate/Personal Representative for a person **with no legal guardian or other legal agent shall meet the following conditions:**
   1. The person receiving services shall be determined to lack capacity by the attending physician;
   2. The attending physician's determination shall be documented in the COR or Therap record;
   3. The person designated as Surrogate/Personal Representative shall meet the requirements set forth in Delaware Code, Title 16 §2507 (refer to definition P).

K. The need for a legal Surrogate/Personal Representative and the process for such shall be reviewed with the individual and his/her family, by the Family Support Specialist or contracted agency, at the initial contact. Exhibit I may be used if documentation of the attending physician's determination regarding to capacity is needed.

L. Physical Examination forms shall include the following assessment by the physician:
   Does the individual have the capacity to understand the significant benefits, risks and alternatives to proposed health care and to make and communicate a health-care decision? ______ Yes
   ______ No

M. The attending physician's determination relative to capacity shall be documented via the Annual Physical Examination or a similar written statement from the physician.

N. Reasonable efforts shall be taken to limit the use and disclosure of protected health information to the minimum necessary to accomplish the intended purpose.

O. The viewing of hard copies of confidential information shall be arranged so that a witness is present, for the purpose of safeguarding and protecting the confidential information.

P. Requested information that has been approved by HIM shall be released in accordance with 16 Delaware Code § 1121 (19). The cost of the purchase shall not exceed community standards.

Q. Access to an individual's electronic record via the Therap system shall be protected by the same laws and regulations as are paper copies of confidential information.

R. Access to Therap electronic records shall be discontinued by the Therap Provider Administrator

when the applicable consent is withdrawn, expires or is no longer valid.

S. An adult individual who receives DDDS services may request that a Surrogate/Personal Representative who does not hold legal guardianship be denied or restricted access to confidential information, in accordance with 45 CFR 164.522 . Such a request shall be documented by the DDDS Social Worker/Case Manager or agency Program Coordinator, as applicable, in the Social Assessment or Therap IDF and copied to the Health Information Management (HIM) Department.

T. All DDDS employees shall sign a "Confidentiality Statement" at the beginning of employment and shall periodically be informed of what constitutes privacy and breach of confidentiality. All other persons/contracted agencies who have access to confidential information as specified by Standard "D" shall either sign a Confidentiality Statement/Agreement or Business Associate Agreement prior to being permitted access to confidential information.

U. Confidential information shared verbally through meetings and discussion shall be subject to the same confidentiality requirements as apply to written information.

V. Violation of this policy may be grounds for contract termination and for possible legal action on the behalf of the individual receiving services.

W. Nothing in this policy shall be construed to prohibit federal, state, or local officials from having access to confidential records which may be necessary in connection with audits or the enforcement of federal and state laws and regulations which relate to those records.

X. Any individual may file a HIPAA Privacy Act Complaint Form to the DDDS Privacy Officer if he/she has reason to believe that there has been a violation of a HIPAA Privacy Regulation (45 CFR, Section 164).

Y. Freedom of Information Act (FOIA) Requests, for the release of "public record" (as opposed to protected health information), as per Delaware Code, Title 29, Chapter 100 shall be forwarded to the DDDS Director.

VI. PROCEDURES

Request to Release or View Confidential Information

RESPONSIBILITY	ACTION
DDDS Social Worker/Case Manager Family Support Specialist Contracted Program Coordinator	1. Upon receipt of a completed Surrogate/Personal Representative Request to Release Information, completes the bottom portion of the form. 2. Faxes completed Surrogate/Personal Representative Request to Release Information form or the Release of Information Authorization or other HIPAA compliant authorization to release information to the DDDS Health Information Management Department (HIM) within one (1) working day of receiving completed form. Sends original authorization form to HIM within two (2) working days.

Request to Release Information

Responsible	Action
Health Information Management Dept. (HIM)	3. Communicates promptly with the applicable DDDS Social Worker/Case Manager, Family Support Specialist or contracted Program Coordinator and instructs him/her whether or not the request to release or information is approved. • if approved, sends approval in writing to the above contact person; • if not approved, sends written correspondence to the person requesting information explaining why the request cannot be honored.
DDDS Social Worker/Case Manager Family Support Specialist Contracted Program Coordinator	**If Approved by HIM** 4. Immediately sends requested paper information approved by the HIM to the authorized person **OR** 5. Immediately coordinates with the person authorized/approved to receive information, to have the required **view only** privileges necessary to access Therap documents approved for viewing **OR** 6. Immediately makes arrangements with the requesting person to view the authorized confidential information by the next working day. A responsible employee shall be present to monitor the record viewing and safeguard the confidential information.

Request for Copy of Archived Information (at HIM)

Responsible	Action
Health Information Management Dept. (HIM)	7. Sends approved requested information to authorized individual within two (2) working days of receipt of the authorization **OR** 8. Sends letter to person making request for release of information explaining the reason (s) the request cannot be honored, if applicable.

VII. SYNOPSIS

This policy continues to address the requirements to protect confidential information and delineate the process by which information may be disclosed. HIPAA regulations defer to the States to define "personal representatives". As such, the State of Delaware has embraced the definition of "surrogate" as found in 16 Del. C., § 2507. The revisions to this policy have been expanded to include confidential information stored in Therap electronic records.

VIII. REFERENCES

A. 16 Del.C., §1121 (6), (19), 1122
B. 16 Del. C., § 1230-1232
C. 16 Del. C., § 2507
D. 27 Del.C., § 10001
E. DHSS Policy Memorandum #5

IX. EXHIBITS

A. Statement of Confidentiality of Information
B. Confidentiality Statement
C. Release of Information Authorization
D. Surrogate/Personal Representative Request to Release Information
E. HIPAA Privacy Act Complaint Form
F. Delaware Code, Title 16, §2507
G. Annual Physical Examination Form- Community Services/Adult Special Populations
H. Designation of Surrogate

EXHIBIT A

Delaware Health and Social Services
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

STATEMENT OF CONFIDENTIALITY OF INFORMATION

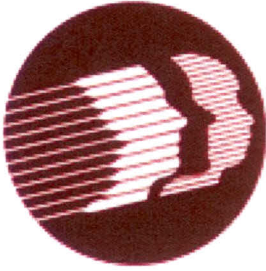
This record is the property of Delaware Health and Social Services. Its confidentiality must be protected by all staff against loss, damage, tampering, unauthorized access, use or duplication.

All information contained in this record is considered confidential. Providing or allowing access to information in this record to a person who is not authorized to have that information within the scope of his/her job or without valid consent for release of that information is a breach of confidentiality.

Breach of confidentiality is a violation of federal Health Insurance Portability and Accountability Act (HIPAA), Medicaid regulations, Delaware Nursing Home regulations, the Department of Health and Social Services Policy Memorandum #5 and Division of Developmental Disabilities Services policy and may subject the violator to disciplinary action, civil or criminal legal action.

Reviewed by PARC on 04/11/05
Form # 30/Admin

EXHIBIT B



Delaware Health and Social Services
Division of Developmental Disabilities Services

CONFIDENTIALITY STATEMENT

I hereby understand and agree that:

1. Personal information, in any form, about any individual receiving services from the Division of Developmental Disabilities Services or one of its contracted agencies is confidential and may be privileged;

2. Confidential information shall be protected and shared only with my supervisor(s) and/or others who have an absolute need to know;

3. If I have a question about confidentiality, I will ask my immediate supervisor. If my immediate supervisor is not available, I will follow my supervisory reporting line to obtain an answer;

4. Sharing confidential information outside the context of a professional/service and support discussion is expressly prohibited, and

5. Any breach of confidentiality may result in disciplinary action up to and including termination.

As witnessed by my signature below, I certify that I have read this Confidentiality Statement, or it has been read to me, and I have had the opportunity to discuss my questions and concerns.

____
Name

____
Witness

____
Date

EXHIBIT C

Delaware Health and Social Services
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

-Release of Information Authorization-

I hereby authorize: **The Division of Developmental Disabilities Service/Business Associate**
Health Information Management Department
26351 Patriots Way
Georgetown, DE 19947

to release information concerning ____
(Individual's Name and Date of Birth)

for the purpose of: ____
____

List Specific Items Requested	Frequency of Request

____
Printed Name of Individual or Guardian and Date

____
Signature of Individual or Guardian and Date

____
Mailing Address

____
Home Phone #

____
Mailing Address

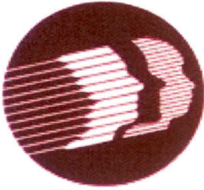
____
E-Mail Address (not required)

Consent automatically expires one (1) year from the date signed unless earlier expiration date is designated.

Information disclosed may be re-disclosed by the recipient and is no longer protected by the Division of Developmental Disabilities Services

PARC Revised: 05/18/11
Form # 33/Admin

EXHIBIT D



Delaware Health and Social Services
Division of Developmental Disabilities Services

Surrogate/Personal Representative Request to Release Information

I herby authorize: **The Division of Developmental Disabilities Services/Business Associate**
Health Information Management Department
26351 Patriots Way, Georgetown, DE 19947

to release information concerning ____.
(Individual's Name and Date of Birth)

for the purpose of: ____

____

Check Therap documents requested to **view/print**:
_______ T- Log (ID Note)
_______ General Event Report (Incident Report)
_______ Essential Lifestyle Plan (with assessments)
_______ Individual Service Plan
_______ Individual Data Form
_______ Emergency Data Form
_______ Health Tracking Forms

Check COR documents requested to **copy**:
_______ Essential Lifestyle Plan (ELP)
_______ ID Notes, specify date(s): ________
_______ Incident Report: **Specify date(s) and/or frequency: ______________________**
_______ Current Nursing Assessment
_______ Other (specify): ___________________
____
____

I attest that I am the Personal Representative for the aforementioned named individual as evidenced by the following identified relationship (please initial one) and delineated in Delaware Code, Title 16, Section 2507.

_____ Spouse (unless petition for divorce has been filed)
_____ Parent
_____ Adult who has exhibited special care and concern for the individual and who is legal guardian
_____ Adult Grandchild
_____ Adult Sibling
_____ Adult Niece/Nephew

____ ____________________
Signature of Surrogate/Personal Representative ***Date***

For Use by DDDS Social Worker/Case Manager/Family Support Specialist

The signatory above is the surrogate/personal representative on record, in accordance with Delaware Code, Title 16, Section 2507. ____________ Yes ___________ No

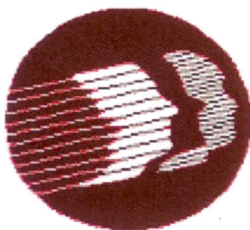
The adult individual receiving services has requested a restriction of uses and disclosures.
_____________Yes _____________ No

____ ____________________
Social Worker/Case Manager/Family Support Specialist ***Date***

Consent automatically expires one (1) year from the date signed unless earlier expiration date is designated or is rescinded.

PARC Revised 06/17/11
Form # 41/Admin

EXHIBIT E



Division of Developmental Disabilities Services

HIPAA Privacy Act Complaint Form

I. Please explain the reason for submitting a HIPAA Privacy Act Complaint. It is important that you are as specific as possible so that your complaint can be thoroughly reviewed/ investigated.

____
____
____
____
____
____
____
____
____
____

II. Please explain your response (what you did, what you said) when you became aware of a violation to the HIPAA Privacy Act.

____
____
____
____

III. Please complete information about yourself in case you need to be contacted for further information.

Name: ____
Title: ____
Address: ____
____

Phone # and best time to contact you:____________________________

IV. Please submit this completed form to the following address:

Stockley Center
Attention: HIPAA Privacy/Complaints Officer
26351 Patriots Way
Georgetown, DE 19947
(302) 934-8031

Reviewed by PARC on 04/11/05
Form # 34 /Admin

EXHIBIT F

Delaware Code, Title 16, Chapter 25

§ 2507. Surrogates.

(a) A surrogate may make a health care decision to treat, withdraw or withhold treatment for an adult patient if the patient has been determined by the attending physician to lack capacity and there is no agent or guardian, or if the directive does not address the specific issue. This determination shall be confirmed in writing in the patient's medical record by the attending physician. Without this determination and confirmation, the patient is presumed to have capacity and may give or revoke an advance health care directive or disqualify a surrogate.

(b)(1) A mentally competent patient may designate any individual to act as a surrogate by personally informing the supervising health-care provider in the presence of a witness. The designated surrogate may not act as a witness. The designation of the surrogate shall be confirmed in writing in the patient's medical record by the supervising health-care provider and signed by the witness.

(2) In the absence of a designation or if the designee is not reasonably available, any member of the following classes of the patient's family who is reasonably available, in the descending order of priority, may act, when permitted by this section, as a surrogate and shall be recognized as such by the supervising health-care provider:

a. The spouse, unless a petition for divorce has been filed;

b. An adult child;

c. A parent;

d. An adult sibling;

e. An adult grandchild;

f. An adult niece or nephew.

Individuals specified in this subsection are disqualified from acting as a surrogate if the patient has filed a petition for a Protection From Abuse order against the individual or if the individual is the subject of a civil or criminal order prohibiting contact with the patient.

(3) If none of the individuals eligible to act as a surrogate under subsection (b) of this section is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values and who is reasonably available may make health care decisions to treat, withdraw or withhold treatment on behalf of the patient if appointed as a guardian for that purpose by the Court of Chancery.

(4) A supervising health-care provider may require an individual claiming the right to act as a surrogate for a patient to provide a written declaration under the penalty of perjury stating facts and circumstances sufficient to establish the claimed authority.

(5) A mentally competent patient may at any time disqualify a member of the patient's family from acting as the patient's surrogate by a signed writing or by personally informing the health-care provider of the disqualification.

(6) A surrogate may make a decision to provide, withhold or withdraw a life-sustaining procedure if the patient has a qualifying condition documented in writing with its nature and cause, if known, in the patient's medical record by the attending physician.

(7) A surrogate's decision on behalf of the patient to treat, withdraw or withhold treatment shall be made according to the following paragraphs and otherwise meet the requirements of this chapter:

a. Decisions shall be made in consultation with the attending physician.

b.1. The surrogate shall make a health-care decision to treat, withdraw or withhold treatment in accordance with the patient's individual instructions, if any, and other wishes to the extent known by the surrogate.

2. If the patient's instructions or wishes are not known or clearly applicable, the surrogate's decision shall conform as closely as possible to what the patient would have done or intended under the circumstances. To the extent the surrogate knows or is able to determine, the surrogate's decision is to take into account, including, but not limited to, the following factors if applicable:

i. The patient's personal, philosophical, religious and ethical values;

ii. The patient's likelihood of regaining decision making capacity;

iii. The patient's likelihood of death;

iv. The treatment's burdens on and benefits to the patient;

v. Reliable oral or written statements previously made by the patient, including, but not limited to, statements made to family members, friends, health care providers or religious leaders.

3. If the surrogate is unable to determine what the patient would have done or intended under the circumstances, the surrogate's decision shall be made in the best interest of the patient. To the extent the surrogate knows and is able to determine, the surrogate's decision is to take into account, including, but not limited to, the factors, if applicable, stated in subsection (b)(7)b.2. of this section.

(8) In the event an individual specified in subsection (b)(2) of this section claims that the individual has not been recognized or consulted as a surrogate or if persons with equal decision making priority under subsection (b)(2) of this section cannot agree who shall be a surrogate or disagree about a health-care decision, and a patient who lacks capacity is receiving care in a health-care institution, the attending physician or an individual specified in subsection (b)(2) of this section may refer the case to an appropriate committee of the health-care institution for a recommendation in compliance with this chapter, and the attending physician may act in accordance with the recommendation of the committee or transfer the patient in accordance with the provisions of § 2508(g) of this title. A physician who acts in accordance with the recommendation of the committee is not subject to civil or criminal liability or to discipline for unprofessional conduct for any claim based on lack of consent or authorization for the action.

EXHIBIT G

DELAWARE HEALTH & SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
COMMUNITY SERVICES / ADULT SPECIAL POPULATIONS

Kent County Office	Sussex County Office	New Castle County Office
Thomas Collins Building 540 S. DuPont Hwy., Suite 8 Dover, DE 19901 Phone: 302-744-1110 FAX: 302-739-5535	26351 Patriots Way, 101 LL Georgetown, DE 19947 Phone: 302-933-3100 FAX: 302-934-6193	Fox Run Plaza, 2nd Floor 2540 Wrangle Hill Road Bear, DE 19701 Phone: 302-836-2100 FAX: 302-836-2649

Physical Examination

Name: ________________________ MCI #:______________ Sex:__________ D.O.B.: ____________

Exam Date: ____________ Ht.:__________ Wt.:__________ Temp.: __________ BP:________________

P:____________ R:__________ Allergies:____

Physical Examination:

	Normal	Abnormal	Comments
Scalp/Hair			
Ears/Hearing			
Eyes/Vision			
Nose/Mouth/Pharynx			
Neck/Thyroid			
Skin/Nails			
Chest/Breast			
Heart			
Lungs			
Spine			
Abdomen			
Genitalia (external)			
Prostate			
Pelvic/Pap Smear			
Uppe Extremities			
Lower Extremities			

Colon/rectal Cancer Screening:_________________________________ Guiac Result:__________

Annual Flu Vaccine Recommended: Yes _______ No ________ Date ________________

Annual T.B. Screening: P.P.D________________ Chest X-ray:_________ Other:____________________

RETURN IN 2 DAYS TO CHECK ARM FOR PPD TEST RESULTS

Results:____

IMMUNIZATIONS

	Current	Needed	Date Received	Current Medical Diagnosis
Tetanus				1.
Influenza				2.
Pneumococcal				3.
MMR				4.
DPT				5.
Polio				6.
Hepatitis B Vaccine				
Varicella (Chicken Pox)				
Other:				

Name: ____________________________ **MCI #**: ________________

Diet as recommended by nutritionist____

Other ____

LAB Tests / Screenings Ordered

Urinalysis_________________________________
Chem Profile_______________________________
Liver Profile________________________________
Hepatitis Screen____________________________
PAP Smear_________________________________
Chest X-Ray________________________________
Other:_____________________________________

CBC_________________________________
Thyroid______________________________
Lipids_______________________________
PSA_________________________________
Mammogram__________________________
Bone Density_________________________

Restrictions:	Unlimited	Limited	Avoid
Walking			
Standing			
Stooping			
Kneeling			
Lifting			
Pushing			
Pulling			
Humid Conditions			
Dry Conditions			
Dusty Conditions			
Other			

Next recommended physical exam - annual ________ 2 yrs __________ 3 yrs __________

Recommendations/Referrals/Adaptive Equipment:

____

____

____

Medications: [Include dosage and frequency]

____

____

____

Was the individual informed of his/her physical status? ______ Yes ______ No

If "no" or "unable," was the individual's physical status discussed with his/her surrogate/guardian.

________ Yes ________ No

Does the individual have the capacity to understand the significant benefits, risks and alternatives to proposed health care and to make and communicate a health-care decision? ______ Yes ______ No

Note to Physician: The aforementioned information is required, in accordance with CFR 164.502 (g) and DE Code, Title 16, §2507, in order to determine if DDDS may release records to a designated surrogate.

Signature:___________________________________

Address:____________________________________

Telephone:__________________________________

EXHIBIT H

Delaware Health and Social Services
Division of Developmental Disabilities Services

Designation of Surrogate/Personal Representative

I certify that ____________________________ does ______ or does not ______have the capacity to understand
Name of Individual and DOB

the significant benefits, risks and alternatives to proposed health care and to make and communicate a health-care decision?

To Physician:
Assessment of capacity is requested, in accordance to CFR 164.502 (g) and Delaware Code Title 16, Section 2507, to determine if DDDS may release records to a designated surrogate.

____
Name of Physician (Print)

____
Signature of Physician

____
Address of Physician

____
Telephone Number

PARC Revised 06/29/11
Form #43Admin