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REVIEW OF PATIENT MEDICAL INFORMATION DISCLOSURE PROCEDURES TO GUARANTEE LEGAL ASPECTS OF CONFIDENTIALITY MEDICAL RECORD AT LEVEL THREE HOSPITAL DR. REKSODIWIRYO IN 2021

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Abstract : Every health service facility is required to be able to maintain the confidentiality of medical records because the information in medical records is confidential. The purpose of releasing medical information is, among others, to maintain the confidentiality of the patient's medical history, to avoid releasing patient medical information to unauthorized parties, to avoid lawsuits for health workers who provide patient medical information and for hospitals. Based on the results of the initial survey at the Hospital Tk.III dr.Reksodiwiryo, it was found that the standard procedure for releasing patient medical record information exists but has not been carried out according to standards. The purpose of this study was to determine the procedure for releasing patient medical record information to insurance parties such as BPJS and Jasa Raharja. The research location is at Tk.III Hospital dr.Reksodiwiryo Padang. The implementation time starts from August to September 2021. The research method used is qualitative research with a case study approach. The informant determination technique used in this study was purposive sampling. Informants or respondents as research subjects are the head of the medical record, the medical record officer in the medical record document storage section, and the case mix section officer. The results of the study showed that the release of patient medical information from BPJS and Jasa Raharja had standard operating procedures, an approval form for the release of patient information, and a manual regarding the release of patient information. However, its implementation in the field was not carried out in accordance with SOPs and guidelines and the consent form for the release of patient information was not filled in. The suggestion is that it is hoped that medical record officers and parties involved in releasing patient medical information must carry out these activities in accordance with standard operating procedures and/or applicable manuals.

IndexTerms **- Release of Information, Procedures, Medical Records**

I. INTRODUCTION

Based on Law Number 44 Year 2009 that the hospital is a health facility that provides individual health services which include promotive, preventive, curative and rehabilitative services. According to the Ministry of Health of the Republic of Indonesia Number 129 of 2008 concerning Minimum Service Standards for Hospitals, it is explained that one of the services that must be provided by hospitals is medical records. Medical records have uses, namely aspects of Administration,

Legal, Financial, Research, Education and Documentation or simply abbreviated as "ALFRED". Because of the many uses of medical records, medical records must be managed properly in accordance with applicable laws and regulations.

In accordance with Permenkes No. 269/Menkes/Per/III/2008 concerning medical records, that medical records contain information about the patient's identity, examination results, treatment that has been given, as well as other actions and services that have been provided to patients. The Permenkes also explains that medical record documents are the property of health care facilities, while the contents of medical records are the property of the patient. Therefore, every health service facility is required to be able to maintain the confidentiality of medical records because the information in medical records is confidential.

The information in this medical record needs to be maintained for security, privacy, confidentiality and safety. The provision of medical information must follow the applicable procedures, medical information can be provided if the patient signs a letter of consent and authorizes a third party to obtain medical information about himself. This aims to protect the

hospital from further demands. The purpose of releasing medical information, among others, is to maintain the confidentiality of the patient's medical history, avoid releasing patient medical information to parties who do not have the right, avoiding lawsuits for health workers who provide patient medical information and for hospitals (Susanto and Sugiharto, 2017).

Requests for the release of medical information include, among others, the insurance company, the patient/patient's family, the referral hospital, the police in the form of (visum et repertum), and for court purposes. At this time there are many businesses that are engaged in insurance, including sickness insurance, accident insurance, labor insurance treatment, education insurance, and others. To be able to pay an insurance claim from the policyholder, the insurance company must first obtain certain information contained in a patient's medical record while receiving treatment at the hospital. (Susanto and Sugiharto, 2017).

With increasing public awareness to use insurance services so that the number of policyholders increases, hospitals must be able to provide a standard form that provides maximum protection to patients and speeds up the time for filling it out by hospital staff. To complete the requirement that the power of attorney/approval for medical treatment must be signed by the person concerned, the hospital provides a power of attorney form, so that the signature can be obtained when the patient is admitted to be treated (Susanto and Sugiharto, 2017).

Based on the results of the initial survey at the Hospital Tk.III dr.Reksodiwiryo, it was found that the standard procedure for releasing patient medical record information exists but has not been carried out according to standards. This can be detrimental to the patient and the hospital if there are demands in the future. The purpose of this study is to find out how the procedure for releasing patient medical information is to ensure the legal aspects of confidentiality of patient medical records. Therefore, the researchers are interested in raising the title of the proposal from this grant according to the research scheme with the title "Review of the Procedure for the Release of Patient Medical Information in Order to Guarantee the Legal Aspects of Confidentiality of Medical Records at Tk.III Hospital dr. Reksodiwiryo Padang in 2021".

II. RESEARCH METHODOLOGY

The research method used is qualitative research with a case study approach. This research was conducted at Tk.III Hospital dr. Reksodiwiryo Padang. The research time is from August to September 2021. The informant determination technique used in this research is purposive sampling using the principle of conformity, namely the determination of the data sources on the interviewees/research informants who were selected with certain considerations and objectives (Moleong, 2014). The informants who became the source of data in this study were the Medical Record Leader, the Case Mix Section Medical Record Officer, and the Medical Record Officer. The method of data collection is through observation, document review, and in-depth interviews. The analysis technique carried out using the data analysis technique proposed by Miles and Huberman (1992) includes three simultaneous activities, namely: data reduction, data presentation, conclusion drawing/verification (Suwandi, 2008). Analysis of the data that will be used to analyze the data of this study was carried out using content analysis techniques. Researchers used triangulation as a technique to check the validity of the data.

III. RESULTS AND DISCUSSION

3.1 Result

Medical information of a patient can be provided to related parties, including for the patient or patient's family, BPJS, and Jasa Raharja. The number of BPJS patients seeking treatment at the Tk.III Hospital Dr. Reksodiwiryo Padang from January to June 2021 can be seen in table 1 below:

Table 1. Number of Patient Visits from BPJS

Number	Number of Patients		Month Of Service
	outpatient	Inpatients	
1	11.168	430	January
2	10.555	435	February
3	12.256	506	Maret
4	11.240	603	April
5	9633	468	May
6	11.113	599	Juny

Based on table 1, the report on the number of BPJS patient visits who came for treatment at the Dr. Reksodiwiryo Hospital Padang shows that the number of BPJS patients from January to June 2021 from inpatients was 55,849 people and outpatients were 3041 patients.

The number of patients using raharja services who came for treatment at the dr.Reksodiwiryo Hospital Padang from January to June 2021 can be seen in table 2 below:

Table 2. Number of Patient Visits from BPJS

Number	Number of Patients	Month Of Service
1	4	January
2	10	February
3	11	Maret
4	3	April
5	3	May
6	5	Juny

Based on table 2, the number of visits by raharja service patients who came for treatment at the dr.Reksodiwiryo Hospital in Padang from January to June 2021 was 36 people.

Based on the results of interviews with all research informants, information was obtained that in releasing patient medical information from BPJS and Jasa Raharja had standard operating procedures and manuals related to the release of patient information. In addition, the hospital provides a consent form for the release of patient information which contains the identity of the patient or patient's family who are willing to provide the contents of the medical record file to those who have the right to access information on the contents of the medical record file based on hospital policies and applicable regulations. However, from the results of the interview, it was found that the permission from the patient or the patient's family was not carried out. This form is only a formality that must be available in the patient's medical record folder. Although in the medical record the form is available.

From the results of field observations, documents related to the release of this information contained Standard Operating Procedures (SOP) and manuals for the release of patient medical information. The purpose of the SOP for the release of patient medical information is to protect the patient's rights to the confidentiality of medical record data.

The procedures for releasing patient medical information at the Hospital Tk.III dr.Reksodiwiryo are:

1. Receiving requests for release of information in writing from patients and/or court orders.
2. If the patient is under 14 years of age, request the release of written information from the parent or guardian.
3. Ensure that the requester for information is the patient himself by checking the patient's identity card.
4. If the request is authorized by another person, it must be accompanied by a power of attorney stamped from the patient and a photocopy of the patient's identity.
5. If the request for information release comes from another party or a third party (eg companies, insurance companies, etc.) it must be accompanied by a power of attorney with sufficient stamp duty from the patient.
6. If the request for information is for research purposes, the information is not accompanied by the identity of the data owner.
7. Delivering information for the benefit of health insurance, employers, and others by adhering to the principle of need to know, which is minimal but sufficient, relevant and accurate.
8. Release of information for internal and external by adhering to the SOP for borrowing medical record files.
9. Release information for the benefit of patients by adhering to the SOP for medical resume requests.

Units related to the release of patient medical information are the medical record section, the inpatient department, outpatient department, and the emergency department.

3.2 Discussion

In accordance with Permenkes No. 269/Menkes/Per/III/2008 concerning medical records, that medical records contain information about the patient's identity, examination results, treatment that has been given, as well as other actions and services that have been provided to patients. The Permenkes also explains that medical record documents are the property of health care facilities, while the contents of medical records are the property of the patient. Therefore, every health service facility is required to be able to maintain the confidentiality of medical records because the information in medical records is confidential.

The information in this medical record needs to be maintained for security, privacy, confidentiality and safety. The provision of medical information must follow the applicable procedures, medical information can be provided if the patient signs a letter of consent and authorizes a third party to obtain medical information about himself. This aims to protect the hospital from further demands. The purpose of releasing medical information, among others, is to maintain the confidentiality of the patient's medical history, avoid releasing patient medical information to parties who do not have the right, avoiding lawsuits for health workers who provide patient medical information and for hospitals (Susanto and Sugiharto, 2017).

One of the requests for the release of medical information is for insurance companies, such as BPJS patients and Jasa Raharja. To be able to pay insurance claims from policyholders, insurance companies must first obtain certain information contained in a patient's medical record while receiving treatment at the hospital (Susanto and Sugiharto,

2017). A claim is an application or demand by a policy owner against an insurance company for the payment of compensation in accordance with the articles of a policy. Jasa Raharja's insurance claim is a claim for compensation by the company under the terms of the agreement in which Jasa Raharja by accepting a premium binds itself to compensate the insured that may be suffered.

With increasing public awareness to use insurance services so that the number of policyholders increases, hospitals must be able to provide a standard form that provides maximum protection to patients and speeds up the time for filling it out by hospital staff. To complete the requirement that the power of attorney/approval for medical treatment must be signed by the person concerned, the hospital provides a power of attorney form, so that the signature can be obtained when the patient is admitted to be treated (Susanto and Sugiharto, 2017).

Based on the results of the study, the number of BPJS patient visits who came for treatment at the Dr. Reksodiwiryo Hospital Padang showed that the number of BPJS patients from January to June 2021 from inpatients was 55,849 and outpatients were 3041 patients. The number of visits from raharja service patients who came for treatment at the dr.Reksodiwiryo Hospital in Padang from January to June 2021 was 36 people. From these data, it can be seen that the number of BPJS patients is very large, so the release of this patient information must be carried out according to the SOP.

However, based on the results of interviews with all informants, information was obtained that in releasing patient medical information from BPJS and Jasa Raharja had standard operating procedures and guidebooks related to the release of patient information. In addition, the hospital provides a consent form for the release of patient information which contains the identity of the patient or patient's family who are willing to provide the contents of the medical record file to those who have the right to access information on the contents of the medical record file based on hospital policies and applicable regulations. However, from the interviews, it was found that the consent form for the release of patient information was not filled out. The officer did not ask permission from the patient or the patient's family. This form is only a formality that must be available in the patient's medical record folder.

From the results of field observations, documents related to the release of this information contained Standard Operating Procedures (SOP) and manuals for the release of patient medical information. However, the implementation was not carried out in accordance with the SOP or the guidebook for the release of the information. In contrast to the results of research conducted by Rachmadhani (2015) that at Qadr Hospital Tangerang does not have SPO (Standard Operating Procedures) in terms of releasing patient medical record information.

In the Law of the Republic of Indonesia Number 44 of 2009 concerning hospitals, including: Article 32 paragraph (1, point i) “every patient has the right, one of which is to obtain privacy and confidentiality of the illness he suffers including his medical data; obtain information including diagnosis and procedures medical action, the purpose of medical action, alternative actions, risks and complications that may occur, and the prognosis of the actions taken as well as the estimated cost of treatment.

In the Regulation of the Minister of Health 269 of 2008 concerning medical records, including: (a) Article 10 paragraph (3) "the request must be made in writing to the head of the health service facility"; (b) Article 11 paragraph (1) "explanations on the contents of medical records may only be made by a doctor or dentist who treats a patient with the patient's written permission or based on statutory regulations"; (c) Article 12 paragraph (2) "the contents of the medical record are the property of the patient" paragraph (3) "the contents of the medical record as referred to in paragraph 2 are in the form of a summary of medical records" paragraph (4) "summary of medical records as referred to in paragraph (3) can be given, recorded, or copied by the patient or person who is authorized or with the written consent of the patient or patient's family who is entitled to it.

Consent to Release of Medical Information. Although the information contained in the medical record can be disclosed, the release of such information must be through the written consent or permission of the patient or the patient's attorney. This is intended to protect the patient's right to privacy and protect health care facilities in the legal act of protecting the right to confidentiality of patient information. With written permission or consent to the release of medical information, it must be accompanied by the patient's signature.

Overall, security, privacy, confidentiality and safety are the devices that fortify the information in the Medical Record. The hospital as the owner of the information in the medical record, the procedure for releasing the medical record information must also be accompanied by written permission from the patient as well as the presentation of the contents of the medical record, the doctor who treats the patient must be the doctor.

Based on the results of the study that RSUD dr. Soediran Mangun Sumarso already has established policies and procedures regarding the release of medical information. At the hospital dr. Soediran Mangun Sumarso during 2011 in terms of completeness of the requirements for releasing medical information has been fulfilled so as to facilitate the process of releasing medical information. While the information needed in the release medical information for Jasa Raharja's insurance claims is in accordance with the information needed by Jasa Raharja, and the information needed is in the form of vital sign charts, laboratory results, resumes, results of supporting examinations such as radiodiagnostics (Wuryaningsih, etc., 2011).

IV. CONCLUSION

1. The number of visits by BPJS patients who came for treatment to the dr.Reksodiwiryo Hospital in Padang from January to June 2021 from 55,849 inpatients and 3041 outpatients.
2. The number of visits from raharja service patients who came for treatment at the dr.Reksodiwiryo Hospital in Padang from January to June 2021 was 36 people.
3. Based on the results of interviews, information was obtained that in releasing patient medical information from BPJS and Jasa Raharja had standard operating procedures, consent forms for releasing patient information, and manuals related to the release of patient information. However, its implementation in the field was not carried out in accordance with SOPs and guidelines and the consent form for the release of patient information was not filled in.

Suggestion:

1. Medical record officers and parties involved in releasing patient medical information must carry out these activities in accordance with standard operating procedures and/or applicable manuals.
2. It is expected that the medical record officer will ask the patient or the patient's family to fill in the consent form for the release of patient information.

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