



Preventing Information Blocking: User Guide to Open Notes and Results Release

Updated 9/23/2021 | For questions, please contact informationblocking@nyp.org



EXECUTIVE SUMMARY

1. **Open Notes and Results Release** refer to the automatic release of clinical notes and results to patients/proxies via the Connect Patient Portal, unless a clinician prevents the release due to allowable exceptions to prevent physical harm or protect patient privacy. The goal is to improve patient engagement and access to electronic health information by **preventing health information blocking**.
2. **All note types authored by any ED, Inpatient and Outpatient user will be automatically released to the patient via the Connect Patient Portal as soon they are signed/finalized, EXCEPT for those authored under the following services:**
 - Psychiatry
 - Toxicology
 - Social Work, Case Management, Care Coordination
 - Child Life and Creative Arts Therapy
 - Psychosocial Rehab
 - Spiritual Care

Starting 10/25/21, notes for patients 0-11 years old and >18 years old will be automatically released to patients and their proxies on the Connect Patient Portal. Notes for patients 12-17 years old will also be automatically released soon.

3. **Clinicians can manually prevent the release of some notes and results to honor allowable exceptions** to prevent physical harm to the patient or others, protect patient privacy, or upon patient request. Exceptions should be few, and most notes should be released.

Starting 10/25/21, you will no longer be able to configure your notes to “not release to the patient” by default. If your notes are currently configured to “not release to the patient” by default, please set them to “release to the patient” by default instead using [these instructions](#).

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Introduction

What is Open Notes and Results Release?



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What is Information Blocking?

- [Information blocking](#) is a practice that a healthcare provider or organization knows or should know is likely to **interfere** with a patient, proxy, or other authorized third-party's access, exchange, or use of electronic health information. **Interfere** means to delay, prevent, or discharge a person's ability to access medical records.
- In 2016, a piece of federal legislation called the [21st Century Cures Act](#) was passed that **prohibits information blocking**, with the goal of minimizing barriers for releasing electronic health data to patients.
- The [Final Rule](#) for implementation of this legislation was released in 2020, which requires medical institutions across the US to electronically release notes and results to patients without delay.

To comply with recent federal legislation to prevent information blocking, the New York Consortium has implemented two major changes to our electronic health systems in 2021 called [Open Notes](#) and [Results Release](#).

What is Open Notes and Results Release?

Open Notes and Results Release refer to the automatic and immediate release of electronic notes and results to patients and their proxies via the Connect Patient Portal, unless a clinician prevents the release to honor allowable exceptions to prevent harm or protect patient privacy.

- **This means that patients will be able to view finalized electronic notes and results in near real-time using the Connect patient portal while they are under evaluation.** Previously, most results were released electronically to patients within 2-3 days, and most notes were released upon request from the medical records office.
- **Patients may also see their finalized notes and results before their healthcare team.** While this is powerful, there may be communication pitfalls since patients may not have the medical knowledge to interpret the information.
- It is therefore critical for clinicians to educate themselves regarding which notes and results are automatically released, inform patients that they may see their notes and results before the healthcare team, and know how to respond to patient requests and queries.

Why are we doing this?

The goal of Open Notes is to improve information transparency, empower patients to engage in their care, and improve communication between patients and their care team.

- Patients have long had a legal right to access their entire medical record. However, the process of obtaining this record can be opaque and difficult to navigate. The 21st Century Cures Act seeks to empower patients by making access to electronic health information simple and instantaneous.
- **Specific goals include:**
 - Increasing patient understanding and involvement in decisions
 - Improving care coordination and reducing costs
 - Identifying and fixing errors in the record
 - Improving patient safety and quality
- Peer-reviewed literature shows that offering patients ready access to notes and results can improve care across multiple domains, especially for vulnerable populations. Institutions that have already adopted this practice report greater patient satisfaction with minimal impact on clinical workflows.

How are we implementing this change?

1. Creation of the Open Notes & Results Release Workgroup

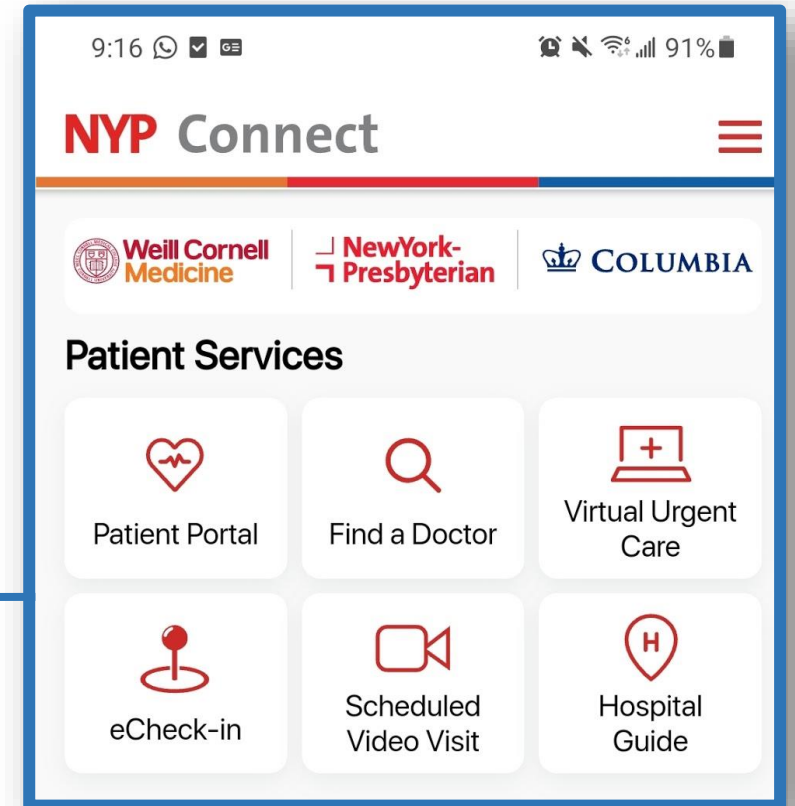
- Tripartite workgroup established with close clinician input and feedback to ensure that we follow federal and state regulatory requirements while continuing to safeguard patient safety and privacy.
- ED, Inpatient and Ambulatory/Surg are covered under the same umbrella.

2. Updates to our Electronic Health Records (EHRs)

- Epic and our legacy EHRs have been updated with new features to enable most notes and results to be shared automatically with patients and their proxies. Clinicians can also prevent the release of some notes and results under allowable exceptions to prevent harm or protect patient privacy.

3. Updates to the Connect Patient Portal

- The **Connect Patient Portal** is the main method for patients to access their health data, including medical problems, medications, allergies, immunizations, care plan, lab and radiology results, etc.
- This portal has been updated with information for patients about what to expect under Open Notes and Results Release.



Impact on Clinicians

How does Open Notes & Results Release impact my clinical practice?



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How do clinicians around the country feel about Open Notes?



74% of 6064 clinicians surveyed nationally agree sharing notes with patients is a good idea.

61% would recommend note sharing to other clinicians.

26% reported a patient found an error that the doctor considered clinically important.

63% reported no change in the amount of time spent on notes.

C DesRoches et al, JAMA Network Open, 2020

Which notes are released to patients?

Most ED, Inpatient and Outpatient notes that are

SIGNED

will be automatically released to the patient and their proxies via Connect after the note is signed.

Most ED, Inpatient and Outpatient notes that are

**SHARED,
PENDED,
OR AWAITING COSIGN BY ATTENDING**

will not be automatically released until Signed. Notes that require Cosign will be released after the note is Cosigned.

What exactly do you mean by “note”?

“Notes” refer to pieces of electronic documentation authored and filed in the electronic medical record by an ED, Inpatient or Outpatient user. Examples include Provider Notes, Progress Notes, or Consult Notes. “Notes” do not include Secure Chat messages, In-Basket notifications, flowsheet documentation, or the After Visit Summary. Some sensitive notes authored by users are excluded from Open Notes, such as the SAFE Note. For a full list of exceptions, see [this page](#).

Which notes are **not** released to patients?

In New York State, there are 3 common allowable reasons to prevent the release of a note:

1 TO PREVENT PHYSICAL HARM

A clinician can prevent the release of a note or result if they believe that viewing the note may cause substantial **physical harm** to the patient, staff, or others. Causing mental or emotional harm alone is **NOT** an allowable reason to block release.

2 TO PROTECT PATIENT PRIVACY

A **direct request from the patient** to prevent the release of a note or result to Connect is allowable under this exception. Information compiled in a note for use in civil, criminal or administrative actions or proceedings also applies.

3 TO PROTECT PSYCHIATRIC INFO

In general, for notes containing psychiatric information, **clinicians can make a good faith determination** of whether there is risk of **physical harm** to patient or others if that note is released. Notes can be released if there is not significant risk of **physical harm**.

Which notes are **not** released to patients?

To honor the 3 common allowable reasons and exceptions, Epic will **NOT automatically release** the following:

Notes for Pts 11-17 Years Old

These are not automatically released for now since they can contain sensitive adolescent info and maternal info (in newborn notes). In the near future, however, we expect to release more notes for patients <18 years old.

Behavioral Health (BH) Notes

These can contain sensitive information regarding psychiatric conditions.

SAFE Notes

These contain sensitive info about sexual assault and therefore should not be released.

Notes Filed Under these Services

Toxicology
Psychiatry
Psychosocial Rehab
Case Management
Social Work

Spiritual Care
Child Life
Creative Arts Therapy
Therapeutic Recreation

Notes filed under these services can contain sensitive information regarding domestic, elder, and/or child abuse or psychiatric conditions, and are not automatically released because it is infeasible to mitigate potential harm or privacy risk at this time.

How do I prevent note release?

A WORD OF CAUTION

You should only prevent note release if the note falls under the 3 allowable reasons and exceptions.
We recommend that most notes should be released to patients.

Blocking the release of notes without adequate justification can be considered information blocking, especially if notes are not released in a timely fashion when requested.

For clinicians in the service listed below, Epic functionality currently limits the ability to release notes while mitigating harm or privacy risk related to sensitive information. In future, we will provide options to manually release non-sensitive notes in these areas when appropriate.

Toxicology
Psychiatry
Psychosocial Rehab
Case Management
Social Work

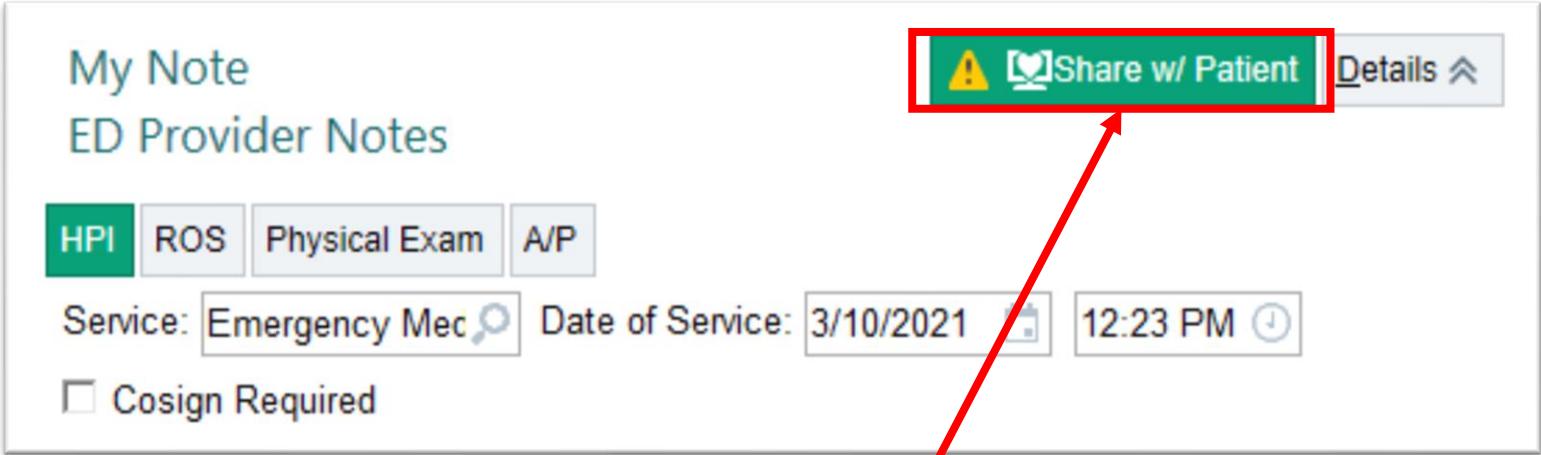
Spiritual Care
Child Life
Creative Arts Therapy
Therapeutic Recreation

How do I prevent note release?

METHOD #1

FOR MOST USERS

The most common method to prevent note release is to unclick the Share w/ Patient button on the individual note.



The screenshot shows a medical note interface. At the top, it says "My Note" and "ED Provider Notes". Below this, there are several buttons: "HPI" (highlighted in green), "ROS", "Physical Exam", and "A/P". Underneath, there are fields for "Service: Emergency Mec", "Date of Service: 3/10/2021", and "12:23 PM". A checkbox labeled "Cosign Required" is also visible. In the top right corner, there is a "Share w/ Patient" button with a warning icon, which is highlighted with a red box and a red arrow. To its right is a "Details" button with an upward arrow icon.

Unclick this Share w/ Patient button to prevent this note from being released to Connect (button will turn gray).

How do I prevent note release?

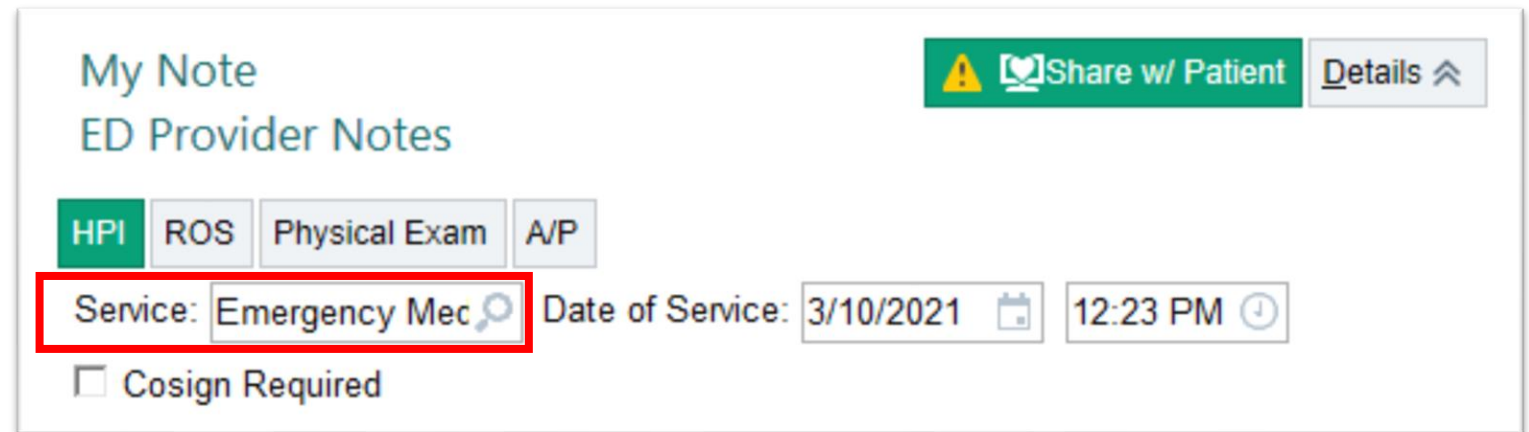
METHOD #2

FOR SPECIAL USERS

Users from the services below can also prevent note release by changing the Note Service on any individual note.

Toxicology
Psychiatry
Psychosocial Rehab
Case Management
Social Work
Spiritual Care
Child Life
Creative Arts Therapy
Therapeutic Recreation

The **Note Service** can be found at the top of every note:



The screenshot shows a medical note interface. At the top right, there are buttons for 'Share w/ Patient' (with a warning icon) and 'Details' (with an upward arrow). Below this, the note title is 'My Note' and the subtitle is 'ED Provider Notes'. There are four tabs: 'HPI' (highlighted in green), 'ROS', 'Physical Exam', and 'A/P'. Below the tabs, the 'Service' dropdown menu is open, showing 'Emergency Mec' selected and highlighted with a red box. To the right of the service dropdown, there are fields for 'Date of Service: 3/10/2021' and '12:23 PM'. At the bottom, there is a checkbox labeled 'Cosign Required'.

How do I change my default sharing settings?

If you have set your notes to **Do Not Share by Default** in Epic using the **Sharing Settings Navigator**, please change your settings to **Share by Default** instead using the instructions on the right.

Starting October 25, 2021, you will no longer be able to set your notes to “Do Not Share by Default” in Epic.

How to access and use the **Sharing Settings Navigator** from inside any patient’s chart:

1. Click here and select **Sharing Settings**, or type “Sharing Settings” in Chart Search.

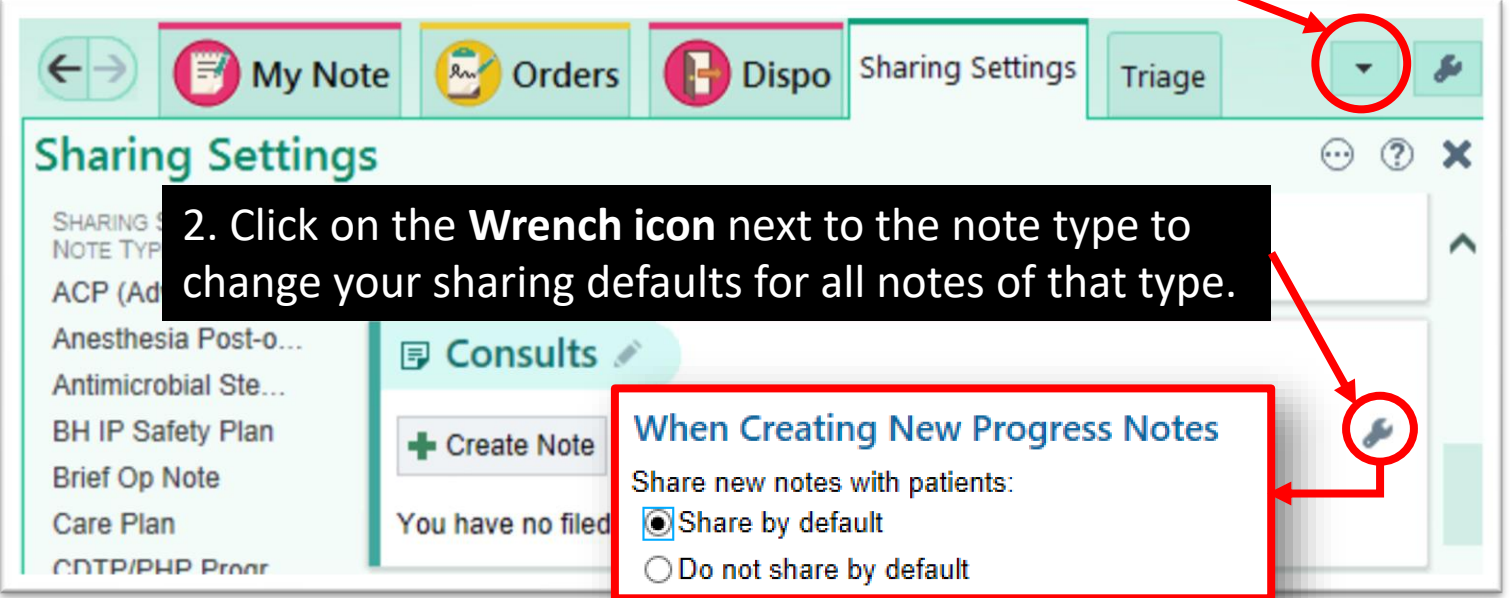
2. Click on the **Wrench icon** next to the note type to change your sharing defaults for all notes of that type.

When Creating New Progress Notes

Share new notes with patients:

Share by default

Do not share by default



What does the **Sensitive** button do?

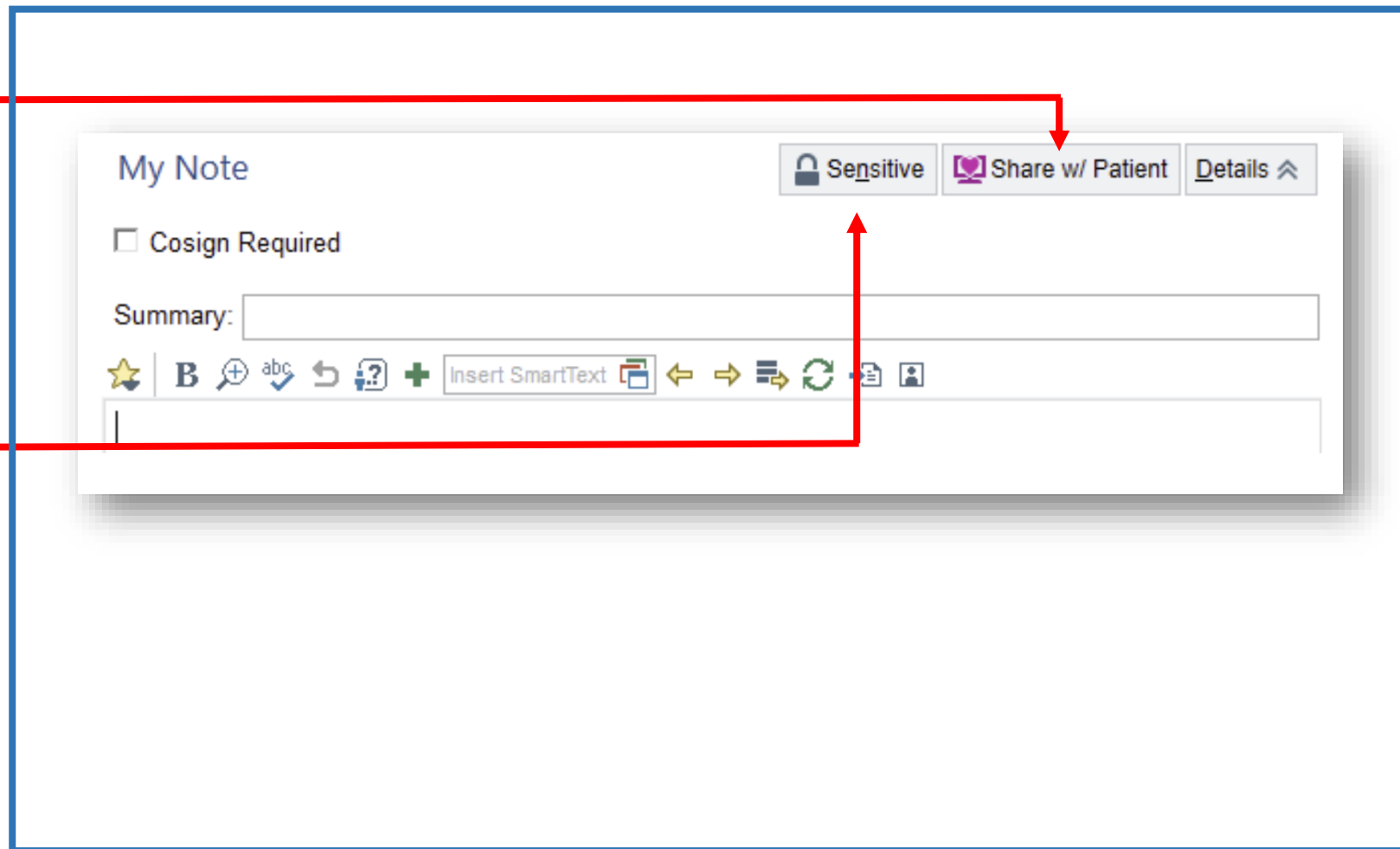
UNCLICKING SHARE W/ PATIENT

Note can still be viewed by staff but not by the patient/proxies.

CLICKING SENSITIVE

Only YOU (the note author) can see the note. While patients/proxies can't see the note, **one else can either** (including billers and other clinical staff). The note becomes a private note to yourself.

This should almost never be used.



Can you summarize how note release works?

We recommend that most notes be released to patients.

NOT AUTOMATICALLY RELEASED

These notes are **NOT** automatically released by Epic at the Connect or Note level, meaning they will **NOT** be released to patients via Connect **EVEN IF** the “Share w/ Patient” button is clicked on the patient’s chart.

1. Notes for Pts 11-17 Years Old
2. Psych/Behavioral Health Notes
3. SAFE Notes
4. Notes filed by these Services

Toxicology
Psychiatry
Psychosocial Rehab
Spiritual Care
Case Management
Social Work
Child Life
Creative Arts Therapy
Therapeutic Rec.

PREVENTING NOTE RELEASE

Method 1: The most common method to prevent note release is to unclick the **Share w/ Patient** button on the individual note.

Method 2: Users from these sensitive services can also prevent note release by changing the **Note Service** on individual notes to any of the services listed in this box.

Notes that are not released automatically can still be accessed by patients or proxies by completing an HIM Request Form ([see slide 29](#)).

With very rare exceptions, you should **NOT** use the “Sensitive” button to prevent note release.

Which results are released to patients?

Which results are automatically released to Connect?

- **Most** lab results, pathology results, radiology reports and procedure reports across the ED, Inpatient and Outpatient settings are automatically released.

Which results are **not** automatically released to Connect?

- **Some sensitive lab results that always require manual release to Connect include:**
 - Genetic test results for all patients
 - HIV test results for all patients
 - STI test results for patients < 18 years old only - *RPR, VDRL and GC Tests (urine and swab)*
 - Pregnancy test results for patients < 18 years old only - *Urine and Serum bHCG (not ultrasound results)*

Can I prevent automatic release to Connect?

- Preventing the release of specific results is allowed to prevent patient harm or ensure patient privacy.
- The decision to prevent release should be made at the individual patient level.

How do I prevent result release?

METHOD #1

WHILE ORDERING THE TEST

On the test order screen, click the **Manual Release Only** button to prevent the result being automatically released to the patient on Connect.

The screenshot shows a software interface for ordering a "DRUG SCREEN, URINE W/O CONFIRM" test. At the top right, there are "Accept" and "Cancel" buttons. The "Frequency" section includes a dropdown menu set to "STAT" and several other options: "AM draw", "PM draw", "Once", "Once timed", and "Prior to Discharge". The "Starting" date is "3/9/2021" with "Today" and "Tomorrow" buttons, and the time is "At: 1513". Below this, it says "First Occurrence: Today 1513" and has a "Show Scheduled Times" link. A red box highlights the "Release to patient" section, which contains three buttons: "Immediate" and "Manual release only". Below this are two sections for providing reasons: "Reason for preventing immediate release" with a dropdown menu showing "Patient request" and "Reasonable likelihood of causing patient harm", and "Additional details for preventing immediate release" with a text input field. At the bottom, there is a "Comments" section with a "+ Add Comments (F6)" button. A blue bar at the very bottom contains a "Next Required" button and "Accept" and "Cancel" buttons.

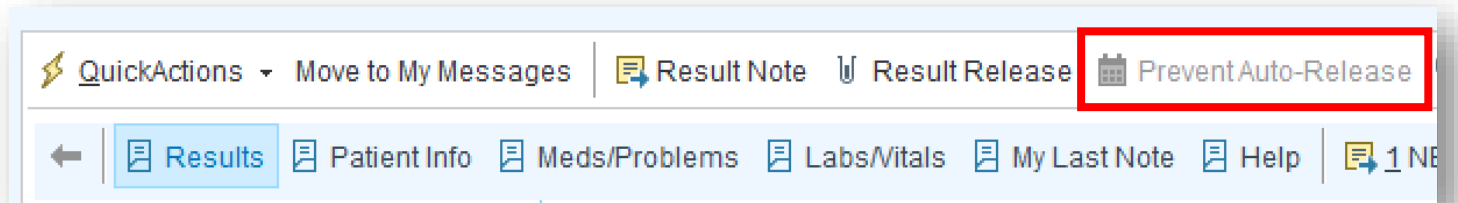
How do I prevent result release?

METHOD #2

AFTER ORDERING THE TEST (from the In-Basket or Results View)

On the menu bar, click the **Prevent Auto-Release** button to prevent the result being automatically released to the patient on Connect.

If the patient has already viewed the result on Connect, this button will be grayed out.



Impact on Patients

What do patients see with Open Notes & Results Release?



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How do patients around the country feel about Open Notes?

Annals of Internal Medicine

ORIGINAL RESEARCH

Inviting Patients to Read Their Doctors' Notes: A Quasi-experimental Study and a Look Ahead

Tom Delbanco, MD*; Jan Walker, RN, MBA*; Sigall K. Bell, MD; Jonathan D. Darer, MD, MPH; Joann G. Elmore, MD, MPH; Nadine Farag, MS; Henry J. Feldman, MD; Roanne Mejilla, MPH; Long Ngo, PhD; James D. Ralston, MD, MPH; Stephen E. Ross, MD; Neha Trivedi, BS; Elisabeth Vodicka, BA; and Suzanne G. Leveille, PhD, RN

Delbanco, Walker, et al, Annals of Internal Medicine

Three out of four patients reported:

- Taking better care of themselves
- Understanding their health and medical conditions better
- Feeling more in control of their health and health care
- Being better prepared for visits
- Doing better with taking their medications as prescribed

JAMIA
A SCHOLARLY JOURNAL OF INFORMATICS IN HEALTH AND BIOMEDICINE

Inviting patients and care partners to read doctors' notes: OpenNotes and shared access to electronic medical records

Jennifer L Wolff,¹ Jonathan D Darer,² Andrea Berger,³ Deserae Clarke,⁴ Jamie A Green,³ Rebecca A Stametz,⁴ Tom Delbanco,⁵ and Jan Walker⁵

Wolff, et al. JAMIA

- **88%** of patients and **86%** of caregivers had better formulated questions for the doctor.
- **86%** of patients and **82%** of caregivers had more productive discussions about the patient's care.
- **94%** of patients and their caregivers said they had a better understanding of health conditions, better remembered the care plan, and felt more in control.

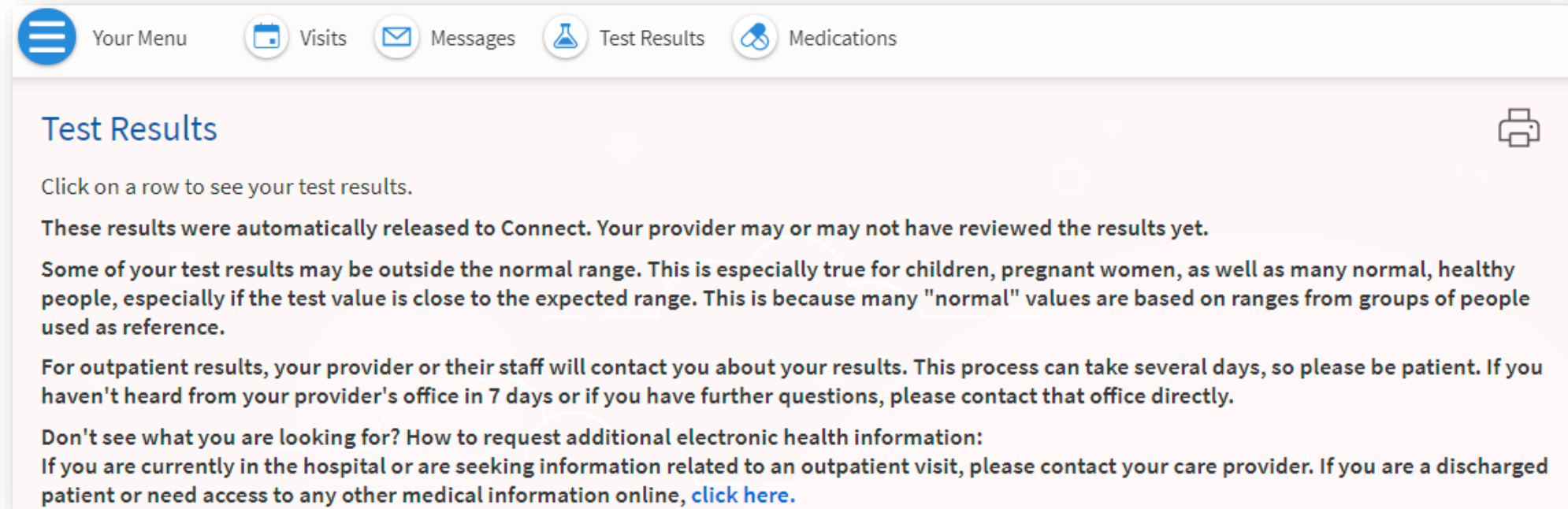
Since 2017, more than 200,000 office visit notes have been shared with New York Consortium patients with similar feedback.

How will patients be educated about Open Notes?

Patients have been messaged via the Connect Patient Portal to inform them of Open Notes.

How will patients be educated about Results Release?

The language in Connect has been updated to address potential patient concerns. When patients open the “Test Results” page in Connect, they see this message:



The screenshot shows the 'Test Results' page in the Connect patient portal. At the top, there is a navigation bar with icons and labels for 'Your Menu', 'Visits', 'Messages', 'Test Results', and 'Medications'. The 'Test Results' icon is highlighted. Below the navigation bar, the page title 'Test Results' is displayed on the left, and a printer icon is on the right. The main content area contains the following text:

Click on a row to see your test results.

These results were automatically released to Connect. Your provider may or may not have reviewed the results yet.

Some of your test results may be outside the normal range. This is especially true for children, pregnant women, as well as many normal, healthy people, especially if the test value is close to the expected range. This is because many "normal" values are based on ranges from groups of people used as reference.

For outpatient results, your provider or their staff will contact you about your results. This process can take several days, so please be patient. If you haven't heard from your provider's office in 7 days or if you have further questions, please contact that office directly.

Don't see what you are looking for? How to request additional electronic health information:
If you are currently in the hospital or are seeking information related to an outpatient visit, please contact your care provider. If you are a discharged patient or need access to any other medical information online, [click here](#).

Remember to also set expectations with patients upfront at the time of ordering!

How do patients receive results in Connect?

Patients will receive a **daily digest** of results in Connect by default.

To change this setting, instruct your patient to:

1. Log into Connect.
2. From the Menu, go to “Communication Preferences.”
3. Expand the “Health” option.

If your patient prefers to receive more frequent messages for results, instruct them to:

4. Unclick this checkbox called “receive a daily summary between 8-10 AM on a business day.” The patient will now receive multiple “tickler” messages each time a new result is finalized that they have not yet seen.

If your patient prefers to stop receiving messages for results, instruct them to:

5. Click this envelope icon next to “Test Result” in the “Email” column.

Communication Preferences

Choose how you would like to receive Connect notifications.
Appointment Confirmation options cannot be edited through Connect.
You can manage your settings for push notifications on your mobile device.

	Email	Text	Call	Mail
Appointments Alerts and notifications about upcoming or past appointments.				
Messages Receive updates from your healthcare organization.				
Health Notifications when new information is available about your care.				
Health Maintenance Reminder ⓘ				
Medical Document Request				
Research Study Invitation				
Test Result				

Receive a daily summary between 8-10 AM on a business day

Recommended Best Practices

Are there suggestions for how to improve my documentation and communication with patients under Open Notes & Results Release?



What should I NOT change about my documentation under Open Notes?

1. Continue to be professional.

- **Always use professional language when describing patient care or interprofessional interactions.** Do not create unnecessary medicolegal risk by using judgmental or colloquial terms to document patient care.
- For instance, “pending ongoing discussion with consultant” rather than “multiple back-and-forth disagreements with Dr. X causing care delays.”

2. Continue to be transparent and accurate.

- **Check that all medications, problem lists, and allergies are up to date.**
- **Beware of inaccurate templates and macros.** Double check that your macro does not auto-populate a portion of the exam that you did not perform.
- **Be transparent. Discuss what you write and write what you discuss.**

3. Continue to document fully in medical terms, even though the patient will see your note.

- **Continue to document probable, possible and suspected conditions.**
- **Continue to use clinical terminology.** Unlike patient discharge instructions, it is not necessary to document at a 6th grade reading level.
- While Open Notes focuses on communicating with patients, the medical record must also clearly and accurately communicate clinical, legal, and billing information. The desire to improve communication with patients, while important, should not trump the other purposes of the medical record.

Adapted from: Chimowitz H. and Fernandez L. Sharing Visit Notes: Getting Patients and Physicians on the Same Page. *Fam Pract Manag.* 2016 Nov-Dec;23(6):10-13.

What COULD I change about my documentation under Open Notes?

1. Consider avoiding acronyms or abbreviations that could be misinterpreted.

- **Avoid acronyms that could be misinterpreted by patients** (e.g., “SOB”).
- **Expand abbreviations rather than oversimplify or redefine them** (e.g., “shortness of breath” rather than “trouble breathing”). Keep in mind that the chart still needs to convey clinical information using accurate medical terms.

2. Consider describing behaviors rather than judgments.

- **Use factual language rather than potentially judgmental terms.**
- For example, “Patient could not recall” instead of “poor historian.”
- Keep in mind that patient non-compliance or disagreement should still be documented factually and not omitted from the medical record.

Adapted from: Chimowitz H. and Fernandez L. Sharing Visit Notes: Getting Patients and Physicians on the Same Page. Fam Pract Manag. 2016 Nov-Dec;23(6):10-13.

How should I communicate with patients about results?

1. Set expectations upfront.

- **Whenever possible, let the patient know that they may see their results in the Connect portal before you or another member of the healthcare team has a chance to review them.** Explain that this is to help the patient access their results as quickly as possible, without delay.
- Offer the patient contact information to reach you or a member of the healthcare team should they have any questions upon seeing their results.

2. Ask patients to review their proxy settings in Connect.

- **Whenever possible, ask patients if they are comfortable with their proxies seeing their test results, and help them set their proxy settings in Connect accordingly.** This is particularly important for pediatric and vulnerable populations regarding potentially sensitive test results.

3. Know how to address patients' requests to access results.

- Please [see this page](#) for instructions on how to advise patients or family members requesting access to results.

CASE EXAMPLES



Open Notes Case Example #1

CASE EXAMPLE

*25 year old female presents with RUQ pain. Reports 3 days of RUQ pain, vomiting and fever. She also endorses having felt **depressed**. She feels safe at home and denies any DV. She used to take an antidepressant but ran out of her prescription months ago. She does not have a therapist.*

RECOMMENDED BEST PRACTICE

Releasing this note to the patient via Connect would not cause substantial physical harm and there are no privacy issues. Therefore, **it should still be released.**

Open Notes Case Example #2

CASE EXAMPLE

*25 year old female with history of schizophrenia and multiple psychiatric admissions presents with RUQ pain. Reports 3 days of RUQ pain, vomiting and fever. She denies suicidal ideation but does **report homicidal thoughts** regarding a prior partner. She feels safe at home and denies any DV. She does have a therapist but per review of chart she is non-compliant with visits and medication. She has had several inpatient psychiatric admissions. She has a history of attempted elopement from the psychiatric ward in the past. She has a violence flag noted in her chart for violence toward ED staff in the past.*

RECOMMENDED BEST PRACTICE

Given this patient's psychiatric past including violence, elopement and homicidal ideation, releasing this note is high risk for potential physical harm to staff. It should therefore not be released.

APPENDIX



Considerations for Students, Residents & APPs

Any **resident or APP** note that requires Cosign by a supervising physician will not be released until it is **Cosigned**.

Notes authored by **medical students** will not be released to the patient even if they are Cosigned.

Remember that you can **manually** prevent the release of any note to prevent physical harm or protect privacy.

MEDICAL STUDENTS

- Notes authored by medical students will **NOT** be released to the patient, even if they are Cosigned by an attending.
- **However, if an attending takes over an ED or inpatient note to make edits, it WILL be released to the patient after the attending Signs.** The attending will become the note author instead of the student, and the note therefore will be released.

RESIDENTS

- Resident notes that require Cosign by a supervising physician will not be released until Cosigned. This ensures that the resident's note is reviewed before the patient sees it.
- **ED and inpatient notes authored by residents that do NOT require Cosign WILL be released to the patient after the resident Signs.** This means the note will be seen by the patient without attending review.

APPs

- The requirement for Cosign for PA or NP notes may differ by department. Check with your dept leadership for clarification.

Considerations for Patient Proxies

Open Notes

Results Release

FOR PATIENTS 0-11 YEARS OLD

Notes are auto-released to Connect (cannot be viewed by patient or proxies).

Parent/guardian proxies will be able to view all results released to the patient's Connect.

FOR PATIENTS 12-17 YEARS OLD

Notes are **not** auto-released to Connect (cannot be viewed by patient or proxies).

The patient will be able to view all results released to their Connect, but **proxy accounts will not be able to view their results** unless requested through HIM.

FOR PATIENTS AGE 18 YEARS AND OLDER

Adult proxies will be able to view all notes released to the patient's Connect.

Adult proxies will be able to view all results released to the patient's Connect.

How to Handle Requests from Patients or Proxies

What if a patient or proxy asks me to change my note?

- **If you agree with the request, make the change to your note in real time after discussion with the patient or proxy.**
- If you do not agree or are unable to make the change in real-time, **refer the patient or proxy to Health Information Management (HIM).** Give them the contact info below or refer them to the Medical Record Request Form on Connect. HIM will reach out to you via email for next steps.

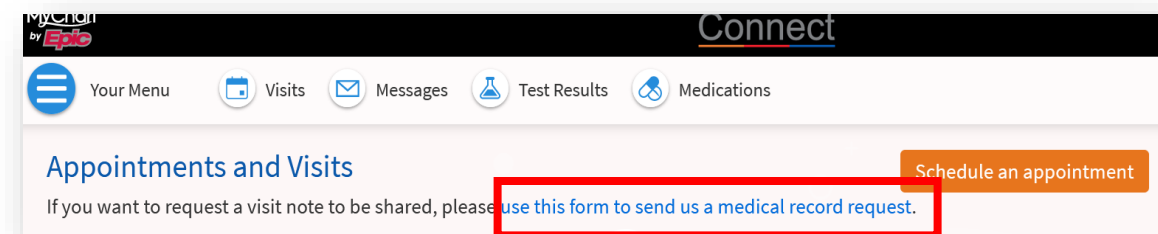
What if a patient or proxy asks for notes or results are not automatically released to Connect?

- Common examples are scanned documents, parents requesting to see notes for children 0-12 years old, or patients requesting to see their behavioral health notes (assuming no substantial risk of patient harm).
- **These requests must be honored.** Direct the patient to Health Information Management (HIM) using the contact info below, or refer them to the Medical Record Request Form on Connect.

HIM CONTACT INFO FOR PATIENTS

- **For Weill Cornell Medicine:** 646-962-6930
- **For New York Presbyterian**
 - <https://www.nyp.org/patients-visitors/medical-records>
- **For Columbia Doctors**
 - <https://www.columbiadoctors.org/about-us/medical-records>

HIM REQUEST FORM ON CONNECT



Where to Go for Help

Open Notes and Results Release is a big cultural change, but can lead to patient empowerment, improved patient experience, and better quality of care.

For general questions, please contact the Open Notes Workgroup at InformationBlocking@nyp.org

To report an IT issue or error, please contact the NYP Help Desk at servicedesk@nyp.org or 212-746-4357

Additional Help for Patient Record Release:

- NYP - <https://www.nyp.org/patients-and-visitors/medical-records>
- CUIMC - <https://www.columbiadoctors.org/about-us/medical-records>
- WCMC - <https://weillcornell.org/privacy>
 - Click on the Notice of Privacy Practices for instructions

Additional Resources:

- [Read patient stories here.](#)
- [OpenNotes International Movement](#)
- [Information Blocking FAQs from HealthIT.gov](#)
- [ONC Cures Act Final Rule](#)