

HIPAA Exhibit 5002A  
**Designated Record Set**

The Designated Record Set refers to a group of records comprised of medical records and billing records about a patient maintained by a Yale healthcare provider; or used by a Yale healthcare provider to make decisions about the individual.

Note that the components of the designated record set are not necessarily filed in one location or in one medium. Patients may be directed to obtain components of their designated record set at various locations.

Any reference to the Medical Record includes the Electronic Medical Record (EMR) and/or the paper record.

The following documents which are part of the permanent medical record are included in the Yale designated record set:

- Advance Directives
- Consents and Authorizations
- Consultations
- Correspondence and Calls recorded in the medical record
- Demographic information
- Diagnostic Imaging Reports
- Discharge Instructions
- EEG Reports
- EKG Reports
- Forms that are included in the permanent record
- Graphic and Flow Sheets
- History, including past Medical and Surgical History
- Home Health Documentation
- Identification Sheet/Face Sheet
- Immunization Records
- Laboratory Reports
- Medical Release Forms
- Medication Records
- Nursing Documentation
- Notes
- Pathology Reports
- Photographs (if included in the medical record)
- Physical Exam
- Problem List
- Progress Notes (including interdisciplinary documentation)
- Reports of Operations/Procedures
- Scanned documents
- Therapy Reports
- (Past) Medical records archived electronically or stored in paper or other media
- Requests for Amendment
- Amendments
- Denials of Requests for Amendments

The following documents that are part of billing records retained for patients are also included in the Designated Record Set:

- Life Time Insurance Authorization (LTIA) (scanned image)
- Medicare Advanced Beneficiary Notice
- Payment Agreement
- Requests for Amendment
- Amendments
- Denials of Requests for Amendments