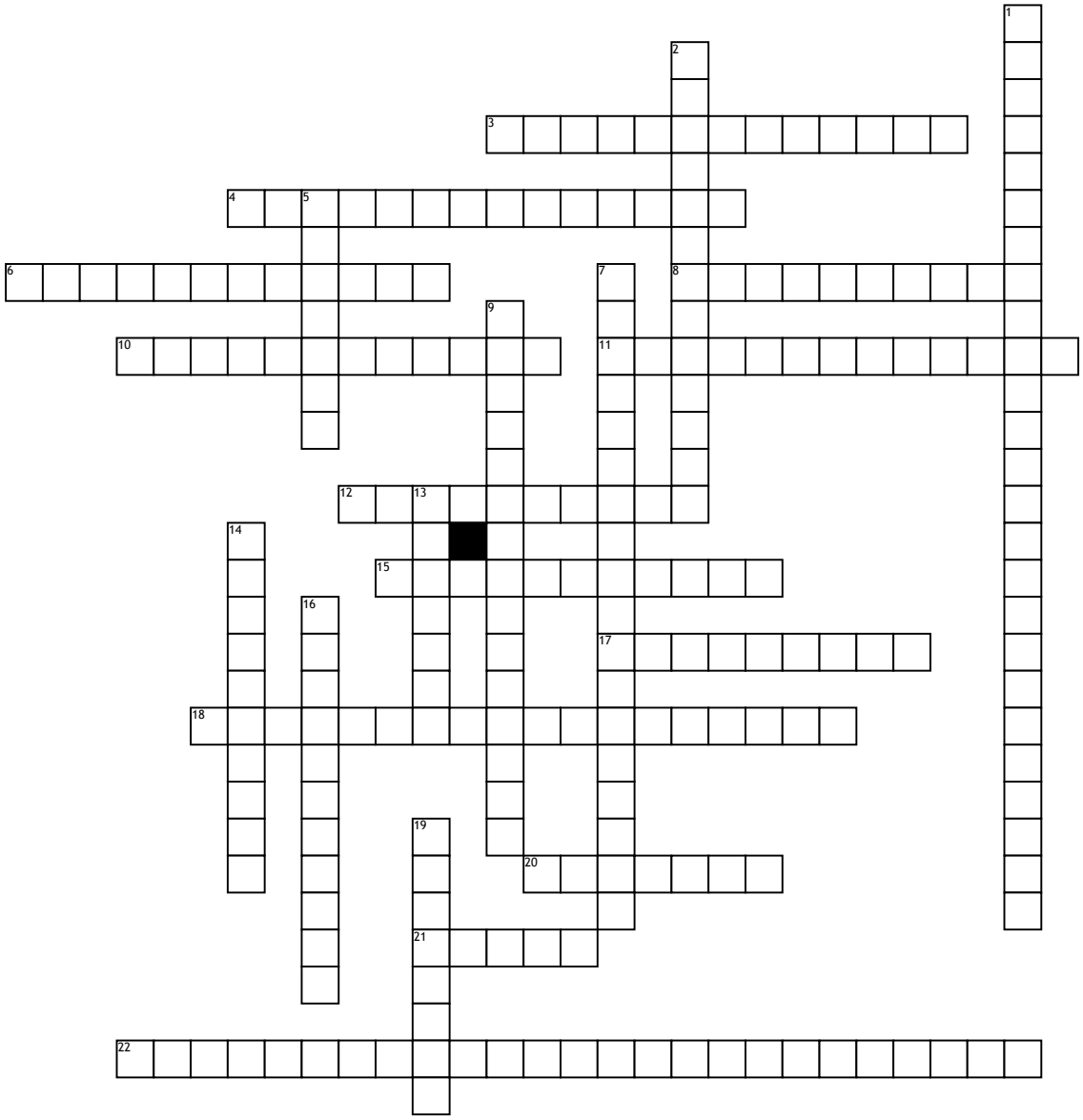
Name: _____ Date: _____

Chapter seven -Health information Functions



Across

3. The granting of permission to disclose confidential information for purposes other than treatment, payment, or healthcare operations..

4. A list of the operations and surgical procedures performed ina health care facility that is sequenced according to the code numbers of the classification system in use.

6. A health record that includes both paper and electronic elements

8. The removal of a document from standard view within an electronic document management system.

10. An official designation indicating that a healthcare facility is in compliance with the Medicare Condition of Paticipation.

11. A computer software program designed to prevent unauthorized use of an information resource.

12. The steps taken to implement a policy.

15. The act of breaking down the components of a health record into pieces that can no longer be recognized as parts of the original record.

17. The process whereby inactive health records are stored and made available for future use in compliance with state and federal requirements.

18. A list or database created and maintained by a healthcare facility to record the name and identification number of every patient who has ever been admitted or treated in the facility

20. Situation in which a patient is issued a medical record number that has been previously issued to a different patient.

21. An organized list of specific data that serves to guide, indicate, or other facilitate reference to the data.

22. A system of health record identification and storage that uses a combination of alphabetic letters(usually the first two letters of the patient's last name) and numbers to identify individual records.

Down

1. A plan in which health information is shared among providers.

2. Patient health records that have been removed from the active file area.

5. Specialty software used to facilitate the assignment of diagnostic and procedural codes according to the rules of the coding system

7. A unique numeric or alphanumeric identifier assigned to each patient's record upon admission to a healthcare facility.

9. Is the process of identifying the source of health record entries by attaching a handwritten signature, the author's initials, or electronic signature.

13. Situation in which a patient is issued more than one medical record number from an organization with multiple facilities.

14. Health information management function that takes place outside of a traditional office setting.

16. The process of extracting information from a document to create a brief summary of a patient's illness, treatment, and outcome

19. Governing principles trhat describe how a department or an organization is supposed to handle a specific situation.