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Chapter seven -Health information Functions

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| **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. |