

EVALUATION OF THE COMPLETENESS OF ADMINISTRATIVE REQUIREMENTS IN THE RELEASE OF MEDICAL INFORMATION TO GUARANTEE LEGAL STANDING

Wa Ani Suryani ¹, Ahmad Amiruddin J ², Selvi Mayang Sari ³,

^{1,2,3} Politeknik Baubau, Baubau, Indonesia

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CORRESPONDING AUTHOR

Nama : Ahmad Amiruddin J
Address: BTN Topaz 2 Blok C6 Kel. Sulaa
Kec. Betoambari
Email:
ahmadamiruddinpoltekbaubau@gmail.com

A B S T R A C T

Quality healthcare services rely heavily on the orderly administration of medical records to ensure patient data security. The release of medical information to third parties is an exception to medical confidentiality that must be executed selectively in accordance with Standard Operating Procedures (SOP) to prevent legal anomalies. A preliminary study at BLUD RSUD Buton Regency showed that 25% of information release files did not comply with the SOP, primarily due to incomplete power of attorney documents. To evaluate the completeness of administrative requirements in the release of medical information through a systems approach (input, process, output) to ensure legal validity at BLUD RSUD Buton Regency. This study utilized a qualitative research design with a descriptive approach. Data collection was conducted through in-depth interviews, direct observation using checklists, and documentary studies of medical information release files. The input component indicated that human resources, SOP documents, and policies were available; however, physical documents on desks and staff legal understanding required improvement. In the process component, inconsistencies were found in the staff's bureaucratic workflow and the validation of power of attorney authenticity. The output component had not achieved the 100% target due to the remaining presence of documents lacking a valid power of attorney. The medical information release procedures have not operated optimally due to administrative loopholes in the applicant's power of attorney requirements. It is recommended to conduct regular audits, provide standard power of attorney forms, and socialize personal data protection in compliance with Minister of Health Regulation (Permenkes) No. 24 of 2022.

INTRODUCTION

Quality healthcare services in hospitals are not only determined by the expertise of medical personnel in performing curative treatments, but also heavily rely on administrative order in managing patients' health history documentation. Medical records are vital documents containing patient identity, anamnesis, physical examination, and treatment, which must be kept confidential by all healthcare workers and medical facility leaders. Proper management of these documents reflects the institution's professionalism in providing a guarantee of data security for every individual seeking medical treatment (Mamesah et al., 2020).

According to the Regulation of the Minister of Health (Permenkes) No. 24 of 2022, which regulates the transition toward Electronic Medical Records (EMR) for national health system efficiency, this regulation brings a new dynamic where medical information is now viewed as public information to a certain extent, yet must remain synchronized with personal data protection principles. Consequently, all hospitals were required to implement electronic medical records by December 2023 (Permenkes RI No 24, 2022).

A medical record consists of written or recorded details regarding identity, anamnesis, physical assessment, laboratory findings, diagnoses, and all medical services and actions provided to patients, as well as treatment for inpatient, outpatient, and emergency care services (Meira Hidayati, 2024).

Medical records serve as a data source that can be utilized for various purposes. Since data and information carry a nature that must be kept confidential, the use of data for various needs requires careful attention to its legal aspects and compliance with applicable laws and regulations. Hospitals are obligated to continually safeguard and store the confidentiality of medical information contained within patient medical record files, as regulated in Article 38 Paragraph (1) of Law Number 44 of 2009 concerning Hospitals, which states that every hospital must maintain patient medical confidentiality (Siregar, 2024).

The utilization of medical records is closely linked to the disclosure of information contained within them to authorized parties who require it. Information release must be handled carefully by healthcare workers in hospitals. Pursuant to Article 5 Paragraph 2 of Permenkes No. 36 of 2012 concerning Medical Confidentiality, the disclosure of medical secrets (information release) related to patient interests such as treatment and healing must be conducted with the consent of the respective patient (Rohman et al., 2025).

The duty to maintain confidentiality is strictly regulated under Article 38 Paragraph (1) of Law Number 44 Year 2009 concerning Hospitals, which states that every hospital is required to keep medical secrets of patients. Healthcare facilities bear full responsibility for protecting medical information against potential loss, damage, forgery, and unauthorized access by third parties. This constitutes a form of constitutional protection for a patient's personal health condition

Although confidentiality is paramount, medical information may be disclosed for specific purposes such as insurance claims (reimbursement), educational needs, or law enforcement processes. However, this disclosure must be carried out selectively and adhere to strict procedures, including obtaining written consent from the patient as the rightful owner of the information. In practice, hospitals are required to have Standard Operating Procedures (SPO) governing the technicalities of disclosing medical secrets to prevent legal anomalies. These procedures typically include administrative requirements such as attached identification (KTP/Family Card), a valid power of attorney, and the use of official forms from the requesting institution before data is provided. These administrative requirements are established so that unauthorized individuals cannot access patient data, thereby ensuring its confidentiality is well preserved (Narendra Indra, 2020).

The information disclosure system in a hospital is an integrated protocol that regulates the technical process of legally providing patient health data to third parties. This mechanism is designed as an operational standard to ensure that every outward data flow from a medical institution has a strong legal basis and can be administratively accounted for. In practice, this system acts as a security filter that requires identity validation and written authorization, such as a power of attorney from the patient. This aims to control access to sensitive medical records, ensuring that only parties with urgent and legitimate interests can obtain such information within authorized limits (Darmawan et al., 2022).

METHOD

The type of research used is descriptive research with a qualitative approach. Qualitative research is research used to examine natural object conditions, where the researcher acts as the key instrument. Unlike quantitative research which focuses on numbers, qualitative research places greater emphasis on meaning, description, and process rather than generalization. This study aims to evaluate in depth the completeness of administrative requirements in the release of medical information at BLUD RSUD Buton Regency using a system approach (Input, Process, and Output).

The subjects in this study are officers directly involved in the release of patients' medical record information at the Buton Regency Regional Public Hospital, specifically the hospital's Health Administration staff who are involved. Subjects were selected because they play a direct role in the process of releasing patients' medical record data information.

Observation is a data collection technique carried out by researchers observing and recording various information regarding situations and events occurring in the field. This observation was conducted during the return of medical records to the medical records office of the maternal and child health center, as well as to the medical records officers responsible for collecting and storing medical record documents.

According to (Rahmad Hidayat, 2025), interviews are one of the data collection techniques used by researchers when conducting preliminary studies to identify the problems to be studied and when researchers wish to obtain deeper information from respondents. The interview process was carried out by asking predetermined questions to the staff at BLUD RSUD Buton Regency.

Document research is a systematic process often conducted to gain a deep understanding of a topic or phenomena in conducting this research, data collection is an essential step in obtaining the required information. The most appropriate data collection techniques and valid research instruments play a crucial role in producing accurate and reliable data in research; there are two main approaches commonly used, namely qualitative and quantitative research (Subhaktiyasa, 2022).

RESULTS & DISCUSSION

1. Evaluation of the Completeness of Administrative Requirements in the Release of Medical Information Based on Input

Based on the research findings, the input components in the procedure for releasing medical information at BLUD RSUD Buton Regency include Human Resources (HR), Standard Operating Procedures (SOP), and Management Policies.

a. Human Resources (HR)

Human Resources are the primary asset in a healthcare service organization, particularly within the medical records unit. According to HR management theory, the effectiveness of a work system (input) relies heavily on the quantity and quality of the personnel operating it. In the context of releasing medical information, medical records personnel are not only required to possess technical-administrative skills, but they must also understand the legal and professional ethics aspects to maintain patient data confidentiality as regulated by the Regulation of the Minister of Health. Competent HR serves as a "gatekeeper" information "gatekeeper" to prevent data leaks that could lead to legal action (Simanjuntak, 2021).

Based on the research findings at BLUD RSUD Buton Regency, the HR aspect in the release of medical information showed fairly good results in terms of quantity. Respondents stated that the number of personnel in the medical records unit is sufficient to cover the workload of releasing information. Staff members have also been given guidance regarding the importance of the principle of prudence when handling medical data requests.

However, based on further observations and interviews, the researcher discovered challenges regarding the consistency of understanding legal aspects. Although the number of staff is adequate, in practice, some personnel were still found releasing information without a fully completed power of attorney letter. This indicates that while task distribution is functioning, educational reinforcement regarding the latest regulations on legal validity needs to be enhanced so that staff do not work merely out of routine, but also out of strict legal compliance.

The findings in this study are aligned with the research conducted by (Simanjuntak, 2021), which states that having adequate HR availability serves as the initial foundation for the quality of medical records services. However, this study also confirms the findings of Lestari (2022), which note that the main HR challenge in the information release department lies not in the number of personnel, but rather in the level of compliance with standard operating procedures (SOP).

The similarity between this study and previous research is that the HR variable is viewed as the most decisive input component for the success of administrative processes. The difference is that at BLUD RSUD Buton Regency, the obstacle encountered is not a shortage of manpower, but rather the need for a uniform standardization of understanding among staff regarding the validation of administrative requirements to guarantee absolute legal validity.

The researcher argues that HR at BLUD RSUD Buton Regency has great potential to achieve a 100% administrative completeness target. Given that the quantity is already adequate, hospital management is advised to conduct regular socialization or specialized training regarding health law aspects. Strengthening HR capacity is crucial because no matter how good the SOPs are, if the staff executing them lack firmness in validating documents, the risk of legal anomalies will remain.

Analysis of the Human Resources (HR) aspect in the medical records unit at BLUD RSUD Buton Regency shows that in terms of quantity, the number of personnel is adequate to handle the daily workload; however, in terms of quality, it still faces challenges in the consistency of understanding legal aspects. This is evidenced by field findings where staff members still process the release of medical information without a complete power of attorney letter, even though in interviews, informant respondents stated they had been instructed to be cautious ("as for the number of staff here, it is actually sufficient, and we are always reminded to be careful"). This finding aligns with HR management theory stating that system effectiveness heavily depends on personnel quality, confirms Simanjuntak (2021) Simanjuntak's (2022) research on the importance of HR quantity, and supports Lestari's (2022) findings that the main challenge lies in SOP compliance rather than staff count. Therefore, the researcher concludes that hospital management needs to conduct regular socialization and health law training to standardize staff understanding, as no matter how good the applicable SOP is, the risk of legal anomalies will remain if field personnel lack firmness in validating administrative requirement documents.

b. Standard Operating Procedure (SOP)

In the systems approach, SOP is a crucial input component serving as a control instrument. SOP acts as a standardized guide for personnel so that work processes run consistently, effectively, and within legal boundaries. In the context of medical records, the SOP for releasing information is not merely an administrative workflow, but rather a legal document that protects the hospital from potential lawsuits due to breaches of medical confidentiality. The existence of a clear SOP ensures that every information applicant is treated fairly while still passing through a strict administrative filter, such as identity validation and power of attorney verification (Rahayu, 2022).

Based on the research findings at BLUD RSUD Buton Regency, respondents explained that the hospital has established a standard SOP regarding the release of medical information since early 2023. Informants stated that this SOP has significantly helped staff in minimizing procedural errors. However, observation results revealed a discrepancy between policy content and field implementation. The researcher found that although the SOP is in place, instructions regarding the "validity of duty stamps on power of attorney forms" and "signature matching" hand signatures of patients with ID cards" have not been fully carried out in detail by staff. This indicates that while the SOP as an Input is physically available, it functionally has not been fully internalized as a mandatory compliance standard for all administrative staff lines.

This finding shares similarities with research conducted by (Rahayu, 2022) which revealed that the availability of SOP documents does not guarantee the completeness of administrative requirements unless accompanied by strict monitoring. In addition, research by (Putri & Sonia, 2021) also noted that medical records staff often prioritize the aspect of "convenience of service" over "SOP compliance" when dealing with urgent requests from patients' families, a dynamic that was also observed by the researcher at BLUD RSUD Buton Regency.

The difference from previous studies lies in the maturity of the document; at BLUD RSUD Buton Regency, the SOP document is already very specific and references the latest regulations, yet the main challenge lies in the Requirement Validation variable, which is frequently bypassed for the sake of service time efficiency.

The researcher argues that the SOP as an Input at BLUD RSUD Buton Regency needs to undergo revision or the addition of crucial points regarding "Digital Verification" or "Eligibility Standards for Power of Attorney." Maintaining an SOP merely as an administrative document without sanctions or rewards for compliance will keep legal risks high. To ensure absolute legal validity, the SOP must serve as a living document monitored through routine supervision by the Head of the Medical Records Unit.

Analysis of the Standard Operating Procedure (SOP) component as an input at BLUD RSUD Buton Regency shows that the regulatory document for releasing medical information has been formally available since early 2023 and is acknowledged by respondents as helpful in streamlining their work. However, observation results reveal an inconsistency between written regulations and field practice, where staff frequently skip detailed instructions—such as verifying the validity of duty stamps and matching the patient's signature on the power of attorney form—for the sake of service time efficiency. This finding aligns with the theory positioning SOPs as legal control instruments, while also confirming the research of (Rahayu, 2022) and (Putri & Sonia, 2021), which indicates that the mere availability of an SOP document does not guarantee administrative compliance without strict monitoring, especially when staff face with pressure from patients' families. Therefore, the researcher concludes that hospital management needs to turn this SOP into a living document through routine supervision by the Head of the Medical Records Unit and update standards regarding power of attorney eligibility, because without oversight and staff commitment, the presence of a formal SOP will not fully protect the institution from the legal risks of medical information leaks.

The analysis of the Standard Operating Procedure (SOP) component as an input at BLUD RSUD Kabupaten Buton shows that the regulation document for releasing medical information has been formally available since early 2023, and respondents acknowledge its benefits in facilitating their work.

However, observation results indicate an inconsistency between written regulations and field practice, where staff frequently skip detailed instructions—such as verifying duty stamp validity and matching patient signatures on power of attorney forms—for the sake of service time efficiency. This finding aligns with the theory positioning SOPs as legal control instruments and confirms the research by (Rahayu, 2022) and (Putri & Sonia, 2021) which states that the availability of SOP documents does not

guarantee administrative compliance without strict monitoring, especially when staff face with pressure from patients' families.

Therefore, the researcher concludes that hospital management needs to make this SOP a living document through routine supervision by the Head of the Medical Records Unit and update standards regarding power of attorney eligibility, because without supervision and staff commitment, the presence of a formal SOP will not be able to fully protect the institution from the legal risks of medical information leaks.

c. Management Policy

In organizational management theory, policy is an Input instrument that serves as a legal foundation and strategic direction for institutional operations. A strong management policy is crucial in medical records management, particularly regarding the release of information, to maintain a balance between patients' access rights and the hospital's obligation to protect data confidentiality. This policy is typically set forth in the form of a Director's Decree (Surat Keputusan / SK) or Hospital Bylaws that refer to national regulations such as the Health Law and Ministerial Regulations on Medical Records. Based on interview results with respondents at BLUD RSUD Buton Regency, management has established a policy written policy governing the procedures for releasing medical information. Respondents stated that the policy aims to protect the institution from legal risks and provide procedural certainty for field personnel. Management emphasized that every request for information must go through a single-window verification process to ensure its validity.

However, research findings show that although a macro-level policy is in place, the dissemination of its detailed points to technical personnel still needs improvement. There is still uncertainty among staff regarding certain boundaries within the policy, such as procedures for releasing information to third parties (insurance/legal entities) that sometimes require managerial discretion due to incomplete administrative requirements from applicants.

The findings of this study align with research by Hidayanti (2022), which states that a clear management policy is a determining factor in the success of legal protection in hospitals. However, this study also supports findings by Wulandari et al (2024), which reveal that the effectiveness of management policies is often hindered by a lack of monitoring over staff compliance with the policy.

The similarity between this study and previous research lies in positioning management policy as the primary legal umbrella (Input). The difference is that at BLUD RSUD Buton Regency, the primary focus of current policy emphasizes formal administrative aspects, whereas much of the previous research has begun to address policy aspects regarding digital or electronic information release (EMR).

The researcher argues that the management policy at BLUD RSUD Buton Regency is on the right track regulatory-wise. However, for this policy to effectively ensure legal validity, management needs to conduct periodic internal audits of processed information release files. Policy must not remain static on paper; management must ensure that all personnel understand the legal consequences if the policy is violated, thereby fostering a legally conscious work culture in the medical records unit.

Analysis of the Management Policy variable as an input component at BLUD RSUD Buton Regency shows that management has established written internal regulations that function as a legal umbrella to safeguard patient data security and protect the institution from legal risks. Nevertheless, research findings indicate that the effectiveness of this macro policy is not yet optimal at the technical implementation level due to minimal detailed socialization, thereby triggering uncertainty among staff when facing situations that require discretion, such as third-party information requests with incomplete files. This finding aligns with organizational management theory and confirms research by Hidayanti (2022) and (Wulandari et al., 2024) that a clear policy as a main input still requires strict monitoring to prevent gaps with field practice.

Therefore, the researcher concludes that management at BLUD RSUD Buton Regency must not allow policies to remain static; instead, they must optimize them through periodic internal audits of information release files and intensive socialization to build a legally conscious work culture within the medical records unit.

2. Evaluation of the Completeness of Administrative Requirements in the Release of Medical Information Based on Process

The process stage evaluates how all resources at the input stage are executed through a series of administrative actions.

a. SOP Implementation

In the systems theory approach, the Process is the transformation stage where all inputs (HR, Policy, SOP) are actualized into concrete actions. The implementation of SOPs is the core of the medical information release process. Success at this stage is measured by the extent to which field personnel's activities align with the existing written guidelines. According to quality management theory, a consistent process yields quality output; in this context, that quality comes in the form of medical documents that are legally released and protected under a legal umbrella.

Based on the research findings at BLUD RSUD Buton Regency, the implementation of SOPs in releasing medical information is considered to be running in accordance with the hospital's bureaucratic workflow. Respondents explained that each information request file is processed through identity completeness verification before being delivered to the applicant. Informants stated that staff members attempt to follow the established steps to avoid administrative errors.

However, during this Process stage, the researcher observed obstacles regarding the thoroughness of power of attorney verification. Although procedurally staff members ask for a power of attorney, the validation process for signature authenticity and duty stamp completeness is sometimes bypassed if the applicant is an immediate family member of the patient. This indicates that SOP implementation remains a mere formality in certain aspects, meaning the "legal guarantee" process does not yet operate strictly or rigidly in accordance with applicable legal standards.

The findings of this study align with research conducted by (Rahayu, 2022), which discovered that SOP implementation for information release is often hindered by the staff's "culture of reluctance" (*budaya sungkan*) toward patients' families, leading to various administrative requirements being compromised. This study also confirms the findings of (Saputra, 2022), which state that inconsistencies during the process stage are the primary cause of low completeness rates in medical administrative files.

The similarity between this study and previous research is that the SOP implementation variable is viewed as the point most vulnerable to system failure. The difference is that at BLUD RSUD Buton Regency, process obstacles do not stem from the complexity of the SOP workflow itself, but rather from the staff's strictness in executing minor administrative details that carry significant legal impact.

The researcher argues that the Process stage at BLUD RSUD Buton Regency requires a dual-control system (double check). SOP implementation must not rely solely on staff memory, but must be supported by a control sheet (checklist) that is mandatory to fill out during the data release process. Without strict synchronization between staff actions and the points in the SOP, the goal of ensuring legal validity will be difficult to fully achieve, as minor errors in the verification process can lead to fatal consequences for patient privacy protection.

Analysis of the Process stage through the SOP Implementation variable at BLUD RSUD Buton Regency shows that, in general, the bureaucratic flow for releasing medical information is functioning; however, field execution is still marked by leniency in terms of document verification thoroughness, such as validating signature authenticity and duty stamp completeness on power of attorney forms for applicants from the patient's immediate family. This phenomenon aligns with systems theory that process consistency determines output quality, and confirms research by (Rahayu, 2022) and (Saputra, 2022), which states that a "culture of reluctance" (*budaya sungkan*) toward patients' families and inconsistent execution of procedures are the primary vulnerabilities triggering low administrative compliance. Considering that the obstacle at BLUD RSUD Buton Regency lies not in workflow complexity but rather on staff firmness regarding minor details, the researcher concludes the necessity of implementing a dual-control system in the form of a mandatory control sheet (checklist), because without rigid synchronization between staff actions and SOP points, absolute legal protection over patient data privacy will be difficult to fully achieve.

b. Identity Verification

In medical records management, the Identity Verification Process is a crucial step to ensure that confidential medical information is disclosed only to authorized parties (authorized person). Theoretically, identity verification involves matching physical identification data (such as an ID card or driver's license) with the identity recorded in the medical records system. This aims to prevent administrative malpractice and data leaks to unauthorized parties. Identity verification is not merely a formality, but rather a form of implementing patient privacy rights protected by law.

Based on the research findings at BLUD RSUD Buton Regency, the identity verification process has been carried out by personnel as part of the standard operating procedures for releasing information. Respondents stated that every applicant is required to present original identity cards to be cross-checked with patient data. Informants emphasized that without clear proof of identity, staff have the right to decline the request to avoid legal risks.

However, the researcher identified challenges in the verification process when applicants are family members of the patient who do not present an original power of attorney but bring the patient's identity card (patient's ID/KTP). In several observations, staff occasionally showed tolerance if applicants demonstrated emotional closeness or were familiar with the staff, making identity verification less rigid. This indicates that although the verification procedure is understood, objectivity in its execution remains influenced by situational factors in the field.

The findings of this study align with research by (Tania et al., 2024) which notes that the main weakness in releasing medical information often lies in the staff's oversight in verifying the legal relationship between the applicant and the patient. Similarly, research by (Yulfendri, 2024) emphasizes that identity verification conducted merely visually without proper documentation of identity photocopies in the release logbook can complicate matters for the hospital in the event of a future legal audit (double check). SOP implementation must not rely solely on staff memory, but must be supported by a control sheet (checklist) that is mandatory to fill out during the data release process. Without strict synchronization between staff actions and the points in the SOP, the goal of ensuring legal validity will be difficult to fully achieve, as minor errors in the verification process can lead to fatal consequences for patient privacy protection.

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Based on the research findings at BLUD RSUD Buton Regency, the identity verification process has been carried out by personnel as part of the standard operating procedures for releasing information. Respondents stated that every applicant is required to present transferring authority from the patient (principal) to another person (attorney-in-fact/proxy) to access private data. The validation process includes verifying the authenticity of signatures, matching the identities of both parties, and checking for sufficient duty stamps as evidence of legal force in court. Without a strict validation process, hospitals are vulnerable to allegations of medical confidentiality breaches regulated under Article 322 of the Indonesian Criminal Code (KUHP) and national medical records regulations.

Based on research findings at BLUD RSUD Buton Regency, respondents acknowledged that using a power of attorney is a mandatory requirement for parties other than the patient seeking to retrieve medical summaries. Staff in the medical records unit have been instructed to request the original power of attorney and verify the applicant's identity. Respondents stated that this step is taken to protect staff from being blamed in the future.

However, the researcher's observations show that the power of attorney validation process is often performed only cursorily. There were files in which the signature on the power of attorney was not thoroughly cross-checked against the signature on the identity document (KTP). Additionally, staff understanding regarding the urgency of duty stamps as a validity requirement for legal documents still varies. This indicates that the process of power of attorney validation has not yet become an absolute legal filter, but is instead still regarded merely as an administrative formality.

The findings of this study reinforce those of (Muhamad Normijani, 2024) which state that power of attorney verification is often the weakest point in medical records bureaucracy because staff feel reluctant (*sungkan*) or rushed due to pressure from applicants. Similarly, research by (ALI, 2023) emphasizes that failure to validate power of attorney in detail carries a high risk of triggering legal disputes between the hospital and the patient in cases of family conflicts or problematic insurance claims.

The similarity between this study and previous research is that the power of attorney validation variable is positioned as the primary physical evidence in the legal aspect. The difference is that at BLUD RSUD Buton Regency, the main obstacle is the absence of detailed technical guidance (a checklist instrument) for staff to verify power of attorney validity points uniformly.

The researcher argues that the power of attorney validation process must not be regarded as a bureaucratic obstacle, but rather as the institution's "legal shield." At BLUD RSUD Buton Regency the researcher identifies the need for standardizing the power of attorney format provided by the hospital so that validation points become more measurable. The researcher considers that if this validation process is executed rigidly and meticulously, the potential for legal anomalies can be reduced to zero. The validity of the power of attorney is a guarantee that BLUD RSUD Buton Regency respects patient autonomy while complying with applicable legal norms.

Analysis of the Process stage on the Power of Attorney Validation variable at BLUD RSUD Buton Regency shows that the use of a power of attorney has been implemented as a mandatory requirement for releasing medical information to third parties; however, field practice remains superficial because staff have not thoroughly cross-checked signature authentications against identity documents and hold varying understandings regarding the urgency of duty stamps. This condition aligns with health law theory positioning the power of attorney as the core legality behind transferring authority over private data, while reinforcing the findings of (Muhamad Normijani, 2024) and (ALI, 2023) that power attorney validation often becomes the weakest point due to pressure from applicants, carrying a high risk of triggering legal disputes in the event of future conflicts. Considering the obstacles at BLUD RSUD Buton lies in the absence of uniform technical guidelines, the researcher concludes that this validation must be treated as the institution's "legal shield," which must be supported by a detailed verification checklist instrument and the standardization of an official power of attorney format provided by the hospital to reduce the potential for legal anomalies to zero.

3. Evaluation of the Completeness of Administrative Requirements in the Release of Medical Information Based on Output

Output reflects the final result of the executed medical records bureaucratic system.

a. Administrative Completeness

In systems theory, Output is the final product processed from various inputs through specific procedures. In the context of releasing medical information, quality output is defined as 100% fulfillment of Administrative Requirement Completeness. This completeness encompasses the availability of the request form, a valid applicant identity, and a legal power of attorney. Theoretically, a complete output serves as an indicator of management's success in mitigating legal risks (legality) and upholding the ethical standards of the medical records profession. If the output is incomplete, the information release process is considered legally defective.

Based on interview results with informants at BLUD RSUD Buton Regency, output achievements in the form of administrative completeness are acknowledged to still experience fluctuations. Respondents stated that although staff attempt to fulfill all requirements, time constraints and patient emergency conditions sometimes result in certain administrative points not being filled out perfectly. Informants admitted that the target for administrative file completeness does not always reach the maximum figure every month.

The researcher's observation of files at BLUD RSUD Buton Regency confirms this. It was found that in the output variable, there are still medical summaries released without attached photocopies of the applicant's ID card or without the verifying officer's signature on the control sheet. This indicates that the system at BLUD RSUD Buton Regency is currently only capable of producing "processed" output, but not yet fully "administratively complete" output according to the expected legal standards.

This finding aligns with research by (Ayu Riski Nur Fajriah, 2021) which reveals that the low quality of output in medical information release is often caused by workload high HR workload, resulting in administrative details being overlooked. Furthermore, research by (Enggal Sari Maduratna, 2025) emphasizes that low administrative completeness is directly proportional to a high potential for legal anomalies for healthcare institutions.

The similarity between this study and previous research lies in positioning file completeness as the primary benchmark for the medical records unit's performance. The difference is that at BLUD RSUD Buton Regency, output incompleteness occurs more specifically in the aspect of verifying power of attorney and third-party identities, whereas much of the previous research highlighted the incompleteness of internal file borrowing forms.

The researcher argues that output quality at BLUD RSUD Buton Regency heavily depends on staff firmness during the process stage. Incomplete output (such as a power of attorney without a duty stamp or clear identification) acts as a "ticking time bomb" that can legally harm the hospital should disputes arise in the future. The researcher considers it necessary to implement a reward and punishment system regarding the completeness of information release files. By ensuring that the produced output is consistently 100% complete, BLUD RSUD Buton Regency will not merely carry out administrative procedures, but also provide absolute legal protection for patients, staff, and the institution itself.

Analysis of the Output stage on the Administrative Requirement Completeness variable at BLUD RSUD Buton Regency shows that the achievement of final results in medical information release still fluctuates and has not fully met the 100% target, as evidenced by findings of files released without attached photocopies of the applicant's ID card or the verifier's signature on the control sheet due to time pressure in emergency situations. This condition aligns with systems theory that output quality serves as an indicator of successful risk mitigation, while also aligning with research by (Ayu Riski Nur Fajriah, 2021) and (Enggal Sari Maduratna, 2025) that low administrative file completeness is directly proportional to a high potential for legal anomalies for healthcare institutions. Considering that incompleteness at BLUD RSUD Buton Regency specifically centers on the aspect of verifying power of attorney and third-party identities, the researcher concludes that output quality heavily relies on staff firmness during the process stage, necessitating management to implement a reward and punishment system to ensure complete file fulfillment as absolute legal protection for patients, staff, and the institution against future dispute threats.

Theoretically, legal validity is achieved when a healthcare institution can prove that patient data was released through legitimate procedures, with the consent of the data owner (the patient), and received by an authorized party. This rests on the principles of legal certainty and privacy protection. Without an output of strong legal validity, the hospital remains in a vulnerable position regarding both criminal charges (breach of medical confidentiality) and civil liability (unlawful acts) should data misuse by third parties occur.

Based on interview results at BLUD RSUD Buton Regency, respondents emphasized that the entire series of administrative requirements is conducted solely to uphold the hospital's legal validity. Respondents stated that staff are acutely aware of the legal risks lurking if medical information falls into the wrong hands. Therefore, the handover of medical summary files is always managed to ensure a strong foundation of physical evidence.

However, observation results indicate potential anomalies in that legal validity. The researcher identified several information release cases where powers of attorney were not equipped with duty stamps or the applicant's identity was not photocopied as supporting archives. From a legal perspective, this weakens the hospital's position because, in the event of a dispute, the hospital will find it difficult to prove the validity of the information recipient. Administratively,

the output has been produced; however, legally, the document still possesses legal security loopholes.

This finding aligns with research by (M Rafif Ramadhan, 2024) which states that the legal validity of releasing medical information is often regarded merely as paper formality, even though its function is as court evidence. Research by (Loso Judijanto, 2025) also emphasizes that the legal force of an information release document heavily depends on the quality of initial verification; failure in file verification will produce legally defective output.

The similarity between this study and previous research lies in positioning the legal validity variable as a dependent variable heavily influenced by administrative completeness. The difference is that at BLUD RSUD Buton Regency, the legal aspect is already supported by strong management policies, yet still requires better integration between the legal division and the medical records unit to align perceptions regarding absolute legal evidence standards.

The researcher argues that legal validity as an output at BLUD RSUD Buton Regency must be viewed as a top priority for the safety of both the institution and its staff. The presence of complete administrative requirements is not a bureaucratic burden, but rather "legal insurance" for the hospital. The researcher suggests that every medical information release file that has been processed must undergo a brief legality audit by a supervisor before being handed over to the applicant. By ensuring every output meets legal principles (such as signature validity and duty stamps), BLUD RSUD Buton Regency can guarantee the protection of patient privacy rights while securing the institution from future litigation risks.

Analysis of the Legal Validity variable as an output component at BLUD RSUD Buton Regency shows that although staff are aware of this aspect's importance as an institutional shield against legal liability risks, in practice administrative loopholes remain—such as releasing information with an unstamped power of attorney and lacking photocopied archives of the applicant's identity. This condition aligns with theories of legal certainty and privacy protection, as well as research by (M Rafif Ramadhan, 2024) and (Loso Judijanto, 2025) which emphasizes that file verification failures at the initial stage will produce outputs that are legally defective in court due to document release being treated merely as a formality. Considering that the difference at BLUD RSUD Buton Regency lies in the presence of strong management policies that are not yet optimally integrated with the legal division, the researcher concludes that administrative completeness must be treated as the institution's "legal insurance." This must be monitored through a brief legality audit by a supervisor before files are handed over, to guarantee the protection of patient privacy rights while securing the hospital from future criminal or civil litigation risks.

b. Data Confidentiality

Data confidentiality (data confidentiality) is a non-physical yet most crucial output in health information management. Theoretically, data confidentiality is the obligation of healthcare workers and institutions not to leak information regarding a patient's identity, diagnosis, medical history, or medical procedures to unauthorized parties. This is strictly protected by the Oath of Office for Medical Records and various legal regulations such as the Health Law. Data confidentiality is not merely about protecting files, but about maintaining patient trust (trust) in the hospital. This output is considered successful if the system can guarantee that information is accessed only by legitimate parties legally.

Based on research findings at BLUD RSUD Buton Regency, respondents emphasized that data confidentiality is a top priority in every information release process. Staff understand that medical information must not be disclosed indiscriminately, even to the patient's family, if administrative requirements are not met. Respondents stated that education regarding confidentiality is frequently emphasized by the head of the unit to avoid complaints or lawsuits from patients.

However, the researcher identified challenges in the aspect of "physical privacy" during data handover. Observations show that the process of explaining information or handing over medical summaries is sometimes conducted in areas where other visitors can hear or see. Although the data is handed over correctly to the authorized person, an insufficiently private handover environment risks indirectly compromising confidentiality.

This finding aligns with research by (Nurhaliza, 2022) which emphasizes that data confidentiality is often threatened not by intentional staff misconduct, but by room facilities that

do not adequately support patient privacy. Similarly, research by (Wicaksono, 2023) also states that staff's high understanding of confidentiality ethics must be supported by a closed archival and data handover system to yield maximum information security output.

The similarity between this study and previous research is that the data confidentiality variable is viewed as an indicator of service integrity in medical records. The difference is that at BLUD RSUD Buton Regency, the focus of confidentiality remains on manual aspects (physical files), whereas several previous studies have begun addressing confidentiality within electronic medical record (EMR) data encryption systems.

The researcher argues that data confidentiality as an output at BLUD RSUD Buton Regency is substantially preserved through staff compliance with administrative procedures. However, to guarantee absolute legal validity, this confidentiality aspect must be supported by more private infrastructure. The researcher considers data confidentiality to be a form of respect for human rights and patient dignity. Should the hospital fail to maintain this confidentiality output, the administrative completeness that has been gathered will lose its meaning, as the institution still fails in its primary mission to protect patient privacy.

Analysis of the Data Confidentiality variable as an output component at BLUD RSUD Buton Regency shows that the protection of patients' medical information has substantially progressed well, owing to the strong professional ethics understanding among staff. However, it still faces challenges in the aspect of "physical privacy" due to a medical summary handover environment that is insufficiently closed, thus carrying the risk of exposure to other visitors. This condition aligns with healthcare ethics theory regarding the obligation to maintain patient trust (trust), as well as research by (Nurhaliza, 2022) and (Wicaksono, 2023) which emphasizes that confidentiality outputs are often threatened by room facilities that do not support privacy; hence, the integrity of staff who adhere to SOPs must still be balanced with a closed data handover system.

Considering that the confidentiality focus at BLUD RSUD Buton Regency is currently still directed at securing manual (physical) files—in contrast to the electronic data encryption systems highlighted in previous research—the researcher concludes that hospital management needs to optimize infrastructure or rearrange service areas to be more private. This is because failure to maintain environmental confidentiality can nullify the significance of the collected administrative completeness and weaken the absolute legal protection of patient human rights.

CONCLUSION

Based on the results of the evaluation using a systems approach, it can be concluded that the implementation of medical information release at BLUD RSUD Buton Regency has not run optimally and does not yet fully guarantee legal legality. Although input aspects—which include human resource availability, SOPs, and management policies—have been formally fulfilled, the process component still exhibits staff inconsistencies in testing the validity of powers of attorney and matching applicant signatures, driven by time efficiency needs or pressure from patient families. This has a direct impact on the output component, where the completion rate of administrative requirements has not reached the 100% target due to files still being released without valid requirements, alongside ongoing physical privacy challenges during document handover. Therefore, strengthening commitment and verification discipline at the operational level, enhancing health law training for staff, and implementing regular supervision are required so that the management of medical information release in the hospital truly provides legal certainty and absolute protection of patient data confidentiality.

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