HAS 104A ARMY MEDICAL RECORDS MANAGEMENT PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. Code 12 maps to which category?

A. Retiree

B. Active duty dependent

C. Guard/reserve

D. Retiree dependent

2. What is the primary purpose of encryption in electronic medical records?

A. Encryption makes data publicly readable.

B. Encryption eliminates the need for passwords.

C. Encryption reduces data storage cost.

D. Encryption protects data confidentiality by rendering information unreadable without the proper key.

3. How does the Army handle patient transfers to ensure continuity of care?

A. Transfer only after patient discharge.

B. Ensure timely exchange of complete records with receiving facility, maintain MPI linkage, and update location in the chart.

C. Delete prior records to save space.

D. Reconcile with third-party vendors only.

4. Secretarial Designee are individuals approved for care by which authority?

A. Individuals approved by the secretary of defense for care.

B. Individuals approved by the local hospital for care.

C. Individuals approved by the surgeon general.

D. Individuals approved by the commander's spouse.

5. Which of the following describes the data typically logged by an EMR audit trail?

A. Patient demographics and insurance information.

B. The sequence of medical decisions.

C. Access times, user IDs, and actions performed on the record.

D. The physical location of the chart at retrieval.

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6. What does the Privacy Act of 1974 state regarding medical records?

A. Medical records are exempt from any protection.

B. Medical records are stored only electronically.

C. Medical records are obtained within a system of records protected by the Privacy Act.

D. Medical records can be shared with any requester without notice.

7. What is the role of quality improvement in HIM?

A. Develops new software for record management without evaluating outcomes.

B. Focuses solely on legal compliance.

C. Identifies gaps in record-keeping; implements corrective actions; monitors outcomes to improve accuracy, completeness, and privacy.

D. Preserves all records indefinitely regardless of retention.

8. Which of the following is an eligible family member?

A. Un-remarried former spouse.

B. Cousin.

C. Parent of member.

D. Aunt.

9. PHI may be released to the State Social Security Administration in the context of which process?

A. Filing for disability benefits

B. Filing for a driver's license

C. Enrolling in school

D. Applying for a loan

10. What is the purpose of a patient authorization for release of information (ROI)?

A. To allow unrestricted disclosure of PHI to any recipient.

B. To authorize disclosure only after patient consent for every use.

C. To require disclosure be limited to the patient only.

D. To legally permit disclosure of PHI to specific recipients for defined purposes.

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Answers

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1. C
2. D
3. B
4. A
5. C
6. C
7. C
8. A
9. A
10. D

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Explanations

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1. Code 12 maps to which category?

A. Retiree

B. Active duty dependent

C. Guard/reserve

D. Retiree dependent

Codes in the patient category field identify the beneficiary status to guide eligibility and routing in the medical system. They separate active duty members, their dependents, retirees, and Guard/Reserve members. Code 12 maps to Guard/Reserve because this category is used for service members in the National Guard or Reserve and their dependents who are not on active duty and not retirees. This distinction matters since eligibility rules and access to benefits differ between active duty, retirees, dependents, and reserve components. The other statuses describe different groups: retirees have completed service, active duty dependents are tied to someone on active duty, and retiree dependents belong to retirees. Thus, the code set places Guard/Reserve in its own category, which is why code 12 corresponds to that group.

2. What is the primary purpose of encryption in electronic medical records?

A. Encryption makes data publicly readable.

B. Encryption eliminates the need for passwords.

C. Encryption reduces data storage cost.

D. Encryption protects data confidentiality by rendering information unreadable without the proper key.

Encryption in electronic medical records focuses on safeguarding patient privacy by turning data into unreadable ciphertext unless the correct decryption key is used. This protects information both when it's stored and when it's transmitted, so unauthorized individuals cannot interpret the data even if they access it. It does not make data public, it does not remove the need for passwords, and it doesn't aim to reduce storage costs; its primary purpose is confidentiality through controlled access.

3. How does the Army handle patient transfers to ensure continuity of care?

A. Transfer only after patient discharge.

B. Ensure timely exchange of complete records with receiving facility, maintain MPI linkage, and update location in the chart.

C. Delete prior records to save space.

D. Reconcile with third-party vendors only.

Continuity of care during transfers relies on getting complete, accurate patient information to the next care setting without delay, while keeping the patient's identity consistent across systems and showing where the patient is in the chart. Timely exchange of complete records with the receiving facility ensures clinicians have all diagnoses, meds, allergies, labs, and treatment plans to continue care smoothly and avoid unnecessary repetition or errors. Maintaining the Master Patient Index linkage guarantees the patient is correctly identified across facilities and information systems, so the right records match the right person and no history is misattributed. Updating the location in the chart signals current status and where to find the patient, reducing confusion for staff and enabling proper follow-up and coordination. Delaying transfer until discharge creates gaps in care, deleting prior records removes essential history, and reconciling only with third-party vendors fails to provide the direct, comprehensive record exchange and patient identification needed for safe, continuous care.

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4. Secretarial Designee are individuals approved for care by which authority?

A. Individuals approved by the secretary of defense for care.

B. Individuals approved by the local hospital for care.

C. Individuals approved by the surgeon general.

D. Individuals approved by the commander's spouse.

Secretarial Designees are empowered to approve medical care by authority of the Secretary of Defense. This designation creates a centralized, official channel for approving care in specific DoD contexts, ensuring consistent decisions across military treatment facilities. Local hospitals handle day-to-day care decisions, the surgeon general oversees medical policy and readiness rather than issuing individual care approvals, and a commander's spouse has no official authority to approve care. The key point is that the authorization comes from the Secretary of Defense, delegating limited decision-making to designees for particular circumstances.

5. Which of the following describes the data typically logged by an EMR audit trail?

A. Patient demographics and insurance information.

B. The sequence of medical decisions.

C. Access times, user IDs, and actions performed on the record.

D. The physical location of the chart at retrieval.

EMR audit trails are about security and accountability, recording who accessed a patient's record, when they did so, and what actions they performed. The data typically logged include the exact access time, the user ID, and the specific action taken on the record (such as viewed, edited, deleted, or exported). This focus helps detect unauthorized access, track user activity, and support investigations or compliance requirements. Other items describe the content or management of the record rather than the access events. Patient demographics and insurance information are part of what's stored in the chart, not the log of who touched it. The sequence of medical decisions concerns clinical content rather than access activity, and the physical location of the chart at retrieval relates to physical record handling rather than an electronic audit history.

6. What does the Privacy Act of 1974 state regarding medical records?

A. Medical records are exempt from any protection.

B. Medical records are stored only electronically.

C. Medical records are obtained within a system of records protected by the Privacy Act.

D. Medical records can be shared with any requester without notice.

The important idea here is that the Privacy Act protects records about individuals that a federal agency maintains in a system of records. Medical records held by the Army fall into this category, so they are treated as part of a system of records protected by the Act. This means there are specific protections and procedures: the agency must publish a system of records notice, inform individuals about what is collected, grant access and the ability to amend their records, and limit disclosures to only authorized routine uses. The other statements don't fit because the Act does not provide blanket exemptions for medical records, does not restrict storage to electronic only, and does not allow sharing with any requester without proper notice and regulatory disclosure guidelines.

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7. What is the role of quality improvement in HIM?

A. Develops new software for record management without evaluating outcomes.

B. Focuses solely on legal compliance.

C. Identifies gaps in record-keeping; implements corrective actions; monitors outcomes to improve accuracy, completeness, and privacy.

D. Preserves all records indefinitely regardless of retention.

Quality improvement in health information management is a systematic, data-driven approach to enhance the quality of medical records by identifying gaps, taking corrective actions, and monitoring outcomes to raise accuracy, completeness, and privacy. This reflects how HIM works to continuously improve how records are created, stored, and protected, so they support safe patient care and compliance. In practice, you review records and processes to spot missing or incorrect information, implement changes such as updated workflows, better forms, or staff training, and then track metrics to confirm that the changes lead to real improvements. The goal isn't just meeting legal requirements or adding features; it's about continuously improving the fidelity and privacy of the records through ongoing measurement and adjustment. Other options miss this dynamic, data-driven loop. Developing software without evaluating outcomes focuses on tools rather than results; focusing only on legal compliance overlooks data quality and privacy improvements; preserving records indefinitely ignores how retention, accuracy, and privacy practices must be balanced with actual record usefulness and protection.

8. Which of the following is an eligible family member?

A. Un-remarried former spouse.

B. Cousin.

C. Parent of member.

D. Aunt.

In DoD medical records privacy rules, an eligible family member is someone who can receive a member's protected health information without a separate authorization in certain care-related contexts. A key part of this definition is that a current spouse and a former spouse who has not remarried are considered eligible family members. The reason the un-remarried former spouse fits is that the legal marital relationship persists for eligibility purposes even after divorce, so they may be involved in the member's care and records disclosures when allowed by policy. Cousins, aunts, or even a parent typically aren't in the eligible family member category unless there's a specific legal role (for example, a guardian or a defined personal representative) or particular care arrangements. So among the given options, the un-remarried former spouse best matches the standard definition for an eligible family member.

9. PHI may be released to the State Social Security Administration in the context of which process?

A. Filing for disability benefits

B. Filing for a driver's license

C. Enrolling in school

D. Applying for a loan

PHI can be released to the State Social Security Administration when someone is applying for disability benefits because the SSA needs medical information to determine if the person meets the criteria for disability and the level of impairment. This is a permitted disclosure under HIPAA when a government benefits program requires medical evidence to decide eligibility. The other activities listed do not involve SSA disability determinations and typically do not require sharing medical records with the SSA, unless there's a separate authorization.

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10. What is the purpose of a patient authorization for release of information (ROI)?

A. To allow unrestricted disclosure of PHI to any recipient.

B. To authorize disclosure only after patient consent for every use.

C. To require disclosure be limited to the patient only.

D. To legally permit disclosure of PHI to specific recipients for defined purposes.

The main idea being tested is how patient control over the disclosure of PHI is enforced through a formal authorization. An ROI is a written permission that lets a patient designate specific people or organizations that may receive their protected health information and specifies the exact purposes for which it can be disclosed. This ensures privacy by making disclosures intentional and limited, rather than open-ended. This is not an unrestricted release or a blanket approval for every use or every recipient. It isn't limited to disclosures to the patient themselves either; it empowers the patient to approve sharing with others, such as a family member, another healthcare provider, an insurer, or a researcher, but only for the defined purpose. The authorization is used when sharing information falls outside routine disclosures (like treatment, payment, or health care operations) or when a recipient isn't covered under those standard categories, requiring explicit patient consent. ROIs typically spell out what PHI is involved, who may receive it, for what purpose, how long it's valid, and include the patient's signature; and it can be revoked in writing.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://has104a.examzify.com

We wish you the very best on your exam journey. You've got this!

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