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Retention of Medical/Dental Record Protocol

Objective: (Facility Name) must maintain medical/dental records on all patients in accordance with accepted professional standards and practices. The medical/dental records are completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.

Responsibility: The Medical Records Supervisor/ Privacy Officer and/or their appointed designee will maintain documentation of all HIPAA related compliance materials including but not limited to policies, procedures, written communication, complaints/allegations of violations, etc. in either a written or electronic format.

All (Facility Name) Staff are directly responsible for the safekeeping of all patient medical/dental records. Medical Records Staff are responsible for the maintenance of this protocol.

Protocol: (Facility Name) recognizes the confidentiality of medical/dental record information and provides safeguards against loss, destruction, or unauthorized use. Written procedures govern the use and removal of records and the conditions for release of information. The patient's written consent is required for release of information not authorized by law.

The medical/dental record contains sufficient information to identify the patient clearly to justify the diagnosis (es) and treatment, and to document the results accurately. All medical/dental records contain the following general categories of data:

- Documented evidence of the assessment of the needs of the patient, of an appropriate plan of care, and of the care and services furnished
- Identification data and consent forms
- Medical history
- Report of physical examinations, if any
- Observations and progress notes
- Reports of treatments and practice findings
- Discharge summary including final diagnosis (es) and prognosis

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Completion of records and centralization of reports

Current medical/dental records and those of discharged patients are completed promptly. All practice information pertaining to a patient is centralized in the patient's practice record. Each physician signs electronically the entries that (s)he makes in the medical/dental record.

Retention and preservation

Medical/dental records are retained for at least:

- The period determined by the respective state statute, or the statute of limitations in state; or
- In the absence of a state statute
- Seven (7) years after the date of discharge; or
- In the case of a minor, three (3) years after the patient becomes of age (18 years old) under state law or seven (7) years after the date of discharge, whichever is longer.

Location and facilities

(Facility Name) Medical Records Department maintains adequate facilities and equipment, conveniently located, to provide efficient processing of practice records (reviewing, indexing, filing, and prompt retrieval).

References:

Adopted as §405.1723, 35 FR 10511 (June 27, 1970); amended and redesigned as §405.1722 at 41 FR 20863 (May 21, 1976, effective June 21, 1976); coded from 20 CFR 405.1722 at 42 FR 52826 (Sept. 30, 1977); redesigned from §405.1722 and amended at 60 FR 2325 (Jan. 9, 1995, effective Feb. 8, 1995).

Appendix C. California Health and Safety Code §1232221(January 1, 2003)

California Welfare and Institutions Code§ 14124.1

Health Insurance Portability and Accountability Act (HIPAA) Privacy & Security Rule, 45 CFR 160-164.524

Section 13101 - 13424 of Title XIII (Health Information Technology for Economic and Clinical Health Act) of the American Recovery and Reinvestment Act of 2009