ADMINISTRATIVE POLICY AND PROCEDURE MANUAL

Subject: Medical Records **No. VII. 14**

Policy

The medical record documents the health care experience of the patient. As such, it is important that the medical records be completed in a proper and timely fashion. All forms/ reports in a medical record must contain the patient's first and last name and the medical record number. It is also essential that the record be safely maintained and that the confidentiality of the information is controlled. The medical record is the property of the hospital, which retains responsibility for its use. The attending physician will be ultimately responsible for completion of the chart.

Procedure

I. Completion of Medical Records

Completion of records must be done in the Health Information Management Department ("HIM"), (formerly Medical Records) or at Grand Rounds by resident and staff physicians within 30 days of discharge.

A. Delinquent Records

1. Any medical record not completed within 30 days after discharge shall be considered delinquent. Physicians with delinquent records shall be subject to suspension of admitting privileges and possible relinquishment of clinical privileges as per Rules and Regulations of the Medical Staff.

B. Operative and Procedure Reports

1. Operative reports should be dictated immediately upon completion of the operation or procedure.
2. It is the attending physician's responsibility to see that the resident or PA completes all assigned dictations.

C. Discharge Diagnoses

1. Discharge diagnoses and procedures performed are to be recorded on the discharge summary and operative report.

D. Discharge Summaries

1. Discharge summaries are to be dictated on the Nursing Unit at the time of discharge. If not dictated on the Nursing Unit, the summary may be dictated in the HIM Department. It is the attending staff physician's responsibility to see that the resident or PA completes assigned discharge summary dictations.

II. Removal of Medical Records

A. Records are not to leave the Hospital except to comply with a statute, a court order, or a subpoena; or to protect the records in the event of a disaster. Subpoenas are answered by HIM Department personnel or designee.

B. Records are not to be taken to residents' quarters or physicians' offices.

C. All records of inpatients are retrieved from patient units and returned to the HIM Department before 8:00 AM after the day of discharge. Any physician wishing to dictate records may do so on the Nursing Unit on the day of discharge, in the HIM Department, or from any house phone.

D. Medical records will not be removed from the HIM department or nursing stations except as follows:

1. To patient treatment areas, as needed for direct patient care, and to be returned the same day.
2. To conferences at that hospital, and must be returned immediately following the conference.
3. To the morgue when a post mortem is to be performed and to be returned within forty-eight hours.
4. To nursing stations for all inpatients who have had previous hospital admissions.
5. To doctors' private offices with an inpatient, during which time the patient's clinical record will be handled by an escort only and to be returned to the nursing unit with the patient.
6. To hospital administrative offices as necessary to conduct hospital business.
7. To Quality Improvement at each hospital.

III. Authorization to See or Obtain Medical Records

A. The HIM department is responsible for the release of medical record information. Release of records will be in conformance with the provision of Act 1990-148. All requests for copies of records should be referred to the HIM department immediately.

B. Confirmation of hospitalization, admission and discharge dates may be given without authorization, except in cases involving psychiatric admissions. In these cases, **NO** information should be released without authorization. Resident and staff physicians may not give information from medical records. All inquiries are to be referred to the HIM Department.

C. An individual has the right to inspect and copy Protected Health Information (PHI) which is used in making health care decisions about the individual for as long as the covered entity maintains that information.

Individuals have no automatic right to access to:

- psychotherapy notes,

- information provided to authorities related to a criminal, civil or administrative action,
- PHI that is maintained by a covered entity that is subject to or exempted from CLIA.

Main Line Health will respond to written requests from patients related to protected health information within 30 days of such requests provided the information is stored on site. If the information is stored off-site, MLH will respond within 60 days.

D. Main Line Health may deny a patient access to PHI under certain circumstances, such as when access would endanger the patient or otherwise as prohibited by law. In such cases, a written denial will be sent to the patient and the denial letter will outline the process for appealing the decision of the facility, including how to file a complaint with Secretary of Health and Human Services. (See Attachment A)

Denials of access to PHI will automatically be reviewed by the Privacy Officer and legal counsel prior to notifying the patient of any adverse decision.

E. Main Line Health will charge the prevailing rate for copying and mailing PHI to patients.

IV. An Authorization to Disclose Health Information must be completed prior to releasing confidential patient information. (See Attachment B)

A. Faxing Information from HIM

1. Main Line Hospitals authorize faxing for transmitting medical information when a legitimate medical emergency arises, and the information is required to treat the patient. Any faxing or request for faxed documents must be done at the request of a physician currently treating the patient. Faxing of medical records for purposes other than patient care is strictly prohibited.
2. HIM may require the requesting party to fax their request in order to verify authenticity. After this, the requested material will be faxed. The fax from the requesting party will be filed in the Correspondence Section of the medical record.

B. Nonprofit Hospital Insurance plans

Nonprofit hospital insurance plans, such as Blue Cross, Blue Shield, and Inter-County, and governmental payors, such as Medicare and Medicaid do not need authorization for requested medical data on patients covered by such plans. A charge is not made for this service.

C. Private Hospital Insurance Plans

Upon receipt of a written authorization or proof of assignment of the bill to the insurance company, signed by the patient, copies of medical records will be released to such insurance companies. A charge is made for this service.

D. Law Enforcement Agencies

Information may not be released to law enforcement officer, local police, state or federal agents unless they have authorization from the patient, a subpoena, a court order, or a search warrant. The identify of the law enforcement official should be confirmed prior to the release of any information.

The one exception to the rule is with respect to blood alcohol records. The Pennsylvania Motor Vehicle Code contains a statutory exception allowing the results of blood alcohol testing to be released to law enforcement officers at their request (without the requirement of a warrant or other legal process) when such officer determines that probable cause exists to believe that the patient was operating a motor vehicle while under the influence of alcohol or a controlled substance, or that the individual was operating a motor vehicle which was involved in an accident in which the operator or passenger of any vehicle involved or a pedestrian required treatment at a medical facility, or was killed. State and Federal boating and maritime laws also permit release of blood alcohol records in similar instances.

In response to a coroner's subpoena, the hospital will provide the coroner's office with a complete copy of the patient's most recent admission to the hospital, unless the coroner's subpoena specifically request copies of other admissions. It is not permissible to release records to the corner in response to a coroner's subpoena where such a disclosure is (or re-disclosure) is prohibited by law (i.e. mental health records alcohol and substance abuse records, records containing HIV-related information).

E. Armed Forces and Government Agencies

Information may not be released to Veterans Administration, armed forces and other government agencies unless they have a signed authorization from the patient/legal representative or are specifically authorized by law to obtain such information. Upon receipt of proper authorization, the competed forms or other necessary information are released directly to the party requesting the information and not to the patient.

F. Allied Health Students

Allied Health students on an approved affiliation at Main Line Hospitals may review medical records with the written permission of their immediate supervisors. Each student must sign a confidentiality statement. These records must be reviewed in the HIM Department. Records may not be copied and no patient identifying information may be used.

G. Residents, Fellows, and Medical Students

Residents, Fellows, and Medical Students may access the medical records of their supervising physician's patients for teaching and learning purposes. Medical students must review the medical records in the HIM Department. No records may be copied and no patient identifying information may be used.

H. Referring Physicians

A referring physician may review his/her patient's medical record in the HIM Department at any time.

I. Other Health Care Providers

Medical records may be reviewed by physicians, nurses, and allied health personnel actively involved with the treatment of the patient. Anyone not actively involved with the patient's care needs consent of the patient to review the medical record.

In emergency situations information may be given to other health care providers without authorization, if the provider is currently treating the patient. In this situation, the MLH HIM Department receiving the request will ask that the requesting party fax us their release form or written request on letterhead stating why the patient is not capable of authorizing the release. The requesting party should be called back upon receipt of the fax to verify authenticity. Once this is done, the information should be faxed. A follow-up release, signed by the patient once he/she is capable of doing so, should be requested.

Information from a patient's medical record may be released at any time to other health care providers by a written authorization from the patient/legal representative. Copies of charts may be sent at no charge.

J. Patient

1. A patient has a legal right to review his medical record during his/her hospitalization unless specifically prohibited from doing so by the attending physician. Such prohibition must be documented in the patient's medical record. A patient also may allow family members to review his/her medical record.
2. After discharge, a patient may have access to information contained in his/her medical record, only after it has been completed by the physician(s). A scheduled appointment will be made by the HIM Department for the patient to review his/her records within the Department, under supervision.
3. The patient may obtain a copy of his/her completed medical record, unless the hospital is advised by the attending physician that, in the best interest of the health of the patient, the record should not be disclosed. Such a judgment must be in writing and signed by the attending physician. When a patient requests a copy of a psychiatric chart, prior approval of the attending physician will be obtained.
4. For patients who expire in the hospital, their records cannot be released until the most recent admission is completed by the physician. A release form must be completed, returned and signed by the Executor or Executrix of the estate. A copy of the document assigning Executor or Executrix status must also accompany the release.
5. Patients or other parties, who request test results over the phone, are to be referred to the physician who ordered the test or the patient's primary care physician. Under no circumstances will test results be given out by the HIM personnel.
6. Patients may request restrictions on the use and disclosure of their protected health information. Patients may request that PHI not be used for:
   (1) Treatment, payment or hospital operations; and,
   (2) May not be disclosed to a patient's family members, relatives, close personal friends or any other individuals identified by the patient.

MLH may or may not agree to the restriction but will accommodate all reasonable requests if disclosure of PHI could endanger the individual. MLH may refuse to accommodate a request if individual has not provided information as to how payment, for instance, will be handled or if the individual has not specified an alternative address or method of contact.

V. Use of Medical Records for Research

Medical records will be available to staff physicians, residents, and fellows for statistical and research purposes if the research has IRB approval. Records shall not be used as a basis for case presentation without the consent of the attending physician. Records requested for research or statistical purposes may be reviewed in the HIM Department only. No records may be copied and no patient identifying information may be used.

VI. Use of Medical Records for Committees

All medical records shall be available to Hospital Committees and conferences concerned with patient care evaluation. Approval of the attending physician or the patient for such confidential use is not necessary.

VII. Documentation Integrity

Information in the patient medical record, whether paper or electronic, must be timely, accurate and truthful. There will be zero tolerance for any type of record falsification. Falsification is defined as the fabrication, in whole or in part, through omission or commission, of any information provided. This includes re-drafting, reformatting, altering, or deleting document content. Documentation should be contemporaneous and recorded in the patient record at or near the time of service.

The following are examples of prohibited documentation practices:

- Documenting care or completing checklists in advance
- Withholding information
- Completing/signing Informed consent before being explained to patient
- Making late entries in the patient record without being labeled as such
- Back-dating/timing any medical record entry
- Cutting/pasting parts of other provider's electronic notes
- Falsifying narcotic records
- Sharing passwords and/or electronic signature PIN numbers
- Dictating any report without direct involvement in the care

Medical Record entries must be the following:

1. Fact based and objective
    - Original document must be contained in the medical record
    - Preliminary findings and observations should be noted as such
    - Results of studies, tests and evaluations and actions are properly noted
    - Free from negative comments about any individual, including the patient or family

member

2. Accurate
    - Every page or image in the medical record must identify the patient and contain one other unique MLH identifier (account number, medical record number, CID or EEID number). Labels/barcodes should not obscure any documentation
    - Discrete multi-page forms must have each page identified (ie 1 of 6)
    - no misfiles
3. Legible
4. Created in normal course of patient care
    - Entries should be made according to standard content guidelines
    - Entries made on only approved forms
    - Free of Abbreviations as defined in the "Do Not Use" policy.
5. Timely
    - Entries should be made at the time of or shortly following the encounter or event. Documentation in advance of care rendered is prohibited.
    - Late entries and addenda shall be noted as such with the reason for the late entry given
    - Identifiable and clearly noted date and time (month, day, year, military time)
6. Free from alteration:
    - Records must be free from inadvertent or intentional alterations.
    - Draw a line through blank or unused sections to prevent alterations on paper records
    - Written in ballpoint pen with permanent blue or black ink. Red pen may be used in accordance with Nursing policies.
    - Use of pencil is prohibited.
    - Error corrections done in a manner that does not obliterate original entry, error so marked, corrections note indicated and date and signature of individual making correction entered.
    - Use of whiteout is prohibited
    - If an error in documentation is made a line should be made through the incorrect information. It should be dated and signed and the reason stated and the correct documentation entered.
    - An entry must **NOT** be obliterated and "white-out" may not be used.
7. Addendums/Late Entries:

    Late entries or addendums are acceptable if recorded correctly. A late entry or addendum must be identified as such and have the current date and authentication signature
8. Authenticated
    - Signature on each entry
    - Initials or title indicating professional credentials as approved in Medical Staff R&R
    - Every entry must be authenticated by the author, dated and timed. Each entry shall also contain the beeper number of the author.
    - Counter signatures are used as required by law
9. Corrections to the entries in the Lifetime Clinical Record (LCR) are addressed in policy HIM 8.2

VIII. <u>Disposition of Records</u>

All medical records shall be retained for a minimum of seven years from date of last activity. Records may be retained on microfilm or stored offsite.

Medical records of minors shall be retained until the patient reaches majority and then for a period of seven years or seven years from date of last activity, whichever is longer.

Obstetrical records shall be retained for 25 years from date of most recent live birth or seven years from date of last activity, whichever is longer.

IX. Retention of Medical Records

Hospitals and ambulatory surgical facilities must maintain medical records, whether original, reproductions or microfilm for a minimum of seven years following the discharge of a patient. If the patient is a minor, records shall be kept on file until his majority and then for seven years or as long as the records of adult patients are maintained.28Pa.Code Section115.23; 28Pa.Code Section 563.6

Physicians shall retain medical records for at least seven years from the date of the last medical service for which a medical record entry is required. The medical record for a minor patient shall be retained until one year after the minor patient reaches majority, even if this means that the physician retains the record for a period of more than seven years.

If a hospital discontinues operation, the DOH will be notified in writing by HIM as to the location where medical records will be stored and who will be responsible for record retrieval services. Records will be retained for at least 5 years after any hospital closure. Prior to any destruction, public notice will be made to permit former patients, or their representative to request their records. Public notice will be in at lest two forms, legal notice and a display advertisement in a newspaper of general circulation. (PA Code 115.23)

X. Medical Record Security

Medical records are stored in the HIM Department. During shifts that are only partially staffed, third shift, weekends and holidays the department is locked. During these times entrance to the department is only for physicians for record completion and for others needing to request a record for patient care.

When not staffed by HIM, the Department is locked and only Unit Nursing Supervisors and the ER Nursing Supervisor have access for the purpose of retrieving medical records only for patient care. Records needed for studies or auditing purposes are to be retrieved by HIM staff during regular business hours.

Origination Date: 7/93

Previous Revision Date: 10/98, 12/99 5/03, 3/08,
Review Date: 2/01, 3/04, 3/05, 3/06
Revision Date: 11/08

Key Contact: System Director HIM, Compliance and Privacy

Main Line Health
Jefferson Health System

Denial of Access to Protected Health Information

Patient's Name: _____

Home Address: _____

_____

Home Phone: _____ **Date of Birth:** _____

Dates of Service: _____

Medical Record Number: _____

Your request to access or obtain a copy of your protected health information from the Main Line Health facility checked below

ڤ **Bryn Mawr Hospital** ڤ **Lankenau Hospital** ڤ **Paoli Hospital** ڤ **Bryn Mawr Rehab**

has been denied for the following reason:

ڤ not entitled to access, not the legal guardian

ڤ not permitted by attending physician

ڤ other: _____

As provided for in federal law and in the Main Line Health System's privacy policies, you ☐ do ☐ do not have the right to have this denial reviewed by a licensed health care practitioner who did not participate in the decision to deny your request.

If this denial is reviewable, please indicate your request by checking the appropriate box below and submitting this form within thirty (30) days to Main Line Health's Privacy Office at the following address:

Privacy Office
Main Line Health
Lankenau Hospital
100 Lancaster Avenue
Wynnewood, PA 19096

If you wish to register a complaint regarding this denial, please contact the Privacy Officer at the address above. Your written complaint must contain your name, the specific details of your complaint and how you wish to have the complaint resolved.

You may also file a written complaint with the Secretary of the Department of Health and Human Services. Your complaint must describe the acts or omissions that you believe to be in violation of applicable law. A complaint to the Secretary may be submitted either by mail or electronic transmission within 180 days of the date you first knew or should have known of the occurrence of the act or omission upon which you have based your complaint.

☐ I request a review of MLH's denial of my request to access or obtain a copy of my personal health information by a licensed health care professional selected by MLH who did not participate in the decision to deny my request.

I understand that if this is my first request during the past 12 months for an accounting of disclosures, then I will receive my accounting free of charge. I understand that if I have made more than one request during the past 12 months for an accounting of disclosures, the Main Line Health System will charge the prevailing rate set by state law for the copying of medical records. Main Line Health will provide an estimated cost if requested. If the fee is unacceptable, I may rescind this request.

_____ _____

Signature of Patient (or Guardian) Date

_____ _____

Printed Name of Guardian Relationship to Patient

After you have completed this form, please return it to the Health Information Management Department at the appropriate facility:

HIM Department
Lankenau Hospital
100 Lancaster Avenue
Wynnewood, PA 19096

FAX: 610-645-8491

HIM Department
Bryn Mawr Hospital
130 S. Bryn Mawr Avenue
Bryn Mawr, PA 19010

FAX: 610-526-4581

HIM Department
Paoli Memorial Hospital
255 W. Lancaster Avenue
Paoli, PA 19301

FAX: 610-296-2520

HIM Department
Bryn Mawr Rehabilitation Hospital
414 Paoli Pike
Malvern, PA 19355

FAX: 610-647-2295

ATTACHMENT B

Main Line Health

□ Bryn Mawr Hospital
130 South Bryn Mawr Avenue
Bryn Mawr, PA 19010

□ Bryn Mawr Rehab
414 Paoli Pike
Malvern, PA 19355

□ Lankenau Hospital
100 Lancaster Avenue
Wynnewood, PA 19096

□ Paoli Memorial Hospital
255 West Lancaster Avenue
Paoli, PA 19301

Authorization for Disclosure of Health Information

I hereby authorize _____to release medical information from the records of:
(Name of Institution)

Patient Name: _____ DOB: _____ SS#:_____

Covering the period(s) of care (list applicable dates of treatment):_____

Information to be disclosed (Check all applicable items to be released; for a complete chart copy, place a check in all boxes)

□ Discharge Summary	□ ER Record	□ Progress Notes
□ Discharge Instructions	□ X-Ray Reports	□ Medication Records
□ History and Physical	□ Lab Reports	□ Doctor's Orders
□ Consultations	□ EKG/ECG Tests	□ Nurse's Notes
□ Operative Report	□ Therapy Notes	

□ Other (please specify):_____

I understand that any information released pursuant to this request will not include any information related to my treatment for AIDS/HIV, psychiatric care and treatment for drug and alcohol abuse unless specifically checked below.

□ AIDS/HIV □ Psychiatric Care/Treatment □ Treatment for Drug or Alcohol use/abuse

I understand that Main Line Health may deny this request under limited circumstances as provided for under state or federal regulations governing the protection of personally identifiable health information. I further understand that except as otherwise permitted under applicable federal law, I have the right to have a denial of my request reviewed by a licensed health care professional selected my Main Line Health who did not participate in the decision to deny my request.

I understand that MLH will notify me of its decision to approve or deny my request to access or obtain a copy of the requested information within thirty (30) days of receiving this request if the information is maintained or accessible on-site or within sixty (60) days if the requested information in not maintained on-site. If MLH is unable to comply with my request within the specified timeframes, it may extend the applicable deadline for up to thirty (30) days by notifying me in writing.

This information is to be disclosed to:

Name of Person or Institution: _____

Address: _____

City/State/Zip Code: _____ Phone # (for questions):_____

For the purpose of (required): _____

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken to comply with this request. This authorization will automatically expire in six (6) months unless otherwise revoked or indicated to expire on _____ (date not to exceed six months). In accordance with PA state law, I understand that there is a fee for obtaining copies of records, except for copies mailed directly to a healthcare facility or physician, and I agree to pay such charges.

_____ _____ _____
(Signature of patient or legal guardian) (Relationship to Patient) (Date)

_____ _____
(Signature of Witness) (Date)

Verbal Release of Mental Health Information:

Verbal Consent to Release mental health information is acceptable if the patient is physically unable to provide a signature and verbal consent is witnessed by two persons.

We, the undersigned, certify that _____was physically unable to provide a signature, that he/she understood the nature of this release and freely gave his/her consent.

_____ _____ _____ _____

(Witness) (Date) (Witness) (Date)

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FORM

1. Please complete the Authorization for Disclosure of Health Information Form in its entirety. Incomplete forms will be returned to the sender for completion.

2. The patient or legally authorized representative (see #7 below) must sign and date the form.

3. Please mail the form to the appropriate facility to the attention of the "Health Information Management Department". The address for each hospital is listed at the top of the authorization form. **(Electronic copies cannot be accepted).**

4. Records will be mailed directly to the party listed as the recipient on the authorization form. We do not fax records to recipients unless needed for emergent patient care by another healthcare provider.

5. If the records are needed for continuing care purposes and are mailed directly to a physician or other healthcare facility, the records will be mailed free of charge.

6. Records for all other purposes are subject to copying charges in accordance with PA State Law. An invoice will be mailed to you and payment will be expected prior to the records being copied and mailed.

7. The following is a list of persons authorized to sign the disclosure of health information form:
   - If the patient is 18 years of age or older and is competent, then the patient must sign. No one else is authorized to sign.
   - If the patient is 14 years of age or older and was treated for a psychiatric admission, then the patient must sign.
   - If the patient is a minor (under 18 years of age) or under 14 years of age for psychiatric admission, then the parent or legal guardian must sign.
   - If the patient is over 18 years of age and is incompetent, then the legal representative must sign and provide proof of legal representation. (e.g. a photocopy of power of attorney documents or other legal documents).
   - If the patient is deceased, the surviving spouse or other legal representative must sign and provide proof of legal representation (e.g. a photocopy of executor documentation, power of attorney, etc.).

Please contact the Health Information Management Department (Medical Records) at the appropriate facility if you have additional questions or need further assistance.

ATTACHMENT C

Guidelines to Retention of Hospital and Medical Records

Record	Recommended Retention	Required Retention	Remarks
Patient Control Registers			
A. Emergency Department Log - this log must include: 1. Name 2. Date 3. Time of arrival 4. Name of those dead on arrival shall also be entered 5. Note if patient has every been patient at same hospital before		3 years	1978 *Rules and Regulations for Hospitals,* Pennsylvania Department of Health, 28 Pa. Code, Section 117.42.
B. Operating Room Log 1. Name and number of patient 2. Names of surgeons and surgical assistants 3. Name of anesthetists 4. Type of anesthesia given 5. Pre- and post-operative diagnosis 6. Type of surgical procedure and presence or absence of complications of surgery	Permanent		Required without specific time limit by 1978 *Rules and Regulations for Hospitals,* PA DOH, 28 Pa. Code, Section 135.4.
Medicare Records			
A. Hospital copies of bills including billing rooms, supporting documents and other business and accounting records referring to specific claims. B. Cost report material including original invoices, canceled checks, worksheets, and other material necessary to support accuracy of cost report. C. Utilization review and related material. D. Hospital physician agreements on which Part A/Part B allocations are based.		5 years after the month the cost report is filed with the intermediary	*Hospital Insurance Manual,* HIM-10, Sections 480 and 480.1. For example, if the cost report for the period ending 10/31/87 was filed with the intermediary 1/15/88, all billing materials (including utilization review committee reports) must be retained until 2/1/93.
Medical Assistance Program		4 years	*Medical Assistance Handbook* - Chapter 1163.43.
Nuclear Medicine			
A. Instrument Log Book 1. Calibration dates 2. Technologists 3. Source of reference standards 4. Maintenance & repair records and dates of service		Life of equipment	1978 *Rules and Regulations for Hospitals,* PA DOH, 28 Pa. Code, Section 129.35.
B. Radioisotope Records 1. Receipt 2. Transfer 3. Use 4. Storage 5. Delivery 6. Disposal 7. Reports of overexposure		Permanent	10 CFR 30.51 and 1978 *Rules and Regulations for Hospitals,* Pennsylvania Department of Health, 28 Pa. Code, Section 129.34.

Record	Recommended Retention	Required Retention	Remarks

C. Reports 1. Inpatient 2. Outpatient		7 years	For inpatients, original reports retained in chart and maintained per 1978 *Rules and Regulations for Hospitals,* Pennsylvania Department of Health, 28 Pa. Code, Section 115.23. Minor records are maintained 7 years following the age of majority, 28 Pa. Code, Section 115.23(b). It is recommended that outpatient records be maintained as long as facility's policy for maintenance of inpatient records.
Special Care Units			
A. Instrument Log Books 1. Documentation of safety testing of patient care equipment used in special care units shall be retained for the life of the equipment.		Life of equipment	1978 *Rules and Regulations for Hospitals,* Pennsylvania Department of Health, 28 Pa. Code, Section 133.22©.
Clinical Laboratory			For detailed guidelines related to the retention of lab related materials, specimens and reports, please consult the MLCL Policy and Procedure Manual available from the lab administrator. For inpatients, original reports should be retained in the chart and maintained per 1978 *Rules and Regulations for Hospitals,* Pennsylvania Department of Health, 28 Pa. Code, Section 115.23 and 115.23(b). It is recommended that outpatient records be maintained as long as the facility's policy for maintenance of inpatient records.
Radiology			Medicare conditions of participation 42 CFR, Section 482.26(d)(2ii).
A. Films		5 years	
B. Scans		5 years	
C. Other image records		5 years	
D. Inpatient reports		7 years	
E. Outpatient reports			For inpatients, original reports retained in chart and maintained per 1978 *Rules and Regulations for Hospitals,* Pennsylvania Department of Health, 28 Pa. Code, Section 115.23 and 115.23(b).

Record	Recommended Retention	Required Retention	Remarks
Other Ancillary Departments (e.g., social service, respiratory therapy, physical therapy, etc.)			For inpatients, original reports retained in chart and maintained per 1978 *Rules and Regulations for Hospitals,*

A. Inpatient reports B. Outpatient reports		7 years	Pennsylvania Department of Health, 28 Pa. Code, Section 115.23 and 115.23(b).
C. Log books	7 years		
D. Quality control records	7 years		
E. Maintenance records	7 years		
F. Equipment servicing (rehab)		Life of equipment	28 Pa. Code, Section 131.11
Clinical Psychological Services	Recommendations of the American Psychological Association		
A. Records of psychological services	Retained intact for 3 years after the completion of planned services or after the date of last contact with the user.		For inpatient services, reports should be placed in the chart and maintained per 1978 *Rules and Regulations for Hospitals,* PA DOH, 28 Pa. Code, Section 115.23 and 115.23(b).
B. Summary of the record	Should be maintained an additional 12 years.		
Correspondence (relating to a medical record)	7 years		No requirement, but consideration should be made to retaining correspondence for as long as the medical record is maintained. If microfilming is done, this correspondence should be considered for microfilming as well.
Infant Footprints		Permanent	May use microfilm records. 28 Pa. Code, Section 115.25.
Medical records of a minor		7 years following age 18	Records on minors shall be kept on file until majority, and then for 7 years **or as long as the records of adult patients are maintained.** 28 Pa. Code, Section 115.23(b).
Medical Record 1. Face sheet 2. History & physical exam 3. Musculoskeletal exam 4. Diagnostic and therapeutic orders 5. Progress notes by physicians or those authorized by them 6. Discharge summary 7. Laboratory reports 8. Radiology reports (interpretations) 9. Radiotherapy reports & consults 10. Consultations 11. Informed consents 12. Anesthesia record 13. Operative report 14. Prenatal record 15. Labor & delivery record	Please refer to JCAHO Standards, AOA Accreditation Manual, and the DOH *Rules and Regulations for Hospitals* for specific retention requirements. Hospitals may choose to keep summary of key elements of the medical record permanently if the record is destroyed after 7 years.	7 years following discharge of patient	1978 *Rules and Regulations for Hospitals,* PA DOH, 28 Pa. Code, Section 115.23. Records may be microfilmed.

Record	Recommended Retention	Required Retention	Remarks
Medical Record 16. Face sheet 17. History & physical exam 18. Musculoskeletal exam 19. Diagnostic and therapeutic orders 20. Progress notes by physicians or those authorized by them			

21. Discharge summary 22. Laboratory reports 23. Radiology reports (interpretations) 24. Radiotherapy reports & consults 25. Consultations 26. Informed consents 27. Anesthesia record 28. Operative report 29. Prenatal record 30. Labor & delivery record 31. Autopsy report 32. Pathology report 33. All clinical information and treatment documentation related to the patient's stay 34. Nursing notes and entries by non-physicians 35. post-anesthesia record 36. Reports and results of procedures and tests 37. Records of transplant donors and recipients 38. Copy of discharge instructions 39. Reports of monitoring equipment 40. Social service record 41. Birth and death forms			
Emergency Services 1. Patient identification 2. Time of arrival 3. By whom transported 4. Pertinent history of illness or injury 5. Clinical, laboratory, roentgenologic findings 6. Diagnosis 7. Treatment given 8. Condition at time of discharge 9. Final disposition of patient 10. See **Emergency Department Log** for more information		To be made part of patient's unit record	1978 *Rules and Regulations for Hospitals,* Pennsylvania Department of Health, 28 Pa. Code, Section 117.43. JCAHO Standards Emergency Services (ER) AOA Accreditation Requirements
Outpatient Services A. Patient Medical Records 1. Patient identification 2. Relevant history of illness or injury and physical findings 3. Diagnostic and therapeutic orders 4. Clinical observations, including the results of treatment 5. Reports of procedures, tests, and results 6. Diagnostic impression		To be made part of patient's unit record	1978 *Rules and Regulations for Hospitals,* Pennsylvania Department of Health, 28 Pa. Code, Section 119.24 and 115.31-115.34. Required JCAHO Standards Ambulatory Care Services
HIPAA Related Forms and Documents		6 years	Health Insurance Portability and Accountability Act of 1996, §