CA

70751 Medical Record Availability

(a)

Records shall be kept on all patients admitted or accepted for treatment. All required patient health records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon the request of: (1) The admitting licensed healthcare practitioner acting within the scope of his or her professional licensure. (2) The nonphysician granted privileges pursuant to Section 70706.1. (3) The hospital or its medical staff or any authorized officer, agent or employee of either. (4) Authorized representatives of the Department. (5) Any other person authorized by law to make such a request.

(1)

The admitting licensed healthcare practitioner acting within the scope of his or her professional licensure.

(2)

The nonphysician granted privileges pursuant to Section 70706.1.

(3)

The hospital or its medical staff or any authorized officer, agent or employee of either.

(4)

Authorized representatives of the Department.

(5)

Any other person authorized by law to make such a request.

(b)

The medical record, including X-ray films, is the property of the hospital and is maintained for the benefit of the patient, the medical staff and the hospital. The hospital shall safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.

(c)

Patient records including X-ray films or reproduction thereof shall be preserved safely for a minimum of seven years following discharge of the patient, except that the records of unemancipated minors shall be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.

(d)

If a hospital ceases operation, the Department shall be informed within 48 hours of the arrangements made for safe preservation of patient records as above required.

(e)

If ownership of a licensed hospital changes, both the previous licensee and the new licensee shall, prior to the change of ownership, provide the Department with written documentation that: (1) The new licensee will have custody of the patients' records upon transfer of the hospital and that the records are available to both the new and former licensee and other authorized persons; or (2) Arrangements have been made for the safe preservation of patient records, as above required, and that the records are available to both the new and former licensees and other authorized persons.

(1)

The new licensee will have custody of the patients' records upon transfer of the hospital and that the records are available to both the new and former licensee and other authorized persons; or

(2)

Arrangements have been made for the safe preservation of patient records, as above required, and that the records are available to both the new and former licensees and other authorized persons.

(f)

Medical records shall be filed in an easily accessible manner in the hospital or in an approved medical record storage facility off the hospital premises.

(g)

Medical records shall be completed promptly and authenticated or signed by a licensed healthcare practitioner acting within the scope of his or her professional licensure within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a signature by a licensed healthcare practitioner acting within the scope of his or her professional licensure, only when that licensed healthcare practitioner acting within the scope of his or her professional licensure, has placed a signed statement in the hospital administrative offices to the effect that he/she is the only person who:(1) Has possession of the stamp or key. (2) Will use the stamp or key.

(1)

Has possession of the stamp or key.

(2)

Will use the stamp or key.

(h)

Medical records shall be indexed according to patient, disease, operation and

licensed healthcare practitioner acting within the scope of his or her professional licensure.

(i)

By July 1, 1976 a unit medical record system shall be established and implemented with inpatient, outpatient and emergency room records combined.

(j)

The medical record shall be closed and a new record initiated when a patient is transferred to a different level of care within a hospital which has a distinct part skilled nursing or intermediate care service.