75055 Unit Patient Health Records

(a)

Records shall be permanent, either typewritten or legibly written in ink and shall be kept on all patients accepted for treatment. All health records of discharged patients shall be completed and filed within 30 days after termination of each episode of treatment and such records shall be kept for a minimum of 7 years, except for minors whose records shall be kept at least until one (1) year after the minor has reached the age of 18, but in no case less than seven (7) years. All exposed X-ray film shall be retained for seven years. All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon the request of the attending physician, the clinic or any authorized officer, agent or employee of either, or any other person authorized by law to make such request.

(b)

Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws.

(c)

If a clinic ceases operation, arrangements shall be made for the safe preservation of the patients' health records. The Department shall be informed by the clinic of the arrangements within 48 hours before cessation of operation.

(d)

The Department shall be informed within 48 hours, in writing, by the licensee whenever patient health records are defaced or destroyed before termination of the required retention period.

(e)

If the ownership of the clinic changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide the Department with written documentation stating: (1) That the new licensee shall have custody of the patients' health records and these records shall be available to the former licensee, the new licensee and other authorized persons; or (2) That other arrangements have been made by the current licensee for the safe preservation and the location of the patients' health records, and that they are available to both the new and former licensees and other authorized persons.

(1)

That the new licensee shall have custody of the patients' health records and these records shall be available to the former licensee, the new licensee and other authorized persons; or

(2)

That other arrangements have been made by the current licensee for the safe preservation and the location of the patients' health records, and that they are available to both the new and former licensees and other authorized persons.

(f)

Patients' health records shall be current and kept in detail consistent with good medical and professional practice and shall describe the services provided to each patient. All entries shall be dated and be authenticated with the name, professional title, and classification of the person making the entry.

(g)

Patients' health records shall be stored so as to be protected against loss, destruction or unauthorized use.

(h)

Patient health records shall be filed in an easily accessible manner in the clinic. Storage of records shall provide for prompt retrieval when needed for continuity of care. Prior approval of the Department is required for storage of inactive health records away from the facility premises.

(i)

The patient health record shall be the property of the facility and shall be maintained for the benefit of the patient, health care team and clinic and shall not be removed from the clinic, except for storage purposes after termination of services.