79351 Patient Health Record Availability

(a)

Accurate and complete records shall be maintained on all patients admitted or accepted for treatment. All required records, either 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 attending licensed healthcare practitioner acting within the scope of his or her professional licensure; (2) Any authorized employee, agent or officer of the hospital; (3) Authorized representatives of the Department; or (4) Any other person authorized by law to make such a request.

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(b)

The patient health record is the property of the CDRH and is maintained for the

benefit of the patient, the attending physician, the staff and the CDRH. The CDRH shall safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.

(c)

Patient health records or reproductions thereof shall be preserved safely for a minimum of seven (7) years following discharge of the patient, except that the records of minors shall be kept at least one (1) year after such minor has reached the age of 18 years and, in all cases not less than seven (7) years.

(d)

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

(e)

If ownership of a CDRH 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' health records upon transfer of the CDRH and the health 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 patients' health records, and that the health records are available as required in (1) above.

(1)

The new licensee will have custody of the patients' health records upon transfer of the CDRH and the health 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 patients' health records,

and that the health records are available as required in (1) above.

(f)

Patient health records shall be filed in an easily accessible manner in the CDRH or in a Department-approved health record storage facility off the CDRH premises.

(g)

Patient health records shall be completed promptly and authenticated or signed by the attending physician or psychologist within two weeks following the patient's discharge. Patient health records may be authenticated by a signature stamp or computer key, in lieu of the attending physician's or psychologist's signature, only when that physician has placed a signed statement in the CDRH 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)

Patient health records shall be indexed according to patient, diagnosis and physician.

(i)

A unit health record system shall be established and implemented with inpatient, outpatient and emergency room records combined.