A Physician’s Guide to Medical Record Access and Retention

2014

Information and guidance for physicians provided by the Illinois State Medical Society
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INTRODUCTION

Medical record access and retention guidelines are found in many portions of the Illinois Compiled Statutes. Recognizing that many physicians need detailed information regarding these issues, the Illinois State Medical Society (ISMS) has produced this brochure to guide physicians so that they are in compliance with the law with respect to medical record access and medical record retention issues. Additionally, good risk management principles are included as guidelines for medical record documentation. While the content of the brochure is educational and informational in nature, it is not intended to serve as legal advice.

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The Oath of Hippocrates of Kos, which physicians swear by, states:

. . . All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.

In light of this oath, medical records and their content are not to be released unless a physician has:

- Consent from the patient or his/her personal representative for treatment, payment or health care operations purposes\
- Knowledge of an express legal exception²
- An appropriate subpoena or court order³
- A written authorization from the patient or his/her personal representative

If one of these four conditions exists, the physician may generally release a copy of the medical record in accordance with the guidelines outlined below. THE ORIGINAL RECORD SHOULD NOT BE RELEASED, EXCEPT IN RESPONSE TO A COURT ORDER OTHER THAN A SUBPOENA, OR AT THE REQUEST OF A PHYSICIAN’S DEFENSE COUNSEL WHEN THE RECORD IS NECESSARY FOR LITIGATION.

Information subject to release consists of all information relative to the diagnosis, treatment, prognosis, history, charts, pictures and plates, kept in connection with the treatment of a patient and payment for the treatment, whether or not it is in the patient’s actual medical record.⁴ If records from other providers (often referred to as secondary records) are a part of the patient’s entire record, then they are also subject to release regardless of any prohibition from the previous treating professional. Under HIPAA privacy rules, financial records are part of the actual medical record or protected health information (PHI) subject to release.⁵
Authorization

Those who may authorize access to medical records are:

- A patient who is:
  - 18 years of age or older
  - A minor who is, or was, married
  - A pregnant minor
  - A minor who is a parent
  - A legally emancipated minor (court documents should be provided to establish emancipation)
  - A minor, 12 years or over, seeking treatment for alcoholism, drug use, sexually transmitted diseases including AIDS and HIV, or in a family in which another family member abuses drugs or alcohol or the minor
  - A minor seeking treatment for mental health or developmental disabilities
  - A victim seeking treatment for sexual abuse or assault
  - A minor seeking treatment for birth control services when the minor is married, a parent, or pregnant; has the consent of his/her parent or legal guardian; to whom failure to provide such treatment would create a serious health hazard; or who is referred for such by a physician, clergyman or planned parenthood agency

- A legal guardian

- A parent

- An executor of a person’s estate

- An attorney-in-fact, power of attorney for health care, or surrogate

A physician must obtain the applicable authorization (also referred to as consent) in order to release medical information. Once consent is obtained for treatment, payment, or health care operations, all subsequent treating or consulting physicians, other health care professionals, laboratories, and health care facilities may receive copies of medical records without a specific authorization, with the exception of records of mental health, alcoholism, drug abuse, and HIV/AIDS treatment. It is recommended that a written authorization (consent) be obtained at the first patient encounter in the office. No specific time limitations exist for an authorization or consent. This authorization or consent should be for treatment, payment, and health care operations. Under HIPAA privacy rules, a physician must offer a patient a copy of the practice’s Notice of Privacy Practices and obtain acknowledgment of receipt or document refusal of the patient to sign an acknowledgement at the first patient encounter in the office. All this can be accomplished by obtaining the patient’s signature on the appropriate form. (See page 22 for specific information about accessing medical records resources, including HIPAA model policies and procedures.)

All other disclosures are either mandated by law or require that the patient sign an authorization. An authorization is simply permission to disclose records. (See page 22 for specific information about accessing medical records resources, including HIPAA model policies and procedures.) Further, there are certain situations in which the duty to release or report medical information absolves the physician from the need to obtain authorization. In these cases, only the information necessary to fulfill the request or reporting obligation may be released.
Those situations include:

- Coroner’s inquiries
- Requests by a Peer Review Organization (PRO) under contract by the federal government or certain other government agencies
- Workers’ compensation cases
- Communicable disease reporting
- Sexually transmitted disease reporting
- Child or elder abuse reporting

When a physician knows that a minor patient’s parents are divorced, the physician may wish to ask the custodial parent whether anything is specified in the divorce decree with respect to health care. Unless specifically advised of contrary terms in a divorce decree (which the physician should see and retain a copy of) the physician is authorized to discuss these matters with any parent.

**Physician Records**

Generally, upon written request, physicians are required by law to provide copies (or permit examination) of medical records to a patient, patient’s attorney or patient’s physician. Under HIPAA privacy rules, patient health information, called protected health information (PHI), consists of medical records and billing information. Patients should be advised that requests for medical records will include only patient health care information, unless the patient specifically requests billing information.

All physicians and groups are required under the HIPAA privacy rules to establish office policy regarding the release of medical records. Physicians practicing in groups who have seen the patient in the recent past should all be notified when a request for records has been made. From a risk management standpoint, it may be preferable for a member of the practice to review the content with a patient prior to giving copies of records to that patient. Further, as a practical matter of course, physicians would be well advised to construct medical records with the thought that they will be shared with their patients, insurers, attorneys, etc., as permissible by law. THEREFORE, SPECIFIC TYPES OF RECORDS REQUIRING A SPECIFIC AUTHORIZATION SUCH AS RECORDS OF MENTAL HEALTH, ALCOHOLISM, DRUG ABUSE AND HIV/AIDS TREATMENT...
SHOULD BE KEPT IN A SEPARATE OR SEPARABLE PORTION OF A MEDICAL RECORD. Physicians should not send these records without a specific authorization. (See page 22 for specific information about accessing model medical records forms.)

An authorized request for a patient’s medical record must be honored within 30 days of receipt. If a copy cannot be provided within 30 days, then a written explanation of why the records cannot be provided must be given to the requestor (within the original 30 days). The records ultimately must be provided within 60 days of a request.

When a hospital closes, patient hospital records are usually shipped to the nearest hospital. The Illinois Department of Public Health (IDPH) maintains a listing of the locations of these records.

Physicians are not required to release hospital records unless they are a part of the patient’s office medical record. A patient should request hospital records from the hospital.

**Hospital Records**

Upon request, hospitals are required by law to provide copies (or permit examination) of patient medical records to a patient, patient’s physician or patient’s attorney once the patient has been discharged. Requests for patient records must be given to the administrator of the hospital. An authorized request for a patient’s hospital records must be honored within 30 days of receipt. If a copy cannot be provided within 30 days, then a written explanation of why the records cannot be provided must be given to the requestor (within the original 30 days). The records ultimately must be provided within 60 days of a request.

**Nursing Home Records**

Nursing homes’ records kept by the facility or by the physician are required, by law, to be provided (or permitted examination) to a resident, a resident’s guardian, or parent if the resident is a minor. The facility may charge a reasonable fee for copying the records. Specific requirements for the content, form, retention and transfer of patient records are set forth in IDPH rules.
Mental Health and Developmental Disabilities

There are specific guidelines for consent and disclosure of records and communications under the Mental Health and Developmental Disabilities Confidentiality Act. Access to medical records kept in conjunction with the provision of mental health services or services for the developmentally disabled may be provided to:

- The parent or guardian of a patient who is under 12 years of age
- The patient if he/she is 12 years of age or older
- Any other person on the patient’s behalf if authorized in writing by the patient who is at least 12 years of age
- The parent or guardian of a patient who is at least 12 years of age but under 18, if the patient is informed and does not object or if the therapist does not find that there are compelling reasons for denying such access
- The guardian of a patient who is 18 years of age or older
- An attorney or guardian ad litem who represents a minor 12 years of age or older in any judicial or administrative proceeding provided that the court or administrative hearing officer has entered an order granting the attorney this right
- An agent appointed under a recipient’s power of attorney for health care or property, when the power of attorney authorizes the access
- An attorney-in-fact appointed under the Mental Health Treatment Preference Declaration Act
- Any person in whose care and custody the recipient has been placed pursuant to Section 3-811 of the Mental Health and Developmental Disabilities code
- An independent team of experts under Brian’s Law shall be entitled to inspect and copy the records of any recipient whose death is being examined by such a team pursuant to the mortality review process authorized by Brian's Law.

Only information relevant to the purpose for which disclosure is sought may be disclosed. A blanket consent to the disclosure of unspecified information should not be considered as valid. A specific authorization is required to release these records. (See page 22 for specific information about accessing model medical records forms.)

A patient’s mental health information may be shared with a Health Information Exchange (HIE) by an HIE, person, therapist, facility, agency, interdisciplinary team, integrated health system, business associate, or covered entity without specific consent by the patient.

If a parent or guardian is denied access, the parent or guardian may petition the court for access. Under a valid court order, disclosure of confidential information may be required. If a physician receives a demand for the release of information under the Mental Health and Developmental Disabilities Confidentiality Act pursuant to a subpoena or court order, it should be reviewed by legal counsel prior to any disclosure of information.

Genetic Testing Information

Genetic testing information is specifically protected as confidential and privileged. A specific written release is necessary to disclose this information. However, persons who need to know the information to conduct tests or provide care or treatment may be given genetic testing information without a release.
Workers’ Compensation

Upon written request, hospitals, physicians and others providing treatment for workers’ compensation injuries are required by law to provide copies of a patient’s medical records to the patient, a patient’s employers, or employers’ workers compensation insurance company as the case may be, or any other party to any proceeding for compensation before the Industrial Commission for their attorneys. A physician must obtain patient authorization (see page 22 for specific information about accessing model medical records forms) when a workers’ compensation case is alleged, but no claim has formally been filed. These medical records must be limited to care or treatment for the employment injury, unless otherwise required by a court order. Physicians who furnish medical records in workers’ compensation cases may collect appropriate fees based on the 2014 rates published by the Comptroller, available at http://www.ioc.state.il.us/office/fees.cfm. Health care professionals are not limited to collecting a $20 subpoena fee, nor are they required to provide copies of medical records free of charge. (See page 22 for specific information about accessing medical records resources, including allowable copying fees.) HIPAA privacy rules require these disclosures or releases to be tracked.

Communicable Disease Reporting

Physicians are required by law to report incidents of various communicable diseases to the IDPH. The IDPH treats the information and records as confidential and non-discoverable. A physician is immune from liability in reporting such in good faith. HIPAA privacy rules require these disclosures or releases to be tracked.

Sexually Transmitted Disease Reporting

Physicians are required by law to report incidents of various sexually transmitted diseases to the IDPH. The IDPH may disclose these reports only under specified circumstances. HIPAA privacy rules require these disclosures or releases to be tracked. The IDPH and its authorized representatives treat the information and records related to known or suspected cases of sexually transmissible diseases as confidential and non-discoverable, except:

- When made with the consent of all persons to which the information applies
- When made for statistical purposes and medical or epidemiologic information is summarized so that no person can be identified and no names are revealed – identification of all persons is masked
- When made to medical personnel, appropriate state agencies, or courts of appropriate jurisdiction to enforce the provisions of the law

Mandated Reports to Government

Generally, reports of diseases, conditions, injuries, communicable diseases, venereal diseases, sexually transmitted diseases and procedures to state and local government entities are confidential and non-discoverable. Physicians receive good faith immunity for civil and criminal actions for reporting. HIPAA privacy rules require these disclosures or releases to be tracked.
When made to persons determined by the IDPH to be or have been at potential risk of HIV transmission pursuant to the law

When authorized by the AIDS Registry System regulations

When authorized by the AIDS Confidentiality Act

When made to a school principal pursuant to the AIDS Confidentiality and Testing Code

Keeping medical information related to sexually transmitted diseases in a separate file or portion of a file record is recommended (but not required except for HIV test results).

**Child, Elder and Disabled Adult Abuse and Neglect Reporting**

Physicians are required by law to report incidents of suspected abuse and neglect of children, and incidents of suspected abuse, neglect, or exploitation of persons 60 years old or older. Physicians may also report incidents of suspected abuse or neglect of adults with disabilities. In reporting these matters, the physician cannot allege communications are privileged. Consequently, communications and medical records concerning reports of suspected abuse and neglect can be obtained by law enforcement and welfare agencies to carry out investigations of these reports. HIPAA privacy rules require these disclosures or releases to be tracked.

**Subpoenas/Court Orders**

Either party to a lawsuit may have a subpoena issued. The subpoena calls for testimony at a deposition or trial or requests certain documents. A physician who receives a subpoena must respond in some acceptable way. Not responding would hold the physician at risk of being held in contempt of court. Under the HIPAA privacy rules, a physician or practice must comply with a subpoena:

- When it is accompanied by an order of a court or administrative tribunal (disclosure is limited to protected health information (PHI) expressly authorized by the order); or
- When it is a discovery request or other lawful process and it is not accompanied by a court order or administrative tribunal, and:
  - the practice is satisfactorily assured that the individual has been given notice of the request (the party seeking the PHI provides a written statement to the practice with documentation demonstrating the individual has been contacted, or attempted to be contacted, that the notice to the individual was descriptive enough to permit the individual to raise an objection to the proceeding, and the time for objections has elapsed and no objections were filed or filed objections were resolved and disclosures are consistent with resolution), or
the practice is satisfactorily assured that the party seeking information has made reasonable efforts to receive a qualified protective order (the party seeking the PHI provides a written statement to the practice with documentation demonstrating that the parties to the dispute have agreed to and presented a qualified protective order to the court or administrative tribunal or the party seeking the PHI has requested a qualified protective order from such court or administrative tribunal).

In all situations pursuant to a subpoena (other than a workers’ compensation subpoena), it is recommended that the physician have a patient written authorization for release or protection order from a court prior to turning over any medical information.

When a physician receives a subpoena for original records, as long as the record can be authenticated by testimony or a notarized statement attesting to the authenticity of the copies, it is acceptable to submit photocopies as opposed to original copies. When a physician receives a court order, copies of the medical record may generally be released. However, there may be circumstances where original records are mandated. In such cases the physician should keep a copy of the medical record and number the pages of the original record before release so that they may be counted when the original is returned. Any specific questions regarding the process should be taken to a physician’s attorney.
While Illinois does not have a statute on retention of physician medical records, the statute of limitations on malpractice damages and hospital retention statute should be used as guides for medical record retention. The statute of limitation states:  

No action for damages for injury or death against any physician, dentist, registered nurse or hospital duly licensed under the laws of this State ... arising out of patient care shall be brought more than 2 years after the date on which the claimant knew, or through the use of reasonable diligence should have known, or received notice in writing of the existence of the injury or death for which damages are sought in the action, whichever of such date occurs first, but in no event shall the action be brought more than 4 years after the date on which the act occurred or omission or occurrence alleged.

Some Exceptions to the Above Statement

If the action accrued to an individual under the age of 18 years, the statute states:

No action for damages for injury or death against any physician, dentist, registered nurse or hospital duly licensed under the laws of this State ... arising out of patient care shall be brought more than 8 years after the date on which the act or omission or occurrence alleged ... provided, however, that in no event may the cause of the action be brought after the person's 22nd birthday.

If the person entitled to bring action ... is at the time the cause of action accrued, under a legal disability ... then the period of limitations does not begin to run until the disability is removed.

If a person liable to an action fraudulently conceals the cause of such action ... the action may be commenced at any time within 5 years after the person entitled to bring the same discovers that he or she has such cause of action.

The Hospital Licensing Act generally requires:

Hospital patient records be maintained for 10 years after the last patient encounter.
Guidelines for Retention

Every physician must consider the guidelines outlined below when tailoring a specific medical record retention policy that best suits his/her practice.

The overall general recommendation is retention of all medical records, including photographs, videotapes, radiographs, slides or other diagnostic testing items of patients (adults and minors except childhood immunization records), for 10 years after the last patient encounter.

- It is appropriate to retain medical records for that period which would be the longest statute of limitations. In most instances, that would be 4 years in Illinois. If this is an existing and continuing patient, the 4 year period should begin to run from the time that the patient ceases being a patient. If this is a child, 8 years is the period, unless they continue to be a patient. Many defense counsel, for understandable reasons, recommend that records be retained indefinitely. This, at times, makes it easier to defend a case. However, the statute of limitations tends to be the best to utilize.
Although the X-ray Retention Act applies to hospitals, as a rule of thumb, it is best to retain X-rays up to the longest applicable statute of limitations. Thus, X-ray and roentgen photographs should be retained for 5 years unless the statute of limitations on damages exceeds the 5 year time period, e.g., as in the case of a minor. If litigation is pending before the 5 year mark, the film must be kept 12 years from the date it was produced or until notification that the case has been concluded.

Pursuant to Food and Drug Administration regulations, facilities that perform mammograms must maintain mammograms and associated records in a patient’s permanent medical record for a period of not less than 5 years, or not less than 10 years if the patient has no additional mammograms performed at that facility, or until the patient requests a permanent transfer of her records to a medical institution, her physician or herself and the records are in fact transferred. Further, Illinois law requires that mammography images or films transferred to a patient’s physician be retained by the physician for a minimum of 5 years.

It should be noted that the above does not hold true for records that fraudulently conceal the cause of an action. In such cases, records would need to be retained indefinitely as the action may be commenced at any time within 5 years after the person entitled to bring the action discovers that he or she has such cause.

The statute of limitations dictates that the period of limitations does not begin to run for those individuals who have permanent disabilities until the disability is removed. Moreover, individuals protected under the Mental Health and Developmental Disabilities Confidentiality Act may seek damages against a physician at any time. Thus, all medical records of persons under a legal disability, including a mental health disability must be retained indefinitely.

The National Childhood Vaccine Injury Act of 1986 dictates that all immunization records as of March, 1988, be retained permanently.

Medicaid records, including billing records, are required to be retained 5 years.

Medicare records, including billing records, are required to be retained at least 5 years.

OSHA requires employers to preserve and maintain an accurate record of occupational exposure. It is suggested that such records be retained for 30 years.

It is recommended that any medical records involved in a malpractice claim be retained permanently.

Hospitals must retain hospital patient records for 10 years.

All HIPAA required documentation must be retained for at least 6 years. (See page 22 for specific information about accessing medical records resources, including HIPAA model policies and procedures.)

* “Permanently” means as long as the physician has a current license to practice medicine, plus the applicable statute of limitations period.
Contractual obligations entered into by a physician or practice may alter the medical record and financial record retention guidelines contained herein.

**Other Records**

Aside from medical records:

- **Patient Account Records** – Invoices, cash receipts, superbills, explanation of benefits (EOB) correspondence, etc., once paid or acknowledged, should be retained for the retention period adopted for patient medical records.

- **Tax documents** – It is advisable to keep permanently books in which payments for services are recorded, tax returns and other tax documents. Generally, the IRS must challenge within 3 years of the due date or the date of filing; however, individuals suspected of fraud or failure to file may be investigated at any time.

- **Appointment books** should be retained permanently. From a risk management standpoint it is advised that phone logs and message books also be retained permanently.

- **Personnel Records** – The *Fair Labor Standards Act* requires physicians to keep payroll records for at least 3 years. The IRS mandates a 5-year retention period for payments to various governmental entities. It is advisable to keep employee benefit program records permanently.

- **All HIPAA required documentation** must be retained for at least 6 years. (See page 22 for specific information about accessing medical records resources, including HIPAA model policies and procedures.)

As a general rule, in those situations where the records must be maintained indefinitely (i.e., mental health records and vaccinations), once the physician’s estate is closed, no action can be taken against it. If the practice is sold, liability on retention of records is usually transferred from the seller to a buyer of a practice pursuant to the contract terms.
Generally, medical records are the property of the physician. Patients have a right to request access to the contents of the records, but do not have a right to original medical records.

In a physician group, the ownership of medical records is determined by physician group policy. If no policy on ownership of medical records exists, then the medical record is owned by the physician(s) who treat(s) the patient.

In a hospital, the hospital owns the medical records.

**Patient Notification**

By way of general notice principles, a letter and/or publication is sufficient to let patients know that a physician is leaving practice and that copies of medical records will be available via the physician’s office policy. (See ISMS “A Physician’s Guide for Departing or Closing a Medical Practice” brochure [ISMS website]) Specifically, Illinois law states: A physician must provide the public with at least 30 days prior notice of the closure of the physician’s practice. The notice must include an explanation of how copies of the physician’s records may be accessed by patients. The notice may be given by publication in a newspaper of general circulation in the area in which the physician’s practice is located.

**Purging Records**

There is no mandated way to purge medical records, X-rays and mammograms once it is determined that they may be destroyed. However, from a risk management standpoint the records should be shredded or burned as confidentiality safeguards.
First and foremost, medical records play a vital role in the ongoing care and treatment of patients. They serve as the primary vehicle for retaining and communicating important patient care information. In today’s rapidly changing health care delivery market, medical records have become important tools to communicate to third parties such as other health care professionals, health care providers, insurance companies and payors. They are also essential in the successful defense of a medical liability claim.

The quality of the medical record directly affects the view other physicians, health care providers, payors and others have of the care rendered by the physician. A complete, accurate and objective record provides a solid foundation for peer review, utilization review, and the defense against allegations of negligence. If the medical record lacks the information necessary to demonstrate that the physician has met the standard of care, then it is extremely difficult to defend the care provided, even if the medical care did comply with the existing standard. For these reasons, the importance of what the physician includes in the medical record becomes apparent. Under the HIPAA privacy rules, a physician must document disclosure of records for other than the treatment, payment or operations purposes.69 This documentation must be retained for 6 years. (See page 22 for specific information about accessing medical records resources, including HIPAA model policies and procedures.)
Guidelines for Documentation

To document the care provided, information that clearly demonstrates the physician’s reasoning in arriving at a diagnosis and selecting and providing a specific treatment should be included in the record. The medical record should include:

- Identification of the patient on all pages within the record
- The patient’s medical history
- Documentation of the patient’s complaint(s)
- A report of the physical examination(s)
- Reports of test findings including EKGs, laboratory and X-ray reports
- The physician’s diagnosis, including differential diagnoses
- The treatments performed or recommended
- Documentation of informed consent
  Include appropriate informed consent forms and narrative documentation that the patient understood the risks and benefits of the recommended procedures or treatments as well as the alternatives, including the probable consequences of not undergoing the treatment. Informed consent discussions conducted with the patient’s family members should also be documented.
- Patient educational efforts and activities, including documentation of discussions, written materials and patient teaching as well as any outside referrals to augment teaching (dieters, nurse educators, exercise instruction, etc.) or patient support groups
- Documentation of informed refusal of specific recommended course of treatment
- Frequent progress notes detailing the patient’s response to treatment
- The patient’s condition on discharge, including any instructions given to the patient regarding medication and follow-up care
- Signed acknowledgment of receipt of or refusal of the patient to sign an acknowledgment of receipt of the Notice of Privacy Practices (HIPAA Privacy Rules)
- Any requests by patients to amend their medical records and any response (HIPAA Privacy Rules)
- Any disclosure of medical records for other than treatment, payment or operations and patient authorizations and subpoenas (HIPAA Privacy Rules)
- Any patient requests for confidential communications (HIPAA Privacy Rules)
- Any patient request for restrictions (HIPAA Privacy Rules)
- Patient phone calls

Calls where medical advice or a renewal of medicine is given should be documented in the medical record and signed by the person who spoke to the patient. Specifically, there are four instances in which it is particularly important to document phone calls in the record:

1. Whenever a patient reports a complication of care, the complication (including the symptoms described by the caller) and the advice given should be noted in the medical record. The instructions given to the patient as to what to do if the symptoms are not relieved by the advice given should also be included.

2. Whenever a patient seeks treatment advice by phone, it is important to document the symptoms reported and the advice given.

3. Renewals or prescriptions for medication by phone should also be documented in the record in order to adequately monitor how many and what kinds of medications the patient receives. Use of a medication flow sheet provides a convenient and efficient method of recording and tracking all prescription renewals, adverse reactions, and drug interactions.

4. It is important that evening and weekend calls be documented as carefully as office hour calls. Many physicians carry adhesive-backed note pads or phone message pads to document after-hour calls that can be filed directly into the record once completed. Others use small dictating devices and have their phone messages transcribed and entered into the record.

- Patient advice

It is important to document the instructions given to patients, especially with regard to follow-up treatment and appointments. This documentation is important in providing for good continuity of care. It is also important to memorialize what the patient was advised in the event the patient does not follow the physician’s instructions and alleges that he/she was not properly instructed.

- Patient informed refusal or patient noncompliance

It is important to document instances of patient noncompliance such as when a patient refuses to undergo a recommended course of treatment, fails to comply with treatment instructions, does not return for follow-up care or fails to see a consultant. Documentation of noncompliance can provide valuable information for subsequent providers, as well as corroboration of a patient’s comparative negligence, which can be used effectively in the defense of some medical liability cases. This documentation should explain how the physician has addressed the patient’s noncompliance or refusal.

- Missed or cancelled appointments

For the same reason, in some circumstances, it is crucial to be able to prove whether or not the patient was seen by the physician. For example, the severity of “failure to diagnose” or “delay in diagnosis” allegations may be mitigated by proof of the patient’s failure to keep scheduled appointments. Therefore, documenting both missed and cancelled appointments in the patient’s record is important.

To document a missed appointment, enter the appointment date, the words “missed appointment” or “no show” and the initials of the person entering the note in the record. To document a canceled appointment, enter the date, the words “canceled appointment of (date)” and the initials of the person entering the note in the record. Any attempts by office staff to contact the patient to reschedule should also be documented in the record; at least two documented attempts should be made.
Under the HIPAA privacy rules, bills and correspondence about billing (unless this information is maintained in a separate section of the record) are considered part of the protected health information (PHI) or HIPAA “designated record set.”

The medical record should not include:

- Referrals to incident reports or to risk management, quality assurance and peer review activities or meetings
- Correspondence to or from your insurance company or attorney
- Assignment of blame to others or self-serving remarks
- Use of defensive sounding excuses, rationalizations or denials of wrongdoing, or words like “mistake,” “error,” or “inadvertent”
- Critical remarks about a patient’s personality or appearance that have no clinical relevance
- Alterations of any kind including late entries that are not clearly identified with the date upon which they were made.
- Subjective remarks

In general, good medical records are:

**Objective:** Documentation that includes objective facts that support the physician’s diagnosis, plan and treatment will be less open to misinterpretation by others. The record should reflect only information that is factual at the time of the entry; speculation or premature conclusions should be avoided.

**Timely:** To be credible, records must be contemporaneous with the events they describe. The credibility of what is written can be jeopardized if the notes are written weeks or months after the event. Dictation of operative reports and discharge summaries should be completed as close to the event as possible.

**Comprehensive:** The medical record is a valuable tool for patient care and defense of that care, but only if it is complete and accurate. The record should tell a story so that a third party could use the record to develop an accurate reconstruction of events. Each entry should include a date and the initials of the person writing the note.

**Legible:** Writing that is illegible can result in patient injuries and lead to malpractice litigation. Legible handwriting is especially important in group practices, and in hospitals where other health professionals rely on the written entries to treat patients or carry out orders. Physicians with poor handwriting are encouraged to dictate as many of their medical record notes as possible. In addition, dictated records tend to be more complete. If records are dictated and transcribed, physicians are encouraged to review the transcription notes to check for typographical errors. Using a stamp “signed but not read” does not absolve the physician from responsibility for record contents.
Descriptive: Use of vague terms such as “fair” or “better” does not accurately describe the patient’s condition and leaves room for misinterpretation.

Neat: Sloppy records can cause clinical errors if they cause difficulty in following the care rendered. In addition, third parties may assume that the sloppy records are reflective of the care provided.

Charting Methods

There are several charting methods used by physicians and other health care professionals to help ensure that the appropriate information is included in the record. One of the most commonly used methods is the SOAP format. The SOAP format and other problem-oriented charting styles help to prompt complete and consistent entries.

The SOAP format calls for a sentence to be recorded for each of the letters in the acronym. S = subjective data: the patient’s description of the symptoms or condition, i.e., the patient’s complaint; O = Objective findings: the description of the physician’s findings or observations about the patient, i.e., the history and exam; A = Assessment: a description of the physician’s assessment of the subjective complaints and objective findings; P = Plan: the physician’s plan for current and future treatment plans.

An alternative charting method is to employ a journalistic technique, using WHERE, WHY, WHAT, and HOW to record progress notes. For example, record entries reflect WHERE the patient has pain, WHY the patient has pain (i.e., the physical finding and diagnosis), WHAT the physician’s recommended treatment is and HOW the patient will be followed.

Regardless of the type of charting system, it is important that it be used consistently and that each note be complete and accurate.

Correction of Records

Changes to the medical record should be made only to correct an error or omission and only during the course of medical treatment, as close as possible to when the care was provided.

HIPAA also allows patients to ask for a correction of the record.

(See page 22 for specific information about accessing medical records resources, including HIPAA model policies and procedures.)

If a documentation error occurs, the proper way to make corrections is to draw a single line through the erroneous portion so that it can still be read. Larger portions may be corrected by drawing an “X” through the entire section. Erasures, the use of correction fluid, cutting and pasting, or total obliteration of information in the record should never be done. The word “error” should be written above the lined-out or crossed-out portion and the correction should be dated and initialed.
If, upon review of the record, the physician believes that important information was left out, an addendum to the record can be added. The addendum should be clearly dated with the current date and labeled, “Addendum to the note of (date of previous record).” The addition should be made in the next available space in the record. However, additions or addenda should be made infrequently and only if information subsequently remembered is important to the patient’s medical care.

Under no circumstances should the physician make changes or additions to the record if the physician suspects that a patient may bring suit, or if litigation has been initiated. A jury may view this as an admission of culpability even though the change may have been a legitimate attempt on the part of the physician to clarify the treatment rendered.

**Destruction of Records and Other Materials**

A physician can be held liable for the failure to provide medical records or other materials during a malpractice trial. This failure can generate a new lawsuit separate from the related malpractice claim if it can be shown that the “spoiled” evidence (missing records) has some bearing on the plaintiff’s ability to prove that the standard of care was not met. Allegations of “spoliation” may arise from the physician’s intentional destruction or alteration of evidence, the inadvertent loss or inability to find an item in the record, such as a lab report, or the failure to create a required record. Therefore, physicians are encouraged to review the medical record retention guidelines outlined within this brochure before making the decision to destroy any records.

Good documentation of patient care will not eliminate liability for injuries caused by lack of knowledge or technical errors. However, because the quality of documentation is assumed to reflect the clarity of clinical reasoning and attention to detail exercised by clinicians, excellent documentation is at the heart of a solid defense in peer review, utilization review and court. The investment of time, effort and practice in improving documentation can be invaluable.

**ACCESS TO MEDICAL RECORD RESOURCES**

For the most up-to-date model medical records forms, form letters, policies and procedures (including HIPAA) referenced in this document:

1. Go to [www.ismie.com](http://www.ismie.com)
2. Click on “Risk Management”
3. Click on “Resource Library”
4. Log in
5. Select “Medical Records Resources”

**OR**

1. Go to [www.isms.org](http://www.isms.org)
2. Click on “Member’s Center”
3. Click on “Medical Legal Library”
4. Log in
5. Select “Medical Records Resources”
On July 30, 2012, PA 97-0867 was signed by Governor Quinn. It amended the Code of Civil Procedure by modifying a recently-enacted section which allows for a new way of authorizing the release of a deceased patient’s records. The changes bring the law in line with HIPAA and clarify that personal representatives may not be charged a handling fee.

With the passage of the bill, when no executor or administrator of the decedent’s estate or power of attorney for health care agent exists and the decedent did not specifically object in writing to disclosing his or her medical records, then their records must be released upon written request of a person, who is considered to be a personal representative of the patient for the purpose of the release of a deceased patient’s health care records, in one of these categories:

1. The decedent’s surviving spouse
2. If there is no surviving spouse, then any one or more of:
   a. an adult son or daughter of the deceased,
   b. parent of the deceased, or
   c. adult brother or sister of the deceased.

Those enumerated persons must pay a statutory fee, present a copy of the decedent’s death certificate, and sign an “Authorized Relative Certification” in order to receive a copy of the records.

Health care facilities and practitioners who rely on a copy of a certification in good faith will have the same immunity from civil and criminal liability as those who rely on a power of attorney for health care.

Previously, a deceased person’s health care records were only released upon written request of the executor or administrator of the decedent’s estate or to their appointed health care power of attorney agent.

Attached is a model Authorized Relative Certification, adopted directly from the statute. Although using this form is not required, certification must be in a substantially similar form.

**MODEL AUTHORIZED RELATIVE CERTIFICATION**

I, (insert name of authorize relative), certify that I am an authorized relative of the deceased, (insert name of the deceased). (A certified copy of the death certificate must be attached.)

I certify that to the best of my knowledge and belief that no executor or administrator has been appointed for the deceased’s estate, that no agent was authorized to act for the deceased under a power of attorney for health care, and the deceased has not specifically objected to disclosure in writing.

I certify that I am the surviving spouse of the deceased; or

I certify that there is no surviving spouse and my relationship to the deceased is (circle one):

1. An adult son or daughter of the deceased
2. Either parent of the deceased
3. An adult brother or sister of the deceased

I certify that I am seeking the records as a personal representative who is acting in a representative capacity and who is authorized to seek these records under Section 8-2001.5 of the Code of Civil Procedure.

This certification is made under penalty of perjury.*

Dated: (insert date)

(Print Authorized Relative’s Name)

(Authorized Relative’s Signature)

(Authorized Relative’s Address)

735 ILCS 5/8-2001.5

*Note: Perjury is defined in Section 32-2 of the Criminal Code of 1961, and is a Class 3 felony.*
REFERENCES

1. 45 CFR § 164.506 (b).
2. 45 CFR § 164.512.
3. 45 CFR § 164.512(e).
4. 45 CFR § 160.103 definitions of “health information,” “individually identifiable health information,” and “protected health information.”
5. 45 CFR § 160.103 definition of “health information.”
7. 325 ILCS 10/1
8. 45 CFR § 164.506.
9. 45 CFR § 164.508(a); 740 ILCS 110/4 and 5; 410 ILCS 305.
10. 45 CFR § 164.520(c)(2)(i).
11. 750 ILCS 5/602.1
12. 735 ILCS 5/8-2001, as partially preempted by 45 CFR § 164.524(b).
13. 45 CFR § 160.103 definition of “health information.”
14. 45 CFR § 164.530(b)(1).
15. 735 ILCS 5/8-2001, as partially preempted by 45 CFR § 164.524(b).
17. 210 ILCS 85.
18. 210 ILCS 45/2-104; 77 Ill. Adm. Code § 300.1810-300.1850.
20. 740 ILCS 110.
22. 740 ILCS 110/7(c).
23. 740 ILCS 110/5(c).
24. 740 ILCS 110/5(b).
25. 740 ILCS 110/9.5.
26. 740 ILCS 110/4(a).
27. 410 ILCS 513/15.
28. 410 ILCS 513/30(a)(1).
29. 410 ILCS 513/30(a)(3).
30. 820 ILCS 305/8(a).
31. 820 ILCS 305/8(a).
32. 45 CFR § 164.528.
33. 745 ILCS 45/1; People v. Calvo (1982), 59 Ill. Dec. 639, 84 Ill. 2d 130; 432 N.E. 223.
34. 45 CFR § 164.528.
35. 410 ILCS 315; 77 Ill. Adm. Code Pr. 690; 20 ILCS 2305; 745 ILCS 45/1; People v. Calvo (1982), 59 Ill. Dec. 639, 84 Ill. 2d 130; 432 N.E. 223.
36. 45 CFR § 164.528.
37. 410 ILCS 325; 77 Ill. Adm. Code 693.30. See also, 410 ILCS 320/2.
38. 45 CFR § 164.528.
41. 410 ILCS 305/9; 77 Ill. Adm. Code 697.140.
42. 77 Ill. Adm. Code 697; 410 ILCS 315/2(a).
43. 325 ILCS 5/4.
44. 320 ILCS 20/4(a-5).
45. 20 ILCS 2435/20.
46. 325 ILCS 5/4; 320 ILCS 20/4(a-5).
47. 45 CFR § 164.528.
48. 735 ILCS 5/2-1101, 45 CFR § 164.512(e) (1).
49. 735 ILCS 5/2-1101, 45 CFR § 164.512(e) (1).
50. 45 CFR § 164.512(e)(1).
51. 735 ILCS 5/13-212(a).
52. 735 ILCS 5/13-212(b).
53. 735 ILCS 5/13-212(c).
55. 210 ILCS 85/6.17(c).
56. 210 ILCS 90/1.
57. 21 CFR § 900.12.
58. 420 ILCS 40/28.
60. 735 ILCS 5/13-212(c).
61. 740 ILCS 110.
62. 42 USC 300aa-25.
63. 42 CFR § 485.721.
64. 42 CFR § 485.721; Medicare’s Electronic Data Interchange (EDI) Agreement.
66. 210 ILCS 85/6.17(c).
67. 45 CFR § 164.530.
68. 735 ILCS 5/8-2003.on
69. 45 CFR § 164.530(j)(2).
70. 45 CFR § 160.103 definitions of “health information,” “individually identifiable health information,” and “protected health information.”

ISMS and ISMIE Mutual guidance: This is for educational purposes and is neither intended as nor should be considered legal advice or a standard of care.