	<b>POLICIES AND PROCEDURES</b>
<b>Policy #: HS 3.53</b>	<b>Lead Department: Health Services</b>
<b>Title: Medical Records</b>	
<b>Original Date: February 1996</b>	<b>Last Revision Date: July 2006</b>
<b>Approved by: Barbara Flynn, RN</b>	
<b>Applies to: All Lines of Business</b>	

***Policy Objective:***

To describe the Alliance guidelines for maintaining medical records at the primary care sites.

Each primary care office will be responsible for maintaining adequate medical records of patient care according to the Alliance policies outlined below.


***I. MEDICAL RECORD MAINTENANCE PROCEDURE***

**A. Responsibility:**


1. Each provider office must designate an individual responsible for the clinical record collection, processing, maintaining, storing, retrieving and distributing of clinical records.
2. The individual assigned the responsibility for medical records must have an understanding of the Alliance policies for medical record maintenance.
3. Other office staff must be knowledgeable of the medical record process so they may assist the individual responsible for medical records.
4. Staff will participate in ongoing training regarding member confidentiality and medical records. Each staff member must sign a confidentiality statement that is to be filed in the individual's personnel file.

**B. Filing and Retrieving:**

1. An individual chart for each member must be established.
2. All charts must be protected from loss, tampering, destruction, alteration and unauthorized or inadvertent disclosure of information.
3. Medical records must be filed in an organized manner so they may be retrieved easily when necessary. All papers included in each record must be secured in a manner to prevent loss of items, to include 'sticky notes'.

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #: HS 3.53</b>	<b>Lead Department: Health Services</b>
<b>Title: Medical Records</b>	
<b>Original Date: February 1996</b>	<b>Last Revision Date: July 2006</b>
<b>Approved by: Barbara Flynn, RN</b>	
<b>Applies to: All Lines of Business</b>	

4. Clinical reports must be reviewed by the clinical staff as soon as possible and follow-up of abnormal results documented in the medical record. Reports must be filed into the patient file within one week of receipt.
5. Clinical information must be stored in chronological order. The provider may file test reports (laboratory, radiology, etc.) separately in chronological order or they may be integrated into the body of the medical record. Tabs and dividers should be used to separate chart contents when necessary.
6. The following types of forms must be used for the capture of clinical information and must be filed in the chart in a consistently manner from member to member.
  - a. Data sheet (includes patient demographic information)
  - b. Problem list
  - c. Medication list
  - d. History form
  - e. Physical exam form or stamp
  - f. Pediatric growth charts (as appropriate)
  - g. Immunization summary
7. All medical records information must be kept confidential. Requests for clinical information must not be released except as specified in Section IV of this document.
8. The medical record must be available during a member's medical appointment.

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #: HS 3.53</b>	<b>Lead Department: Health Services</b>
<b>Title: Medical Records</b>	
<b>Original Date: February 1996</b>	<b>Last Revision Date: July 2006</b>
<b>Approved by: Barbara Flynn, RN</b>	
<b>Applies to: All Lines of Business</b>	

C. Storage:


1. Active medical records must be stored within the provider's office area, not in the patient waiting area, patient examining rooms, or other areas accessible to patients. A system must be developed to file each record for easy retrieval: patient last name, SSN or unique patient number, as established by the provider office.
2. Inactive records must be stored for a minimum of 7 years, and may be stored in a locked location off site. These records must be stored in such a manner that they may be retrieved easily if necessary.
3. Medical records with clinical information older than three (3) years may have the older file information stored in the inactive file location. These records must be stored in such a manner that they may be retrieved easily if necessary.
4. Records of minors must be kept at least until one year after the minor has reached the age of 18, but in no case less than seven years.
5. Records must be stored in such a way as to ensure confidentiality. After hours, the records should be secured in locked areas. If this is not possible, all after hours janitorial staff or other individuals with access to the building must sign a confidentiality release.

***II. CLINICAL RECORDS DOCUMENTATION STANDARDS***

A. Basic medical record format:

1. Individual chart for each member
2. Name, address, age (birthdate), sex, and phone number
3. Social security number
4. Name of nearest relative or other contact in case of emergency
5. Plan identification and Medi-Cal number


B. Clinical information:

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #: HS 3.53</b>	<b>Lead Department: Health Services</b>
<b>Title: Medical Records</b>	
<b>Original Date: February 1996</b>	<b>Last Revision Date: July 2006</b>
<b>Approved by: Barbara Flynn, RN</b>	
<b>Applies to: All Lines of Business</b>	

1. Medical history to include: current medical complaint or condition, known allergies, untoward reactions to drugs, past medical history, family history, significant health problems, personal habits (alcohol and/or tobacco use).
2. Vital signs, as clinically indicated, and the signature of the person performing these functions.
3. Initial physical examinations; subsequent physical exam findings as indicated.
4. Office laboratory procedures.
5. Office surgical procedures must be documented, including anesthetic used, and a statement whether a specimen was submitted for pathologic examination. A signed consent form for invasive procedures must be on file.
6. History of allergies on the problem list of medication list and on the chart cover. NOTE: Patients who have no known allergies will have this notation on the record.
7. Problem list must list chronic medical problems with the date the problem began noted.
8. A current list of the patient's medications for chronic medical problems must include name of the drug, dosage and frequency.

C. Other clinical information:

1. Dated laboratory, radiology and pathology reports with results/findings
2. Consultation reports.
3. Significant telephone advice provided by office staff.
4. Recent hospital histories, physicals and discharge summaries, regardless of whether or not the physician was the admitting provider.
5. Ambulatory surgery reports.
6. Emergency department encounters; progress notes or notation in record of the outcome/treatment plan and any follow up needs.
7. Patient education must be documented, including information on age appropriate preventive services.
8. Immunizations must be recorded, with documentation of the manufacturer and lot number of the vaccine.
9. TARs, RAFs, other administrative forms.

 <p>LA ALIANZA • THE ALLIANCE CENTRAL CALIFORNIA <b>ALLIANCE</b> FOR HEALTH</p>	<b>POLICIES AND PROCEDURES</b>
<b>Policy #: HS 3.53</b>	<b>Lead Department: Health Services</b>
<b>Title: Medical Records</b>	
<b>Original Date: February 1996</b>	<b>Last Revision Date: July 2006</b>
<b>Approved by: Barbara Flynn, RN</b>	
<b>Applies to: All Lines of Business</b>	


- D. Records must be signed by each staff person or health care provider at each encounter, including the first initial, last name and title of the person making the entry.
- E. The provider may use forms of their own choosing for documentation of medical care; however, the above policies for clinical record documentation are required.

**III. ON-SITE REVIEW OF MEDICAL RECORDS**

- A. The Medical records policies listed above will be used by the Alliance Quality Management Department to review provider records. These reviews will be conducted on an ongoing basis for randomly selected providers.

**IV. CONFIDENTIALITY OF MEDICAL INFORMATION**


- A. Definitions from the confidentiality of Medical Information Act of the California Civil Code Part 56.
  1. “Authorization” means permission granted for the disclosure of medical information.
  2. “Medical information” means any individually identifiable information in possession of or derived from a provider of health care regarding a patient’s medical history, mental or physical condition, or treatment.
  3. “Patient” means any natural person, whether or not still living, who received health care services from a provider of health care and to whom medical information pertains.
  4. “Provider of health care” means any person licensed or certified pursuant to the Business and Professions Code: any person licensed pursuant to the Osteopathic Act or the Chiropractic Act: any person licensed pursuant to the Health and Safety Code: any clinic, health dispensary, or health facility licensed pursuant to the Health and Safety Code: and any group practice prepayment health care service plan

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #: HS 3.53</b>	<b>Lead Department: Health Services</b>
<b>Title: Medical Records</b>	
<b>Original Date: February 1996</b>	<b>Last Revision Date: July 2006</b>
<b>Approved by: Barbara Flynn, RN</b>	
<b>Applies to: All Lines of Business</b>	


regulated pursuant to the Knox-Keene Health Care Service Plan Act of the Health and Safety Code.

B. Medical information may be disclosed by providers as follows:

1. No provider of health care shall disclose medical information regarding a patient of the provider without first obtaining an authorization, except as provided in (2) or (3) to follow.
2. A provider of health care shall disclose medical information if the disclosure is compelled by any of the following:
  - a. By a court, pursuant to an order of the court.
  - b. By a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority.
  - c. By a party to a proceeding before a court or administrative agency.
  - d. By a board, commission, or administrative agency pursuant to an investigative subpoena issued under the Government Code.
  - e. By an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum issued under the Code of Civil Procedure, or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.
  - f. By a search warrant lawfully issued to a government law enforcement agency.
  - g. When otherwise specifically required by law.
3. A provider of health care may disclose medical information as follows:


	<b>POLICIES AND PROCEDURES</b>
<b>Policy #: HS 3.53</b>	<b>Lead Department: Health Services</b>
<b>Title: Medical Records</b>	
<b>Original Date: February 1996</b>	<b>Last Revision Date: July 2006</b>
<b>Approved by: Barbara Flynn, RN</b>	
<b>Applies to: All Lines of Business</b>	

- a. The information may be disclosed to providers of health care or other health care professionals or facilities for purposes of diagnosis or treatment of the patient.
  
- b. The information may be disclosed to an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, or any other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payment to be made. The information may also be disclosed to another provider as necessary to assist the other provider in obtaining payment for health care services rendered by the provider to the patient.
  
- c. The information may be disclosed to any person or entity that provider billing, claims management, medical data processing or other administrative services for providers or for any of the persons or entities specified in paragraph (b) above. However, no information so disclosed shall be further disclosed by the recipient in any way, which would be violative of this part.
  
- d. The information may be disclosed to organized committees and agents of professional societies or of medical staffs of licensed hospitals, or to professional standards review organizations, or to persons or organizations insuring, responsible for, or defending professional liability which a provider may incur, if the committees, agents organizations, or persons are engaged in reviewing the competence or qualification of health care professionals or in reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges.
  
- e. The information in the possession of any provider of health care may be reviewed by any private or public body responsible for licensing or accrediting such provider of health care. However, no patient identifying medical information may be removed

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #: HS 3.53</b>	<b>Lead Department: Health Services</b>
<b>Title: Medical Records</b>	
<b>Original Date: February 1996</b>	<b>Last Revision Date: July 2006</b>
<b>Approved by: Barbara Flynn, RN</b>	
<b>Applies to: All Lines of Business</b>	

from the premises except as expressly permitted or required elsewhere by law.

- f. The information may be disclosed to the county coroner in the course of an investigation by the coroner's office.
  - g. The information may be disclosed to public agencies, clinical investigators, health care research organizations, and accredited public or private nonprofit education or health care institutions for bona fide research purposes. However, no information so disclosed shall be further disclosed by the recipient in any way, which would permit identification of the patient.
- C. All authorization for the release of medical information by a provider or health care shall be valid if it:
- 1. Is handwritten by the person who signs it or it is typed.
  - 2. Is clearly separate from any other language present on the same page and is executed by a signature which serves no other purpose than to execute the authorization.
  - 3. Is signed and dated by one of the following:
    - a. The patient. A patient who is a minor may only sign an authorization for the release of medical information obtained by a provider of health care in the course of furnishing services to which the minor could lawfully have consented under the Civil Code.
    - b. The legal representative of the patient, if the patient is a minor or incompetent. However, authorization may not be given under this subdivision for the disclosure of medical information obtained by the provider of health care in the course of furnishing services to which a minor patient could lawfully have consented under the Civil Code.

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #: HS 3.53</b>	<b>Lead Department: Health Services</b>
<b>Title: Medical Records</b>	
<b>Original Date: February 1996</b>	<b>Last Revision Date: July 2006</b>
<b>Approved by: Barbara Flynn, RN</b>	
<b>Applies to: All Lines of Business</b>	

- c. The spouse of the patient or the person financially responsible for the patient, where the medical information is being sought for the sole purpose of processing and application for health insurance or for enrollment in a nonprofit hospital plan, a health care service plan, or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan.
  - d. The member or personal representative of a deceased patient.
4. States the specific uses and limitations on the types of medical information to be disclosed.
  5. States the name of functions of the provider of health care that may disclose the medical information.
  6. States the name of functions of the persons or entities authorized to receive the medical information.
  7. States the specific uses and limitations on the use of the medical information by the persons or entities authorized to receive the medical information.
  8. States a specific date after which the provider of health care is no longer authorized to disclose the medical information.
  9. Advises the person signing the authorization of the right to receive a copy of the authorization.
- D. Upon demand by the patient or the person who signed an authorization, a provider of health care possessing the authorization shall furnish a true copy of the authorization.
  - E. Unless there is specific written request by the patient to the contrary, a provider, upon an inquiry concerning a specific patient, may release at their discretion any of the following information: the patient's name, address, age, and sex; a general description of the reason for treatment (whether an injury, a burn, poisoning, or other condition); the general nature of the injury, burn,



**POLICIES AND PROCEDURES**

<b>Policy #: HS 3.53</b>	<b>Lead Department: Health Services</b>
<b>Title: Medical Records</b>	
<b>Original Date: February 1996</b>	<b>Last Revision Date: July 2006</b>
<b>Approved by: Barbara Flynn, RN</b>	
<b>Applies to: All Lines of Business</b>	

poisoning, or other condition; the general condition of the patient; and any information that is not medical information.

**Revision History:**

<b>Review Date</b>	<b>Revised Date</b>	<b>Approved By</b>
<b>December 1998</b>		<b>Barbara Flynn, RN</b>
<b>July 2000</b>		<b>Barbara Flynn, RN</b>
<b>July 2002</b>		<b>Barbara Flynn, RN</b>
<b>July 2006</b>		<b>Barbara Flynn, RN</b>