Patient Records

The medical record serves three primary purposes: communication, documentation for billing, and to demonstrate quality of care (or lack thereof). They facilitate communication between health care team members, document telephone messages, document follow up on consultation recommendations, pertinent negatives in HPI, H & P and family history, include dose, quantity, frequency and refills for medications ordered, list tests and procedures ordered and results reviewed, document progress of treatment, missed and follow up appointments, clearly describe medical analysis and decision making, and document risk/benefit and options discussed as well as informed consent. Records must also reflect actual service performed so that billing, diagnosis and procedure codes are supported by the records.

Records must be legible, accurate, complete, timely and properly corrected, and signed in order to achieve their purposes. They must be maintained at least 7 years from the date of the last office visit and longer is recommended for obstetrics and pediatric patients. Old records must be destroyed/disposed of properly. Alteration of medical records, including late additions without proper identification and dating can constitute a criminal offense and provide grounds for discipline.

Treatment of friends and family in a casual setting is the practice of medicine and requires that a medical record be kept, even if stored in your home.

Upon request, patient records must be released within 30 days of the request (a thorough summary can substitute). You must also release prior treatment records generated by a different provider or facility that are in your possession. You may charge $1.00/page up to $100 maximum, whichever is less. You may charge for the duplication of non-routine materials at your cost + $10 or 10%, whichever is less. If a record is under 10 pages, $10 may be charged for that record. Situations in which you may not charge a fee for records include:

- when you terminate a patient from your practice
- when an established patient follows a physician to another practice
- for the translation or transcription of illegible records
- for completing temporary disability forms
- when you cease practice or when you leave practice for more than 3 months
- when you close your office/practice