BULLHOOK
Community Health Center

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POLICY

MEDICAL RECORDS **3017**

The medical record serves as a permanent record of an individual's health, the documentation of problems and their treatment and/or resolution. For this reason, the utmost care is to be given to the maintenance and safeguarding of the medical records chart on each individual patient. Bullhook Community Health Center medical records are all electronic. Access is granted by staff members role in the clinic and monitored by the clinical coordinators running audits to assure that only the appropriate staff are entering and/or documenting in the patient records. All paper medical records are to be stored in the medical records room, that is fire proofed and locked at all times, these records will be kept until the appropriate date of destruction.

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Each individual patient who is seen in/at Bullhook Community Health Center will have a medical chart unique to that patient. These charts are currently kept through Electronic Health Records (EHR). Each patient seen at Bullhook Community Health Center will sign a consent for treatment and fill out a basic information sheet providing full name, current address, telephone number, place of employment, insurance, etc. They will also complete a HIPAA Patient Consent and Notification form. These forms will be scanned into the EHR and marked as completed so that appropriate billing and data collection can be carried out. The information sheets will be updated on a yearly basis.

The EHR will include when applicable: Identification and social data, Consent forms, Pertinent medical history, Assessment of the health status and care needs of the patient, A Brief summary of the episode, Disposition and instructions to the patient, Reports of physical examinations, Diagnostic and laboratory results, Consultations, Physician's order, Reports of treatment, medication and other pertinent information necessary to monitor the patient's progress. Electronic signatures will also be included.

MAINTENANCE OF THE MEDICAL RECORD:

It shall be the responsibility of the Bullhook Community Health Center provider to maintain the medical records and to ensure that they are completely and accurately documented, readily accessible, and systematically organized. Provider notes will be placed within the EHR within 24 hours of the patient encounter. All lab, x-ray and other medical information will be scanned into the health record immediately after their inspection by the examining provider. This includes letters from consulting providers and previous medical records from providers. All entries will be marked to show who documented or scanned the records into the permanent electronic chart.

ACCESSIBILITY OF MEDICAL RECORDS:

Confidentiality of all documentation in each patient's medical record will be maintained at all times at the highest level of professional standards and in compliance with all State and Federal Regulations. The

medical records will be available and accessible only to the staff and provider of Bullhook Community Health Center. Training of new employees will include security and confidentiality of the medical record.

Copies of medical records will be available to each patient or in the case of a minor, his/her legal guardian, at any time upon the patient or guardians request. Copies of patient medical records will only be released to specific parties upon receipt of a signed release for medical information which clearly designates what records may be released and to whom the records may be released. Patient records will be released to other providers for continuity of care in accordance with CFR42 and all applicable guidelines.

If subpoena is received requesting medical information, the information may be released if Bullhook Community Health Center has received satisfactory assurance that reasonable efforts have been made by the party requesting the information to notify the subject whose medical information is being disclosed. Satisfactory assurance consists of a written statement and accompanying documentation that:

1. The party requesting the information has provided written notice to the individual whose record is being requested.
2. The notice included sufficient information about the litigation or proceeding to permit the individual to object to the release if so desired.
3. The time for the individual to raise objections to the court or administrative body has elapsed.

A reasonable fee per page will be charged for the copies of the medical records in question where allowed by law.

Medical information may be released in response to a qualified protective order, provided that a written statement and accompanying documentation are received demonstrating that:

1. The parties have agreed to a qualified protective order from the court or administrative tribunal.
2. The parties have requested a qualified protective order from the court or administrative tribunal.

No medical records may leave the premises of Bullhook Community Health Center without the express consent of the Chief Executive Officer i.e. laptops with access to the electronic medical record. Every attempt will be made to safeguard the information contained in the medical record and to maintain its confidentiality whether in paper or electronic format.

Please refer to Policy 2016 for retention of record. Any patient that has Medicare Insurance will be kept for ten (10) years after last activity or death. Active records in paper format will be kept in the medical records room. Inactive records will be stored in a secure, locked room. Medical records or any document containing patient information will be destroyed by shredding.

Cindy Smith
CHIEF EXECUTIVE OFFICER

Date 10-17-17

Carol A. Rephlo
CHAIR, BOARD OF DIRECTORS

Date 10-9-17

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