PURPOSE:

The Medical Record is compiled and kept for the benefit of the patient, the physician, and the hospital. As such, the record is an integral part of patient care, as well as an important legal document. In view of the vital nature of the content of the medical record, it is imperative that controls are established to ensure the security of the record and to assure accessibility to the record at all times. In addition, the professional data contained within the medical record are considered confidential communications between the patient and the physician. As such, data from the medical record are also confidential between the patient and all hospital personnel, and this confidentiality must be preserved by all.

The Medical Records Department's primary responsibility is to the patient whose record it maintains, preserving and protecting their records and holding inviolate the privileged contents. As part of meeting these responsibilities, the hospital must restrict the removal of the record from the Medical Records Department and define the kinds of information that may be taken from the record.

POLICY:

Medical records shall not be removed from hospital premises except upon receipt of a subpoena, at which time an authorized employee will follow designated procedures for the preservation of the record.

Medical records shall not be taken from the Medical Records Department to other areas of the hospital, except as outlined in this policy. Exception: records sent to off-site storage when HMH space becomes limited.

Requests for the release of confidential information contained within the medical record, received by another department, are to be referred to the Medical Records Department, to assure that proper methods are exercised in protecting the patient's privacy.
PROCEDURE:

I. REMOVAL OF THE MEDICAL RECORD FROM THE MEDICAL RECORD DEPARTMENT

A. Medical records may be signed out to the following departments for the purpose of continuity of patient care:

1. **Patient Care Units**: When a patient has been admitted to Huntington Memorial Hospital.

2. **Outpatient/Clinic Department**: When a patient has an appointment or has come to the clinic for treatment.

3. **Emergency Room**: When a previous patient record is needed for patient care.

4. **Risk Management**: When a chart needs to be reviewed by the risk management coordinator.

5. **Quality Management**: When a chart needs to be processed for the purposes of peer review.

6. **Utilization Management**: When a chart needs to be reviewed by Medi-Cal for utilization review and payment approval process.

B. Once a medical record has been signed out the following rules apply -

1. The Medical Records Department cannot assume responsibility for maintaining records outside the confines of the department. Until the record is returned, the last person requesting the record will be held responsible for the chart, and the confidentiality of the information contained within the chart.

2. Records signed out to a given area will be kept in one designated secure location.

3. Records will not be removed from the area to which they have been signed out. No physician may be allowed to remove the record from an assigned area of responsibility; i.e., Medical Records Department, Outpatient Department, and Nursing Units.

4. If the patient is transferred from one patient care area to another within HMH, the record is transferred with the patient. Failure to notify Medical Records of any such transfer maintains responsibility for that record at the area the record was originally signed out to, and that area will be responsible for locating that record and returning it to Medical Records.
5. Records that must accompany patients going to other facilities for diagnostic tests are to be Xerox copies only. The original record shall never be removed from the hospital.

6. Upon patient discharge, inpatient records will be picked up and delivered to the Medical Records Department within 24 hours. (Records not available at that time must be forwarded to the medical record department within 2 hours or a call will be placed to the medical records department at x5054 with a status report. Records are NEVER sent via the tube system.)

**EXCEPTION:** Records of expired patients will be sent immediately to Decedent Affairs in Medical Records.

If an autopsy has been requested, and a properly executed Autopsy Permit has been obtained, the charts and two copies of the autopsy permit will be picked up by Pathology Department. Pathology may retain the chart for two days to abstract the clinical history for the autopsy protocol.

7. All records will be returned to the Medical Records Department from Outpatient/Clinic and the Emergency Department within 24 hours of the time the record was sent out.

8. All records normally kept in the Dispensary/Clinic area are to be returned to that area within 24 hours of the time the record was sent out. The medical record again becomes the responsibility of the Medical Records Department once it has been returned to the department.

C. Medical records may be signed out to the following departments for purposes of evaluation of medical care and continuing education:

1. **Pathology Department:** For a period of two days.

2. **Business Office:** Signed out in the morning, to be returned the same day.

3. **Conferences and Meetings:** Records will be signed out the day of the meeting, to be returned immediately following the meeting.

4. **Utilization Management:** May receive a record upon request for a period of two days.

4. **Quality Management:** May take records to Medical Staff meetings, to be returned immediately following the meeting.
II. ACCESS TO THE MEDICAL RECORD: All other physicians and hospital personnel requiring access to the medical record for the completion of their routine work will be allowed to review records in the confines of the Medical Records Department. Charts will be pulled for review within 24 hours of the request.

III. "LOST" OR "MISSING" RECORDS: After diligent searches to locate a record have proven fruitless, "lost" or "missing" records should be reported via the Occurrence Reporting System.

REFERENCE: Joint Commission Standard (IM 02.02.03)

SOURCE: Medical Records Department