

SWEET MEDICAL CENTER POLICY & PROCEDURES MANUAL

CLINICAL

MEDICAL RECORDS

The medical record serves as a record of an individual's health and the documentation of problems and their treatment and/or resolution. For this reason, the utmost care is to be given the maintenance and safeguarding of the medical record on each individual patient. The electronic medical records (EMR) terminal server will be backed up each day and the tape stored in the safe deposit box at First Bank of Montana in Chinook. All paper medical records and the EMR server are to be housed within the main desk area, which is enclosed by two (2) fire doors. It is the responsibility of the Receptionist to make sure this area is secured upon the completion of normal clinic hours and/or evacuation of all personnel in the event of Fire Drill, report of Fire, Bomb Threat or Disgruntled employee/visitor by closing both fire doors upon assurance of evacuation.

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Each individual patient who is seen in the Sweet Medical Center will have a medical record, unique to that patient. Patients new to Sweet Medical Center, Inc. after September 1, 2008 will have only an EMR established. Patients who were served by Sweet Medical Center, Inc. prior to that date will have a historical paper chart, but all new information will be stored in the EMR.

Each patient seen at SMC will sign a consent form and fill out a basic information sheet, providing full name, current address, marital status, place of employment, insurance coverage, etc so that appropriate billing activities may be carried out. Each individual patient who is seen in the Sweet Medical Center will complete a HIPAA Patient Consent Form and Notification Form. These information sheets will be scanned into the electronic record as a permanent document..

The medical record will include as applicable: identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition and instructions to the patient; reports of physical examination, diagnostic and laboratory test results and consultative findings; all physician's orders, reports of treatment and medications and other pertinent information necessary to monitor the patient's progress; signatures of the physician or other health care professionals. Electronic signatures are acceptable.

Maintenance of the Medical Record

It shall be the responsibility of the physician and/or physician's assistant to ensure that patient visits are completely and accurately documented. Office notes will be entered into

the medical record within a reasonable amount of time. All lab and x-ray reports will be scanned into the EMR after their inspection by the examining physician or physician's assistant. Letters obtained from consulting physicians will be scanned into the medical record as soon as possible after perusal by the attending physician or physician's assistant. Clinical personnel other than providers will initial all entries that they make in the electronic medical record as they are entered.

Accessibility of Medical Records

Confidentiality of all material contained within each patient's medical record will be maintained at the highest professional standards and, at all times. A patient's medical record will be available only to the staff and attending physicians of SMC. Each employee will be advised that use of the medical record will be confined to activities applicable to duties within the clinic itself.

Copies of medical records will be available to each patient or in the case of a minor, to his/her legal guardian at any time on the patient's request. Copies of the patient's medical record will only be released to specified parties upon receipt of a signed release for medical information, designating what records may be released and to whom the records may be released.

If a subpoena is received requesting medical information, the information may be released if Sweet Medical Center, Inc. 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 demonstrates that

- The party requesting the information has provided written notice to the individual whose information is being sought.
- The notice included sufficient information about the litigation or proceeding to permit the individual to raise an objection.
- The time for the individual to raise objections to the court of administrative body has elapsed.

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

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

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No paper medical record may leave the clinic premises and no information from the EMR may be transmitted from the clinic without the express consent of the Administrator. Every attempt will be made to safeguard the information contained in the medical record and to maintain its confidentiality.

Medical records shall be kept for six (6) years after death or six (6) years after the date of last activity unless the patient is a minor. If the patient is a minor, the record shall be kept until the patient will have reached the age of 18 plus five (5) years. Inactive records will be stored in a secure, locked room. Paper medical records will be destroyed by shredding.

Approved: _____
(Date)

Chair, Board of Directors