

CHAPTER 115. MEDICAL RECORD SERVICES**GENERAL PROVISIONS**

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Cross References

This chapter cited in 28 Pa. Code § 117.52 (relating to minimum requirements for sexual assault emergency services); 28 Pa. Code § 127.35 (relating to patient care records); 28 Pa. Code § 129.37 (relating to patient records); 28 Pa. Code § 131.24 (relating to patients' medical records); 28 Pa. Code § 139.28 (relating to patient medical records); and 28 Pa. Code § 141.26 (relating to patient dental records).

GENERAL PROVISIONS**§ 115.1. Principle.**

The hospital shall maintain facilities and services adequate to provide medical records which are accurately documented and readily accessible to authorized persons requiring such access and which can be readily used for retrieving and compiling information.

§ 115.2. Organization and staffing.

A hospital shall have a medical record service. It shall be directed, staffed and equipped to ensure the accurate processing, indexing and filing of all medical records.

§ 115.3. Director.

(a) The medical records service shall be under the direction and supervision of a certified medical records practitioner. If no certified person is available on a full-time basis, a certified person shall be employed on a part-time or consulting basis.

(b) The director of the medical record service should advise, administer, supervise, and perform work involved in the development, analysis, maintenance and use of medical records and reports.

(c) When the director is employed on a part-time or consulting basis, he shall organize the department, train the regular personnel, and make periodic visits to the hospital to evaluate the records and the operation of the service. A written contract specifying his duties and responsibilities shall be kept on file and made available for inspection by the Department's surveyor.

Authority

The provisions of this § 115.3 issued under section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)); and section 803 of the Health Care Facilities Act (35 P. S. § 448.803).

Source

The provisions of this § 115.3 amended through December 3, 1982, effective December 4, 1982, 12 Pa.B. 4129. Immediately preceding text appears at serial page (52797).

§ 115.4. Medical record personnel.

At least one full-time or part-time employe shall provide regular medical service. Other personnel shall be employed as needed to effectively perform the functions assigned to the medical record department.

Authority

The provisions of this § 115.4 issued under 67 Pa.C.S. §§ 6101—6104 (Repealed); and Reorganization Plan No. 2 of 1973 (71 P. S. § 755-2) (Renumbered).

Source

The provisions of this § 115.4 amended September 19, 1980, effective September 20, 1980, 10 Pa.B. 3761. Immediately preceding text appears at serial page (37833).

§ 115.5. Education programs.

The hospital shall provide orientation, on-the-job training, and regular in-service, either hospital-based or outside the hospital, education programs for medical records personnel. Employees should be encouraged to participate in job-related workshops, institutes or correspondence education courses available outside the hospital.

§ 115.6. Job descriptions.

There shall be written job descriptions for all medical records personnel which are made available to them.

FACILITIES**§ 115.11. Principle.**

The medical record service shall be properly equipped to enable its personnel to function in an effective manner and to maintain medical records so that they are readily accessible and secure from unauthorized use.

POLICIES AND PROCEDURES FOR MEDICAL RECORDS SERVICE**§ 115.21. Identification and filing of medical records.**

The medical record service shall maintain a system of identification and filing to facilitate the prompt location of the medical record of a patient.

§ 115.22. Storage of medical records.

Medical records shall be stored in such a manner as to provide protection from loss, damage and unauthorized access.

§ 115.23. Preservation of medical records.

(a) Medical records, whether original, reproductions or microfilm, shall be kept on file for a minimum of 7 years following the discharge of a patient.

(b) If the patient is a minor, records shall be kept on file until his majority, and then for 7 years or as long as the records of adult patients are maintained.

(c) If a hospital discontinues operation, it shall make known to the Department where its records are stored. Records are to be stored in a facility offering retrieval services for at least 5 years after the closure date. Prior to destruction, public notice shall be made to permit former patients or their representatives to

claim their own records. Public notice shall be in at least two forms, legal notice and display advertisement in a newspaper of general circulation.

Authority

The provisions of this § 115.23 issued under 67 Pa.C.S. §§ 6101—6104; and Reorganization Plan No. 2 of 1973 (71 P. S. § 755-2).

Source

The provisions of this § 115.23 amended September 19, 1980, effective September 20, 1980, 10 Pa.B. 3761. Immediately preceding text appears at serial page (37834).

Cross References

This section cited in 28 Pa. Code § 139.28 (relating to patient medical records).

§ 115.24. Microfilming medical records.

Medical records may be microfilmed immediately after completion. Microfilming may be done on or off the premises. If done off the premises, the hospital shall take precautions to assure the confidentiality and safekeeping of the records. The original of microfilmed medical records shall not be destroyed until the medical records department has had an opportunity to review the processed film for content.

Authority

The provisions of this § 115.24 issued under section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)); and section 803 of the Health Care Facilities Act (35 P. S. § 448.803).

Source

The provisions of this § 115.24 amended through December 3, 1982, effective December 4, 1982, 12 Pa.B. 4129. Immediately preceding text appears at serial page (55622).

§ 115.25. Infant footprints.

The imprint of infant footprints shall be retained. Microfilm records are acceptable to meet this requirement.

§ 115.26. Automation of medical records.

Nothing in this subpart shall be construed to prohibit the use of automation in the medical records service, provided that all provisions in this chapter are met and the information is readily available for use in patient care. Innovations in medical record formats, compilation and data retrieval are specifically encouraged.

§ 115.27. Confidentiality of medical records.

All records shall be treated as confidential. Only authorized personnel shall have access to the records. The written authorization of the patient shall be pre-

mented and then maintained in the original record as authority for release of medical information outside the hospital.

Notes of Decisions

Assertion of Confidentiality Privilege

Since a hospital owes a duty to limit access to the medical records of its patients, it is proper to consider a claim of physician-patient privilege by a hospital when its medical records are subpoenaed, even though such right or privilege is ordinarily properly asserted only by the patient. *In re June 1979 Allegheny County Investigating Grand Jury*, 415 A.2d 73 (Pa. 1980).

Evidence Not Excluded

Blood alcohol test results which were reported to a police officer were not suppressed under the exclusionary rule in that the patient's rights were violated by the nurse who volunteered the information as a private individual, not the police officer. *Commonwealth v. Ellis*, 608 A.2d 1090 (Pa. Super. 1992); appeal denied 620 A.2d 489 (Pa. 1993).

Argument by a defendant, charged with driving under the influence, that medical purposes blood test should have been suppressed by hospital personnel in accordance with confidentiality regulations failed because the regulations governing confidentiality were subject to the exceptions contained in the Motor Vehicle Code which provide that no hospital or medical personnel may refuse to perform or provide the results of a blood alcohol test when requested by a police officer. *Commonwealth v. Hipp*, 551 A.2d 1086 (Pa. Cmwlth. 1988).

Cross References

This section cited in 28 Pa. Code § 115.28 (relating to ownership).

§ 115.28. Ownership.

Medical records are the property of the hospital, and they shall not be removed from the hospital premises, except for court purposes. Copies may be made available for authorized appropriate purposes such as insurance claims, and physician review, consistent with § 115.27 (relating to confidentiality of medical records).

Notes of Decisions

Subpoena

The provisions of this section do not cover a situation where a subpoena has been issued for medical records where there is no case yet before a court, so the records obtained under such a subpoena were suppressed. *Commonwealth v. Jolly*, 486 A.2d 515 (Pa. Super. 1984).

Since medical records are the property of the hospital, not each individual patient, and are to be removed from hospital premises only for court purposes, a subpoena for the production of such records was properly served on the hospital. *In re June 1979 Allegheny County Investigating Grand Jury*, 415 A.2d 73 (Pa. 1980).

§ 115.29. Patient access.

Patients or patient designees shall be given access to or a copy of their medical records, or both, in accordance with § 103.22(b)(15) (relating to implementation). Upon the death of a patient, the hospital shall provide, upon request, to the executor of the decedent's estate or, in the absence of an executor, the next of kin responsible for the disposition of the remains, access to all medical records of the deceased patient. The patient or the patient's next of kin may be charged for the

cost of reproducing the copies; however, the charges shall be reasonably related to the cost of making the copy.

Authority

The provisions of this § 115.29 issued under section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)); and section 803 of the Health Care Facilities Act (35 P. S. § 448.803).

Source

The provisions of this § 115.29 amended through December 3, 1982, effective December 4, 1982, 12 Pa.B. 4129. Immediately preceding text appears at serial page (55623).

Notes of Decisions

Health Care Facilities Act

Inmate who avers right to copies of his medical records at cost reasonably related to cost of making copies pursuant to regulation that pertains to patient access to medical records and to health care facilities as defined in the Health Care Facilities Act failed to state a claim because inmate does not allege he is a patient as defined by the Act or that Department of Corrections operates a health care facility within the meaning of the Act. *Richardson v. Beard*, 942 A.2d 911, 914-915 (Pa. Cmwlth. 2008)

Illustrative Cases

Requiring a patient to sign a release of liability in exchange for medical records violated the public policy of freely accessible records underlying this section. *Soxman v. Goodge*, 539 A.2d 826 (Pa. Super. 1988).

Subpoena

Since medical records are the property of the hospital, not each individual patient, and are to be removed from hospital premises only for court purposes, a subpoena for the production of such records was properly served on the hospital. *In re June 1979 Allegheny County Investigating Grand Jury*, 415 A.2d 73 (Pa. 1980).

Standing

The plaintiff-clients, whose attorneys purchased photocopies of the clients' hospital records for the purpose of prosecuting their clients' personal injury and medical malpractice claims, did not have standing to bring a treble-damages claim because they are not "direct purchasers," as required by *Illinois Brick Co. v. Illinois*, 431 U. S. 720, 52 L. Ed. 2d 707, 97 S. Ct. 2061 (1977). However, these clients are not barred from seeking injunctive relief under section 16 of the Clayton Act. *McCarthy v. Recordex Service*, 80 F.3d 842 (3d Cir. 1996), cert. denied, 136 L.Ed. 2d 42 (U. S. 1996).

POLICIES AND PROCEDURES FOR PATIENT MEDICAL RECORDS

§ 115.31. Patient medical records.

(a) An adequate medical record shall be maintained for every inpatient, outpatient and patient treated or examined in the emergency unit. This record shall contain data from all episodes of care and treatment of the patient whether services were performed on an inpatient basis, on an outpatient basis, or in the emergency unit. The unit record system should be used whenever feasible. When it is not feasible or appropriate to combine all inpatient, outpatient and emergency records of an individual patient into a unitary record, a system shall be established to:

(1) Assemble, when necessary, all divergently located record components when an inpatient is admitted to the hospital or appears for a prescheduled outpatient appointment.

(2) Require placing copies of pertinent portions of an inpatient's medical record, such as the discharge resume, the operative note and the pathology report, in the outpatient or combined outpatient/emergency unit record file.

(b) A patient's medical records shall be complete, readily accessible and available to the professional staff concerned with the care and treatment of the patient.

Authority

The provisions of this § 115.31 issued under 67 Pa.C.S. §§ 6101—6104; and Reorganization Plan No. 2 of 1973 (71 P. S. § 755-2).

Source

The provisions of this § 115.31 amended September 19, 1980, effective September 20, 1980, 10 Pa.B. 3761. Immediately preceding text appears at serial page (37836).

Cross References

This section cited in 28 Pa. Code § 117.43 (relating to medical records); 28 Pa. Code § 119.24 (relating to patient medical records); 28 Pa. Code § 135.13 (relating to patient's medical record; pre-operative procedures); and 49 Pa. Code § 16.95 (relating to medical records).

§ 115.32. Contents.

(a) The medical record shall contain sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately.

(b) If a member of the hospital's medical staff has performed a physical examination consistent with the medical staff bylaws within 30 days prior to a patient's admission to the hospital, a reasonably durable, legible copy of the record of this examination may be used in lieu of an admission history and report of physical examination. An interval admission note shall, however, be recorded, including any additions to the history and any subsequent changes in the physical findings.

(c) If the patient was admitted to another hospital within 30 days prior to his admission, the medical staff or attending physician shall determine whether to record its own complete history and physical examination. The hospital shall, with the written authorization of the patient, request the records of the previous admission from the other hospital as soon as possible.

(d) A medical record shall include notes by authorized house staff members and individuals who have been granted clinical privileges, consultation reports, nurses' notes and entries by specified professional personnel.

(e) A medical record shall include the findings and results of any pathological or clinical laboratory examinations, radiology examinations, medical and surgical treatment, and other diagnostic or therapeutic procedures.

(f) A medical record shall include a provisional diagnoses; primary and secondary final diagnoses, the latter if necessary; a clinical resume; and, where appropriate, necropsy reports.

Authority

The provisions of this § 115.32 issued under 67 Pa.C.S. §§ 6101—6104; and Reorganization Plan No. 2 of 1973 (71 P. S. § 755-2).

Source

The provisions of this § 115.32 amended September 19, 1980, effective September 20, 1980, 10 Pa.B. 3761. Immediately preceding text appears at serial page (37837).

Cross References

This section cited in 28 Pa. Code § 119.24 (relating to patient medical records); 28 Pa. Code § 135.13 (relating to patient's medical record; preoperative procedures); 28 Pa. Code § 157.23 (relating to patient records); 28 Pa. Code § 711.43 (relating to client records); 28 Pa. Code § 711.53 (relating to client records); 28 Pa. Code § 711.62 (relating to client records); 28 Pa. Code § 711.72 (relating to client records); 28 Pa. Code § 711.83 (relating to client records); 28 Pa. Code § 711.93 (relating to client records); and 49 Pa. Code § 16.95 (relating to medical records).

§ 115.33. Entries.

(a) All significant clinical information pertaining to a patient shall be incorporated in the patient's medical record.

(b) Entries in the record shall be dated and authenticated by the person making the entry.

(c) Symbols and abbreviations may be used only when they have been approved by the medical staff and when there exists a legend to explain them.

(d) Oral orders shall include the date and signature of the person recording them. They shall be given and authenticated in accordance with the provisions of § 107.62 (relating to oral orders). All other orders shall be recorded in accordance with the provisions in §§ 107.61 and 107.62—107.65 (relating to medical orders).

(e) A single signature on the face sheet of a record shall not suffice to authenticate the entire record. Each entry shall be individually authenticated.

(f) Notation of unusual incidents shall be entered in accordance with the provisions of § 109.37 (relating to unusual incidents) and Chapter 151 (relating to fire, safety and disaster services).

(g) Records of patients discharged shall be completed within 30 days following discharge.

Authority

The provisions of this § 115.33 issued under 67 Pa.C.S. §§ 6101—6104; and Reorganization Plan No. 2 of 1973 (71 P. S. § 755-2).

Source

The provisions of this § 115.33 amended September 19, 1980, effective September 20, 1980, 10 Pa.B. 3761. Immediately preceding text appears at serial page (37838).

Cross References

This section cited in 28 Pa. Code § 119.24 (relating to patient medical records); 28 Pa. Code § 135.13 (relating to patient's medical record; preoperative procedures); and 49 Pa. Code § 16.95 (relating to medical records).

§ 115.34. Medical records review.

(a) Medical records shall be reviewed periodically in accordance with medical staff bylaws, rules and regulations by the medical records committee, or its equivalent, established under § 107.26(b)(4) (relating to additional committees).

(b) The medical records committee:

(1) Shall review records for completeness and shall establish requirements regarding completion of medical records, including a system for disciplinary actions for those who do not complete records in a timely manner.

(2) Shall make recommendations to the medical staff, regarding any changes in the format of the records.

(3) Should review the medical records to ensure that the recorded clinical information is sufficient for the purpose of medical care evaluation.

Cross References

This section cited in 28 Pa. Code § 119.24 (relating to patient medical records); and 49 Pa. Code § 16.95 (relating to medical records).

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