A. GENERAL INFORMATION

The facility must maintain complete medical records for every client, in accordance with accepted professional standards. The medical records must be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. Each entry must be signed.

A record must be maintained of every client encounter with the staff. All staff, including non-medical workers, should record every encounter (including telephone calls), reason for encounter, and any action taken.

1. Confidentiality

   a. Custody of Records

      1) The public health agency is the legal custodian of client records. It is responsible for the provision of a safe place for storage of client records to prevent disclosure to unauthorized persons.

      2) Client records should be kept in locked files when not in use and must not be left where other than authorized persons have access to them.

   b. Disclosure of Confidential Information - Conditions and Limitations

      1) The Open Records Law

         a) The Colorado General Assembly, during its 1968 session, passed Senate Bill No. 3, which is commonly referred to as the Open Records Bill, the intent of which was to establish the public policy of the state that public records be open for inspection by any person except as provided by law. This bill became law July 1, 1968, and an analysis of the general content may provide insight to the importance of maintaining well organized, complete, and objective records.

         b) Medical records are not listed in the exceptions. The law states that the custodian of records (defined as any authorized person having personal custody and control of the public records in question, e.g., the community health nurse) shall deny the right of inspection of medical records <u>except</u> to the "person in interest." The person in interest means and includes the person who is the subject of a record or any representative designated by said person of interest if the subject of the record is under legal disability.

         c) The law further states that either the custodian or person of interest may request a professionally qualified person to be present to interpret records. If, in the opinion of the custodian of a public record, disclosure of the contents of said record could produce substantial injury to the public interest, he may apply to the district court of the district in which the record is located for an order permitting him to restrict such disclosure.

d) The foregoing provisions apply to the inspection of records, as contrasted with the release or transmittal of records. The law, however, provides that in all cases in which a person has the right to inspect a public record, he may request that he be furnished copies of such record. The custodian may make such rules and regulations with reference to the protection of such records and the prevention of unnecessary interference with the regular discharge of the duties of the custodian or his office.

2) The Person in Interest

a) The client or duly appointed legal representative has the right to free access to the information recorded in his record with the limitations as stated in the Open Records Law.

b) In addition, CRS 1973, 25-1-801, provides that a client may not have access to any records pertaining to psychiatric or psychological problems or notes by a physician that in the opinion of a licensed physician who practices psychiatry and is an independent third party would have significant negative psychological impact upon the client. The person in interest has the right to assume that the material in his record is strictly confidential, and that it will not be shared with other persons or agencies without his informed consent. It is possible to obtain a release of informed consent. Information may not be released without informed consent of the client. A records release form should be prepared in triplicate, and all copies signed. The copies are then used as follows:

- (original) to request information from another agency;
- (copy) to the client/family;
- (copy) retain in the client's record.

3) Other Agencies or Services

a) Information may be released to other agencies or persons with the written consent of the "person in interest." Information is not released unless the public health agency is reasonably sure that:

- The confidential nature of the information will be preserved; and
- Information obtained will be used for the purpose related to the request from the inquiring agency or person and for no other purpose.

b) Records may be subpoenaed by the courts without the person's consent. Medicare and Medicaid regulations also provide for inspection of records. In addition, information may be released to other agencies or persons in accordance with specific statutory provisions (e.g., CRS 1973, 25-01-107 [1F], 25-01-312, 25-03-204, 25-04-402, 25-04-508. This list is not necessarily exhaustive).

4) Other Considerations in Maintaining Confidentiality

   a) All persons employed in the public health agency should be oriented to the importance of safeguarding the confidential nature of the record and any other client information.

   b) Privacy and confidentiality in gathering client information by interview or any other means is essential.

   c) Office and clinic facilities should be such that client information is not inadvertently revealed to persons in the waiting room or any place else.

   d) Discretion must be used in engaging a client in discussion in his home or on the street while neighbors, relatives, or other persons are present.

5) Confidentiality and HIPAA

   For policy related to rules and regulations of HIPAA, please refer to the Family Planning Administrative Manual, Section I.

2. Documentation

   a. Each entry must be signed by the person providing the information or service**.** If the full name of the signer is not used in the medical record, a signature sheet with full name, title, and signature of each individual making entries in the chart must be maintained.

   b. Every physician must sign his/her entries into the medical record. For the purpose of quality assurance, a physician should also co-sign 10% of the entries of a nurse-midwife or nurse practitioner or other appropriately trained person for whom the physician is responsible. All entries of a physician assistant must be co-signed, according to Colorado statutes.

   c. All laboratory, X-ray, and referral follow-up reports should be reviewed, initialed, and dated by; (1) the provider (preferable); or (2) the clinic nurse/coordinator before filing in the chart. The provider(s) must be notified as soon as possible of any abnormal lab results for appropriate treatment, referral, or follow-up. This information must be documented in the chart.

   d. It shall be documented in the chart when information is presented to the client either by means of translation or reading the information aloud to the client. For clients with noted drug allergies, an alert will be stamped on the front of the chart to inform the provider.

3. Accessibility of medical records

   a. The records must be systematically organized to facilitate retrieval and compiling of information. In Colorado, the client has a right to directly view her/his medical record. Therefore, the medical record should be maintained in such a manner that the client or the client's attorney has access to it upon request.

b. Funding agencies such as Health and Human Services, have the right to review charts of those individuals whose care is supported by their funds. The original medical record is the property of the clinic. However, the client or her/his attorney, upon presentation of appropriate documentation, is entitled to copies of the record.

4. Retention of records

   a. Each public health agency should have an established policy regarding the length of time for retention of records and the method of disposing of client records. This is usually done by obtaining a ruling from the agency or county attorney.

   b. It is recommended that all client records be retained for a minimum of 7 years plus current year after discharge; or, in the case of a minor, after the 18th birthday.

5. Destruction of records

   a. When materials no longer need to be retained, in order to ensure the confidentiality of records, they should be destroyed.

   b. Shredding, burning, or soaking are three acceptable methods.

6. Indexes and files

   a. The filing system should be arranged in the form that is most convenient for the family planning facility.

   b. A color coding may be used to identify charts of users of various methods of contraception

7. Content of client record

   The medical record must contain sufficient information to identify the client, justify the diagnosis or clinical impression, and warrant the treatment and end results.

   The record shall contain the following:

   a. Personal Data

      1) Client identification.
      2) Name, address, and telephone number.
      3) Name of someone who may be contacted to reach client.
      4) Name, address, telephone number, and relationship to client of a person who may be contacted in the event of a medical emergency. For the client under 18, the parent or guardian should be listed.
      5) Dates of visits.
      6) Identification of other sources of medical care.

b. Clinical data

1) Medical history, which must be updated at least annually or more often as indicated.
2 Report of the physical examination.
3) Documentation of laboratory tests ordered, results, and follow-up.

c. Diagnostic and therapeutic orders, observations, clinical findings, and action taken

1) Indication of treatments and/or medications given, observations, and action taken.
2) Progress notes.
3) Special instructions.
4) Follow-up contact when applicable.
5) Any telephone calls to or from a client regarding medical problems.
6) Referral forms.
7) Written follow-up of referrals.

Whenever possible, a summary of relevant health-related encounters in other health facilities should be included in the client's family planning medical record.

8. Record audit

a. Internal record audits shall be performed at least monthly, to determine completeness of records, e.g., blanks filled in, releases and consent signed appropriately, physician and staff signatures, etc.

b. A full Medical Chart Audit under the direction of Colorado Department of Public Health and Environment will be performed every **third** year by an independent auditor. (See Risk Management/Quality Assurance Policy).