

Medical Records: Documentation, Access, Retention, Storage, Disposal, and Closing a Practice

Observe, record, tabulate, communicate.

-Sir William Osler (1849-1919)

Introduction

The Washington Medical Commission provides this guidance to physicians and physician assistants (practitioners) on the appropriate documentation of a medical record; special considerations for maintaining an electronic health record; providing access to medical records; the retention, storage and disposal of medical records; and handling records when closing a practice. The Commission recognizes that in some practice settings, practitioners may not have control over the records and may not be able to fully implement the recommendations made below. The Commission appreciates the variety of medical practices and urges practitioners to exercise reasonable judgment which may vary by specialty in the application of the guideline. An appendix contains a history of the medical record, illustrative examples of complaints regarding medical records made to the Commission, and additional information on the implementation of electronic health records.

Guideline

I. Documentation

A. Purpose of the Medical Record

As part of delivering high-quality, safe, and integrated medical care, it is critically important that each practitioner maintains accurate, clinically useful, timely, and consistent medical records. A practitioner should maintain a medical record for each patient for whom he or she provides care. Notes, either handwritten, typed or dictated, must be legible. Dictation must be transcribed, reviewed, and signed within a reasonable time. The practitioner must ensure that the transcription of notes is accurate, particularly when using dictation or voice-recognition software.

The medical record is a chronological document that:

1. Records pertinent facts about an individual's health and wellness;
2. Enables the treating care provider to plan and evaluate treatments or interventions, making clear the rationale for diagnoses, plans and interventions;
3. Enhances communication between professionals, assuring the patient optimum continuity of care;
4. Assists both patient and practitioner in communication with third party participants;

5. Facilitates the practitioner's development of an ongoing quality assurance program;
6. Provides a legal document for verification and/or audit of the delivery of care; and
7. Is available as a source of clinical data for research and education.

B. The Essential Elements of a Medical Record

The practitioner should include the following elements in all medical records:

1. The purpose of each patient encounter and appropriate information about the patient's history and examination, the patient's perspective and preferences, plan for any treatment, and the care and treatment provided;
2. The patient's pertinent medical history including serious accidents, operations, significant illnesses, and other appropriate information;
3. Prominent notation of medication and other significant allergies, or a statement of their absence;
4. Known or suspected reactions including allergy warnings;
5. Clearly documented informed consent obtained from the patient or from a person authorized to consent on behalf of the patient. In some emergency situations, the reason for a lack of informed consent should be clearly documented; and
6. The date of each entry, and the time as appropriate.

C. Additional Elements of a Medical Record

The following additional elements reflect commonly accepted standards for medical record documentation:

1. Each page in the medical record contains the patient's name or ID number.
2. Personal biographical information such as home address, employer, marital status, emergency contact information and all telephone numbers, including home, work, and mobile phone numbers.
3. Each entry in the medical record contains the author's identification. Author identification may be a handwritten signature, initials, or a unique electronic identifier.
4. All drug therapies are listed, including dosage instructions and, when appropriate, indication of refill limits. Prescription refills should be recorded.
5. Encounter notes should include appropriate arrangements and specified times for follow-up care.
6. All consultation, laboratory, and imaging reports should be entered into the patient's record, reviewed, and the review documented by the practitioner who ordered them. Abnormal reports should be noted in the record, along with corresponding follow-up plans and actions taken.
7. An appropriate immunization record is kept up to date by the primary care provider and, ideally, readily accessible by all clinicians caring for the patient, as technology permits.
8. Documentation of appropriate preventive screening and services being offered in accordance with accepted practice guidelines, as relevant to the visit and/or the specific provider's role in caring for the patient.
9. Documentation of other persons present during the encounter.

Where possible, the practitioner should avoid judgmental language in the medical record. The practitioner should consider that patients increasingly have access to and will read their own medical record. The practitioner should also be aware that a patient has a statutory right to submit a concise statement describing a correction or amendment for inclusion in the medical record. [RCW 70.02.110](#). For a history of the medical record, see Appendix, Part I.

D. Special Considerations When Using an Electronic Health Record

An electronic health record (EHR), a digital version of the traditional paper-based medical record, documents health care that took place within a practitioner’s office, single health care facility or health care system as well as all other communications (records of phone calls, emails, etc.) between the health care team and the patient. [1] The ideal EHR is designed to contain and share information among all involved providers, patients, and their designated caretakers.

The EHR offers a number of potential benefits over the paper medical record. However, as with any innovation, there are challenges and potential hazards in its meaningful use. The Commission recognizes several problematic documentation practices while using an EHR that in some instances interfere with delivery of high-quality, safe, and integrated medical care; impede medico-legal or regulatory investigation; or are fraudulent.

1. Recommendations for Practitioners

The following recommendations, which are not necessarily exhaustive, are intended to inform practitioners of the appropriate use of an EHR, and to indicate how the Commission will evaluate a medical record, including records that are the product of an electronic system.

The patient record in an EHR should reflect the same or improved content and functionality as that produced in traditional formats, and will be held to essentially the same standard.

a. A practitioner using an EHR must ensure:

- i. authorized use and compliance with state and federal privacy and security legal requirements, law, and with institutional privacy and security policies;
- ii. a timely, accurate, succinct, and readable entry;
- iii. consistency and accuracy between various aspects of a record; and
- iv. assumption of ultimate responsibility for trainees’ and scribes’ documentation.

b. Retention or re-entry of inaccurate, inconsistent, or outdated information in the EHR from historic entries should be avoided. Original information needs to be retrievable from a separate location in the EHR via a secure and permanent audit trail.

c. A practitioner’s actions and decision-making should be accurately reflected in the documentation. The record will include a description of any shared decision-making process, when appropriate.¹

¹ EHRs have the potential to support shared decision-making. Studies show that EHRs that have incorporated shared decision-making tools result in improved clinical outcomes. *The Promise of Electronic Health Records to Promote Shared Decision Making: A Narrative Review and a Look Ahead*, Medical Decision Making, Vol. 38(8) 1040-1045 (2018). For more information on shared decision making, see the Washington State Health Care Authority [web site](#) on shared decision making, and the Bree Collaborative [web site](#) describing its work on this topic.

- d. Documenting aspects of a practitioner-patient interaction that did not transpire, such as indicating that components of a physical examination were performed when they were not, even when it occurs inadvertently because of EHR design or function, may be considered fraud. Similarly, when documentation about a significant aspect of the practitioner-patient interaction is not present, the assumption is that it did not occur.
- e. It is important to distinguish those portions of the history that were obtained by the note writer from those that were copied or carried forward from another practitioner's note. [2] The practitioner must recognize that "carry forward" or "cut-and-paste" functions, even when done automatically by the EHR software, represent significant risks to patient safety. Concerns about "clinical plagiarism" or fraudulent billing may arise when appropriate and accurate attribution of copy-paste or carry-forward information is missing from an EHR note. Practitioners should carefully review and edit any EHR-generated note to assure its accuracy prior to authenticating it.
- f. Laboratory and imaging data should only be brought into the practitioner's note when pertinent to the decision making process for the patient. Wholesale importation of laboratory data and imaging data that is already documented elsewhere in the chart is to be avoided as such practice can make interpretation of medical records by subsequent caregivers extremely difficult.
- g. The practitioner should assure that problem lists and medication lists are kept current, and that they are not cluttered with outdated information.

Examples of complaints received by the Commission relating to EHRs can be found in Appendix, Part II.

2. Suggestions for EHR Software Developers and Healthcare Institutions

The fruitful evolution of the EHR will require collaboration between entities that develop and purchase EHR systems and practitioners who use the EHR. The primary goal of the EHR is to promote high-quality, safe, and integrated health care. Other roles, such as documentation to support coding and billing, are secondary. It is unfortunate that, in general, these roles seem reversed in current EHR systems. With this in mind, the Commission offers suggestions about potential EHR improvements for software developers and health care institutions, and believes that practitioners should be involved in collaborative efforts with those entities to improve the EHR.

- a. Practitioners and clinical information specialists have an important role to play in development, decision-making, evaluation and improvement of EHR systems.
- b. EHR systems should result in a patient record that is organized, concise, and easily-readable. Lengthy and redundant information in the EHR, a source of common practitioner complaint, makes it difficult for other practitioners to identify data within the EHR that is relevant to actual patient care. [3]
- c. EHR systems should also include tools to support the clinician to use best practices when available as well as shared decision-making.
- d. An ultimate goal of the EHR universe should be widely compatible systems allowing seamless transfer and sharing of electronic medical information within and among practitioners, medical offices and clinics, hospitals and other health care institutions, as well as patients and their caregivers.
- e. It is essential to have capacity within EHR systems to correct errors as soon as they come to light, and thereby prevent their perpetuation. The original documentation must be retrievable in the EHR via secure and permanent audit trail.

- f. As patients increasingly have access to their EHR, they will undoubtedly find information within the medical record that is erroneous or with which they disagree. There should be a mechanism in place within healthcare institutions to respond to patients' questions and concerns that arise from review of their EHR, and to allow patients to submit a correction or amendment for inclusion in the medical records. [RCW 70.02.110](#).
- g. Software supporting EHR clinical documentation should be designed and constructed for the type of provider who will use it (e.g., specialty, training) and the context in which it will be employed (e.g., admitting, consulting, ambulatory). It should automatically attribute information to each author. [\[4\]](#)
- h. The medical record serves many audiences who need to be considered in the design and implementation of EHR systems. To meet their potential, EHRs should incorporate comprehensive decision support that:
 - i. leads to improved patient outcomes;
 - ii. ensures safe transitions of patients from one practitioner, facility, or office to another;
 - iii. allows easy tracking and reporting of patient care metrics and outcomes; and
 - iv. promotes patient-centered communication between patients and the health care system. [\[3\]](#)
- i. Health care institutions should consider having mechanisms in place to monitor documentation quality and practitioner satisfaction with the EHR, and to identify changes to support improved usability, validation, integrity, and quality of data within the EHR. [\[4\]](#)
- j. The EHR should be designed for maximum portability and interoperability of information to benefit the patient and the public health. Full integration into the Washington State Health Information Exchange provides benefit to the patient requiring treatment when away from their medical home and provides meaningful data to assess population health. Technology vendors should design their systems with these functions as standards and institutions should mandate these functionalities as standard requirements for their implemented systems.
- k. The EHR should support rapid, minimally complicated integration with the state's prescription monitoring program to facilitate inquiry in those systems.

For additional information on the implementation of an EHR, see the Appendix, Part III.

II. Access to Medical Records

A practitioner's practices relating to medical records under his or her control should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient's care. The Commission recognizes that electronic health records systems may not be compatible, making it challenging to send records to a practitioner in another electronic health record system. Practitioners should do the best they can to get medical records to patients and subsequent providers in a usable format.

- A. Per [RCW 70.02.080](#), a practitioner is legally obligated to make medical records available to a patient to examine or copy within 15 days of the request. A practitioner may deny the request under circumstances specified in [RCW 70.02.090](#).

- B. Except for patients appealing the denial of social security benefits, the practitioner may charge a reasonable fee for making records available to a patient, another provider, or a third party and is not required to honor the request until the fee is paid. [RCW 70.02.030\(2\)](#). What constitutes a reasonable fee is defined in [WAC 246-08-400](#). The practitioner cannot, however, withhold the records because an account is overdue or a bill is owed.
- C. To prevent misunderstandings, the practitioner's policies about providing copies or summaries of medical records and about completing forms should comply with appropriate laws and should be made available in writing to patients when the practitioner-patient relationship begins.
- D. The failure to provide medical records to patients in violation of RCW 70.02 can result in disciplinary action by the Commission.

III. Retention of Medical Records

- A. There is no general law in Washington requiring a practitioner to retain a patient's medical record for a specific period of time.² The Commission appreciates the variety of medical practices and urges practitioners to exercise reasonable judgment which may vary by specialty for the retention of medical records. When appropriate, the Commission concurs with the Washington State Medical Association recommendation that practitioners should retain medical records and x-rays for at least:
 - 1. ten years from the date of a patient's last visit, prescription refill, telephone contact, test or other patient contact;
 - 2. 21 years from the date of a minor patient's birth;
 - 3. six years from the date of a patient's death; or
 - 4. indefinitely, if the practitioner has reason to believe:
 - a. the patient is incompetent;
 - b. there are any problems with a patient's care, or
 - c. the patient may be involved in litigation.
- B. A practitioner should consider whether it is feasible to retain patients' medical records indefinitely.
- C. A practitioner should verify the retention time required by their medical malpractice insurer.
- D. A practitioner should inform patients how long the practitioner will retain medical records.

IV. Storage of Records

- A. A practitioner is responsible for safeguarding and protecting the medical record, whether in electronic or paper format, and for providing adequate security measures.
- B. A practitioner may contract with a third party to act as custodian of the medical records. The responsible person, corporation, or legal entity acting as custodian of the records must comply with federal and or state confidentiality laws and regulations.

² [RCW 70.02.160](#) requires a health care provider to maintain a record of existing health care information for at least one year following receipt of an authorization to disclose that health care information and during the pendency of a patient's request either to examine or copy the record or to correct or amend the record. For hospital medical record retention requirements, see [RCW 70.41.190](#).

V. Disposing of Records

- A. When retention is no longer required, records should be destroyed by secure means. The Privacy Rule in the Health Insurance Portability and Accountability Act (HIPAA) prohibits digital and paper records containing confidential information from being thrown away in a public dumpster or recycling bin until they have been rendered unreadable or indecipherable by shredding, burning or other destruction.
- B. A practitioner should give patients an opportunity to claim records or have them sent to another provider before records are destroyed. For some practitioners, the nature of their specialty will make notifying patients impractical.

VI. Handling Medical Records When Closing a Medical Practice

- A. The obligation to make medical records available to patients and other providers continues even after a practitioner closes a medical practice.
- B. The recommendations in this section do not apply to:
 - 1. A practitioner who leaves a multi-practitioner practice. In that instance, the remaining practitioners in the practice typically assume care of the patients and retain the medical records.
 - 2. A specialist or other practitioner who does not have ongoing relationships with patients. These practitioners typically provide patient records to the referring practitioner, the patient's primary care provider, or directly to the patient.
- C. Prior to closing a practice, a practitioner should notify active patients and patients seen within the previous three years.
- D. The notice should be given at least 30 days in advance, with 90 days being the best practice.
- E. The notice should be given by:
 - 1. individual letter to the last known patient address;
 - 2. electronically, if this is a normal method of clinical communication with the patient; or
 - 3. placing a notice on the practitioner's web site, if the practitioner has a web site.
- F. The notice should include:
 - 1. the name, telephone number and mailing address of the responsible entity or agent to contact to obtain records or request transfer of records;
 - 2. how the records can be obtained or transferred;
 - 3. the format of the records, whether hard copy or electronic;
 - 4. how long the records will be maintained before they are destroyed; and
 - 5. the cost of recovering records or transferring records as defined in [Chapter 70.02 RCW](#).
- G. The practitioner is encouraged to provide notice to the local medical society, whether the practitioner is a member or not.
- H. If the practitioner practices as part of an institution, the institution may provide the notice of the closing of the practice.

- I. If the practice closes due to the practitioner's death, the practitioner's estate becomes the owner of the medical records and is encouraged to provide this notification to patients.
- J. Disciplinary action by the Commission, including suspension, surrender or revocation of the practitioner's license, does not diminish or eliminate the obligation to provide medical records to patients.

There is no more difficult art to acquire than the art of observation, and for some it is quite as difficult to record an observation in brief and plain language.

-Sir William Osler (1849-1919)

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