State of Washington
Medical Quality Assurance Commission

Guideline

Title:	Retention of Medical Records	GUI2017-02
References:	Chapter 70.02 RCW	
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Purpose

The Medical Quality Assurance Commission (Commission) issues these guidelines to assist physicians and physician assistants (collectively "practitioners") in the proper maintenance, retention and disposition of medical records.

Guidelines

A. Retention of Records

1. There is no general law in Washington requiring a practitioner to retain a patient's medical record for a specific period of time.[1] The Commission concurs with the Washington State Medical Association recommendation that practitioners should retain medical records and x-rays for at least:
    a. ten years from the date of a patient's last visit, prescription refill, telephone contact, test or other patient contact;
    b. 21 years from the date of a minor patient's birth;
    c. six years from the date of a patient's death; or
    d. indefinitely, if the practitioner has reason to believe:
        i. the patient is incompetent;
        ii. there are any problems with a patient's care, or
        iii. the patient may be involved in litigation.
2. A practitioner should consider whether it is feasible to retain patients' medical records indefinitely.

[1] 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.

3. A practitioner should verify the retention time required by their medical malpractice insurer.
4. A practitioner should inform patients how long the practitioner will retain medical records.

B. Storage of Records

1. Medical records, whether in electronic or paper format, should be stored to allow for lawful access and in a place that maintains confidentiality.
2. 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.

C. Providing Medical Records to Patients or Other Providers

1. 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.
2. A practitioner must honor a request by a patient to disclose health care information to another provider or third party. The practitioner may charge a reasonable fee and is not required to honor the request until the fee is paid.
3. The failure to provide medical records to patients in violation of RCW 70.02 can result in disciplinary action by the Commission.
4. 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.

D. Disposing of Records

1. 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.
2. A practitioner should give patients an opportunity to claim records of have them sent to another provider before records are destroyed.

E. Closing a Medical Practice

1. The obligation to make medical records available to patients and other providers continues even after a practitioner closes a medical practice.
2. The recommendations in this section do not apply to:
    a. Practitioners who leave a multi-practitioner practice. In that instance, the remaining physicians in the practice typically assume care of the patients and retain the medical records.

   b. Specialists or other practitioners who do 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.
3. Prior to closing a practice, a practitioner should notify active patients and patients seen within three years.
4. The notice should be given at least 30 days in advance, with 90 days being the best practice.
5. The notice should be given by:
   a. individual letter to the last known patient address; and
   b. electronically, if this is a normal method of clinical communication with the patient; and
   c. notice in the local newspaper.
6. The notice should include:
   a. the name of the responsible entity or agent to contact to obtain records or request transfer of records, telephone number and mailing address;
   b. how the records can be obtained or transferred;
   c. the format of the records, whether hard copy or electronic;
   d. how long the records will be maintained before they are destroyed; and
   e. the cost of recovering records or transferring records as defined in Chapter 70.02 RCW.
7. The practitioner should also provide notice to the local medical society, whether the practitioner is a member or not.
8. If the practice closes due to the practitioner's death, the practitioner's estate becomes the owner of the medical records and should provide this notification to patients.