CHAPTER 563. MEDICAL RECORDS

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Authority

The provisions of this Chapter 563 issued under Chapter 8 of the Health Care Facilities Act (35 P. S. §§ 448.801a—448.820), specifically sections 448.801a and 448.803; section 2101(a) and (g) of The Administrative Code of 1929 (71 P. S. § 532(a) and (g)), unless otherwise noted.

Source

The provisions of this Chapter adopted January 23, 1987, effective March 25, 1987, 17 Pa.B. 376, unless otherwise noted.

§ 563.1. Principle.

The ASF shall maintain complete, comprehensive and accurate medical records for every patient to ensure adequate patient care.

§ 563.2. Organization and staffing.

(a) The ASF shall have a medical record service. It shall be directed, staffed and equipped to ensure the accurate processing, indexing and filing of medical records.

(b) At least one full-time or part-time employe shall provide regular medical record service.

§ 563.3. Facilities.

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.

§ 563.4. 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.

§ 563.5. Storage of medical records.

Medical records shall be stored to provide protection from loss, damage or unauthorized access.

§ 563.6. Preservation of medical records.

(a) The facility shall have a written policy regarding the retention of records. 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 an ASF 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 local newspaper of general circulation.

§ 563.7. Microfilming medical records.

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

§ 563.8. Automation or computerization of medical records.

Nothing in this subpart prohibits the use of automation or computerization in the medical records service, if the 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.

Source

The provisions of this § 563.8 amended October 22, 1999, effective November 22, 1999, 29 Pa.B. 5583. Immediately preceding text appears at serial page (256580).

§ 563.9. Confidentiality of medical records.

Records shall be treated as confidential. Only authorized personnel shall have access to the records. The written authorization of the patient shall be presented and then maintained in the original record as authority for release of medical information outside the ASF.

§ 563.10. Ownership.

There shall be written policies and procedures which specify who has access to medical records, under what conditions records may be removed from the ASF, and under what conditions medical record information may be released. Medical records are the property of the ASF, and they may not be removed from the premises except for court purposes. Copies may be made available for authorized appropriate purposes, such as insurance claims and practitioner review.

§ 563.11. Patient access.

Patients or patient designees shall be given access to or a copy of their medical records, or both. The patient or the patient's designee may be charged for the cost of reproducing the copies; however, the charges shall be reasonably related to the cost of making the copy.

§ 563.12. Form and content of record.

The ASF shall maintain a separate medical record for each patient. Every record shall be accurate, legible and promptly completed. Patient medical records shall be constructed to stand alone and be easily identified as ASF records. Medical records shall include at least the following:

(1) Patient identification.

(2) Pertinent medical history and results of physical examination.

(3) Preoperative diagnostic studies—entered before surgery—if performed.

(4) The presence or absence of allergies and untoward drug reactions recorded in a prominent and uniform location in all patient charts on a current basis.

(5) Documentation of properly executed, informed patient consent.

(6) Entries related to anesthesia administration.

(7) Findings and techniques of the operation, including a pathologist report on tissue removed during surgery.

(8) Notes by authorized staff members and individuals who have been granted clinical privileges, nurses' notes and entries by other professional personnel.

(9) Written and verbal disposition recommendations and instructions given to the patient.

(10) Significant medical advice given to a patient by telephone.

(11) Discharge summary including discharge diagnosis.

Source

The provisions of this § 563.12 amended October 22, 1999, effective November 22, 1999, 29 Pa.B. 5583. Immediately preceding text appears at serial page (256581).

Cross References

This section cited in 28 Pa. Code § 563.13 (relating to entries).

§ 563.13. Entries.

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

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

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

(d) Notation of unusual incidents shall be entered in the medical record.

(e) Necessary documentation on the patient's medical record as specified in § 563.12 (relating to form and content of record) shall be completed in a timely manner not to exceed 30 days.

Source

The provisions of this § 563.13 amended October 22, 1999, effective November 22, 1999, 29 Pa.B. 5583. Immediately preceding text appears at serial page (256581).

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