

Minnesota Medical Association Issue Brief

MANAGEMENT OF PHYSICIAN OFFICE MEDICAL RECORDS

NOTE: The following information regarding the maintenance of medical health records is intended only as general information. Retention of medical records can and will vary depending of the facts of each situation. Physicians and clinic managers with specific legal questions should seek the advice of an attorney.

The State of Minnesota does not specify the length of time for which medical records must be retained. Retention of all medical records should be dealt with in a consistent manner. Patients should be informed of the retention policy of the clinic.

Ownership of Medical Records

As a general rule the tangible, physical medical record is owned by the physician or facility responsible for compiling and maintaining it. Although the physician has the right to possess and control the medical record the patient generally has the right to access and control the distribution of the information contained in the record.

The AMA's Council on Ethical and Judicial Affairs has stated that even though the physician or provider owns the patient's medical record, the patient has the right to access the record and to provide copies to other physicians upon proper authorization. The opinion further states that it is inappropriate to withhold access to medical records until the patient's bill has been paid.¹

Therefore, it is the responsibility of the physician to maintain the record and make provisions for protecting the record against loss, defacement, tampering or use by unauthorized individuals.

Release of Records to Patients and Third Parties

The patient, or their legal representative, generally has broad control over the release of his or her medical records to third parties. Under Minnesota law, upon written request, a provider must supply to a patient complete and current information possessed by that provider concerning any diagnosis, treatment and prognosis of the patient in terms and language the patient can reasonably be expected to understand.²

Minnesota law further states that upon a patient's written request, a provider, at a reasonable cost to the patient, must promptly furnish to the patient copies of the patient's health record and the pertinent portion of the record relating to a condition specified by the patient. However, the statute clearly states that providers may not charge a fee to patients seeking to review their records for the purpose of reviewing current medical care. The law does not define the term "current medical care."

Generally, providers may charge for copies of patient records. Charges are computed based on the percentage change in the regional Consumer Price Index (CPI). The Minnesota Department of Health computes the maximum 2002 charges to be \$1.03 per page and \$13.55 for time spent retrieving and copying records, but consideration may be given for lowering the charge if multiple pages are to be copied. In addition to per page copy charges, physicians may charge the patient the actual cost of reproducing x-rays plus no more than \$13.55 for time spent retrieving and copying the x-rays. The clinic may also charge for: shipping/delivery, certification, notarization, review of the record for specific content, viewing of the record by the requester, reproduction of photographs, and facsimile transmission.³

Worker's Compensation

Minnesota law states that health care providers may charge for copies of any records or reports regarding work injury claims for which payment is sought. Charges for copies provided shall be reasonable. For the first request, the charge shall not exceed \$.75 per page, no retrieval fee is allowed. Other requests from the payer or any other party may be charged a \$10 retrieval fee and \$.75 per page. The provider may charge fees different than what is stated above but the combination of retrieval fee and per page copy may not exceed the sum established by the rule.⁴

Social Security Disability

Under a new law enacted in 2002, a provider must not charge a fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of social security disability income or social security disability benefits under title II or title XVI of the Social Security Act. For the purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided.

Confidentiality

Patient health care information is considered confidential and should be released only in accordance with a health care information disclosure policy developed by the physician or clinic.

Under Minnesota law, a provider, or a person who receives health records from a provider, may not release a patient's health records to any person without a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release unless 1) the release is authorized by law 2) for the limited purpose of disclosure of immunization data or 3) for a medical emergency. Health care providers have an obligation to maintain patient privacy and to release information only when appropriate.

Retention of Records

Although Minnesota law does not address the issue of retention of clinic/physician office medical records generally, the American Medical Association had developed standards and ethical opinions that may be of assistance. AMA guidelines state that physicians have an

obligation to retain patient records that may reasonably be of value to a patient. An appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time. The AMA recommends that in all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims.⁵

The following are general guidelines for time periods that medical records should be retained for litigation and regulatory purposes.

Adult Records

Records of patients who were 18 years or older when first seen, other than obstetrical patients, should be retained as long as the individual is a patient of the clinic and then for at least seven years following the date of last treatment.

Minors

Records for minors and obstetrical patients should be retained for at least fourteen years, or until the patient reaches age 25 (age of majority plus seven years).

Decedents

Records should be retained for at least seven years after the date of death of the individual.

Medical Malpractice Statute of Limitations

Minnesota provides that all professional liability claims against health care providers, regardless of the injury or the basis of the cause of action, must be brought within four years from the date of the alleged malpractice. That last date of treatment is used as a general guide for which a medical malpractice cause of action accrues. In special cases, specifically those involving products or devices, a six-year time period could apply.

Board of Medical Practice

There is a seven-year statute of limitations for the Board of Medical Practice to review complaints and take disciplinary action against a physician.

Medicare/Medicaid

All records pertaining to Medicare/Medicaid must be maintained for a minimum of five years.

Third Party Payor Contracts

Some insurers and other third party payors require that health plan enrollee's medical

records be kept for a certain time period. Physicians should review all contracts with third party payors to ensure compliance in this area.

Incompetent Patients

Statutes of limitations applied to claims by incompetent patient's present complex legal questions. Legal advice should be sought before the record of any incompetent patients (or patients who experience a period of incompetency during the course of the physician-patient relationship) are destroyed.

Health Care/Advanced Directives

In regard to advanced directives, Minnesota law requires that a copy of the patient's health care directive be made a part of the individual's medical record. Health care providers should develop policies for retaining advanced directives. The law does not specify a specific retention period and health care directives are not defined as part of the permanent medical record. But it is a crime to destroy an advanced directive without the patient's consent. It should be stored by either hard copy or on microfilm with the medical record.

Immunization Records

The Public Health Service Act Immunization Program and the National Childhood Vaccine Injury Act require that records on immunizations must be kept for ten years.

Physicians should inquire as to whether their county operates a confidential immunization registry service.

Storage of Records

Generally, a healthcare provider remains liable for any disclosure of health information during or after a closure. Therefore, the provider must make appropriate plans to protect the integrity of the records and the confidentiality of the information they contain, while assuring access for continued patient care.

The clinical office policy should designate when records are to be moved to an off-site storage facility. The general recommendation is three to five years following the last date of service.

When selling, transferring, or closing a practice, the physician should contact a health lawyer to help determine applicable local laws before doing anything with the records.⁶

When closing a practice

The physician should make an effort to notify patients of the closure so that patients have the option of requesting that copies of records be sent to a new health care provider/facility. The facility should notify the Minnesota Department of Health of the closing and where the records are being stored or transferred.⁷

Retirement or Death of a Physician

If the deceased or retired physician is part of a group practice, then records will generally remain part of the group practice. If the physician is in solo practice, patients should be offered the opportunity to transfer records to a new provider.

Sale of a Medical Practice:

During the sale, the buyer has the opportunity to assume care of the patients, and the responsibility of maintaining records. The patient retains the right to have the records transferred to another health care provider and should be notified prior to the sale.

Storage of Records

There are a number of options for medical record storage including hard-copy form, microfilm, CD-ROM, and online storage.⁸ Regardless of the storage method:

- Records be stored using a filing system and storage area that safeguards the records from loss, tampering, defacement, or use of unauthorized personnel
- Secured methods including storage of records in locked cabinets or rooms
- During on-site review of a record, measures should be taken to ensure that records have not been tampered with
- A record should not be removed from a health care facility without subpoena or court order.
- A sign-out system should be used when a record is removed from storage.

Destruction of Records

Clinic administrators should establish clear record destruction policies, and procedures should be taken so that all documents are destroyed and confidentiality is maintained. Methods of destruction may include shredding, incineration, or appropriately secured recycling. Computerized medical records must have the

same confidentiality considerations applied. It is recommended that clinics work with their software vendor to determine how to purge or destroy old computerized records to ensure patient confidentiality is protected.

When planning to destroy medical records, a physician should consult with a health lawyer familiar with record-retention requirements. If possible, the physician should give patients sufficient notice and an opportunity to retrieve their records.

Summary

Although the State of Minnesota has few specific mandatory requirements for the retention of medical health records, it is important for physicians to have a clean set of guidelines for the retention and release of medical records. Patients should be informed of the retention policy of the facility in which their medical health records are being stored. Once again, physicians and clinic managers with specific legal questions should seek the advice of an attorney.

Endnotes

¹ Council on Ethical and Judicial Affairs Opinion # 7.02

² Minnesota Statute §144.335 Subd. 2a

³Information on the Maximum Charges for copying records can be found at <http://www.health.state.mn.us/divs/hpsc/dap/maxcharge.pdf>

⁴ MN Rule 5219.0330 / Minnesota Statute §176.135 subd. 7 / MHIMA Chapter 2.11.2

⁵ **AMA Guidelines 7.05:**

Physicians have an obligation to retain patient records which may reasonably be of value to a patient. The following guidelines are offered to assist physicians in meeting their ethical and legal obligations:

1. Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient's chart. In

deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time.

2. If a particular record no longer needs to be kept for medical reasons, the physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.
3. In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information.
4. Whatever the statute of limitations, a physician should measure time from the last professional contact with the patient.
5. If a patient is a minor, the statute of limitations for medical malpractice claims may not apply until the patient reaches the age of majority.
6. Immunization records always must be kept.
7. The records of any patient covered by Medicare or Medicaid must be kept at least five years.
8. In order to preserve confidentiality when discarding old records, all documents should be destroyed.
9. Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity. (IV, V) Issued June 1994.

⁶The Minnesota Medical Association can provide sample forms and letters to notify patients and authorize records transfers.

⁷Contact the Health Information Clearinghouse and Managed Care Information Line at the Minnesota Department of Health. Contact number: 651-282-6314.

