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|  MEDICAL RECORDS  | NO. 172A |
|  1. The Administrator or their designated representative is responsible for maintaining records which will include clinical, medical, and psychosocial information.
2. Clinical records will be kept current, complete, dated signed, readily accessible and will contain the following general categories:
3. Written Assessments of the needs of the patient.
4. Written plan of care.
5. Authentication of hospital diagnosis (Discharge Summary, Report from Patient's Attending Physician Transfer Form).
6. Identification data and consent forms.
7. Medical and nursing history of the patient.
8. Report of physical examination(s).
9. Diagnostic and therapeutic orders.
10. Observations and progress notes.
11. Reports of treatments and clinical findings.
12. Discharge summary including final diagnosis and prognosis.
13. Records will be retained until audited and audit questions are resolved. In the case of a minor, until they turn 23 years, or 5 years after the date the patient is discharged, whichever period is longer.
14. The clinical records of the patients become the private property of the facility. Information contained in the clinical records is treated as confidential and copies of the clinical records may be disclosed to authorized persons upon written authorization of patient or legal guardian.
15. The medical record may be removed by court subpoena.
16. In the event of an emergency, the book or Kardex of current computer doctors’ orders will be removed from the facility by the Charge Nurse. When possible, the master patient card index will be removed by the Medical Records Clerk or responsible person.

See Medical Record Instruction Manual. |
| Approved: | EffectiveDate: | Revision Date:3/17 | Change No.: | Page: 1 of 1 |