Frequently Asked Questions: Medical Records Issues
By Laura A. Dixon, BS, JD, RN, CPHRM, and Susan Shepard, MSN, MA, RN, CPHRM
of The Doctors Company

Q: How long should records be kept?
A: Although states may have different guidelines or laws, The Doctors Company recommends retaining records for the following time periods:
- California only—indefinitely, or for at least 25 years after the patient’s last visit.
- Adult patients—10 years from the date the patient was last seen.
- Minor patients—28 years from the patient’s birth.
- Deceased patients—five years from the date of death.

Q: Are videos, x-ray films, EKGs, fetal monitor strips, photos, etc., part of the medical record?
A: Yes. Any and all data collected at the time of a patient encounter, regardless of form, is part of the medical/legal document.

Q: Does the medical record include financial information such as billing and insurance data?
A: In some states, yes. Physicians should review billing documents for any reference to the specific health care provided.

Q: How long should billing records, telephone calls/messages, and appointment books be kept?
A: The Doctors Company recommends the following:
- Billing records in all states should be retained for seven years, according to Internal Revenue Service standards, and may be kept in a separate file.
- Telephone calls that pertain to medical care should be documented in the medical record and kept according to the above medical record retention guidelines.
- Appointment books may be kept for one year.

Q: If a patient brings his or her past medical records to my office, am I required to maintain all of the copies?
A: The physician should review, extract, and photocopy any information that he or she might need from that record and then return the original documents to the patient. Otherwise, you must maintain such copies for the same length of time as the medical record.

Q: How should hard copy paper records be destroyed?
A: The only safe methods for destroying paper records are incineration or shredding. A destruction method for electronic medical records has yet to be determined.
Q: Where can medical records be stored?
A: Inactive records may be thinned from the active patient cases and stored outside the office suite. Take the following factors into consideration when making arrangements for long-term storage:

- **Privacy**—protect the records from unauthorized persons.
- **Safety**—protect the records from fire or flood damage and unauthorized access or theft.
- **Accessibility**—make sure the records are easy to retrieve and copy.

Q: Can records be transferred to microfilm, microfiche, or disk or stored in a computer?
A: Yes. Privacy, safety, and accessibility can also guide you when transferring records to microfilm, microfiche, or disk or when storing records in a computer. Computer data should be backed up at regular intervals and stored offsite.

Q: Is it sufficient to back up a copy of an electronic health record (EHR) onto a disk?
A: Yes. However, you should store a copy of the EHR software along with the data itself, to make sure the records can be read in the future. Alternatively, you could save the data in PDF format so it can be read without special software. If you use an application service provider—where your data is stored by the EHR vendor and you access it online—your contract should include terms that ensure your data will be available to you when you're ready to make arrangements for long-term storage.¹

Q: Can I thin and purge medical records prior to storage?
A: Yes. Copies of other health care providers' medical records, such as hospital records, can be purged because the originals will be maintained by the hospital.

Q: Can I sell my records when I sell my practice?
A: Yes. We suggest that you include the recommended retention time and access capability as part of your sales agreement.

Q: If I move to another state, can I take my records with me?
A: Yes, with the same conditions prevailing for retention and accessibility. It might be reasonable to alert your active/current caseload of your move in order to give patients an opportunity to request a copy of their medical records.

Q: If a patient requests a copy before I move, can I give him or her the original record?
A: No. The original is the property of the physician, who has a duty to maintain the record.
Q: Can a physician take medical records home for documentation completion?
A: No. The only time an active, original medical record should be out of an office is when it is required to be present in a court of law.

Q: If someone claiming to be a representative of a deceased patient’s estate requests a copy of the chart, what do I need to do?
A: You must verify that the individual is a qualified representative of the decedent’s estate (for example, the executor). The individual should provide a copy of an official document from the state as proof.

References

About the Authors
This article is by Laura A. Dixon, BS, JD, RN, CPHRM, Director, Department of Patient Safety, Western Region, and Susan Shepard, MSN, MA, RN, CPHRM, Director, Patient Safety Education.