

15.2 PURPOSE AND CONTENT OF THE MEDICAL RECORD AND RECORD RETENTION

Policy: Title X providers must maintain documentation of client care in client medical records. Medical records must be accurate, complete and systematically organized to facilitate prompt retrieval of information. Documentation must be made on the same day services are rendered and must document all services provided to clients.

A medical record is a permanent record of any encounter with a client resulting in the provision of clinical services.

Title X clinics must retain medical records in accordance with accepted medical standards and state laws.

Purposes of the Medical Record:

1. To serve as a basis for planning client care.
2. To serve as a basis for affecting continuity in the evaluation of the client.
3. To furnish documentary evidence of the client's medical evaluation, treatment and change in condition during the period of care or treatment.
4. To document communication between the responsible clinician and any other health professional contributing to the client's care.
5. To serve as the basis for evaluating the quality of medical care.
6. To assist in protecting the legal interest of the client, the clinic and the responsible clinician.

Procedure:

Purpose and Content of Medical Record

1. The client's medical record must contain sufficient information to identify the client, indicate where and how the client can be contacted, justify the clinical impression or diagnosis, and warrant the treatment and end results.
2. If the service site uses a non-electronic (i.e. paper) health record system, the client's medical record should be kept separate from the client's financial information and must be kept separate from the Client Visit Record (CVR).
3. The required content of the medical record includes, but is not limited, to:
 - a. Personal data
 - b. General consent
 - c. Informed consents
 - d. Health history, physical exam, laboratory test orders and results, clinical findings, plans for care including treatments, follow-up and special instructions
 - e. Refusal of services
 - f. Allergies and untoward reactions to drug(s) recorded in a prominent and specific location
 - g. Reports of clinical findings, diagnostic and therapeutic orders
 - h. Counseling and social service staff entries
 - i. Referral, follow-up and continuing care
 - j. Scheduled revisits

Record Retention

1. Title X family planning clinics should develop their own policy with input from the medical director regarding the retention of client medical records. Considerations include client population, storage space, services provided, and statute of limitations.
2. Charts retained for medical conditions should be coded as such for easy, accurate retrieval.
3. Records must be destroyed by shredding in order to maintain client confidentiality and safeguard against loss or use by unauthorized persons.

4. Any information that is related to a retained chart should be kept on file including the current clinic protocols, policies, procedures, educational and medical instructional handouts related to protocols for any potential legal reference.

Administrative Rules of Montana

- [37.106.314 Minimum Standards for All Health Care Facilities: Medical Records:](http://www.mtrules.org/gateway/RuleNo.asp?RN=37%2E106%2E314)
<http://www.mtrules.org/gateway/RuleNo.asp?RN=37%2E106%2E314>
- [37.106.402 Minimum Standards for a Hospital: Medical Records:](http://www.mtrules.org/gateway/RuleNo.asp?RN=37%2E106%2E402)
<http://www.mtrules.org/gateway/RuleNo.asp?RN=37%2E106%2E402>
- [37.85.414 Maintenance of Records and Auditing \(Medicaid\):](http://www.mtrules.org/gateway/RuleNo.asp?RN=37%2E85%2E414)
<http://www.mtrules.org/gateway/RuleNo.asp?RN=37%2E85%2E414>