Legal Health Record Policy Template

Template

Provided By:

The National Learning Consortium (NLC)

Developed By:

Health Information Technology Research Center (HITRC)

Rural Wisconsin Health Cooperative Workgroup

*The material in this document was developed by Regional Extension Center staff in the performance of technical support and EHR implementation. The information in this document is not intended to serve as legal advice nor should it substitute for legal counsel. Users are encouraged to seek additional detailed technical guidance to supplement the information contained within. The REC staff developed these materials based on the technology and law that were in place at the time this document was developed. Therefore, advances in technology and/or changes to the law subsequent to that date may not have been incorporated into this material.*

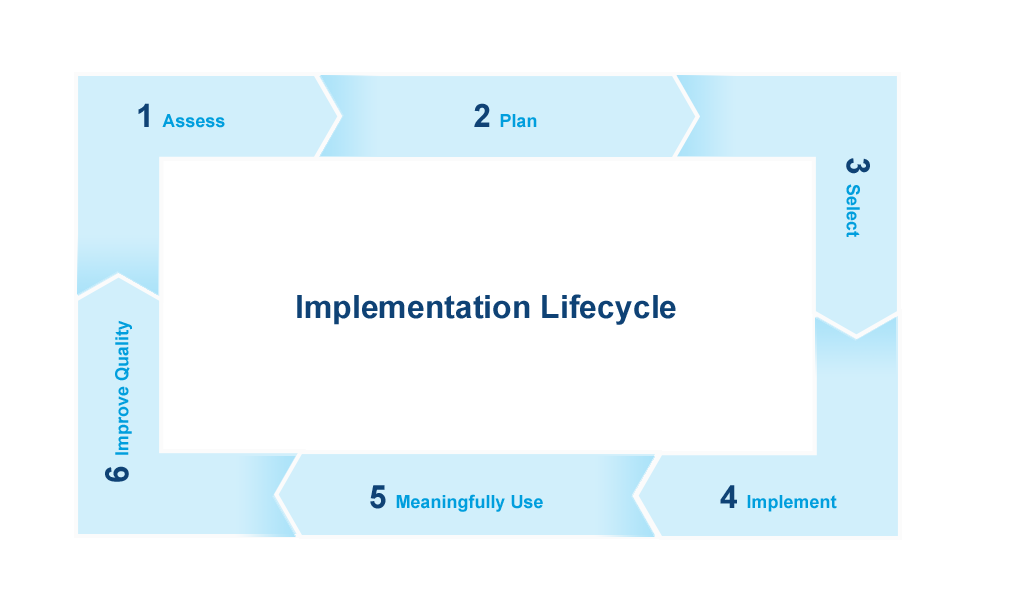
National Learning Consortium

The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and resources designed to support healthcare providers and health IT professionalsworking towards the implementation, adoption and meaningful use of certified EHR systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC’s outreach programs ([REC](http://www.healthit.gov/providers-professionals/regional-extension-centers-recs), [Beacon](http://www.healthit.gov/providers-professionals/beacon-community-centers), [State HIE](http://www.healthit.gov/providers-professionals/state-health-information-exchange)) and through the [Health Information Technology Research Center (HITRC)](http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__rec_program/1495) Communities of Practice (CoPs).

The following resource is an example of a tool used in the field today that is recommended by “boots-on-the-ground” professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

**EHR Implementation Lifecycle**



Description & Instructions

The Legal Health Policy template is intended to aid providers and Health IT implementers with Continuing Quality Improvement. It can be used to identify the organization legal health record for business and legal purposes and to ensure that the integrity of the legal health record is maintained so that it can support legal and business needs.

This is only a template policy and must be revised according to the needs and capabilities of each individual organization utilizing the template. The appropriate person or committee should approve this policy at each organization. Some provisions of this policy may be inapplicable or need to be adjusted depending on circumstances specific to each organization. Everything that is considered a note to the organization adopting the policy has been placed in brackets. These notes should be taken out before the policy is finalized, except for instances such as [organization], in which case the adopting organization's name should be filled in.

Source material and endnotes have been placed in Appendix 2 of this policy template.

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# Purpose

The purpose of this policy is to identify the legal health record of [organization] for business and legal purposes and to ensure that the integrity of the legal health record is maintained so that it can support legal and business needs.[[1]](#endnote-1)

# Policy Statement

It is the policy of [organization] to create and maintain health records that, in addition to their primary intended purpose of clinical and patient care use, will also serve the business and legal needs of [organization].[[2]](#endnote-2)

# Scope

This policy applies to all uses and disclosures of the legal health record for administrative, business, or evidentiary purposes. It encompasses records that may be kept in a variety of media including, but not limited to, electronic, paper, digital images, video, and audio. It excludes those health records not normally made and kept in the regular course of the business of [organization].[[3]](#endnote-3)

# Definitions

* Legal Health Record: The legal health record is the officially declared record of healthcare services provided to an individual delivered by a provider.  It is the record that would be released upon receipt of an authorized request.
* Designated Record Set:A group of records maintained by or for a covered entity that is: (1) the medical and billing records about individuals maintained by or for a covered health care provider; (2) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (3) used, in whole or in part, by or for a HIPAA covered health care provider to make decisions about individuals. For purposes of a designated record set, "record" means any item, grouping, or collection of information that includes protected health information (as such term is defined in 45 C.F.R. § 160.103) and is maintained, collected, used, or disseminated by or for a covered entity.*[[4]](#endnote-4)* Not all records that are part of the designated record set will belong in the legal health record.
* Clinical Record: A group of records created for and/or used for the clinical care of the patient. The clinical record belongs in both the legal health record and the designated record set. Examples of clinical records include:*[[5]](#endnote-5)*
* History and physical
* Orders and Results
* Progress notes
* Lab reports (including contract lab reports)
* Progress notes
* Vital signs
* Assessments
* Consults
* Clinical reports
* Authorizations and consents
* Source Clinical Data: Data created and/or used in the development of the Clinical Record. Such data belongs in both the legal health record and the designated record set. Examples of source clinical data include, but are not limited to:*[[6]](#endnote-6)*
* X-rays
* Images
* Fetal strips
* Videos
* Pathology slides
* External Records and Reports: Available records and reports generated outside of [organization]. Such records and reports may or may not belong in the designated record set and legal health record. Examples of external records and reports include, but are not limited to:
* External records referenced for patient care: other providers’ records, records provided upon transfer
* Patient generated records
* Personal health records
* Committee Reports of Patient-Specific Care Decision: Hospital Committee reports reflecting decisions impacting patient care should not be kept in the record. In those circumstances, practitioners should document the care implications and may reference the fact that a Committee report was considered in determining the course of patient care.
* Administrative and Financial Data: Patient-specific administrative or financial data. Such data belongs in the designated record set but not in the legal health record.*[[7]](#endnote-7)* Examples of administrative and financial data include:
* Super bills/encounter forms
* Remittance advice
* Case management records
* **Metadata:** descriptive data that characterize other data to create a clearer understanding of their meaning and to achieve greater reliability and quality of information. Metadata consist of both indexing terms and attributes.[[8]](#endnote-8)
* **Personal Health Record:** an electronic, universally available, lifelong resource of health information needed by individuals to make health decisions. Individuals own and manage the information in the PHR, which comes from healthcare providers and the individual. The PHR is maintained in a secure private environment, with the individual determining access rights. The PHR is separate from and does not replace the legal health record of any provider.[[9]](#endnote-9)
* Shadow Records: Copies of medical record documents generated by clinical departments as working documents. Clinicians are responsible for ensuring such documents are not used for documenting clinical information that is not already included within the legal health record.[[10]](#endnote-10)

# Template for Policy Content

## Declaration of [Organization’s] Legal Health Record

The <INSERT Organization Name> legal health record is the officially declared record of healthcare services provided to an individual delivered by a provider.  It is the record that will be released upon receipt of an authorized request. The following categories of records are considered part of the legal health record (refer to Appendix 1 to determine whether specific types of records are considered part of the legal health record): clinical records; source clinical data; and external records and reports, if such records and reports are used to make decisions about, and provide health care services to an individual (refer to the section below governing external records). Committee reports and administrative and financial data about patients are generally not considered part of the legal health record.

*[NOTE: Appendix 1, the Legal Health Record Matrix, is a sample inventory of the documents and data that comprise the legal health record. The Matrix identifies (1) the record types that make up the legal health record, (2) the media type in which the record is stored (paper, electronic, scanned, or transcribed), (3) if not paper, the primary source system of the record type, (4) if not paper, the date when electronic storage of this record type began, (5) if not paper, the date when printing of this record type stopped. Additionally, the Matrix identifies the record types that are part of the organization’s designated record set.* ***The Matrix is only a starting point—each organization must carefully review the Matrix and determine for itself which documents and records will constitute the organization's legal health record.****]*

## Document Completion (Lockdown)

Paper portions of the record are considered complete when [*to be completed by each organization*]. Electronic portions of the records are considered complete when [*to be completed by each organization*].

[*NOTE: Each organization will define when both paper and electronic portions of the record are considered complete, and organizations may already have done so in separate polices.[[11]](#endnote-11) Records must be completed promptly and no later than thirty (30) days after a patient's discharge from the hospital.[[12]](#endnote-12) Different categories of documents, whether transcriptions, nursing documentation, scanned documents, etc., may have different rules. It is recommended that a multidisciplinary group be included in discussions to define when electronic documentation will be considered complete.*]

Once the defined completion thresholds are reached, electronic documents are locked and available as read-only. Any subsequent additions, changes, or deletions will be handled as indicated in Section 3.

## Amendments And Corrections

In order to mitigate the need for changes to the record, all attempts will be made to correctly identify patients and their medical conditions prior to documenting within the record. However, there will be instances when changes need to be made to the <INSERT Organization Name> legal health record after it has been completed. Changes may come in the form of addendums (significant clinical corrections), amendments (clarifications), and deletions (elimination of information).

If a change needs to be made, the following rules will apply:

* Patient Name
* Date of Service
* Account Number
* Medical Record Number
* Original Report that the addendum is to be attached to
* Date, time, and signature of the addendum
* Identification and tracking of corrections will not be limited to a background or back-end program visible only to IT staff.[[13]](#endnote-13)
* Corrections will be made in the source system (where it was originally created) as well as in the long-term medical record, data repository, and/or archive system.[[14]](#endnote-14)
* The original incorrect entry or document will be maintained with the corrected entry or companion document added to it.[[15]](#endnote-15)
* For deletions, the electronic system should be able to hide the original data from view. However the original information must be retained and made available if necessary. *[NOTE: Different systems will handle this in different ways.]*[[16]](#endnote-16)
* Once a document has been amended, <INSERT Appropriate Staff or Department> will distribute updated copies of the document as required pursuant to HIPAA policies and procedures,[[17]](#endnote-17) or as otherwise determined by the <INSERT Organization Name>. [*NOTE*: *HIPAA provides individuals with the right to request amendment of their protected health information and requires covered entities to notify those who have been provided protected health information, which is the subject of the amendment, of accepted amendments. In certain circumstances, organizations may determine to notify others of amendments regardless whether the amendment was initiated at the request of the subject of the information at issue*.]

## Authentication, Timing and Dating

[*NOTE: The organization should already have separate policies and procedures (or medical staff bylaws or rules and regulations) that address all or some of the issues below regarding authentication of medical record entries. If this is the case, the organization may consider removing this section from the policy and including a reference here to such policy.*]

Consistent with state and federal law, all entries in the medical record will be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided.[[18]](#endnote-18)

* The time and date of each entry will be accurately documented.[[19]](#endnote-19) The author will separately date and time his/her signature authenticating an entry, even when there may already be a date and time on the document, since the latter may not reflect when the entry was authenticated. If the date and time are automatically recorded with the author's authentication of an electronically-generated document, the requirements of this section would be satisfied.[[20]](#endnote-20)
* <INSERT Organization Name> shall verify the identity of the author of each entry, including faxed orders/entries or computer entries.[[21]](#endnote-21) [NOTE: Organizations with a specific method for verification may wish to include more detail here.]
* Each author of an entry must verify that the entry being authenticated is his/her entry or that he/she is responsible for the entry, and that the entry is accurate.[[22]](#endnote-22) [NOTE: Organizations with a specific method for verification may wish to include more detail here.]
* The requirements for dating and timing do not apply to orders or prescriptions that are generated outside of the hospital until they are presented to the hospital at the time of service. Once the hospital begins processing such an order or prescription, it will be responsible for ensuring that the implementation of the order or prescription by the hospital is promptly dated and timed in the patient’s medical record.[[23]](#endnote-23)

*[NOTE: The organization should define how entries are actually authenticated—authentication of medical record entries may include written signatures, initials, computer key, or other code, depending on the circumstances. When electronic authorizations are used for authentication, the hospital will have policies and procedures to ensure that such authorizations are used only by the individuals whose signature they represent.[[24]](#endnote-24) The organization should have HIPAA policies that address safeguarding of user name and password/key/other method of authentication, but could include policy language here if no other policy addresses such safeguards.]*

* <INSERT Organization Name>’s policies and/or medical staff rules and regulations will address counter-signature requirements and processes.[[25]](#endnote-25)

*[NOTE: There may be times when an individual forgets to enter documentation at the time of care delivery and another individual makes entries on his or her behalf. Policy must indicate when this is appropriate and how it will be handled based on functionality within the EHR. To ensure adherence to state regulatory requirements, organizations should also review state-specific guidelines on authenticating orders.[[26]](#endnote-26) Note that state and federal law will have an effect on how this part of the policy is drafted. Under state and federal law, certain types of orders for services may be made only by physicians, or at least with their cosignature; cosignatures of verbal and telephone orders must be within 48 hours; and if a practitioner signs an order or entry on behalf of another (and has independent authority under his/her licensure/privileges to issue such an order him-/herself), the signing practitioner will generally become responsible for the order or entry. Whatever process or language that may be adopted here must be coordinated with those state and federal limitations.]*

* Authentication of each health record entry should be visible to anyone with access to the entry. Authentication should not be limited to a background or back-end program visible only to IT staff. Authentications should be readable when documents are printed.[[27]](#endnote-27)

## Versioning

[NOTE: In circumstances in which the organization has multiple document versions (such as when preliminary transcribed reports are made available for viewing prior to authentication or review by the author), the organization will use this section to define the following:

* *Whether all versions of a document will be displayed or just the final version*
* *Who has access to the various versions of a document*
* *How the availability of versions will be flagged in the EHR.*
* *The acceptable period of time allowed for a document to remain in draft form before the author reviews and approves it (e.g., 24 to 72 hours).[[28]](#endnote-28)*

*It is recommended that a multidisciplinary group of physicians, risk management, HIM, and IT professionals should be included in making these determinations.[[29]](#endnote-29)*]

Once a document is no longer considered a draft or has been authenticated, any changes or alterations should be made following the procedures for amendments and corrections (see Section 3).[[30]](#endnote-30)

**[***NOTE: Other Considerations Regarding Versioning*

Every organization should determine the capacity of their medical record in each state of being (paper, hybrid, or fully electronic) to allow appropriate viewing of earlier versions of documents and develop policy that reflects the capability of the individual EHR. At the very least, caregivers should be made aware that earlier versions of documents exist and must be able to access them if needed.*[[31]](#endnote-31)*

Policies and procedures are also needed detailing how disclosures of documents with multiple versions are to be handled. Are all versions to be released or only the final version? Each organization must specify what will be released when copies of the record are requested. It may be acceptable to release only the final version of documents if there have been no changes between versions except the addition of signatures or minor editorial changes. However, if clinical information that may have been critical to caregiver decision making has changed, it may be appropriate to release previous versions of documents in addition to the final version.[[32]](#endnote-32)

Another consideration is the HIPAA requirement to inform those parties who may have been sent copies of health records when there is a change (as discussed in Section 3 of this policy template).*[[33]](#endnote-33)*]

## External Records, Including from PHRS And Information Exchanges

Only if external records and reports are used to make decisions about the health care of an individual in order to provide the individual with health care services do they become part of the <INSERT Organization Name>’s legal health record.[[34]](#endnote-34) Records created pursuant to a contract (such as a reference lab or outsourced radiology services), and records generated by other providers that are used for planning patient care (such as records received in an Emergency Medical Treatment and Active Labor Act transfer between hospitals) will be included in the legal health record if the records are used by a practitioner to make care decisions.[[35]](#endnote-35)

Copies of personal health records that are created, owned, and managed by the patient and are provided to the <INSERT Organization Name> will be considered part of and will be incorporated into the legal health record only if the information is used to provide patient care services, review patient data, or document observations, actions, or instructions. This includes patient-owned, -managed, and -populated tracking records, such as medication tracking records and glucose and insulin tracking records.[[36]](#endnote-36)

Clinical records accessed from health information exchanges will be considered part of the legal health record only if the information is used to provide patient care services, review patient data, or document observations, actions, or instructions.

[NOTE: The organization should include here a procedure for identifying external information that has been used to provide patient care services and thus is part of the legal health record. The health records manager or other designated position should collaborate with clinicians to develop such a procedure. This may entail somehow marking the information, special delivery provisions (e.g., sending records to HIM department), or other methods that help clearly indicate that external information was used. Once identified as such, provisions will be made for including this in the patient’s record, whether paper or electronic. Within the record, consideration will be given to filing or indexing the external information under a separate tab or section of the electronic or paper record developed for this purpose.*[[37]](#endnote-37)*]

## Outpatient Records

The <INSERT Organization Name> will maintain a medical record for each patient who receives outpatient services. The record shall be maintained and correlated with inpatient and emergency medical records.

*[NOTE: The organization may already have a separate policy addressing outpatient records or providing that they will be correlated with inpatient and ER records. If this is the case, the organization may consider removing this section and including only a reference to the other policy.*

*Also, to the extent that this or another policy and associated Matrix (Appendix 1) do not identify the organization’s clinic legal health record, a separate policy should be developed for that purpose. This hospital policy format may be customized to specifically identify the clinic legal health record.]*

## Responsibilities

It is the responsibility of <INSERT the health records manager or other designated position> to[[38]](#endnote-38):

* Work in conjunction with information services, legal services, and [other stakeholders] to create and maintain a matrix or other document that tracks the source, location, and media of each component of the health record. [see Appendix 1 for matrix]
* Identify any content that may be used in decision-making and care of the patient that may be external to the organization (outside records and reports, PHRs, e-mail, etc.) and to determine whether such content should be included as part of the legal health record. [*NOTE: The organization may wish to include in this responsibility the verification of the validity of external records. In some circumstances, such as when records are received from other health care providers or the patient provides records that he/she created (e.g., insulin tracking records), there may be no need for additional verification. But if records are received from an unfamiliar source (e.g., an unfamiliar PHR source) or there is a question raised as to the validity of any record, further verification should be pursued because including unverified records in the legal health record could put the organization at risk.*]
* Develop, coordinate, and administer a plan that manages all information content, regardless of location or form that comprises the legal health record of <INSERT Organization Name>.
* Develop, coordinate, and administer the process of disclosure of the legal health record and other health information.
* [NOTE: The organization may want to include additional responsibilities here.]

## Maintenance and Revision

The Legal Health Record Policy will be reviewed and revised as necessary on an annual basis or as often as necessary to ensure that the information it contains is up-to-date and reflects current information. The <INSERT Organization Name> will be responsible for ensuring policy maintenance and revision.

## Staff Education and Training

Relevant members of the <INSERT Organization Name> workforce shall be provided education and training in the Legal Health Record Policy upon hire and as needed to reflect any significant changes to the policy. Workforce members with specific responsibilities for LHR and DRS disclosure shall receive the necessary education and training required to ensure that they can carry out their assigned duties.

# Appendix 1 - Legal Health Record Matrix

[*NOTE: The determinations below regarding the listing of types of records and whether those records are part of the LHR, DRS, or both, are decisions that need to be made by each individual organization. Note that there will be ambiguity in determining whether certain types of record are part of the LHR, DRS, or both—different organizations could reasonably disagree about some of the determinations below.*]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Type of Record or Document | Media Type: (P)Paper,  (E)Electronic, (S)Scanned, (T)Transcribed | Primary Source System (If not paper based) | Electronic Storage Start Date | Stop Printing Start Date | Part of (LHR)Legal Health Record, (DRS) Designated Record Set, or (B) Both |
| Facesheet |  |  |  |  | B |
| Advance Directive |  |  |  |  | DRS [*NOTE: if the advance directive is used to make decisions regarding providing health care services to a patient, it may also be considered part of the LHR*] |
| H&Ps: Dictated Hospital Report |  |  |  |  | B |
| Short Form |  |  |  |  | B |
| Clinic Notes |  |  |  |  | B |
| ACOG Forms |  |  |  |  | B |
| OB Outpatient Record |  |  |  |  | B |
| Newborn Physical Examination Sheet |  |  |  |  | B |
| Fetal strips |  |  |  |  | B |
| Inpatient ER Dr./Nurse Reports |  |  |  |  | B |
| Inpatient ER Orders, Vitals, Etc. |  |  |  |  | B |
| Inpatient Ambulance Reports |  |  |  |  | B |
| Inpatient Code Blue Forms |  |  |  |  | B |
| Outpatient ER Orders, Vitals, Etc. |  |  |  |  | B |
| Outpatient ER Ambulance Report |  |  |  |  | B |
| Outpatient ER Code Blue Forms |  |  |  |  | B |
| Discharge Summary |  |  |  |  | B |
| 48 Hr. Discharge Summary |  |  |  |  | B |
| Consultations |  |  |  |  | B |
| Old Records-other facilities |  |  |  |  | DRS [NOTE: Are these records ever used to provide the patient with health care services? If so, this might change to "B."] |
| Nursing Home Reports |  |  |  |  | DRS [NOTE: Are these records ever used to provide the patient with health care services? If so, this might change to "B."] |
| Copies of treatment from other facilities/providers |  |  |  |  | DRS [NOTE: Are these records ever used to provide the patient with health care services? If so, this might change to "B."] |
| Surgery: Operative Report |  |  |  |  | B |
| Pathology Report |  |  |  |  | B |
| Operative Pictures |  |  |  |  | B |
| Endoscopy Record |  |  |  |  | B |
| Anesthesia Record |  |  |  |  | B |
| Operating Rm. Nursing Assess. |  |  |  |  | B |
| “Yellow” EKG Sheets |  |  |  |  | B |
| Post Anesthesia/RR Record |  |  |  |  | B |
| Pre-operative Checklist |  |  |  |  | B |
| Consents: Initial Treatment |  |  |  |  | B |
| Surgical/all types of procedures |  |  |  |  | B |
| Delivery Summary |  |  |  |  | B |
| Physician Progress Notes |  |  |  |  | B |
| Diagnostic and Therapeutic Orders |  |  |  |  | B |
| Medication Reconciliation Form |  |  |  |  | B |
| Transfusion Sheets |  |  |  |  | B |
| Lab Results |  |  |  |  | B |
| Reference Lab Results |  |  |  |  | B |
| Radiology Reports |  |  |  |  | B |
| X-ray films/images, videos |  |  |  |  | B |
| EKGs: Electrocardiogram |  |  |  |  | B |
| Dictated Results |  |  |  |  | B |
| Mounted Strips |  |  |  |  | B |
| Echocardiogram Report |  |  |  |  | B |
| Stress Test Report |  |  |  |  | B |
| Pulmonary Function: Reports |  |  |  |  | B |
| Records (graphs, etc.) |  |  |  |  | B |
| Other Diagnostic Results |  |  |  |  | B |
| Therapy (Rehab): Initial Evaluation |  |  |  |  | B |
| Notes |  |  |  |  | B |
| Autopsy |  |  |  |  | B |
| Anatomic |  |  |  |  | B |
| MARs |  |  |  |  | B |
| Nursing Assessments & Notes |  |  |  |  | B |
| Transfer Forms |  |  |  |  | B |
| [*name of clinic*]: Physician Notes |  |  |  |  | B |
| Well Visit Forms |  |  |  |  | B |
| Nursing Home Visit Notes |  |  |  |  | DRS [NOTE: Are these records ever used to provide the patient with health care services? If so, this might change to "B."] |
| Problem/Summary Lists, forms, etc. |  |  |  |  | B |
| Correspondence and Notes of Other Communication with the Patient (e.g., phone call) |  |  |  |  | DRS [NOTE: Are these records ever used to provide the patient with health care services? If so, this might change to "B."] |
| Case Management/UR forms |  |  |  |  | [NOTE: such forms should probably be included in the legal health record only if they are used to make patient-specific health care decisions.] |
| Medicare Notification Forms (IM) |  |  |  |  | DRS |
| ROI Authorizations |  |  |  |  | DRS |
| Fax coversheet |  |  |  |  | DRS [NOTE: unless the fax coversheet contains substantive information, it may not be considered part of either the LHR or DRS.] |

\*NOTE: Any printed electronic/transcribed report that has a handwritten note written on it becomes a permanent part of the legal health record

\*\*Designated Record Set is separate and distinctive policy.

# Appendix 2 - Standards to Consider in Defining the Legal Health Record

* Health Insurance Portability and Accountability Act (HIPAA) of 1996
* Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) – CAH, PPS, Rural Health Clinic
* State Hospital Regulations (DHS chapter 124)
* Other State Laws
* Accreditation Standards
* Joint Commission
* American Osteopathic Association
* DNV Healthcare, Inc.
* State Public Health Regulations
* State Medical Malpractice Laws

1. “AHIMA--Developing a Legal Health Record Policy;” Members of AHIMA EHR Practice Council [↑](#endnote-ref-1)
2. ibid [↑](#endnote-ref-2)
3. ibid [↑](#endnote-ref-3)
4. 45 C.F.R. § 164.501. Note that a separate policy and procedure addresses the designated record set, which is a term defined by HIPAA that is relevant to patient access to and requests for amendment of records. [↑](#endnote-ref-4)
5. ibid [↑](#endnote-ref-5)
6. ibid [↑](#endnote-ref-6)
7. ibid [↑](#endnote-ref-7)
8. “AHIMA--Developing a Legal Health Record Policy;” Members of AHIMA EHR Practice Council [↑](#endnote-ref-8)
9. ibid [↑](#endnote-ref-9)
10. “Legal Parameters of the EMR and Hybrid Medical Record;” Sarah Coyne [↑](#endnote-ref-10)
11. “Developing a Legal Health Record Policy,” AHIMA Workgroup [↑](#endnote-ref-11)
12. 42 C.F.R. § 482.24(b); Medicare State Operations Manual, Appendix W, Tag C-0306; Wis. Admin. Code DHS § 124.14(3)(c). [↑](#endnote-ref-12)
13. “Developing a Legal Health Record Policy,” AHIMA Workgroup [↑](#endnote-ref-13)
14. “The Strategic Importance of Electronic Health Records Management,” AHIMA Workgroup 2004 [↑](#endnote-ref-14)
15. ibid [↑](#endnote-ref-15)
16. ibid [↑](#endnote-ref-16)
17. ibid [↑](#endnote-ref-17)
18. ibid [↑](#endnote-ref-18)
19. ibid [↑](#endnote-ref-19)
20. ibid [↑](#endnote-ref-20)
21. ibid [↑](#endnote-ref-21)
22. ibid [↑](#endnote-ref-22)
23. ibid [↑](#endnote-ref-23)
24. ibid [↑](#endnote-ref-24)
25. ibid [↑](#endnote-ref-25)
26. “Developing a Legal Health Record Policy,” AHIMA Workgroup [↑](#endnote-ref-26)
27. ibid [↑](#endnote-ref-27)
28. ibid [↑](#endnote-ref-28)
29. ibid [↑](#endnote-ref-29)
30. ibid [↑](#endnote-ref-30)
31. “The Strategic Importance of Electronic Health Records Management,” AHIMA Workgroup 2004 [↑](#endnote-ref-31)
32. ibid [↑](#endnote-ref-32)
33. ibid [↑](#endnote-ref-33)
34. “AHIMA--Defining and Disclosing the DRS and LRH;” Michelle Dougherty and Lydia Washington [↑](#endnote-ref-34)
35. Ibid [↑](#endnote-ref-35)
36. “AHIMA Update: Guidelines for Defining the Legal Health Record for Disclosure Purposes.” [↑](#endnote-ref-36)
37. “AHIMA--Defining and Disclosing the DRS and LHR;” Michelle Dougherty and Lydia Washington [↑](#endnote-ref-37)
38. “AHIMA--Developing a Legal Health Record Policy;” Members of AHIMA EHR Practice Council [↑](#endnote-ref-38)