Clinical Operations Policy 605

The Maintenance of Clinical Records

Effective Date: July 31, 2019
Supersedes Date: May 1, 2023
Review Date: May 2026

Policy: All client records will be current, orderly, secure, and confidential.

Procedure:

I. Current Practice

a. Documentation should be scanned into the EMR system, IMS. This is to include all protocol forms, reports, patient signed forms, etc. These forms should be entered as the date the patient was seen and under the correct heading for the type of appointment and paperwork completed.

II. Confidentiality

a. All patient information is to be kept confidential and should never be discussed with anyone not directly involved in the case.
b. All requests for confidential information are to be handled by the HIPAA Privacy Office, their designee, or business office.
c. The signed release of information is valid for a period of 4 months.
    i. At the age of 18 years, patients should sign a current release of information for themselves.
    ii. Individuals over the age of 18 and under the guardianship of parents, a person, or an agency, will need to provide proof of a Healthcare Power of Attorney that will then be into their electronic file.
    iii. A release signed by a patient, parent, or guardian, is required before a report can be set to an entity other than the referring agency.
    iv. No Protected Health Information (PHI) will be divulged over the telephone without signed consent.
    v. Refer to the Clinical Operations Policy 215 or the SCSD HIPAA Manual or the HIPAA Compliance Committee for further information regarding HIPAA.

III. Prior to August 2023

a. Location and security of Patient Physical Master Files
    i. Each patient was given a physical file, prior to August 2023. These files are kept in the file room, located in the business office. The file room is monitored during working hours and is only accessible via badge access after-hours.
    ii. Patient physical files are to never leave the building. A student or faculty member may review the file, if needed, within the file room.
b. Order of Master Files (blue)
    i. Each blue file contains the following information. Documents not listed below were not kept in the file and scanned into the previous

EMR system, Cerner, before being transferred to the new EMR system, IMS.

ii. Left Side
    1. Demographic sheet containing all demographic information, insurance, and parent/guardian information.

iii. Right Side
    1. MSHC Reports such as the SLP original evaluation or DDS reports; SLP test forms including protocol forms; Audiology hearing aid data.

c. The physical files (tan and blue) will be kept in the file cabinet for 5 years. After a file has been inactive for 5 years, it is removed, and placed in a locked closet in MSHC for an additional 5 years.
    i. Tennessee law specifies that medical records are to be kept for 10 years after the last professional contact.
    ii. The records of minors are kept for 10 years after the last professional contact and/or until the minor is 19 years of age, whichever is longer