



Medical Record Retention, Access and Maintenance

What professional responsibilities do physicians have with regard to medical records?

Physicians have both ethical and legal responsibilities relating to the maintenance and privacy of medical records.

According to the American Medical Association (AMA), Code of Medical Ethics, medical records serve important patient interests for present and future health care needs, as well as insurance, employment, and other purposes. Physicians have a professional responsibility to safeguard the confidentiality of patients' personal information, and thus have an ethical obligation to manage medical records appropriately. This obligation includes not only managing the records of current patients, but also retaining old records for possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient's authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies.

Specifically, AMA Code of Medical Ethics Opinion 3.3.1 states that physicians, or the individual responsible for the practice's medical records, should make the medical record available in the following circumstances:

- As requested or authorized by the patient (or the patient's authorized representative)
- To the succeeding physician or other authorized person when the physician discontinues his or her practice (whether through departure, sale of the practice, retirement, or death)
- As otherwise required by law

In addition to ethical requirements, Minnesota physicians may be subject to disciplinary action by the Board of Medical Practice for failure to adhere to adequate medical record practices. A physician may be subject to disciplinary action for improper management of medical records, including failure to maintain adequate medical records, failure to comply with certain requests for medical records, or failure to furnish a medical record or report required by law.

Therefore, it is the responsibility of the physician, or the individual responsible for the practice's medical records, to maintain adequate records and ensure that the practice or institution has and enforces clear policy with respect to managing access to a patient's medical record and information.

Who owns a patient's medical records?

Although the tangible, physical medical record is generally understood to be owned by the physician or facility responsible for compiling and maintaining the medical record, patients have broad control over the release of their medical records to third parties. Under Minnesota law, upon request, a provider must supply to a patient the complete and current information possessed by that provider concerning any diagnosis, treatment, and prognosis of the patient in terms and language the patient can reasonably be expected to understand. Minnesota law also requires providers to provide to patients, in a clear and conspicuous manner, a written notice concerning practices and rights with respect to access to health records.

Minnesota law further states that, upon a patient's written request, a provider, at a reasonable cost to the patient, shall promptly furnish to the patient: (1) copies of the patient's health record, including, but not limited to, laboratory reports, X-rays, prescriptions, and other technical information used in assessing the patient's health conditions; or (2) the pertinent portion of the record relating to a condition specified by the patient. With the consent of the patient, the provider may instead furnish only a summary of the record. The provider may exclude from the health record written speculations about the patient's health condition, except that all information necessary for the patient's informed consent must be provided.

Can a provider charge a fee to a patient requesting access to his or her medical record?

Minnesota Statute §144.292 regulates the fees that providers may charge for providing copies of health records to patients in most circumstances. Generally speaking, providers may not charge a fee when a patient requests a copy of his or her record for purposes of reviewing current medical care. Providers may, however, charge a fee for copies of patient records that are requested for other purposes or for records of care that was previously provided. The maximum permissible charge for medical records change each year based on the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U), published by the Department of Labor. Information regarding the maximum charges for patient records can be found on the Minnesota Department of Health's website. In addition to per page copy charges, physicians may charge the patient the actual cost of reproducing x-rays plus no

(continued on next page)

Medical Record Retention, Access and Maintenance

(continued from previous page)

more than \$10 for time spent retrieving and copying the x-rays. Different standards apply for health records relating to worker's compensation claims, Social Security disability claims, and for patients receiving public assistance.

Worker's Compensation

Allowable fees for health records relating to worker's compensation claims are established in Minnesota Rules 5219.0300. Health care providers may charge for copies of any records or reports regarding work injury claims for which payment is sought. Charges for copies provided must be reasonable and, for the first request, the charge must not exceed \$0.75 per page. Other requests for copies of existing medical records or data may be charged a \$10 retrieval fee and \$0.75 per page. The provider may charge fees different than what is stated above but the combination of retrieval fee and per page copy may not exceed the sum established by the rule.

Social Security Disability and Public Assistance

A provider or its representative may charge a \$10 retrieval fee, but may not charge a per page fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act. Additionally, no fee may be charged for health records provided to a person who is receiving public assistance or to a person who is represented by an attorney on behalf of a civil legal services program or a volunteer attorney program based on indigency. For the purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided.

How should medical records be stored?

Proper storage of medical records is an important component of a practice, and is particularly important when selling, transferring, or closing a practice. According to the AMA Code of Medical Ethics, physicians, or the individual responsible for the practice's medical records, should appropriately store records not transferred to the patient's current or new physician. Furthermore, a patient must be notified about how to access the stored record and for how long the record will be available following the closure, transfer, or sale of a practice. As a general rule, the tangible, physical medical record is owned by the physician or facility responsible for compiling and maintaining it. Although the physician has the right to possess and control the medical record, the patient generally has the right to access

and control the distribution of the information contained in the record.

Generally, a healthcare provider remains liable for any disclosure of health information during or after a closure. Therefore, the provider must make appropriate plans to protect the integrity of the records and the confidentiality of the information they contain, while ensuring access for continued patient care. When selling, transferring, or closing a practice, the physician, or the individual responsible for the practice's medical records, should consult with an attorney to help determine what to do with medical records (1) when closing a practice; (2) after the retirement or death of a physician; and, (3) during and after the sale of a medical practice.

How long must a physician retain a patient's medical records?

Minnesota law does not specify the length of time that physicians must maintain medical records; however, the context in which medical records are created often determines the length of time which the records must be retained.

Medicare and Medicaid Requirements

The Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules require a covered entity, such as a physician billing to Medicare, to retain required documentation for six years from the date of its creation or the date when it was last in effect, whichever is later. Medicare managed care program providers must maintain records for at least 10 years and additional Medicare or Medicaid retention requirements may apply.

Hospitals

Unlike individual physicians, hospitals have specific record maintenance requirements under Minnesota law. Minnesota hospitals must indefinitely maintain each patient's individual permanent medical record.

Third Party Payer Requirements

Some insurers and other third party payers require that health plan enrollees' medical records be kept for a certain time period. Physicians should review all contracts with third party payers to ensure compliance in this area.

Although Minnesota law does not address the issue of physician retention of medical records specifically, the AMA Code of Medical Ethics provides some guidance. AMA Medical Ethics Opinion 3.3.1 states that, to manage medical records responsibly, physicians should "use medical considerations to determine how long to keep records, retaining information that another physician seeing the patient for the first time could reasonably be expected to need or want to know unless otherwise required by law, including:

(continued on next page)

Medical Record Retention, Access and Maintenance

(continued from previous page)

- Immunization records (which should be kept indefinitely)
- Records of significant health events or conditions and interventions that could be expected to have a bearing on the patient's future health care needs, such as records of chemotherapy.”

Retention of all medical records should be dealt with in a consistent manner and patients should be informed of the retention policy of the clinic. Physicians, or the individual responsible for the practice's medical records, should seek the advice of an attorney with questions about how long to retain specific medical records.

How should medical records be destroyed?

Clinics should establish clear record destruction policies and procedures should be established and followed so that all documents are properly destroyed and confidentiality is maintained. According to the AMA, physicians, or the individual responsible for the practice's medical records, should ensure that the records that are to be discarded are destroyed in such a way that confidentiality is protected – for example, shredding a paper document so that the information in the document is inaccessible.

When planning to destroy medical records, a physician, or the individual responsible for the practice's medical records, should consult with an attorney familiar with record-retention requirements and who can provide advice on methods of destruction if clear policies are not in place at the clinic. If possible, the physician, or individual responsible for the patient's medical records, should give patients sufficient notice and an opportunity to retrieve their records.

Where can I find additional information?

Additional information about health privacy and medical record requirements are available at:

- [American Medical Association Code of Medical Ethics: Opinion 3.3.1, Management of Medical Records.](#)
- [Minnesota Health Information Clearinghouse: Frequently Asked Questions about Medical Records](#)
- [Minnesota Board of Medical Practice: Patients' Access to their Medical Records](#)
- [Minnesota Health Records Act: §§144.291-144.34](#)
- [Medicare Learning Network Health Care Professionals' Privacy Guide](#)
- [U.S. Department of Health And Human Services HIPAA Frequently Asked Questions for Professionals](#)

Disclaimer

The information in this document is intended to provide general education only, and does not provide specific legal advice. This document does not create an attorneyclient relationship and is not a substitute for the advice of an attorney. It is always best practice to obtain legal advice from an attorney with expertise in the relevant subject matter and jurisdiction. Contract law varies from state-to-state, and this document is not intended to address each state's laws. The Minnesota Medical Association makes no guarantee as to the completeness of the information in this document.

For more information, contact:

Becca Branum, JD
Policy Counsel
Minnesota Medical Association
PHONE: 612-362-3738
EMAIL: bbranum@mnmed.org