Allied Health Medical Law & Ethics

Module D. 1

The Medical Record

Purposes of the Medical Record

- Medical picture from birth to death
- Depicts all instances of management of patient's health care and health patterns
- Provides data and statistics
  - Birth
  - Death
  - Communicable diseases

Contents of the Medical Record

- Personal information
- Admitting Dx
- Consent forms
- Consultation reports
- Clinical notes
- Discharge summary

Charting Guidelines

- Errors require correction
- Nothing should be deleted
- Accurate and timely
- Comprehensive notes
- Credible entries

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Medical Record Ownership

- Physicians or owners of health care facility
- Patients have legal right of "privileged communication" and access to records
- Patients may be given a copy of their medical record

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Medical Record Confidentiality

- Release of information
  - should not be released to a third party without patient's written consent
- Only specific records requested should be copied and sent

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Retention and Storage of Medical Records

- Legally, records must be stored for a minimum of ten years from time of last entry
- Current records usually kept within physician's office
- Former patient records may be stored elsewhere

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Electronic Medical Records

- Data on patient records can be created, modified, authenticated, stored, and retrieved by computer
- Special measures should be taken to establish identification and user verification codes for access

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Use of Medical Record in Court

- **Improper Disclosure**
  - Civil and criminal liability for releasing medical records without proper authorization
- **Subpoena *Duces Tecum***
  - Written order requiring person to appear in court
  - Follow appropriate guidelines

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Suggested Reference

Fremgen, B.F., Medical Law and Ethics, 5th edition (2016). Pearson Education, Inc. ISBN 978-0-13-399898-6

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Credits

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