



Archive and Destruction of Patient Records

If you have run out of room to store paper records you may need to archive the original documents. A comprehensive archive process, with written policies and procedures will help you meet your professional standards and legislative requirements.

A physician who closes a medical practice is responsible for the secure storage and disposition of the patient records from that medical practice. This applies if the physician manages the storage of the records himself and when he contracts with another physician or service provider.

You may have inactive patient records – patients may have deceased, left your practice, or simply have not returned to the practice for a length of time.

The Health Information Act makes information security provisions requiring custodians to protect individually identifying health information in their custody or control by making reasonable security arrangements to protect against unauthorized access, collection, use, disclosure, or destruction. These same procedures apply to other types of important records in your practice – employee, accounting, business contracts, for example – that requires secure safeguards.

Whatever the reason that you have decided that you need to archive your records, the following are key points for your consideration.

Inventory:

Whether you plan to move, archive, or transfer the patient files to another custodian, you need to know what patient records you currently have. Prepare an inventory or listing of all patient records that you have initiated during your practice. This can often be generated from existing data sources like your billing or EMR system's central patient index. The inventory should include, at minimum, the following information:

- Patient's first and last name
- Date of birth
- First and last visit date
- Primary physician's name

See the sample procedure "Archive and Destruction of Patient Records" and its forms to help you record your inventory.

Records Retention:

Determine which, if any, records have met the minimum records retention policy and which could be securely destroyed. The Alberta College of Physicians and Surgeons Retention Schedule states that chart destruction may occur 10 years after the end of the year in which the

last visit was recorded and at the end of the 20th year following birth for records of minors who are no longer patients whichever comes later. (CPSA Standard 21, section 9).

Note: sometimes it seems that it is easier to keep records forever rather than destroy them after the retention periods and legislative requirements are met. However, remember that you may be required to produce or provide access to records for as long you continue to have custody of records.

Destruction:

Ensure that you have recorded which records have been destroyed, the method of destruction, and the date and signature of the person responsible for the destruction. See the disclosure log form in the sample procedure “Archive and Destruction of Patient Records”.

Information Manager:

If a physician closing his/her medical practice is unable to provide ongoing management of patient medical records, either personally or through a colleague, they should be put into commercial storage for custody, transfer as necessary, and destruction when that is appropriate. The above steps to create an inventory of patient records apply here, too.

When a doctor leaves a group practice, there should be a satisfactory arrangement made for transfer of appropriate records; the patients should not be left with the responsibility of obtaining them.

If you outsource the work of archiving your records, the vendor will likely be considered an information manager (as defined by Health Information Act) or a business associate in other legislation.

An Information Management Agreement (IMA) is a legislative requirement of the Health Information Act. Section 66(2) requires that the agreement be in writing; section 7.2 of the Health Information Regulation specifies the details of the agreement.

Patient Access:

The information in a medical record belongs to and must be provided to the patient when it is requested. In the event of closing a medical practice you can anticipate that there will be many requests to access records. Review (and revise if necessary) your written policies and procedures to ensure that you have an efficient process that accurately documents the request.

The custodian has the right to charge a fee for access requests as defined by Health Information Act s 67 and Health Information Regulation, s 9, 10, 11, and 12. The basic fee of \$25 may be applied (or waived by the custodian). Additional fees may be charged for producing a copy of a record. See Health Information Regulation Schedule. (for example, photocopies \$0.25 per page after the first 25 pages, producing a record from an electronic record \$10 per ¼ hour)

Reminders:

1. This archive and destruction log is maintained permanently by the Clinic Manager on behalf of the custodian(s).
2. Archive and destruction can be done at two separate stages. You may archive (or thin out) paper records for a transition period and record the archived records in the log. When the records meet retention periods (and the practice makes appropriate decisions) the archive log can be used again as destruction log.
3. Prior to implementing, ensure that you have reviewed and documented your records retention requirements with related professional colleges and legislation.

This document management tip is intended to help you along your journey by guiding you through a series of questions and providing resources to get started.

It is expected that you will review and refine these documents to meet your needs.

Related Information Managers Ltd resources:

Document Management Tip: Scan and Shred Quality Assurance – or - Quality Assurance Document Imaging (Scan) to EMR
Document Management Tip: Closing (or Moving) a Physician Practice
Practice Management Nugget Webinar: Archive and Shred Oh My!

Resources and References:

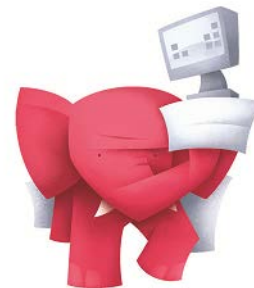
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Information Managers provides a workshop series on *Privacy, Confidentiality, and Security for Medical Offices*© for clinics by webinar, public workshops and customized on-site workshops to private practices.

Information Managers *It's the elephant in the room: your practice depends on your record management, and the privacy and protection of all kinds of confidential information.*



But sometimes taking care of this elephant can be a challenge.

We're here to help. Information Managers specializes in health information management, policies & procedures, records management, clinic management practice efficiency and workflow consultation as well as privacy and security in the Health Care sector.

We give you the confidence to take care of the elephant in the room.

This publication provides general guidance for a medical office in Alberta. Consultation with your information systems, health records, and privacy office is recommended. For additional assistance, contact Information Managers Ltd.

Procedure #____: Archive and Destruction of Patient Records

Start Date:

Revision Date :

Approved By:

Date:

Purpose: Record patient records which have been purged and destroyed

Scope: All original patient records

Prerequisites: Must meet retention requirements

Materials Needed: Outdated, inactive patient records

Performed by:

1. Identify patient records that are eligible to be purged and destroyed.
 - a. Retention Schedule: The Alberta College of Physicians and Surgeons Retention Schedule states that chart destruction may occur 10 years after the end of the year in which the last visit was recorded and at the end of the 20th year following birth for records of minors who are no longer patients whichever comes later. (CPSA Standard 21, section 9)If purging records in 2014,
 - i. Last visit must be 2004 or earlier and
 - ii. Patient's date of birth must be 1994 or earlier

If records have patient demographic sheet at the front of the chart,

2. Review patient record to ensure that each page in the record belongs to the same patient.
3. Ensure patient demographic sheet has (at minimum) the following:
 - a. First and last name (circle in felt marker)
 - b. Date of birth (circle in felt marker)
4. Remove patient demographic sheet
5. In addition, record (in felt marker at bottom of page):
 - a. The first and last visit date
 - b. The primary physician
 - c. Date purged, initials of staff, and how record was destroyed (this could be pre-printed on computer generated labels for consistency and efficiency)
6. Maintain patient demographic sheets, in alphabetical order by last name, in binder (location details)
7. Look up patients and append a note in the central patient index and add date of destruction.
 - a. Consider – if patient was not previously in central patient index, should it be entered at this time?
 - b. **If records do not have patient demographic sheet at the front of the chart,** record the patient information in a separate document (sample attached). To make retrieval of information easier, this could be entered into an excel spreadsheet.

Archive and Destruction of Patient Records Log

Last Name	First Name	Other Name	Date of Birth (spell month)	First visit date	Last visit date	Primary physician	Date purged	Initials of Staff	How destroyed