7 AAC 12.770. MEDICAL RECORD SERVICE

(a) Each facility, with the exception of home health agencies, hospice agencies, intermediate care facilities for the mentally retarded, and birth centers, must have a medical record service that complies with the applicable provisions of this section. A frontier extended stay clinic must comply with (b), (d), (g), and (i) - (k) of this section in addition to the requirements of 7 AAC 12.483.

(b) A facility must keep records on all patients admitted or accepted for treatment. The medical records, including x-ray films, are the property of the facility and are maintained for the benefit of the patients, the medical staff, and the facility. Medical records are subject to the requirements of AS 18.05.042, 7 AAC 43.030, and 7 AAC 43.032. This section does not affect other statutory or regulatory requirements regarding access to, use of, disclosure of, confidentiality of, or retention of record contents, or regarding maintenance of health information in patients' records by health care providers. A facility must maintain originals or accurate reproductions of the contents of the originals of all records, including x-rays, consultation reports, and laboratory reports, in a form that is legible and readily available

(1) upon request, to the attending physician or other practitioner responsible for treatment, a member of the facility's medical staff, or a representative of the department; and

(2) upon the patient's written request, to another practitioner.

(c) Each in-patient medical record must include, as appropriate

(1) an identification sheet which includes the

(A) patient's name;

(B) medical record number;

(C) patient's address on admission;

(D) patient's date of birth;

(E) patient's sex;

(F) patient's marital status;

(G) patient's religious preference;

(H) date of admission;

(I) name, address, and telephone number of a contact person;

(J) name of the patient's attending physician;
(K) initial diagnostic impression;

(L) date of discharge and final diagnosis; and

(M) source of payment;

(2) a medical and psychiatric history and examination record;

(3) consultation reports, dental records, and reports of special studies;

(4) an order sheet which includes medication, treatment, and diet orders signed by a physician;

(5) progress notes for each service or treatment received;

(6) nurses' notes which must include

(A) an accurate record of care given;

(B) a record of pertinent observations and response to treatment including psychosocial and physical manifestations;

(C) an assessment at the time of admission;

(D) a discharge plan;

(E) the name, dosage, and time of administration of a medication or treatment, the route of administration and site of injection, if other than by oral administration, of a medication, the patient’s response, and the signature of the person who administered the medication or treatment; and

(F) a record of any restraint used, showing the duration of usage;

(7) court orders relevant to involuntary treatment;

(8) laboratory reports;

(9) x-ray reports;

(10) consent forms;

(d) A facility must maintain procedures to protect the information in medical records from loss, defacement, tampering, or access by unauthorized persons. A patient's written consent is required for release of information that is not authorized to be released without consent. A facility may not use or disclose protected health information except as required or permitted by 45 C.F.R. Part 160, subpart C, and 45 C.F.R. Part 164, subpart E, revised as of October 1, 2005, and adopted by reference.

(e) A record must be completed within 30 days of discharge and authenticated or signed by the attending physician, dentist, or other practitioner responsible for treatment. The facility must establish policies and procedures to ensure timely completion of medical records. A record may be authenticated by a signature stamp or computer key instead of the treating practitioner's signature.
if the practitioner has given a signed statement to the hospital administration that the practitioner is the only person who

(1) has possession of the stamp or key; and

(2) may use the stamp or key.

(f) Medical records must be filed in accordance with a standard health information archival system to ensure the prompt location of a patient’s medical record.

(g) The facility must ensure that a transfer summary, signed by the physician or other practitioner responsible for treatment, accompanies the patient, or is sent by electronic mail or facsimile transmission to the receiving facility or unit, if the patient is transferred to another facility or is transferred to a nursing or intermediate care service unit within the same facility. The transfer summary must include essential information relative to the patient’s diagnosis, condition, medications, treatments, dietary requirement, known allergies, and treatment plan.

(h) Each facility subject to the provisions of this section, with the exception of an ambulatory surgical facility and a frontier extended stay clinic, must employ the services of a health information administrator who is registered by the American Health Information Management Association or a records technician who is accredited by the American Health Information Management Association to supervise the medical record service. If the administrator or technician is a consultant only, the administrator or technician must visit the facility not less than biannually to organize and evaluate the operation of the service and to provide written reports to the medical record service and the administration of the facility.

(i) The facility must safely preserve patient records for at least seven years after discharge of the patient, except that

(1) x-ray films or reproductions of films must be kept for at least five years after discharge of the patient; and

(2) the records of minors must be kept until the minor has reached the age of 21 years, or seven years after discharge, whichever is longer.

(j) If a facility ceases operation, the facility must inform the department within 48 hours before ceasing operations of the arrangements made for safe preservation of patient records as required in this section. The facility must have a policy for the preservation of patients’ medical records in the event of the closure of the facility.

(k) If ownership of the facility changes, the previous licensee and the new licensee shall, before the change of ownership, provide the department with written documentation that

(1) the new licensee will have custody of the patient’s records upon transfer of ownership, and that the records are available to both the new and former licensee and other authorized persons; or

(2) arrangements have been made for the safe preservation of patients’ records, as required in this section, and the records are available to the new and former licensees and other authorized persons.