

(d) Medical records.

- (1) There shall be a medical record department with adequate space, equipment and qualified personnel, to include at least one registered record librarian or a person with equivalent training and experience, in a hospital of one hundred beds or over.
- (2) A medical record shall be started for each patient at the time of admission with complete identification data and a nurse's notation of condition on admission. To this shall be added immediately an admission note and orders by the attending or a resident Physician. A complete history and physical examination shall be recorded by the physician within twenty-four hours of admission and always before surgery, except in cases of unusual emergency.
- (3) All medical records shall include proper identification data; the clinical records shall be prepared accurately and completed promptly by physicians and shall include sufficient information to justify the diagnosis and warrant the treatment; doctors' orders, nurses' notes and charts shall be kept current in an acceptable manner; all entries shall be signed by the person responsible for them.
- (4) Medical records shall be filed in an accessible manner in the hospital and shall be kept for a minimum of twenty-five years after discharge of patients, except that original medical records may be destroyed sooner if they are microfilmed by a process approved by the state department of health.
- (5) Medical records shall be completed within fourteen days after discharge of the patient except in unusual circumstances which shall be specified in the medical staff rules and regulations. Persistent failure by a physician to maintain proper records of his patients, promptly prepared and completed, shall constitute grounds for suspending or withdrawing his medical staff privileges.