TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

Ambulatory Clinic Policy and Procedure

Title:	**Medical Record Documentation and Confidentiality**	Policy Number:	**5.01**
		Version Number	**5**
Regulation Reference:	**TAC 165, Joint Commission, HIPAA**	Effective Date:	**10/2010**
		Original Approval:	**3.1996**

POLICY STATEMENT:

It is the policy of the TTUHSC Ambulatory Clinics to express in writing its policy on medical record documentation of patient care.

SCOPE:

This policy applies and will be distributed to all TTUHSC School of Medicine Clinics, also known as Texas Tech Physicians.

PROCEDURE:

1. **The patient's clinic medical record shall be completed and signed** legibly in blue or black ink or electronically in the EMR record by those practitioners involved in the patient's care each visit.
2. **Teaching Physician documentation shall reflect** appropriate presence and participation each visit when resident staff are involved in the patient's care. The paper record must be signed legibly or the EMR record signed electronically.
3. **Consultants or providers from any other specialty area shall document** their clinical impressions and treatments, legibly in the paper medical record with his or her signature or electronic signature in the EMR record.
4. **Each visit, the clinic records should include, as applicable:**
    a. an update of demographic data;
    b. the information should include name, date of birth, date of visit and medical record number and be placed in the designated area of the pages in the medical record
5. **The practitioner(s) shall be responsible for documentation** of the following subjective and objective findings with his or her signature:
    a. chief complaint or reason for the visit;
    b. vital signs as appropriate;
    c. summary list, as appropriate, including chronic problems, medications, and allergies (see Lubbock Ambulatory Clinic Policy 5.04);
    d. documentation and findings of assessments, as appropriate, including pain;
    e. diagnostic and therapeutic procedures, tests and results with the practitioners' notation to indicate review of those results;
    f. conclusions or impressions drawn from the history and examination, including diagnosis or conditions;
    g. treatment rendered, including essential details of procedures and medications given;

h. relevant patient education;

i. reassessments as indicated;

j. all diagnostic and therapeutic orders;

k. consultation reports;

l. all addendums or corrections made to the medical record will be recorded as the actual date of notation, not date of service.

6. **All corrections to the paper medical record** will be made with one single line through the documentation, initialed and dated. Documentation in the medical record is to be completed within 14 business days of the visit. A campus may require a shorter time for completion if specified by their Regional Dean. Services must be documented prior to billing. See HSC OP 52.07, Billing Compliance Plan.

7. **Personnel assigned by Clinic Administrators will print weekly EMR reports** identifying records which have not been completed within 14 business days. Physicians will be contacted by Administrators requesting urgent completion of delinquent records. The Department Chair will be notified immediately by the Administrator of a physician's continued non-compliance with this policy.

8. **Medical Records should be reviewed periodically** in accordance with each campuses Performance Improvement Plan.

9. **Paper charts should be returned to the designated Custodian of Medical Records** no later than 72 hours after date of service to increase the availability of the medical record for patient care, completion and ensure patient confidentiality.

10. **TTUHSC employees shall protect the confidentiality** of clinic medical records as required by the law. See HSC OP 52.09, Confidential Information.

11. **It shall be the policy of the Medical Records Department to release information** after receiving a HIPAA compliant written authorization from the patient except for payment, treatment and healthcare operations.

12. **The Central Medical Records Department is the Custodian of Medical Records** for all providers with the exception of:

Lubbock:	Odessa:
Ophthalmology Department Psychiatry Department Student Health	WIC Clinics

APPROVAL AUTHORITY:

This policy shall be recommended for approval by the Joint SOM Policy Committee to the Regional Deans with final signatory authority by the Deans, School of Medicine.

RESPONSIBILITY AND REVISIONS:

It is the responsibility of the Joint SOM Policy Committee to review and initiate necessary revisions based on collaboration and input by and through Quality Improvement/Performance Improvement and Risk Management. Administrative and technical management of this policy, including web site maintenance, will be the responsibility of the Lubbock Office of Performance Improvement.

Signatory approval on file by:	Steven L. Berk, MD Dean, School of Medicine
	Jose Manuel de la Rosa, M.D. Dean, School of Medicine, El Paso