MEDICAL LICENSURE COMMISSION OF ALABAMA ADMINISTRATIVE CODE

CHAPTER 545-X-4 MISCELLANEOUS

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545-X-4-.01 Rules For Processing Of Appeals To The Medical Licensure Commission.

(1) Time for Appeal. Notice of appeal must be initiated in writing and directed to the Commission and filed within thirty (30) days from the date of the letter of notice of the Board of Medical Examiners denying an application for an initial certificate of qualification, an application for reinstatement of a certificate of qualification, or an application for removal of voluntary restrictions to a certificate of qualification.

(2) Scope of Appeal. The appeal to the Commission shall not be a hearing de novo, but shall be limited to consideration of the record of the proceedings before the Board. In the event the Commission, based upon its examination of the record as a whole, finds the applicant is qualified for licensure, then the Commission may order the Board to issue a certificate of qualification to the applicant. In the event the appeal grows out of a denial by the Board for removal of a voluntary restriction to his or her certificate of qualification (as provided in Code of Ala. 1975, §34-24-360(g), the Commission shall have the right to

affirm the Board's action, or order the Board to modify its action as the Commission deems appropriate. For good cause, and within the discretion of the Commission, the appellant may, upon application, be permitted to supplement the record on appeal, upon a showing that the evidence was newly discovered or was not reasonably available to the appellant at the time of the hearing before the Board. In the event that such application is granted, the Board shall be afforded an opportunity to respond or to refute such evidence.

(3) Record on Appeal. The record on appeal shall consist of:

(a) A verbatim transcript of the proceedings before the Board, including the testimony of witnesses, statements of the appellant and/or counsel, and statements of the Board;

(b) Copies of all documents introduced into evidence at the hearing and considered by the Board in reaching its determination; and

(c) Copies of all pleadings, motions, briefs and arguments, or other documents filed before the Board in connection with the hearing.

(d) It shall be the responsibility of the appellant, at his expense, to ensure the complete and accurate preparation of the record on appeal, and to assure that one copy is filed with the Commission in a timely manner. The Board shall be required to furnish, at a reasonable rate based on the actual cost, copies of all documents in the possession of the Board which constitute a portion of the record.

(4) Briefs. Neither the appellant nor the Board shall be required to submit a brief or argument, but shall be permitted to do so either by counsel or pro se. The brief and argument, if submitted, in no event shall exceed twenty pages in length. It is suggested, but not required, that the appellant submit proposed findings of fact germane to the record on appeal which support the contentions raised in the brief and argument.

(5) Oral Argument. Upon request to the Commission, the appellant or a representative of the Board shall be permitted to appear personally or be represented by counsel before the Commission to present such oral argument as he or she may deem appropriate; provided, however, that the matters to be argued are limited to the record and that the Commission shall be entitled to set reasonable time limits upon such presentation.

(6) Decision of Commission. It shall be the duty of the Commission to render a decision within sixty days from the date of the submission of the record on appeal or the brief and argument of the appellant, whichever comes later.

(7) Extensions and Other Orders. The Commission may, upon application of the appellant or the Board, and for good cause, grant extensions of time and make other appropriate orders as shall be required to accommodate special situations not foreseen in these rules.
Author: Medical Licensure Commission, Wallace D. Mills Statutory Authority: Code of Ala. 1975, §34 Wayne P. Turner, Attorney for the Medical Licensure Commission
Statutory Authority: Code of Ala. 1975, §34 Author: Wayne P. Turner, Attorney for the Medical Licensure Commission Code of Ala. 1975, §§34-24-360-(22) History: **New Rule:** Filed February 25, 2005; effective April 1, 2005. **Amended:** Filed December 10, 2018; effective January 24, 2019. 24-330.
History: **New Rule:** Filed February 25, 2005; effective April 1, 2005. **Amended:** Filed December 10, 2018; effective January 24, 2019. 24-330. Filed May 6, 1983. **Amended:** Filed November 30, 2007; effective January 4, 2008. **Amended:** Filed December 10, 2018; effective January 24, 2019.

545-X-4-.02 Administrative Handling Of Complaints.

It is the policy of the Commission to allow and encourage the Board of Medical Examiners to investigate all cases of possible physician misconduct and to refer charges regarding said misconduct to the Commission whenever it is determined by a majority of the Board that sufficient grounds exist for the referring of said charges.
Author:
Statutory Authority: Code of Ala. 1975, §§34-24-313, 34-24-361.
History: Filed May 6, 1983.

545-X-4-.03 Attendance Guidelines.

It is resolved by the Commission that the Commission encourages the consistent and regular attendance of its members.
Author:
Statutory Authority: Code of Ala. 1975 §34-24-311.
History: Filed May 6, 1983.

545-X-4-.04 Commission Directory (Repealed).

(Repealed)
Author:
Statutory Authority: Code of Ala. 1975, §34-24-311.
History: Filed May 6, 1983. **Repealed:** Filed March 4, 2003; effective April 8,2003.

545-X-4-.05 Acupuncture Rules And Regulations.

(1) Acupuncture is deemed by the Medical Licensure Commission to be an experimental procedure of which the safety and medical effectiveness has not been established. The Commission therefore determines that while acupuncture practice by licensed physicians should not be absolutely prohibited, some safeguards are necessary to ensure that the public is not harmed or victimized by unprofessional practices, such as the unskilled or uninformed application of acupuncture treatment, or unfounded claims of effectiveness.

(2) The Commission therefore determines that it shall be deemed unprofessional conduct, and grounds for action against the license of any physician pursuant to Code of Ala. 1975, §34-24-360(a), for a physician to offer or administer acupuncture treatment except in compliance with the requirements set forth by the Federal Food and Drug Administration in Federal Register Vol. 88, No. 46, p 6419 (March 9, 1973). In administering this requirement, the Commission establishes the following criteria, which must be adhered to by physicians licensed by the Commission:

(a) All acupuncture devices in this state must be labeled properly according to applicable Federal Food and Drug requirements.

(b) A physician must secure a patient's informed consent according to the guidelines established at 21 Code of Federal Regulations, §130.37, and no claims of therapeutic or diagnostic effectiveness may be made by a physician.

(3) The Commission hereby announces its intention to require that physicians wishing to investigate and experiment with the use of acupuncture treatment must comply fully with the above stated requirements of this Commission and with the requirement of the Federal Food and Drug Administration cited herein.
Author: Alabama Medical Licensure Commission
Statutory Authority: Code of Ala. 1975, §§34-24-311, 34-24-337.
History: Filed May 6, 1983. **Amended:** Filed November 25, 2003; effective December 30, 2003. **Amended:** Filed December 10, 2018; effective January 24, 2019.

545-X-4-.06 Unprofessional Conduct.

Unprofessional conduct shall mean the Commission or omission of any act that is detrimental or harmful to the patient of the physician or detrimental or harmful to the health, safety, and welfare of the public, and which violates the high standards of

honesty, diligence, prudence and ethical integrity demanded from physicians and osteopaths licensed to practice in the State of Alabama. Furthermore, without limiting the definition of unprofessional conduct in any manner, the Commission sets out the below as examples of unprofessional conduct:

(1) The refusal by a physician to comply, within a reasonable time, with a request from another physician for medical records or medical information when such request is accompanied by a properly executed authorization of the patient.

(2) Intentionally, knowingly or willfully causing or permitting a false or misleading representation of a material fact to be entered on any medical record of a patient.

(3) Intentionally, knowingly or willfully preparing, executing or permitting the preparation by another of a false or misleading report or statement concerning the medical condition or extent of disability of a patient.

(4) The prescribing, dispensing, administering, supplying or otherwise distributing of any Schedule II amphetamine and/or Schedule II amphetamine-1ike anorectic drug in violation of Code of Ala. 1975, §20-2-54, as amended in Act No. 83-890, Special Session, 1983.

(5) The failure to report to the Alabama State Board of Medical Examiners any final judgment rendered against such physician during the preceding year or any settlement in or out of court during the preceding year, resulting from a claim or action for damages for personal injuries caused by an error, omission or negligence in the performance of his professional services without consent as required by Code of Ala. 1975, §34-24-56.

(6) The refusal or failure by a physician to comply with an order entered by the Medical Licensure Commission or by the Board of Medical Examiners issued pursuant to Code of Ala. 1975, Section 34-24-360(19) or (20) or pursuant to Code of Ala 1975, Section 34-24-361(h).

(7) Intentionally or knowingly making a false, deceptive or misleading statement in any advertisement or commercial solicitation for professional services and/or intentionally or knowingly making a false, deceptive or misleading statement about another physician or group of physicians in any advertisement or commercial solicitation for professional services.

(8) Failure or refusal of a J-1 physician to comply with waiver service requirements stated in the J-1 Visa Waiver Affidavit and Agreement signed by a J-1 physician.

(9) Conduct which is immoral and which is willful, shameful, and which shows a moral indifference to the standards and opinions of the community.

(10) Conduct which is dishonorable and which shows a disposition to lie, cheat, or defraud.

(11) Failing or refusing to maintain adequate records on a patient or patients.

(12) Prescribing or dispensing a controlled substance to oneself or to one's spouse, child, sibling (including step- and half-siblings), parent, intimate partner, or to any other person where the physician's professional objectivity, the patient's autonomy, or informed consent are substantially compromised, unless such prescribing or dispensing is necessitated by emergency or other exceptional circumstances.

(13) Signing a blank, undated or predated prescription form.

(14) Representing that a manifestly incurable disease or infirmity can be permanently cured, or that any disease, ailment or infirmity can be cured by a secret method, procedure, treatment, medicine or device, if such is not the fact.

(15) Refusing to divulge to the board or commission upon demand the means, method, procedure, modality of treatment, or medicine used in the treatment of a disease, injury, ailment or infirmity.

(16) Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or osteopathy or in applying for privileges or renewing an application for privileges at a health care institution.

(17) Sexual misconduct in the practice of medicine as defined in Rule 545-X-4-.07.

(18) Representing or holding oneself out as a medical specialist when such is not the case.

(19) Failing to furnish information in a timely manner to the board or Commission if requested by the board or Commission.

(20) Failing to report to the board in a timely manner information required to be reported by Code of Ala. 1975, Section 34-24-361(b).

(21) Giving false testimony in any judicial or administrative proceeding.

(22) The violation of any rule promulgated by the Alabama Board of Medical Examiners or the Medical Licensure Commission pursuant to

their rule making authority as set forth in the Alabama Administrative Procedures Act.

(23) The refusal or failure by a physician to comply with any voluntary agreement entered into between the physician and the Board of Medical Examiners and/or the Commission.
Author: Wayne P. Turner, Wallace D. Mills
Statutory Authority: Code of Ala. 1975, §34-24-360(2).
History: Filed February 3, 1984. **Amended:** Filed June 4, 1985. **Amended:** Filed July 11, 2000; effective August 15, 2000. **Amended:** Filed March 4, 2003; effective April 8, 2003. **Amended:** Filed June 24, 2005; effective July 27, 2005. **Amended:** Filed December 10, 2018; effective January 24, 2019. **Amended:** Published July 31, 2024; effective September 14, 2024.

545-X-4-.07 Sexual Misconduct In The Practice Of Medicine: A Joint Statement Of Policy And Guidelines By The State Board Of Medical Examiners And The Medical Licensure Commission.

(1) The prohibition against sexual contact between a physician and a patient is well established and is embodied in the oath taken by physicians, the Hippocratic Oath. The prohibition is also clearly stated in the Code of Medical Ethics of the American Medical Association. The reason for this proscription is the awareness of the adverse effects of such conduct on patients. The report of the Council on Ethical and Judicial Affairs of the American Medical Association indicates that most researchers now agree that the effects of physician-patient sexual contact are almost always negative or damaging to the patient. Patients are often left feeling humiliated, mistreated, or exploited.

(2) Further, a patient has a right to trust and believe that a physician is dedicated solely to the patient's best interests. Introduction of sexual behavior into the professional relationship violates this trust because the physician's own personal interest compete with the interests of the patient. This violation of trust produces not only serious negative psychological consequences for the individual patient but also destroys the trust of the public in the profession.

(3) Sexual conduct with a patient occurs in many circumstances ranging from situations where a physician is unable to effectively manage the emotional aspects of the physician-patient relationship to consciously exploitative situations. Underlying most situations is a disparity of power and authority over a physically or emotionally vulnerable patient.

(4) The prohibition against sexual contact between a physician and a patient is not intended to inhibit the compassionate and caring aspects of a physician's practice. Rather, the prohibition is

aimed at behaviors which overstep the boundaries of the professional relationship. When boundaries are violated, the physician's patient may become the physician's victim. The physician is the one who must recognize and set the boundaries between the care and compassion appropriate to medical treatment and the emotional responses which may lead to sexual misconduct.

(5) The Board of Medical Examiners and the Medical Licensure Commission is each charged with responsibilities for protecting the public against unprofessional actions of physicians and osteopaths licensed to practice medicine in Alabama. Immoral, unprofessional or dishonorable conduct is grounds for disciplining the license of a physician under the provisions of Code of Ala. 1975, §34-24-360(2). A physician's sexual contact with a patient is a violation of this statute.

(6) The Board of Medical Examiners investigates allegations of sexual misconduct against physicians. The Medical Licensure Commission makes decisions following a hearing concerning disposition of formal complaints filed with it by the Board of Medical Examiners. It is the goal of each organization to ensure that the public is protected from future misconduct. In some cases, revocation of license is the only means by which the public can be protected. In other cases, the Board or the Commission may restrict and monitor the practice of a physician who has actively engaged in a rehabilitation program. Rehabilitation of a physician is a secondary goal that will be pursued if the Board and the Commission can be reasonably assured that the public is not at risk for a recurrence of the misconduct.

(7) The Board and the Commission remind physicians of their statutory duty to report sexual misconduct or any conduct which may constitute unprofessional conduct or which may indicate that a physician is unable to practice medicine with reasonable skill or safety to patients. It is the individual physician's responsibility to maintain the boundaries of the professional relationship by avoiding and refraining from sexual contact with patients.

(8) Physicians should be alert to feelings of sexual attraction to a patient and may wish to discuss such feelings with a colleague. To maintain the boundaries of the professional relationship, a physician should transfer the care of a patient to whom the physician is attracted to another physician and should seek help in understanding and resolving feelings of sexual attraction without acting on them.

(9) Physicians must be alert to signs indicating that a patient may be encouraging a sexual relationship and must take all steps necessary to maintain the boundaries of the professional relationship including transferring the patient.

(10) Physicians must respect a patient's dignity at all times and should provide appropriate gowns and private facilities for dressing, undressing and examination. In most situations, a physician should not be present in the room when a patient is dressing or undressing.

(11) A physician should have a chaperone present during the examination of any sensitive parts of the body for the protection of both the patient and the physician. A physician should refuse to examine sensitive parts of the patient's body without a chaperone present.

(12) To minimize the understandings and misperceptions between a physician and patient, the physician should explain the need for each of the various components of an examination and for all procedures and tests.

(13) Physicians should choose their words carefully so that their communications with a patient are clear, appropriate and professional.

(14) Physicians should seek out information and formal education in the area of sexual attraction to patients and sexual misconduct and should in turn educate other health care providers and students.

(15) Physician should not discuss their intimate personal problems/lives with patients.

(16) Sexual Misconduct. Sexual contact with a patient is sexual misconduct and is unprofessional conduct within the meaning of Code of Ala. 1975, §34-24-360(2).

(17) Sexual Contact Defined. For purposes of §34-24-360(2), sexual contact between a physician and a patient includes, but is not limited to:

(a) Sexual behavior or involvement with a patient including verbal or physical behavior which:

1. may reasonably be interpreted as romantic involvement with a patient regardless whether such involvement occurs in the professional setting or outside of it;

2. may reasonably be interpreted as intended for the sexual arousal or gratification of the physician, the patient or both; or

3. may reasonably be interpreted by the patient as being sexual.

(b) Sexual behavior or involvement with a patient not actively receiving treatment from the physician, including verbal or

physical behavior or involvement which meets any one or more of the criteria in Section 1 above and which:

1. results from the use or exploitation of trust, knowledge, influence or emotions derived from the professional relationship;

2. misuses privileged information or access to privileged information to meet the physician's personal or sexual needs; or

3. is an abuse or reasonably appears to be an abuse of authority or power.

(18) Diagnosis and Treatment. Verbal or physical behavior that is required for medically recognized diagnostic or treatment purposes when such behavior is performed in a manner that meets the standard of care appropriate to the diagnostic or treatment situation shall not be considered as prohibited sexual contact.

(19) Patient. The determination of when a person is a patient for purposes of this policy is made on a case by case basis with consideration given to the nature, extent and context of the professional relationship between the physician and the person. The fact that a person is not actively receiving treatment or professional services from a physician is not determinative of this issue. A person is presumed to remain a patient until the patient-physician relationship is terminated.

(20) Termination of Physician-Patient Relationship. Once a physician patient relationship has been established, the physician has the burden of showing that the relationship no longer exists. The mere passage of time since the patient's last visit to the physician is not solely determinative of the issue. Some of the factors considered by the Board in determining whether the physician-patient relationship has terminated include, but are not limited to the following: formal termination procedures; transfer of the patient's care to another physician; the reasons for wanting to terminate the professional relationship; the length of time that has passed since the patient's last visit to the physician; the length of the "professional relationship; the extent to which the patient has confided personal or private information to the physician; the nature of the patient's medical problem; the degree of emotional dependence that the patient has on a physician; the extent of the physician's general knowledge about the patient".

(a) Some physician-patient relationships may never terminate because of the nature and extent of the relationship. These relationships may always raise concerns of sexual misconduct whenever there is sexual contact.

(b) Sexual contact between a physician and a former patient after termination of the physician-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of "the exploitation of trust, knowledge, influence or emotions" derived from the professional relationship.

(21) Consent. A patient's consent to initiation of or participation in sexual behavior or involvement with a physician does not change the nature of the conduct nor lift the statutory prohibition.

(22) Impairment. In some situation, a physician's sexual contact with a patient may be the result of a mental condition which may render the physician unable to practice medicine with reasonable skill and safety to patients pursuant to §34-24-360(19).

(23) Discipline. Upon a finding that a physician has committed unprofessional conduct by engaging in sexual misconduct, the Commission will impose such discipline as the Commission deems necessary to protect the public. The sanctions available to the Commission are set forth in §34-24-361 and §34-24-381, and include restriction or limitation of the physician's practice, revocation or suspension of the physician's license, and administrative fines.

Author: Wendell R. Morgan, Attorney For The Board Of Medical Examiners

Statutory Authority: Code of Ala. 1975, §34-24-311.

History: **New Rule:** Filed December 20, 1996; effective January 24, 1997. **Amended:** Filed December 10, 2018; effective January 24, 2019.

545-X-4-.08 Joint Guidelines Of The State Board Of Medical Examiners And Medical Licensure Commission For Medical Records Management.

(1) Definitions.

(a) ACTIVE PATIENTS. Active patients are any patients treated by the physician one or more times during the immediately preceding thirty-six (36) months.

(b) NOTIFICATION. Notification shall be conducted by US Mail in a form letter to the active patients at their last known address or an electronic message sent via a HIPAA compliant electronic record system or HIPAA-compliant electronic health record system that provides a means of electronic communication to the patient and is capable of sending the patient a notification that a message is in the patient's portal.

(c) PERSONAL REPRESENTATIVE. The executor, administrator, or such other person as may be authorized under Title 43 to act as a fiduciary and to settle and distribute the estate of a decedent. The trustee of a trust established as a substantial part of the estate plan of a deceased physician or any other person having legal control over the medical records of the patients of a deceased physician shall also be responsible for compliance with these rules in the same manner as a personal representative.

(2) General Guidelines.

(a) Medical records serve important patient interests for present health care and future needs, as well as for insurance, employment, and other purposes. In keeping with the professional responsibility to safeguard the confidentiality of patients' personal information, physicians have an ethical obligation to manage medical records appropriately. This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient's authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies. Physicians should maintain legible, well-documented records reflecting the history, findings, diagnosis, and course of treatment in the care of a patient. Medical records should be maintained by the treating physician for such period as may be necessary to treat the patient, in compliance with these rules, and for such additional time as may be required for medical and legal purposes.

(b) Access. On a legally compliant request of a patient or a patient's legal representative, a physician or his or her practice shall provide a copy of the medical record to the patient or to another physician, attorney, or other person designated by the patient or the patient's legal representative. A patient or his or her legal representative may authorize a physician or his or her practice to provide a copy of a specific portion or a summary of the medical record when the medical record is in non-electronic form and the patient or his or her legal representative knowingly waives his or her right to a copy of the full record. The cost of reproduction shall not exceed what is authorized under state and federal law. Records subpoenaed by the State Board of Medical Examiners are exempt from this law. Physicians charging for the cost of reproduction of medical records should give primary consideration to the ethical and professional duties owed to other physicians and their patients and waive copying charges when appropriate.

(c) Retention of Medical Records. Medical records shall be retained for a period of not less than five (5) years from the

physician's and/or other providers within his or her practice last professional contact with the patient except for the following:

1. Immunization records which have not been transmitted to the immunization registry maintained by the State Board of Health shall be retained for a period of not less than one (1) year after the minor reaches the age of majority or ten years from the date of the physician's and/or other providers within his or her practice last professional contact with the patient, whichever is longer;

2. X-rays, radiographs and other imaging products shall be retained for at least five (5) years after which if there exist separate interpretive records thereof, they may be destroyed. However, mammography imaging and reports shall be maintained for ten (10) years;

3. Medical records of minors shall be retained for a period of not less than one (1) year after the minor reaches the age of majority or ten (10) years from the date of the physician's and/or other providers within his or her practice last professional contact with the patient, whichever is longer;

4. Notwithstanding the foregoing, no medical record involving services which are under dispute shall be destroyed until the dispute is resolved.

(d) Destruction of Medical Records.

1. No medical record shall be singled out for destruction other than in accordance with the established office operating procedures.

2. Records shall be destroyed only in the ordinary course of business according to established office operating procedures that are consistent with these rules and state and federal privacy requirements.

3. Records may be destroyed by burning, shredding, permanently deleting, or other effective methods in keeping with the confidential nature of the records.

4. When records are destroyed, the time, date and circumstances of the destruction shall be recorded and maintained for not less than four (4) years. The record of destruction need not list the individual patient medical records that were destroyed but shall be sufficient to identify which group of destroyed records contained a particular patient's medical records.

(e) Retention and Access by Physicians Practicing Telemedicine. Physicians who practice medicine via telemedicine have the same duty as all other physicians to adhere to these rules relating to medical records. Physicians who provide care via telemedicine must retain access to the medical records which document their delivery of health care services via telemedicine. A physician who is unable to access and produce the medical records documenting his or her practice of medicine via telemedicine upon demand for inspection or review by the Board of Medical Examiners or Medical Licensure Commission shall be in violation of Code of Ala. 1975, §34-24-360(2) and (23).

(3) Minimum Requirements for Patient Notification. The retirement, death, license suspension or revocation, and the departure of a physician from a practice group all create conditions under which patients must be notified of the triggering event. Timely and informative patient notification is critical to ensure a patient's ability to secure continuity of care. At a minimum, the notification to patients shall identify the physician who treated the patient, the general reason for the patient to being notified, an explanation of how the patient may obtain his or her medical records, a HIPAA authorization for the patient to complete, how long the medical records will be made available to the patient, and the intended disposition of the medical records if no instructions are received within the time provided.

(4) Disposition of Patient Medical Records. All physicians shall plan for the disposition of patient medical records in accordance with this rule.

(a) Disposition of Patient Medical Records upon Physician's Death. When a physician dies while in active medical practice, notification shall be sent by the physician's practice if in a group practice within thirty (30) days following the death of the physician. If the physician is not a member of a group practice, the notice shall be sent by the personal representative of the physician's estate within thirty (30) days of appointment of an executor or administrator by the Probate Court to all his or her active patients. The notification to active patients shall contain a HIPAA-compliant form for the patient to sign to authorize copies of the patient's records be sent to a new physician, the patient, or the patient's representative, and shall include clear directions to the patient for submission of the form to effectuate the timely transfer of records. The party sending the notice shall bear the costs of notifying the physician's patients.

1. For physicians who are in solo practice the physician should include compliance with these rules as part of his or her estate planning.

2. In addition to the notice requirement stated above, the personal representative of a physician's estate should ensure that all medical records are transferred either to the custody of another physician or to a HIPAA-compliant entity that agrees in writing to act as custodian of the records. Medical records shall be maintained in custody in their original or legally reproduced form for the retention periods specified above, during which time the personal representative shall make the medical records available for transfer to the deceased physician's active patients. After the expiration of the retention period, the personal representative may dispose of or destroy the medical records in compliance with state and federal law.

(b) Disposition of Medical Records upon Physician's Retirement. When a physician retires, it is his or her, if in solo practice, or his/her group practice's responsibility to send notification of retirement not less than thirty (30) days prior to retirement to all active patients. The physician must ensure that all medical records are transferred to the custody of his or her active patients, to another physician, or to a HIPAA-compliant entity that agrees in writing to act as custodian of the records. Medical records shall be maintained in custody in their original or legally reproduced form in compliance with the retention periods set forth in (2)(c). The notification to active patients shall contain a HIPAA-compliant form for the patient to sign to authorize copies of the patient's records to be sent to a new physician, the patient, or the patient's representative, and shall include clear directions to the patient for submission of the form to effectuate the timely transfer of records.

(c) Disposition of Medical Records upon Physician's License Suspension or Revocation. When a physician's medical license is suspended or revoked, the physician or his or her practice shall send notification of the suspension or revocation within thirty days of the suspension or revocation to all active patients. The cost of sending the patient notifications shall be borne by the physician whose license is suspended or revoked. The notification must contain a copy of the Medical Licensure Commission's Order of Suspension or Revocation. The physician must ensure that all medical records are transferred either to the custody of the physician's active patients, to another physician, a physician practice group, or to a HIPAA-compliant entity that agrees in writing to act as custodian of the records. Medical records shall be maintained in custody in their original or legally reproduced form in compliance with the retention periods set forth in (2)(c). The notification to active patients shall contain a HIPAA-compliant form for the patient to sign in order to authorize copies of the patient's records to be sent to a new physician, the patient, or the patient's representative, and shall include clear directions

to the patient for submission of the form to effectuate the timely transfer of records.

(d) Disposition of Medical Records upon Departure from the Group. The responsibility for notifying patients and paying for the cost of the notification of a physician who leaves a group practice but continues to practice medicine shall be governed by the physician's employment contract with the group practice. If no contractual provision exists pertaining to medical records upon departure, and the group does not elect to notify the patients, then the departing physician shall be responsible for notifying all active patients and be responsible for the cost of such notification. Absent a contractual provision to the contrary, the party who notifies the patients of the departure shall bear the costs of notification and reproducing or transferring medical records. Patient notification, records retention, and record dispersal shall be accomplished in accordance with this rule.

1. Any provision of the physician's employment contract notwithstanding, the departing physician's active patients shall be notified of the physician's new address and offered the opportunity to have copies of their medical records forwarded to the departing physician at his or her new practice.

2. A group shall not withhold the medical records of any patient who has authorized their transfer to the departing physician or any other physician. The patient's freedom of choice in choosing a physician shall not be interfered with, and the choice of physician in every case should be left to the patient. The patient shall be informed that upon authorization, his or her records will be sent to the physician of the patient's choice.

3. Absent a contractual provision to the contrary, when the group or medical practice undertakes to notify patients of the physician's departure, the group shall bear the cost of notifying patients and reproducing or transferring medical records. When the departing physician is responsible for notifying patients of his or her departure, the practice shall cooperate with the physician by providing the physician a list of the active patients and their last known mailing address and contact information, and the physician shall bear the cost of notifying his or her patients and reproducing or transferring medical records.

(e) Sale of a Medical Practice. A physician, a physician group practice, or the estate of a deceased physician may sell the elements that comprise his or her practice, one of which is its goodwill, i.e., the opportunity to take over the patients of the seller by purchasing the physician's medical records.

Notwithstanding the above, the sale of a physician owner's equity in a medical practice that continues to operate, and which does not constitute the sale of the entire practice, does not constitute a medical sale for the purposes of this rule. Therefore, the transfer of records of patients is subject to the following:

1. The selling physician, his or her estate, or group practice must ensure that all medical records are transferred to another physician or covered entity or business associate operation on its behalf. Medical records shall be maintained in custody in their original or legally reproduced form in compliance with the retention periods set forth in (2)(c).

2. All active patients shall be notified within thirty (30) days of the transfer that the physician, his or her estate, or group practice is transferring the practice to another physician, group practice, or entity who will retain custody of their records, and that at their written request the copies of their records will be sent to another physician, the patient, or the patient's representative.

(f) Disposition of Medical Records when a Physician is Unavailable. When a physician goes on vacation, goes on sabbatical, takes a leave of absence, leaves the United States, or is otherwise voluntarily unavailable to his or her patients, the physician shall arrange to provide his or her patients access to their medical records.

(g) Abandonment of Records. It shall be a violation Code of Ala. 1975, §34-24-360(2) and (23) for a physician to abandon his or her practice without his or her practice making provision for the maintenance, security, transfer, or to otherwise establish a secure method of patient access to their records.

(5) Violations. Violation of any provision of these rules is grounds for disciplinary action pursuant to Code of Ala. 1975, §34-24-360(2) and (23).

Author: Alabama Medical Licensure Commission
Statutory Authority: Code of Ala. 1975, §34-24-311.
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Amended: Published November 30, 2021; effective January 14, 2022.

545-X-4-.09 Minimum Standards For Medical Records.

The maintenance of adequate medical records is an integral part of good medical care. Adequate records are necessary to ensure continuity of care, not only by the physician who maintains a particular record, but by other medical professionals. Therefore, every physician licensed to practice medicine in Alabama shall maintain for each of his or her patients, a record which, in order to meet the minimum standard for medical records, shall:

(1) be legible, and written in the English language;

(2) contain only those terms and abbreviations that are or should be comprehensive to other medical professionals;

(3) contain adequate identification of the patient;

(4) indicate the date any professional service was provided;

(5) contain pertinent information concerning the patient's condition;

(6) reflect examinations, vital signs, and tests obtained, performed, or ordered and the findings or results of each;

(7) indicate the initial diagnosis and the patient's initial reason for seeking the physician's services;

(8) indicate the medications prescribed, dispensed, or administered and the quantity and strength of each;

(9) reflect the treatment performed or recommended; document the patient's progress during the course of treatment; and

(10) include all patient records received from other health care providers, if those records formed the basis for a treatment decision by the physician.

Author: Wayne P. Turner, Attorney for the Medical Licensure Commission
Statutory Authority: Code of Ala. 1975, §§34-24-360-(22)
History: New Rule: Filed February 25, 2005; effective April 1, 2005. **Amended:** Filed December 10, 2018; effective January 24, 2019.

545-X-4-.10 Service Of Pleadings, Notices And Other Papers.

(1) Unless provided for elsewhere in these rules, service of pleadings, notices, and other papers by the Commission, parties,

or interested persons may be affected by one of the following methods:

(a) by service in accordance with the Alabama Rules of Civil Procedure;

(b) by placing notice in the U.S. Mail properly addressed with necessary postage affixed, which service shall be deemed perfected upon mailing;

(c) by third-party commercial carrier for delivery within three calendar days with delivery receipt required, in which case service is deemed perfected upon delivery;

(d) by electronic mail upon agreement if the recipient to accept service by electronic mail, which service shall be deemed perfected upon receipt by the sender of an electronic mail acknowledging or showing receipt by the person upon whom service was intended.

(2) Where an appearance has been entered by an attorney on behalf of a party or interested person, service under this rule made by made upon said attorney.
Author: Wallace D. Mills
Statutory Authority: Code of Ala. 1975, §41-22-12(a).
History: **New Rule:** Filed December 10, 2018; effective January 24, 2019.

545-X-4-.11 Dishonored Checks.

In the event a check, draft, or other negotiable instrument drawn on a bank or depository institution which has been made payable the Commission is dishonored by the financial institution on which it was drawn, the Commission shall charge a dishonored check fee in the amount of $30.00. The Commission shall not process or shall rescind as incomplete any application, license, certificate, or renewal thereof until such time as the original fee and the additional dishonored check fee provided for herein has been received by the Commission. After a check, draft, or other negotiable instrument has been dishonored, the Commission may delay processing of any application, certificate, or renewal until a subsequent check or draft has been honored, or the Commission may require payment by certified funds.
Author: Wallace D. Mills, Effie Hawthorne
Statutory Authority: Code of Ala. 1975, §8-8-15.
History: **New Rule:** Published August 31, 2021; effective October 15, 2021.