

**ALABAMA STATE COMMITTEE OF PUBLIC HEALTH
DIVISION OF LICENSURE AND CERTIFICATION
ADMINISTRATIVE CODE**

**CHAPTER 420-5-7
HOSPITALS**

420-5-7-.13 Medical Record Services.

(1) The hospital shall have a medical record service that has administrative responsibility for medical records. A medical record shall be maintained for every individual evaluated or treated in the hospital.

(2) Organization and staffing. The organization of the medical record service shall be appropriate to the scope and complexity of the services performed. The hospital shall employ adequate personnel to ensure prompt completion, filing, and retrieval of records.

(3) Form and retention of record. The hospital shall maintain a medical record for each inpatient and outpatient. Medical records shall be accurately written, promptly completed, properly filed and retained, and accessible. The hospital shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

(a) Medical records shall be retained in their original or legally reproduced form for a period of at least five years. In the case of minor patients, records shall be retained for at least five years after the patient has reached the age of majority.

(b) The hospital shall have a system of coding and indexing medical records. The system shall allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.

(c) The hospital shall have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital shall ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records shall be released by the hospital only in accordance with federal or state laws, court orders, or subpoenas.

(4) Content of record. The medical record shall contain information to justify admission and continued hospitalization,

support the diagnosis, and describe the patient's progress and response to medications and services.

(a) All patient medical record entries shall be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

1. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering practitioner, except as noted below.

2. All orders, including verbal orders, shall be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient and authorized to write orders by hospital policy.

3. All verbal orders must be authenticated within such time period as provided by hospital policy, but no more than 30 days following entry of the order.

(b) All records shall document the following, as appropriate:

1. Evidence of:

(i) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination shall be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

(ii) An updated examination of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration. Documentation of the updated examination shall be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

2. Admitting diagnosis.

3. Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.

4. Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.
5. Properly executed informed consent forms for procedures and treatments specified by the medical staff.
6. All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.
7. Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.
8. Final diagnosis with completion of medical records within 30 days following discharge.

(5) The hospital shall maintain a plan to transfer all records to another facility in the event the hospital ceases operation.

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