

Change Page

Section 5.1.a -- Central Patient Records

REVISION DATE	CHANGE NUMBER	CHANGE
3/23/2011	1	Click here for red letter version of policy
12/29/1999	1	POLICY NAME: Change "Central Patient Filing -- 5.1.a" to "Central Patient Records -- 5.1.a"
12/29/1999	2	POLICY: Change "A central patient filing system" to "A central patient medical record* system"
12/29/1999	3	PURPOSE: Change "To consolidate all the records of an individual patient into a central patient filing system." to "To readily access all the records of an individual patient from a central patient record system, whether paper or electronic."
12/29/1999	4	PROCEDURE, 1st paragraph: Change "The central patient filing system for active records must utilize color coded file folders which are filed numerically." to "The central patient record system for the non-electronic portion of active records must utilize color coded file folders which are filed numerically."
12/29/1999	5	PROCEDURE, 3rd paragraph: Change "Any record that is removed from the clinic must be signed out to the person responsible for that record" to "Any record that is removed from the central patient record system for an off-site visit or for review/entries by a provider (other than the provider seeing the patient in clinic that day) must be signed out to the person removing that record. An outguide must be completed and inserted into the record's location in the central record system to document the location of the record and the provider who has removed the record. A completed outguide is not necessary when a record is removed from the central patient record system for a clinic visit that day."
12/29/1999	6	FOOTNOTE: Add "** A patient medical record is defined as patient information on paper, printed forms, cards, tape, disk or any information-transmitting media."