TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™

Ambulatory Clinic Policy and Procedure

Title:	**Medical Record Documentation and Confidentiality**	Policy Number:	**5.01**
		Version Number	**7**
Regulation Reference:	**TAC 165, Joint Commission, HIPAA, 22 TAC 291.34, CMS 3.3.2.4 - Signature Requirements**	Effective Date:	**2/2016**
		Original Approval:	**3/1996**

POLICY STATEMENT:

It is the policy of Texas Tech University Health Sciences Center (TTUHSC) Ambulatory Clinics to maintain accurate and timely documentation of all patient care.

SCOPE:

This policy applies to all TTUHSC Ambulatory clinics operated through its Schools.

PROCEDURE:

1. **The patient's clinic medical record shall be completed and signed** legibly in blue or black ink or electronically in the Electronic Health Record (EHR) by those practitioners involved in the patient's care within 14 calendar days of each encounter. 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.

    a. Written Signatures: Written signatures with a title (M.D., PA, etc.) are the preferred form of authentication on paper medical records. All signatures must be identifiable and on file for verification. A list of written signatures and initials will be maintained in each clinic department.

    b. Electronic Signatures: An electronic signature is used in the Electronic Health Record or in diagnostic reports. The practitioner who uses the electronic signature represents he/she is the only one who has access to their electronic signature by personal password and they are the only one who will use it.

    c. No signature stamps are allowed.

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 EHR 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 EHR 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 medical record or EHR.

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 documentation and findings of assessments, as appropriate, including pain;

d. Diagnostic and therapeutic procedures, tests and results with the practitioners' notation to indicate review of those results;

e. Conclusions or impressions drawn from the history and examination, including diagnosis or conditions;

f. Treatment rendered, including essential details of procedures and medications given;

g. Relevant patient education and the patient's understanding;

h. Reassessments as indicated;

i. All diagnostic and therapeutic orders;

j. Consultation reports;

k. 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.

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

8. **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.

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

10. **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.

11. **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 Ambulatory Policy Committee to the Council of Deans.

RESPONSIBILITY AND REVISIONS:

It is the responsibility of the Joint Ambulatory Policy Committee to review and initiate necessary revisions based on collaboration and input by and through Quality Improvement/Performance Improvement, Risk Management and the Office of Institutional Compliance.

RIGHT TO CHANGE POLICY:

TTUHSC reserves the right to interpret, change, modify, amend or rescind this policy in whole or in part at any time to reflect changes in policy and/or law.

CERTIFICATION:

This policy was approved by the Council of Deans on February 4, 2016.