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Hampton Family Practice Record Retention, Storage and Disposal/Destruction of Historical PAPER Medical Records

It is the policy of Hampton Family Practice to retain, store and destroy medical records in compliance with applicable legal and regulatory requirements set for by the Department of Health and Human Services and Virginia Code.

§ 54.1-2910.4. Health record retention.

Practitioners licensed under this chapter shall maintain health records, as defined in § 32.1-127.1:03, for a minimum of six years following the last patient encounter. However, such practitioners are not required to maintain health records for longer than 12 years from the date of creation except for (i) health records of a minor child, including immunizations, which shall be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child or (ii) health records that are required by contractual obligation or federal law to be maintained for a longer period of time. Health records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative are not required to be maintained beyond such transfer or provision.

Destruction of **PAPER** Medical Records

In accordance with the information above, Hampton Family Practice will adopt the following protocol:

In absence of investigation, litigation or legal hold, records may be destroyed with retention guidelines outlined by the state retention schedule or beyond the maximum period by Hampton Family Practice as deemed appropriate.

- Based upon the complete adoption of the Electronic Medical Record in 2012, paper records for deceased patients or patient's or Inactive patients, defined as a patient without a servicing encounter in the last 3 years, will be maintained a minimum of 6 years from the last encounter date. All immunization records will be maintained electronically regardless off status.

- Paper records for minors will be maintained until the child reaches 18 with a minimum of 6 years from the last encounter regardless of age. All immunization records will be maintained electronically.

- If the patient has an electronic chart, immunizations will be stored in the electronic health record, otherwise stored in a designated file location.

- Paper records for active patients, defined as a patient with an encounter receiving a service in the last 3 years, will be maintained 12 years from the date of creation. Any immunization records will be maintained electronically.

- Historical paper records that are scanned into any electronic medical record system approved by Hampton Family Practice will be destroyed after scanning, indexing and quality checking has taken place. Records will be held on site, in paper format for a period of 30 days post scanning, then destroyed.

Storage of PAPER Medical Records

- Storage areas for inactive records can include either an area inside the facility that has been approved for records storage use, or an off-site, private, professional record storage facility with which Hampton Family Practice has an active contract for storage and retrieval services. of inactive medical records.

- Storage areas approved for records storage must be physically secure and environmentally controlled to protect records from unauthorized access and damage or loss due to temperature fluctuations, fire, water damage, pests and other hazards.

- Any inactive records moved to off-site storage are boxed, labeled and logged out of our medical record tracking system to allow for efficient access and retrieval if needed.

- Any paper-based records involved in litigation or investigation are considered to be active records and will be stored on site in a secured file designated as such.

Adoption of Electronic Medical Records

Hampton Family Practice fully adopted electronic medical records in 2012. A documented abstraction process took place at that transition. All medical information beginning in 2012 is maintained within a patient's electronic medical records in its entirety unless otherwise documented.