**Section 250.1510 Medical Records**

a) Facilities

1) The hospital shall maintain medical record facilities with adequate supplies and equipment.

2) Medical records shall be stored safely. Medical records shall be handled so as to assure safety from water seepage or fire damage and are to be safeguarded from unauthorized use.

b) Organization

1) Responsible Personnel

A) A qualified health information practitioner (registered health information administrator or accredited health information technician) shall be employed or contracted as the director of the medical records department.

B) The director of the medical records department shall participate in educational programs relative to health information activities, on-the-job training and orientation of other medical record personnel, and in-service health information educational programs. Professional consultation services shall be provided for the health information practitioner.

2) An adequate, accurate, timely, and complete medical record shall be maintained for each patient. Minimum requirements for medical record content are:

A) Patient identification and admission information;

B) The history of the patient as to chief complaints, present illness and pertinent medical history, family history, and social history;

C) A physical examination report;

D) Provisional diagnosis;

E) Diagnostic and therapeutic reports on laboratory test results, x-ray findings, any surgical procedure performed, any pathological examination, any consultation, and any other diagnostic or therapeutic procedure performed;

F) Orders and progress notes made by the attending physician and, when applicable, by other members of the medical staff and allied health personnel;

G) Observations notes and vital sign charting made by nursing personnel; and

H) Conclusions as to the primary and any associated diagnoses; brief clinical resume; disposition at discharge, including instructions and medications; and any autopsy findings on a hospital death.

3) For record requirements pertaining to obstetric patients and newborn infants, see Section 250.1830(h).

4) A committee of the organized medical staff shall be responsible for reviewing medical records to ensure adequate documentation, completeness, promptness, and clinical pertinence.

5) The hospital shall establish requirements for the completion of medical records and for the retention period for medical records. The hospital shall issue policies and procedures pertaining to the use of medical records and the release of medical record information. Discharge diagnoses shall be expressed in terminology of a recognized disease nomenclature.

6) When a hospital provides a sexual assault survivor with a voucher in compliance with Section 250.750(d), *the hospital shall make a copy of the voucher and place it in the medical record of the sexual assault survivor. The hospital shall provide a copy of the voucher to the sexual assault survivor after discharge upon request*. (Section 5(b-5) of the Sexual Assault Survivors Emergency Treatment Act)

c) Authentication of Medical Record Entries

1) All entries into the medical record shall be authenticated by the individual who made or authorized the entry. "Authentication," for purposes of this Section, means identification of the author of a medical record entry by that author, and confirmation that the contents are what the author intended, except that telephone orders may be authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient and who is authorized to write orders pursuant to Section 250.330.

2) Medical record entries shall include all notes, orders or observations made by direct patient care providers and any other individuals required to make the entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments, including, but not limited to, radiologic or electrocardiographic reports, operative reports, reports of pathologic examination of tissue and other similar reports. The medical record may include entries that are transmitted by facsimile machine, provided that the faxed copies are on non-thermal paper and that the faxed copies are dated and authenticated pursuant to hospital policy approved by the medical staff.

3) Written signatures or initials and electronic signatures or computer-generated signature codes are acceptable as authentication. All signatures or initials, whether written, electronic, or computer-generated, shall include the initials of the signer's credentials.

4) If a hospital uses electronic signatures or computer-generated signature codes for authentication purposes, the hospital's medical staff and governing board shall adopt a policy that permits authentication by electronic or computer-generated signature. The policy shall identify those categories of the medical staff, allied health staff or other personnel within the hospital who are authorized to authenticate patient records using electronic or computer-generated signatures.

5) At a minimum, the policy shall include adequate safeguards to ensure confidentiality, including, but not limited to, the following:

A) Each user shall be assigned a unique identifier that is generated through a confidential access code.

B) The hospital shall certify in writing that each identifier is kept strictly confidential. This certification shall include a commitment to terminate a user's use of a particular identifier if it is found that the identifier has been misused. "Misused" shall mean that the user has allowed another person or persons to use his or her personally assigned identifier, or that the identifier has otherwise been inappropriately used.

C) The user shall certify in writing that he or she is the only person with user access to the identifier and the only person authorized to use the signature code.

D) The hospital shall monitor the use of identifiers periodically and take corrective action as needed. The process by which the hospital will conduct the monitoring shall be described in the policy.

6) A system employing the use of electronic signatures or computer-generated signature codes for authentication shall include a verification process to ensure that the content of authenticated entries is accurate. The verification process shall include, at a minimum, the following provisions:

A) The system shall require completion of certain designated fields for each type of document before the document may be authenticated, with no blanks, gaps or obvious contradictory statements appearing within those designated fields. The system shall also require that previously authenticated entries are corrected or supplemented by additional entries, separately authenticated and made after the original entry.

B) The system shall allow the user to verify that the document is accurate and that the signature has been properly recorded.

C) The hospital shall, as part of its quality assurance activities, periodically sample records generated by the system to verify the accuracy and integrity of the system.

7) A user may terminate authorization for use of electronic or computer-generated signature upon written notice to the Director of Medical Records or other person designated by the hospital's policy.

8) Each report generated by a user shall be separately authenticated.

d) Indexing

1) A patient index that serves as a key to the location of the medical record of each person who is or has been an inpatient shall be maintained as a perpetual master index. A daily register of patients admitted to the hospital and babies born in the hospital shall be maintained.

2) Medical records shall be classified and indexed according to diagnoses, surgical procedures, and physician, and other indices shall be developed as deemed necessary for the advancement of medical care.

3) The International Classification of Diseases shall be used as the statistical classification for purposes of uniformity and compatibility of data between and among hospitals.

e) Preservation

1) All original medical records or photographs of records shall be preserved in accordance with Section 6.17 of the Act.

2) The hospital shall have a policy for the preservation of patient medical records if the hospital closes.

3) Prior to completing a change of ownership pursuant to Section 250.120(g) and (h), the buyer and seller shall inform the Department which party is responsible for record preservation. If one single party is not responsible for complete record preservation, then the parties shall provide the Department with a list identifying the records each party is responsible for preserving. No new license will be issued to the new person, legal entity, or partnership until the plan for record preservation is submitted to the Department.

(Source: Amended at 43 Ill. Reg. 12990, effective October 22, 2019)