

UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE – JACKSONVILLE

Resident Manual

MEDICAL RECORDS

An official record must be made of any examination, prescription, or treatment given a patient. No patients or employees are to be given prescriptions, have diagnoses made, or have medical treatment of any kind rendered without proper documentation on the medical record. To view specific policies concerning medical records select the policies button from the Infonet Homepage or click <http://intrashands1/Policyindex/> and select Health Information Mgt from the Policies by Department pull-down menu. Medical Staff rules and regulations provide detailed information in the documenting in the patient's medical record.

1. **GENERAL:** The Health Information Management/Medical Records Department is located in the basement of the clinical center campus. Hours of operation: 7 days a week, 24 hours a day.

Providers are expected to provide legible, complete, clear, consistent, precise, and reliable documentation of the patient's health history, present illness, and course of treatment for the duration of the patient's stay in the hospital. This includes observations, evidence of medical decision-making in determining a diagnosis and treatment plan as well as the outcomes of all tests, procedures, and treatments. This documentation should be as complete and specific as possible. In the event that the documentation is not clear, a query asking for clarification may be sent to the attending physician in Epic.

2. **CONFIDENTIALITY:** Medical records information can be released only with the proper written consent of the patient, legal guardian, subpoena, or by court order. Any requests for release of medical information should be processed by the Health Information Management Department. The medical record is the property of the hospital and as such should not be removed from hospital grounds except by court order, subpoena, or applicable statute, and a record custodian must accompany the record.
3. **RECORD AVAILABILITY:** Access to and availability of patient medical records will follow the procedures as defined in Access to Patient Medical Records. All medical record information since 2004 is available through the EPIC electronic record system. Prior records are in paper format stored off-site. Contact the Health Information Management Department to retrieve.
4. **RELEASE OF EMERGENCY DEPARTMENT RECORDS:** It is the policy of the hospital that medical records be released only with proper consent and authorization, through the Health Information Management Department.
5. **SUBPOENAS:** Contact Health Information Management for assistance. An official legal copy of the medical record must be provided by the H.I.M. Department and tracked as being sent.
6. **CONTENT OF THE MEDICAL RECORD:** The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment,

UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE – JACKSONVILLE Resident Manual

document the course and results accurately and facilitate continuity of care among health care providers. (Policy HIM-01-002)

7. **ABBREVIATIONS:** An abbreviation list is available on the Infonet under the Physician Tab (http://intrahands1/physicians/Abbreviations_Page.asp).
8. **ERRORS/CORRECTIONS:** The supervising attending practitioner may change statements in the medical record made by the resident by adding an addendum in EPIC. Errors made or noted in the EPIC electronic record need to be reported immediately to HIM Department for investigation and resolution.
9. **EPIC NOTE/REPORT COMPLETION:** The following notes are to be completed in the EPIC electronic record system. For documentation details please reference the Medical Staff Rules and Regulations and noted policies:
 - History & Physical – Policy # MS-06-001
 - The history and physical examination will be completed within twenty-four (24) hours of admission or prior to surgery. A resident, fellow, medical student, or ARNP/PAs may record part or all of the patient's history and physical examination, but the supervising Medical Staff member must countersign it.
 - Operative/Procedure Notes – Policy #MS-06-006
 - Consultation Note - Policy # MS-06-004
 - Discharge Summary – Policy # MS-06-002
10. **AUTHENTICATION OF ENTRIES:** Entries made in the EPIC electronic record are dated, timed and electronically signed by each author. Designated notes are to be co-signed by Attending Physician.
11. **COMPLETION OF MEDICAL RECORDS:** The medical record should be complete at the time of discharge, but no later than thirty (30) days subsequent to the date of discharge. Charts not complete within thirty (30) days of the patient's discharge will be declared delinquent and the attending notified. See Medical Staff Rules and Regulations for further chart completion details.