

COLORADO

Guidelines for the Release and Retention of Medical Records

Revised February 20, 2015

This is a summary of the most frequent asked questions of COPIC's Patient Safety and Risk Management Department. These guidelines reflect HIPAA concerns, Colorado Medical Board policies, and our own recommendations about the issue. Their primary use should be in the area of records requested for possible medical liability litigation.

RELEASE OF RECORDS

- 1) It should go without saying that no part of the medical record should be altered at the time of a request for records.
- 2) Colorado law (C.R.S. 25-1-802) makes clear that records shall be available for inspection or copying to the patient, or the patient's personal representative if accompanied by written authorization/request. HIPAA likewise requires that medical records be made available to the patient or the patient's personal representative for inspection or copying.
- 3) There are no exceptions for things such as failure to pay the treatment bill, failure to follow treatment instructions, failure to return, etc.
- 4) Records pertaining to mental health problems should not be made available if the disclosure may be harmful to the patient. In such instances, following completion of a treatment program, you may provide a summary of mental health problems upon written request and authorization. In extreme cases an attorney for the patient may ask a court to decide whether those parts of the records should be provided to the patient.
- 5) With the addition of the HIPAA guidelines, as of April 14, 2003, patients must be provided with a copy of the physician's "Notice of Privacy Practices" and must sign an "Acknowledgment of Receipt of Privacy Practices." If the patient refuses to sign the acknowledgment, office staff may complete a "Refusal to Acknowledge Receipt of Privacy Practices." Whether or not the patient signs the acknowledgment, after the patient has received the "Notice of Privacy Practices," no further patient consent is necessary for the following uses of Protected Health Information:
 - a) Use for treatment purposes (consulting with other physicians, sharing information among co-treating providers, referrals to specialists, prescribing medications or medical equipment, etc.)
 - b) Use for payment purposes (information requested from the patient's health insurance company to make payment for services rendered or providing information to other providers so they can secure payment for services rendered)
 - c) Use for health care operations (quality assessment/improvement activities, business planning and development, licensing and credentialing, and all the services

provided by your medical malpractice insurance company).

Only the minimum necessary may be disclosed for these purposes.

- 6) If the release of medical records is not for treatment, payment or health care operations, or another exception does not apply, the patient must authorize the release of medical records, in writing, for a specific purpose. You must use a HIPAA-compliant “Authorization to Use or Disclose My Health Information,” which should clearly identify the patient and must be signed and dated by the patient or the patient’s authorized representative. It should also state exactly what information should be included or excluded (e.g. STDs and psychiatric or psychological notes). The person to whom the records are delivered should be clearly identified on the authorization. There must be an expiration date on the authorization.. The authorization must warn the patient that information so disclosed may no longer remain private and must advise the patient the authorization can be revoked. A sample HIPAA-compliant authorization is available on our website.
- 7) Colorado Medical Board policy 40-7 states that 30 days is “reasonable notice” when records have been requested. When records are requested in response to a patient’s exercise of the right to review their medical records under HIPAA, guidelines require a response within a reasonable time, but no later 30 days of a written request in most circumstances.
- 8) Patient or representative may be required to pay for the reasonable, cost based fee for obtaining a copy of his/ her patient record. For requests from persons other than the patient or the patient’s representative, the Colorado Statute (C.R.S. 25-1-801) has determined “Reasonable fees” to be an amount not to exceed: (effective: April 18, 2014)
 - a) \$18.50 for the first ten, \$0.85 per page for next 30 pages, and \$0.57 per page for each additional page, except that, if the medical records are stored on microfilm, \$1.50 per page;
 - b) For radiographic studies, actual reproduction costs for each copy of a radiograph;
 - c) If the authorized person requests certification of the medical records, a fee of \$10.00;
 - d) Actual postage and electronic media costs, if applicable; and
 - e) Applicable taxes.

Under HIPAA, copies must be provided in the form and format requested by the patient (e.g. an electronic copy in pdf format) if the provider then has the capability.

- 9) In those instances where a patient cannot, or chooses not to, pay the fee for copying of medical records identified in paragraph 8 above, the physician at a minimum must make the records available to the patient for inspection or otherwise provide

access to the records. No fee can be charged for inspection under either Colorado law or HIPAA.

- 10) Unless a summary of the case has already been prepared and is a part of the medical record (e.g., a hospital summary at the time of discharge), such a summary should not be made for a requesting party. In the event that the request is repeated, you are probably well advised to get advice from COPIC prior to preparing such a summary.
- 11) Except as indicated above, a physician must provide copies of all patient records located in the medical chart, including patient records generated by previous physicians.
- 12) Withholding parts of the medical record simply because you do not believe that the patient wants those parts is not valid. Of course, you may ask the requesting party which parts are desired. In general, however, the entire medical record is requested. If portions of the record are withheld from release for reasons noted in these guidelines, such as mental health, minor's issues, etc., this should be clearly communicated to the receiving party.
- 13) Never release the original medical records under any circumstances. The physician is the legal custodian of the medical record, and it is your duty to protect its integrity.
- 14) If a patient is transferring to another provider, within the same corporation but at a different site, the original record may be transferred to the new site. The transferring provider site shall be responsible to notify the patient where his/her records can be located and must have documentation to show where and when the records were sent. The ultimate recipient of the records shall then be responsible to follow these medical retention guidelines.
- 15) Release of medical records involving treatment of minors requires special care and you should call COPIC with specific questions in this regard.

RETENTION OF MEDICAL RECORDS

From time to time in a practice the question will arise, “How long should we keep medical records?” While we don’t have definitive answers, we can provide you with the following guidelines:

- 1) The medical record is critical in a medical liability action, and its loss may considerably harm the physician in the defense of a claim.
- 2) To be absolutely safe, all medical records should be retained forever. However, in many circumstances this is impractical.
- 3) The following items should be considered in making your decision as to how long to retain records:
 - a) The Colorado Medical Board policy is as follows:
 - i) The Board recognizes that it is impractical in most cases to maintain records indefinitely. Consequently, the Board has surveyed the rules and guidelines of other state medical boards and insurance liability carriers to develop the following guidelines for records retention.
 - ii) The Board recommends retaining all patient records for a minimum of 7 years after the last date of treatment, or 7 years after the patient reaches age 18—whichever occurs later.
 - iii) Ten years for Medicare, Medicaid and other Federally funded programs.
 - iv) At the time of discontinuation of practice, patients should be notified and instructed to submit a written authorization/release if they wish their records transferred to another physician. Records should be retained after discontinuation of practice using the previous guidelines.
 - 1) The Board recommends sending letters to patients seen in the last 3 years notifying them of discontinuance of practice;
 - 2) The physician may want to place a notice in the newspaper announcing discontinuance of practice;
 - 3) If all records are being transferred to another physician, patients should be notified as above.
 - v) If litigation or Board investigation is anticipated or filed, records must be retained until resolution of the matter.
 - vi) When records are destroyed, it should be done in a manner that maintains patient confidentiality.
 - vii) The Board advises physicians to consult with their medical liability insurance carrier regarding any guidelines it may have for record retention.

- b) Colorado's two-year statute of limitations begins to run on the date both the injury and its cause are known or should have been known by the exercise of reasonable diligence.
 - c) Minors can usually bring suit two years after reaching the age of majority (18 years old).
 - d) For incompetent patients, the statute of limitations runs if and when they are determined competent or when a legal representative is appointed.
- 4) Under the federal False Claims Act, any health care provider that participates in Medicare, Medicaid, or any other federally funded health care program is potentially liable. The federal government has 10 years in which to pursue False Claims Act violations.
 - 5) Considering all the above, it is probably prudent to retain all patient records for a minimum of 10 years after the last treatment, or 10 years after the patient reaches their age of majority (age 18 in the state of Colorado)—whichever comes last.
 - 6) In selected circumstances you might consider saving the more complex records or those records with known serious patient problems for a longer period of time.
 - 7) The "bottom line" is that there is no absolute answer.
 - 8) If the physician/patient relationship terminates, the physician should receive written authorization to transfer records to another physician.
 - 9) At the time of the physician's retirement, patients should be notified of the day on which the practice will be closed. Notice should also be given that if they wish their records transferred to another physician, they should submit written authorization. Records should be retained after retirement using the same guidelines as above.
 - 10) In the event of a physician's death, the estate should retain the records using these guidelines.
 - 11) When medical records are destroyed, it should be done consistent with Colorado Medical Board policy 40-7 and 40-8, as well as in a manner that maintains patient confidentiality as required by HIPAA.
 - 12) For additional information regarding the proper procedures when leaving, closing, relocating or retiring from a practice, please refer to Colorado Medical Board policy 40-8 and HIPAA Frequently Asked Questions on the OCR website.
 - 13) Please call COPIC's Patient Safety and Risk Management department if you have further questions at (800) 421-1834, ext. 6396 or (720) 858-6396. All Colorado Medical Board policies can be found at www.dora.state.co.us/medical/policies.htm.

Colorado Medical Board Policy

POLICY NUMBER: 40-07
Title: Guidelines Pertaining to the Release and Retention of Medical Records
Date Issued: February 10, 2000
Date(s) Revised: August 9, 2001 (paragraph 6 revised); 11/08/01 (paragraph 10 added); 5/15/03 (paragraph 10 revised); 1/13/05 (entire policy revised); November 18, 2010
Reference:
Purpose: To provide guidelines to physicians and medical offices with respect to the Colorado Medical Board's expectations regarding patient record release and retention.

POLICY: The Colorado Medical Board ("Board") has adopted the attached guidelines pertaining to the release and retention of medical records.

Medical Records Release

1. Colorado statute (25-1-802 C.R.S.) makes clear that records shall be available to the patient upon submission of a written authorization/request. There are no exceptions for circumstances such as the patient's failure to pay an outstanding bill for clinical services, failure to follow treatment instructions, or failure to return for follow-up care.
2. The statute does make an exception for psychiatric or psychological illnesses. (See §25-1-802 C.R.S.) Therefore, not all provisions of this policy apply to requests for copies of medical records related to psychiatric or psychological illnesses.
3. Disclosure of information concerning drug or alcohol problems may be restricted by the Federal confidentiality statute (42 C.F.R. Part 2) in some instances. The statute defines specific consent requirements such as purpose of disclosure, limitation of information released, right to revocation, expiration date of release, and signature of patient.
4. A valid request for release of records must be in writing. It should clearly identify the patient and be signed and dated by the patient or the patient's authorized representative.
5. The Board has concluded that except where medical urgency otherwise requires a more prompt response, thirty days is "reasonable notice" when records have been requested.
6. Physicians may charge a reasonable fee for copying of records and may ask for payment in advance. The Board notes that the Colorado Department of Public Health and Environment (CDPHE) has published rules setting forth reasonable costs for copies of medical records in licensed facilities. The Board considers these rules to be reasonable guidelines for physicians providing copies of medical records. It is customary when a patient is transferring care for physicians to provide copies of records to another physician's office free of charge.
7. Items such as x-rays, fetal monitor strips and electrocardiograms, which may not at the time of the request be physically in the medical record, are nonetheless considered part of the medical record. If these are specifically requested, then they must be copied and provided to the patient. The physician may charge the requesting party the cost of copying these records in advance.

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8. In those instances where a patient cannot, or chooses not to, pay the fee for copying of medical records identified in paragraphs 6 and 7 above, the physician at a minimum must make the records available to the patient for inspection or otherwise provide access to the records.
9. Unless a summary of the case has already been prepared and is part of the medical record (e.g. a hospital summary at the time of discharge), a physician is not obligated to provide one.
10. This policy does not supercede state and federal law. A physician must provide patient records in compliance with state and federal law.
11. The Board advises physicians to consult with their medical liability insurance carrier regarding any guidelines it may have for record release.

Retention and Protection of Medical Records

1. Pursuant to section 12-36-140, C.R.S, each licensed physician and physician assistant shall develop a written plan to ensure the security of patient medical records. The plan shall address at least the following:
 - a. The storage and proper disposal, if appropriate, of patient medical records;
 - b. The disposition of patient medical records in the event the licensee dies, retires or otherwise ceases to practice or provide medical care to patients; and
 - c. The method by which patients may access or obtain their medical records promptly if any of the events described in paragraph b of this subsection occurs.
2. A licensee shall inform each patient, in writing, of the method by which the patient may access or obtain his or her medical records if an event described in paragraph b of subsection 1 of this section occurs. If a medical practice is composed of multiple licensees, one notification may be provided to patients on behalf of all licensees within the medical practice.
3. A licensee shall attest at the time of license renewal that he or she has developed a plan in compliance with section 12-36-140, C.R.S.
4. The Board recognizes that it is impractical in most cases to maintain records indefinitely. Consequently, the Board has surveyed the rules and guidelines of other state medical boards and insurance liability carriers to develop the following guidelines for records retention.
5. The Board recommends retaining all patient records for a minimum of 7 years after the last date of treatment, or 7 years after the patient reaches age 18 - whichever occurs later.
6. At the time of discontinuation of practice, patients should be notified and instructed to submit a written authorization/release if they wish their records transferred to another physician. Records should be retained after discontinuation of practice using the guidelines above.
 - a. The Board recommends sending letters to patients seen in the last 3 years notifying them of discontinuance of practice;
 - b. The physician may want to place a notice in the newspaper announcing discontinuance of practice;
 - c. If all records are being transferred to another physician, patients should be notified as above.
7. In the event of a physician's death, the estate should retain the records utilizing the guidelines above.
8. In case of litigation or Board investigation, records must be retained until resolution of the matter.
9. When records are destroyed, it should be done in a manner that maintains patient confidentiality.
10. The Board advises physicians to consult with their medical liability insurance carrier regarding any guidelines it may have for record retention.

West's Colorado Revised Statutes Annotated

Title 25. Health

Administration

Article 1. Administration (Refs & Annos)

Part 8. Patient Records (Refs & Annos)

C.R.S.A. § 25-1-801

§ 25-1-801. Patient records in custody of health care facility--definitions

Effective: April 18, 2014

Currentness

(1)(a) Every patient record in the custody of a health facility licensed or certified pursuant to section 25-1.5-103(1) or article 3 of this title, or both, or any entity regulated under title 10, C.R.S., providing health care services, as defined in section 10-16-102(33), C.R.S., directly or indirectly through a managed care plan, as defined in section 10-16-102(43), C.R.S., or otherwise shall be available for inspection to the patient or the patient's personal representative through the attending health care provider or the provider's designated representative at reasonable times and upon reasonable notice, except records withheld in accordance with 45 CFR 164.524(a). A summary of records pertaining to a patient's mental health problems may, upon written request and signed and dated authorization, be made available to the patient or the patient's personal representative following termination of the treatment program.

(b)(I)(A) A health facility licensed or certified pursuant to section 25-1.5-103(1) or article 3 of this title, or both, or an entity regulated under title 10, C.R.S., providing health care services, as defined in section 10-16-102(33), C.R.S., directly or indirectly through a managed care plan, as defined in section 10-16-102(43), C.R.S., or otherwise, must provide copies of a patient's medical records, including X rays, to the patient or the patient's personal representative upon request and payment of the fee a covered entity may impose in accordance with the "Health Insurance Portability and Accountability Act of 1996", Pub.L. 104-191, as amended, and any rules promulgated pursuant to the act, or to a third person who requests the records upon submission of a HIPAA-compliant authorization, valid subpoena, or court order and upon the payment of the reasonable fees.

(B) The health care facility must deliver the medical records in electronic format if the person requests electronic format, the original medical records are stored in electronic format, and the medical records are readily producible in electronic format.

(II) In the event that a licensed health care professional determines that a copy of any X ray, mammogram, CT SCAN, MRI, or other film is not sufficient for diagnostic or other treatment purposes, the health facility or entity shall make the original of any such film available to the patient or another health care professional or facility as specifically directed by the patient pursuant to a written authorization-request for films and upon the payment of the reasonable costs for such film. If a health facility releases an original film pursuant to this subparagraph (II), it shall not be responsible for any loss, damage, or other consequences as a result of such release. Any original X ray, mammogram, CT SCAN, MRI, or other film made available

pursuant to this subparagraph (II) shall be returned upon request to the lending facility within thirty days.

(c) The hospital or related facility or institution shall post in conspicuous public places on the premises a statement of the requirements set forth in paragraphs (a) and (b) of this subsection (1) and shall make available a copy of said statement to each patient upon admission.

(d) Nothing in this section shall be construed to require a person responsible for the diagnosis or treatment of sexually transmitted infections or addiction to or use of drugs in the case of minors pursuant to sections 25-4-402(4) and 13-22-102, C.R.S., to release patient records of such diagnosis or treatment to a parent, guardian, or person other than the minor or his or her designated representative.

(2) All requests by a patient or the patient's personal representative for inspection of the patient's medical records made under this section shall be noted with the time and date of the request and the time and date of inspection noted by the attending health care provider or his or her designated representative. The patient or personal representative shall acknowledge the fact of the inspection by dating and signing the record file. A health care facility shall not charge a fee for the inspection of medical records.

(3) Nothing in this section shall apply to any nursing institution conducted by or for the adherents of any well-recognized church or religious denomination for the purpose of providing facilities for the care and treatment of the sick who depend exclusively upon spiritual means through prayer for healing and the practice of the religion of such church or denomination.

(4) For the purposes of this section, medical information transmitted during the delivery of health care via telemedicine, as defined in section 12-36-106(1)(g), C.R.S., is part of the patient's medical record maintained by the health care facility.

(5) As used in this part 8, unless the context otherwise requires:

(a) "HIPAA-compliant" means in compliance with the "Health Insurance Portability and Accountability Act of 1996", Pub.L. 104-191, as amended.

(b) "Personal representative" has the meaning set forth in 45 CFR 164.502.

(c)(I) "Reasonable fees" means an amount not to exceed:

(A) Eighteen dollars and fifty-three cents for the first ten pages, eighty-five cents per page for the next thirty pages, and fifty-seven cents per page for each additional page; except that, if the medical records are stored on microfilm, one dollar and

fifty cents per page;

(B) For radiographic studies, actual reproduction costs for each copy of a radiograph;

(C) If the authorized person requests certification of the medical records, a fee of ten dollars;

(D) Actual postage and electronic media costs, if applicable; and

(E) Applicable taxes.

(II) Notwithstanding any other provision of this part 8:

(A) If a patient record is requested by a third-party entity under the “Laura Hershey Disability-Benefit Support Act”, part 22 of article 30 of title 24, C.R.S., the third party may obtain one free copy of the record for the application process or for an appeal or reapplication when required by the disability benefit administrator;

(B) If maximum rates have already been established by statute or rule for a state or local government entity, those rates prevail over the rates set forth in this part 8; and

(C) This part 8 does not apply to coroners requesting medical records pursuant to section 30-10-606, C.R.S.

Credits

Added by Laws 1976, H.B.1018, § 1. Amended by Laws 1983, H.B.1076, § 1; Laws 1997, H.B.97-1157, § 1, eff. April 19, 1997; Laws 2001, Ch. 300, § 10, eff. Jan. 1, 2002; Laws 2003, Ch. 57, § 36, eff. July 1, 2003; Laws 2009, Ch. 112, § 20, eff. April 9, 2009; Laws 2013, Ch. 217, § 60, eff. May 13, 2013; Laws 2014, Ch. 125, § 2, eff. April 18, 2014.

Notes of Decisions (6)

C. R. S. A. § 25-1-801, CO ST § 25-1-801

Current through the Second Regular Session of the Sixty-Ninth General Assembly (2014) and amendments adopted through the Nov. 4, 2014 General Election.

West's Colorado Revised Statutes Annotated

Title 25. Health

Administration

Article 1. Administration (Refs & Annos)

Part 8. Patient Records (Refs & Annos)

C.R.S.A. § 25-1-802

§ 25-1-802. Patient records in custody of individual health care providers

Effective: April 18, 2014

Currentness

(1)(a) Every patient record in the custody of a podiatrist, chiropractor, dentist, doctor of medicine, doctor of osteopathy, nurse, optometrist, occupational therapist, audiologist, acupuncturist, direct-entry midwife, or physical therapist required to be licensed under title 12, C.R.S., a naturopathic doctor required to be registered pursuant to article 37.3 of title 12, C.R.S., or a person practicing psychotherapy under article 43 of title 12, C.R.S., except records withheld in accordance with 45 CFR 164.524(a), must be available to the patient or the patient's personal representative upon submission of a valid authorization for inspection of records, dated and signed by the patient, at reasonable times and upon reasonable notice. A summary of records pertaining to a patient's mental health problems may, upon written request accompanied by a signed and dated authorization, be made available to the patient or the patient's personal representative following termination of the treatment program.

(b)(I)(A) A copy of the records, including radiographic studies, must be made available to the patient or the patient's personal representative, upon request and payment of the fee a covered entity may impose in accordance with the "Health Insurance Portability and Accountability Act of 1996", Pub.L. 104-191, as amended, or to a third person who requests the medical records upon submission of a HIPAA-compliant authorization, a valid subpoena, or a court order, and payment of reasonable fees.

(B) The health care provider must provide the medical records in electronic format if the person requests electronic format, the original medical records are stored in electronic format, and the medical records are readily producible in electronic format.

(II) If a licensed health care professional determines that a copy of a radiographic study, including an X ray, mammogram, CT SCAN, MRI, or other film is not sufficient for diagnostic or other treatment purposes, the podiatrist, chiropractor, dentist, doctor of medicine, doctor of osteopathy, nurse, optometrist, audiologist, acupuncturist, direct-entry midwife, or physical therapist required to be licensed under title 12, C.R.S., or, subject to the provisions of section 25-1-801(1)(a) and paragraph (a) of this subsection (1), the person practicing psychotherapy under article 43 of title 12, C.R.S., shall make the original of any radiographic study available to the patient, the patient's personal representative, a person authorized by the patient, or another health care professional or facility as specifically directed by the patient, personal representative, authorized person,

or health care professional or facility pursuant to a HIPAA-compliant authorization and upon the payment of the reasonable fees for the radiographic study. If a practitioner releases an original radiographic study pursuant to this subparagraph (II), the practitioner is not responsible for any loss, damage, or other consequences as a result of the release. Any original radiographic study made available pursuant to this subparagraph (II) must be returned upon request to the lending practitioner within thirty days.

(2) Nothing in this section shall be construed to require a person responsible for the diagnosis or treatment of sexually transmitted infections or addiction to or use of drugs in the case of minors pursuant to sections 25-4-402(4) and 13-22-102, C.R.S., to release patient records of such diagnosis or treatment to a parent, guardian, or person other than the minor or his or her designated representative.

(3) For purposes of this section, "patient record" does not include a doctor's office notes.

(4) All requests by a patient or the patient's personal representative for inspection of his or her medical records made under this section shall be noted with the time and date of the request and the time and date of inspection noted by the health care provider or his or her designated representative. The patient or the patient's personal representative shall acknowledge the inspection by dating and signing the record file. A health care provider shall not charge a fee for the inspection of medical records.

(5) For the purposes of this section, medical information transmitted during the delivery of health care via telemedicine, as defined in section 12-36-106(1)(g), C.R.S., is part of the patient's medical record maintained by a health care provider.

Credits

Added by Laws 1976, H.B.1018, § 1. Amended by Laws 1997, H.B.97-1157, § 2, eff. April 19, 1997; Laws 1997, H.B.97-1220, § 69, eff. Aug. 6, 1997; Laws 2001, Ch. 300, § 11, eff. Jan. 1, 2002; Laws 2009, Ch. 112, § 21, eff. April 9, 2009; Laws 2014, Ch. 125, § 3, eff. April 18, 2014.

Notes of Decisions (6)

C. R. S. A. § 25-1-802, CO ST § 25-1-802

Current through the Second Regular Session of the Sixty-Ninth General Assembly (2014) and amendments adopted through the Nov. 4, 2014 General Election.

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