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CMA Legal Counsel

Retention of Medical Records

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CALIFORNIA STATUTORY RETENTION PERIODS

California statutory authorities which specifically regulate a physician's retention of medical records are found, among other places, in the Medi-Cal Act, the law governing the Emergency Medical Services Fund, the California Uniform Controlled Substances Act, the Knox-Keene Act, OSHA rules, and the Worker's Compensation laws.¹

Medi-Cal. Physicians must retain the records of Medi-Cal patients for three years after the date that the last service was rendered under the Medi-Cal program. (Welfare & Institutions Code §14124.1.)

EMS Fund. Physicians must retain the records of patients for whom reimbursement was received from the Emergency Medical Services Fund for three years after the date that the last service reimbursed under this program was rendered. (Health & Safety Code §1797.98e.)

Prescription Books. Prescription books with copies of prescriptions issued must be kept for three (3) years. (Health & Safety Code §11168)

Controlled Substances. Every physician who prescribes, dispenses or administers a controlled substance classified in Schedule II must make and keep a record of that transaction for at least three years. *See* Health & Safety Code §11191. That record must contain the following information:

- a) The name and address of the patient;
- b) The date;
- c) The name, strength and quantity of the controlled substance(s) involved; and
- d) The pathology and purpose for which the prescription is issued.

Effective July 1, 2004, physicians who dispense Schedule II drugs must also record all the following:

- a) Patient's full name, address, gender and date of birth;
- b) Physician's category of licensure, license number and DEA number;
- c) Pharmacy prescription number, license number and DEA number;

¹ Licensed clinics, adult day care centers, home health facilities, hospitals, and other licensed health facilities may have other statutory obligations to keep medical records. Physicians who practice in facilities which are licensed by the Department of Health Services should make sure the facility complies with all record retention requirements.

- d) NDC number of controlled substance dispensed;
- e) Quantity dispensed;
- f) ICD-9 code, if available; and
- g) Dispensing date.

Effective January 1, 2005, this additional information will also be required for Schedule III drugs.

(Health & Safety Code §11190.)

Knox-Keene Act. Under the Knox-Keene Act, all records, books, and papers of a plan and of any provider must be open to inspection during normal business hours by the Commissioner of Corporations. Providers must maintain such records and provide such information to the plan or to the Commissioner as may be necessary for compliance by the plan with the provisions of the Knox-Keene Act and its regulations. This requirement appears to pertain to medical records as well. Such records must be retained by the provider for at least two years, and this obligation is not terminated upon a termination of the agreement. (28 C.C.R. §1300.67.8.)

OSHA Rules. Special requirements apply to certain records of employees exposed to toxic substances or harmful physical agents. Specifically, the Occupational Safety and Health Standards Board's General Industrial Safety Orders require that the medical record of each employee must be maintained for *at least the duration of employment plus thirty years*. See 8 C.C.R. §3204(d).

Worker's Compensation. QMEs must retain all medical-legal reports for five years from the date of the employee's evaluation. (8 C.C.R. §39.5.)

CONTRACTUAL AGREEMENTS TO RETAIN RECORDS

Finally, there may be provisions in contracts you have signed with your medical malpractice carrier, insurance companies, HMOs, etc. that specify, as a minimum, how long you need to keep records pertaining to at least some of your patients. This time period, if it exists, will vary with each contract.

RECORDS RETENTION AND LIABILITY FOR OWNERS OF CLINICAL LABORATORIES

Owners and laboratory directors of all clinical laboratories, including those laboratories that cease operations, shall preserve "medical records and laboratory records" for three years from the date of testing, examination, or purchase, unless a longer retention period is required pursuant to any other provision of law, and shall maintain an ability to provide those records when requested by the Department of Health Services or its duly authorized representative. (Business & Professions Code §1265.) "Medical records" means the test requisition or test authorization, or the patient's chart or medical record, if used as the test requisition, the preliminary and final test or examination results, and the name of the person contacted if the laboratory test or examination result indicated an imminent life-threatening result, or was of panic value. "Laboratory records" means records showing compliance with CLIA and California law during a laboratory's operation that are actual or true copies, either photocopies or electronically reproducible copies, of records for patient test management, quality control, quality assurance, and all invoices documenting the purchase or lease of laboratory equipment and test kits, reagents, or media. (*Id.*) Information contained in these records must be confidential and disclosed only as authorized by law. The Department or any person injured as a result of a laboratory's abandonment or failure to retain records pursuant to this law may bring a lawsuit for any amount of reasonable damages suffered as a result.

Business & Professions Code §1271.1 imposes a risk of liability upon *owners* of licensed clinical laboratories for failure to maintain medical records, reports, cytology slides and cell blocks for the required periods of time. Specifically, if the laboratory ceases operation and a person is injured as a result of the inability to obtain any of the records and tissue samples just mentioned due to the clinic's failure to retain them for the minimum statutory period,² that person may sue on the grounds of "abandonment of records." *Personal* liability may be imposed upon:

- a) Any or all partners of the clinic in the case of a general partnership;
- b) Any or all general partners of a limited partnership; or
- c) In the case of a corporation, the chairperson of the board, the chief executive officer, and/or the president of the corporation.³

Physicians with ownership interests in licensed clinical laboratories should be aware of this potential liability exposure from failure to properly retain records and tissue specimens in the event the clinic ceases to operate. **CAUTION:** *There are significant limitations on the circumstances in which a physician may have an ownership interest in a clinical lab.* For more information see **CMA ON-CALL document #0315, "Clinical Laboratories: Self-Referral and Fee-Splitting Prohibitions."**

HIPAA PRIVACY RULES

The privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Rules) became effective April 14, 2003. The HIPAA Privacy Rules apply to physicians and other health care providers that use electronic means to perform HIPAA covered transactions, such as the transmission of health claims, remittance or payment advice or any of the other electronic transactions included in the HIPAA Transaction Rules. They also cover those who pay for healthcare (health plans) and clearinghouses. The HIPAA Privacy Rules apply with respect to all "protected health information" (PHI), whether in paper, oral or electronic form. For more detailed information on HIPAA, including the definition of "covered entity," see **CMA ON-CALL document #1600, "HIPAA Overview."**

The HIPAA Privacy Rules do not create new rules governing the retention of medical records. However, they do establish rules governing the retention of all the documentation created in compliance with those rules. Specifically, covered physicians must maintain all the following in written or electronic form for at least six (6) years from the date of its creation or the date it was last in effect:

- a) all HIPAA Privacy Rule required policies and procedures;
- b) all HIPAA Privacy Rule related communications required to be in writing; and
- c) all HIPAA Privacy Rule related actions, activities or designations required to be documented.

(45 C.F.R. §164.530(j).)

² Business & Professions Code §§1271 and 1274 require that medical records, cytology slides and cell blocks be retained by licensed clinical laboratories for a minimum of five years, and cytology reports (including a report correcting errors in a previous report) for a minimum of ten years.

³ This constitutes a rare example where, in a particular circumstance, a statute specifically removes protection from *personal* liability usually afforded principals of a corporation.

RECOMMENDED RETENTION PERIODS

The statute of limitations in California generally requires that an adult's action for medical malpractice be brought within "three years after the date of injury or one year after the plaintiff discovers, or through the use of reasonable diligence should have discovered, the injury," whichever is shorter. For patients under the age of eighteen, a malpractice action must be brought within three years of the date of the alleged wrongful act, except that patients under the age of six have at least until their eighth birthday. The statute of limitations can be extended, however, if a patient can show fraud or intentional concealment on the part of the physician, or the presence of a foreign object which has no therapeutic or diagnostic effect. In addition, with respect to minors, it may be extended where the parent or guardian and the defendant's insurer or health care provider commit fraud or collusion in the failure to bring an action on behalf of the injured minor. Moreover, the statute applies only to cases of "professional negligence." While the courts have interpreted the term "professional negligence" broadly, it is possible that cases involving contract or other disputes may be subject to other statutes of limitations with broader tolling provisions.

Option 1: Retain Records Indefinitely

Despite the lack of a general statutory requirement and the relatively brief three-year period mandated for Medi-Cal, EMSF records, and certain controlled substance records, it is recommended that *all* medical records be retained indefinitely. This recommendation is based on two primary considerations: patient protection and physician protection. As the DES cases demonstrate, scientific advances make it impossible for a physician to predict what information will be desirable or necessary to aid in a patient's future treatment. Nor can physicians determine when the statute of limitations will bar a suit for professional negligence. Court decisions continue to erode its presumed protection. For example, in *Call v. Kezirian* (1982) 135 Cal.App.3d 189, 185 Cal.Rptr. 103, the court ruled that the statute of limitations in a mother's suit against her obstetrician for failure to diagnose Down's Syndrome was suspended until the parents actually learned that the abnormality would have been discovered through amniocentesis. The decision of the California Supreme Court in *Brown v. Bleiberg* (1982) 32 Cal.3d 426, 186 Cal.Rptr. 228, is even more startling. In that case, the patient was allowed to bring an action *12 years* after surgery because it was unclear whether the physician explained the surgery sufficiently to enable the patient to discover the negligent cause of her injury. More recently, in *Warren v. Schechter* (1997) 57 Cal.App.4th 1189, 67 Cal.Rptr.2d 573 *rev. denied*, a *multi-million dollar verdict* was upheld in a case which was not filed for *8½ years* after the surgery at issue. The court concluded that the complication of the gastric surgery, severe metabolic bone disease, did not manifest for 8 years, and that until that risk manifested there was no "injury" for purposes of the statute of limitations. If the physicians in these cases had destroyed their records, how could they fairly defend themselves?

As these examples illustrate, physicians may need medical records after prolonged periods of time have elapsed, and it would be difficult if not impossible for a physician to predict in which cases medical records may become necessary.

Option 2: Retain Records at Least 10 years After Last Date Patient is Seen, with Exceptions

Some physicians will find it impractical to maintain medical records indefinitely, and despite the risk, destroy records after a certain period of time has elapsed. In the event the physician decides to institute some policy for the destruction of medical records, there are several matters which deserve consideration. First, information provided by the Truck Insurance Exchange to the California Association of Hospitals and Health Systems concerning professional liability claims against *hospitals*, indicates that 99% of these claims are filed within 10 years of the incident giving rise to the claim. Similar data was obtained by one of California's physician-directed professional liability carriers concerning claims against physicians. This suggests a *minimum* medical retention period of 10 years after the *last date the patient is seen*. Minors'

records should be kept longer in those cases where the 10 years elapses before the minor has reached the age of 18. In no event should a minor's records be destroyed until *at least* one year after the minor has reached the age of 18. In addition, the records of pregnant women should be retained long enough to assess the effects of medication or treatment received on the fetus, requiring retention at least until the child reaches the age of majority. Finally, it is unlikely that a patient's estate will file a claim after the patient has been dead for five years or more.

Option 3: Retain Records 25 years After Last Date Patient is Seen

Because it may be difficult to keep track of these differing retention periods, you may wish to consider adopting an across-the-board retention period of 25 years after the last date of treatment. This 25-year period has the additional advantage of providing a greater measure of protection against the possibility that records will be destroyed before a suit is filed. It must be emphasized, however, that in the unlikely event a claim is filed after records are destroyed, it may be difficult, if not impossible to defend the case adequately.

METHODS OF RETENTION

While the retention of medical records will certainly impose added costs, even if they are sent to "dead" storage, microfilmed, or placed on computers, these costs are minimal in comparison with the potential liability which could arise if the records are prematurely destroyed.

Physicians Retiring or Closing Practice

The ideal situation, if you are retiring, is to have the physician or physicians who take over your medical practice agree to fulfill the physician's medical records obligations, upon the written authorization of the patient. You would be well advised to obtain the written agreement of the purchasers of your practice that they will retain your records for an adequate period of time, comply with appropriate requests for medical information, and permit you to have access to the records should that become necessary. Should such an agreement not be possible, there may be a physician or medical group in the community who will agree to provide this service as a courtesy or for a reasonable fee. The county medical society may be able to provide assistance in this regard. In the alternative, the records should be safeguarded in a manner which protects the patients' confidentiality and permits access should that become necessary. Whoever maintains the records should comply with the complex requirements governing the confidentiality of and access to medical records.

DESTRUCTION OF MEDICAL RECORDS

If medical records are to be destroyed, precautions should be taken to protect the confidentiality of this information. It is a violation of the Confidentiality of Medical Information Act to negligently dispose, abandon or destroy medical records in a manner which fails to reserve their confidentiality (Civil Code §56.101.) For more information on the CMIA and the enormous penalties which may be imposed for violations, *see* [CMA ON-CALL document #1101, "Confidentiality: CMIA, IIPPA and the HIPAA Privacy Rules."](#) Shredding or burning will ensure that confidentiality is maintained. Commercial records destruction companies may be found in the yellow pages under "Business Records Destroyed" or comparable heading. Companies vary as to pricing and method of destruction.

TRANSFER OF MEDICAL RECORDS

Upon receipt of a written request from the patient for transfer of medical records to another physician, it is generally advisable to transfer a copy of the records rather than the originals, unless the physician has entered into an agreement with the physician who is to receive the records for their maintenance as

discussed above. Reasonable costs for duplication of records requested by a patient may be charged to the patient, but records should not be withheld if the patient is unable to pay. For more information on patient requests for medical records, *see* [CMA ON-CALL document #1150, "Patient Access to Medical Records."](#)

STOLEN MEDICAL RECORDS

Once in a while physicians find that an employee or patient has taken original medical records without authorization. The courts generally uphold the right of a business to recover documents which have been improperly removed from the premises, even though the person who removed them would be entitled to obtain copies of the documents through the civil discovery process. *See Pillsbury, Madison & Sutro v. Schectman* (1997) 55 Cal.App.4th 1279, 65 Cal.Rptr.2d 69, *rev. denied*.

We hope this information is helpful to you. CMA is unable to provide specific legal advice to each of its more than 30,000 members. For a legal opinion concerning a specific situation, consult your personal attorney.

For information on other legal issues, use CMA ON-CALL, or refer to CMA's California Physician's Legal Handbook. This book contains legal information on a variety of subjects of everyday importance to practicing physicians. Written by CMA's Legal Department, the book is available on a fully searchable CD-ROM, or in a six-volume, softbound format. To order your copy, call (800) 882-1262 or visit CMA's Bookstore at www.cmanet.org.