

# Medical Documentation Retention Period (Federal Law)

Entities	Type of Document	Retention Period	Citation	Remarks
<b>Hospital (Inpatient &amp; Outpatient)</b>	Hospital medical record for inpatient and outpatient	Five (5) years	42 CFR § 482.24	<ul style="list-style-type: none"> <li>(i) Evidence of a physical examination, including a health history, performed no more than 7 days prior to admission or within 48 hours after admission.</li> <li>(ii) Admitting diagnosis.</li> <li>(iii) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.</li> <li>(iv) Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.</li> <li>(v) Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.</li> <li>(vi) All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.</li> <li>(vii) Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.</li> <li>(viii) Final diagnosis with completion of medical records within 30 days following discharge.</li> </ul>
<b>Healthcare Provider (Medicare Part B)</b>	Medicare claims	Six (6) years, Three (3) months	Medicare Manual Chapter 24 clm104c24	The provider will retain all original source documentation and medical records pertaining to any such particular Medicare claim for a period of at least 6 years, 3 months after the bill is paid.
<b>Healthcare Provider Agreements</b>	Medical and other records of individuals transferred to/from hospital	Five (5) years	42 C.F.R. § 489.20	Medical and other records related to individuals transferred to or from the hospital must be retained for a period of 5 years from the date of the transfer.
<b>Long Term Care Facilities</b>	Long term care facilities (Nursing facilities clinical records)	Five (5) years from date of discharge (if there are no state law requirement.) Three (3) years (minor) when a resident reaches legal age	42 CFR § 483.75	The facility must maintain clinical records on each resident for Five (5) years from the date of discharge when there is no requirement in State law; or for a minor, three (3) years after a resident reaches legal age under State law in accordance with accepted professional standards and practices that are: <ul style="list-style-type: none"> <li>(i) Complete.</li> <li>(ii) Accurately documented.</li> <li>(iii) Readily accessible.</li> <li>(iv) Systematically organized.</li> </ul>

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<b>Rural Health Clinics</b>	Rural healthcare clinics (Patient Health Record)	Six (6) years from date of last entry and longer if required by State laws	42 CFR § 491.10	<p>The clinic or center must maintain clinical record for each patient receiving health care services for six (6) years from date of last entry, and longer if required by State statute. The record includes:</p> <ul style="list-style-type: none"> <li>(i) Identification and social data, consent forms (evidence), medical history, assessment of health status and health care needs of patient, brief summary of the episode, disposition, and instructions to the patient.</li> <li>(ii) Reports of physical examinations, diagnostic and laboratory test results, &amp; consultative findings.</li> <li>(iii) All physician's orders, reports of treatments and medications, &amp; other pertinent information necessary to monitor the patient's progress.</li> <li>(iv) Signatures of the physician or other health care professional.</li> </ul> <p>The clinic or center must maintains the confidentiality of record information and provides safeguards against loss, destruction or unauthorized use. The clinic must also maintain written policies and procedures which govern the use and removal of records &amp; the conditions for release of information.</p>
<b>Hospital (Radiology)</b>	Records of radiologic services	Five (5) years	42 CFR § 482.26	<p>The hospital must maintain the following for at least 5 years:</p> <ul style="list-style-type: none"> <li>(i) Copies of reports and printouts.</li> <li>(ii) Films, scans, and other image records, as appropriate.</li> </ul>
<b>Hospital (Nuclear Medicine)</b>	Nuclear medicine services	Five (5) years	42 CFR § 482.53	<p>The hospital must maintain signed and dated reports of nuclear medicine interpretations, consultations, and procedures for at least 5 years.</p>
<b>Covered Entities (Entities governed by HIPAA)</b>	Entities governed by Health Insurance Portability and Accountability Act	Six (6) years	45 CFR § 164.500	<p>An entity governed by Health Insurance Portability and Accountability Act of 1996 (HIPAA) shall retain the following for Six (6) years from the date of its creation or the date when it was last in effect or date of incident, whichever is later:</p> <ul style="list-style-type: none"> <li>(i) Policies and Procedures implemented.</li> <li>(ii) Documents related to disclosure of PHI.</li> <li>(iii) An amendment in PHI.</li> <li>(iv) Requests for accounting of disclosures.</li> <li>(v) Requests for additional protections or confidential communications.</li> <li>(vi) Complaints about practices.</li> <li>(vii) Records of workforce training on privacy and security policies and procedurs.</li> <li>(viii) Business Associate Agreements.</li> <li>(ix) Notices of Privacy practices.</li> <li>(x) Details of unauthorised disclosure and measures to prevent such disclosure in fulture.</li> </ul>

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<b>Clinical Records (Comprehensive Outpatient Rehabilitation Facilities)</b>	Comprehensive outpatient rehabilitation facilities; clinical records	Five (5) years after patient discharge	42 CFR § 485.60	<p>Clinical record must contain sufficient information to identify the patient. The facility must retain clinical record for 5 years after patient discharge. Documentation on each patient must be consolidated into one clinical record that must contain:</p> <ul style="list-style-type: none"> <li>(i) The initial and subsequent reassessments of the patient's needs.</li> <li>(ii) Current treatment plan.</li> <li>(iii) Identification data and consent/authorization forms.</li> <li>(iv) Pertinent medical history, past and present.</li> <li>(v) A report of pertinent physical examinations if any.</li> <li>(vi) Progress notes or documentation that reflect patient reaction to treatment, tests, or injury, or the need to change the established plan of treatment.</li> <li>(vii) Upon discharge, a discharge summary including patient status relative to goal achievement, prognosis, and future treatment considerations.</li> </ul>
<b>Laboratory</b>	Laboratory requirements	Various	42 CFR §§ 493.1105	<p>The laboratory must retain its records and, as applicable, slides, blocks, and tissues as follows:</p> <ul style="list-style-type: none"> <li>(i) Test requisitions and authorizations. At least 2 years.</li> <li>(ii) Test procedures. At least 2 years after a procedure has been discontinued.</li> <li>(iii) Analytic systems records. At least 2 years.</li> <li>(iv) Proficiency testing records. At least 2 years.</li> <li>(v) Quality system assessment records. At least 2 years.</li> <li>(vi) Test reports. At least 2 years.</li> <li>(vii) Slide, block, and tissue retention as: (a) Retain cytology slide preparations for at least 5 years from the date of examination. (b) Retain histopathology slides for at least 10 years from the date of examination.</li> </ul> <p>Blocks. Retain pathology specimen blocks for at least 2 years from the date of examination.  Tissue. Preserve remnants of tissue for pathology examination until a diagnosis is made.</p>