Subject: Clinical Records Management

Date Effective: January 6, 2022

Date Reviewed:______________________ **Reviewed By:**________________________

Date Reviewed:______________________ **Reviewed By:**________________________

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Approved By:____

A. Ann Kirven, Interim Executive Director

Policy:

It is the policy of Sumter Behavioral Health Services that all persons served will have a single complete and accurate clinical record documenting progress through treatment. The clinical record will be managed in a way to ensure complete client confidentiality in accordance with the Federal Confidentiality Regulations.

Procedure:

1. Creating and Maintaining Clinical Records

   a. A clinical record will be created for every new patient upon completion of patient intake services. New records are created electronically in the CareLogic system. See Intake Procedures for specifics in requirements of the record.
   b. When a patient re-enters services all documentation should be produced within the same electronic record for that patient. If a prior paper chart had been created for the patient, it may be scanned into the electronic document library, or accessed from Medical Records for review.
   c. After a patient is discharged from all treatment programs, the program staff is to review all records for completeness.

2. Location, Storage and Disposal of Paper Clinical Records

   a. Old Paper clinical records for all discharged clients will be maintained within the Records Management Department.
   b. Patient records shall not be taken from the facility by employees without direct approval by the Director or designee.

   c. All paper patient records are to be maintained for a period of ten (10) years from the last date of service. If at anytime during the destruction process; legal action, debt collection, or re-entry into services occurs, the record is pulled from Records Management and the destruction date is updated.

   d. All paper clinical records will be forwarded to Records Management within 10 days of Discharge.

3. Requests for Patient Information

   a. With a valid consent, limited clinical information may be released to anyone specifically named by the patient to receive such information. For further information regarding release of information. See Confidentiality Policy, or Guidelines for the Release of Confidential Information.

4. Patient Access to Clinical Records

   a. See Patient Access to Their Clinical Record

5. Cost to Access Clinical Records

   a. Due to the cost of retrieving and copying information from clinical records copy charges may be applied. For copies of one to ten pages a fee of $12.00 will be charged. Any requests exceeding ten pages will be charged an additional .25 cents per page.