Medical Records

I. Content of the Medical Record

A. The attending practitioner shall be responsible for the preparation of a complete, current, and legible medical record for each patient.

B. Unless otherwise noted, all documentation contained within the patient's medical record, including outpatient and Emergency Department records, shall be completed within a time period not to exceed thirty (30) days from the date of discharge.

C. Each medical record will include, at a minimum: the appropriate recording of the patient's medical history and physical examination; the physicians physical findings; provisional diagnosis and clinical observations; including results of therapy and nursing notes; impression and plan of action; diagnostic and therapeutic orders; appropriate informed consents; special reports such as consultations; clinical laboratory, radiology and nuclear medicine services, medical and/or surgical treatment, operative report and pathological findings; progress notes; final diagnosis; condition at discharge; discharge summary; instructions provided for further care such as medications, diet, limitations of activity and follow-up care dates; and an autopsy report when performed.

1. The attending physician of record maintains the ultimate responsibility for signature on the Death Certificate within two (2) working days of the death, unless the attending physician is out of town, or, unless an autopsy has been requested. If the attending physician is not available or declines to authenticate the Death Certificate, the respective Medical Staff Department Chairperson will be contacted to assist in meeting this obligation. If the respective Medical Staff Department Chairperson is not available or cannot assist in the completion of the Death Certificate, the Chief of Staff will be contacted and his/her assistance requested.

II. History and Physical

A. A complete admission history and physical examination shall in all cases, be written and/or dictated and on the chart within twenty-four (24) hours of admission.

1. Every inpatient History and Physical must be dictated within twenty-four (24) hours of admission by the attending physician.

   a. A History and Physical must be dictated at the time the order is written to change a patient's status from Observation Status to an Inpatient admission.

2. Outpatient surgery/procedure encounters, uncomplicated OB deliveries and newborn encounters, and observations encounters that are 48 hours or less require a written or dictated history and physical report.

B. A current history and physical must be on the medical record prior to any surgery and/or procedure that places the patient at risk (See V.B.9.). If the surgeon is not the physician dictating the history and physical, the surgeon is responsible for providing a written

note, prior to surgery, indicating the preoperative diagnosis and reflecting that the patient received a physical examination. When a history and physical examination is not recorded before an operation, anesthesia, or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the attending physician states in writing that such delay would be detrimental to the patient.

C. The History and Physical report includes all pertinent findings resulting from an assessment of all systems of the body and shall include the following:

1. Chief Complaint;
2. Details of the present illness, including when appropriate, assessment of the patient's emotional behavior;
3. Relevant past, social, and family histories (appropriate to patient's age), including:
    a. Surgeries,
    b. Allergies,
    c. Medications,
    d. Conditions,
4. Review of body systems;
5. Relevant physical examination; to include *at a minimum* a review of the following systems:
    a. Neuro,
    b. Heart,
    c. Lungs,
    d. Abdomen,
    e. Current Medications.
6. Conclusions or impressions drawn from the medical history and physical exam;
7. Diagnosis or diagnostic impression;
8. Statement of the course of action/treatment plan.

D. If a History and Physical Examination is performed within thirty (30) days prior to a patient's admission to the Hospital, a reasonable, legible copy of the report may be used in the patient's hospital medical record in lieu of the admission history and report of the physical examination, provided the report was recorded by a Licensed Independent Practitioner authorized to perform History and Physical Examinations as per the Medical Staff Rules and Regulations.

1. In such instances, an appropriate update assessment note, written by a Licensed Independent Practitioner authorized to perform History and Physical Examinations as per the Medical Staff Rules and Regulations, must always be entered into the patient's medical record within twenty-four (24) hours of

admission and/or prior to the start of any surgery and/or procedure that places the patient at risk.

2. The update assessment note should include information regarding any changes that may have occurred since the previously recorded History and Physical Examination.

3. It is up to the discretion of the facility if the History & Physical Update Note form is utilized to satisfy this requirement.

E. Exclusions:

1. Non-inpatient (See V.B.9.) procedures, which do not require a History and Physical prior to the procedure, are as follows:

a. ANESTHESIA**/Non-invasive Procedures**

1) Peripheral IV

2) Intubation or line placement at a code

b. CARDIOLOGY**/Non-invasive Procedures**

1) All cardiology procedures are exempt, except: procedures requiring conscious sedation to general anesthesia.

c. GASTROENTEROLOGY**/Non-invasive Procedures**

1) All gastroenterology procedures without the use of moderate/conscious sedation to general anesthesia.

d. NEUROLOGY**/Non-invasive Procedures**

1) Somatosensory evoked response

2) Electromyelogram (EMG)

3) Electroencephalogram (EEG)

4) Visual evoked response (VER)

5) Brainstem auditory evoked response

e. PULMONARY**/Non-invasive Procedures**

1) All pulmonary procedures without the use of moderate/conscious sedation to general anesthesia.

f. OB/GYN**/Non-invasive Procedures**

1) Insertion of prostaglandin gels

2) Laminaria insertion

g. PATHOLOGY**/Non-invasive Procedures**

1) Bone marrow aspiration and biopsy

2) Fine needle aspiration

3) Scrapings to obtain cells for cytology

h. RADIOLOGY**/Non-invasive Procedures**

1) All General Diagnostic Radiology procedures without the use of moderate/conscious sedation to general anesthesia.

i. SURGERY**/Non-invasive Procedures**

1) Suture removal

2) Dressing change

3) Peripheral IV

2. It shall be noted that at any such time a procedure takes place with the use of moderate/conscious sedation to general anesthesia, on an inpatient or outpatient basis, the responsible licensed independent practitioner will document a preoperative diagnosis and a physical examination in the patient's medical record.

F. Obstetrical Records

1. The current obstetrical record shall include a complete prenatal record, which shall provide documentation of the history of the patient's current condition.

a. Prenatal records utilized to document the history of the patient's current condition may not exceed thirty (30) days from the date of admission.

b. The prenatal record may be a legible copy of the attending physician/practitioners office record transferred to the hospital before admission.

2. An obstetrical History and Physical examination form must be completed that includes pertinent additions to the history and any subsequent changes in the physical findings.

3. C-Section patients are considered surgical patients and must have a History & Physical Examination dictated.

G. Pediatric Records (0-17 years of age)

1. All history and physicals require the aforementioned items, in addition to developmental age, length or height and weight, head circumference (if appropriate), and immunization status.

H. Podiatry

1. Patients admitted for Podiatric care are a dual responsibility involving the Podiatrist and a physician member of the Medical Staff. Podiatric patients must be admitted by a physician member of the Medical Staff and seen by the Podiatrist as a consultant.

a. Podiatrist's responsibilities:

1) A detailed history justifying hospital admission,

2) A detailed description of the examination of the extremity and a pre-operative diagnosis.

b. Physician's responsibilities:

1) Medical history pertinent to the patient's general health,

2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

I. Dental

1. Patients admitted for Dental care are a dual responsibility involving the Dentist and a physician member of the Medical Staff. Dental/Oral Surgery patients must be admitted by a physician member of the Medical Staff and seen by the Dentist as a consultant.

a. Dentist's responsibilities:

1) A detailed history justifying hospital admission,

2) A detailed description of the examination of the oral cavity and a pre-operative diagnosis.

b. Physician's responsibilities:

1) Medical history pertinent to the patient's general health,

2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

III. Progress Notes

A. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. They should provide a chronological report of the patient's course in the hospital and should reflect any change in the condition and the results of treatment. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

1. Progress notes shall be legibly handwritten on all patients at least daily.

2. Progress notes must be dated, timed, and authenticated.

IV. Consultations

A. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record.

1. The report must be dictated and/or legibly handwritten.

2. A limited statement, such as "I concur" does not constitute an acceptable report of consultation.

B. When operative procedures are involved, the surgical consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

C. A request for a Consultation requires a written order on a physician's order sheet by the requesting physician/practitioner and a notation in the Progress Notes by the requesting physician/practitioner. It is the obligation of the ordering physician/practitioner to contact the consulting physician directly.

1. Consultations should be performed within 24 hours of their request.

V. Diagnostic & Therapeutic Procedures / Operative Reports

A. A brief handwritten post-procedure note shall be entered in the medical record immediately following the procedure and shall include:

1. The names of the licensed independent practitioners and his/her assistants;
2. Name of the procedure(s) performed;
3. Description of the procedure(s) performed;
4. Description of the findings of the procedure;
5. Any estimated blood loss;
6. Any specimens removed;
7. Postoperative diagnosis(es).

B. In addition, a detailed operative report must be dictated immediately after an operative surgery and/or procedure that places the patient at risk and record in detail:

1. The names of the licensed independent practitioners and his/her assistants;
2. Name of the procedure(s) performed;
3. Description of the procedure(s) performed;
4. Description of the findings of the procedure;
5. Any estimated blood loss;
6. Any specimens removed;
7. Postoperative diagnosis(es).
8. Immediately is defined as upon completion of the operation or procedure and/or prior to the patient being transferred to the next level of care.
9. A procedure that places the patient at risk/invasive procedure are defined as all procedures involving the puncture or incision of an instrument, or insertion of an instrument, or insertion of a foreign material into the body. Procedures that place the patient at risk may be performed for diagnostic or treatment related purposes.
10. Any practitioner with uncompleted operative reports twenty four (24) hours following the day of the operation shall have his/her medical staff privileges automatically suspended and may no longer schedule elective outpatient procedures.

VI. Discharge Summaries

A. A concise and up-to-date Discharge Summary shall be written or dictated within 30 days of discharge on all medical records of patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries and normal newborn infants. This includes patients hospitalized for observation care.

    1. All patients admitted for a period that exceeds forty-eight (48) hours and/or undergo a C-section delivery shall require a dictated discharge summary.

B. A handwritten final progress note may be utilized in lieu of a dictated report on all medical records of patients being treated for minor conditions and/or hospitalized under forty-eight (48) hours. This includes patients hospitalized for observation care.

    1. The final progress note shall document the patient's:

        a. Diagnosis,

        b. Procedures performed,

        c. Condition at discharge,

        d. Discharge instructions,

        e. Required follow up care.

C. In the event that a patient is discharged from the hospital after electing to sign out against medical advice (AMA), it is the responsibility of the attending physician to document the events that transpired up until the point the patient signed out AMA in accordance with the aforementioned discharge summary requirements.

D. In the event that a patient's discharge from the hospital is postponed and/or delayed, it is the responsibility of the attending physician to document the circumstances contributing to the delay to ensure that the discharge summary is up-to-date with the patient's condition at the time of discharge, in the format of a discharge summary addendum.

E. In the event of death, a summation statement is added to the record indicating the events leading to death. The attending physician may elect to delegate the completion of the death summary to another physician of record. The death summary shall be assigned to the attending physician at discharge unless there is a physician's order present in the medical record transferring the service to another physician.

    1. In the event that a patient expires prior to being seen by a physician, the physician of record is responsible to document the disposition of the patient, the diagnosis, and historical impression received upon accepting the patient into his/her services via a final progress note entry.

F. The principal and secondary diagnoses shall be recorded on the discharge summary and/or the final progress note, without the use of symbols or abbreviations. Principal diagnoses shall be defined as "the diagnosis of the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." This will be deemed equally as important as the actual discharge order.

G. In the event that the final diagnosis is not present within the discharge summary or

corresponding progress notes and/or the final diagnosis conflicts with the alternate documentation present within the medical record, the attending physician is responsible to respond to, sign and date a “physician coding query form.”

H. The discharge summary shall include the following information:

1. Admit date;
2. Discharge date;
3. Discharge diagnosis(es);
4. Advanced Directive/Code Status;
5. Consultations;
6. Procedures/Operations performed;
7. Pertinent Tests/Labs/Diagnostic & Radiological Data;
8. Summary of hospitalization;
   a. Reason for admission,
   b. Brief history of present illness,
   c. Hospital course,
   d. Condition at discharge.
9. Discharge plans;
   a. Discharge medications,
   b. Disposition,
   c. Discharge instructions,
   d. Required follow-up care.

VII. Clinical Entries

A. All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated.

B. A signature on the final page of a dictated report authenticates the entire report.

C. Only an author can authenticate his/her own entries.

D. Rubber stamp signatures may not be utilized for authentication in the medical records.

E. Computer and electronic signatures may be utilized for authentication in the medical records.

F. The respective surgeon shall be responsible for completing the cancer staging form reflecting the AJCC stage assigned/initiated.

G. In the event that it is necessary to correct an entry in the medical record, the authorized person shall line out the incorrect data with a single line in ink, leaving the original entry legible. The person shall note the reason for the change, the date and time of striking,

and sign the note.

1. Appropriate cross-referencing shall be placed in the medical record when necessary to provide explanation for the correction.

2. The correction shall never involve erasure or obliteration of the data that is corrected.

VIII. Symbols, Abbreviations, and Acronyms

A. The Hospital will maintain a list of “Do Not Use” symbols, acronyms, and abbreviations in accordance with the Joint Commission’s National Patient Safety Goals.

1. Stedman’s Abbreviations, Acronyms, & Symbols shall be the reference of choice.

IX. Preprinted Orders

A. Pre-printed orders, Guidelines or Protocols may be formulated by the various departments by disease state, diagnosis, or treatment in consultation with applicable services, to include but not limited to nursing, pharmacy, respiratory, radiology, etc.

1. Such orders are subject to the approval of the Medical Executive Committee.

B. A practitioner's preprinted orders, when applicable to a given patient, shall be reproduced in detail on the Order Sheet of the patient’s record, dated, timed, and authenticated by the practitioner.

1. These orders shall be reviewed and updated during the physician/practitioner’s credentialing cycle.

X. Treatment Orders

A. Attending physicians/practitioners are responsible for all medical orders on their patients.

B. Attending physicians/practitioners are responsible to provide a written order to designate a transfer of care to another attending physician.

1. Temporary coverage provided by an alternate attending physician/practitioner in the absence of attending physician/practitioner’s must be designated with a written order.

C. A written order must be written by the attending physician.

1. All orders shall be authenticated, dated, and timed as soon as possible but not to exceed forty-eight (48) hours after being given by the ordering physician/practitioner.

D. All orders written by an Allied Health Practitioner must be co-authenticated by the supervising physician as soon as possible but not to exceed twenty-four (24) hours after being given by the ordering physician/practitioner.

E. Telephone/Verbal Orders

1. A telephone/verbal orders shall be considered to be in writing when dictated to

one of the following:

a. A Registered Nurse and/or Licensed Practical Nurse

b. Registered Pharmacists

2. The following clinicians may accept telephone/verbal orders for their specialty only:

a. Registered Dietitians

b. Physical Therapists

c. Respiratory Therapists

d. Radiology Technicians

e. Speech Therapists

f. Occupational Therapists

3. All telephone/verbal orders for medications require a verification “read-back” of the complete order by the person giving the order. All verbal orders shall be authenticated, dated, and timed within forty-eight (48) hours after they have been given by the ordering physician/practitioner.

F. The physician/practitioner's orders shall be written clearly, legibly, and completely. Orders that are illegible or improperly written shall not be carried out until rewritten or clarified by the person(s) authorized to transcribe physician’s orders as per Section 10.4.

G. The use of “Resume,” "Renew," "Repeat," "Continue Orders," and similar unspecific terms is not acceptable.

H. All orders for non-invasive diagnostic testing written by a physician/practitioner that is not a member of the medical staff can be honored provided that the physician/practitioner would not be personally rendering patient care within the hospital.

1. All orders shall contain the diagnosis substantiating the need for the test.

a. The use of verbiage that includes “rule out” or “possible” is prohibited.

2. The department receiving the order will be responsible for contacting the ordering physician/practitioner to verify that the order or prescription is valid and came from the ordering physician/practitioner.

3. The department receiving the order will be responsible for verifying the practitioner/physician’s license is active.

4. A physician/practitioner must be a member of the medical staff to provide patient care.

I. All previous orders are canceled when patients go to surgery. “Resume pre-op orders” is not acceptable as a post-operative order.

J. All daily orders of Laboratory, Radiology and Cardiology studies automatically expire after three (3) days.

K. Orders for medication must designate drug, dosage, method/route, frequency and duration (if different from automatic stop orders) of administration. Single dose range orders shall be accepted.

XI. Restraint Orders

A. The Medical Staff shall recognize and follow Hospital policy regarding the time within which the order must be obtained for each use of restraint or seclusion and the maximum time for use of either intervention.

XII. Authentication of Dictated Reports

A. In the event a chart is deemed delinquent, another physician/practitioner may be assigned the task of completing the discharge summary, under the supervision of the Medical Executive Committee. Said completion of the discharge summary will not relieve the physician/practitioner of record of his/her responsibility to review and authenticate the medical record.

B. All dictated reports must be authenticated. At a minimum, the history and physical, operative report, consultation report and discharge summary must be authenticated.

1. A signature on the final page of a dictated report authenticates the entire report.
2. Rubber stamp signatures are not authorized as a form of authentication in the medical record.
3. The attending physician/practitioner is responsible for and shall authenticate the following medical record reports/entries:
    a. History and Physical Examination
    b. Discharge Summary
    c. His/Her Own Progress Notes and Orders
    d. His/Her Own Operative Reports
4. A consulting physician/practitioner is responsible for authenticating the following medical record reports/entries:
    a. His/Her Own Progress Notes and Orders
    b. His/Her Own Operative Reports
    c. His/Her Own Consultation Reports

XIII. Persons Authorized to Make Medical Record Entries

A. The following persons may make entries in medical records of hospital patients:

1. Members of the Medical Staff
2. Allied Health Professional Staff
3. Nursing Personnel
4. Physicians Assistants

5. Dieticians
6. Physical Therapists
7. Respiratory Therapists
8. Social Workers
9. Speech and Occupational Therapists
10. Diagnostic testing staff
11. Pharmacists

B. When granted privileges per the policy the following clinicians are authorized, in coordination with a co-signature of a supervising physician/practitioner:

1. Approved Healthcare program students
2. Medical Students
3. Physician Assistant Students
4. Nurse Practitioner Students
5. Clinical
6. Interns
7. Residents

C. Case Management

1. Case managers may document information in the medical record as required by Medicare, Medicaid, Federal and State Laws and regulations.

   a. The Medical Executive Committee may authorize other persons or classes of persons to make such entries, based on the relationship between their specific job function and the relation to patient care.

XIV. Incomplete Records Filed as Complete

A. An incomplete medical record is defined as a "medical record lacking any required element or required authentication."

B. Medical records shall not be permanently filed until they are completed by the responsible physician/practitioner or ordered to be filed complete by Medical Executive Committee.

C. An otherwise incomplete medical record may be declared complete for the purpose of filing in the following instances:

1. Medical Staff member deceased
2. Medical Staff member no longer on staff
3. Medical Staff member unavailable permanently or protractedly for other reasons.

D. The Director of the Health Information Management Department will sign a memorandum in record stating that the record is being filed as incomplete due to one of

the aforementioned reasons.

1. The memorandum shall be created by the Director of Health Information Management Department and the Chief of Staff.

XV. Delinquent Medical Records

A. A medical record is deemed delinquent under the following circumstances:

1. A history and physician examination is not present within twenty-four (24) hours of admission and/or prior to any surgery/procedure that places the patient at risk.

   a. In the event a History and Physical Examination that has been performed within thirty (30) days prior to patient's admission to the Hospital is utilized in lieu of the admission history and report of the physical examination, an appropriate update assessment note must always be present in the medical record within twenty-four (24) hours of admission and/or prior to the start of any surgery and/or procedure that places the patient at risk.

2. A detailed operative report is not dictated immediately after any operative surgery and/or procedure that place the patient at risk.

3. Not all entries are completed within thirty (30) days from the date of discharge.

XVI. Record Completion

A. Medical record documentation shall be completed in an on-going manner throughout the patient's encounter.

B. A medical record is defined as delinquent if any of the following apply:

1. A physician does not complete the record within thirty (30) days from the date of discharge.

2. The History and Physical Report is not recorded or updated within twenty-four (24) hours of admission and/or immediately prior to a procedure.

3. The Operative Note is not dictated nor written immediately after surgery.

4. Discharge Summary shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours.

   a. A Final Progress Note is required on patients hospitalized less than forty-eight (48) hours. It is the attending physician's responsibility for completing the Discharge Summary.

5. Any signatures remain outstanding thirty (30) days from the date of discharge.

C. Temporary Suspension of Privileges

1. At midnight on the thirtieth (30th) day post discharge, a physician whose delinquent medical records have not been completed shall have his/her admitting privileges suspended at The Valley Health System facility where he/she has the delinquent records via the Siemens Doctor Profile Maintenance/Invision System and the Siemens Soarian e-HIM Electronic Document Management System.

2. Physicians on the Current Physician Suspension List shall not admit, consult, or perform any professional services for any newly admitted patients in the hospital at which they have had their privileges suspended.

3. In the interest of patient care and safety, all patients that have been under Obstetrical Care throughout the duration of their pregnancy shall be classified as an existing patient of their Attending Physician and thereby are exempt from suspension lock out.

   a. The Chief Executive Officer (CEO) and/or the Administrator on Call of the facility at which the physician is suspended are the entities privy to override a physician's suspension status.

4. Physicians on the Current Physician Suspension List will not be allowed to proceed with any elective invasive or non-invasive, non-emergency cases until all delinquent medical records are completed for the individual facility at which their privileges have been suspended.

   a. For patients not yet admitted but with surgery scheduled, the Surgery Department is responsible to contact the physician the evening prior to surgery notifying the physician of the expectation that all delinquent medical records are completed prior to the start of any surgical cases.

   b. The HIM Department, in the interest of patient care, will deactivate the physician's suspension status on a temporary basis pending the physician's compliance with the completion of his/her delinquent medical records.

      1) In the event that the physician does not complete all delinquent medical records during the course of the same business day that the agreement to temporarily lift the suspension was made, the HIM Department will notify the facility Chief Executive Officer and/or Administrator on Call who will determine a future course of action.

      2) Physicians on the Current Physician Suspension List will be removed from the elective emergency call coverage list for the facility at which they are suspended.

      3) The physician's admitting privileges shall be reinstated for the facility at which they were suspended via the Siemens Doctor Profile Maintenance/Invision and Soarian e-HIM Electronic Document Management System, upon confirmation that the physician has fulfilled his/her obligations to complete the assigned deficiencies.

      4) The individual facilities in the Valley Health System reserve the right to enact and enforce a monetary fine schedule against physicians whose admitting privileges have been suspended, and also reserve the right to reinstate admitting privileges upon satisfaction of any outstanding fines with completion of delinquent medical records.

D. Voluntary Relinquishment of Medical Staff Membership and Clinical Privileges:

1. If a member of the medical staff accumulates sixty (60) continuous days of administrative suspension, he/she shall be considered for Automatic Relinquishment of Privileges by the respective facility's Medical Executive Committee.
2. The Chief of Staff shall notify the member in writing that his/her Medical Staff membership and clinical privileges will be automatically relinquished unless he/she completes all outstanding medical records.
3. If the member fails to complete all outstanding medical records and has been on suspension equal to or greater than ninety (90) days, the member shall be deemed to have voluntarily automatically relinquished his/her Medical Staff membership and clinical privileges.
4. Once the physician has voluntarily resigned as a member at any facility in The Valley Health System, the records will be filed as "complete" within the Soarian e-HIM Electronic Document Management System.
5. If/when the physician wishes to re-apply for privileges at any facility in The Valley Health System, any and all incomplete medical records are to be completed prior to his/her application being approved by the Medical Staff Office.

XVII. Informed Consent

A. Elements of informed consent:

1. The proceduralist physician/practitioner shall be responsible for obtaining the patient's informed consent.
2. The medical record shall contain evidence of informed consent for operative and invasive procedures on an approved informed consent form.
3. The medical record shall record both the patient and physician/practitioner signature acknowledgement that the physician/practitioner has personally informed the patient including an explanation of anticipated proceed(s) the risk and benefits of the procedure, problems related to recuperation, alternatives and their risks and benefit and the risks related to not receiving the proposed care, treatment and services.
4. In the case of an emergency surgery/procedure when consent is not obtainable, the reason shall be enter in the patient's medical record prior to the surgery/procedure.
5. If applicable, the patient should also be informed of the name of the physician/practitioner who has primary responsibility for the patient's care, the identity and professional status of individuals responsible for authorizing and performing procedures or treatments, any professional relationship to another health care provider or institution that might suggest a conflict of interest, their relationship to educational institutions involved in the patient's care, and any business relationships between individuals treating the patient, or between the

organization and any other health care, service, or educational institutions involved in the patients care.

XVIII. Release of Medical Records

A. Release of information, removal of records, and access to records shall be permitted only as authorized herein and by applicable state and federal laws, including statutes, regulations and court decisions. In all cases, no such releases of information, access to records, or removal of records shall be permitted except where such action has been consented to in writing by the patient or legal guardian qualified to execute such consent on behalf of the patient, except in those circumstances where applicable state and federal law authorizes releases, access, or removal of such records without the written consent of the patient or a competent guardian; provided, however, that:

1. In the event of re-admission of a patient, all previous records shall be available for the use of the attending practitioner in treating such patient, irrespective of whether such patient will be attended by the same physician that attended him during the previous admission or by another practitioner.

2. Access to all medical records of all patients, both currently hospitalized and discharged, shall be afforded, consistent with preserving the confidentiality of personal information concerning individual patients, to (i) the Governing Board, the CEO, the Chief of Staff, the Medical Executive Committee and any Medical Staff or Department Committee, or any special committee specifically so empowered, for analysis and evaluation of the quality of those records, of the proper utilization of the Hospital, and of the quality of patient care in the Hospital, and with respect to decisions regarding reappointment to the Medical Staff, modification of staff status or privileges, or corrective action; (ii) members in good standing of the Medical Staff for bona fide study and research; and (iii) such other persons as the Governing Board, the CEO, the Chief of Staff, the Medical Executive Committee, the Performance Improvement Committee, may deem necessary to facilitate analysis and evaluation of the quality of those records, of the proper utilization of the Hospital, or of the quality of patient care in the Hospital, and with respect to decisions regarding reappointment to the Medical Staff, modification of staff status or privileges, or corrective action.

3. All records are the property of the Hospital. All radiology imaging, photographs, videotapes, and photographic slides are the property of the Hospital and may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statue, or with the permission of the CEO. Pathology specimens and microscopic slides are the property of the designated vendor utilized to process the specimens and/or slides and may be retrieved accordingly from those vendors.

4. Unauthorized removal of charts or other records from the Hospital or unauthorized disclosure to third parties of the contents thereof, shall be grounds for corrective action, including, but not limited to, suspension of the offending practitioner from the Medical Staff and from exercising privileges in the Hospital for a period to be determined by the Medical Executive Committee of the Medical

Staff, subject to the approval of the Governing Board.

XIX. Access to Medical Records

A. Access to all medical records of all patients shall be afforded to appointees of the staff for bona fide study and research, gathering relevant statistical information, use in quality assessment activities and other appropriate analysis, preserving the confidentiality of personal information concerning the individual patients.

1. The Medical Executive Committee of the Medical Staff and hospital administration shall approve all such projects.
2. Subject to the discretion of the Chief Executive Officer, former members of the medical staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.