

Patient Access to Medical Records

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This report identifies and explains state law on patient access to medical records in a question and answer format. Throughout the report, the terms "medical records" and "health records" are used interchangeably reflecting their usage in statute. In some cases, the term "hospital records" is also used.

PATIENT ACCESS TO MEDICAL RECORDS FROM INDIVIDUAL HEALTH CARE PROVIDERS

Do Patients Have Access to Their Medical Records?

Yes. The law requires a health care provider, except in limited circumstances, to supply a patient, upon request, complete and current information the provider has about the patient's diagnosis, treatment, and prognosis. The provider must also notify a patient of any test results in his possession or requested by the provider for purposes of diagnosis, treatment, or prognosis. **(CGS § 20-7c(b)).**

A patient may obtain copies of his or her medical records by asking the provider in writing. The patient's attorney or authorized representative can also make such a request from a health care provider. Such records include bills, x-rays, copies of lab report results, prescriptions, contact lens specifications under certain conditions, and other technical information used to assess the patient's health condition. **(CGS § 20-7c(c)).**

The provider must supply the health record within 30 days of the request. **(CGS § 20-7c(c)).**

When Can a Provider Withhold This Information?

By law, a provider can withhold medical information from a patient if he reasonably determines that the information would be detrimental to the patient's physical or mental health or would likely cause the patient to harm himself or someone else. In such a case, the provider can supply the information to an appropriate third party or another provider who can release it to the patient. **(CGS § 20-7c(d)).**

Is There a Cost to Obtain Medical Records?

A provider can charge up to 45 cents per page, including any research fees, handling fees or related costs, and the cost of first class postage, if applicable, to furnish the patient's health record. Also, the provider can charge a patient the amount necessary to cover the costs of materials for providing a copy of an x-ray. **(CGS § 20-7c(c)).**

A provider cannot charge for supplying a health record if the person documents that it is necessary to support a Social Security claim or appeal. **(CGS § 20-7c(c)).**

What about Information Concerning Psychiatric or Psychological Conditions?

The law specifically says that its provisions for patients' access to their records (cited above, CGS § 20-7c(a)-(d)) do not apply to "any information relative to any psychiatric or psychological problems or conditions." **(CGS § 20-7c(e)).**

Which Providers Are Covered By These Provisions?

The law applies to people licensed or certified to furnish the following health care services: medicine and surgery, chiropractic, naturopathy, podiatry, athletic training, physical therapy, occupational therapy, substance abuse counseling, radiography, midwifery, nursing, dentistry, dental hygiene, optometry, optics, respiratory care, pharmacy, psychology, marital and family therapy, clinical social work, professional counseling, veterinary medicine, massage therapy, electrology, hearing instruments, and speech pathology and audiology. **(CGS § 20-7b(b); § 20-7c(a))**.

Can a Patient's Medical Records Be Released to Another Provider?

If the patient asks in writing, a provider must furnish a copy of the patient's health record to another provider. This includes x-rays and copies of lab reports, prescriptions, and other technical information used in assessing the patient's condition. The written request must specify the name of the provider who is to receive the record. The patient is responsible for the reasonable costs of providing the information. **(CGS § 20-7d)**.

PATIENT ACCESS TO RECORDS FROM HOSPITALS AND OTHER HEALTH CARE INSTITUTIONS

Can a Person Access His Hospital Records?

Yes. By law, a health care institution (which includes a hospital and other health care facilities, see **CGS § 19a-490**), must provide a copy of a patient's health record upon the written request of the patient, his attorney, or authorized representative. The health record includes copies of bills, lab reports, prescriptions, and other technical information used in assessing the patient's condition. **(CGS § 19a-490b(a))**.

The institution must also give the patient or his designated provider a reasonable opportunity to examine retained tissue slides and retained pathology tissue blocks. When the patient, his attorney or his designated health care provider asks in writing, a health care institution must send the original retained tissue or slide or original retained tissue block directly to the institution, lab or physician the patient designates. **(CGS § 19a-490b(a))**.

Another statute requires each private or public hospital receiving state aid to allow a patient it treats and discharges, or his physician or attorney, to examine his hospital record, at the patient's request. The record includes the history, bedside notes, charts, pictures, and plates kept concerning the treatment. The patient, or his physician or attorney must be allowed to make copies of such information. **(CGS § 4-104)**.

Can the Health Care Institution Charge for These Records?

An institution can charge up to 65 cents per page, including any research, clerical, and handling fees or related costs, and first class postage, if applicable. The institution can also charge the amount necessary to cover the costs of materials for providing a copy of an x-ray or for furnishing an original retained slide, an original tissue block, or a new section cut from a retained pathology tissue block. **(CGS § 19a-490b(a))**.

The institution cannot charge if the health record is necessary for a documented Social Security claim or appeal. An institution must provide the requested health record within 30 days of the request, unless the patient's request was received less than 30 days from his

discharge. In that case, the institution must provide the record when it is completed. (**CGS § 19a-490b(b)**).

An institution cannot deny a records request because of a person's inability to pay the required fees. The person must have an affidavit attesting to his inability to pay. (**CGS § 19a-490b(d)**).

RETENTION OF MEDICAL RECORDS-INDIVIDUAL HEALTH CARE PROVIDERS

How Long Must a Health Care Provider Keep a Patient's Medical Records?

Generally, a provider must retain a patient's medical records for seven years after the last treatment date, or three years from the patient's death. (**Department of Public Health (DPH) Regs. § 19a-14-42**).

Pathology slides, EEGs, and ECG tracings must also be retained for seven years, but as subsequent ECGs are taken, previous ones may be discarded if the results are unchanged. (**DPH Regs. § 19a-14-42(a)**).

Lab reports and PKU reports must be kept for five years and X-ray film for three years. (**DPH Regs. , § 19a-14-42(b), (c)**).

What Happens When a Health Care Provider Dies or Retires?

A provider who terminates a practice (or his executor or responsible relative in the case of death) must inform patients by notice published in a local newspaper and a letter sent to each patient seen within the past three years before the date the practice was discontinued. The patients' medical records must be kept for 60 days after the notice. (**DPH Regs. § 19a-14-44**).

What if a Patient Changes Providers?

If a patient changes providers and asks the former provider to transfer the records to the new primary care provider, the first provider need no longer retain the records. (**DPH Regs. § 19a-14-43**).

RETENTION OF RECORDS-HOSPITALS

How Long Must a Hospital Retain a Patient's Records?

Medical records must be filed in an accessible manner in **THE HOSPITAL AND KEPT A MINIMUM OF 25 YEARS AFTER THE PATIENT'S DISCHARGE. ORIGINAL RECORDS CAN BE DESTROYED SOONER IF THEY ARE MICROFILMED BY A PROCESS APPROVED BY DPH.** (DPH REGS. § 19-13-D3(D)(6)).

What Happens to the Records if a Health Care Institution Closes?

When a health care institution that ceases operations gives up its license to DPH, it must provide the department with a certified document specifying where its patient health records will be stored and the procedure for patients, former patients or their authorized representatives to access the records. (**PA 05-272; CGS § 19a-490b(e)**).

ELECTRONIC MEDICAL RECORDS

Must Health Care Providers and Institutions Keep Medical Records in an Electronic Format?

The law allows licensed health care institutions to create, maintain or use medical records or medical record systems in electronic format, paper, or both if the system can store medical records and patient health care information in a reproducible and secure manner. **(PA 05-168; CGS § 19a-25c).**

State law also allows health care providers with prescriptive authority to use electronic prescribing systems. **(PA 05-168; CGS § 19a-25b).**

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