

19a-14-40. Medical records, definition, purpose**Medical Records****19a-14-40. Medical records, definition, purpose**

The purpose of a medical record is to provide a vehicle for: documenting actions taken in patient management; documenting patient progress; providing meaningful medical information to other practitioners should the patient transfer to a new provider or should the provider be unavailable for some reason. A medical record shall include, but not be limited to, information sufficient to justify any diagnosis and treatment rendered, dates of treatment, actions taken by non-licensed persons when ordered or authorized by the provider; doctors' orders, nurses notes and charts, birth certificate work-sheets, and any other diagnostic data or documents specified in the rules and regulations. All entries must be signed by the person responsible for them.

(Effective August 29, 1984.)

19a-14-41. Professions involved

Each person licensed or certified pursuant to the following chapters and Acts shall maintain appropriate medical records of the assessment, diagnosis, and course of treatment provided each patient, and such medical records shall be kept for the period prescribed: chapters 334b, 370 thru 373, 375, 376, 378 thru 381, 383 thru 384, 388, 398, 399, and Public Acts 83-352 and 83-441.

(Effective August 29, 1984.)

19a-14-42. Retention schedule

Unless specified otherwise herein, all parts of a medical record shall be retained for a period of seven (7) years from the last date of treatment, or, upon the death of the patient, for three (3) years.

- (a) Pathology Slides, EEG and ECG Tracings must each be kept for seven (7) years. If an ECG is taken and the results are unchanged from a previous ECG, then only the most recent results need be retained. Reports on each of these must be kept for the duration of the medical record.
- (b) Lab Reports and PKU Reports must be kept for at least five (5) years. Only positive (abnormal) lab results need be retained.
- (c) X-Ray Films must be kept for three (3) years.

(Effective August 29, 1984.)

19a-14-43. Exceptions

Nothing in these regulations shall prevent a practitioner from retaining records longer than the prescribed minimum. When medical records for a patient are retained by a health care facility or organization, the individual practitioner shall not be required to maintain duplicate records and the retention schedules of the facility or organization shall apply to the records. If a claim of malpractice, unprofessional conduct, or negligence with respect to a particular patient has been made, or if litigation has been commenced, then all records for that patient must be retained until the matter is resolved. A consulting health care provider need not retain records if they are sent to the referring provider, who must retain them. If a patient requests his records to be transferred to another provider who then becomes the primary provider to the patient, then the first provider is no longer required to retain that patient's records.

(Effective August 29, 1984.)

19a-14-44. Discontinuance of practice

Upon the death or retirement of a practitioner, it shall be the responsibility of the practitioner or surviving responsible relative or executor to inform patients. This must be done by placing a notice in a daily local newspaper published in the community which is the prime locus of the practice. This notice shall be no less than two columns wide and no less than two inches in height. The notice shall appear twice, seven days apart. In addition, an individual letter is to be sent to each patient seen within the three years preceding the date of discontinuance of the

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19a-14-50. Definitions

practice. Medical records of all patients must be retained for at least sixty days following both the public and private notice to patients.

(Effective August 29, 1984.)

19a-14-50. Definitions

For the purposes of these regulations, "Doctor" means either a physician licensed pursuant to Chapter 370 of the Connecticut General Statutes or an Optometrist licensed pursuant to Chapter 380 of the Connecticut General Statutes.

(Effective August 29, 1986.)

19a-14-51. Optician record retention

For each client fitted with prescription eyeglasses or prescribed contact lenses, a licensed optician shall keep a record. When prescription items are dispensed by a registered apprentice optician, the supervising licensed optician must verify the accuracy of all the data included in the client record and indicate this on the record. A client record shall contain the following:

- (a) Prescription Eyewear Records shall include:
 - (1) Doctor's prescription and date, including name of prescribing doctor;
 - (2) Date of delivering said prescription, to include any duplication of existing lenses;
 - (3) Facial measurements, to include but not be limited to: interpupillary measures; frame size determinations, including eye size, bridge size, temple length;
 - (4) Name of frame provided; and
 - (5) Lens description to include: lens materials; placement of optical centers; lens tint; and, when applicable, multifocal type and placement of multifocal.
- (b) Contact Lenses Prefit
 - (1) Prefitting record shall include: date of client visit; doctor's written prescription; doctor's keratometric measures if such measures are provided, and such other measures or observations which are properly within the optician's scope of practice as defined by Connecticut General Statutes Section 20-139;
 - (2) Any information which would contraindicate the fitting of contact lenses;
 - (3) The date of the examining doctor's prescription;
 - (4) A prefitting biomicroscopic record of the external eye made by the doctor, if such is provided; and
 - (5) Any notice provided to the client regarding the length of time after which the prescription will not be refilled.
- (c) Contact Lens Dispensing Records on the dispensing of contact lenses shall include:
 - (1) All particular lens parameters including manufacturer;
 - (2) Date of client instruction in handling and hygiene;
 - (3) Visual acuity recorded with dispensed contact lenses as obtained by use of a standardized snellen-type chart;
 - (4) If performed, a summary of observations of the physical relationship between dispensed contact lens and cornea, including, but not limited to, biomicroscopic observations;
 - (5) A recommended wearing schedule; and
 - (6) A summary of recommended follow-up.
- (d) Contact Lens Follow-up Records of visits subsequent to the actual dispensing of contact lenses shall include:
 - (1) Date of each visit;
 - (2) Client's current wearing schedule;
 - (3) Visual acuity recorded with dispensed contact lenses, obtained by use of a standardized snellen-type chart;
 - (4) Date of next recommended visit; and
 - (5) A description of any perceived changes in visual acuity or obvious anomalies, and a record of any report made to the client or prescribing doctor.

(Effective August 29, 1986.)

