

Provisions of Connecticut General Statutes  
Medical Records

**Sec. 20-1. Healing arts defined.** The practice of the healing arts means the practice of medicine, chiropractic, podiatry, natureopathy and, except as used in chapters 384a and 388, the practice of optometry.

**Secs. 20-2 to 20-7. Examining boards, generally.** Sections 20-2 to 20-7, inclusive, are repealed.

**Sec. 20-7a. Billing for clinical laboratory services. Cost of diagnostic tests.**

**Financial disclosures to patients.** (a) Any practitioner of the healing arts who agrees with any clinical laboratory, either private or hospital, to make payments to such laboratory for individual tests or test series for patients shall disclose on the bills to patients or third party payors the name of such laboratory, the amount or amounts charged by such laboratory for individual tests or test series and the amount of his procurement or processing charge, if any, for each test or test series. Any person who violates the provisions of this section shall be fined not more than one hundred dollars.

(b) Each practitioner of the healing arts who recommends a test to aid in the diagnosis of a patient's physical condition shall, to the extent the practitioner is reasonably able, inform the patient of the approximate range of costs of such test.

(c) Each practitioner of the healing arts who (1) has an ownership or investment interest in an entity that provides diagnostic or therapeutic services, or (2) receives compensation or remuneration for referral of patients to an entity that provides diagnostic or therapeutic services shall disclose such interest to any patient prior to referring such patient to such entity for diagnostic or therapeutic services and provide reasonable referral alternatives. Such information shall be verbally disclosed to each patient or shall be posted in a conspicuous place visible to patients in the practitioner's office. The posted information shall list the therapeutic and diagnostic services in which the practitioner has an ownership or investment interest and therapeutic and diagnostic services from which the practitioner receives compensation or remuneration for referrals and state that alternate referrals will be made upon request. Therapeutic services include physical therapy, radiation therapy, intravenous therapy and rehabilitation services including physical therapy, occupational therapy or speech and language pathology, or any combination of such therapeutic services. This subsection shall not apply to in-office ancillary services. As used in this subsection, "ownership or investment interest" does not include ownership of investment securities that are purchased by the practitioner on terms available to the general public and are publicly traded; and "entity that provides diagnostic or therapeutic services" includes services provided by an entity that is within a hospital but is not owned by the hospital. Violation of this subsection constitutes conduct subject to disciplinary action under subdivision (6) of subsection (a) of section 19a-17.

**Sec. 20-7b. Definitions.** For purposes of sections 20-7b to 20-7e, inclusive:

(a) "Patient" means a natural person who has received health care services from a provider for treatment of a medical condition, or a person he designates in writing as his representative; and

(b) "Provider" means any person or organization that furnishes health care services and is licensed or certified to furnish such services pursuant to chapters 370 to 373, inclusive, 375 to 384a, inclusive, 388, 398 and 399 or is licensed or certified pursuant to chapter 368d.

**Sec. 20-7c. Access to medical records. Mandatory notification to patient of certain test results.** (a) For purposes of this section, "provider" has the same meaning as provided

in section 20-7b.

(b) (1) A provider, except as provided in section 4-194, shall supply to a patient upon request complete and current information possessed by that provider concerning any diagnosis, treatment and prognosis of the patient. (2) A provider shall notify a patient of any test results in the provider's possession or requested by the provider for the purposes of diagnosis, treatment or prognosis of such patient.

(c) Upon a written request of a patient, a patient's attorney or authorized representative, or pursuant to a written authorization, a provider, except as provided in section 4-194, shall furnish to the person making such request a copy of the patient's health record, including but not limited to, bills, x-rays and copies of laboratory reports, contact lens specifications based on examinations and final contact lens fittings given within the preceding three months or such longer period of time as determined by the provider but no longer than six months, records of prescriptions and other technical information used in assessing the patient's health condition. No provider shall refuse to return to a patient original records or copies of records that the patient has brought to the provider from another provider. When returning records to a patient, a provider may retain copies of such records for the provider's file, provided such provider does not charge the patient for the costs incurred in copying such records. No provider shall charge more than sixty-five cents per page, including any research fees, handling fees or related costs, and the cost of first class postage, if applicable, for furnishing a health record pursuant to this subsection, except such provider may charge a patient the amount necessary to cover the cost of materials for furnishing a copy of an x-ray, provided no such charge shall be made for furnishing a health record or part thereof to a patient, a patient's attorney or authorized representative if the record or part thereof is necessary for the purpose of supporting a claim or appeal under any provision of the Social Security Act and the request is accompanied by documentation of the claim or appeal. A provider shall furnish a health record requested pursuant to this section within thirty days of the request. No health care provider, who has purchased or assumed the practice of a provider who is retiring or deceased, may refuse to return original records or copied records to a patient who decides not to seek care from the successor provider. When returning records to a patient who has decided not to seek care from a successor provider, such provider may not charge a patient for costs incurred in copying the records of the retired or deceased provider.

(d) If a provider reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to harm himself or another, the provider may withhold the information from the patient. The information may be supplied to an appropriate third party or to another provider who may release the information to the patient. If disclosure of information is refused by a provider under this subsection, any person aggrieved thereby may, within thirty days of such refusal, petition the superior court for the judicial district in which such person resides for an order requiring the provider to disclose the information. Such a proceeding shall be privileged with respect to assignment for trial. The court, after hearing and an in camera review of the information in question, shall issue the order requested unless it determines that such disclosure would be detrimental to the physical or mental health of the person or is likely to cause the person to harm himself or another.

(e) The provisions of this section shall not apply to any information relative to any psychiatric or psychological problems or conditions.

(f) In the event that a provider abandons his or her practice, the Commissioner of Public Health may appoint a licensed health care provider to be the keeper of the records, who shall be responsible for disbursing the original records to the provider's patients, upon the request of any such patient.

**Sec. 20-7d. Release of patient's medical records to another provider.** A copy of the patient's health record, including but not limited to, x-rays and copies of laboratory reports, prescriptions and other technical information used in assessing the patient's condition shall be furnished to another provider upon the written request of the patient. The written request shall specify the name of the provider to whom the health record is to be furnished. The patient shall be responsible for the reasonable costs of furnishing the information.

**Sec. 20-7e. Medical records maintained by agencies.** The provisions of sections 20-7b to 20-7d, inclusive, shall not apply to medical records maintained by any agency as defined in section 4-190.

Regulations of Connecticut State Agencies  
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 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.)