

Charleston/Dorchester Community
Mental Health Services

MEDICAL RECORDS POLICY

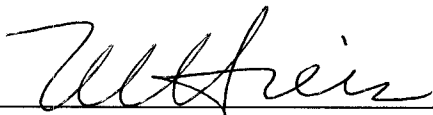
Policy:

The Charleston/Dorchester Community Mental Health Center will efficiently organize and monitor Medical Records in a manner that is consistent with confidentiality mandates and accepted standards for safeguarding, storage and handling.

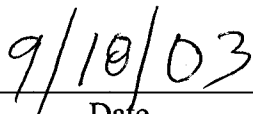
Procedures:

1. All medical records will be stored in designated medical records rooms under double lock, i.e., cabinet locks and door locks.
2. There will be only one designated medical records room in each Charleston/Dorchester Community Mental Health Center service building.
3. One member of the administrative staff shall be assigned as Medical Records Manager in each building where medical records are kept. This individual's Job Description will reflect this responsibility. Job duties will include:
 - a. Managing access to medical records.
 - b. Protecting the security and confidentiality of medical records.
 - c. Monitoring and tracking records within the building.
 - d. Reviewing records for closure and transfers in and out of the building.
 - e. Monitoring and tracking records which must be temporarily removed from the building.
 - f. Ensuring there is a back-up method for retrieving information from Client Information System should system be unavailable for extended period of time.
 - g. Coordinating communication to appropriate personnel to reasonably protect all medical records against fire, water damage, and other hazards.

4. The movement of medical records will be monitored in the following ways:
 - a. "Out-cards" will be substituted in files for removed medical records and will identify the medical record and staff person retaining the record
 - b. Records being transferred will contain a chart review form which indicates the following activities by the medical records manager:
 1. That the chart has been reviewed for QA standards
 2. The date that the chart leaves the service
 3. The name of the service program to which the chart is being transferred
 4. The date that the chart arrives in the receiving service
 - c. A sign-out sheet will be posted in the medical records room for recording the following information on any chart leaving the service building temporarily:
 1. Client name
 2. Record #
 3. Staff person retaining the record
 4. Date out
 5. Date in
5. All service areas may develop additional building-specific program policies and procedures that are consistent with this Center's policy. They will be sent to the Health Insurance Portability & Accountability [HIPAA]/Medical Records Liaison for review prior to implementation.



Thomas G. Hiers, Ph.D.
Executive Director



Date