Confidentiality of Medical Records in Ohio

Current Law in the State of Ohio

The purpose of the memorandum is to address pertinent issues involving medical records, confidentiality, disclosure, etc.

The issues addressed reflect the position adopted by the Ohio State Dental Board as noted.

Medical Record: Any document or combination of documents that pertains to a patient's medical history, diagnosis, prognosis, or medical condition, and that is generated and maintained in the process of the patient's health care treatment. R.C. 3701.74(A)(2).

Do not include in a patient record:

- Care related to another patient
- peer review/quality assurance information/documents
- correspondence/notes from attorneys
- aberrant/deviant statements

Duty to Retain Records

Ohio statutes do not directly address a physician's/dentist's responsibility regarding the retention of medical records. However, licensed health care facilities must maintain medical records for at least six (6) years from the date of discharge. OAC 3701-83-11(E). Further, under Ohio law, a medical malpractice case must be commenced within one year after the cause of action accrues, except that, if prior to the expiration of that one year period, a claimant gives the provider written notice that he/she is considering bringing a malpractice action. RC 2305.11(B). The statute of limitations is tolled for persons within the age of minority or of unsound mind. RC 2305.16. Federal Medicaid claims have a statutory seven (7) year look back period.

Therefore, it is suggested that a physician/dentist maintain patient records for at least seven (7) years, but the best advice would be to keep the records indefinitely.

Ownership of and Access to Medical Records

Hospital Records

A hospital should prepare a finalized medical record within 30 days after treatment. A patient who wishes to examine or obtain a finalized medical record must submit a signed written request to the hospital. Within a reasonable time, the hospital must permit inspection or a copy within a reasonable amount of time. However, if a physician who has treated the patient determines for clearly stated reasons that disclosure of the requested documents is likely to have an adverse effect on the patient, the hospital must provide the record to a physician designated by the patient. RC 3701.74(C).

Physician/Dentist Records

Ohio law does not directly address patient access to records kept by a private physician. However, the American Medical Association (AMA) and the American Dental Association (ADA) has rendered opinions on the issue.

Availability to Other Physicians:

Medial records should be made available on request to another physician presently treating the patients, so long as proper authorization (release) has been granted by the patient. Medical records should not be withheld because of an unpaid bill for medical services. AMA Opinion 7.01.

Dentists are obliged to safeguard the confidentiality of patient records. Dentists shall maintain records in a manner consistent with the protection of the welfare of the patient. Upon request of a patient or another dental practitioner, dentists shall provide any information that will be beneficial for the future treatment of that patient. ADA Code Section 1.B.

A dentist has the ethical obligation on request of either the patient or the patient's new dentist to furnish, either gratuitously or for nominal cost, such dental records or copies or summaries of them, including dental x-rays or copies of them, as will be beneficial for the future treatment of that patient. This obligation exists whether or not the patient's account is paid in full. ADA Advisory Opinion 1.B.1.

Information and Patients:

Notes made in treating a patient are primarily for the physician's own use and constitute his/her personal property. However, on request of the patient, a physician should provide a copy or a summary of the record to the patient or to another physician, or other person designated by the patient.

The record is a confidential document involving the physician-patient relationship and should not be communicated to a third party without the patient's prior written consent, unless required by law or to protect the welfare of the individual or the community. Physicians may charge a reasonable fee for copying medical records. AMA Opinion 7.02.

The dominant theme in [ADA] Code Section 1-B is the protection of the confidentiality of a patient's records. The statement in this section that relevant information in the records should be released to another dental practitioner assumes that the dentist requesting the information is the patient's present dentist. The former dentist should be free to provide the present dentist with the relevant information from the patient records. This may often be required for the protection of both the patient and the present dentist. There may be circumstances where the former dentist

has an ethical obligation to inform the present dentist of certain facts. Dentists should be aware, however, that the laws of the various jurisdictions in the United States are not uniform, and some confidentiality laws appear to prohibit the transfer of pertinent information such as HIV seropositivity.

Absent certain knowledge that the laws of the dentist's jurisdiction permit the forwarding of this information, a dentist should obtain the patient's written permission before forwarding health care records which contain information of a sensitive nature, such as HIV seropositivity, chemical dependency or sexual preference. If it is necessary for a treating dentist to consult with another dentist or physician with respect to the patient, and the circumstances do not permit the patient to remain anonymous, the treating dentist should seek permission of the patient prior to the release of data from the patient's records to the consulting practitioner. If the patient refuses, the treating dentist should then contemplate obtaining legal advice regarding the termination of the dentist/patient relationship. ADA Advisory Opinion 1.B.2

Departure from a Group Practice:

The patients of a physician who leaves a group practice should be notified that the physician is leaving the group. Patients of the physician should also be notified of the physician's new address and offered the opportunity to have their medical records forwarded to the departing physician at his or her new practice. It is unethical to withhold such information upon request of a patient. If the responsibility for notifying the patients falls to the departing physician rather than to the group, the group should not interfere with the discharge of these duties by withholding patient lists or other necessary information. AMA Opinion 7.03.

Sale of a Medical Practice:

A physician or the estate of a deceased physician may sell to another physician the elements that comprise his/her practice, such as furniture, fixtures, equipment, office leasehold, and goodwill. In the sale of a medical practice, the purchaser is buying not only furniture and fixtures, but also goodwill, i.e. the <u>opportunity</u> to take over the patients of the seller. The transfer of records of patients is subject to the following:

(i) All active patients should be notified that the physician (or the estate) will be transferring the practice to another physician who will retain custody of their records and that at their written request, within a reasonable time as specified in the notice, the records or copies will be sent to any other

physician of their choice. Rather than destroy the records of a deceased physician, it is better to retain them subject to requests from patients that they be sent to another physician.

(ii) A reasonable charge may be made for the cost of duplicating the records.

AMA Opinion 7.04.

Alteration/Amendment of Records

An intentional alteration, falsification or destruction of medical records by a doctor, to avoid liability for his or her medical negligence, is sufficient to show actual malice, and punitive damages may be warded whether or not the act of altering, falsifying, or destroying records directly causes compensable harm. Moskovitz v. Mt. Sinai Medical Center (1994), 69 Ohio St.3d 638.

Further, with respect to dentists, this conduct could constitute a violation of the Dental Practice Act, which could result in formal disciplinary action. RC 4715.30(A)(2).

The Ohio State Medical Association suggests correcting errors by drawing a single line through the incorrect portion, writing "error" above the lined-out item, and initialing and dating the error.

Confidentiality of Medical Records

Generally, Professional Privilege prohibits the disclosure of protected information. Patients only can waive the privilege.

RC 4731.22(B)(4): Physicians can be disciplined for willfully betraying a professional confidence.

RC 2317.02(B)(1): Communications between patients and their dentists and physicians are privileged and protected.

Exceptions:

- Filing of a malpractice/wrongful death lawsuit
- Consent to disclosure by spouse of deceased or parent/guardian
- **Regulatory Board investigation**
- Criminal Action

Duty to Release Medical Records

Medical records may, and in some cases must be, disclosed in several situations:

1. Report of Crime: RC 2921.22

2. Report of Communicable Diseases: OAC 3701-3-01, et seq.

3. Report of Vital Statistics: OAC 3701-5

4. Duty to Report Child or Elder Abuse: RC 2151.421 (child)
RC 5201.61 (elder).

5. **In Response to a Subpoena**:

- Miller v. State Medical Board of Ohio (1989), 44 Ohio St.3d 136, ("Because the statute in question contains safeguards designed to protect patient confidentiality, which is the same purpose served by the physician-patient privilege, we find that the physician-patient privilege does not preclude turning patient records over to the State Medical Board pursuant to RC 4731.22(C)(1)"). The Dental Board has a similar provision in RC 4715.03(D).

- State Medical Board of Ohio v. Murray (1993), 66 Ohio St.3d 527 (information contained in the Board's investigation remains confidential and is not subject to discovery in any civil action).

- Ohio State Dental Board v. Ronald D. Rubin, 104 Ohio App. 3d 773 (Hamilton Co. 1995), ("…we are persuaded that the interest of the public at large, served here through the Board's investigation….outweighs the interests to be served by invocation of the dentist-patient privilege…")

Medical Record Keeping: Tips

The following general guidelines are taken from the Physician's Guide to Ohio Law (6th ed.) published by the Ohio State Medical Association[1]:

Do's:

1. Record the patient's identification on each page of the chart.
   - Use a separate file for each family member

2. Record the complete date (dd/mm/yy) on each entry.

3. Sign each entry with your name and title/position.

4. Use permanent ink.

5. Write legibly and use only standard abbreviations.
   - Dictated notes are legible when transcribed and often result in more detailed medical records
   - Notes that are entered into a patient record by someone other than the physician should be reviewed and initialed by the physician

[1] Although these tips were prepared with physicians in mind, the information is certainly applicable to dentists.

6. Record all of the following information immediately:
    - mode of contact (phone, office visit, etc.)
    - reason for contact
    - treatment, information or advice given
    - outcome of contact
    - plan for future care or follow-up

7. Fill in any blanks, recording both negative and positive information

8. Correct any error or mistake by drawing a single line through the incorrect portion, writing “error” above the lined-out item, and initialing and dating the error.

9. Prominently display all medications and patient allergies/ contradictions.

10. Document all patient instructions and educational material given.

11. Document the disclosure of informed consent.

12. Document the details of the patient’s noncompliance with treatment or advice.

Don’t’s:

1. Using “white out,” erasing or obliterating a chart entry in any way.

2. Using subjective comments about a patient, i.e., “patient is a fruitcake” (instead, quote the patient’s words and describe the patient’s behavior).

3. Using names without describing their role in the patient’s future care, i.e. write “referred to Dr. Jane Doe for allergy testing” instead of “referred to Dr. Jane Doe”.

4. Recording information that is not pertinent to the future care of the patient, i.e., if an error occurred, you should describe the error and not explain, rationalize, or argue your case in the medical record.

5. Criticizing the care that the patient received from other providers and facilities.

6. Speculating or drawing medical conclusions about a patient’s condition without adequate substantiating data and factual interpretations.

7. Filing a chart before it has been checked for both accuracy and completeness.

8. Altering records after a lawsuit has been filed.

DENTISTS:

It is important to note that the Ohio State Dental Board has never disciplined a licensee for “overdocumentation”.

Remember the saying: if it is not written, it did not exist or happen. On dental charts, be sure to date chart entries, and designate who provided the treatment. Also include a detailed patient history, all diagnostic tests and findings, periodontal problems, radiographic interpretations, anesthesia doses, medication, the rationale for tooth removal, diagnosis and the treatment recommended, etc.

It is important to obtain informed consent from a patient/guardian prior to performing dental treatment. In so doing, consider the PARQ method:

- Explain what **P**rocedure is being proposed,
- Explain what Alternative treatments may be available,
- Explain what Risks are involved,
- Answer any Questions the patient may have,

And then document this PARQ information in the patient record.