By-Law 6: Medical Records

Standards governing the keeping of medical records as part of the practice of medicine, made pursuant to paragraph 15(1)(o) of the *Medical Act, 2011*.

1. Application of this By-Law

(1) This By-Law applies to any records containing patient information in the possession or control of a medical practitioner.

(2) For records which are considered to be under the control of a regional health authority (RHA), this By-Law applies provided that this By-Law is not contrary to the policies of the RHA. In the event that a subsection of this By-Law is contrary to a policy of the RHA, the policy of the RHA shall prevail for that subsection only.

(3) Where records referred to in this By-Law are records to which the *Personal Health Information Act* (*PHIA*) also applies, a medical practitioner must meet the requirements of this By-Law to the extent that it is possible to comply with both this By-Law and *PHIA*. Medical practitioners are responsible to make themselves, and their staff, familiar with the information regarding compliance with *PHIA*.

2. Information to be Recorded and Retained

(1) A medical practitioner must ensure that there is recorded and retained an individual record for each patient (the "Medical Record") which includes:

(a) the full name, address, and date of birth of the patient;

(b) the patient's medical care plan number, if patient has one;

(c) the name and contact information of the patient's legal representative or substitute decision maker, if applicable;

(d) the name and address of the patient's primary care physician and of any health care professional who referred the patient, if applicable;

(e) the date of each professional encounter of the medical practitioner with the patient, including each occasion on which the patient is seen or spoken to by telephone by the medical practitioner;

(f) a contemporaneous record of the assessment and disposition of the patient by the medical practitioner for each visit, including:

(i) evidence of use of SOAP (Subjective, Objective, Assessment, Plan) or other similar plan appropriate to area of practice;

(ii) relevant family medical history and personal medical history of the patient, as obtained and updated by the medical practitioner from visit to visit, including pertinent negatives;

(iii) the findings of the physical examination and other medical examinations performed by the medical practitioner, including pertinent negatives;

(iv) the provisional diagnosis, or diagnosis/diagnoses made;

(v) investigations ordered by the medical practitioner;

(vi) a description of each drug or other treatment prescribed or administered by the medical practitioner, including prescribed drug dosage and duration;

(vii) a record of any professional advice given by the medical practitioner; and

(viii) particulars of any referral made by the medical practitioner;

(g) results of investigations ordered by the medical practitioner, which should have stamped or otherwise recorded on them the date received by the medical practitioner's office, the dated and initial (or otherwise distinctively marked by the medical practitioner) at the time of his/her review, and the date and manner the results were communicated to the patient by the medical practitioner or by an appropriately-trained staff person.

(h) copies of correspondence and reports concerning the patient, prepared by or under the direction of the medical practitioner; and

(i) copies of consultant reports, operative reports, discharge summaries and other information created by other physicians or health-care practitioners which is relevant to the patient's medical care.

(2) In circumstances where a medical practitioner views any of the reports or other documents referred to in paragraph 2(1)(g) or 2(1)(i) on an electronic health record network, the medical practitioner shall ensure that an electronic record of their review and consideration of the report or document is maintained within the electronic record.

(3) It is recommended that the Medical Record also include, where applicable:

(a) a cumulative patient profile, contextual to the physician-patient relationship, detailing:

(i) current medications and treatments;

(ii) allergies and drug reactions;

(iii) ongoing health conditions and identified risk factors;

(iv) medical history, including family medical history;

(v) social history;

(vi) health maintenance plans (e.g. immunizations, screening tests); and

(vii) date the cumulative patient profile was last updated; and

(b) chronic disease flow sheets.

3. Multiple physician entries

(1) If more than one medical practitioner is making entries into the Medical Record of a patient, a system should be used to ensure that the physician making each individual entry is identifiable.

4. Daily Diary

(1) In addition to the Medical Record for each individual patient, medical practitioners shall also keep, for each work day, a day book, daily diary, appointment sheets or an equivalent record containing the names of all patients seen, treated or in respect of whom professional services are rendered on that day.

5. Making and Retaining Medical Records

(1) Medical Records must be:

(a) legibly written, typewritten, or electronically recorded in accordance with this By-Law;

(b) kept in a systematic manner;

(c) kept in a secure manner, and accessible only to:

(i) the medical practitioner;

(ii) such persons employed or associated with the medical practitioner's practice who are specifically authorized by the medical practitioner to access a patient record and who are made aware by the medical practitioner of the need to maintain the confidentiality of patient records; and

(iii) patients and other authorized persons in accordance with the *PHIA* and any other applicable law, regulation, By-Law, Standard of Practice or Practice Guideline of the College.

(2) Medical Records may be made, or converted to, and retained by a medical practitioner by using an electronic information system, including a practice management system, an electronic medical record system, an electronic database or an authorized regional or provincial information system, only if it has the following characteristics:

(a) all requirements of this By-Law continue to be met;

(b) the system is capable of printing the recorded information promptly;

(c) the system maintains an audit trail that:

(i) records the user identification of the person who accesses the information;

(ii) records the date and time of each entry of information for each patient;

(iii) indicates any changes in the recorded information;

(iv) preserves the original content of the recorded information when changed or updated;

(v) is capable of being printed separately from the recorded information for each patient; and

(vi) retains a description of the information that is accessed or that could have been accessed;

(d) the system includes, at a minimum, password management and access controls and provides other reasonable protections, including:

(i) the system automatically backs up files and allows the recovery of backed-up files or otherwise provides reasonable protection against loss of, damage to, and inaccessibility of, information;

(ii) the system has data protection functionality, which it is recommended include appropriate virus protection and encryption; and

(iii) all transfer of information from the system is done through secure communications.

6. Altering Medical Records

(1) Where it is necessary to alter an existing Medical Record, the alteration shall be made in such manner as to not remove, delete, erase, or render illegible each previously existing record, and the date of the alteration shall be clearly noted in the vicinity of each such alteration.

(2) If a correction of a patient's Medical Record is requested by the patient, and the medical practitioner agrees, the alteration should be made as soon as reasonable possible and must be made in accordance with section 6(1).

7. Retention Period

(1) A medical practitioner must keep, or cause to be kept, a patient's Medical Records for a minimum of:

(a) 10 years following the date of last provision of service to a patient by that medical practitioner, or

(b) in the case of a patient who at the date of last provision of service was under the age of 19 years, until that patient attains the age of 21 years or for 10 years following the date of last provision of service to that patient, whichever is the longer period.

(2) A medical practitioner must keep a patient's medical records for a time period longer than that set out in section 7(1) in the following circumstances:

(a) if the medical record contains personal health information that is the subject of a request for access or request for correction under *PHIA*, in which case the medical practitioner must retain the medical record for as long as necessary to allow the individual to exhaust any recourse under *PHIA*; or

(b) if the medical practitioner has received written notice, prior to destruction of the patient's medical record, that the record may be evidence in or relevant to any investigation, inquiry, action or other proceeding.

8. Continuing Responsibility

(1) A medical practitioner continues to be responsible to keep, or cause to be kept, medical records in accordance with this By-Law even if:

(a) the medical practitioner has retired;

(b) the medical practitioner has left the Province;

(c) the medical practitioner has discontinued or changed his or her practice; or

(d) the doctor-patient relationship is terminated.

(2) Medical Records must be retained in such a manner that they are available to be disclosed, in accordance with the *PHIA*, to:

(a) the patient; and

(b) another person authorized by the patient or by law to disclosure.

(3) A medical practitioner must retain Medical Records, in such a manner as to ensure that the Medical Records are secure from unauthorized access, in one of the following places:

(a) in the medical office (or clinic) in which the physician practises; or

(b) in bonded commercial storage, provided an appropriate information manager agreement is in place.

(4) Excepting in a circumstance described in section 7(2), a medical practitioner may terminate the personal responsibility as custodian of a patient's medical records by transferring complete custody and control of the records to the patient or to the patient's authorized representative, to another medical practitioner, or to a RHA, provided:

(a) in the case of an intended transfer to the patient or to the patient's authorized representative, the patient or patient's authorized representative must confirm in writing the transfer is voluntarily accepted; or

(b) in the case of an intended transfer to another medical practitioner or to a RHA, that:

(i) the requirements of *PHIA* are met, in particular, s. 39(1)(j), 39(2), and 39(3);

(ii) the other medical practitioner or RHA has confirmed in writing that the transfer is accepted as the new custodian of the medical record; and

(iii) notification of the transfer is given to the College.

(5) A medical practitioner planning to cease practice in the Province must give prior written notification to the College of where patients' Medical Records will be retained, or of the authorized person to whom Medical Records have been transferred.

9. Destruction of Medical Records

(1) Following the applicable period of retention, Medical Records which are not required to be retained must be destroyed in such a way that reconstruction of the record is not reasonably foreseeable in the circumstances.

Document History

Approved by Council	September 24, 2011
Reviewed & Updated	December 7, 2019 September 9, 2017
Expected Review Date	December 7, 2024
Publication Date	January 6, 2020