Frequently Asked Questions

Medical Records Documentation & Management

This companion document is intended to provide physicians with general advice to support their understanding of the expectations set out in a College Standard of Practice.

This document may be edited or updated for clarity at any time. Please refer back to the document regularly to ensure you are aware of the most recent advice.

Do I have to create a medical record for every patient encounter?

If you have assessed, treated, or provided formal consultative services to a patient, you must create or contribute to the patient's medical record.

How soon after providing medical services should I create a medical record?

You must create a record as close in time as practicable. Your memory about the details of the encounter may fade with time and/or be blurred by subsequent events. Documenting as soon as practicable helps to ensure the accuracy and comprehensiveness of the record. It also allows for timely access to the record by other health professionals involved in the patient's care.

What should I document?

You must document a comprehensive record of each professional encounter. The College's Standard of Practice on Medical Records Documentation & Management sets out the specific requirements. Please refer to the first page of the Standard of Practice.

I noticed an error in a record I authored. What should I do?

You must alter the medical record to ensure its accuracy. Clearly identify the alteration and the date the alteration was made. If you are removing incorrect information from a record, the original entry must be clearly labeled as incorrect, and the date the record was altered must be indicated.

If you are using a paper record, cross out the error, ensuring it can still be read, and note the date that you crossed it out. If you need to add information, clearly identify that the information is an addition to the record and note the date the addition was made.

If you are using an electronic record, make a note within the relevant field or by adding an Addendum which details the error, the correction, and the date of the correction. If you need to

add information, add it through a note within the relevant field or through an Addendum. Clearly indicate that the information is an addition to the record and note the date the addition was made.

I need to add more information to a record which I authored. What should I do?

You can add additional information to a medical record to ensure its accuracy. Clearly identify the information added as an addition to the record and note the date the addition was made.

If you are using a paper record**,** add the information, clearly identifying that the information is an addition to the record, and note the date the addition was made.

If you are using an electronic record, add the information through a note within the relevant field or through an Addendum. Clearly indicate that the information is an addition to the record and note the date the addition was made.

Who owns a patient's medical record?

The information contained within a medical record belongs to the patient. The person or organization responsible for the creation, assembly, and management of the record is the "custodian" of the information.

Can I charge a patient for a copy of their medical record?

This service would be considered an uninsured service for which you may request a fee directly from the patient. Please see the College's Practice Guideline on Uninsured Services for more information.

I am in a private practice where there are multiple contributors to the record. Where do I find more information about the College's requirement for a data-sharing agreement?

For physicians who have joined the provincial electronic medical record program, eDOCSNL has created Agreement Templates which can be used to assist in the creation of a data-sharing agreement. It is recommended that you seek professional advice prior to entering into legal agreements relating to your medical practice.

I am no longer providing care to a patient, what should I do with their medical record?

The patient's medical record must be stored in a safe and secure environment which ensures its confidentiality.

If your patient is an adult (19 years+) you must store the record for 10 years following the date of last entry into the record. If your patient is not yet an adult, you must store the record for 10

years following the date of last entry into the record or until the patient reaches the age of 21, whichever is longest.

The College's Standard of Practice on Medical Records Documentation & Management sets out some exceptions to the retention period requirements. Please refer to page five of the Standard of Practice.

If you are closing your practice, please see the next question for additional information.

I am leaving my medical practice. How do I store medical records?

Medical records must be stored in a safe and secure environment which ensures their confidentiality. This includes taking reasonable steps to protect records from theft or loss and restricting access to authorized persons. Record management protocols must be in place to regulate who can gain access to the medical record and what they can do, according to their role and responsibilities.

You may choose to transfer medical records to another custodian or a bonded record retention facility for the purposes of secure storage. If you are transferring records, please note that you must ensure that a written contract is in place with the accepting custodian or record retention facility that ensures the requirements of the College's Standard of Practice on Medical Records Documentation & Management and those outlined in the Personal Health Information Act will continue to be met.

For information on closing or taking leave from a medical practice, please see the Closing or Taking Leave from a Medical Practice page on the College's website.

I am leaving my medical practice. How long do I have to store medical records?

For adult patients (19 years+), you must store the record for 10 years following the date of last entry into the record. For patients who are not yet adults, you must store the record for 10 years following the date of last entry into the record or until the patient reaches the age of 21, whichever is longest.

The College's Standard of Practice on Medical Records Documentation & Management sets out some exceptions to the above requirements. Please refer to page five of the document.

Can I destroy medical records after the applicable retention period?

You may destroy medical records following the applicable retention period (see above). You must ensure the records are destroyed in such a way that they cannot reasonably be reconstructed.

I still have questions. Who can help me?

Contact the College by email. We will direct your inquiry to the appropriate person at our office.

Document History

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