I POLICY STATEMENT
The medical record (Clinical Information) exists in both a paper and electronic format. This policy outlines the documentation types and locations of this information, and the process used to retrieve patient’s clinical information.

II PURPOSE
1 To provide timely access and retrieval of patient care information for care providers and others with a need to know for TPO.
2 Maintain data integrity throughout the medical record regardless of the media (format) in which it is created or maintained.
3 Maintain the patient’s clinical information for the time frame as required by governing agencies.

III DEFINITIONS
Treatment, Payment, and Health Care Operations – (TPO)
Protected Health Information – (PHI)
Electronic Format – Information contained in a computer application, used to access clinical information, retained in electronically and available when there is a need to know for TPO.
Hard Copy Form – A paper document containing clinical information available as information on a patient’s physical, paper medical record.
Electronic Medical Record Development Team – (EMRDT) A team of representative from key ancillary, clinical and support disciplines planning and developing the electronic medical record.
Picture Archiving Communication System - (PACS)
Emergency Center – (E.C.)

IV GUIDELINES
The patient’s medical record consists of several documents in various forms and formats. Following are some of those:
1. Handwritten documents;
2. Dictated voice files;
3. Transcribed documents;
4. Computer generated documents (i.e. Electrocardiogram, Pulmonary function Tests, Laboratory results, Vascular Laboratory, PACS, etc.);
5. Electronic documentation of patient clinical data and/or information (i.e., electronic E.C. documentation; Electronic Fetal Monitoring System, etc.);
6. Documents from other facilities in paper form.

V SOURCE AND LOCATION OF PATIENT CLINICAL (HEALTH) INFORMATION:
1. Non-Electronic (Paper) Information:
a. Various clinical and ancillary areas including ancillary, nursing and other care providers receive and/or generate clinical information in paper format.
b. Copies of information from another source are available in hard copy paper format until they are scanned to an electronic image.
c. This information is maintained in paper format on the patient’s Original paper medical record and/or in the various ancillary units until it is scanned to an electronic format, or until the maximum retention time has been met.

2. Electronic Information:
   a. Various clinical and ancillary areas and/or computer applications within Carondelet Health Network generate clinical information.
   b. This information is stored in a designated repository within the Carondelet Information System.
   c. This information is accessed with an authenticated user sign-on to the application or repository where clinical information is maintained for a period of time required per policy.

VI. AVAILABILITY OF PATIENT CLINICAL INFORMATION:
1. Non-Electronic (Paper) Information:
   a. Information that is not electronically created by Carondelet Health Network is available in a hard copy, paper format and located as described above.
   b. The information is available to the user by having access to the patient’s paper, hard copy medical record or the files in the various units as described above.

2. Electronic Information:
   a. Information created or maintained by Carondelet Health Network in electronic format is available on the Carondelet Information System.
   b. The information is available to the user by accessing the computer application or repository where clinical information is maintained.

VI. SPECIAL CONSIDERATIONS
Patient paper, hard copy medical records are maintained at the hospital sites as well as multiple off-site clinics and drawing stations. These areas include but are not limited to: Outreach laboratory stations; Green Valley Clinic; St. Mary’s Imaging Clinic, Carondelet Imaging Clinic; Hospice; etc.

VII. REFERENCES
American Health Information Management Association (AHIMA)

VIII. APPROVAL

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