Retention of Health Information (1999 update)

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Health information management professionals traditionally perform data and information warehousing functions (e.g., purging) utilizing all media including paper, images, optical disk, computer disk, microfilm, and CD-ROM. These warehouses or resources from which to retrieve, store, and maintain data and information include, but are not limited to, application-specific databases, diagnostic biomedical devices, master patient indexes, and patient medical records and health information.

One data integrity characteristic of warehousing is relevancy of data or information. To ensure the availability of relevant data and information, appropriate retention schedules must be established. To support this requirement, the following information has been compiled. It includes AHIMA's retention recommendations (see Table 1), accreditation agency retention standards (see Table 2), federal health record retention requirements (see Table 3--PDF file), and state laws or regulations pertaining to retention of health information (see Table 4--PDF file).

Table 1 -- AHIMA's Recommended Retention Standards

Health Information	Recommended Retention Period
Diagnostic images (such as x-ray film)	5 years
Disease index	10 years
Fetal heart monitor records	10 years after the infant reaches the age of majority
Master patient/person index	Permanently
Operative index	10 years
Patient health/medical records (adults)	10 years after the most recent encounter
Patient health/medical records (minors)	Age of majority plus statute of limitations
Physician index	10 years
Register of births	Permanently
Register of deaths	Permanently
Register of surgicial procedures	Permanently

Recommendations

- Each healthcare provider should ensure that patient health information is available to meet the needs of continued patient care, legal requirements, research, education, and other legitimate uses
- Each healthcare provider should develop a retention schedule for patient health information that meets the needs of its patients, physicians, researchers, and other legitimate users, and complies with legal, regulatory, and accreditation requirements
- The retention schedule should include guidelines that specify what information should be kept, the time period for which it should be kept, and the storage medium (paper, microfilm, optical disk, magnetic tape, or other)
- Compliance documentation

- Compliance programs should establish written policies to address the retention of all types of documentation. This documentation includes clinical and medical records, health records, claims documentation, and compliance documentation. Compliance documentation includes all records necessary to protect the integrity of the compliance process and confirm the effectiveness of the program, including employee training documentation, reports from hot lines, results of internal investigations, results of auditing and monitoring, modifications to the compliance program, and self-disclosures

- The documentation should be retained according to applicable federal and state law and regulations and must be maintained for a sufficient length of time to ensure their availability to prove compliance with laws and regulations

- The organization's legal counsel should be consulted regarding the retention of compliance documentation

- The majority of states have specific retention requirements that should be used to establish a facility's retention policy. In the absence of specific state requirements for record retention, providers should keep health information for at least the period specified by the state's statutes of limitations or for a sufficient length of time to prove compliance with laws and regulations. If the patient was a minor, the provider should retain health information until the patient reaches the age of majority (as defined by state law) plus the period of the statute of limitations, unless otherwise provided by state law. A longer retention period is prudent, since the statute may not begin until the potential plaintiff learns of the causal relationship between an injury and the care received. In addition, under the False Claims Act (31 USC 3729), claims may be brought for up to seven years after the incident; however, on occasion, the time has been extended to 10 years

- Unless longer periods of time are required by state or federal law, the American Health Information Management Association recommends that specific patient health information be retained for established minimum time periods. (See Table 1.)

Table 2: Accreditation Agency Retention Standards

Accreditation Agency	Retention Standard	Reference
Accreditation Association for Ambulatory Health Care (AAAHC)	Requires organizations to have policies that address retention of active clinical records, the retirement of inactive clinical records, and the retention of diagnostic images.	*1999 Accreditation Handbook for Ambulatory Care*
American Accreditation Healthcare Commission/URAC	Member Protection Standard #7 states "the network shall have storage and security of confidential health information, access to hard copy and computerized confidential health information; records retention; and release of confidential health information."	*Health Network Accreditation Manual*
CARF...the Rehabilitation Accreditation Commission	Requires organizations to have policies that address record retention. Retention periods are not specified for behavioral health. Retention periods are not specified for employment and community services. Requires organizations to have policies that address retention of records and electronic records.	*Adult Day Services Standards Manual* *1999 Medical Rehabilitation Standards Manual*
Community Health Accreditation Program (CHAP)	Retention periods are not specified.	

Joint Commission on Accreditation of Healthcare Organizations	IM.6.1-The retention time of medical record information is determined by the organization based on law and regulation, and on its use for patient care, legal, research, and education activities.	*1998-99 Comprehensive Accreditation Manual for Ambulatory Care*
	IM.6.1-The organization determines how long clinical record information is kept consistent with law, regulation, and the requirements of care, delivery, legal, research, or educational activities.	*1999-2000 Comprehensive Accreditation Manual for Behavioral Care*
	IM.5.1-The network determines how long health records and other data and information are retained.	*1998-2000 Comprehensive Accreditation Manual for Health Care Networks*
	IM.9-The organization develops and implements a policy for retaining data and information for the home healthcare record.	*1999-2000 Comprehensive Accreditation Manual For Home Care*
	IM.6.1-The hospital determines how long medical record information is retained, based on law and regulation and the information use for patient care, legal, research, and education purpose.	*Comprehensive Accreditation Manual For Hospitals: The Official Handbook* (Update 4, November 1997)
	IM.7.1.3-The retention time of medical record information is determined by the organization based on law and regulation, and on its use for resident care, legal, research, and education activities.	*1998-1999 Comprehensive Accreditation Manual for Long Term Care*
National Commission on Correctional Health Care (NCCHC)	Inactive health records are retained according to legal requirements for the jurisdiction and are reactivated if a juvenile or inmate returns to the system or facility.	*Standards For Health Services in Juvenile Detention and Confinement Facilities (1995)* *Standards for Health Services in Jails (1996)* *Standards For Health Services in Prisons (1997)*
National Committee For Quality Assurance (NCQA)	Retention periods are not specified.	

Table 3 & 4 are saved as PDF files. You can download and view the files using Adobe Acrobat Reader.

Table 3

Table 4

*Note: Portable Document Format [PDF] files are in Adobe Acrobat format, and you must have the Acrobat Reader to open them. To get a free copy of the Acrobat Reader, go to the Adobe web site.

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Notes

This practice brief replaces an earlier practice brief published in the January 1997 *Journal of AHIMA*.

Laws addressing health information continue to evolve. Consult with legal counsel regarding recent legislation and/or the advisability of retaining records for longer periods of time.

Prior to disposing of records, review AHIMA's practice brief "Destruction of Patient Health Information," Originally published in 1996, Updated in April, 2000 *Journal of AHIMA*.

References

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Related AHIMA practice briefs:

- Protecting Patient Information After a Facility Closure (March 1999)
- Data Quality Management Model (June 1998)
- Destruction of Patient Health Information (January 1996)- Updated April 2000

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