LOS ANGELES GENERAL MEDICAL CENTER POLICY

Subject: HEALTH/MEDICAL RECORD: RETRIEVAL OF PATIENT'S RECORD AFTER TREATMENT	Original Issue Date: 11/13/98	Policy # 408
	Supersedes: 5/9/17	Effective Date: 7/10/23
Policy Owner(s): Health Information Management Executive Sponsor(s): Chief Operations Officer		

Departments Consulted:	Reviewed & approved by:	Approved by:
Health Information Management Health Information Committee	Attending Staff Association Executive Committee Senior Executive Officer	(Signature on File) Chief Operations Officer
		(Signature on File) Chief Executive Officer

PURPOSE

To support timely availability of patient information through prompt uploading of patient's any paper medical record documents and loose correspondence relevant to the electronic medical record system by ensuring routine retrieval from emergency departments, clinics, and inpatient areas after the patient has been treated and/or discharged.

POLICY

Los Angeles General Medical Center patients' health/medical records must be available for patient care, patient safety, quality review, revenue reimbursement, and administrative and legal matters upon request by authorized users. The Health Information Management Department (HIM) is responsible for retrieving documents from designated areas within patient care units, prepping, scanning, validating, and ensuring that the patient's record and loose correspondence are uploaded to the patient's electronic health record, within 48-72 hours after the patient has been treated and/or is discharged.

For closer to real time availability, patient care unit staff may send medical record documents to be uploaded to the electronic medical record system directly to the HIM document imaging email box as scanned attachments using their multifunctional devices or desktop scanners. Unit staff may also fax documents directly to the document imaging fax line. The HIM staff will upload the scanned documents to the electronic medical record.

PROCEDURE

- After the patient is discharged from an inpatient area, the discharge record, documentation that is on paper, must be available for daily pick-up by HIM staff the day of discharge, placed in designated location within each unit. Unit staff shall not retain paper records of discharged patients without prior approval from the HIM department.

- Emergency Department Records, paper documentation, are picked up on a daily basis by the HIM staff after the patient is discharged. Emergency Room staff shall place documents in established location within unit for secure retrieval. Emergency room staff shall not retain paper records of discharged patients without prior approval from HIM department.

- If a patient is transferred from the emergency room to an inpatient unit, the paper documents shall follow the patient to comprise the inpatient unit paper record until the patient is discharged from the inpatient unit.

- Clinic Records, paper documentation, are picked up on a daily basis by the HIM staff after the clinic session is finished. Clinic staff shall promptly place documents in established location within unit to ensure secure retrieval. Clinic staff shall not retain paper records of discharged patients without prior approval from the HIM department.

- Ancillary records, paper documentation, (laboratory, radiology, EKG, etc.) are picked up daily by the HIM staff (when applicable).

- All patient records and correspondence must be available for viewing with in the electronic health record within 48-72 hours of the patient's discharge.

- All units must make records available for pick up immediately following the patient's discharge and documents shall reflect the appropriate patient label for identification purposes. Unit staff must print and affix the correct patient label for each document. The correct patient label shall reflect the patient's name, Medical Record Number, and FIN corresponding to the date of service.

RESPONSIBILITY

Health Information Management
Administration
Attending Staff
Residents
Allied Health Professionals
Nursing Staff
Unit Support staff

PROCEDURE DOCUMENTATION

Health Information Management Policy and Procedure Manual

REFERENCES

TJC RC.01.03.01
CMS 482.24 (b)
California Code of Regulations, Title 22, Sections 70751 and 71551
California Code of Regulations, Title 8, Sections 70723 and 3204
DHS Policy #881, Retention of Medical Records and X-Ray Films

REVISION DATES

April 9, 2002; April 19, 2005; September 29, 2008; November 12, 2013; May 9, 2017; July 7, 2023