

SP 17.0 Health Record Retention

Effective: March 1, 2006

Amended: July 1, 2010

Purpose and Objective

As part of a regulated profession, members have an obligation to make health records available to patients and other appropriate parties. Members also require the ability to manage and dispose of health records.

Definition(s)

Under the *Health Information Act*: “record” means a record of health information in any form, and includes notes, images, audiovisual recordings, x-rays, books, documents, maps, drawings, photographs, letters, vouchers and papers and any other information that is written, photographed, recorded or stored in any manner, but does not include software or any mechanism that produces records.

Patient records must be maintained for a minimum of **ten (10) years** from the last entry or, if the patient was less than 18 years old at the time of the last entry, ten (10) years from the day the patient became 18 years old (until age 28 years old).

A record should not be disposed of in the regular garbage, but destroyed by secure and confidential shredding. There are service companies available who will shred or destroy records.

Any records stored off-site must be in a safe and secure facility where access is only available to authorized personnel. Records stored at an off-site facility must be inventoried with the name of the patient, date of the last visit and date it was sent to storage.

Records may be kept by electronic or optical means or a combination. The member shall take reasonable steps to ensure that the electronic or optical means are so designed and operated that the notation, report, record, order, entry, signature or transcription is secure from loss, tampering, interference or unauthorized use or access. Appropriate backup and security measures are required.

Enforceability

Any member identified to the Complaints Director as non-compliant in the Standard of Practice related to record retention is subject to the investigations and complaints process under Part 4 of the *Health Professions Act*. Identification of non-compliance may occur as a result of the Practice Visit process, patient complaint or any other means by which this information may be brought to the attention of the Complaints Director.

