

**HIPPA**  
**MEDICAL RECORDS**  
**LAWS**  
**(WA, OR, CA)**

## WASHINGTON STATE

OFM Fiscal Note Website

WACs > Title 246 > Chapter 246-08 > Section 246-08-400

246-08-395 << 246-08-400 >> 246-08-420

WAC 246-08-400 Agency filings affecting this section

### How much can a medical provider charge for searching and duplicating medical records?

RCW 70.02.010(15) allows medical providers to charge fees for searching and duplicating medical records. The fees a provider may charge cannot exceed the fees listed below:

(1) Copying charge per page:

(a) No more than one dollar and two cents per page for the first thirty pages;

(b) No more than seventy-eight cents per page for all other pages.

(2) Additional charges:

(a) The provider can charge a twenty-three dollar clerical fee for searching and handling records;

(b) If the provider personally edits confidential information from the record, as required by statute, the provider can charge the usual fee for a basic office visit.

(3) This section is effective July 1, 2009, through June 30, 2011.

(4) HIPAA covered entities: See HIPAA regulation Section 164.524 (c)(4) to determine applicability of this rule.

[Statutory Authority: RCW 70.02.010(15) and 43.70.040. 09-13-102, § 246-08-400, filed 6/17/09, effective 7/1/09; 07-12-029, § 246-08-400, filed 5/30/07, effective 7/1/07. Statutory Authority: RCW 70.02.010(14) and 43.70.040. 06-11-166, § 246-08-400, filed 5/24/06, effective 6/24/06. Statutory Authority: RCW 70.02.010(12) and 43.70.040. 05-12-013, § 246-08-400, filed 5/20/05, effective 7/1/05. Statutory Authority: RCW 70.02.010(12), 43-70-040 [43.70.040] and 70.02.900. 03-14-036, § 246-08-400, filed 6/23/03, effective 7/24/03. Statutory Authority: RCW 70.02.010 and 43.70.040. 01-16-009, § 246-08-400, filed 7/19/01, effective 8/19/01; 99-13-083, § 246-08-400, filed 6/14/99, effective 7/15/99. Statutory Authority: RCW 70.02.010(12) and 43.70.040 . 97-12-087, § 246-08-400, filed 6/4/97, effective 7/5/97. Statutory Authority: RCW 43.70.040 and 70.02.101(12). 95-20-080, § 246-08-400, filed 10/4/95, effective 11/4/95.]

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<http://apps.leg.wa.gov/WAC/default.aspx?cite=246-08-400>

## OREGON STATE

### Patient's Access to Physician Medical Records

847-012-0000 (1) Physicians shall make pertinent information in the medical record available to the patient. Physicians shall comply with the patient's written request within a reasonable time, not to exceed 30 days.

(2) At the discretion of the physician, disclosure of any portion of the medical record to the patient may be made in the form of an accurate representative summary of the factual information contained within the written account(s). Upon request, copies of pertinent x-rays will be provided in lieu of interpretive summaries.

(3) For the purposes of these rules, "medical record" does not include the personal office notes of the physician or personal communications between a referring and consulting physician relating to the patient. However, at the discretion of the physician, such notes and communications, or summaries thereof, may be included in the disclosure.

(4) If the physician disclosing the medical record to a patient believes, in good faith, that the release of any portion of the medical record would be injurious to the health or well-being of the patient, such disclosure of any portion of the medical record may be denied. The rationale for such a decision should be documented.

(5) The physician may establish reasonable charges to the patient for the costs incurred in providing the patient with copies of any portion of his/her medical record. Such charges may include cost of reviewing, summarizing and/or reproducing the original medical record and x-rays. However, a patient shall not be denied summaries or copies of his/her medical record because of inability to pay.

(6) Violation of this rule may be cause for disciplinary action under ORS 677.190.

### COMMON QUESTIONS & ANSWERS ABOUT MEDICAL RECORDS

I am about to retire - what do I do with my patient records? What kind of notice must I give my patients? What kind of notice do I give the Board? May I keep an active license?

It is suggested that Board licensees who are retiring from the active practice take the following actions:

Notify patients by letter of the effective date of your retirement from active practice.

Notify patients who do not require the immediate services of a health care provider where their records will be stored and who should be contacted in the event the records are needed. This information should also be reported to the Oregon Medical Board.

Advise patients that they may either seek the services of another health care provider or that you will assist them in locating another health care provider through referrals from your office.

Advise patients that their records will be forwarded to another provider of their choice upon receipt of a properly signed release form.

Advise patients that their office will remain open for a reasonable length of time to facilitate the transfer of records and for the collection of outstanding accounts.  
Inform the Oregon Medical Board of the correct mailing address after retirement.

Whether or not a Board licensee can choose to maintain an active license depends on several factors. There are several options available. For questions about license status, call the Board's Registration section and your options will be explained thoroughly.

#### How long must I keep my patient records?

The Oregon Medical Association recommends that physicians keep patient records, including those of deceased patients (adults and minors) for a minimum of ten years after the patient's last contact with the physician. If space permits, it is preferable to retain records of all living patients indefinitely. This recommendation applies to other licensees of the Board as well.

#### Does my doctor or other Board licensee have to let me see my records if I ask?

Yes, with very few exceptions you have the right to access to your records. Keep in mind, however, that the actual records belong to the doctor. Oregon Medical Board Administrative Rule 847-12-000 states that upon written request, a copy or summary of the medical record must be made available to the patient. Physicians should comply with these requests within a reasonable time, not to exceed 30 days.

A reasonable charge for costs incurred in providing patients with a copy or summary of the record can be made; however, the patient cannot be denied the material because of inability to pay or because of an outstanding bill for previous services.

#### My doctor or other Board licensee retired/moved--how do I find my records?

Contrary to what many people believe, there is no central storage place for medical records. The Board asks each retiring or departing licensee for an address where his or her medical records will be stored (often it is with a former partner or clinic). Once they provide the Board with that information, that address is put on the Board's computer, and may be obtained by calling (971) 673-2700 preferably between the hours of 1:00 and 4:00 p.m.

#### SUMMER/FALL 2002 OMB NEWSLETTER ARTICLE

Your Records, Your Friends By Philip F. Parshley, M.D. OMB Medical Director

With the startling revelation by the Institute of Medicine in *To Err Is Human* that 44,000 to 98,000 deaths from medical errors occur in this country every year, emphasis has been placed on developing systems to prevent these errors rather than assigning blame to individuals. Every Oregon Medical Board (OMB) licensee can contribute to this process by reassessing the systems that lead to the development of medical records in his or her office. In addition, the medical record can be a healthcare provider's most valuable friend, when that provider is challenged by a malpractice suit, a hospital medical staff organization, the OMB or other regulatory organizations.

The standard of care requires a very complete documentation of every aspect of the medical care physicians provide their office patients. There are certain specific components that the OMB expects to find in the medical record.

First, it must be in the record and legible - or it didn't happen! Two pieces of pertinent information that frequently fail to make the medical records are progress notes you forgot to write or dictate, and telephone communications with the patients, consultants, former treating physicians, and the patient's family. Those who share call with you and your staff need readable information from your chart in order to assist you in providing quality care for your patients.

The SOAP (Subjective, Objective, Assessment, Plan) format is considered the standard of care with a separate set of entries for each major issue. The Subjective part is expected to contain a detailed history of the presenting issues, including identifying previous providers who have dealt with the present problems and what those providers did for the patient, a record of past illnesses, procedures, current medications, allergies, and a review of systems. The review of systems may be facilitated by a printed questionnaire which the patient completes. If you review the patient's responses on that form with the patient, perhaps with expansion of issues in your handwriting followed by your initials, date and time, you will demonstrate that you have reviewed the information.

The Objective part is a detailed complete physical examination that may vary based on the specialty of the examiner. This would also include laboratory and imaging results.

Your Assessment should include your reasoning for your diagnosis, as well as alternative diagnoses, if pertinent.

The Plan should have an explanation for your choice of action, especially if there are alternatives, and indicate the alternatives that were discussed with the patient. It is always a good idea to note that the patient was asked if he/she had any questions, and their answer. Note the expected date of revisit.

Physicians are currently being overwhelmed by more and more paperwork, but written protocols are very worthwhile to make certain that the professional providers and the office staff understand what is expected of them in all aspects of the practice. For example nothing is to be filed and buried somewhere in the chart without the pertinent physician's readable signature or initials. This includes everything from chart notes, to diagnostic studies, to copies of portions of the hospital records forwarded to the office, to consultant reports and virtually anything else that goes into the medical record in the office.

Your office should have protocols to see that preventive measures such as immunizations, screening procedures and counseling about tobacco, alcohol and drugs will be addressed in a timely manner. Protocols to track failed and canceled appointments, as well as failure to report for diagnostic studies or consultations, should be developed. If you are referred a patient for consultation and he or she fails to keep the appointment, notify the referring health care provider. You might consider a protocol to track follow-up procedures on previous problems.

Some other protocols that are strongly urged are policies on staff placing date, time and signature on any entries they make in the chart, handling telephone calls to the practitioners, phoning prescriptions, emergencies both in the office and those phoned to the office, threatening behavior toward staff or practitioner, and triage guidelines for staff giving response time according to

category. These written protocols are important even in small medical offices with only one employee. Since there is inevitable turnover of staff, these written protocols will make orientation of new employees and additional practitioners much easier and more reliable.

The presence of a problem list and particularly a medication list, or even better, a medication flow sheet, has become the standard of care for any primary care provider or any provider who has patients receiving multiple medications or even a single medication on a regular basis. The medication flow sheet is considered critical if chronic pain is an issue as is a Material Risk Notice; the latter being required by law (Oregon Revised Statutes [ORS] 677.485 and Oregon Administrative Rules [OAR] 847-010-0030).

Electronic records will and are making records better, but there are drawbacks. Using voice-recognition computer software for medical records is risky unless you are willing to carefully edit and correct the final result. There should be some mechanism to prevent changes in the electronic record once the author has signed off on the content. If you dictate or use an electronic record, be sure you edit what comes back for errors and date the final result.

Hospital medical records usually document a much faster pace of events than those in the office environment. Under these circumstances, it is absolutely critical that the progress notes, orders and any acknowledgment of laboratory and imaging studies be dated and timed. The more critical is the patient, the more important the time record. Documentation of the note by time as well as date may save your bacon many times over.

Resist the urge to write in blank forms for lab results in a "progress notes," with plans to return and fill them in later in the day. This is a formula for disaster. A great deal can transpire between the writing of the progress note and the time when the laboratory reports are received by that physician. This could easily make the accompanying plan of action in that progress note inappropriate, negligent, and/or below the standard of care.

Do not in any way change the medical record. This is the kiss of death! If you are caught, you might as well ask how many pounds of flesh the plaintiff, the OMB, or the medical staff committee would like you to sacrifice. If you find errors later, make a dated and timed note of the changes without erasing the original. Better still, make a late entry in the current part of the record indicating the error and what you feel the correct entry should have been.

Promptly correcting errors transcription of your dictation acceptable. Even then, to be safe should initial and date the corrected copy. In this day and age, more patients have access to their records and may become incensed by they read. It is not uncommon receive a "demand" that the record be changed to reflect what the patient believes to be correct. you find that an error has been made you do not have to change your record. If an error has been made, you may change it as outlined above. If no error has been made you may acknowledge the concern of the patient in the record, but original entry may remain unchanged.

Specific procedures in the medical record keeping have changed with the passage of time, but not the need for such records, nor the importance of their accuracy and legibility. The difference

between top-notch records and less than- desirable records can mean difference between a career saved and a career lost - not to mention limb, or a life!

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Page updated: January 06, 2009

[http://www.oregon.gov/OMB/TOI Medical Records.shtml](http://www.oregon.gov/OMB/TOI_Medical_Records.shtml)

## CALIFORNIA STATE

### Is there a law that says I can see or copy my medical records?

You can make a written request to either review or obtain a copy of your medical records pursuant to Health and Safety Code sections 123100 through 123149.5. The laws which authorize access to your records are available on the Internet and you might wish to review them for information about time lines a physician has to meet and the fees he or she may charge to provide the records. You can view these laws at the following Web site:  
<http://leginfo.ca.gov/calaw.html>

### How can I get a copy of my medical records?

Click here for this information.

### Can a doctor charge me for copies of my medical records or x-rays?

Yes, pursuant to Health & Safety Code section 123110, a doctor can charge 25 cents per page plus a reasonable clerical fee. For diagnostic films, such as an x-ray, MRI, CT and PET scans, you can be charged the actual cost of copying the films. This only applies if you have made a written request for a copy of your medical records to be provided to you.

### What if my doctor won't give me a copy of my records?

As long as you requested your medical records in writing, to be sent directly to you (and not to anyone else, like your new doctor), the physician is required to send you a copy within specified time limits. If you are having difficulty getting your records, you can file a complaint with the Medical Board. If we can substantiate the complaint, as the physician's licensing agency, the Board will take the appropriate action against the physician's license for failing to provide the records within the legal time limit.

### Does a doctor have to give me a copy of reports or records he got from me or from other doctors?

The guidelines from the California Medical Association indicate that physicians must provide anything that they are maintaining in the medical record for you (as the patient), which includes records from other providers. So, for example, you should be able to receive a copy of a specialist's consultation report from your primary care physician, since he/she has incorporated it as a part of your medical chart. You don't need "special permission" from the specialist nor do you need to obtain this report only from the specialist.

### How long does a physician need to retain medical records?

There is no general law requiring a physician to maintain medical records for a specific period of time. However, there are situations or government health plans that require a provider/physician to maintain their records for a certain period of time. Several laws specify a three-year retention period: Welfare and Institutions Code section 14124.1 (which relates to Medi-Cal patients), Health and Safety Code section 1797.98(e) (for services reimbursed by Emergency Medical Services Fund), and Health and Safety Code section 11191 (when a physician prescribes, dispenses or administers a Schedule II controlled substance). The Knox-Keene Act requires that HMO medical records be maintained a minimum of two years to ensure that compliance with the act can be validated by the Department of Corporations. In Workers' Compensation Cases,

qualified medical evaluators must maintain medical-legal reports for five years. Health and Safety Code section 123145 indicates that providers who are licensed under section 1205 as a medical clinic shall preserve the records for seven years. However, there is no general statute which relates to all other types of medical records.

How long does a physician have to send me the copy of medical records I requested?

If you made your request in writing for the records to be sent directly to you, the physician must provide copies to you within 15 days. The physician can charge a reasonable fee for the cost of making the copies. If the physician's office advises you that a fee will be charged for the records, the medical records do not need to be provided until the fee is paid. If the physician does not comply within the time frame you can file a written complaint with the Medical Board.

What is the penalty if a physician does not respond to my request for a copy of my medical records?

The Medical Board may take any action against the physician which is appropriate for failing to provide the records within the legal time limit. This can range from making sure that the doctor actually does provide you the copy you requested, to a citation and fine or disciplinary action against the physician's medical license.

How can I correct an error in my records?

The patient can write an "Addendum" to be placed in his or her medical file. The original information will not be removed, but the new information, signed and dated by the patient, will be placed in the file. Health and Safety Code section 123111 states that an adult patient "shall have the right to provide to the health care provider a written addendum with respect to any item or statement in his or her records that the patient believes to be incomplete or incorrect. The addendum shall be limited to 250 words per alleged incomplete or incorrect item in the patient's record and shall clearly indicate in writing that the patient wishes the addendum to be made a part of his or her record. The health care provider shall attach the addendum to the patient's records and shall include that addendum whenever the health care provider makes a disclosure of the allegedly incomplete or incorrect portion of the patient's records to any third party."

Who owns medical records? Do the records belong to me?

No, they do not belong to the patient. Medical records are the property of the medical provider (or facility) that prepares them. This includes films and tracings from diagnostic imaging procedures such as x-ray, CT, PET, MRI, ultrasound, etc. The patient has a right to view the originals, and to obtain copies under Health and Safety Code sections 123100 - 123149.5.

Do x-ray films belong to me?

No, just like any other medical records, diagnostic films and tracings belong to the physician's office or facility where they were made. The fees you paid for the x-rays or other diagnostic imaging were for the expertise, equipment, and supplies to take the images and diagnose them. You have a right to obtain copies of your films if you make a written request that they be provided directly to you and not to anyone else. The physician can charge you the actual cost of making the copies of the films.

How do I get my medical records if my doctor moves away/retires/dies?

There is no central "repository" for medical records. If a physician moves, retires, or passes away, sometimes another physician will either "buy out" or take over his/her practice. The "active" patients are usually notified by mail (as a courtesy), and told where to obtain their records. If you cannot locate the physician, you may want to contact your local county medical society (which is part of the California Medical Association) to see if they have any information about the physician's practice (e.g., did someone else take over the practice?). For assistance you may go to their Web site: <http://www.cmanet.org/>.

Additionally, you can contact the Medical Board's licensing division at 916-263-2382 (press option 1), or on the Board's Web site's profiles at Check Your Doctor, to obtain the physician's address of record for his or her license. Write to the doctor at that address, even if the doctor has died, and request that a copy of your records be sent to you. If the address has a forwarding order on it, your letter will be forwarded to the doctor's new address. The doctor has 15 days from the time your letter is received to send you a copy of your records, if the records are still available.

If the doctor died and did not transfer the practice to someone else, you might have to check your local Probate Court to see whether the doctor has an executor for his or her estate. You could then contact the executor to see if you can get a copy of the records. Depending on how much time has passed, whoever is appointed as the custodian of records can have the records destroyed.

#### How do I get my medical records transferred to my new doctor?

Transferring records between providers is considered a "professional courtesy" and is not covered by law. Most physicians do not charge a fee for transferring records, but the law does not govern this practice so there is nothing to preclude them from charging a copying fee. There is also no time limit on transferring records. You might wish to contact your local medical society to see if it has developed any guidelines on medical record transfer issues.

If you want to insure that your new doctor receives a copy of your medical records from your previous doctor, you can write your previous doctor requesting that a copy of your medical records be sent directly to you. When you receive your records, you can provide a copy of those records to any provider you choose. If you select this method, the doctor must provide the records within 15 days of receipt of your request.

#### Can a doctor charge to send a copy of my records to another doctor?

Most physicians do not charge a fee for transferring records, but the law does not govern this practice so there is nothing to preclude them from charging a copying or transfer fee. There is also no time limit for record transfers, or no penalty for failure to transfer the records, since this is a professional courtesy. You might wish to contact your local medical society to see if it has developed any guidelines on record transfer issues.

#### How do I obtain copies of my lab results?

Health and Safety Code section 123148 requires the health care professional who requested the test be performed to provide a copy of the results to the patient, if requested either orally or in writing. When the patient requests his/her lab results, the health care provider should provide the results to the patient within a "reasonable" time period after the results are received by the

provider. Depending on the results of the tests, some physicians may want the patient to schedule an appointment to review and discuss the results and any follow-up testing or treatment that might be required. The test results cannot be released by the lab performing the test and must be released by the provider requesting the test(s).

[http://www.medbd.ca.gov/consumer/complaint\\_info\\_questions\\_records.html](http://www.medbd.ca.gov/consumer/complaint_info_questions_records.html)