11. Medication record reflecting the drug given, date, time, dosage, route of administration, and signature and status of the person administering the drug. Initials may be used after the person's full signature appears at least once on each page of the medication record. Allergies, including allergy to latex, shall be listed on the medication record;

12. A record of self-administered medications, if the patient self-administers, in accordance with the policies and procedures of the hospital's pharmacy and therapeutic committee, or its equivalent;

13. Reports of laboratory, radiological, and diagnostic services;

14. A discharge summary, which includes the reason for admission, findings, treatment, condition on discharge, medication on discharge, final diagnosis, and, in the case of death, the events leading to death and the cause of death. For cases where the patient is discharged alive within 48 hours of admission and is not transferred to another facility, for normal newborns, and for uncomplicated deliveries, a discharge note may be substituted for the discharge summary. The discharge note includes at least the patient's condition on discharge, medications on discharge, and discharge instructions; and

15. A report of autopsy, if performed by the hospital, with provisional anatomic diagnoses recorded in the medical record within three days. The complete protocol is included in the medical record within the time specified in hospital policies and procedures.

(e) Any adverse incident, including patient injuries, shall be documented in the patient's medical record.

(f) If the patient is transferred to another health care facility (including a home health agency) on a nonemergency basis, the hospital shall maintain a transfer record reflecting the patient's immediate needs and send a copy of this record to the receiving facility at the time of transfer. The transfer record shall contain at least the following information:

1. Diagnoses, including history of any serious physical conditions unrelated to the proposed treatment which might require special attention to keep the patient safe;

2. Physician orders in effect at the time of discharge and the last time each medication was administered;

3. The patient's nursing needs;

4. Hazardous behavioral problems;

5. Drug and other allergies; and

6. A copy of the patient's advance directive, where available.

(g) Medical records shall be completed within 30 days of discharge.

(h) Medical records shall be retained and preserved in accordance with N.J.S.A. 26:8–5 et seq.

(i) Original medical records of components of medical records shall not leave hospital premises unless they are under court order or subpoena or in order to safeguard the record in case of a physical plant emergency or natural disaster.

(j) Any consent form for medical treatment that the patient signs shall be printed in an understandable format and the text written in clear, legible, nontechnical language. In the case where someone other than the patient signs the forms, the reason for the patient's not signing it shall be indicated on the face of the form, along with the relationship of the signer to the patient.

(k) The patient's death shall be documented in the patient's medical record upon death.

(*l*) Recording errors in the medical record shall be corrected by drawing a single line through the incorrect entry. The date of correction and legible signature or initials of the person correcting the error shall be included.

(m) All medical records, including outpatient medical records, shall be organized in a uniform format within each clinical service.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Electronic and fax order requirements specified at (b)1–2; outpatient records included at (c).
Amended by R.1992 d.132, effective March 16, 1992.
See: 23 N.J.R. 3256(a), 24 N.J.R. 942(a).
Text on documentation of advance directives added at (d) and (e).
Petition for Rulemaking.
See: 25 N.J.R. 3563(d).
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
In (a), substituted "at least once every three years, revised more frequently" for "annually, revised" in the introductory paragraph; in (b), added a second sentence in 2iv; in (d), rewrote 6, and inserted a reference to allergy to latex in 11; inserted a new (e); and recodified former (e) through (*l*) as (f) through (m).

8:43G–15.3 Medical record patient services

(a) Health care practitioners who provide clinical services to the patient shall enter clinical/progress notes in the patient's medical record, when the services are rendered.

(b) Notes that provide a full and accurate description of the care provided to the patient shall be made in the medical record at the time clinical services are provided. Notes that provide a description and an evaluation of the patient's response to treatment shall be made in the medical record.

(c) The medical record shall either accompany the patient when he or she leaves the patient care unit for clinical services in other departments of the hospital or shall be

retrievable by authorized personnel on a computerized system with a restricted access and entry system.

(d) If a patient or the patient's legally authorized representative requests, in writing, a copy of his or her medical record, a legible, written copy of the record shall be furnished at a fee based on actual costs. One copy of the medical record from an individual admission shall be provided to the patient or the patient's legally authorized representative within 30 days of the request, in accordance with the following:

1. The fee for copying records shall not exceed $1.00 per page or $100.00 per record for the first 100 pages. For records which contain more than 100 pages, a copying fee of no more than $0.25 per page may be charged for pages in excess of the first 100 pages, up to a maximum of $200.00 for the entire record;

2. In addition to per page costs, the following charges are permitted:

i. A search fee of no more than $10.00 per patient per request. (Although the patient may have had more than one admission, and thus more than one record is provided, only one search fee shall be permitted for that request. The search fee is permitted even though no medical record is found as a result of the search.); and

ii. A postage charge of actual costs for mailing. No charges shall be assessed other than those permitted in (d)1 and 2 above;

3. The hospital shall establish a policy assuring access to copies of medical records for patients who do not have the ability to pay; and

4. The hospital shall establish a fee policy providing an incentive for use of abstracts or summaries of medical records. The patient or his or her representative, however, has a right to receive a full or certified copy of the medical record.

5. For purposes of this subsection, "legally authorized representative" means the following:

i. Spouse;

ii. Immediate next of kin;

iii. Legal guardian;

iv. Patient's attorney;

v. Patient's third party insurer; and

vi. Worker's compensation carriers, where access is permitted by contract or law, but limited only to that portion of the medical record which is relevant to the specific work-related incident at issue in the worker's compensation claim.

(e) The fee for copying medical records shall be based on actual costs, which in no case shall exceed $1.00 per page and $10.00 per search, in the case of the following:

1. Where the patient has authorized release of his or her medical record to a person or entity other than those identified in (d) above, including but not limited to physicians or other practitioners who provided care to the patient, or attorneys representing such providers; or

2. The patient subsequently requests additional copies of a medical record which has been furnished in accordance with (d) above.

(f) Access to the medical record shall be limited only to the extent necessary to protect the patient. A verbal explanation for any denial of access shall be given to the patient or legal guardian by the physician and there shall be documentation of this in the medical record. In the event that direct access to a copy by the patient is medically contraindicated (as documented by a physician in the patient's medical record), the medical record shall be made available to a legally authorized representative of the patient or the patient's physician.

(g) The patient shall have the right to attach a brief comment or statement to his or her medical record after completion of the medical record.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Record copying fees and standards specified at (d) through (g).
Petition for Rulemaking.
See: 29 N.J.R. 5335(a), 30 N.J.R. 3338(a).
Amended by R.1999 d.436, effective December 20, 1999.
See: 31 N.J.R. 367(a), 31 N.J.R. 614(a), 31 N.J.R. 4293(c).
Rewrote the section.
Petition for Rulemaking.
See: 35 N.J.R. 1962(a), 2751(b), 4333(a).
Administrative change.
See: 36 N.J.R. 1192(a).

Case Notes

Department of Health had jurisdictional authority to sanction violators of rule governing fees that health care providers could charge for copying medical records, but Department did not have exclusive jurisdiction to adjudicate such issues, and overcharged patients had a private cause of action against the violators. Boldt v. Correspondence Management, Inc., 320 N.J.Super. 74, 726 A.2d 975 (N.J.Super.A.D. 1999).

8:43G–15.4 Medical records staff qualifications

There shall be a full-time medical record director who is an accredited record technician or a registered record administrator under a certification program approved by the American Medical Record Association.

8:43G–15.5 Staff education

Requirements for the medical record staff education and training program shall be as provided in N.J.A.C. 8:43G–5.9.

(3) To a patient as authorized by this rule within 30 days of request (or promptly in the event of emergency); and

viii. A licensee wishing to continue a system of computerized patient records, which system does not meet the requirements of (b)3i through vii above, shall promptly initiate arrangements for modification of the system which must be completed by October 19, 1993. In the interim, the licensee shall assure that, on the date of the first treatment of each patient treated subsequent to October 19, 1992, the computer entry for that first visit shall be accompanied by a hard copy printout of the entire computer-recorded treatment record. The printout shall be dated and initialed by the attending licensee. Thereafter, a hard copy shall be prepared for each subsequent visit, continuing to the date of the changeover of computer program, with each page initialed by the treating licensee. The initial printout and the subsequent hard copies shall be retained as a permanent part of the patient record.

(c) Licensees shall provide access to professional treatment records to a patient or an authorized representative in accordance with the following:

1. No later than 30 days from receipt of a request from a patient or an authorized representative, the licensee shall provide a copy of the professional treatment record, and/or billing records as may be requested. The record shall include all pertinent objective data including test results and x-ray results, as applicable, and subjective information.

2. Unless otherwise required by law, a licensee may elect to provide a summary of the record in lieu of providing a photocopy of the actual record, so long as that summary adequately reflects the patient's history and treatment. A licensee may charge a reasonable fee for the preparation of a summary which has been provided in lieu of the actual record, which shall not exceed the cost allowed by (c)4 below for that specific record.

3. If, in the exercise of professional judgment, a licensee has reason to believe that the patient's mental or physical condition will be adversely affected upon being made aware of the subjective information contained in the professional treatment record or a summary thereof, with an accompanying notice setting forth the reasons for the original refusal, shall nevertheless be provided upon request and directly to:

i. The patient's attorney;

ii. Another licensed health care professional;

iii. The patient's health insurance carrier through an employee thereof; or

iv. A governmental reimbursement program or an agent thereof, with responsibility to review utilization and/or quality of care.

4. Licensees may require a record request to be in writing and may charge a fee for the reproduction of records, which shall be no greater than $1.00 per page or $100.00 for the entire record, whichever is less. (If the record requested is less than 10 pages, the licensee may charge up to $10.00 to cover postage and the miscellaneous costs associated with retrieval of the record.) If the licensee is electing to provide a summary in lieu of the actual record, the charge for the summary shall not exceed the cost that would be charged for the actual record.

5. If the patient or a subsequent treating health care professional is unable to read the treatment record, either because it is illegible or prepared in a language other than English, the licensee shall provide a transcription at no cost to the patient.

6. The licensee shall not refuse to provide a professional treatment record on the grounds that the patient owes the licensee an unpaid balance if the record is needed by another health care professional for the purpose of rendering care.

(d) Licensees shall maintain the confidentiality of professional treatment records, except that:

1. The licensee shall release patient records as directed by a subpoena issued by the Board of Medical Examiners or the Office of the Attorney General, or by a demand for statement in writing under oath, pursuant to N.J.S.A. 45:1–18. Such records shall be originals, unless otherwise specified, and shall be unedited, with full patient names. To the extent that the record is illegible, the licensee, upon request, shall provide a typed transcription of the record. If the record is in a language other than English, the licensee shall also provide a translation. All x-ray films and reports maintained by the licensee, including those prepared by other health care professionals, shall also be provided.

2. The licensee shall release information as required by law or regulation, such as the reporting of communicable diseases or gunshot wounds or suspected child abuse, etc., or when the patient's treatment is the subject of peer review.

3. The licensee, in the exercise of professional judgment and in the best interests of the patient (even absent the patient's request), may release pertinent information about the patient's treatment to another licensed health care professional who is providing or has been asked to provide treatment to the patient, or whose expertise may assist the licensee in his or her rendition of professional services.

Historical and Statutory Notes

Source: L.1920, c. 99, § 25, p. 209 [1924 Suppl. § 22–19c(25)].

1965 Legislation

The 1965 amendment substituted "funeral director" for "undertaker" and inserted the references to fetal death and marriage.

Cross References

Birth defects registry, see § 26:8–40.20 et seq.
Obstructing administration of law or other governmental function, see § 2C:29–1.
Offering false instruments for filing, see § 2C:21–3.

Administrative Code References

Access to death records, see N.J.A.C. 8:2A–1.2.

Library References

American Digest System

Registration of vital statistics and report of contagious diseases, see Health and Environment ⇐34.

Encyclopedias

Registration of births and deaths, see C.J.S. Health and Environment § 41.

WESTLAW Research

Health and environment cases: 199k[add key number].

26:8–5. Institutional records

The person in charge of a hospital, almshouse, lying-in, penal, or other institution, public or private, to which any person resorts for treatment of disease or for confinement, or is committed by process of law, shall make a record of all the personal and statistical particulars relative to each inmate in such institution, at the time of admission, and shall make a complete medical record covering the period of such person's confinement in such institution.

The medical records provided for herein or photographic reproductions thereof shall be retained by the custodian of records of such institution for a period of 10 years following the most recent discharge of the patient, or until the person confined therein reaches the age of 23 years, whichever is the longer period of time. In addition, a discharge summary sheet shall be retained by such custodian of records for a period of 20 years following the most recent discharge of the patient. The discharge summary sheet shall contain the patient's name, address, dates of admission and discharge and a summary of the treatment and medication rendered during the

patient's stay. Any X-ray films related to such confinement, or any size reproductions thereof which maintain the clarity of the original shall be retained by such custodian of records for a period of 5 years.

In case of any person admitted or committed for treatment of disease, the physician in charge shall specify, for entry in the record, the nature of the disease and where, in his opinion, it was contracted.

The personal particulars and information required by this section shall be obtained from the individual himself if practicable; and when not, they shall be obtained in as complete a manner as possible from relatives, friends, or other persons acquainted with the facts.

Amended by L.1970, c. 288, § 1, eff. Dec. 14, 1970; L.1975, c. 282, § 1, eff. Jan. 12, 1976.

Historical and Statutory Notes

Source: L.1920, c. 99, § 23, p. 208 [1924 Suppl. § 22–19c(23)].

1975 Legislation

The 1975 amendment inserted "or any size reproductions thereof which maintain the clarity of the original" in the fourth sentence of the second paragraph.

Cross References

Confidentiality of records made pursuant to provisions of Title 30, see § 30:4–24.3.
Expunging records of commitment, see § 30:4–80.8 et seq.

Administrative Code References

Ambulatory care facilities, maintenance of records, see N.J.A.C. 8:43A–13.1 et seq.
Long-term care facilities, medical records, see N.J.A.C. 8:39–35.1 et seq.

Law Review Commentaries

Access to medical records. Robert J. Conroy, Mark D. Brylski and Kathy Opperman, 118 N.J.Law. 32 (Feb.1987).

Library References

American Digest System

Registration of vital statistics and report of contagious diseases, see Health and Environment ⇐34.

Regulation and supervision of asylums, see Asylums ⇐3.

Regulation and supervision of hospitals, see Hospitals ⇐3.

Encyclopedias

Registration of births and deaths, see C.J.S. Health and Environment § 41.

Regulation and supervision of asylums and institutional care facilities, see C.J.S. Asylums and Institutional Care Facilities §§ 5 to 8.

Regulation of hospitals in general, see C.J.S. Hospitals §§ 3 to 6.

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of section effective 180 days following enactment of L.2003, c. 246, approved January 12, 2004.

pter:

eans statistics concerning ~~birth~~ births, deaths, fetal deaths ~~and~~, estic partnerships established pursuant to P.L.2003, c. 246

ans the birth, death, fetal death ~~and~~, marriage and domestic om which vital statistics are produced.

eans the State registrar of vital statistics; "Local registrar" or local registrar of vital statistics of any district; and "registration means a registration district as constituted by this article.

th" means the complete expulsion or extraction from its mother of on, irrespective of the duration of pregnancy, which, after such r shows any other evidence of life such as beating of the heart, ical cord, or definite movement of voluntary muscles, whether or has been cut or the placenta attached.

ion effective until 180 days following enactment of L.2003, c. uary 12, 2004, see § 26:8–4, ante.

78, § 32, eff. June 1, 1965; L.2003, c. 221, § 12, eff. Jan. 9, 2004;

Historical and Statutory Notes

pproved January 12,

ect on the 180th day at the Commissioners ices and Banking and nticipatory administra- shall be necessary for the implementation of the act; and the provisions of sections 47 through 56 shall apply to policies or contracts issued or renewed on or after the effective date."

Executive Order:

Issuance of Copies of Vital Records. McGreevey Executive Order No. 18, Apr. 24, 2002.

nish information relative to birth, death or marriage

ction effective until 180 days following enactment L.2003, c. 246, approved January 12, 2004.

State registrar in person, by mail, by means of the NJ–EDRS, or trar; every physician, midwife, informant, funeral director, or owledge of the facts relative to any birth, death, fetal death, or uch information as he may possess, upon a form provided by the gh the NJ–EDRS, or upon the original birth, death, fetal death, r its electronic facsimile or digitized form thereof.

'8, § 33, eff. June 1, 1965; L.2003, c. 221, § 13, eff. Jan. 9, 2004.

n effective 180 days following enactment of L.2003, c. 246, 2, 2004, see § 26:8–4, post.

nish information relative to birth, death or marriage

section effective 180 days following enactment .2003, c. 246, approved January 12, 2004.

tate registrar in person, by mail, or through the local registrar, informant, funeral director, or other person having knowledge v birth, death, fetal death, ~~or~~ marriage or domestic partnership, ation as he may possess, upon a form provided by the State

registrar or upon the original birth, death, fetal death, ~~or~~ marriage or domestic partnership certificate.

Amended by L.1965, c. 78, § 33, eff. June 1, 1965; L.2003, c. 221, § 13, eff. Jan. 9, 2004; L.2003, c. 246, § 15.

For text of section effective until 180 days following enactment of L.2003, c. 246, approved January 12, 2004, see § 26:8–4, ante.

Historical and Statutory Notes

2003 Legislation

L.2003, c. 246, § 60, approved January 12, 2004, provides:

"This act shall take effect on the 180th day after enactment, except that the Commissioners of Health and Senior Services and Banking and Insurance may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act; and the provisions of sections 47 through 56 shall apply to policies or contracts issued or renewed on or after the effective date."

26:8–5. Institutional records

Administrative Code References

Standards for services and licensure of adult and pediatric day health services facilities, see N.J.A.C. 8:43F–3.22, 8:43F–3.23, 8:43F–8.1.

Notes of Decisions

Private actions 1

1. Private actions

Appellate court would not create tort for violation of statute requiring hospitals to preserve patient records, since statute did not expressly authorize suit by individual for loss of records and violation of statute did not have causal relation to physical injury suffered by patient. Proske v. St. Barnabas Medical Center, 313 N.J.Super. 311, 712 A.2d 1207 (A.D.1998), certification denied 158 N.J. 685, 731 A.2d 45. Action ⇐ 3

26:8–6. Registration of midwives and undertakers

a. Every midwife and ~~undertaker~~ funeral director shall register annually his name, address and occupation, and his license number, with the local registrar of the district in which he resides. ~~Such registration shall also be made~~ and shall register that information with the local registrar immediately upon ~~removing~~ moving to another registration district.

b. The provisions of subsection a. of this section, with respect to funeral directors, shall be satisfied by the implementation of periodic data exchanges between the State Board of Mortuary Science and the State registrar, which shall begin no later than 18 months after the date of enactment of P.L.2003, c. 221, in a manner to be prescribed by the State registrar.

Amended by L.2003, c. 221, § 14, eff. Jan. 9, 2004.

ARTICLE 2. ADMINISTRATIVE PERSONNEL

26:8–7. Registration of vital records by state department

Historical and Statutory Notes

Executive Order:

Issuance of Copies of Vital Records. McGreevey Executive Order No. 18, Apr. 24, 2002.