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### MEDICAL RECORDS

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Keeping proper medical records is vital to the success of your practice and essential if you should ever need to defend yourself against a malpractice suit. In fact, the courts will view a carefully annotated treatment record as your testimony, on your own behalf, that you practiced responsible medicine during the course of the patient's treatment. See Appendix CC for an in-depth discussion of documentation of psychotherapy.

#### **KNOW YOUR STATE LAWS**

Retain your records at least as long as you are required to by state law. Since the requirement varies from state to state, you'll have to find this out when you start your practice. It is also good to remember that there is generally no statute of limitations on how much time can pass before a former patient or his family can file a malpractice suit. If you've got a case that strikes you as problematic, it might be good to hold on to your documentation even after you've met the state requirement.

#### **MAKE YOUR RECORD COMPLETE**

Although record-keeping procedures will vary in different practice settings, the following should be included in all psychiatric records:

1. Name, address, and telephone number(s) of patient (and designated others if the patient has granted appropriate authorization for you to communicate with others)
2. Any signed informed consents for treatment and authorizations for release of information to others, including managed care companies and third-party payers
3. All pertinent medical history
4. Your initial assessment and subsequent reassessments of the patient's needs
5. The dates of service, as well as length of time and service provided
6. Reports from psychological testing, physical examinations, laboratory data, etc.
7. Prescriptions or medications, adjustments to dosage, complaints about side effects, etc.
8. Progress notes or other documentation that reflects a patient's reaction to treatment or the need to vary treatment
9. Any consultations with colleagues about the patient
10. What actions you took and why, and what actions you considered but rejected and why—especially with regard to serious situations such as suicide, homicide, or transference problems

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11. Copies of correspondence concerning the patient
  12. A discharge summary, if relevant, including the patient's status relative to goal achievement, prognosis, and future treatment considerations
  13. Documentation of the termination process

### **WHAT NOT TO INCLUDE**

Just as it's important to include all the appropriate notations and documents in your patients' medical records, it's equally important to leave out the inappropriate ones. Avoid personal criticisms of the patient, and avoid using the names of third parties—for example, the person with whom the patient is having an affair. It's best to avoid all extraneous references to matters that you or your patient would not want to have seen by utilization reviewers, parents (if the patient is a minor), legal representatives of deceased patients, plaintiff's attorneys in malpractice actions, or government agencies that might seek access to the record for purposes of security clearance.

### **DOCUMENT EXCEPTIONAL CIRCUMSTANCES**

Be sure to document any circumstances that strike you as out of the norm. For instance, if the patient balks at your treatment plan or if the spouse or parents of a suicidal patient refuse to become involved in the patient's treatment, you must be sure to note these issues and file a detailed account of how you handled them.

### **KEEP YOUR RECORDS IN A SAFE PLACE**

Records should be kept in a secure place, accessible only to those in your office who have reason to need them. If you keep your records on a computer, use a password to keep them secure, have a separate hard copy that is stored in a secure place, and be sure to back up your data regularly. Make sure your staff observes very strict protocols in handling the files. Everyone in your office must understand the necessity of confidentiality concerning patients and their records.

### **ALTERING DOCUMENTS**

In situations where you have a legitimate cause to alter a record—if a mistake was made and needs to be rectified, for example—make sure you carefully date the correction and note that you are correcting an error. Make your correction by drawing a single-line through the wrong information and be sure to date and initial the correction. Altering records to avoid looking bad in court after a case has been brought can be fatal to your case. As we noted earlier, no records should be destroyed before the time established by state law, and it's not a bad idea to keep them beyond that if you think a question may arise sometime in the future.