I. **Policy Statement:**
Student Health Services medical records will be maintained in accordance with the high standards in the health care profession and all applicable laws and regulations. The goal is to promote excellence in health care delivery by keeping medical records in a manner that optimizes the use of patient information while preserving confidentiality. Appropriate steps will be taken to ensure that SHS medical records are accurate, clear, complete, well-organized, accessed and used only as authorized, and appropriately secured.

II. **Purpose:**
To establish guidelines for the contents, maintenance, and confidentiality of patient medical/clinical records that meet the requirements set forth in federal and state laws and regulations, and to define the portion of an individual’s health care information, whether in paper or electronic format, that comprises the SHS Medical Record.

III. **Definition of Medical Record and General Standards:**
**Medical Record:** The Medical Record is the collection of information and documentation created and/or maintained by SHS that is directly related to a patient’s health care at SHS. The Medical Record is sometimes known as the treatment record.

The Medical Record for each patient shall contain sufficient accurate information to identify the patient, support the diagnosis, justify the treatment, document the course of treatment and results, and promote the continuity of care among health care providers. This information may be in the form of print, electronic, or scanned documents, and may be in various locations. Each Medical Record shall be created, maintained, and accessed in accordance with SHS policies. Entries to the Medical Record shall be made by a person who has knowledge of the acts, events, opinions and/or diagnoses relating to the patient, and shall be made at or around the time indicated in the documentation.

**Exclusions:**
The Medical Record excludes any information or documentation that does not directly relate to the provision of health care to the patient at SHS. Examples of information or documentation that is not part of the Medical Record:

1. records managed by the patient (e.g. self glucose monitoring)
2. information received from a University official that is not directly related to the provision of health care to the individual at SHS (e.g. information regarding students received from the Dean of Students, the Office of Residence Life, the Boston University Police Department, or a faculty member).

The Medical Record also excludes psychotherapy notes, which are notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. Psychotherapy notes do not include information concerning medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date, all of which may be included in the Medical Record.

The Medical Record typically includes notes of in-person patient visits at SHS and notes of telephone calls as well as email correspondence with SHS providers concerning the patient’s health care at SHS. Records received from another treatment facility or provider may or may not be included as part of the SHS Medical Record.

The Medical Record is the record that will be released in response to a request for release by the patient (or legal representative) or a subpoena or court order to release the patient’s medical records. The Medical Record will be certified as the SHS medical record.

IV. Procedures:

A. Maintenance of the Medical Record

1. A Medical Record shall be maintained for every individual who is evaluated or treated in any of the departments within SHS.
2. The Medical Record contents can be in electronic formats, including digital images, or in paper (hard copy) format.
3. The current electronic Medical Record is an integrated health record that contains information from various sources that are involved in the coordinated care of patients at SHS: medical, mental health, AOD, laboratory, nutrition, and sports medicine.

B. Confidentiality

1. As a general rule, the Medical Record and all other personal information regarding students will be kept confidential. Information may be disclosed only as provided by applicable federal or Massachusetts law.
2. Disclosures of health information are required or permitted by law without patient consent in various specific circumstances. Examples:
a) Serious Threat to Health or Safety: Disclosure is permitted if necessary to protect the health or safety of the patient or others. (Disclosure of confidential communications with a mental health care provider may be permitted if the patient or other person is in clear and present danger.)
b) Public Health Risks: Reporting to public health authorities is mandated in certain circumstances.

3. Certain health information is highly confidential and, as a general rule, may be released only with informed written consent. This includes medical record information about:
   a) HIV/AIDS status
   b) Genetic testing
   c) Substance abuse (alcohol or drug)
   d) Sexually transmitted diseases
   e) Mental health counseling and confidential communications with a mental health care provider

4. Explanation regarding FERPA and HIPAA:
   a) As a general rule, SHS medical records are not subject to the rules for use or disclosure of education records under the Family Educational Rights and Privacy Act and its regulations (FERPA). Accordingly, SHS staff may not disclose information from a student’s SHS Medical Record in reliance on FERPA, which permits the disclosure of information from the student’s education record to other University officials who have a legitimate educational interest. Information about a student that has been obtained in connection with treatment of the student may be disclosed to University officials only with the student’s consent or as necessary to protect the health or safety of the student or another individual.

   b) SHS medical records are not subject to the Health Insurance Portability and Accountability Act and its regulations (HIPAA). It can be helpful to use the same terminology and standards as are used in HIPAA because they are familiar and they represent appropriately high standards of privacy and security, but HIPAA does not technically apply to SHS.

5. At the time of care, a patient may sign a written release for the release of the entire record or a particular part of the record or the patient may give verbal permission to disclose particular information. For example, a student may choose to permit the disclosure of information to a family member or friend.

6. When outside parties contact SHS with request for information regarding a particular encounter, the permission of the student will be sought prior to release of any information.
7. Blanket release statements for an academic year are generally not acceptable as unexpected problems may arise which students may not want to be disclosed to outside parties.

8. When the health or safety of the patient or the health or safety of others inside or outside the University community is thought to be at risk, providers may use their clinical judgment in deciding to disclose information without the patient’s consent in order to avert or mitigate harm to the patient or the other individual. For example, information may be disclosed to outside resources who need to be involved to facilitate patient safety. Confidential communications from the patient to a mental health provider may be disclosed to a third party without the patient’s consent only if the patient or another person is in clear and present danger.

9. Students will be encouraged to involve family and friends in their care to provide support and help in times of illness.

C. Content

1. Medical record content shall meet all of the state and federal legal requirements as well as standards of the health care profession.

2. All documentation and entries into the medical record must be identified with two pieces of identifying information such as full name, student ID or birth date.

3. Any signed information related to patient care (forms) should be scanned into the patient record in the appropriate location.

4. Documents within the medical record shall be filed chronologically, including all scanned documents or imaging.

D. Entering Documentation in Medical Record

1. Healthcare providers are individually responsible for documentation of patient care in the medical record.

2. The following staff may document in the patient record:
   - Staff physicians, psychologists, social workers, LMHCs, nurses, medical assistants, nursing assistants, approved trainees, registered dieticians (Nutrition and Fitness Center), athletic trainers, and laboratory technicians.

3. Co-signature of notes may be required in the case of trainees and other professionals who require supervision in the delivery of patient care.

This policy is intended to guide patient care. Medical conditions and specific medical situations are often complex and require health care providers to make independent judgments. These policies may be modified by practitioners to achieve maximal patient outcomes.
E. Completion, Timeliness and Authentication of Medical Records

1. Every effort must be made to record medical record entries within 24 hours of when the care or observation is made. The date of notation must be accurately recorded.

2. Staff members will be subject to administrative action, which may include suspension of patient care privileges, for failure to maintain complete and accurate medical records.

3. Electronic medical records contain an electronic signature that requires authentication through password sign on.

4. Scanned records must be signed off by a provider prior to inclusion in the chart to avoid errors.

5. All medical records regardless of their format must be maintained in their entirety, and no document or entry may be deleted from the record.

F. Access to Medical Records for Purposes of Treatment, Payment and Healthcare Operations

1. Treatment purposes: Health care providers who are directly involved in the care of the patient may access the medical record.

   a) Behavioral Medicine and Medical staff sharing in a patient’s care will consult with each other, share information, and access Medical and Behavioral Medicine records of the patient reciprocally to the extent necessary to enhance coordination of the patient’s care.

   b) Providers may access the patient record only if they are directly involved in the care of the patient (or for authorized healthcare operations as described below). Providers should access only the minimum amount of the patient record necessary to provide appropriate and coordinated care. Staff should be careful to avoid sharing information that is not pertinent to the current clinical episode. Access to Behavioral Medicine records and other highly confidential information is strictly limited.

   c) In cases in which a provider expects that record sharing may be necessary, patients should be informed of this fact.
2. Payment Purposes – Authorized and designated SHS staff members may access the patient’s medical record for purposes related to obtaining payment for services.
   a) Coding and abstracting;
   b) Billing including claims preparation, and claims adjustments.
   c) Third Party Payer Reviews

3. Healthcare Operations - Patient medical records may be accessed for routine healthcare operations purposes including:
   a) Peer Review
   b) Quality Improvement Committee – utilization review
   c) Documentation reviews
   d) Teaching/training
   e) Systems administration

4. Access to electronic components of the medical record:
   a) Staff who need access to the electronic components of the medical record (EMR) are required to have a University email account and password, as well as EMR User ID and password. Access will be limited to the minimum necessary for the staff member to perform his/her role as approved by SHS administration.
   b) For each staff member needing access to the record, an Access Authorization Request must be submitted and signed off by the employee’s supervisor, the IT specialist, and the Director.

5. Periodic audits of record access will be performed. Employees accessing patient records inappropriately will be subject to administrative action. Employees will be reminded of these restrictions at regular intervals, and new employees will be trained accordingly.

G. Ownership, Responsibility and Security of Medical Records

1. All medical records, whether paper or electronic, are the property of Boston University. SHS is responsible for their safekeeping.
   a) Designated medical records staff members are responsible for administrative functions for the management of the medical record and verifying that the medical record is complete.
   b) Paper medical records shall be stored in a safe and secure area. Any paper original medical records shall not be removed from the facility except for purposes of long-term storage in accordance with SHS document retention policy.
   c) Electronic medical records shall be secured in accordance with standards similar to HIPAA security standards.
   d) With appropriate safeguards, providers may be granted access to the electronic record remotely through a secure connection. Providers
with remote access must not download patient information onto a non-University computer.

H. Release and Copying of Medical Records

1. General release requirements: The information contained in the patient’s Medical Record shall be accessible to the patient and shall be released at the patient’s request and authorization to the full extent provided by law and SHS policy.
   a) As a general rule, documented verbal or written consent is required to release or disclose medical records verbally or in writing to any outside party, including to parents or guardians.
   b) Non-sensitive records, such as immunizations, may be released to students or outside parties without written consent. A verbal request for such release will be deemed adequate permission.
   c) In response to any request or demand for the release of the entire medical record, only the Medical Record as defined in Section III above will be released.
   d) Access to portions of the medical record may be denied (see Policy and Procedure for Access and Denial of Protected Health Information).
   e) The BU Office of the General Counsel will be promptly consulted for advice when a request from an attorney (or other legal representative), subpoena, court order, or other legal request or demand is received for the release of medical records. The request or demand must be cleared through the BU Office of the General Counsel after the Medical Record is checked by the SHS Medical Records staff.

2. Student requesting records:
   a) Student will fill out and sign a release of information form (“General Authorization to Disclose Protected Health Information”), including where records should be sent.
   b) When a student requests the release of his/her Behavioral Medicine record, the clinician of record will meet with the student to go over the record. The record will be released only after this meeting, if the student still requests release, and only the portion of the record specifically requested.
   c) No record, whether Medical or Behavioral Medicine, will be released without proper student ID.
   d) There is a charge of $10 for release of the entire medical record to the student; there is no charge for release to another health care facility or clinician office.
   e) Records may be sent electronically only through Certified Mail or other authorized secure electronic delivery channel (not regular email) or may be sent through U.S. Mail, marked Confidential.
This policy is intended to guide patient care. Medical conditions and specific medical situations are often complex and require health care providers to make independent judgments. These policies may be modified by practitioners to achieve maximal patient outcomes.

f) Sections of the record require special authorization, before release:
   i. Information relating to AIDS or HIV, including but not limited to testing and the fact that the test was taken
   ii. Genetic testing information including test results
   iii. Information about sexually transmitted diseases
   iv. Mental health counseling and Behavioral Medicine records
   v. Information described in federal laws protecting alcohol and drug abuse records

3. Health care facilities or other third parties requesting records:
   a) Student signs release of information form.
   b) Records may be sent electronically only through Certified Mail or other authorized secure electronic delivery channel (not regular email) or may be sent through U.S. Mail, marked Confidential.
   c) Sections of the record requiring special authorization before release are as noted above.
   d) There is no charge for the release of medical records to third parties.

4. Medical Records staff and/or the clinician will document the actions taken—e.g. the record has been copied and sent out, including the sections that have been copied and sent, date sent and address to which it has been sent.

I. Retention and Storage of Medical Records

1. All medical records will be retained for 30 years from the last encounter, as required by the Massachusetts law for record retention. The Immunization Record must be maintained for 10 years.

2. Paper records concerning students who are not active patients will be archived.
   a) A list of all medical records to be archived will be made and will include full name and Boston University identification number.
   b) These records will be placed in a box that shall contain a list of the contents.
   c) Some inactive records will be stored in space at Boston University, depending on availability.
   d) Designated staff will contact the records storage company when offsite record archiving is required.

J. Amendments to Records

1. EMR – Add an addendum to the electronic document indicating the corrected information, the identity of the individual who created the addendum, the date created, and the electronic signature of the individual making the addendum.
2. Late entry – For notes that were missed or not written in a timely manner, the following must be included:
   a) Identify the new entry as a “late entry”
   b) Enter the current date and time.
   c) Identify or refer to the date and the circumstance for which the late entry or addendum is written.

3. Addendum – For a late entry that provides clarification or additional information to another visit entry:
   a) Document the date and time on which the addendum was made.
   b) Write “addendum” and state the reason for creating the addendum.

4. Errors in Scanning Documents – If a document is scanned to the wrong patient or encounter date:
   a) Reprint the scanned document
   b) Rescan the document to the correct date or patient and void the incorrectly scanned document.

K. Authentication of Entries in the EMR

1. Electronic signatures must meet standards for:
   a) Data integrity – to protect data from accidental or unauthorized changes (e.g., locking the EMR when provider leaves an exam room).
   b) Authentication – to validate the correctness of the information and confirm the identity of the signer through password protection.
   c) Non-repudiation – to prevent the signer from denying that he or she signed the document. (EMR has unique identifier that includes sign on and password for signing of notes.)
   d) Electronic signatures must be affixed by the individual whose name is being affixed to the document and no other individual.
   e) Countersignatures or dual signatures must meet the same requirements.
   f) If one section of a note in the EMR is completed by another staff member, that author must electronically sign under that section.
   g) No individual shall share electronic signature passwords or logon identifier with any other individual.