STATE AGENCIES' RECORDS SCHEDULE

S4: HEALTH RECORDS

(Revised: **11/2010**)

STATE OF CONNECTICUT
Connecticut State Library
Office of the Public Records Administrator
231 Capitol Avenue, Hartford, CT 06106
www.cslib.org/publicrecords

1. **AUTHORITY:** The Office of the Public Records Administrator issues this records schedule under the authority granted it by CGS §11-8 and §11-8a.
2. **SUPERSEDENCE:** This schedule supersedes all previously approved *State Agencies' Records Retention Schedules: S4: Health Records*.
3. **FORMAT:** Retention periods listed on this schedule apply to the record, regardless of physical format. Records may be either hard copy or electronic. If the record is electronic, the custodian of the record must be able to interpret and retrieve the record for the minimum retention period listed for the records series.
4. **DISPOSITION AUTHORIZATION:** This schedule is used concurrently with the *Records Disposition Authorization* (Form RC-108). The RC-108 must be signed by the agency Records Management Liaison Officer (RMLO), the State Archivist, and the Public Records Administrator **prior** to the destruction of public records.
5. **FOIA EXEMPTION:** Pursuant to CGS §1-210(b)(2), medical files, the disclosure of which would constitute an invasion of personal privacy, are exempt from release under the Freedom of Information Act (FOIA).
6. **PATIENT MEDICAL RECORDS:** Patient medical records (inpatient and outpatient) include, but are not limited to: medical questionnaires or histories, results of medical examinations, laboratory tests, medical opinions, diagnoses, progress notes, and recommendations, first aid records, descriptions of treatments and prescriptions, medical complaints, and collateral information received from other institutions used for the purpose of treatment. See Conn. Agencies Regs. §19a-14-40 for further information.

Series #	Records Series Title	Description	Minimum Retention	Disposition	Notes and Citations
(S1-015)	**Accreditation Records**	Consists of records that document the accreditation process from accrediting and regulatory bodies. Including but not limited to: data, correspondence, other supporting documentation, reports received from study committees of accrediting associations and suggestions and recommendations concerning organizational structure and administration.	5 years from date accreditation granted, or until next accreditation, whichever is later	Destroy after receipt of signed Form RC-108	Applies to accreditation at the program, department, and institutional levels.
S4-010	**Admission and Discharge Listings**	Consists of logs, reports, and other records that document admissions and discharges of patients.	Permanent	Maintain in agency	See S4-050 for daily census and status records.
S4-020	**Cancer Registry Records**	Consists of records that document newly diagnosed and follow-up of cancer patients. Including but not limited to: forms submitted to the Department of Public Health (DPH) pursuant to Conn. Agencies Regs. §19a-73-3(a).	10 years from date of discharge or death	Destroy after receipt of signed Form RC-108	Pursuant to CGS §19a-73, health care facilities shall complete an occupational history of each patient who has been newly diagnosed as having contracted cancer. DPH maintains cancer tumor registry information permanently.

Series #	Records Series Title	Description	Minimum Retention	Disposition	Notes and Citations
S4-030	**Clinical Supervision Records**	Consists of records that document counseling sessions for clinical supervision. Including but not limited to: evaluations and audio / video recordings of sessions for training purposes.	5 years from date of session	Destroy after receipt of signed Form RC-108	
S4-040	**Competency to Stand Trial Evaluation Records – Court Clinics**	Consists of records that document the examination of defendants as to their competency to stand trial, pursuant to CGS §54-56d. Including but not limited to: evaluation reports and related documents.	10 years from date of completion of the last evaluation	Destroy after receipt of signed Form RC-108	Pursuant to CGS §54-56d, if a patient is found not competent to stand trial and is committed to a state facility, then a copy of the court clinic report is sent to that facility and should become part of the patient medical record
S4-050	**Daily Census and Status Records**	Consists of records that document daily activities at medical facilities. Including but not limited to: daily appointment sheets, daily hospital census reports, and daily movement sheets, which track patients' movements in and out of the facility (e.g., transfers, discharges, and admissions).	6 months from date of activity	Destroy after receipt of signed Form RC-108	
S4-060	**Death Certificates, Copies of**	Consists of copies of death certificates and death certificate stubs submitted to the Department of Public Health (DPH).	10 years from date of death [Conn. Agencies Regs. §19-13-D3(d)(6)]	Destroy after receipt of signed Form RC-108	Pursuant to Conn. Agencies Regs. §7-62-2, determination of prognosis of death by physician should be documented in the patient medical record.
S4-070	**Death Records – Transfer of Body**	Consists of records that document the transfer of body to morgue or funeral home.	1 year from date of transfer	Destroy after receipt of signed Form RC-108	
S4-080	**Diagnostic Ancillary Testing Requisitions**	Consists of requisitions to conduct laboratory work (e.g., EEG, ECG, EKG, radiology, and MRI).	2 years from date of requisition	Destroy after receipt of signed Form RC-108	
S4-090	**Diagnostic Ancillary Testing Reports**	Consists of records that document laboratory work (e.g., maternal serum screening) maintained by laboratories.	5 years from date of discharge or death [Conn. Agencies Regs.§19a-14-42(b)]	Destroy after receipt of signed Form RC-108	Pursuant to Conn. Agencies Regs. §19a-14-42(b), only positive (abnormal) results need to be retained.
S4-100	**Diagnostic EEG / ECG / EKG Tracings**	Consists of electroencephalography (EEG), electrocardiography (ECG), and electrocardiogram (EKG) graphs and tracings.	7 years from date of discharge or 3 years from date of death [Conn. Agencies Regs. §19a-14-42(a)]	Destroy after receipt of signed Form RC-108	Pursuant to Conn. Agencies Regs. §19a-14-42(a), if an ECG is taken and the results are unchanged from a previous ECG, then only the most recent results need be retained.

Series #	Records Series Title	Description	Minimum Retention	Disposition	Notes and Citations
S4-110	**Diagnostic EEG / ECG / EKG Reports**	Consists of electroencephalography (EEG), electrocardiography (ECG), and electrocardiogram (EKG) diagnostic and interpretation reports.	Duration of corresponding patient medical record [Conn. Agencies Regs. §19a-14-42(a)]	Destroy after receipt of signed Form RC-108	
S4-120	**Diagnostic Radiology Imaging Films**	Consists of radiology diagnostic films, scans, and images (e.g., X-ray).	3 years from date of discharge or death **[**Conn. Agencies Regs.§19a-14-42(c)]	Destroy after receipt of signed Form RC-108	
S4-130	**Diagnostic Radiology Imaging Reports**	Consists of reports of radiology diagnostic films, scans, and images (e.g., X-ray).	7 years from date of discharge or death	Destroy after receipt of signed Form RC-108	
S4-140	**Diagnostic Radiology Imaging Mammography Records**	Consists of radiology diagnostic films, scans, images, and reports for mammograms.	10 years from date of discharge or death [21 CFR §900.12(4)(i)]	Destroy after receipt of signed Form RC-108	Pursuant to the Mammography Quality Standards Act, mammography films and reports must be maintained in a permanent medical record of the patient for a period of not less than 5 years, or not less than 10 years if no additional mammograms of the patient are performed at the facility.
S4-150	**Disease, Operation, and Physician Indices**	Consists of records that document disease, operation, and physician activities at a health care facility.	10 years from date of service	Destroy after receipt of signed Form RC-108	
S4-160	**Emergency Response Logs**	Consists of logs that document emergency responses for respiratory and cardiac cases (e.g., code blue or code red).	1 year from date of response	Destroy after receipt of signed Form RC-108	Separate patient report should be maintained in patient medical record.
S4-170	**Employee Medical Records**	Consists of records that document the health status of an employee (which is made or maintained by a physician, nurse, or other health care personnel, or technician). Including but not limited to: medical and employment questionnaires or histories, results of medical examinations; medical opinions, diagnoses, progress notes, and recommendations; first aid records; descriptions of treatments and prescriptions; and employee medical complaints.	Duration of employment plus 30 years [29 CFR §1910.1020(d)(1)(i)]	Destroy after receipt of signed Form RC-108	See S2-370 for Workers' Compensation Records. See S2-250 for employee medical records *not* involving treatment.

Series #	Records Series Title	Description	Minimum Retention	Disposition	Notes and Citations
S4-180	**HIPAA Protected Health Information Compliance Records**	Consists of records that document compliance with the *Standards for Privacy of Individually Identifiable Health Information* (privacy rule) and Security Rule pursuant to the *Health Insurance Portability and Accountability Act* (HIPAA). Including but not limited to: privacy policies and procedures, privacy practices notices, disposition of complaints, and other actions, activities, and designations.	6 years from the date of creation, or last effective date, whichever is later [45 CFR §164.530(j)]	Destroy after receipt of signed Form RC-108	
S4-190	**Homemaker Home Health Aide Services Patient and Clinical Records**	Consists of records that document the health status of a patient at public or private organization which provides services in the patients' home. Includes nursing, social work services, home health care agencies, and homemaker-home health aide services.	7 years from date of discharge or death [Conn. Agencies Regs. §19-13-D75(a)(2) and §19-13-D88]	Destroy after receipt of signed Form RC-108	
(S1-155)	**Incident Reports**	Consists of reports that document the circumstances surrounding incidents. Including but not limited to: incident reports and related documents used to monitor the number and type of incidents.	10 years from date of report	Destroy after receipt of signed Form RC-108	Incident reports should *not* be filed with the patient's medical record.
S4-200	**Institutional Review Board Records**	Consists of records that document Institutional Review Board (IRB) and Human Investigations Committee (HIC) activities. Including but not limited to: research proposals, progress reports, notes of IRB meetings, lists of IRB members, IRB procedures records of continuing review activities, and related correspondence.	3 years after completion of research or 3 years if research is never conducted [45 CFR §46.115(b)]	Destroy after receipt of signed Form RC-108	
S4-210	**Institutional Review Board Principal Investigator Records**	Consists of records that document Institutional Review Board (IRB) and Human Investigations Committee (HIC) investigator activities retained pursuant to HIPAA. Including but not limited to: documents related to uses and disclosures, authorization forms, business partner contracts, notices of practice, responses to requests to amend or correct information, patient's statements of disagreement, and related complaints.	6 years from date research project ends	Destroy after receipt of signed Form RC-108	Pursuant to 45 CFR §46.115(b), IRB records should be retained for 3 years from date research project ends. However, pursuant to 64 Fed. Reg. 59994, IRB investigator records related to HIPAA should be retained for 6 years (per 45 CFR §160 the statute of limitations period for civil penalties).

Series #	Records Series Title	Description	Minimum Retention	Disposition	Notes and Citations
(S3-330)	**Maintenance Records**	Consists of records that document the maintenance and use of equipment and facilities. Including but not limited to: checklists, logs, requests, and work orders.	3 years, or until audited, whichever is later	Destroy after receipt of signed Form RC-108	
S4-220	**Master Patient Index**	Consists of index that documents all patients currently and previously registered at a health care facility.	Permanent	Maintain in agency	
S4-230	**Mental Health Outpatient Records**	Consists of records that document the psychiatric health status of a patient at outpatient mental health behavioral facilities. Includes free-standing mental health day treatment facilities, intermediate treatment facilities, psychiatric outpatient clinics for adults and case management, and community liaison services.	10 years from date of discharge or closure of case [Conn. Agencies Regs. §19-13-D3(d)(6)]	Destroy after receipt of signed Form RC-108	
S4-240	**Patient Medical Records – Ambulatory Care Clinics and Dental Facilities**	Consists of records that document the health status of a patient at ambulatory care clinics and dental facilities. Including but not limited to: questionnaires and histories, results of examinations, descriptions of treatments and prescriptions, and radiology diagnostic imaging (dental X-ray films).	5 years from date of discharge of patient [Conn. Agencies Regs. §19-13-D49(a)]	Destroy after receipt of signed Form RC-108	Pursuant to Conn. Agencies Regs. §19a-504c-1(h), there must be adequate documentation to provide for continuity of care if patient is an inmate, resident, or client at another facility.
S4-250	**Patient Medical Records – Children, Psychiatric Clinics for**	Consists of records that document the health status of a patient at outpatient psychiatric clinics for children and adolescents less than eighteen years of age.	7 years from date of discharge or death [Conn. Agencies Regs. §17a-20-21]	Destroy after receipt of signed Form RC-108	
S4-253	**Patient Medical Records – Children's General Hospitals**	Consists of records that document the health status of a patient at short-term general hospitals for children and adolescents less than eighteen years of age.	25 years from date of discharge or death [Conn. Agencies Regs. §19-13-D4a(d)(4)]	Destroy after receipt of signed Form RC-108	
S4-255	**Patient Medical Records – Chronic Disease Hospitals**	Consists of records that document the health status of a patient at long-term chronic disease hospitals.	25 years from date of discharge or death [Conn. Agencies Regs. §19-13-D5(d)(4)]	Destroy after receipt of signed Form RC-108	

Series #	Records Series Title	Description	Minimum Retention	Disposition	Notes and Citations
S4-260	**Patient Medical Records – Developmental Services**	Consists of records that document the health status of a patient at developmental services facilities (formerly mental retardation facilities). Includes residential and non-residential facilities (transitional facilities, group homes, community training homes and supervised apartments).	10 years from date of discharge or death [Conn. Agencies Regs. §19-13-D3(d)(6)]	Destroy after receipt of signed Form RC-108	
S4-270	**Patient Medical Records – Dialysis Unit**	Consists of records that document the health status of a patient requiring dialysis at out of hospital outpatient and in-hospital outpatient dialysis units. Including but not limited to: medical questionnaires or histories, patient care plans, treatment orders, and prescriptions (receipt and disposition of controlled substances).	5 years from date of discharge or death [Conn. Agencies Regs. §19-13-D55a(j)(4)]	Destroy after receipt of signed Form RC-108	Records of inpatient dialysis services should be maintained with the patient medical record.
S4-280	**Patient Medical Records – Higher Education Student Health Services**	Consists of records that document the health status and immunization of a patient at higher education institutions. Includes mental health, counseling, and substance abuse for students.	7 years from date student is no longer enrolled in or employee/faculty member is no longer employed at educational institution [Conn. Agencies Regs. §19-13-D43a(g)(5)(B)]	Destroy after receipt of signed Form RC-108	Pursuant to CGS §10a-155(b), a record of the immunization (measles, mumps, rubella, and varicella) must be part of the student's permanent record. The statute does not require the permanent retention of the certificate or other acceptable proof of immunization. DPH requires that the original doctor's certificate or other evidence of immunization be retained until the student leaves the school. For institutions that maintain a separate health facility, these certificates should be incorporated into the students' health records.
S4-285	**Patient Medical Records – Hospices**	Consists of records that document the health status of a patient at short-term special hospice hospitals.	25 years from date of discharge or death [Conn. Agencies Regs. §19-13-D4b(d)(6)]	Destroy after receipt of signed Form RC-108	
S4-290	**Patient Medical Records – Medical and Psychiatric Hospitals**	Consists of records that document the health status of a patient at inpatient medical hospitals and psychiatric hospitals. Includes short-term hospitals, substance abuse facilities, long-term hospitals, and mental health institutions.	10 years from date of discharge or death [Conn. Agencies Regs. §19-13-D3(d)(6)]	Destroy after receipt of signed Form RC-108	

Series #	Records Series Title	Description	Minimum Retention	Disposition	Notes and Citations
S4-300	**Patient Medical Records – Nursing and Convalescent Homes**	Consists of records that document the health status of a patient at nursing homes, chronic and convalescent nursing homes, and rest homes with nursing supervision.	10 years from date of discharge or death [Conn. Agencies Regs. §19-13-D8t(o)(5)]	Destroy after receipt of signed Form RC-108	
S4-310	**Pharmacy Controlled Substance Records**	Consists of records that document the use and disposition of controlled substances. Including but not limited to: audits, inventories, and transfers between pharmacies, prescriptions, and dispositions of controlled substances, night medication sheets, and proof of use sheets.	3 years [CGS §21a-254(g)]	Destroy after receipt of signed Form RC-108	
S4-320	**Pharmacy Review for Drug Regimen**	Consists of records that document pharmaceutical reviews of drug regimens. Includes long-term care and skilled nursing facilities	10 years from date of discharge or death	Destroy after receipt of signed Form RC-108	
S4-330	**Physician's Incomplete or Delinquent Records**	Consists of records that document the status of incomplete or delinquent medical records older than 30 days. Including but not limited to: listings, logs, and reports.	5 years from date of report	Destroy after receipt of signed Form RC-108	
S4-340	**Preadmission Screening Records – Not Admitted**	Consists of records that document preadmission screening for patients not admitted for treatment. Including but not limited to: intake forms and checklists.	6 months from date of screening	Destroy after receipt of signed Form RC-108	Preadmission screening records for admitted patients become part of the patient medical record.
S4-350	**Privileging and Credentialing Records**	Consists of records that document the verification of the credentials of health care practitioners and definitions of their privileges, which are used to increase patient safety and reduce medical errors.	5 years from date of verification	Destroy after receipt of signed Form RC-108	
S4-360	**Psychological Testing Data**	Consists of raw test data (e.g., IQ test) from psychological assessments of patients.	7 years from date of test	Destroy after receipt of signed Form RC-108	
S4-370	**Quality and Performance Improvement Records**	Consists of records that document quality assurance, quality improvement, peer review, and performance improvement activities. Including but not limited to: program evaluations, clinical record reviews, annual process and outcome record audits, patient restraint and seclusion reports, and related reports.	5 years [Conn. Agencies Regs. §19-13-D76(d)(2)]	Destroy after receipt of signed Form RC-108	

Series #	Records Series Title	Description	Minimum Retention	Disposition	Notes and Citations
S4-380	**Social Work Case Files**	Consists of records that document social work activities (e.g., service planning, contracting, counseling, case work, advocacy for the recipient, and crisis intervention) that are maintained as a separate entity and *not* interfiled within the patient medical record.	7 years from date of discharge or death [Conn. Agencies Regs. §19-13-D77(h)]	Destroy after receipt of signed Form RC-108	
S4-390	**Utilization Management / Case Management Records**	Consists of records that document utilization and quality control review of the health care furnished, or to be furnished, to patients (e.g., to establish whether or not acute inpatient admission was medically necessary). Including but not limited to: Medicare material from fiscal intermediaries, correspondence from Medicare beneficiaries, billing forms, and service recording forms.	5 years from date cost report has been filed with intermediary, or until audited, whichever is later [42 CFR §482.24(b)(1)]	Destroy after receipt of signed Form RC-108	Includes peer review organizations (PRO) and quality improvement organizations (QIOs).