COMPONENTS OF A PHYSICIAN PRACTICE
MEDICAL RECORD RETENTION POLICY

The Medical Record Retention Policy in a physician office practice should meet the specific needs of its physicians, its patients, and any other legitimate users. All aspects of the policy should assure compliance with any legal, regulatory, or accreditation requirements applicable to the practice and its physicians. A Medical Record Retention Policy should contain:

- What patient information will be kept and in what format.
- The length of time medical records will be kept, with a specific retention and destruction schedule defined and outlined.
- Whether off-site storage of paper records is necessary. Specific definitions should include which paper records will be moved off-site, when (e.g., after x years of no patient contact) and where (the exact storage location).
- The specific storage media that will be used for various types of records (e.g., paper, electronic, optical disk, microfilm, magnetic tape, external hard drive, etc.).
- A designated employee who will be responsible for enforcing the practice’s record retention policy, including:
  - Identifying those records to be moved to offsite storage.
  - Identifying those records to be purged/destroyed.
  - Maintaining a log of destroyed patient records, including patient name, ID or medical record number, birth date, date of last admission, visit or other contact with the facility, date destroyed, and method of destruction.
- A designated method of disposal (e.g., shredding or burning), including who will do the record destruction (e.g., a designated employee or an outside, commercial vendor or record destruction service).
- If the practice routinely stores patient radiographs with the medical records, appropriate retention schedules and methods of destruction of X-rays when purged should be identified and addressed in the practice’s policies and procedures.