

Kansas Administrative Regulations

Department of Health and Environment

Article 34.—Hospitals

28-34-57. Medical records.

(a) A medical record shall be maintained for each patient cared for in the ambulatory surgical center. The records shall be documented and retrievable by authorized persons.

(b) Each medical record shall be the property of the ambulatory surgical center. Only persons authorized by the governing authority shall have access to medical records. These persons shall include individuals designated by the licensing department for verifying compliance with the state or federal regulations, and for disease control investigations of public health concern.

(c) Each medical record shall be maintained in a retrievable form for 10 years after the date of last discharge of the patient, or one year after the date that the minor patient reaches the age of 18, whichever is greater.

(d) Each medical record shall contain the following information, if applicable:

- (1) Patient identification data;
- (2) patient consent forms;
- (3) patient history and physical;
- (4) clinical laboratory reports;
- (5) physician's or physicians' orders;
- (6) radiological reports;
- (7) consultations;
- (8) anesthesia records;
- (9) surgical reports;
- (10) tissue reports;
- (11) progress notes;

(12) a description of the care given to that patient based on the type of surgical procedure;

- (13) the signature or initials of authorized personnel on notes or observations;
- (14) the final diagnosis;
- (15) the discharge summary;
- (16) discharge instructions to the patient;
- (17) a copy of transfer form; and
- (18) the autopsy findings.

(e) Each record shall be dated and authenticated by the person making the entry. Nursing notes and observations shall be signed and dated by the registered nurse or licensed practical nurse making the entry. Verbal orders by authorized individuals shall be accepted and transcribed only by designated personnel.

(f) The ambulatory surgical center shall furnish, to the appropriate authority, all available information on deceased patients for completion of a death certificate.

(g) The medical record shall be completed within 30 days following the patient's discharge.

(h) Statistical data, administrative records, and records of reportable diseases as required shall be maintained and submitted by the ambulatory surgical center to the licensing department, as requested.

(i) Adequate space, facilities, and equipment shall be provided for completion and storage of medical records.

(j) Nothing in this article shall be construed to prohibit the use of properly automated medical records or use of other automated techniques, if these regulations are met. (Authorized by and implementing K.S.A. 65-431; effective Jan. 1, 1974; amended April 20, 2001.)

***** Authenticated Kansas Administrative Regulation *****