CONNECTICUT VALLEY HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	Organization Focused Functions
CHAPTER 9:	Management of Information
PROCEDURE 9.7:	**Standards for Medical Record Completion**
REVISED:	11/97; Reviewed 04/07; 11/08; 10/20/09; 04/11; 05/23/11; 8/12; 3/7/16; 4/16/18; Reviewed 11/16/18
Governing Body Approval:	11/19/18*(electronic vote)*

PURPOSE: To define ownership of the medical record and establish standards for completion of medical records following discharge of the patient.

SCOPE: All Clinical and HIM Staff

POLICY:

Connecticut Valley Hospital (CVH) maintains written clinical (e.g., "medical") records on all patients, in accordance with accepted professional standards and practices. The medical record is the property of the hospital and is maintained for the benefit of the patient, the medical staff and the hospital. The medical record will not be removed from the hospital except in accordance with a court order, subpoena or statute.

To insure continuity of patient care and assist other physicians who may be treating the patient, all medical records will be completed within 30 days of the patient's discharge from CVH.

PROCEDURE:

A Discharge Summary is dictated/written/typed by the Attending Psychiatrist following discharge of the patient.

The medical record is completed and all required signatures are obtained within 30 days of discharge.

Filing:

The medical record will be filed in Health Information Management Merritt Hall, or Blue Hills HIM Office for the Blue Hills Substance Abuse Program (complete) within 30 days of discharge.