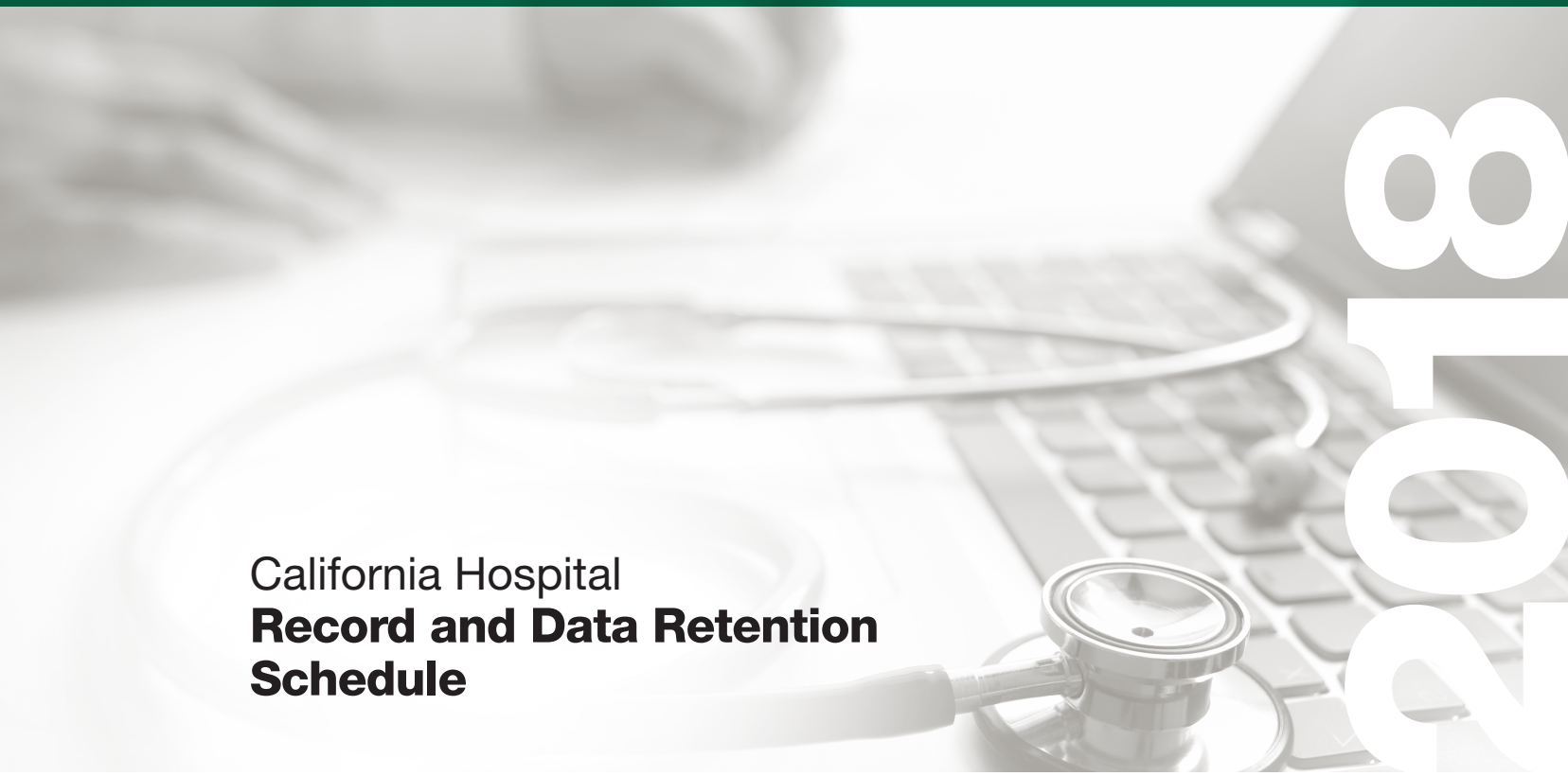
Record Retention



2018

California Hospital
Record and Data Retention Schedule

A guidebook on which records should be kept and for how long

CALIFORNIA HOSPITAL ASSOCIATION

Record and Data Retention Schedule

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Information contained in the manual should not be construed as legal advice or used to resolve legal problems by health care facilities or practitioners without consulting legal counsel. A health facility may want to accept all or some of the guidebook as part of its standard operating policy. If so, the health facility's legal counsel and its board of trustees should review the policy prior to implementation.

Preface

Health care providers create volumes of records dealing with a variety of matters. Some concern the corporate, business and administrative aspects of their operations. Others document unique areas, such as medical staff activities at hospitals. Still others trace the course of care given to patients. Providers naturally consider retaining any record that is of more than passing interest. However, as records accumulate, they occupy valuable space that often could be put to better use. Storing records off-site or in electronic form may alleviate the problem. However, these alternatives are likely to be expensive and do not address the basic question of which records should be kept and for how long.

If health care providers are to deal intelligently with the problem, they must base their decisions upon a firm knowledge of legal requirements and policy considerations. This guide discusses those requirements and considerations, and recommends specific periods for the retention of various classes of records.

The guide contains two sections. The first is a discussion of retention considerations as they pertain to various kinds of records. The second section is a Recommended Retention Schedule. It contains tables listing typical records, legal citations applicable to each health care provider type, and recommended retention periods. This schedule does not list every possible record that may be produced or retained by a health care provider but rather provides recommendations and cites legal requirements for the most common documents. For records not specifically addressed in this guide, CHA recommends considering retention periods for records listed that are of a similar nature or purpose and consulting your legal counsel.

The guide is not designed to serve as a substitute for legal counsel. If there are differences of opinion, or where the law is unclear, a provider should consult legal counsel and then make retention decisions based on the law and its own philosophy, mission and purpose.

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Record Retention Considerations

I. INTRODUCTION

Health care providers create volumes of records dealing with a variety of matters. The question naturally arises, which records should be kept and for how long?

This section of the *Record and Data Retention Schedule* discusses why hospitals and other health care providers should have a record retention policy, the pertinent factors that should be considered when determining how long to keep various documents, and considerations regarding record disposal and/or destruction. The second section of the *Record and Data Retention Schedule* (starting on page 21) is a Recommended Retention Schedule. It contains tables listing typical records, provider types, any applicable legal citations, and recommended retention periods.

The information in this manual applies identically to all records, regardless of media (paper, electronic, microfiche, microfilm, video/audio recording, magnetic tape, CD-ROM, USB sticks, etc.).

This guide is intended to be used as a reference document. The information is accurate at the time of publication; however, the guide does not cover every law, rule or regulation concerning record retention — it focuses on the ones most relevant to hospitals. Due to the dynamic nature of the law, information of this kind is subject to change at any time. **Records should never be destroyed without first verifying that retention requirements have not changed and litigation is not pending.**

All of the laws cited in this manual can be found on the Internet. *(See "Where to Find the Laws Referenced in the Manual," page 75, for instructions on finding the exact language of the laws.)*

II. THE IMPORTANCE OF HAVING A RECORDS MANAGEMENT POLICY

Hospitals and other health care providers are advised to establish and implement written policies and procedures regarding the retention and disposal/destruction of records. Doing so will help the provider achieve compliance with state licensure laws, federal health care program (Medicare, Medi-Cal) requirements, contractual obligations, accreditation organization requirements, and other statutes and regulations. Without a written policy, a provider may retain records longer than necessary, which is costly and inefficient, or dispose of records too soon, resulting in the inability to access important documents when needed. Disposing of records too soon may also lead to fines or penalties. On the other hand, keeping documents too long incurs storage fees. In addition, if a record retention policy limits how long information is kept, the hospital will have less information to search and review if served with a subpoena or other document request. This can save the hospital time and money, both employee time looking through documents and attorney time spent reviewing them.

The policies and procedures should be followed consistently to dispute any allegation that the provider withheld, hid, altered or destroyed evidence relevant to a legal proceeding ("spoliation of evidence"). Spoliation of evidence is a crime in California and at the federal level [Penal Code Section 135; 18 U.S.C. Section 1519]. In addition, if a judge believes that a party to a lawsuit has destroyed evidence, the judge may conclude that the evidence would have been unfavorable to the spoliator.

An employee should be designated to be responsible for implementing and updating the policies and procedures, as well as training and monitoring employees to ensure consistent compliance throughout the organization. It may be helpful to establish a records management committee to review and approve additions and updates to the policies and procedures, and to assist in implementation, training and monitoring/auditing.

A record retention and disposal policy should contain at least the following elements:

1. A statement about the purpose of the policy;
2. Whether the policy covers the entire organization or only certain departments;
3. A statement that the destruction of relevant records will be suspended upon receipt of legal process or other notice of pending or reasonably foreseeable investigations or litigation, whether government or private;
4. A list of employees and/or departments responsible for maintaining and updating the policy;
5. A list of employees and/or departments responsible for moving documents to long-term storage and/or destroying documents in accordance with the policy; and
6. A retention period for each type of record.

III. PRIMARY CONSIDERATIONS IN DEVELOPING A RECORD RETENTION SCHEDULE

A record retention schedule that meets the needs of a health care provider should result from an evaluation of several important primary considerations. Providers should pay particular attention to the following:

1. Legal requirements and considerations;
2. Frequency of use of a record;
3. Space constraints; and
4. Historical or research uses for the records.

These considerations are described more fully below.

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A. Legal Requirements and Considerations

Specific Statutes and Regulations

The health care industry is highly regulated. The number of state and federal government agencies that regulate hospitals and other health care providers is astonishing.[1] Each of these agencies has the authority to audit hospitals, inspect their records, issue regulations that hospitals must follow, and sanction hospitals for noncompliance.

Many state and federal government agencies have issued regulations that specify how long hospitals and other health care providers must keep certain documents. The Recommended Retention Schedule found in the second section of this manual lists these requirements. Providers are required to comply with these retention periods. However, in many cases, compliance with these minimum retention requirements is inadequate to protect the health care provider in all situations. Additional considerations in determining an optimal record retention period are discussed below.

Hospitals should check with county and local agencies regarding any record retention requirements they may have, such as local water quality protection agencies or county health departments. The CHA Recommended Retention Schedule does not include local government retention requirements.

Medi-Cal Requirements

A state law that took effect on Jan. 1, 2018, requires hospitals and other providers of health care services rendered under Medi-Cal or any other Department of Health Care Services program to keep records for at least 10 years, including:

1. Billings.
2. Treatment authorization requests.
3. Copies of remittance advices that accompany reimbursement to providers for services/supplies provided to beneficiaries.
4. Individual ledger accounts reflecting credit and debit balances for each beneficiary.
5. Copies of original purchase invoices for medication, appliances, and assistive devices.
6. Written requests for laboratory testing and all reports of test results.
7. Book records of receipts and disbursements by the provider.
8. All medical records (including each service rendered, date of service, and identification of the person rendering services), service reports, and orders prescribing treatment plans.
9. Records of medications, drugs, assistive devices, or appliances prescribed, ordered for, or furnished to beneficiaries.

1 For example, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Drug Enforcement Administration, Equal Employment Opportunity Commission, Food and Drug Administration, Internal Revenue Service, Office for Civil Rights, Occupational Safety and Health Administration, U.S. Department of Labor, California Department of Public Health, California Board of Pharmacy, California Department of Health Care Services, Cal/OSHA, Fair Employment and Housing Commission, Franchise Tax Board, etc.

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10. For providers of psychiatric and psychological services, patient logs, appointment books or similar documents showing the date and time allotted for appointments of each patient or group of patients, and the time actually spent with the patients.
11. Employment records including shifts, schedules and payroll records of employees.
12. Records of receipts and disbursements of personal funds of beneficiaries held in trust by the provider, if any.

These records must be kept starting from the date the record was created and running for 10 years from the latest of:

1. The final date of the contract period between the plan and the provider,
2. The date of completion of any audit, or
3. The date the service was rendered.

Because most hospitals and other health care providers serve Medi-Cal beneficiaries, and the contract period or audit process may add several years to the 10-year time frame, CHA's Record Retention Schedule shows a 15-year recommended retention period for the records listed above. This recommendation is reflected in the fourth column of the Recommended Retention Schedule. Providers using the Schedule that do not serve Medi-Cal patients may wish to consider a shorter retention period. *(See also "Contracts with Medicare Advantage or Medicare Part D Plans," page 6, and "Accountable Care Organizations," page 7.)*

This law applies to any individual, partnership, group, association, corporation, institution or other entity that provides goods, services, supplies or merchandise, directly or indirectly, including all ordering, referring and prescribing, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal program [Welfare and Institutions Code Section 14043.1(o)]. A health facility or other provider that does not treat Medi-Cal patients or provide any other services regulated by the Department of Health Care Services is not required to comply with this law.

[Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]

Statutes of Limitations

Sometimes hospitals and other health care providers will want to be able to produce records to defend themselves in a lawsuit. It is helpful to understand the time period during which various types of lawsuits may be brought in order to develop an effective retention policy. The time period during which a lawsuit may be brought is called the "statute of limitations." After the statute of limitations has run, it is too late for a plaintiff to bring a lawsuit, and related records will thus not be needed to defend any such suit.

This section of the manual describes several statutes of limitations commonly applicable in the California health care industry. However, it is not possible to list every potentially applicable statute of limitations. Legal counsel should be consulted if a question arises regarding the statute of limitations in a particular situation.

Medical Malpractice Action

In California, a medical malpractice lawsuit (also known as a professional negligence action) must be brought within three years after the date of injury, or one year after the patient discovers, or through the use of reasonable diligence should have discovered, the injury,

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whichever occurs first. Minors have three years to bring a lawsuit, but a minor under the age of six years has three years or until the eighth birthday, whichever is later. The applicable time period is indefinite in cases of fraud, intentional concealment, or the presence of a foreign body that has no therapeutic or diagnostic purpose. [Code of Civil Procedure Section 340.5]

It is important to note that California courts have interpreted the medical malpractice statute of limitations fairly leniently in favor of the patient, and allowed actions to be brought many years after the medical care at issue was provided.

Personal Injury Action

In California, a personal injury lawsuit must be brought within two years [Code of Civil Procedure Section 335.1]. This type of lawsuit includes slip-and-fall injuries on hospital premises, car accidents by employees in hospital-owned vehicles, etc.

Breach of Contract Action

In California, a lawsuit for breach of contract must be brought within four years if the contract is evidenced by writing [Code of Civil Procedure Section 337]. This does not mean that the contract must be a formal, written contract signed by both parties. It means that there must be some written evidence (a letter, e-mail, purchase order, etc.) regarding the contract. If the contract is not evidenced by writing, the statute of limitations is two years [Code of Civil Procedure Section 339].

Federal Fraud and Abuse Actions

The federal government must bring an action against a health care provider for civil monetary penalties within six years from the date on which the claim at issue was presented, the request for payment was made, or the incident occurred [42 C.F.R. Section 1003.1570]. The statute of limitations for False Claims Act suits is also six years after the violation was committed (or within three years after the date when material facts were known or should have been known by the government, but in no case later than 10 years after the violation was committed) [31 U.S.C. Sections 3729 and 3731].

However, health care providers should be aware that there are many different fraud statutes under which the federal government may bring a lawsuit, and each has its own limitations period — for example, criminal fraud, mail fraud, wire fraud, racketeering, etc. *(see, for example, 18 U.S.C. Sections 1031 and 3282)*. There are circumstances under which the government may bring a lawsuit after more than six years have elapsed. Legal counsel should be consulted if questions arise with respect to fraud and abuse statutes of limitations.

Internal Revenue Service Actions

The IRS must generally bring an action within three years from the date of filing of tax returns. However, if a false or fraudulent return is filed, if a willful attempt to evade tax takes place, or no return is filed, the IRS may bring an action at any time. [26 U.S.C. Section 6501]

Accreditation Requirements

Hospitals and other health care providers should review all relevant accreditation requirements to determine whether they contain any record retention obligations. If they do, the providers' policies and procedures should be reviewed and revised as necessary to maintain compliance.

The Joint Commission (TJC) generally requires that hospitals determine appropriate records retention periods based on applicable laws, as well as anticipated uses for patient care, legal, research, operational and educational purposes. TJC notes that documents such as crash cart daily checks, temperature monitoring logs, and meeting minutes and agendas are examples of documents that are not considered part of a patient's medical record, but are required to document compliance with TJC standards. TJC requires organizations to keep all records needed to document compliance with standards dating back to the last full survey. Because surveys may be no more than 39 months apart, hospitals accredited by TJC should keep these records for at least 39 months.

Contracts and Grants

Health care providers should carefully review their contracts and grants to determine whether they contain any record retention obligations. If they do, the providers' policies and procedures should be reviewed and revised as necessary to maintain compliance with the contractual obligation.

Three common record retention contractual provisions in the health care industry are described below.

Medicare Access Clause

A hospital may be both a Medicare-participating provider and a subcontractor under the Medicare program at the same time, if the hospital accepts Medicare patients and also provides services under a contract with another Medicare-participating provider.

The records a participating hospital must retain are included in the Recommended Retention Schedule *(see, for example, "Medicare cost report records," page 29)*.

A hospital that is a subcontractor, or a hospital that enters into agreements with subcontractors, must include an "access" clause in its contracts that allows federal government agencies to access the subcontractor's books and records. Specifically, contracts for services between a Medicare institutional provider and a subcontractor must contain an access clause if the value of the services is $10,000 or more over a 12-month period. This includes contracts for both goods and services in which the service component is worth $10,000 or more.

The clause must permit the Comptroller General of the United States, the U.S. Department of Health and Human Services, and their duly authorized representatives to access to the subcontractor's contract, books, documents, and records until four years after the services are furnished under the contract or subcontract.

If a contract subject to these requirements does not contain the clause, CMS will not reimburse the provider for the cost of the services furnished under the contract and will recoup any payments previously made for services under the contract.

[42 C.F.R. Section 420.302]

Contracts with Medicare Advantage or Medicare Part D Plans

Federal regulations governing the Medicare Advantage (MA) program and Medicare Part D (Medicare prescription drug benefit) require the plans to include a provision in their contracts with first tier, downstream and related entities to maintain records for a minimum of 10 years from the final date of the contract period or completion of audit, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2)]. This includes books, contracts, computer or

other electronic systems, medical records, patient care documentation, and other records that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract [42 C.F.R. Sections 422.504(e)(2)–(4) and 423.505(e)(2)–(4)]. Under certain circumstances, CMS may notify the contractor that it must keep its records longer. *(See also* Medicare Managed Care Manual*, Pub. 100-16, Chapter 11, Section 100.5.)*

Hospitals and other health care providers that have contracted with MA or Medicare Part D plans should ensure that relevant records are maintained in accordance with contractual obligations.

Accountable Care Organizations

Accountable Care Organizations (ACOs) must agree to retain their records for 10 years after the agreement with the Centers for Medicare & Medicaid Services ends, or 10 years after any audit, evaluation, or inspection is concluded, whichever is later. In addition, the ACOs must require their ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities to do the same. Required records include books, contracts, records, documents, and other evidence (including data related to Medicare utilization and costs, quality performance measures, shared savings distributions, and other financial arrangements related to ACO activities) sufficient to enable the audit, evaluation, investigation, and inspection of the ACO's compliance with program requirements, quality of services performed, right to any shared savings payment, or obligation to repay losses, ability to bear the risk of potential losses, and ability to repay any losses to CMS.

The Centers for Medicare & Medicaid Services (CMS) may notify an ACO that it must keep its records longer. In addition, if there has been a termination, dispute, or allegation of fraud or similar fault against the ACO, its ACO participants, its ACO providers/suppliers, or other individuals or entities performing functions or services related to ACO activities, the ACO must retain records for an additional six years from the date of any resulting final resolution of the termination, dispute, or allegation of fraud or similar fault. [42 C.F.R. Section 425.314]

U.S. Department of Health and Human Services Grants

Recipients of grants from the U.S. Department of Health and Human Services must retain financial, statistical and nonexpendable property records, and any other records pertinent to the grants, for three years from the submission of the final expenditure report, or until resolution of all litigation and federal audit findings. Records for real property and equipment acquired with federal funds must be retained for at least three years after final disposition. [45 C.F.R. Section 75.361] Subrecipients and contractors are also subject to this record retention requirement. Recipients, subrecipients, and contractors may wish to retain many of these records longer in accordance with the Recommended Retention Schedule.

B. Frequency of Use

When establishing retention periods, providers should consider how often records will be needed. Records that are used more frequently should be retained in a more quickly accessible form for longer periods of time. As the frequency of use declines, providers may transfer more important records to an image storage media or to outside storage, or consider whether the records should be destroyed.

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C. Space Constraints

The Schedule acknowledges that most providers have limited storage space, both physical and electronic. The amount of space available will influence whether a record should be purged after the minimum required retention period or whether it should be retained longer.

D. Historical or Research Use of Records

These guidelines generally do not address the retention of records for historical or research purposes. However, these considerations may be important to providers. Therefore, providers should consider whether to keep records for historical documentation and/or research activities. The costs of storage, plus the cost of employee and attorney time to review records if a subpoena is received, should be considered.

IV. MEDICAL RECORDS

A. Retention Period Options

Some California health care providers choose to keep their medical records permanently. However, this is not legally required.

Requirements for Providers That Treat Medi-Cal Patients

Until 2018, hospitals and other health facilities were required by CDPH licensing laws to retain medical records of adults for 7 years after discharge or the last patient encounter, and until the age of 19 but no less than 7 years after discharge or the last patient encounter for minors.

However, a state law that took effect on Jan. 1, 2018, requires hospitals and other providers of health care services rendered under Medi-Cal or any other Department of Health Care Services program to keep all medical records of covered patients for at least 10 years starting from the date the record was created until the latest of:

1. The final date of the contract period between the plan and the provider,
2. The date of completion of any audit, or
3. The date the service was rendered.

Because most hospitals and other health care providers serve Medi-Cal beneficiaries, and the contract period or audit process may add several years to the 10-year time frame, CHA's Record Retention Schedule shows a 15-year recommended retention period for medical records. This recommendation is reflected in the fourth column of the Recommended Retention Schedule. Providers using the Schedule that do not serve Medi-Cal patients may wish to consider a shorter retention period. *(See also "Contracts with Medicare Advantage or Medicare Part D Plans," page 6, and "Accountable Care Organizations," page 7.)*

[Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]

This law applies to any individual, partnership, group, association, corporation, institution or other entity that provides goods, services, supplies or merchandise, directly or indirectly, including all ordering, referring and prescribing, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal program [Welfare and Institutions Code Section 14043.1(o)].

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Additionally, skilled nursing facilities that participate in Medicare or Medi-Cal must keep records of minors until they reach the age of 21 [42 C.F.R. Section 483.70(i)].

The medical records of patients not covered by Medi-Cal or other Department of Health Care Services programs do not need to be kept for this longer period of time *(see below)*.

Requirements for Providers That Do Not Treat Medi-Cal Patients

State licensing laws govern how long providers must keep medical records for patients not covered by Medi-Cal or other Department of Health Care Services programs.

Health facilities, home health agencies, primary care clinics and psychology clinics [Title 22, California Code of Regulations, Sections 70751(c) (general acute care hospitals), 71551(c) (acute psychiatric hospitals), 72543(a) (skilled nursing facilities), 73543(a) (intermediate care facilities), 74731(d) (home health agencies), 75055(a)(primary care clinics), 73543(a) (psychology clinics), 77143(c) (psychiatric health facilities) and 79351(c) (chemical dependency recovery hospitals)] must keep medical records as follows:

1. **Adults:** 7 years after discharge or the last patient encounter,
2. **Minors:** Until the age of 19 but no less than 7 years after discharge or the last patient encounter. However, skilled nursing facilities that participate in Medicare or Medi-Cal must keep records of minors until they reach the age of 21 [42 C.F.R. Section 483.70(i)].

California law is inconsistent with respect to record retention requirements for individual practitioners. There is no required retention period for medical records maintained by a physician in a private office setting. However, the California legislature has passed legislation requiring other types of individual practitioners to retain medical records for the same length of time as health facilities [Business and Professions Code Sections 2570.185 (occupational therapists), 2620.7 (physical therapists), 2919 (licensed psychologists), 3007 (optometrists) and 3641 (naturopathic doctors)]. Individual practitioners not specified above are advised to retain medical records for at least seven years after the last patient encounter, and until the patient has reached the age of 19 (but no less than seven years after the last encounter) for minors.

There are medical record retention requirements in the Medicare Conditions of Participation and the *Interpretive Guidelines* for various types of facilities and clinics. These retention requirements are shorter than the California requirements, so they are not listed in detail in this manual.

Alternative Retention Period

An alternative option calls for a universal 25-year record retention policy. A 25-year retention policy has several advantages:

It relieves the provider of the need to differentiate between the medical records of adult patients and those of minor patients, and for Medi-Cal patients and other patients, as it satisfies applicable legal requirements for all classes.

It reduces even further the possibility that a lawsuit will be filed after the medical records are destroyed.

It ensures the longer retention of medical records containing information regarding medical treatment or medications received during pregnancy.

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Each provider must weigh the appropriate factors and determine whether the simplicity and convenience of a 25-year period outweigh the advantages of a shorter period.

B. Test Results, Tracings and Recordings

Providers regularly accumulate the results of diagnostic tests performed upon patients, including radiological studies, laboratory analyses, and tracings and recordings of various kinds. Most will be the subject of an interpretation or report.

California regulations require most types of health facilities to place reports of test results in medical records [Title 22, California Code of Regulations, Sections 70749(a)(8) and (9) (general acute care hospitals), 71549(a)(10) and (11) (acute psychiatric hospitals), 72547(a)(7) and (8) (skilled nursing facilities), 73547(a)(8) and (9) (intermediate care facilities) and 77141(a)(19), (20) and (21) (psychiatric health facilities)]. Accordingly, reports of all diagnostic test results and clinical laboratory test results must be kept as long as the medical record.

X-Ray Films, CT Scans and MRI Results

Under the regulations governing the licensure of general acute care hospitals and acute psychiatric hospitals, "X-ray films or reproduction thereof" must be preserved for at least seven years after discharge, or one year after a minor reaches the age of 18 (but not less than seven years) [Title 22, California Code of Regulations, Sections 70751(c) (general acute care hospitals) and 71551(c) (acute psychiatric hospitals)]. Similarly, skilled nursing facilities, intermediate care facilities and primary care clinics are required to keep all "exposed X-ray film" for seven years [Title 22, California Code of Regulations, Sections 72543(a) (skilled nursing facilities), 73543(a) (intermediate care facilities) and 75055(a) (primary care clinics)]. Most imaging no longer uses "film," but these regulations are still on the books. Although the law is not clear, all imaging records, including CT, PET and MRI, probably should be saved for the prescribed period. Whether radiological studies are kept for a longer period will depend on the same considerations discussed in III. "Primary Considerations in Developing a Record Retention Schedule," page 2.

Clinical Laboratory Test Results

There are specific federal and state laws covering retention of laboratory test results by clinical laboratories [Title 42, Code of Federal Regulations, Section 493.1105; Business and Professions Code Section 1265(j)]. These regulations apply to freestanding laboratories and laboratories situated in hospitals. The laws require laboratories to retain certain information for minimum periods of time, ranging from two to 10 years. These time periods are described in the Schedule.

When a hospital patient is tested at a hospital laboratory, test results will be placed in the patient's hospital medical record where it will be subject to the longer medical record retention periods. A hospital laboratory, therefore, can dispose of information concerning inpatients and outpatients as soon as the minimum legal periods pass.

The situation is different, however, with information concerning individuals who are tested at freestanding laboratories or are referred to a hospital laboratory just to be tested or when just the specimen goes to the hospital laboratory. These patients have no separate medical record on the premises. Therefore, the laboratory should consider keeping its records for a period longer than the minimum prescribed by the law.

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Tracings and Recordings

There are no laws requiring a minimum retention period for tracings or recordings like EKGs, EEGs, EMGs or videotapes of diagnostic tests, surgeries or other procedures. Depending on the test involved, these materials can be quite bulky. Accordingly, it makes sense to have the responsible physician identify the portions that demonstrate significant or unusual results. The provider should keep those portions for as long as it keeps the medical record. The remainder, which most likely would include most of the tracings or recordings, could be disposed of as soon as the patient is discharged or the treatment is complete. If an adverse event takes place, however, the provider may wish to retain the entire tracing or recording.

Fetal Heart Monitor Strips

Hospitals may wish to retain in the medical record just those portions of the fetal heart monitor strips chosen by the physician. Alternatively, hospitals may choose to retain these tracings in their entirety for at least 10 years, or even 25 years. The latter options make it more likely that full monitoring records will be available during the period allowed by the statute of limitations for minors to bring suit.

V. ELECTRONIC RECORDS

Many records created by health care providers formerly stored on paper are now created and stored electronically, and communicated through electronic means both within and beyond the provider's location. Civil Code Section 1633.12 states that if a law requires that a record be retained, the requirement is satisfied by retaining an electronic record, if the electronic record accurately reflects the information set forth when the record was first generated in its final form as an electronic record.

A. Electronic Medical Records Requirements

Providers (including hospitals, clinics and home health agencies) that use electronic systems only must meet the following requirements (these requirements do not apply to medical records if hard copy versions are retained):

1. Any use of electronic record keeping to store medical records must ensure the safety and integrity of those records at least to the extent of hard copy records.
2. The provider must ensure the safety and integrity of all electronic media used to store medical records by employing:
    a. An offsite backup storage system,
    b. An image mechanism that is able to copy signature documents, and
    c. A mechanism to ensure that once a record is input, it is unalterable.
3. Access to electronically stored records must be made available to the Division of Licensing and Certification of CDPH staff promptly, upon request.
4. The provider must develop and implement policies and procedures to include safeguards for confidentiality and unauthorized access to electronically stored medical records, authentication by signature keys and systems maintenance.

Original hard copies of medical records may be destroyed once the record has been electronically stored. The printout of the computerized version is considered the original for

the purposes of providing copies to patients, the Division of Licensing and Certification of CDPH and for introduction into evidence in administrative and court proceedings.

This law does not exempt providers from the requirement of maintaining original copies of medical records that cannot be electronically stored. [Health and Safety Code Section 123149]

(See A. "Change or Deletion of Medical Information: Audit Trails," page 13, regarding the requirement that electronic medical record systems must automatically record and preserve any change or deletion of any electronically stored medical information.)

B. Retention of Electronic Records

Electronic information may be stored in greater quantities, placed in varied configurations and retrieved rapidly when needed. Most importantly for this discussion, there may no longer be as great a need to purge records because of space constraints. Because electronic records require much less space, the temptation is to retain more information for longer periods. However, the question of purging information from an electronic system is identical to that of discarding or destroying hard copy. The same record retention periods apply irrespective of whether a record is electronic, paper, microfiche, microfilm, etc.

Retention policies for electronic records should focus both on transferring information for longer-term storage and on purging information from the system.

VI. DUPLICATE, TRANSITORY AND NONSUBSTANTIVE RECORDS

Health care providers create many duplicate, transitory and nonsubstantive records.

Duplicate records do not need to be retained. Only one version of a record, preferably the original, must be retained. However, providers may prefer to retain electronic versions of records that were originally produced on paper or other hard copy. Records may be transferred from hard copy to electronic format without legal risk, if appropriate backup and other security measures are maintained *(see V. "Electronic Records," page 11)*.

Health care providers also create many transitory and/or nonsubstantive records. These are records that do not establish policy, guidelines, or procedures; do not certify a transaction; do not constitute a receipt; and do not contain final substantive information. Transitory records may include personal notes, meeting notices, cover memos, lunch invitations, preliminary drafts, telephone messages, etc.

Transitory and nonsubstantive records may be discarded when no longer needed, unless there is a legal hold in place *(see VII. "Legal Hold," page 12)*.

VII. LEGAL HOLD

If a hospital or other health care provider has reason to believe that it may be sued or may be the subject of an audit or investigation, legal counsel should be consulted immediately to determine whether to initiate a legal hold. If a legal hold (also called a "litigation hold") is initiated, the usual retention and disposal policies are suspended for records relevant to the potential claim, dispute, lawsuit, audit or investigation. All potentially relevant records (paper and electronic) should be retained in their original form until legal counsel authorizes their destruction or deletion in accordance with the usual record retention schedule.

The occurrence of any of the following should provoke the hospital to consider a legal hold:

1. Service of legal process (subpoena, summons, or the like)
2. Learning of an investigation or audit by a government agency, government contractor, or private entity
3. Receipt of a claim (formal or informal)
4. Receipt of a patient complaint (not including minor complaints)
5. A dispute

All records relevant to the issue should be retained. This includes paper records as well as electronic data and documents (including e-mails). If a medical device, product, equipment, drug, other supply, or patient specimen may be involved, it should be sequestered. Employees and other personnel should be notified to suspend destruction of potentially relevant records, and all steps related to compliance with the legal hold should be documented.

VIII. DELETION, DISPOSAL AND DESTRUCTION OF RECORDS

State and federal privacy laws governing information containing protected health information (e.g., medical records, patient-identifiable billing records, labeled prescription bottles, hospital ID bracelets, etc.) and customer/consumer records impose on providers a duty to ensure that records are properly destroyed and are not improperly disclosed during the destruction process. This portion of the Record and Data Retention Schedule provides a brief, general overview of the laws and recommended procedures surrounding destruction of records. This information applies irrespective of whether the records are in electronic or hard copy form.

A. Change or Deletion of Medical Information: Audit Trails

An electronic health record system or electronic medical record system must automatically record and preserve any change or deletion of any electronically-stored medical information. The record of any change or deletion must include:

1. The identity of the person who accessed and changed the medical information,
2. The date and time the medical information was accessed, and
3. The change that was made to the medical information.

[Civil Code Section 56.101]

For purposes of this requirement, **"electronic medical record"** or **"electronic health record"** means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff [42 U.S.C. Section 17921(5)].

Failure to comply with the above requirements may result in significant financial penalties under the Confidentiality of Medical Information Act (CMIA).

B. Disposal or Destruction of Personal Information

State and federal privacy laws governing individually-identifiable health information and customer/consumer records impose a duty on health care providers to ensure that records

are properly destroyed, and are not improperly disclosed during the destruction process. This portion of the manual discusses the laws and recommended procedures for destruction of records. This information applies to records either in electronic or hard copy form.

Medical Records

The CMIA states that every health care provider, health care service plan, pharmaceutical company, or contractor who creates, maintains, preserves, stores, abandons, destroys or disposes of medical information must do so in a manner that preserves the confidentiality of the information contained therein. [Civil Code Section 56.101]

Failure to comply with the requirements described above may result in penalties under Civil Code Section 56.36, which include civil lawsuits by patients and fines of up to $250,000 per violation. Health care facilities may also be fined up to $250,000 by the California Department of Public Health for a privacy breach [Health and Safety Code Section 1280.15].

The HIPAA regulations do not require any particular method of destruction. However, the Department of Health and Human Services (DHHS) has released guidance stating that if one of the methods of destruction described below is used, and the media containing the PHI is later released to, or accessed by, a third party, it will not be considered a breach under the HITECH regulations. The media on which the PHI is stored or recorded must have been destroyed in one of the following ways:

1. Paper, film, or other hard copy media have been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed. Redaction is specifically excluded as a means of data destruction.
2. Electronic media have been cleared, purged, or destroyed consistent with NIST Special Publication 800-88, “Guidelines for Media Sanitization,” such that the PHI cannot be retrieved.

Providers are not required to follow the guidance. However, if the specified technologies and methodologies are used, no breach notification obligation exists even if a breach occurs. This is referred to as a “safe harbor.”

The Secretary of DHHS must annually update this guidance. The guidance can be found on the DHHS website at https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html. DHHS has also published a document, “Frequently Asked Questions About the Disposal of Protected Health Information,” that may be found at https://www.hhs.gov/hipaa/for-professionals/faq/disposal-of-protected-health-information/index.html.

Federally-Assisted Substance Use Disorder Program Records

Special requirements apply when a federally-assisted substance use disorder program is discontinued or is acquired by another entity [42 C.F.R. Section 2.19]. Legal counsel should be consulted in these circumstances.

Customer Records

The Information Practices Act requires any business that maintains customer records which include personal information to take all reasonable steps to destroy, or arrange for the destruction of, such records by:

1. Shredding;

2. Erasing; or
3. Otherwise modifying the personal information in those records to make it unreadable or undecipherable through any means.

[Civil Code Section 1798.80-1798-84]

This law applies to medical records and other records that could identify a customer, such as records containing a name, Social Security number, contact information, insurance policy number, driver's license number, credit card number, certain passwords and security questions and answers, etc.

Employee Records

The California Constitution has been interpreted to provide employees a right to privacy. It is recommended that records containing employee-identifiable information be treated in the same manner as records containing medical information or customer/consumer information.

Information Derived from Consumer Credit Reports

Regulations adopted under the Fair and Accurate Credit Transactions (FACT) Act of 2003 require businesses that possess consumer information derived from consumer credit reports to properly dispose of the information. A person must take reasonable measures to protect against unauthorized access to or use of the information in connection with the disposal. Compliance with the Information Practices Act (described under "Customer Records," page 14) will likely ensure compliance with the FACT Disposal Rule. However, legal counsel should be consulted if questions arise. [16 C.F.R. part 682]

C. Process

A health care provider may dispose of records itself, or may engage an outside company to dispose of records. Any such company would be acting as the provider's business associate, and a written business associate agreement should be executed. The provider has a duty to ensure the company is competent to perform the task and its proposed method of disposal ensures the confidentiality and security of the records and their ultimate destruction.

A certificate of records destruction should be completed for records destroyed or deleted pursuant to the records management policy. In addition, the disposal of records should be documented in a log. A sample certificate of records destruction that providers may adapt to fit their needs may be found at http://library.ahima.org/doc?oid=105016#.WxceSKrruUk.

IX. CHA'S RECOMMENDED RETENTION SCHEDULE

A. General Retention Period

CHA's Recommended Retention Schedule (starting on page 21) recommends a retention period of six years for general records that might prove valuable for litigation, statistical or business purposes, but are not required to support Medi-Cal or Medicare claims. CHA has chosen this period because the utility of most records declines significantly after six years. The six-year period meets or exceeds the normal statute of limitations for civil actions. However, it would not be sufficient when a claimant alleges fraudulent concealment of a wrongful act, or some other occurrence prolongs the limitation period. CHA's Recommended Retention Schedule recommends a retention period of 15 years for records that support claims for Medi-Cal or Medicare services *(see A. "Legal Requirements and Considerations," page 3)*.

After establishing a general retention period, the Schedule was refined to account for particular demands. For example, it is suggested that providers preserve annual reports and significant statistical compilations longer, as these materials do not demand significant storage space and may be useful for historical, research, or business planning purposes. Additionally, special legal requirements that govern the retention of various records have been taken into account. Also recommended is fairly lengthy retention of credentialing and other medical staff records, as these contain information that is increasingly the subject of litigation. Finally, a two- or three-year retention period is assigned to various other records that are usually of only short-term interest.

NOTE: CHA's Recommended Retention Schedule does not include record retention requirements mandated by the U.S. Securities and Exchange Commission or the Sarbanes-Oxley Act, which applies only to investor-owned organizations that are publicly traded. These organizations should consult legal counsel regarding additional record retention requirements.

B. How to Interpret the Schedule

Column 1: "Record"

This column describes a document, record, or data that a hospital may generate.

Column 2: "Provider Types"

This column describes the types of providers that must comply with the retention requirement described in the row.

Column 3: "Legal Requirements"

This column provides any legal requirements that pertain to the providers listed in column 2 regarding the document described in column 1. The provider is legally required to follow the retention period stated in this column.

Column 4: "Recommended Retention Period"

This column provides CHA's recommendation regarding how long to keep the document described in column 1. Please note that this is only a recommendation, not a legal requirement. A particular provider may wish to keep the document longer than the recommended retention period. On the other hand, a provider may wish to destroy or delete the document sooner than the recommended retention period. Each health care provider should consider the factors described in III. "Primary Considerations in Developing a Record Retention Schedule," page 2, and develop its own retention schedule. It is not mandatory to comply with CHA's recommended retention period.

C. Frequently Asked Questions

Q1: Is every document that a hospital may generate included in the Schedule?

A1: No. It is not possible to list every document that a hospital may generate. The Schedule contains those documents that are commonly used by hospitals and other health care providers, and those documents to which the government has assigned a required record retention period.

Q2: Why is the time period under the fourth column, "Recommended Retention Period," sometimes longer than the legally-required retention period stated in the third column, "Legal Requirements"?

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A2: It is common to find that the retention period listed under "Recommended Retention Period" is longer than the legally-required retention period listed in the "Legal Requirements" column. This is because there are other factors to be considered when determining the minimum retention period in addition to the legal requirement that is specific to that document *(see III. "Primary Considerations in Developing a Record Retention Schedule," page 2)*.

Q3: Does the "Legal Requirements" column list all possible laws that apply to the document described in the first column?

A3: No. The "Legal Requirements" column lists only the laws that are specific to the document described in column 1. However, it does not list all of the laws that represent more general retention considerations, such as statutes of limitations. The laws that represent more general retention considerations are discussed under III. "Primary Considerations in Developing a Record Retention Schedule," page 2.

Q4. How long should I keep a document that is not included in the Schedule?

A4. CHA recommends reviewing the Schedule to find a similar document or a document used for a similar purpose, and keeping the document in question for as long as the similar document must be kept.

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Record Retention Schedule

Health care providers, particularly hospitals, are among the most heavily regulated entities in the United States. State and federal laws specify who is qualified to deliver safe and effective health care, and under what circumstances that care may be provided. In addition, providers are required to meet standards imposed under corporate, labor, tax, workers' compensation, environmental, and criminal law and many, many others.

In order to show that legally-required standards are being met, facilities must document compliance with the law. Records are required by law to be kept by every department of a California health care provider's facility. Sometimes the government specifies precisely how those records are to be maintained and for how long. Most of the time the government does not.

The Schedule that follows gives recommended retention periods for records that are common to health care providers and have statutorily- or regulatorily-mandated retention periods, or are representative of documents that have no legal retention requirements.

Retention Tip: For a document not listed in the Schedule, CHA recommends using the retention period listed for a similar document or for a document required for a similar purpose.

The Schedule gives recommendations for a wide variety of health care providers. In the "Provider Types" column, the following definitions apply:

1. **"All providers"** includes:
    a. Health facilities, as defined below,
    b. Home health agencies,
    c. Primary care clinics,
    d. Psychology clinics,
    e. Individual practitioners,
    f. Groups of practitioners,
    g. Surgery centers, and
    h. Unlicensed outpatient facilities.

2. **"Health facilities"** means a facility that treats persons who are admitted for a 24-hour stay or longer. The term "health facilities" includes the following types of providers:
    a. General acute care hospitals (GACHs),
    b. Acute psychiatric hospitals (APHs),
    c. Skilled nursing facilities (SNFs),
    d. Intermediate care facilities (ICFs),
    e. Special hospitals,
    f. Congregate living health facilities,
    g. Correctional treatment centers,
    h. Psychiatric health facilities (PHFs), and
    i. Chemical dependency recovery hospitals (CDRHs).

[Health and Safety Code Sections 1250 and 1250.2]

The following acronyms are used in the Schedule:

1. **"C.C.R."** means California Code of Regulations.
2. **"C.F.R."** means Code of Federal Regulations.
3. **"U.S.C."** means United States Code.

Retention Tip: *See "Where to Find the Laws Referenced in the Manual," page 75, for instructions on how to find the exact language of the statutes and regulations on the internet.*

ADMINISTRATIVE RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Accident reports		*See "Incident reports," page 24. If an employee is injured, see "Workers' compensation claims files," page 50.*	
Accountable Care Organization (ACO) utilization, quality and financial records	ACO participants, providers and suppliers	Must keep for at least 10 years from end of contract term or completion of audit, whichever is later [42 C.F.R. Section 425.314]	15 years
Accreditation/licensing surveys and plans of correction (TJC, AOA, DNV, CMS, CDPH, IMQ, CAP, etc.)	All providers		6 years (longer if continuing interest)
Adverse event reports to CDPH	Hospitals		6 years after any appeal is concluded
Aerosol transmissible disease and biosafety plan annual review	All providers	Must keep for at least 3 years [8 C.C.R. Section 5199(j)(3)]. *See regulation for required content of record.*	6 years
Appraisal reports (property, building, equipment, etc.)	All providers		Life of asset plus 10 years
Arbitration resolution documents	SNFs that particfipate in Medicare/Medicaid	When facility and resident resolve a dispute by arbitration, must keep arbitration agreement and arbitrator's decision for at least 5 years [42 C.F.R. Section 493.70(n)].	6 years after discharge of patient, longer if readmission is anticipated.
Birth records to local government	Hospitals, practitioners		Permanent
Cancer/tumor registry	Hospitals, practitioners		Permanent
Census (daily)	GACHs, APHs, PHFs, CDRHs	Regulations require these facilities to keep "patient admission rosters," but do not specify a retention period [22 C.C.R. Sections 70733, 71531, 77127, and 79337].	6 years
Certificate of records destruction	All providers		Permanent
Committee agendas, minutes (not otherwise specified in this retention schedule)	All providers		6 years
Communicable disease reports to state and local health departments	All providers		3 years
Construction project contracts and related documents	All providers		Life of building plus 10 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Contracts, leases, and supporting documentation	All providers	Contracts for services between a Medicare institutional provider and a subcontractor must be kept for the life of the contract, plus 4 years, if the value of the services is $10,000 or more over a 12-month period. This includes contracts for both goods and services in which the service component is worth $10,000 or more [42 C.F.R. Section 420.302(b)]. Contracts required by the HIPAA privacy rule must be kept for 6 years [45 C.F.R. Section 164.530(j)]. Regulations require GACHs, APHs, PHFs and CDRHs to keep contracts that are required by regulation, but no retention period is specified [22 C.C.R. Sections 70733, 71531, 77127, 79337]. Contracts that support claims for services rendered to Medicare or Medi-Cal patients must be kept for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	Life of agreement/lease/equipment, plus 6 years; if the agreement supports Medicare or Medi-Cal claims, then life of agreement/lease/equipment plus 15 years
Corporate records, including the following: Articles of Incorporation or partnership agreement; bylaws and rules and regulations of the governing body; minutes of meetings of the governing body	GACHs, APHs, PHFs, CDRHs	Regulations require these facilities to keep these documents, but do not specify retention periods [22 C.C.R. Sections 70733, 71531, 77127 and 79337].	Permanent
Court orders	All providers		Permanent, unless disposal approved by legal counsel
Death records to local government, death certificates	All providers		Permanent
Deeds or titles to property	All providers		Permanent
Disposal of records log	All providers		Permanent

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ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Donations, endowments, trusts, bequests, contributions	All providers		6 years. If a condition is attached to the gift, the records should be kept permanently.
EHR Incentive Program data (Medicare or Medicaid)	Hospitals, eligible professionals	Must keep for at least 6 years *(see FAQ No. 7711 under "Audits" on the CMS Promoting Interoperability Programs website at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ.html.)*	15 years
Grants		*See "Health and Human Services Agency grants," page 23.*	
Grievances and resolution documents	SNFs that participate in Medicare/Medicaid	Must keep for at least 3 years [42 C.F.R. Section 483.10(j)(4)(vii)]	6 years
Health and Human Services Agency grants	Health facilities	Keep financial, statistical and nonexpendable property records, and any other records pertinent to grants, for 3 years from the date of submission of the final expenditure report, or until resolution of all litigation and federal audit findings. Records for real property and equipment acquired with federal funds must be kept for at least 3 years after final disposition. [45 C.F.R. Section 75.361]	6 years

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
HIPAA privacy-related documents (notice of privacy practices; acknowledgment of receipt of notice of privacy practices; correspondence/ forms related to request for access to and amendment of protected health information (PHI); titles of persons/offices responsible for receiving and processing requests for access and amendment; accountings for disclosures; accountings provided to patients; titles of persons/offices responsible for receiving and processing requests for an accounting, correspondence/forms regarding a special restriction; authorization for use/disclosure of PHI; correspondence/forms related to grievances; business associate agreements; breach investigation and notification reports; etc.)	All providers	Must keep for at least 6 years from the date of creation or the date last in effect, whichever is later [45 C.F.R. Section 164.530(j)].	8 years
Incident reports	All providers	*See also "Unusual occurrence reports to CDPH/public health officer (PHO)," page 28.*	10 years
Inspection and approval by state or local fire control agencies	Medicare particiating hospitals	Regulations require written evidence of regular inspection and approval by fire control agencies to be kept, but no retention period is specified [42 C.F.R. Section 482.41].	6 years
Inspection reports by local, state or federal agents	GACHs, APHs, PHFs, CDRHs	Regulations require these facilities to keep inspection reports, but do not specify retention periods [22 C.C.R. Sections 70733, 71531, 77127 and 79337].	6 years
Inspection reports by local, state or federal agents	ICFs	Must keep the latest report of inspection by state or local health authorities with notations made of the actions taken to comply with any recommendations [22 C.C.R. Section 73515].	6 years

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ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Institutional review board (IRB) records	All providers	Must keep until research is completed, plus 3 years [21 C.F.R. Section 56.115]. *See regulation for required content of records. See also 21 C.F.R. Sections 312.62 and 812.140 (2-year retention period for related records).*	Completion of research, plus 10 years
Insurance policies, current and expired, and related claims and correspondence	All providers		Permanent
Intellectual property: copyright, trademark, service mark applications, approvals, and related documents	All providers		Duration of use of mark plus 10 years
Leases		*See "Contracts, leases, and supporting documentation," page 22.*	
Licenses or certificates	All providers		Life of license or certificate, plus 6 years
List of contracted services	Medicare-participating hospitals	Regulations require a list of contracted services to be kept, but do not specify retention periods [42 C.F.R. Section 482.12(e)].	6 years
Master patient index/medical record index number	All providers		Permanent
Meaningful use attestations (Medicare or Medicaid) and supporting data	Hospitals, eligible professionals	Must keep for at least 6 years *(see FAQ No. 7711 under "Audits" on the CMS Promoting Interoperability Programs website at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ.html)*.	15 years
Medical device reports (MDR) and records of MDR reportable events (MedWatch)	Health facilities, clinics, home health agencies, surgery centers	File relating to an adverse MDR event must be kept at least 2 years from the date of the event [21 C.F.R. Section 803.18(c)].	Life of device, plus 6 years

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ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medical device tracking records	Health facilities, clinics, home health agencies, surgery centers	Keep for the period of time the device is in use or in distribution for use. (For example, a record may be discarded if the device is no longer in use, has been explanted, returned to the manufacturer, or the patient has died.) [21 C.F.R. Section 821.60] *See 21 C.F.R. Section 821.30 for a list of information that must be kept in the device tracking record.*	Life of device, plus 6 years
Meeting minutes and agendas needed to document compliance with accreditation requirements	The Joint Commission accreditation organizations	Must keep until next full survey	4 years (unless longer period recommended for specific records elsewhere in this chart)
OSHPD reports (financial, patient discharge data, quality)	Hospitals		20 years
OSHPD reports (seismic)	Hospitals		Permanent
Patient admission roster		*See "Census (daily)," page 21.*	
Patient grievances/complaints — complaint, investigation materials, correspondence	Facilities		6 years after resolution
Patient property: deceased patient's property disposition	Health facilities	Records of disposition of deceased patient's property must be kept for at least 3 years [Probate Code Section 330(d)]. *See chapter 14 of CHA's* Consent Manual *for information about disposition of deceased patient's property.*	5 years after discharge
Patient property: patient cash and valuables receipts, personal property inventory	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	5 years after discharge
Patient property: receipts and disbursements of personal funds of Medi-Cal beneficiaries being held in trust by the provider	Facilities		15 years

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ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Permits	All providers		Life of permit, plus 6 years
Policies and procedures	GACHs, APHs, PHFs	Regulations require these facilities to keep policy and procedure manuals, but do not specify retention periods [22 C.C.R. Sections 70733, 71531 and 77127]. Policies and procedures required by the HIPAA privacy and security rules must be kept for at least 6 years [45 C.F.R. Sections 164.316(b) and 164.530(j)].	Life of policy or procedure, plus 6 years. Must be kept longer for transplant services.
Real estate transaction records, deeds, easements, zoning permits, building permits	All providers		Permanent
Reports, memos, correspondence (not otherwise specified in this retention schedule)	All providers		6 years (unless desired longer for trending or business planning purposes)
Safe patient handling-related documents	GACHs	Must keep for at least 1 year [8 C.C.R. Sections 3203(b) and 5120(e)(1)(B)]	6 years (may also wish to document attendance at training in employee's personnel file)
Statistical data/reports regarding admissions, discharges, outpatient visits, services rendered, transfers, etc. (not otherwise specified in this retention schedule)	All providers		6 years (unless desired longer for trending or business planning purposes)
Statistics on admissions and services	All providers		6 years (longer if needed for business planning purposes)
Summary record of decisions not to transfer a patient to another facility for airborne infection isolation for medical reasons	All providers	Must keep for at least 3 years [8 C.C.R. Section 5199(j)(3)]. *See regulation for required content of record.* The information must also be documented in the patient's medical record.	6 years
Survey, certification and complaint investigation reports; plans of correction	SNFs that participate in Medicare/Medicaid	Must keep at least 3 years [42 C.F.R. Section 483.10(g)(11)]	6 years
Survey reports		*See "Accreditation/licensing surveys and plans of correction (TJC, AOA, DNV, CMS, CDPH, IMQ, CAP, etc.)," page 21.*	

ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Training records — employees (not otherwise specified in this retention schedule)	All providers	Regulations require GACHs to keep documentation as described in 22 C.C.R. Section 70214(d), but do not specify a retention period.	6 years after date of training (may also wish to document attendance in employee's personnel file)
Treatment authorization requests (TARs)	Hospitals	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Unavailability of airborne infection isolation rooms/areas	All providers	Must keep for at least 3 years [8 C.C.R. Section 5199(j)(3)]. *See regulation for required content of record.*	6 years
Unusual occurrence reports to CDPH/public health officer (PHO)	GACHs, APHs	Must keep for at least 2 years [22 C.C.R. Sections 70733 and 71531]. The report made to CDPH/PHO should include only factual information that CDPH/PHO must have. These reports may be obtained by plaintiffs' attorneys from CDPH/PHO by use of a subpoena. The facility likely will also complete an incident report, root-cause analysis, etc. that may be protected from discovery. *See chapter 19 of CHA's* Consent Manual *about the proper establishment of an incident report or medical staff quality assurance report system.*	6 years

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ADMINISTRATIVE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Unusual occurrence reports to CDPH/public health officer (PHO)	SNFs, primary care clinics	Must keep for at least 1 year [22 C.C.R. Sections 72541 and 75053]. The report made to CDPH/PHO should include only factual information that CDPH/PHO must have. These reports may be obtained by plaintiffs' attorneys from CDPH/PHO by use of a subpoena. The facility likely will also complete an incident report, root-cause analysis, etc. that may be protected from discovery. *See chapter 19 of CHA's* Consent Manual *about the proper establishment of an incident report or medical staff quality assurance report system.*	6 years
Unusual occurrence reports to CDPH/public health officer (PHO)	PHFs and CDRHs	Must keep for at least 3 years [22 C.C.R. Sections 77137 and 79339]. The report made to CDPH/PHO should include only factual information that CDPH/PHO must have. These reports may be obtained by plaintiffs' attorneys from CDPH/PHO by use of a subpoena. The facility likely will also complete an incident report, root-cause analysis, etc. that may be protected from discovery. *See chapter 19 of CHA's* Consent Manual *about the proper establishment of an incident report or medical staff quality assurance report system.*	6 years
Workplace violence prevention records: hazard identification, evaluation and correction	Health facilities, HHAs, hospices	Must keep for at least 1 year [8 C.C.R. Sections 3203(b), 3342 and 5120(e)(1)(B)]	6 years

ADMITTING RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Admission and discharge records	GACHs, APHs, PHFs, CDRHs	Regulations require these facilities to keep "patient admission rosters," but do not specify a retention period [22 C.C.R. Sections 70733, 71531, 77127 and 79337].	6 years
Advance Beneficiary Notice	Hospitals	Must keep for at least 5 years from discharge or completion of delivery of care [*Medicare Claims Processing Manual*, Publication 100-04, Chapter 30, Section 50.6.4]. However, the original ABN must be retained in the medical record; thus, California hospitals should retain the ABN in accordance with medical record retention requirements.	File in patient's medical record
Conditions of admission agreements	Health facilities		File in patient's medical record
Emergency department log (must include name; date, time and means of arrival; age; sex; record number; nature of presenting complaint; disposition; time of departure; and names of patients who are dead on arrival)	Hospitals with emergency departments	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)]. Otherwise, must keep for at least 3 years. [Health and Safety Code Section 1317.4; 22 C.C.R. Sections 70413, 70453, and 70651.]	6 years
Emergency department transfer records (medical and other records related to individuals transferred to or from the hospital, including "Transfer Summary" required by Health and Safety Code Section 1317.2(f))	Hospitals with emergency departments	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)]. Otherwise, must keep for at least 3 years. [Health and Safety Code Section 1317.4; 22 C.C.R. Sections 70413, 70453, and 70651.]	Medical records: 15 years — adults 25 years — minors Other records: 6 years
Medicare secondary payer beneficiary questionnaire	All providers	Must keep for 10 years after date of service [*Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.2].	15 years

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BUSINESS AND FINANCE RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Accountable Care Organization (ACO) utilization, quality and financial records	ACO participants, providers and suppliers	Must keep for at least 10 years from end of contract term or completion of audit, whichever is later [42 C.F.R. Section 425.314]	15 years
Audit reports	All providers		7 years
Bank deposits	All providers		7 years
Bank statements	All providers		15 years
Bond records (including how bond-financed investments are used and disposed of; investment and expenditure of bond proceeds)	Tax-exempt facilities	Must keep for 3 years after final redemption *(see IRS webpage at https://www.irs.gov/tax-exempt-bonds/tax-exempt-bond-faqs-regarding-record-retention-requirements#6)*.	15 years after final redemption
Budgets	All providers		7 years
Cash receipts	All providers	Medi-Cal regulations require that "book records of receipts and disbursements" be retained for 10 years from the date of service, end of Medi-Cal contract period, or audit completion, whichever is later [Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]. A similar timeframe exists for records needed to support claims to certain Medicare patients. [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2)]. It is unclear what "book records of receipts" means.	15 years
Cashiers' tapes from bookkeeping machines	All providers		2 years
Chargemaster	Hospitals		15 years
Check registers	All providers		15 years
Checks — canceled • Payroll • Taxes, capital, purchases, important contracts • Other	All providers		 15 years Permanent 15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Claims, billings, and charges to patients, fiscal intermediaries, third-party payers, etc.	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Depreciation schedules — equipment	All providers		Life of equipment, plus 15 years
Disbursements — unclaimed/returned	All providers	Unclaimed checks and disbursements escheat to state after 3 years; the state then attempts to notify recipients [Code of Civil Procedure Section 1510 *et seq.*].	7 years
Employee expense reports	All providers		15 years
Employment tax records (federal)	All providers	Must keep for at least 4 years after due date of tax, or date tax is paid, whichever is later [26 C.F.R. Section 31.6001–1 *et seq.*].	15 years
Exempt Organization Annual Information Returns (IRS Form 990, State Form 199)	Tax-exempt organizations		Permanent
Financial statements (year-end)	All providers		Permanent
Income — daily summary	All providers		7 years
Income tax returns	All providers		Permanent
Invoices — accounts receivable/payable	Providers that participate in Medicare Advantage, Medi-Cal, accountable care organizations, or Medicare Part D	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years

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BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Invoices documenting purchase or lease of clinical laboratory equipment and test kits, reagents, or media	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *(See "Invoices — accounts receivable/payable" above.)*	15 years
Invoices — fixed assets, equipment	All providers		Permanent/life of asset or equipment, plus 15 years
IRS rulings, audit records	All providers		Permanent
Journals — general	All providers		15 years
Ledgers — general	All providers		15 years
Ledgers — individual ledger accounts reflecting credit and debit balances for each Medi-Cal beneficiary	Facilities	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Medi-Cal remittance advices	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Medicare Advantage-related documents	All providers that contract with a Medicare Advantage plan	Must keep for at least 10 years after end of contract term or audit, whichever is later. [42 C.F.R. Section 422.504(i)(2)]. *See "Contracts with Medicare Advantage or Medicare Part D Plans," page 6.*	15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medicare cost report records	Hospitals	Must keep for at least 5 years after the cost report is filed with the intermediary. The records that must be retained are: 1. Billing material: copies of claim forms, supporting documents and forms (e.g., charge slips, daily patient census records, and other business and accounting records referring to specific claims). 2. Cost report material: all data necessary to support the accuracy of entries on annual cost reports including original invoices, cancelled checks, copies of material used in preparing annual cost reports, and other similar cost items, schedules and related worksheets, and contracts or records of dealings with outside sources of medical supplies and services or with related organizations. 3. Medical record material: utilization review committee reports, physicians' certification and recertifications, discharge summaries, clinical and other medical records relating to health insurance claims. 4. Provider physician material: provider physician agreements on which Part A and Part B allocations are based. [*Medicare Claims Processing Manual*, Publication 100-04, Chapter 1, Section 110.3] *See also 42 C.F.R. Sections 413.20 and 413.24. (See also "Resident rotation schedules — location, nature of assignment, vacation, leave of absence, sick time, orientation time, classroom time, etc.," page 64.)*	15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medicare Part D-related documents (prescription drug benefit)	All providers that contract with a Medicare Part D plan	Must keep for at least 10 years after end of contract term or audit, whichever is later [42 C.F.R. Section 423.505(i)(2)]. *See "Contracts with Medicare Advantage or Medicare Part D Plans," page 6.*	15 years
Medicare secondary payer beneficiary questionnaire		*See "Medicare secondary payer beneficiary questionnaire," page 30.*	
Patient accounting files	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Payment receipt books	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Payroll records		*See "Human Resources Records," page 45.*	
Property tax payment records	All providers		Permanent
Purchase orders	All providers		Life of item, plus 7 years
Request for payment	Medicare provider or supplier of DMEPOS, lab, imaging, or home health services	Must keep at least 7 years [42 C.F.R. Section 424.516(f)]	15 years

BUSINESS AND FINANCE RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Returned goods credits	All providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Tax bills, statements, payments, receipts	All providers		Permanent
Tax-exempt status application, supporting documentation, determination letters from IRS and FTB	Tax-exempt organizations		Permanent
Tax returns	All providers		Permanent
Unemployment tax records	All providers	Must keep for at least 4 years after due date of tax, or the date tax is paid, whichever is later [26 C.F.R. Section 31.6001-1; 22 C.C.R. Section 1085–2(c)].	7 years
Volunteer funds raised		*See "Donations, endowments, trusts, bequests, contributions," page 30.*	
Wage and tax statements (W-2 forms)	All providers	Must keep for at least 4 years after due date of tax, or the date tax is paid, whichever is later [26 C.F.R. Section 31.6001–1].	7 years
Withholding allowance certificates (W-4 forms)	All providers	Must keep for at least 4 years after due date of tax, or the date tax is paid, whichever is later [26 C.F.R. Section 31.6001–1].	7 years after termination of employment or new certificate completed

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DEPARTMENT RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Ambulance replenishing records (other than linens)	Facilities	Must keep for at least 5 years [42 C.F.R. Sections 1001.952(v)]	15 years
Appointment books, patient logs, or similar documents showing date and time allotted for appointment of each Medi-Cal patient or group of patients, and time actually spent with such patients	Psychiatric and psychological service providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Appointment calendars (patients' appointments), sign-in sheets	All providers except providers of psychiatric and psychological services to Medi-Cal patients		6 years
Birth records to local government		*See "Birth records to local government," page 21.*	
Compliance audits/ investigations (internal)	All providers		6 years
Compliance hotline log (annual)	All providers		6 years
Crash cart daily records	The Joint Commission accredited organizations	Must keep until next full survey	4 years
Dialysis — hemodialyzer reuse records (procedure, training, equipment, audit records)	Dialysis clinics	Regulations require these documents to be kept, but do not specify a retention period [22 C.C.R. Section 75198]. *See 22 C.C.R. Sections 75189 and 75198 for details about content of required records.*	Life of dialyzer, plus 6 years
Dialysis — dialyzer reuse records (device history records, including patient name, dates of treatment, dates of disinfectant rinsing, type and model, reuse number, results of performance tests, initials or other ID of reprocessing technician, reason for dialyzer failure and subsequent acceptance)	Dialysis clinics	Must keep for at least 6 months after last reprocessing of dialyzer [22 C.C.R. Section 75198(b)(5)]. *See 22 C.C.R. Sections 75189 and 75198 for details about content of required records.*	Life of dialyzer, plus 6 years

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DEPARTMENT RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Emergency department log (must include name; date, time and means of arrival; age; sex; record number; nature of presenting complaint; disposition; time of departure; and names of patients who are dead on arrival)	Hospitals with emergency departments	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)]. Otherwise, must keep for at least 3 years. [Health and Safety Code Section 1317.4; 22 C.C.R. Sections 70413, 70453, and 70651.]	6 years
EMTALA-related records, including records of patients transferred in or out, emergency department log, policies and procedures, etc.	Hospitals with emergency departments	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)]. Otherwise, must keep for at least 3 years. [Health and Safety Code Section 1317.4; 22 C.C.R. Sections 70413, 70453, and 70651.]	6 years
Hardware and software operating instructions, warranties, system requirements, configurations, etc.	All providers		Life of product, plus 2 years
Human tissue intended for transplantation (records regarding donor screening and testing; records regarding supplier, donor and lot identification, receipt, name(s) of recipient(s), storage temperatures, distribution, destruction, disposition of human tissue, expiration dates of all tissues, etc.)	GACHs	Must keep at least 10 years after the date of transplantation (if known), distribution, disposition, or expiration of the tissue, whichever is latest [21 C.F.R. Section 1270.33].	Permanent
Infection control committee, minutes and reports of	GACHs, APHs	Regulations require these facilities to keep their documents, but do not specify retention periods [22 C.C.R. Sections 70733 and 71531].	6 years
Labor room log books	Hospitals	Hospitals that participate in Medicare must keep for at least 5 years [42 U.S.C. Section 1395cc(a)(1)(I)(ii); 42 C.F.R. Section 489.20(r)].	6 years

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DEPARTMENT RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medical transportation records (must include time and date of service for each Medi-Cal beneficiary; odometer readings at each pick-up and delivery location; provider-assigned vehicle ID code; name of operator providing the service, names of beneficiaries transported in total or partial group runs)	Medical transportation providers	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Meeting minutes and agendas needed to document compliance with accreditation requirements	The Joint Commission accreditation organizations	Must keep until next full survey	4 years (unless longer period recommended for specific records elsewhere in this chart)
Motor vehicle maintenance records	All providers		Life of vehicle, plus 6 years
Policy and procedures manuals		*See "Policies and procedures," page 27.*	
Requisitions (internal)	Health facilities		Discretionary
Surgical privileges list	Hospitals	The surgical service of hospitals that participate in Medicare must keep a roster of practitioners specifying the surgical privileges of each practitioner, but no retention period is specified [42 C.F.R. Section 482.51].	Each physician's surgical privileges should be kept in his or her medical staff file *(see "Medical Staff Records," page 63)*. The lists provided to the surgical service should be retained for at least 6 years.
Surgery • Register of operations • Operating room logs	GACHs	Regulations require hospitals to keep a register of operations, but do not specify retention periods [22 C.C.R. Section 70223(f)].	6 years
Temperature monitoring logs	The Joint Commission accredited organizations	`Must keep until next full survey	4 years

NOTE: Individual departments may wish to keep copies of the original records, which are kept at the administrative offices. The department should keep duplicate records only as long as the records are used on a regular basis.

DIETARY DEPARTMENT RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Bacteriological testing of ice	Health facilities		2 years
Dietetic service personnel (number of)	GACHs, APHs	Regulations require these facilities to keep records listing the number of dietetic service workers and their job titles and hours worked, but do not specify retention periods [22 C.C.R. Sections 70275 and 71245].	2 years
Food costs	Health facilities		6 years
Food purchased	GACHs, APHs, SNFs, ICFs	Must keep records of food purchased for at least 1 year [22 C.C.R. Sections 70273(g)(6), 71243(g)(6), 72341(h) and 73333(g)].	3 years
In-service training records for dietetic services personnel (subject areas covered, date and duration of each session, attendance list)	GACHs, APHs, ICFs	Regulations require these facilities to keep these records, but do not specify retention periods [22 C.C.R. Sections 70273(j), 71243(j) and 73335].	6 years after date of training (may also wish to document attendance in employee's personnel file)
Meal counts	Health facilities		2 years
Menus	GACHs, APHs, SNFs, ICFs	Must keep for at least 30 days [22 C.C.R. Sections 70273(g)(5), 71243(g)(5), 72341(g) and 73333(f)].	3 months
Recipes, including ingredients, portion size, nutritional analysis	Health facilities		2 years after discontinuation

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ENGINEERING RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Autoclaves and sterilizers: thermometer charts (daily checking of recording and indicating thermometers) and monthly bacteriological tests (including the bacterial organism used) (ICFs only: recording thermometers are not required on portable sterilizers and autoclaves)	GACHs, APHs, SNFs, ICFs	Must keep for at least 1 year [22 C.C.R. Sections 70833, 71637, 72619 and 73677].	Life of equipment, plus 6 years
Building blueprints, plans, specifications, inspections	All providers		Permanent (or until property is sold)
Calibration records (all gauging and measuring equipment must be regularly calibrated as specified by the manufacturer)	GACHs, APHs	Must keep for at least 2 years [22 C.C.R. Sections 70837 and 71641].	Life of equipment, plus 6 years
Emergency generator records — inspection, performance, exercising period and repairs	GACHs, APHs, SNFs, ICFs	Regulations require these facilities to keep these records, but do not specify retention periods [22 C.C.R. Sections 70841(e), 71645(e), 72641(f) and 73639(f)].	Life of generator, plus 6 years
Equipment records (purchase, operating instructions, maintenance, inspection, repairs, calibrations)	All providers		Life of equipment, plus 6 years
HVAC air filter maintenance records (record of inspection, cleaning, replacement, including static pressure drop. Record must include a description of filters originally installed, ASHRAE atmospheric dust spot test efficiency rating, and criteria established by manufacturer or supplier to determine when replacement or cleaning is necessary. If filter maintenance is performed by an outside company, the hospital may retain a certification from the company stating that these requirements have been met.)	GACHs, APHs, SNFs, ICFs	Regulations require these facilities to keep these records, but do not specify retention periods [22 C.C.R. Sections 70839(b), 71643(b), 72639(b) and 73637(b)].	Life of air filter, plus 6 years
Inspection reports of grounds and buildings	All providers		6 years

ENGINEERING RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Maintenance logs and manuals (heating, air conditioning, ventilation)	GACHs, APHs, SNFs, ICFs, PHFs	Regulations require health facilities to keep maintenance logs and a written maintenance manual, but do not specify retention periods [22 C.C.R. Sections 70837(d), 71641(d), 72655(b), 73653(b) and 77155(b)].	Life of equipment, plus 6 years
Records of inspection, testing and maintenance of non-disposable engineering controls including ventilation and other air handling systems, air filtration systems, containment equipment, biological safety cabinets, and waste treatment systems (include name and affiliation of person performing the test/ inspection/maintenance, date, significant findings, actions)	All providers	Must keep for at least 5 years [8 C.C.R. Section 5199(j)(3)(F)].	Life of equipment, plus 6 years
Work orders	All providers		2 years

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HOUSEKEEPING/ENVIRONMENTAL SERVICES RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Checkout, transfer, isolation records	All providers		2 years
Cleaning records (rooms, equipment, work surfaces, etc.)	All providers		2 years
Environmental exposure analysis using exposure or medical records	All providers	Must keep for at least 30 years [8 C.C.R. Section 3204(d)(1)(C)]	30 years
Environmental (workplace) monitoring or measuring regarding toxic substances or harmful physical agents (including personal, area, grab, wipe, or other form of sampling; collection and analytical methodologies, calculations, and other background data; and analyses)	All providers	Must be kept for at least 30 years [8 C.C.R. Section 3204]. However, background data to environmental monitoring or measuring, such as laboratory reports and worksheets, need only be kept for 1 year.	30 years
Inspection reports of grounds and buildings	All providers		6 years
Hazardous waste (that is not medical waste) — reports, test results, waste analyses, manifests	All providers that generate hazardous waste	Must keep for at least 3 years from due date of report or date waste accepted by transporter [22 C.C.R. Section 66262.40].	30 years
Material Safety Data Sheets	All providers	Must keep for as long as a material is used or stored at a workplace [8 C.C.R. Sections 3204(d)(1)(B)(2) and 5194]. Once the material is no longer used or stored, if the MSDS is destroyed, a record of the identity of the substance or agent, where it was used, and when it was used must be kept for at least 30 years. MSDSs must be immediately accessible to employes during each work shift.	30 years
Medical waste treatment and tracking documents	Small quantity generators of medical waste	Must keep for at least 3 years [Health and Safety Code Section 117943]. *See Health and Safety Code Section 118040 for required content of records.*	30 years
Medical waste treatment and tracking documents	Large quantity generators of medical waste	Must keep for at least 2 years [Health and Safety Code Section 117975]. *See Health and Safety Code Section 118040 for required content of records.*	30 years

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HOUSEKEEPING/ENVIRONMENTAL SERVICES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Pesticide handling training programs	All providers	Must keep for at least 2 years after training program is discontinued [3 C.C.R. Section 6724(a)]. *See regulation for required content of training.* When antimicrobial agents are used only as sanitizers, disinfectants, or medical sterilants, the employer is exempt from complying with this requirement, and instead must comply with Cal/OSHA requirements [3 C.C.R. Section 6720], which require records to be kept for at least one year [8 C.C.R. Section 3203(b)].	6 years after date of training (may also wish to document attendance in employee's personnel file)
Pesticide Safety Information Series leaflets, MSDSs, pesticide use records, employee exposure records, work practice reviews	All providers	Regulations require these records to be kept, but no retention period is specified [3 C.C.R. Section 6723]. When antimicrobial agents are used only as sanitizers, disinfectants, or medical sterilants, the employer is exempt from complying with this requirement, and instead must comply with Cal/OSHA requirements [3 C.C.R. Section 6720]. *See "Material Safety Data Sheets," page 43, and "Employee health (medical) records — Employees subject to OSHA regulations," page 46.*	30 years

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HUMAN RESOURCES RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Aerosol transmissible disease training	All providers	Must keep for at least 3 years after date of training [8 C.C.R. Section 5199)(j)(2)]. *See regulation for required content of record.*	6 years after date of training (may also wish to document attendance in employee's personnel file)
Affirmative action program records	All providers subject to affirmative action requirements	Life of program, plus 1 year [41 C.F.R. Section 60-1.12]	Life of program, plus 6 years
Applications for employment		*See "Employee and applicant records ...," below.*	
Bloodborne pathogen training	All providers	Must keep for at least 3 years [8 C.C.R. Section 5193(h)]	6 years (may also wish to document attendance in employee's personnel file)
Collective bargaining agreements and related documents	All providers	Must keep for at least 3 years [29 C.F.R. Section 516.5].	Life of agreement, plus 10 years
Employee acknowledgment of child abuse and neglect reporting requirement, elder and dependent adult abuse and neglect reporting requirement	All providers		File in employee's personnel file
Employee and applicant records required by the California Fair Employment and Housing Act, Title VII of the Civil Rights Act, the Americans with Disabilities Act, the Genetic Information Nondiscrimination Act, and the Age Discrimination in Employment Act — any personnel or employment record made or kept by an employer, including application forms and resumes submitted by applicants; requests for reasonable accommodation; records relating to recruitment, testing, hiring, promotion, demotion, transfer, recall, layoff, termination, rate of pay and other terms of compensation, garnishment, and selection for training or apprenticeship programs	All providers	Health facilities and primary care clinics must keep for at least 3 years after termination of employment [22 C.C.R. Sections 70725, 71525, 72533, 73527, 75052, 77119, 79333 and 87866]. Other providers must keep for at least 2 years from date of making record or personnel action involved, whichever is later [Government Code Section 12946]. *See also 29 C.F.R. Sections 1602.14 (one year retention period required) and 1627.3(b) (3 years).* Longer if a charge of discrimination has been filed [29 C.F.R. Section 1602.14]	Duration of employment, plus 10 years

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Employee benefit plans — pension and insurance plans	All providers	Must keep for 1 year after termination of plan [29 C.F.R. Section 1627.3].	Permanent
Employee exposure records, including audiometric test results	All providers	Must keep for at least 30 years [8 C.C.R. Sections 3204(d)(1)(B) and 5100(d)]	Duration of employment plus 30 years
Employee handbook	All providers		Permanent
Employee health (medical) records — Employees *not subject* to OSHA regulations	Health facilities, clinics, HHAs	Must keep these records for at least 3 years after termination of employment [22 C.C.R. Sections 70723, 71523, 72535, 73525, 74723, 75052, 77121 and 79331].	Duration of employment, plus 30 years
Employee health (medical) records — Employees *subject* to OSHA regulations	All providers	Federal and California OSHA regulations require that medical records be kept for the duration of employment plus 30 years for all employees who are exposed, *or potentially exposed*, to hazardous substances (including chemical substances, biological agents, and bloodborne pathogens) or to a hazardous environment [29 C.F.R. Sections 1910.1020(d)(1)(i), and 1910.1030(h); 8 C.C.R. Sections 3204(c)(5), 3204(d)(1), 5193(h) and 5199(j)(1)]. *See regulations for required content of records.* Hazardous substances include those listed in the latest edition of the Registry of Toxic Effects of the National Institute for Occupational Safety & Health. Hazardous environments include noise, heat, cold, vibration, repetitive motion, ionizing and nonionizing radiation, and hypo- and hyperbaric pressure. *See also "Noise exposure records," page 47.*	Duration of employment, plus 30 years
Employee polygraph records	All providers	Must keep for at least 3 years [29 C.F.R. Section 801.30]. See regulation for required content of report. *See also Labor Code Section 432.2 for retrictions on employee polygraphs.*	Duration of employment, plus 10 years
Employer Information Report EEO-1	Employers subject to Title VII of the Civil Rights Act of 1964 that have 100 or more employees	Must keep the most recent annual report [29 C.F.R. Section 1602.7].	30 years

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Employment Eligibility Verification Form (INS Form I-9)	All providers	Must keep for at least 3 years after date of hire or 1 year after termination of employment, whichever is later [8 C.F.R. Section 274a.2].	Duration of employment, plus 10 years
Equal Pay Act records — records that relate to payment of wages, wage rates, job evaluations, job classifications, job descriptions, merit systems, seniority systems, other matters that explain the basis for payment of any wage differential to employes of the opposite sex in the same establishment	All providers	Must keep for at least 2 years [29 C.F.R. Section 1620.32]. (Copies of seniority systems and merit systems must be kept for at least 1 year after termination of the system under the Age Discrimination in Employment Act [29 C.F.R. Section 1627.3(b)(2)]).	Records about specific employees: File in employees personnel file. Other records: 30 years
Family Medical Leave Act records — dates of leave, hours of leave, employee notices, employer policies and practices, records of disputes, premium payments	Providers subject to FMLA	Must keep for at least 3 years [29 C.F.R. Section 825.500]. *See also Government Code Section 12946 (2-year retention period required, longer if ongoing litigation).*	Records about specific employees: File in employees personnel file. Other records: 30 years
Garnishment records	All providers		7 years
Labor/management reporting records to Office of Labor-Management Standards	All providers	Must keep for at least 5 years after filing [29 U.S.C. Section 436; 29 C.F.R. Section 405.9].	6 years after filing report
Log of temporary health services personnel	SNFs	Must keep for at least 3 years [22 C.C.R. Section 72533].	6 years
Mammography personnel qualification records		*See "Mammography personnel qualifications for physicians, mammographic radiologic technologists, medical physicists," page 52*	
Material Safety Data Sheets	All providers	Must keep while chemical is being used by employees. When safety data sheets are destroyed, must keep a record of the identity (chemical name, if known) of the substance, where it was used, and when it was used for at least 30 years. [8 C.C.R. Section 3204(d)(1)(B)]	6 years after use of chemical discontinued
Noise exposure records	All providers	Noise exposure measurement records must be kept for at least 2 years [8 C.C.R. Section 5100].	30 years
Orientation and competency validation	GACHs	Must retain in employee's file for the duration of employment [22 C.C.R. Section 70214(a)(4)]	Duration of employment plus 6 years

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
OSHA logs, summaries and reports; OSHA forms 300, 300A, 301 Incident Reports, privacy case list	All providers	Must keep for at least 5 years following the end of the calendar year that the records cover [29 C.F.R. Section 1904.33; 8 C.C.R. Section 14300.33].	6 years
Payroll records, including: • Employee deduction authorizations • Hours worked (daily) • Leaves of absence • Overtime, vacation and sick leave accruals and entries • Time cards • Wage rates and wages paid • Wage statements, itemized	All providers	Retention of comprehensive payroll records is required under numerous federal and state laws, including the Fair Labor Standards Act, Equal Pay Act, Age Discrimination in Employment Act, Title VII of the Civil Rights Act, Americans with Disabilities Act, California Fair Employment & Housing Act, California Unemployment Insurance Code, ERISA and Medi-Cal/Medicare requirements. Although most of the acts require retention for a period no longer than 4 years, ERISA requires current availability of all payroll records necessary to determine entitlement to pension benefits. It is therefore recommended that payroll records be permanently retained. *(See also Labor Code Sections 226(a) and 247.5.)* (As ERISA requirements vary according to the type of pension plan, facilities may wish to have their attorneys review their plans to determine whether a shorter retention period may be appropriate and to determine which payroll records should be retained.) *See also Labor Code Section 1174; 29 C.F.R. Sections 516.5 and 516.6; 22 C.C.R. Sections 70725, 71525, 72533, 73527, 75052, 77119 and 79333.*	Employees not entitled to pension: 15 years Employees entitled to pension: life of employee plus 6 years
Pension records	All providers	*See box immediately above.*	Permanent

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HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Pesticide training program records	All providers	Must keep for at least 2 years [3 C.C.R. Section 6724]. *See regulation for required content of training.* When antimicrobial agents are used only as sanitizers, disinfectants, or medical sterilants, the employer is exempt from complying with this requirement and instead must comply with Cal/OSHA requirements [3 C.C.R. Section 6720], which require records to be kept for at least one year [8 C.C.R. Sections 3203, 5194].	6 years after date of training (may also wish to document attendance in employee's personnel file)
Respirator fit-testing	All providers	Must keep until another fit-testing is performed on the employee [8 C.C.R. Section 5144(m)]. *See regulation for required content of record.*	6 years
Sharps injury log	All providers	Must keep for at least 5 years [8 C.C.R. Section 5193(h)]. *See regulation for required content of log.*	10 years
Sharps injury training	All providers	Must keep for at least 3 years [8 C.C.R. Section 5193(h)]. *See regulation for required content of record.*	6 years (may also wish to document attendance in employee's personnel file)
Unavailablility of vaccine for employees who may be exposed to an aerosol transmissible disease	All providers	Must keep for at least 3 years [8 C.C.R Section 5199(j)(3)]. *See regulation for required content of record.*	6 years
Volunteer personnel records	All providers		6 years after termination of volunteer status
Volunteer sign-in sheets, hours worked, assignments	Facilities		6 years
W-2, W-4 forms		*See "Business and Finance Records," page 31.*	

HUMAN RESOURCES RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Workplace violence prevention records: iolent incident log, reports to Cal/OSHA and injury investigations	Health facilities, HHAs, hospices	Must keep for at least 5 years [8 C.C.R. Section 3342(h)(3)]	6 years
Workplace violence prevention training	Health facilities, HHAs, hospices	Must keep for at least 1 year [8 C.C.R. Section 3342(h)]	6 years after date of training (may also wish to document attendance in employee's personnel file)
Workers' compensation claims files	All providers	Must keep for the latest of: 5 years from date of injury; 1 year from date compensation last provided; until all compensation due or which may be due has been paid; or, if an audit has been conducted within 5 years from the date of injury, until the findings are final [8 C.C.R. Section 10102]. *See 8 C.C.R. Section 10101.1 for required content of file.*	6 years after all compensation paid
Workers' compensation claims log	All providers	Must keep for 5 years from the end of the year to which the log relates [8 C.C.R. Section 10103.2]. *See regulation for required content of log.*	6 years
Workers' compensation self-insureds' claims files	All providers	Claim files must be kept for at least 5 years from date of injury or date on which last compensation benefit paid, whichever is later. Must keep indefinitely if open future medical benefits due. Must be kept in California unless written permission is obtained to retain the records out-of-state. [8 C.C.R. Section 15400.2]	6 years after all compensation paid

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IMAGING/RADIOLOGY RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Dose surveys, air sampling, bioassays, measurements to evaluate release of radioactive effluents	Health facilities and imaging centers	Must keep for duration of license [10 C.F.R. Section 20.103; 17 C.C.R. Section 30275]. *See 10 C.F.R. Section 20.2103 for required surveys and measurements.*	Duration of license plus 30 years. Must keep any records showing potential employee exposures for at least 30 years *(see "Environmental (workplace) monitoring or measuring regarding toxic substances or harmful physical agents (including personal, area, grab, wipe, or other form of sampling; collection and analytical methodologies, calculations, and other background data; and analyses)," page 43)*.
Dose to individual member of public	Health facilities and imaging centers	Must keep for the duration of license [10 C.F.R. Section 20.2107; 17 C.C.R. Section 30275].	Duration of license, plus 30 years
Equipment inspection records	Health facilities and imaging centers		Life of equipment, plus 6 years
Fluoroscopy monitoring readings	Imaging facilities	Must keep at least 3 years [17 C.C.R. Section 30307(b)(2)] *(See regulation for required content of logs.)*	6 years
Mammograms and reports	Mammography facilities	Must keep in patient's medical record for not less than 7 years, or not less than 10 years if no subsequent mammograms of the patient are performed at the facility, unless the original mammogram is transferred to the patient's health care provider or to the patient [42 U.S.C. Section 263b(f)(1)(G)(i); 21 C.F.R. Section 900.12(c); 17 C.C.R. Section 30317.50].	File in patient's medical record
Mammography consumer complaints	Mammography facilities	Must keep for at least 3 years [21 C.F.R. Section 900.12(h)]	6 years

IMAGING/RADIOLOGY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Mammography personnel qualifications for physicians, mammographic radiologic technologists, medical physicists	Mammography facilities	Must keep for at least 2 years after termination of employment/ medical staff membership [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30315.52, 30315.50 and 30455.1 for required qualifications.* In addition, records of personnel no longer employed must be kept until the next annual inspection has been completed and the FDA has determined that the facility is in compliance with MQSA personnel requirements [21 C.F.R. Section 900.12].	File in employee's personnel file
Mammography quality assurance records — records concerning mammography technique and procedures, quality control (including monitoring data, problems detected, corrective actions, effectiveness of corrective actions), safety and protection	Mammography facilities	Must keep until the next annual inspection has been completed and the FDA has determined that the facility is in compliance with the quality assurance requirements, or, for quality control test records, until the test has been performed two additional times at the required frequency, whichever is longer [21 C.F.R. Section 900.12(d)].	Until next inspection, plus 6 years
Mammography records — calibrations, maintenance, machine modifications (must include date of calibration, maintenance, or modification; name of individual making the record; manufacturer's model number, facility's radiation machine ID number)	Mammography facilities	Must keep for at least 3 years [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30316.10-30318.10 for further information about record contents.*	Life of equipment, plus 6 years
Mammography records — processor film strips, phantom images, fixer retention test films, darkroom test films, screen-film contact test films	Mammography facilities	Must keep for at least 1 year [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30316.10-30318.10 for further information about record contents.*	6 years

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IMAGING/RADIOLOGY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Mammography records — QA logs, phantom image score sheets, fixer retention log sheets, repeat analyses, darkroom fog log sheets, screen-film contact log sheets, compression test log sheets, darkroom cleaning logs, intensifying screen cleaning logs, view box cleaning logs, medical physicist survey reports, evaluations and instrument calibration reports, evaluations of new/repaired equipment, medical outcomes audit analyses, consumer complaints, mobile service provider documents	Mammography facilities	Must keep for at least 3 years [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30316.10-30318.10 for further information about record contents.*	6 years/Life of equipment, plus 6 years
Mammography records — receipt, transfer, and disposal of radiation machines (must include date of receipt, transfer, or disposal; name and signature of individual making the records; manufacturer's model number; facility's radiation machine ID number)	Mammography facilities	Must keep until facility ceases use and disposes of the machine [17 C.C.R. Section 30319.20]. *See 17 C.C.R. Sections 30316.10-30318.10 for further information about record contents.*	Life of equipment, plus 6 years
Manifests	Health facilities and imaging centers		30 years
NRC Form 4 — prior occupational dose	Health facilities and imaging centers	Must keep for 3 years [10 C.F.R. Section 20.2104(f); 17 C.C.R. Section 30275].	Duration of employment, plus 30 years
NRC Form 5 — occupational monitoring	Health facilities and imaging centers	Must keep for the duration of license [10 C.F.R. Section 20.2106(f); 17 C.C.R. Section 30275]. Keep also in employee health record. *(See "Employee health (medical) records — Employees subject to OSHA regulations," page 46.)*	Duration of license, plus 30 years
Planned special exposure	Health facilities and imaging centers	Must keep for duration of license [10 C.F.R. Section 20.2105; 17 C.C.R. Section 30275].	Duration of license, plus 30 years
Radiation protection program	Health facilities and imaging centers	Must keep for the duration of license [10 C.F.R. Section 20.2102; 17 C.C.R. Section 30275].	Duration of license, plus 30 years

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IMAGING/RADIOLOGY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Radiation protection program — audits and reviews of content and implementation	Health facilities and imaging centers	Must keep for at least 3 years [10 C.F.R. Section 20.2102; 17 C.C.R. Section 30275].	30 years
Radiation source records: disposal	Health facilities and imaging centers	Must keep for duration of license [17 C.C.R. Sections 30275 and 30293, 10 C.F.R. Section 20.2108].	Duration of license, plus 30 years
Radiation source records: receipt and transfer	Health facilities and imaging centers	Must keep for 3 years following transfer [17 C.C.R. Section 30293].	30 years following transfer
Radiology reports, printouts, films, scans, and other imaging records	Health facilities and imaging centers	Hospitals that participate in Medicare must keep for at least 5 years [42 C.F.R. Section 482.26].	File in patient's medical record
Radioisotopes — receipt, transfer, use, storage, delivery, disposal and reports of overexposure	Health facilities and imaging centers	Must keep for at least 3 years after transfer or disposal of the material. Disposal records must be kept for duration of license. [10 C.F.R. Section 30.51]	30 years
Reports to CDPH of unplanned contamination events involving licensed radioactive material, failure of equipment designed to prevent releases, event requiring unplanned medical treatment, fire or explosion damaging licensed material, etc.	Health facilities and imaging centers	Must keep for duration of license [17 C.C.R. Section 30293]. *See 17 C.C.R. Section 30295 regarding reporting requirements.*	Duration of license plus 30 years. Must keep any records showing potential employee exposures for at least 30 years *(see "Environmental (workplace) monitoring or measuring regarding toxic substances or harmful physical agents (including personal, area, grab, wipe, or other form of sampling; collection and analytical methodologies, calculations, and other background data; and analyses)," page 43)*.
Requests for tests, procedures	Health facilities and imaging centers	Medicare-participating facilities and imaging centers must keep for at least 7 years [42 C.F.R. Section 424.516(f)]	15 years

IMAGING/RADIOLOGY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Surveys and calibrations	Health facilities and imaging centers	Must keep for at least 3 years [10 C.F.R. Section 20.2103; 17 C.C.R. Section 30275]. *See 10 C.F.R. Section 20.2103 for required surveys and calibrations.*	Life of equipment, plus 6 years.
Tests of residual fixer level, darkroom fog, corrective actions	Imaging facilities (other than mammography or dental)	Must keep for at least one year from date of test [17 C.C.R. Section 30308.1]	6 years
X–rays, other imaging data and studies	Health facilities and imaging centers	Must keep for time prescribed for retention of medical records. *See "Medical Records," page 61.*	15 years – adults 25 years – minors

LABORATORY RECORDS AND SPECIMENS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Analytic system records: • Quality control and patient test records, including instrument printouts, if applicable; • Records documenting all analytic systems activities specified in CLIA, 42 C.F.R. Sections 493.1252-493.1289; and • Records of quality control procedures in use, including results on standards and reference materials and action limits when appropriate	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Section 493.1105.*	6 years
Analytic system records — records of test system performance specifications that the laboratory establishes or verifies under 42 C.F.R. Section 493.1253	Freestanding and health facility laboratories	Must keep for the period of time the laboratory uses the test system, but no less than 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Section 493.1105.*	Life of system, plus 6 years

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LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Blood and blood component records (documentation regarding collection processing, testing, storage, distribution, complaints, adverse reaction and quality control records)	Blood banks, freestanding and health facility laboratories that process, test, store or distribute blood components	Must keep for at least 10 years after processing or 6 months after the latest expiration date for the individual product, whichever is later. When there is no expiration date, records must be kept indefinitely. [21 C.F.R. Section 606.160(d)] *See 21 C.F.R. Section 606.160(d) for further information about required record contents. See also 42 C.F.R. Sections 482.27 and 493.1105.*	15 years after expiration date, unless indefinite retention required *(see remarks to the left)*
Blood donor histories and pertinent records	Blood banks, freestanding and health facility laboratories that process, test, store or distribute blood components	Must keep for at least 10 years after processing or 6 months after the latest expiration date for the individual product, whichever is later. When there is no expiration date, records must be kept indefinitely. [21 C.F.R. Section 606.160(d)] *See 21 C.F.R. Section 606.160(d) for further information about required record contents.*	15 years after expiration date, unless indefinite retention required *(see remarks to the left)*
Blood: sample of transfused blood	Health facilities	Must keep for further testing in the event of a transfusion reaction [42 C.F.R. Section 493.1271(d)	2 weeks after last transfusion
Blood transfusion records (including source and disposition)	Freestanding and health facility laboratories that process, test, store or distribute blood components	Must keep for at least 10 years after processing or distribution or 6 months after the latest expiration date for the individual product, whichever is later. When there is no expiration date, records must be kept indefinitely. [21 C.F.R. Section 606.160(d)] *See also 42 C.F.R. Sections 482.27 and 493.1105.*	15 years after expiration date, unless indefinite retention required *(see remarks to the left)*
Blood transfusion-related records for which there is no expiration date	Freestanding and health facility laboratories that process, test, store or distribute blood components	Must keep indefinitely [21 C.F.R. Section 606.160].	Permanent
Correspondence with clinician about malignant neoplasms	Freestanding and health facilities labs	Must keep at least 5 years [Business and Professions Code 1274(a)]	File in patient's medical record

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LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Cytology lab — records of the total number of slides examined by each employee during each 24-hour period and the number of hours spent examining slides in the 24-hour period irrespective of the site or laboratory	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Sections 1265(j) and 1271]. *See also 42 C.F.R. Sections 493.1105 and 493.1274(d)(3)*.	10 years
Cytology reports	Freestanding and health facility laboratories	Must keep for at least 10 years [Business and Professions Code 1271(g)].	File in patient's medical record.
Cytology slides and cell blocks	Freestanding and health facility laboratories	Must keep for at least 5 years from date of examination [Business and Professions Code 1271(g)]. *See also 42 C.F.R. Sections 493.1105 and 493.1274(f).* (Slides may be loaned to proficiency testing programs in lieu of keeping them for the required time period, provided the laboratory receives written acknowledgment of the receipt of slides by the proficiency testing program and keeps the acknowledgment.)	5 years
Equipment inspection, validation, calibration, repair and replacement records	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. If the records relate to equipment used to process blood or blood components, *see "Blood and blood component records (documentation regarding collection processing, testing, storage, distribution, complaints, adverse reaction and quality control records)," page 56, for applicable retention period.*	Life of equipment, plus 6 years
Histopathology slides	Freestanding and health facility laboratories	Must keep for at least 10 years from date of examination [42 C.F.R. Section 493.1105(a)(7)].	10 years
Human tissue intended for transplantation		*See "Human tissue intended for transplantation," page 61.*	

LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Immunohematology records and reports	Freestanding and health facility laboratories	Must keep for at least 10 years after processing or 6 months after the latest expiration date for the individual product, whichever is later. When there is no expiration date, records must be kept indefinitely. [21 C.F.R. Section 606.160(d); 42 C.F.R. Section 493.1105]	Reports about individual patients: file in patient's medical record. Otherwise, keep 15 years unless indefinite retention required *(see remarks to the left)*
Invoices		*See "Invoices documenting purchase or lease of clinical laboratory equipment and test kits, reagents, or media," page 33.*	
Nuclear medicine reports	GACHs, APHs	Must keep for at least 5 years [42 C.F.R. Section 482.53(d)]	File in patient's medical record
Pathology test reports	Freestanding and health facility laboratories	Must keep for at least 10 years [42 C.F.R. Section 493.1105(a)(6)(ii)].	File in patient's medical record
Pathology specimen blocks	Freestanding and health facility laboratories	Must keep for at least 2 years from date of examination. [42 C.F.R. Section 493.1105]	2 years
Patient specimen testing records (including personnel performing the test and, if applicable, instrument printouts)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Sections 493.1105 and 493.1283.*	6 years
Procedure manuals; method of validation (manuals, card files, or flow charts for each procedure performed, including at least: name of procedure, source or reference for the test method, date procedure last reviewed/modified by the director/supervisor, current specific instructions for test performance, standards and controls required, and instructions for collecting and handling specimens to insure test reliability)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)].	Life of manual/ method, plus 6 years

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LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Proficiency testing records	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Sections 493.801 and 493.1105*.	6 years
Quality control/assessment documentation (documentation regarding calibration, control procedures, maintenance and function tests, test result comparison activities, workload limit records, alarm system checks, proficiency testing, corrective actions, etc.)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section1265(j)]. However, quality control records for blood and blood components and immunohematology must be kept for at least 10 years after processing or 6 months after expiration date, whichever is later. [21 C.F.R. Section 606.160; 42 C.F.R. Section 493.1105] *See also 42 C.F.R. Part 493.*	6 years
Registers of tests — logbooks (chronological), accession logs	Freestanding and health facility laboratories		6 years
Report of imminent life-threatening result or panic value (including name of person contacted)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)].	File in patient's medical record
Requests for tests/test requisitions (patient ID, name of submitter, dates of receipt and report, type of test performed, test results).	Freestanding and health facility laboratories	Must keep for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); 42 C.F.R. Section 424.516(f) (7-year retention period); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476]	15 years
Specimen records	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)].	6 years

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LABORATORY RECORDS AND SPECIMENS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Test procedures (must include dates of initial use and discontinuance)	Freestanding and health facility laboratories	Must keep for at least 3 years after a procedure has been discontinued [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Section 493.1105.*	6 years after procedure discontinued
Test reports not otherwise specifically mentioned (final, preliminary and corrected)	Freestanding and health facility laboratories	Must keep for at least 3 years [Business and Professions Code Section 1265(j)]. *See also 42 C.F.R. Section 493.1105.*	File in patient's medical record
Tissue specimens	Freestanding and health facility laboratories	Preserve remnants of tissue for pathology examination until a diagnosis is made on the specimen [42 C.F.R. Section 493.1105].	Until diagnosis is made. May wish to keep longer depending upon type of tissue, how it is preserved, and clinical indications.

NOTE: State and federal laws contain detailed requirements regarding the information to be included in various documents. Laboratories should carefully review Business and Professions Code Section 1265(j) and 42 C.F.R. Section 493.1105 (which requires documentation of compliance with CLIA, 42 C.F.R. Sections 1252-1289) to be sure all required information is captured in the appropriate documents, and retained for the required period of time. Laboratories should also review 21 C.F.R. Section 606.160 if blood or blood components are involved. *(See "Where to Find the Laws Referenced in the Manual," page 75, for instructions on where to find the exact text of each statute and regulation.)*

The College of American Pathologists (CAP) has developed a recommended retention schedule that addresses many records and items not covered in this manual. Hospitals and other providers may wish to consult the CAP schedule.

MEDICAL RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Anatomical gift	Hospital		Permanent
Birth certificates	All providers		Permanent
Birth room record	All providers		Permanent
Cancer/tumor registry files	All providers		Permanent
Death certificates	All providers		Permanent
Electrocardiograms (EKGs)	All providers	Keep only those portions that are specifically selected by the treating provider to be included in the patient's medical record	File in patient's medical record
Electroencephalograms (EEGs)	All providers	Keep only those portions that are specifically selected by the treating provider to be included in the patient's medical record	File in patient's medical record
Electromyograms (EMGs)	All providers	Keep only those portions that are specifically selected by the treating provider to be included in the patient's medical record	File in patient's medical record
Fetal heart monitor strips		Keep only those portions that are specifically selected by the treating provider to be included in the patient's medical record	File in patient's medical record
Human tissue intended for transplantation		*See "Human tissue intended for transplantation (records regarding donor screening and testing; records regarding supplier, donor and lot identification, receipt, name(s) of recipient(s), storage temperatures, distribution, destruction, disposition of human tissue, expiration dates of all tissues, etc.)," page 38.*	
Index to patients' medical records		*See "Master patient index/medical record index number," page 25.*	
Orders and certifications	Medicare provider or supplier of DMEPOS, lab, imagery or home health services	Must keep at least 7 years [42 C.F.R. Section 424.516(f)]	File in patient's medical record

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MEDICAL RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Patient medical records, including: • Admission records • Autopsy reports (and consents for autopsy) • Consent forms • Consultation reports • Diagnoses • Discharge summary • Imaging/radiology reports • Labor and delivery records • Laboratory reports • Medication records • Nurses' notes • Patient histories • Patient identification information • Patient's principal spoken language • Physical examination notes • Physical therapy notes • Physicians' orders • Progress notes • Psychiatric records • Reports of all other tests: EKG, EEG, etc. • Surgical records, complete with: – Anesthesia records – Findings – Operative report – Pathology report – Postoperative diagnoses – Preoperative diagnoses • Vital signs sheets	All providers	Various types of health facilities, home health agencies and individual practitioners are required to keep medical records for at least the following periods: • Adults and emancipated minors — 7 years • Unemancipated minors — 1 year after the minor has reached age 18, and in no event less than 7 years [Business and Professions Code Sections 2570.185 (occupational therapists), 2620.7 (physical therapists), 2919 (psychologists), 4980.49 (marriage and family therapists), 4989.51 (educational psychologists), 4993 (clinical social workers), 4999.75 (professional clinical counselors); Health and Safety Code Section 123145; 22 C.C.R. Sections 70751(c), 71551(c), 72543(a), 73543(a), 74731(d), 75055(a), 75343(a), 77143(c) and 79351(c)] Records that support claims for services rendered to Medicare or Medi-Cal patients must be kept for at least 10 years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later [42 C.F.R. Sections 422.504(i)(2) and 423.505(i)(2); Welfare and Institutions Code Section 14124.1; Title 22, California Code of Regulations, Section 51476] SNFs that participate in Medicare/Medicaid must keep records of minors until they reach the age of 21 [42 C.F.R. Section 483.70(i)]. Prescribers of controlled substances must keep specified records at least 3 years [Health and Safety Code Sections 11190-11191].	15 years — adults 25 years — minors

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MEDICAL RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Resident assessments	SNFs that participate in Medicare/Medicaid	Must keep for at least 15 months [42 C.F.R. Section 483.20(d)]	File in patient's medical record
Video records of diagnostic tests (e.g., arthroscopies)	All providers	Keep only those portions that are specifically selected by the physician to accompany the report in the patient's medical record.	File in patient's medical record

NOTE: *See "Human Resources Records," page 45, for information about employee health records.*

MEDICAL STAFF RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Bylaws and rules and regulations of the medical staff	GACHs, APHs, PHFs, CDRHs	Regulations require hospitals to keep these records, but do not specify retention periods [22 C.C.R. Sections 70703, 70733, 71503, 71531, 77127, 79303, and 79337].	Permanent
Bylaws, rules and regulations, and minutes of meetings of the professional and other staff	PHFs, CDRHs	Regulations require PHFs and CDRHs to keep these records, but do not specify retention periods [22 C.C.R. Sections 77127 and 79337].	Permanent
Call schedules	Hospitals	Hospitals that participate in Medicare must keep ED call schedules for at least 5 years [42 C.F.R. Section 489.20(r)].	6 years
Medical staff committee records, including minutes, reports and other records	GACHs, APHs, PHFs, CDRHs	Regulations require hospitals to keep these records, but do not specify retention periods [22 C.C.R. Section 70703, 70733, 71503, 71531, 79303 and 79337].	Permanent
Medical staff files (credentialing files) for allied health providers (non-employees), physicians, residents, interns, fellows, impaired practitioners — including applications (accepted and rejected), credentials, complaints, CME records, etc.	Hospitals		Length of practitioner's career, plus 6 years

MEDICAL STAFF RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Peer review records	Hospitals		Records regarding individual practitioners: length of practitioner's career, plus 6 years. Other records: 6 years
Quality assurance records, incident reports, root-cause analyses, etc.	Facilities	*See chapter 19 of CHA's* Consent Manual *about the proper establishment of an incident report or medical staff quality assurance report system.*	6 years (unless desired longer for trending purposes)
Resident rotation schedules — location, nature of assignment, vacation, leave of absence, sick time, orientation time, classroom time, etc.	Resident employers	Must keep for at least 5 years after the cost report is filed with the intermediary. *See "Medicare cost report records," page 29.*	15 years
Surgical privileges list		*See "Surgical privileges list," page 39.*	

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NUCLEAR MEDICINE RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Calibration records (including the model and serial number of the instrument, date of calibration, results of calibration, and the name of the individual who performed the calibration)	All providers	Must keep for at least 3 years [10 C.F.R. Section 35.2060].	Life of equipment, plus 6 years
Exposure records		*See "Employee health (medical) records — Employees subject to OSHA regulations," page 46.*	
Interpretations, consultations, and procedures reports	GACHs, APHs	Medicare-participating hospitals must keep for at least 5 years [42 C.F.R. Section 482.53].	File in patient's medical record
Receipt and disposition of radiopharmaceuticals	All providers	Regulations require Medicare-participating hospitals to keep these records, but do not specify a retention period [42 C.F.R. Section 482.53].	10 years

NOTE: *See "Imaging/Radiology Records," page 51, for additional information.*

NURSING RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Nurse staffing data	SNFs that participate in Medicare/Medicaid	Must keep at least 18 months [42 C.F.R. Section 483.35(g)(4)]	15 years
Orientation and competency validation	GACHs	Must retain in employee's file for the duration of employment [22 C.C.R. Section 70214(a)(4)]	Duration of employment plus 4 years
Staff assignment records (including licensing/certification status of staff, patient census for each shift, staff assignment records, posted nurse staffing data)	SNFs	Must keep for at least 3 years [22 C.C.R. Section 72329.1(h)]. *See also 42 C.F.R. Section 483.35.*	15 years
Staffing patterns, including methodology used	APHs	Must keep for at least 6 months [22 C.C.R. Section 71213(i)].	6 years
Staffing plan for each patient care unit, including patient care requirements, staffing levels for registered nurses, and other licensed and unlicensed personnel. Must also record: 1. Staffing requirements as determined by the patient classification system for each unit, documented on a day-to-day, shift-by-shift basis; 2. The actual staff and staff mix provided, documented on a day-to-day, shift-by-shift basis; 3. The variance between required and actual staffing patterns, documented on a day-to-day, shift-by-shift basis; 4. The actual registered nurse, licensed vocational nurse and licensed psychiatric technician assignments to individual patients by licensure category, documented on a day-to-day, shift-by-shift basis.	GACHs	Must keep records of staffing patterns for the time period between licensing surveys. Must keep records of actual RN, LVN, and LPT assignments for at least 1 year. [22 C.C.R. Section 70217(d)(2)]	6 years

PHARMACY RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Alcohol (tax-free), used for medicinal, mechanical (analysis or test), or scientific purposes for patient treatment (records of receipt, shipments, use, destruction, and claims; include date of transaction, quantity and proof)	Hospitals, blood banks, and sanitariums	Must keep for at least 3 years following date of transaction. Must keep records at permit premises. [27 C.F.R. Section 22.164] *See also 27 C.F.R. Sections 22.161 and 22.162 for required content of records.*	6 years
Automated delivery device policies and procedures	Pharmacies	Must keep for at least 3 years after last use [16 C.C.R. Section 1713].	6 years
Chemicals and products used for compounding (records of acquisition, storage, destruction)	Pharmacies	Must keep for at least 3 years [16 C.C.R. Section 1735.3].	6 years
Compounded drug records	Pharmacies	Must keep for at least 3 years. Records to be kept include the master formula; date; personnel who compounded; pharmacist reviewing final product; quantity of each ingredient; manufacturer, expiration date and lot number of each component; equipment used; pharmacy-assigned reference or lot number; expiration date; and quantity compounded. Some exceptions for products compounded on a one-time basis for administration to an inpatient. [16 C.C.R. Section 1735.3]	6 years

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PHARMACY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Controlled substances dispensed, prescriptions	Health facilities, pharmacies	Must keep for at least 2 years records showing the kind and quantity of controlled substances dispensed or administered, the date of dispensing, the names and addresses of persons to whom controlled substances were dispensed or administered, and the names or initials of persons who dispensed or administered the controlled substance [21 C.F.R. Sections 1304.04 and 1304.22]. Prescriptions must be kept for at least 3 years [Business and Professions Code Section 4333; Health and Safety Code Sections 11179 and 11205]. Prescriptions for controlled substances must be kept separate from prescriptions for noncontrolled substances, and may also need to be separated by Schedule [Health and Safety Code Section 11205; 21 C.F.R. Section 1304.04(h)]. *See 21 C.F.R. part 1304 for required content of records.*	6 years
Controlled substances inventories and records (by registered location)	Pharmacies	Must keep for at least 3 years [16 C.C.R. Sections 1707 and 1718; 21 C.F.R. Section 1304.04(a)]. Some records may be kept at a central location if DEA and Board of Pharmacy is properly notified [21 C.F.R. Section 1304.04(a); 16 C.C.R. Section 1707]. Prescriptions for controlled substances must be kept separate from prescriptions for noncontrolled substances, and may also need to be separated by Schedule [Health and Safety Code Section 11205; 21 C.F.R. Section 1304.04(h)]. *See also 21 C.F.R. part 1304.11 for required inventory content and procedure.*	6 years
Controlled substance prescription forms (to whom issued, number issued, etc.)	Health facilities, specified clinics	Must keep at least 3 years [Health and Safety Code Section 11162.1]	6 years after last form used or destroyed

PHARMACY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Controlled substances records	Prescribers	Must keep for at least 3 years [Health and Safety Code Section 11191]. *See Health and Safety Code Section 11190 for specific information that must be documented.* Prescriptions for controlled substances must be kept separate from prescriptions for noncontrolled substances, and may also need to be separated by Schedule [Health and Safety Code Section 11205; 21 C.F.R. Section 1304.04(h)].	6 years
Dialysis drugs and devices for home dialysis patients (prescriptions, invoices showing name of drugs/ devices, quantities, manufacturer, lot number, date, pharmacist)	Pharmacies	Must keep for at least 3 years [16 C.C.R. Sections 1787 and 1790].	6 years
Drugs provided to health care facility or prehospital EMS provider for use by EMS provider	Pharmacy, prehospital EMS provider	Must keep for at least 3 years [Business and Professions Code Section 4119].	6 years
Epinephrine auto-injectors furnished to school districts,county offices of education (records regarding acquisition and disposition)	Pharmacies	Must keep for at least 3 years [Business and Professions Code Section 4119.2].	6 years
Inspection reports by pharmacist of emergency drug supplies in nursing units (must be inspected at least monthly)	GACHs, APHs	Must keep for at least 3 years [22 C.C.R. Sections 70263(f) and 71233(f)].	6 years
Invoices		*See "Business and Finance Records," page 31.*	
Log of destruction of discontinued individual patient's drugs not supplied by the hospital which remain at the hospital after the patient is discharged (must include name of patient, name and strength of drug, prescription number, amount destroyed, date of destruction, signature of witness(es))	GACHs, APHs	Must keep for at least 3 years. Alternatively, the information may be kept in the patient's medical record. [22 C.C.R. Sections 70263 and 71233]	6 years

PHARMACY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Medicare Part D-related documents (prescription drug benefit)	All providers that contract with a Medicare Part D plan	Must keep for at least 10 years [42 C.F.R. Section 423.505(i)(2)]. *See "Contracts with Medicare Advantage or Medicare Part D Plans," page 6.*	15 years
Order form DEA 222 (Copy 3 for filled orders; also copies returned as unaccepted or defective)	Pharmacies	Must keep for at least 2 years [21 C.F.R. Section 1305.17]. *See 21 C.F.R. Sections 1305.03, 1305.13 and 1305.15 for required content of records.*	6 years
Patient medication profile (patient name, address, phone, date of birth, gender, allergies, current medications, medical conditions, etc.; prescription and prescriber information)	Pharmacies	Must keep for at least 1 year from the date the last prescription filled [16 C.C.R. Section 1707.1].	15 years — adults 25 years — minors
Prescriptions and prescription records	Pharmacies	Must keep for at least 3 years [Business and Professions Code Section 4333; Health and Safety Code Section 11179; 16 C.C.R. Section 1707 and 1717(f)]. Prescriptions for controlled substances must be kept separate from prescriptions for noncontrolled substances, and may also need to be separated by Schedule [Health and Safety Code Section 11205; 21 C.F.R. Section 1304.04(h)].	6 years
Quality assurance reviews (investigation and analysis of medication errors)	Pharmacies	Must keep for at least 1 year [16 C.C.R. Section 1711].	10 years
Quality assurance review required by Board of Pharmacy	Pharmacies	Must keep for at least one year [16 C.C.R. Section 1711(f)]	6 years
Recall records — records regarding manufacturer's recall of drugs and records evidencing removal of drugs from all nursing units, satellite pharmacies, etc.	Health facilities		6 years
Records of sale, acquisition, receipt and disposition of drugs (including DEA Form 222, theft and loss reports)	Health facilities, pharmacy	Must keep for at least 3 years [Business and Professions Code Sections 4081, 4105, 4190 and 4333]. Must be kept on the licensed premises unless a written waiver is granted by the Board of Pharmacy. *See also 42 C.F.R. Section 482.25; 21 C.F.R. Section 1304.22.*	6 years

PHARMACY RECORDS (CONT.)			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Records regarding prescriptions purposely mislabeled (as part of a research study or by order of prescriber)	Pharmacies	Must keep for at least 3 years [Business and Professions Code Section 4078].	Research: 30 years after completion of research Order of prescriber: 15 years — adults 25 years— minors
Returned drugs — credit memo	Health facilities, pharmacies	A facility's return of a drug to the manufacturer is exempt from legally-prohibited sale/resale if a credit memo is created, sent to the manufacturer, and retained [21 C.F.R. Section 203.23]. The credit memo must be kept for at least 3 years [21 C.F.R. Section 203.60]. *See 21 C.F.R. Section 203.23 for required content of credit memo.*	6 years
Self-assessment required by Board of Pharmacy	Pharmacies	Must keep for at least 3 years [16 C.C.R. Section 1715]	6 years
Sterile compounding records	Pharmacies	Must keep for at least 3 years [16 C.C.R. Section 1751.1]. *See regulation for required content of records.*	6 years
Sterile injectable product records: name, lot number, amount, date, compounding information.	Pharmacies	Must keep for at least 3 years. For sterile products compounded from one or more nonsterile ingredients, must also keep training and competency evaluation of employees in sterile product procedures, refrigerator and freezer temperatures, certification of sterile compounding environment, other facility quality control logs, inspection for expired or recalled products, preparation records (including master work sheet, preparation work sheet, and end-product evaluation results). [16 C.C.R. Section 1751.1]	6 years
Temperature monitoring logs	The Joint Commission accredited organizations	`Must keep until next full survey	4 years

PUBLIC RELATIONS RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Advertisements (print, radio, television, etc.)	All providers		10 years; may wish to retain those of historical interest permanently
Authorization to use/disclose protected health information (media interviews, etc.)	All providers	HIPAA regulations require authorizations to be kept for at least 6 years [45 C.F.R. Section 164.530(j)].	8 years
Consent to photograph	All providers	HIPAA regulations require authorizations to be kept for at least 6 years [45 C.F.R. Section 164.530(j)]. Thus, if the photograph depicts a patient (as opposed to an employee, volunteer, or model) and is used for purposes other than treatment, payment or health care operations, the consent to photograph must comply with HIPAA authorization requirements and must be kept for at least 6 years.	8 years after discontinuing use of photograph
Marketing materials	All providers		10 years; may wish to retain those of historical interest permanently
Newspaper and magazine clippings (historical)	All providers		10 years; may wish to retain those of historical interest permanently
Photographs — institutional	All providers		10 years; may wish to retain those of historical interest permanently
Press releases	All providers		10 years; may wish to retain those of historical interest permanently
Publications (in-house)	All providers		10 years; may wish to retain those of historical interest permanently

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PURCHASING AND RECEIVING RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Invoices		*See "Business and Finance Records," page 31.*	
Packing slips	All providers		Providers may wish to match packing slips with invoices/ purchase orders and retain together.
Purchase orders		*See "Business and Finance Records," page 31.*	
Purchase requisitions (internal documents)	All providers		2 years
Receiving reports	All providers		2 years
Returned goods credits	All providers	*See "Business and Finance Records," page 31.*	

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RESEARCH RECORDS			
RECORD	**PROVIDER TYPES**	**LEGAL REQUIREMENTS**	**RECOMMENDED RETENTION PERIOD**
Contracts with study sponsors and principal investigators, including related documentation	All providers		30 years after completion of the research
Human subject research records	All providers	Retained records should include medical records.	30 years after completion of the research
Institutional Review Board (IRB) records (research proposals and scientific evaluations; approved sample consent documents; progress reports submitted by investigators; reports of injuries to subjects; minutes of IRB meetings; records of continuing review activities; correspondence between the IRB and investigators; list of IRB members, including name, degrees, representative capacity, experience; any employment or other relationship with the institution; written procedures for the IRB as required by 21 C.F.R. Section 56.108 (a) and (b); statements of significant new findings provided to subjects, as required by 21 C.F.R. Section 50.25)	IRBs	Must keep for at least 3 years after completion of the research [21 C.F.R. Section 56.115; 45 C.F.R. Section 46.115].	Records regarding particular research projects: 30 years after completion of the research General IRB records: 6 years
Other research reports	All providers		6 years (longer if continuing interest)
Research papers published	All providers		10 years; may wish to retain those of historical interest permanently
Research regarding prescriptions purposely mislabeled (as part of a research study)		*See "Records regarding prescriptions purposely mislabeled (as part of a research study or by order of prescriber)," page 71.*	

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Where to Find the Laws Referenced in the Manual

All of the laws discussed in the manual can be found on the Internet.

FEDERAL LAW

A federal statute is written by a United States Senator or Representative. It is voted on by the United States Senate and the House of Representatives, and then signed by the President. A federal statute is referenced like this: 42 U.S.C. Section 1395. "U.S.C." stands for "United States Code." Federal statutes may be found at www.gpo.gov/fdsys or at www.law.cornell.edu.

A federal regulation is written by a federal agency such as the U.S. Department of Health and Human Services or the U.S. Food and Drug Administration. The proposed regulation is published in the Federal Register, along with an explanation (called the "preamble") of the regulation, so that the general public and lobbyists may comment on it. The federal agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to the proposed regulation based on the comments. The final regulation is also published in the *Federal Register*. A federal regulation is referenced like this: 42 C.F.R. Section 482.1 or 42 C.F.R. Part 2. "C.F.R." stands for "Code of Federal Regulations." Federal regulations may be found at www.ecfr.gov. The preamble, however, is only published in the Federal Register and not in the Code of Federal Regulations. The Federal Register may be found at www.federalregister.gov.

The Centers for Medicare & Medicaid Services (CMS) publishes its *Interpretive Guidelines* on the internet. The *Interpretive Guidelines* include information for surveyors on how CMS interprets the Conditions of Participation, and instructions for surveyors on how to assess hospitals' compliance with the Conditions of Participation. They may be found at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html (click on Publication 100-07, "State Operations Manual, then "Appendices Table of Contents"). There are several appendices that hospitals will find useful, for example, A (hospitals), AA (psychiatric hospitals), V (EMTALA), and W (critical access hospitals).

A federal law must be obeyed throughout the United States, including in California, unless the federal law expressly states otherwise. As a general rule, if a federal law conflicts with a state law, the federal law prevails, unless the federal law expressly states otherwise.

If there is no conflict, such as when one law is stricter but they don't actually conflict with each other, both laws generally must be followed. For example, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal law states that providers must conform to whichever provision of federal or state law provides patients with greater privacy protection or gives them greater access to their medical information.

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STATE LAW

A state statute is written by a California Senator or Assembly Member. It is voted on by the California Senate and Assembly, and then signed by the Governor. A state statute is referenced like this: Civil Code Section 56 or Health and Safety Code Section 819. State statutes may be found at www.leginfo.legislature.ca.gov. Proposed laws (Assembly Bills and Senate Bills) may also be found at this website.

A state regulation is written by a state agency such as the California Department of Public Health or the California Department of Managed Health Care. A short description of the proposed regulation is published in the California Regulatory Notice Register, more commonly called the Z Register, so that the general public and lobbyists may request a copy of the exact text of the proposed regulation and comment on it. The state agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to the proposed regulation based on the comments. A notice that the final regulation has been officially adopted is also published in the Z Register. The Z Register may be found at www.oal.ca.gov/notice_register.htm.

A state regulation is referenced like this: Title 22, C.C.R., Section 70707. "C.C.R." stands for "California Code of Regulations." State regulations may be found at https://govt.westlaw.com/calregs/Search/Index.

A state law must be obeyed in California only. As a general rule, if a California law conflicts with a federal law, the federal law prevails, unless the federal law expressly states otherwise. (If there is no conflict, such as when one law is stricter but they don't actually conflict with each other, both laws generally must be followed.)

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