PURPOSE:

This is to establish a documented procedure to ensure that all processes are covered and in accordance with the rules and regulation of the hospital and Philippine law.

LEVEL:

Medical Records Staff, Medical Records Manager, Nurse on duty, Attending Physician, Post Graduate Intern, Resident Doctor, Administrative Employees

POLICY:

Health Records Creation and Documentation:

1 The hospital shall initiate and maintain a standardized health record for every patient assessed or treated and determine the record's content, format and location of entries.

2 Each patient confined, consulted or treated in this hospital shall be identified through a single unit number or patient ID, sufficiently detailed health record that correctly identifies the patient, supports the diagnosis, justifies the treatment, and documents the course and results of treatment.

3 Collection of personal information shall be accompanied by a Data Privacy Consent form to be signed by the patient or his/her authorized representative.

4 The hospital shall use the standardized diagnosis and procedure codes and ensures the standardized use of approved symbols and abbreviations across the hospital.

5 Data in the patient health record shall be coded and indexed to ensure timely production of quality patient care information and statistics.

6 The health records shall follow the standard arrangement:

- 6.1 Admission and Discharge Record
- 6.2 Informed Consent for Admission
- 6.3 Consent Form/ Waiver
- 6.4 Emergency Room Record or Elective Admission Form for OPD patient
- 6.5 History and Physical Examination

6.6 Discharge Summary
6.7 Clinical Laboratory Test Results
6.8 Physician's Order and Progress notes
6.9 Nurses Notes (FDAR)
6.10 Monitoring Sheet
  6.10.1 TPR
  6.10.2 Pain Monitoring Sheet
  6.10.3 Input/Output
  6.10.4 Vital Signs
6.11 Intravenous Fluid Sheet
6.12 Medication Sheet
6.13 Operation Block
  6.13.1 Informed Consent for Surgery
  6.13.2 Informed Consent for Anesthesia
  6.13.3 Anesthesia Record
  6.13.4 PACU Monitoring Sheet
  6.13.5 WHO Surgical Safety Checklists
  6.13.6 Pre-operative Checklist
  6.13.7 Operative Record
  6.13.8 Operative Technique
6.14 Delivery Room Block
  6.14.1 Labor Room Record (Partograph)
  6.14.2 Operative Technique
  6.14.3 Newborn Record
  6.14.4 Essential Intrapartum Newborn Care (EINC)
  6.14.5 Deliver slip
6.15 *Inter-departmental Referral Sheet*
6.16 Blood Request form
6.17 Clinical Abstract
6.18 Nutrition Care Plan
6.19 Medical Social Worker's Notes
6.20 *Physical Therapy Notes*

6.21 Respiratory Therapy Notes
6.22 Interventional Radiology Notes
6.23 Clinical Pharmacist Notes
6.24 AMS Forms (Antimicrobial)
6.25 Fall
6.26 Consultation
6.27 Non-Disclosure Agreement for Access of Health Records
6.28 Patient Referral Form
6.29 Kardex

7 The hospital identifies members of medical staff who are authorized to make entries in the patient health record. Thus, every patient health record entry identifies its author and shall indicate the date and time the entry was made.

8 The Attending Physician/nurse on duty and other authorized staff to document in the health record has the final responsibility for the completeness and accuracy of the data entry in the health record. The discharging nurse on duty shall be responsible in counter checking the completeness of the health record as to documentation and quantity before endorsing the same to the HIMD.

9 The accomplishment of History, Physical Examination shall be done by the resident physician.

10 Discharge Summary/Medical Abstract shall be delegated to the interns. Should the Discharge Summary/Medical Abstract be used as part of the chart, in compliance to DOH mandatory requirements, the intern who accomplishes the form shall sign and write the name of the resident physician, whereas, if the Discharge Summary/Medical Abstract that shall be used for financial assistance, the signature of the PGI, resident physician and the attending physician must be present.

11 The chart of the Newborn (non-pathologic), Normal Spontaneous Delivery, 24-hour admission and Cataract shall no longer require a Discharge Summary/Medical Abstract unless, otherwise requested by the attending physician or patient.

12 The HIMD staff shall assist the attending physician, nurses, resident physician or interns in reviewing records for completeness by checking for omissions and discrepancies to ensure that health records comply with standards and policies.

13 A health record with pending diagnostic results, lacking final diagnosis in the face sheet and incomplete documentation shall be completed in the HIM Dept. within 15 days after the patient's discharge; otherwise, it shall be considered a delinquent health record.

14 The Health Information Management Dept. or Medical Records shall continue to implement quality improvement activities to evaluate the quality service delivered, quality documentation of health records and storage management.

Health Information for Birth Certificate, Death Certificate, Fetal Death:

1 **Certificate of Live Birth**

1.1 Accomplishment of the Certificate of Live Birth shall be in accordance with the Civil Registry Administrative Book No.1, Series of 1993 (Implementing Rules and Regulations of the Republic Act No. 3753 and other laws on Civil Registration).

1.2 All babies born and admitted in the hospital shall have Certificate of Live Birth, certifies by the person who has witnessed the baby's delivery. If the baby born outside or on the way to the hospital (non-institutional delivery), the practitioner who cut the umbilical cord from the mother shall certify the Certificate of Live Birth.

1.3 Only the baby's parents shall be interviewed and shall sign the Certificate of Live Birth. If the mother died or is mentally incapacitated, the husband or any of the nearest kin (mother side) shall act as the informant and shall sign the Certificate of Live Birth.

1.4 Any discrepancies in the data of the mother at the time of admission shall be supported by a duly notarized affidavit of discrepancy or sworn statement.

1.5 Birth Certificate has remarks of "late registration" written in the Annotation portion of the certificate if parents accomplished the required data after the 30-day reglementary period. Certificate of No Entry from the PSA and Local Civil Registrar are the necessary requirements for the processing of the same.

1.6 For illegitimate births, accomplishment of Certificate of Birth shall be in accordance with the Revised Implementing Rules and Regulations of the Republic Act No. 9255, (An Act Allowing Illegitimate Children to Use the Surname of their Father (AUSF)) and other laws of Civil Registration.

1.7 The hospital shall be responsible for the registration of birth certificates of babies of married parents to the Local Civil Registrar, whereas, for illegitimate births, parents shall process the necessary requirements and endorsement to Local Civil Registrar for registration.

1.8 Hospital copy of registered birth certificates shall be kept and retained for safekeeping until the child reaches the age of maturity (18 years).

2 **Certificate of Causes of Death**

2.1 Accomplishment of the Certificate of Causes of Death shall be in accordance with the DOH Administrative Order No. 2020-0008, – Rules on Medical Certification of Cause of Death.

2.2 Data for Death Certificate form shall be accomplished at the area where the patient expired, certify by the doctor on duty who pronounced the patient's death and it shall be endorsed to HIMD as reference in preparing the final and official death certificate.

2.3 Attending physician who is unable to sign the patient's official death certificate shall submit a written authorization where resident on duty who pronounced the patient's death shall sign on his/her behalf.

2.4 All the data given by the informant are presumed correct and the hospital shall not be held liable for any erroneous data entered in the death certificate.

2.5 A clearance slip from the Billing Section shall be submitted by the relative or kin prior to the release of death certificate.

2.6 Official death certificate shall be released only to nearest kin. The person who claimed the death certificate shall be responsible for the Local Civil Registration within the reglementary period of 30 days.

2.7 The relative or next of kin who claims the death certificate of expired patient after the reglementary period of 30 days shall process for a delayed registration. An Affidavit for Delayed Registration at the back portion of the death certificate must be duly notarized.

2.8 When there is a conflict of interest between families, relative of the deceased shall present documents to show ownership such as marriage contract.

2.9 No correction of data (such as name, birthdate, civil status, citizenship) shall be done unless supported by a duly notarized affidavit of correction and other supporting documents. However, a death certificate that bears the Local Civil Registrar registration number will no longer be corrected.

3 Certificate of Fetal Death (Stillbirth)

3.1 Certificate of Certified Death shall be accomplished in the HIMD office and certify by the attending physician or resident doctor on duty.

3.2 Only the baby's parents shall be interviewed and shall sign the Certificate of Fetal Death. If the mother died or is mentally incapacitated, the husband or any of the nearest kin (mother side)

shall act as the informant and shall sign the Certificate of Fetal Death.

Health Record Storage and Safekeeping

1 The hospital safeguards the health records against loss/destruction or unauthorized use.
2 The hospital shall not be held liable for accidental loss or destruction of medical records secondary to calamities or natural disasters.
3 Health records in whatever form or media, shall be kept by the hospital for the duration of time required by the Department of Health and National Archives of the Philippines records retention regulation mandated by Republic Act No. 4226 or the Hospital Licensure Act.
4 The Information Technology Department shall be responsible for the storage of electronic health records on the server, ensuring an efficient and effective program for HIM department with provisions for back-up and records recovery and security measures.
5 All health records that are still in the processing stage shall be placed in the pigeon holes for compliance of deficiencies by all authorized personnel who are responsible for the completeness and accuracy of the data entry in the health records. After which health records shall be filed in the storage area.
6 Inactive records shall be transferred to inactive filing storage to give way to the incoming records, decongest the area and to facilitate retrieval.
7 All boxes of health records shall be stamped " DO NOT DESTROY UNTIL THE YEAR_____".
8 All classified or medico-legal records shall be exempted from the general retention policy and shall not be destroyed until the case is fully resolved or upon the advice of legal counsel.
9 All health records marked for disposal shall be destroyed by means of a shredder machine. Shredding of the entire health records shall be done at a specific site by a 3rd party Contractor.

10 The hospital shall adhere to the provision of Department Order No. 13-A Art.III Rule 2.2. which states that, "Agencies shall not dispose of their health records earlier that the period indicated for each record series."

11 Disposal of health records shall be governed by Department Circular No.70 series of 1996: The Revised Disposition Schedule of Medical Record amending ministry Circular 77 series, Department Circular 2021-0226 and NAP General Circular 3, GRDS.

Health Record Accessibility: Open health records (still admitted)

1 Health records are readily accessible to facilitate patient care, are kept confidential and safe and comply with relevant statutory requirements of codes of practice.

2 Information privacy, confidentiality and securing, including data integrity, shall be strictly observed.

3 A patient's request to access his record may not be allowed to prevent misinterpretation of technical medical information which may lead to complaint/litigation. However, the patient's physical and mental condition shall be explained to him by his attending physician.

4 Physician and members of the allied health profession may review records of patients presently under their care.

5 Physician who is a member of the medical staff but are not member of the team assigned to the patient, shall require a written authorization signed by the patient/parent/guardian and the Attending Physician before they are given access to the record.

6 Members of the medical staff may review charts of readmitted patients for continuity of care with written consent of the main Attending Physician from the last admission or consultation.

7 The privilege against disclosure belongs to the patient and not to the Attending Physician.

8 Patients' relatives making inquiries about the health status of their patients shall be referred to the attending physician.

9 Consent from the patient and Attending Physician shall be required of company physicians presently caring for the patient before giving access to health records.

10 Visiting/Referring consultant shall have access to records of patients referred to them.

11 It shall be the responsibility of the attending physician to inform his patient about the latter's health condition.

12 Student nurses shall have access to health records of patients assigned to them while the patient is still in the ward.

13 Private Nurses shall only be allowed to review the health records of those patients assigned to them.

14 Nurses on duty must always see to it that health records are in secure place away from the patient or patient's relatives.

15 Nurses on duty and Head Nurse shall be liable for the loss of patient's health records while the patient is still admitted.

Closed health records (Discharged and stored in HIMD)

1 As a general rule, No health records shall be brought out of HIMD except for legitimate purposes by legitimate requestors.

2 Legitimate requestor shall include the Main Attending Physician, Resident doctors, Nurse on duty as per old chart to floor, Clinical Chart Audit Team, Infection and Prevention Control Unit, Total Quality Division, Philhealth Section of the hospital, Nurse Director, Nurse Manager for Operations, and Chairpersons of Investigation Committees.

3 Physicians and allied health professionals may review records of patients presently under their care. If a patient is co-managed, the main attending physician shall be notified either by phone or in writing before permitting the borrower to access the health record.

4 HIMD personnel shall seek permission from the last main attending physician based on records if a new physician would want to be given access to the said record.

5 Authorized researchers from other medical institutions could gain access to health records only after an approval of the Medical Director and/or Research Ethics & Review Committee.

6 A written letter of request or a data request form shall be accomplished by the reviewer and approved by the Medical Director before given access to the health records:

- 6.1 City Government
- 6.2 RESU
- 6.3 Provincial Government
- 6.4 PHIC and DOH licensing inspection
- 6.5 Medical Audit Committee Investigation
- 6.6 Complains from Clients
- 6.7 Adjudicatory agencies, i.e., Philippine National Police, National Bureau of Investigation and other law enforcement agencies.
- 6.8 DOH RESU staff is allowed to review charts of cases reported to them as per RA 11332.

Release of Health Information

1 The health record shall not be taken out of the hospital premises except on court orders. Approved research and/or studies shall review the health records inside the HIMD conference room.

2 All information in the health record shall be treated as confidential and shall be safeguarded against loss, destruction and unauthorized use.

3 Only authorized persons shall be given access to health records with personal and sensitive personal information.

4 Patient's representative or next of kin shall submit a written authorization letter from the patient and photocopy both patient and his/her valid ID before the release of health records. The same requirements for the request of digitized records via email.

5 Patients' relatives making inquiries about the health status of the patient shall be referred to the attending physician.

6 Release of information with clinical value shall be done with the consent of the physician in charge to prevent misinterpretation.

7 Verbal requests for clinical information shall be discouraged in favor of a written request.

8 It shall be the policy of all health facilities not to use the health record in any way that will jeopardize the interest of the patient. Though, the hospital may use the health record to defend itself against any complaint or legal controversy/case.

9 The authority to release information is delegated to the Head of the Health Information management Department. In instances where a problem arises beyond his/her control, the matter shall be referred to the Clients Relation Officer and/or Medical Director for decision/appropriate action.

10 Health Information may be released by the hospital without written authorization of the patient in the following:

- 10.1 Court order
- 10.2 Administrative agency order
- 10.3 Subpoena duces tecum
- 10.4 Subpoena ad testificandum
- 10.5 Subpoena mandamus
- 10.6 Arbitration order
- 10.7 Search warrant

11 Health information of psychiatric patients shall be released only upon presentation of a written authorization from the patient's nearest kin or by a person appointed by the court as the legal guardian.

12 Where the patient is a minor, parental consent or that of the legal guardian shall be secured before any information of clinical significance is released.

13 The health record is the physical property of the hospital, However, the patient has a right to the record since its content concerns his/her own clinical information. As such, release of information with clinical value shall be done only upon explicit, written consent/waiver from the patient and attending physician.

14 In cases where litigation is likely to happen and is intended against the health facility or any of its staff, the Medical Director may refuse or deny access to the record even with the patient's written authorization, except on court orders.

15 The issuance of **Certificate of confinement** signed by the HIMD head for patients still admitted and **Medical Certificate** to patients who are discharge with final diagnosis approved and signed by the Attending Physician for legitimate purposes.

16 Certified photocopy of portions of the health record may be released upon patient's request, but shall be limited to patient data sheet, clinical history, discharge summary or medical abstract, laboratory and diagnostic results and report of operation.

17 Employees of the hospital and doctors shall abide with the same standard policy on the release of information needed for reimbursement or insurance claims purposes.

18 No portion of the health record shall be reproduced, printed, photographed, photocopied or created in any manner without the explicit, written consent by the patient or parent/s or guardian of the patient if the latter is a minor and attending physician.

19 In the event the patient is unable to sign the authorization by reason of physical and mental disability, the authorization should be signed by the next of kin or legally appointed guardian. If possible, verification of such disability should be obtained from a physician.

20 If the patient has died, the consent must be signed by the identified next of kin, or by the administrator or executor of the decedent's estate.

21 Release of non-clinical information, i.e., name of patient, address, attending physician, name of relative staying with patient during admission, admission and discharge date shall be in accordance with the provisions of the Data Privacy Act.

22 The staff of the Medical Social Service shall have access to the health records for purposes of establishing patient classification and referrals.

23 Information may be released to other health facilities where the patient is now under their care, upon the facility's written request.

Health Information and Aggregate Data Requests

1 The Data Privacy Officer shall verify the authenticity and purpose of the request for the health data and shall have the authority to approve and disapprove.
2 Legitimate requestors shall fill out the data request form stating the purpose and indicating the sole and exclusive use of the data.
3 Legitimate requestors shall not in any case reproduce, distribute and/or publish the data and shall properly and securely dispose of the same after use.
4 Disclosure of Health Information to legal authorities or any government agency may only be allowed pursuant to lawful order of a court or upon presentation of a written request duly approved by the head of the health facility or any authorized representative.

Report Generation/Statistics

1 All diagnoses and surgical/medical procedures in the health record shall be properly and accurately following the International Classification Standards for generation of statistical reports.
2 The hospital shall adhere to RA 4226 otherwise known as the "- Hospital Licensure Act" by ensuring that the Hospital Statistical report is prepared and submitted to regulatory agencies in accordance with set standards.
3 The hospital shall abide with AO 2013-005 or the National Policy on the Unified Disease Registry System of the DOH based on the final diagnosis for each health record received. HIMD is responsible to report online all reportable cases for UDRS and shall maintain a log of reported cases.

REFERENCES:

1. *R.A. 9255 An Act allowing Illegitimate Child to use the Surname of Father Implementing Rules and Regulations).*
2. *R.A. 8792 Electronic Commerce Act*
3. *R.A. 10173 Data Privacy Act of 2012*
4. *R.A. 11036 The Mental Health Act*
5. *Hospital Information Management Manual 2010 edition, p.84-91*
6. *Manual of Instruction on Civil Registry Forms, National Statistics Office p. 15-52*
7. *DOH A.O. No. 2020-008 or the Rules on Medical Certification of Cause of Death (MCCOD)*
8. *DOH Department Circular No. 2022-0293 – Interim Guidelines on the Assessment of Medical Certification and Cause of Death (MCCOD) in Health Facilities.*
9. *DOH AO 2013-005 or National Policy in the Unified Disease Registry System*
10. *R.A. 4226 Hospital Licensure Act of 1965*
11. *R.A. 9470 National Arhiver of the Philippines Act of 2007*

APPROVAL:

	Name/Title	Signature	Date
Prepared by:	**ROSALIE T. DIOCSON** Medical Records Department Head		
Reviewed:	**DENNIS C. ESCALONA, MN, FPCHA, FPSQua** *Quality Assurance Supervisor*		06-30-22
Recommending Approval:	**FREDERIC IVAN L. TING, MD** OIC- Total Quality Division		
	MA. ANTONIA S. GENSOLI, MD, FPPS, FPCHA Vice President – Chief Medical Officer		
Approved:	**GENESIS GOLDI D. GOLINGAN** President and CEO		