

**State Agencies' Retention/Disposition Schedule S4:
HEALTH INFORMATION MANAGEMENT RECORDS AND CASE FILES**

Item Number	Record Series Title	Minimum Retention Required	Disposition
A. GENERAL RECORDS			
S4-010	Chronic and convalescent nursing homes, rest homes with nursing supervision	10 years following death or discharge	destroy ¹
S4-020	College and university student health services²	7 years after student is no longer enrolled	destroy ¹
S4-030	Court Clinics: Competence to Stand Trial Evaluation Reports pursuant to <i>CSG 54-56d</i>	10 years after the completion of the last evaluation; for patients who are found not competent to stand trial and are committed under <i>CGS 54-56d</i> to a state facility, then a copy of the court clinic report is sent to that facility and becomes part of the medical record	destroy ¹
S4-040	Daily appointment sheets (outpatient)	1 year	destroy ¹
S4-050	Daily hospital census reports	1 year	destroy ¹
S4-060	Daily movement sheets: daily tracking of patients' movements in and out of the facility, <i>i.e.</i>, transfers, discharges and admissions	1 year	destroy ¹
S4-070	Death certificate stub	25 years	maintain with patient

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medical records

Item Number	Record Series Title	Minimum Retention Required	Disposition
A. GENERAL RECORDS CONT.			
S4-080	Dental Department, outpatient records³	7 years ⁴	destroy ¹
Dialysis unit records			
S4-090	a) Out-of-hospital outpatient	5 years after death or discharge	destroy ¹
S4-095	b) Hospital-associated units	25 years	destroy ¹
S4-105	Disease, operation, and physician indices	permanent	maintain in agency
E.E.G. and E.C.G.			
S4-115	a) Tracings	7 years	destroy ¹
S4-120	b) Reports filed with medical record	25 years	destroy ¹
S4-125	c) Requisitions	2 years	destroy ¹
S4-135	Employee medical records (does not include Workers' Compensation records⁵ or health insurance claim records maintained separately from employer's medical program)	duration of employment, plus 30 years ⁶	destroy ¹
S4-145	Free-standing mental health day treatment facilities, intermediate treatment facilities, psychiatric outpatient clinics for adults and case management, and community liaison services	7 years after termination or closure of case	destroy ¹
S4-155	Health statistics (admissions, discharges, inpatient [day], transfers)	3 years or until audited, whichever comes later	destroy ¹

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Item Number	Record Series Title	Minimum Retention Required	Disposition
S4-165	Homemaker and health aide services	7 years after death or termination	destroy ¹
A. GENERAL RECORDS CONT.			
S4-175	Incident reports	10 years	destroy ¹
S4-185	Inpatient records: hospitals (medical and psychiatric)^{7,8}—includes short-term hospitals (general and special), hospices, chronic disease hospitals, substance abuse facilities, long-term hospitals, mental health institutions	25 years following death or discharge	destroy ¹
	Institutional records⁸		
S4-195	a) Institutional health records-Dept. Of Correction	25 years after death or final disposition of case	destroy ¹
S4-200	b) Institutional case records-Department of Children and Family Services	25 years after death or final disposition of case	destroy ¹
	Logs		
S4-210	a) Admissions and discharge log	permanent	maintain in agency
S4-215	b) Correspondence log sheets (release of information)	no requirement	destroy ¹
S4-225	Master patient index cards (multiple)	permanent	maintain in agency
S4-235	Medical records QI (quality improvement)/PI (performance improvement)	5 years	destroy ¹
S4-245	Mental retardation facilities—resident/non-resident	10 years after death or final disposition of case	destroy ¹

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Item Number	Record Series Title	Minimum Retention Required	Disposition
A. GENERAL RECORDS CONT.			
Minutes			
S4-255	a) Administrative and professional staff meetings may be reviewed by JCAHO and/or all committees reporting to executive committee	5 years	destroy ¹
(S1-165)	b) Meetings of boards and commissions	Permanent/Archival	Permanent/Archival ⁹
Personnel information/includes all departments as appropriate¹⁰			
S4-265	a) Orientation and skill inventory	permanent	permanent employee file ¹¹
S4-270	b) Orientation (attendance record, schedule, content outline)	until termination	destroy ¹
S4-275	c) Continuing-education record/in-service individual record of completion of orientation	until termination	destroy ¹
S4-280	d) In-service/continuing-educ. statistics	5 years	destroy ¹
S4-285	e) Competency assessment	permanent	permanent employee file ¹⁰
S4-295	Physician's incomplete records listing (delinquency)—privileging and credentialing (work papers)	5 years	destroy ¹
Preadmission screening forms			
S4-305	a) Patients admitted—kept with medical record	25 years following death or discharge (refer to S4-185)	destroy ¹

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S4-310	b) Patients not admitted	6 months	destroy ¹
S4-320	Pre-screening forms on patients not admitted	6 months	destroy ¹
Item Number	Record Series Title	Minimum Retention Required	Disposition
A. GENERAL RECORDS CONT.			
S4-330	Removal permit stub	25 years	maintain with patient medical records
S4-340	Requisitions for lab work	2 years	destroy ¹
B. NURSING DEPARTMENT			
S4-350	Social work case files: Those maintained as a separate entity and not interfiled within the medical record or master case record.	7 years after death or final disposition of case	destroy ¹
S4-360	Tumor registry information¹²	permanent	maintain in agency
S4-370	Utilization management: Medicare material from fiscal intermediaries, including correspondence from Connecticut Peer Review Organization (CPRO)	5 years after the month cost report has been filed with intermediary, and after all audits are completed	destroy ¹
S4-380	Veteran's Aid Office-case files (patient folders) (inactive¹³)	3 years or until audited, whichever comes later	destroy ¹
S4-390	X-ray films (includes dental X-rays)	7 years	destroy ¹
S4-400	Crash-cart checklist (emergency equipment)	1 year	destroy ¹

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S4-410	Licensure record	current ¹⁴	destroy ¹
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B. NURSING DEPARTMENT CONT.

Logs

S4-420	a) Body log (for transportation for release of body to morgue)	1 year	destroy ¹
S4-425	b) Code blue log (internal document) - respiratory and cardiac cases	1 year	destroy ¹
S4-430	c) Delivery-room and operating-room log	10 years	destroy ¹
S4-435	d) E. D. Logs - Emergency Department	10 years	destroy ¹
S4-440	e) Per diem logs (list of per diem nurses)	5 years	destroy ¹
S4-445	f) Private-patient duty-book	5 years	destroy ¹

S4-455	Master monthly time schedules—official time record, including all changes	5 years	destroy ¹
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S4-465	Nursing/pharmacy procurement record	5 years	destroy ¹
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S4-475	Patient restraint/seclusion report	1 month (information must be included in patient records)	destroy ¹
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S4-485	Policy manual	permanent; revise annually. Keep old policy and procedures separately.	retain permanently
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S4-495	Staffing level, based on acuity classification system or minimum staffing level (may be computer-generated)	5 years	destroy ¹
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S4-505	Staffing worksheet/unit-assignment sheet/service recording form	3 months	destroy ¹
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C. PHARMACY DEPARTMENT

S4-515	Controlled-substance audit	3 years—(CGS Sec. 21a-254(g))	destroy ¹
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S4-525	Night-medication sheet	5 years	destroy ¹
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S4-535	Pharmacy review for drug regimen ¹⁵ (maintain with patient medical record- applies to long-term care/skilled nursing facilities)	25 years following death or discharge (Refer to S4-185)	destroy ¹
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S4-545	Proof-of-use sheet	3 years—(CGS Sec. 21a-254(g))	destroy ¹
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¹ Agency may destroy records only after receiving approval in the form of a signed “Records Disposal Authorization” (RC-108 rev. 1/1999) or other evidence of immunization for the 7-year retention period.

² Regarding immunization records:

- A.) C.G.S. Section 10a-155 requires institutions to maintain records of immunization against measles and rubella for college students.
 - (1) The statute requires that the institution maintain *a record* of immunization and that that records become part of the student’s permanent record.
 - (2) The statute *does not* require the permanent retention of the certificate or other acceptable proof of immunization.
- B.) The Department of Public Health requires that the original doctor’s certificate or other evidence of immunization be retained until the student leaves school. Original record includes photocopy or microfilm of an original.
- C.) The Office of the Public Records Administrator requires institutions that maintain a separate health facility to incorporate these certificates into the students’ health records and to maintain the original certificate

³ When an individual is inmate, resident, client, or patient at another facility, there must be adequate documentation to provide for continuity of care. (*Public Health Code* Section 19a-504c-1(b) [1989])

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⁴ If outpatient dental record is merged with inpatient, then see S4-185 for retention.

⁵ For retention of Workers' Compensation Records, see Schedule S2-400.

⁶ See 29 *C.F.R. (Code of Federal Regulations)* Part 1910.20 (1988).

⁷ Clinics and divisions that are part of an inpatient hospital must follow the retention period for inpatient records.

⁸ These may be subject to historical sampling by the State Archivist.

⁹ Contact State Archivist to arrange transfer.

¹⁰ For the retention period of other personnel records, see Schedule S2 Personnel Records.

¹¹ See Schedule S2-145 for retention requirement for employee files.

¹² Due to the important historical and research significance of this record series, the Office of the Public Records Administrator (PRA) and State Archives recommends that agencies implement retrospective and current ongoing microfilm projects to ensure preservation of information. Please consult the Office of the PRA for technical and procedural guidelines prior to implementing said projects.

¹³ Records become inactive following death or discharge of patient.

¹⁴ The *Public Health Code* Section 19-13-D3(b) Administration (3) is not specific to the review of licenses; however, (3) is interpreted by Department of Public Health to mean adequately qualified (*e.g.*, currently licensed). Licenses are currently renewed annually, so it becomes the responsibility of administration to prove staff are currently licensed (*e.g.*, annual documentation).

¹⁵ (Recommendation of Department of Public Health)—Performed by pharmacist on a nursing unit.