STRUCTURE OF THE UVA HEALTH PATIENT HEALTH RECORD

What is included in the UVA Health patient health record?

- Epic documentation (e.g. created/resulted in Epic)
- Approved clinical forms (consents – including research, waivers, downtime forms, etc.)
- Patient administrative forms (FMLA, pre-authorizations, etc.) *Note: Sender must apply a Patient Administrative document type label*
- Transcribed documents (M*Modal/Acquity)
- Approved ancillary system documentation (either interfaced or scanned)
- Identified – unapproved documentation for 30 days post HIM notification (HIM Miscellaneous)
- Approved research/clinical trial documentation (consents, orders, results, clinical notes)
- Approved outside facility documentation
  - Pre-hospital (transport)
  - Letters with clinical data
  - Transfer/hand-off of care
  - Radiology reports
  - Emergency room/department reports
  - Discharge summaries
  - Operative/Procedure reports
  - Ambulatory reports (aka Clinic or Progress reports)
  - History & physical's
  - Consultation reports
  - Laboratory/Pathology reports (final, not preliminary)
  - Orders (Community Health only)
  - EKG's
  - Vaccinations (Medication Administration Records printed from other health care facilities or state agencies. Hand written vaccine records, including COVID cards, will not be scanned)
  - Outside facility documentation designated by the sender with an approved "granular" outside facility barcode

What is not included in the UVA Health patient health record?

- Non-clinical documentation
- Unapproved clinical forms (including retired)
- Illegible documentation (even on approved forms)
- Non-English documentation/forms (e.g. lacking English translation on same page) (Exception only to financial assistance documentation)
- Reprints from UVA Health Epic (even if written upon) (Exception only for EMTALA completed forms and Amended Consent forms)
- Blank forms (i.e. authorization to release information form signed only by the patient, consent with only the patient label, etc.)

- Inappropriate media (e.g. paper towels, envelopes, etc.)
- Unapproved research/clinical trial documentation (e.g. non-Epic, protocols, non-clinical, etc.)
- Miscellaneous documentation (e.g. mortgage or utility documentation, FAQ's, charitable organizations, etc.)
- Neuropsychiatric testing materials (e.g. IQ tests, etc.)
- Non-approved financial documentation
- Other as identified
- Unapproved outside facility documentation
  - Incident reports (e.g. nursing homes, etc.)
  - Registration cards
  - Discharge instructions/After-visit summaries
  - Progress notes
  - Flow sheets
  - Face sheets
  - Fax cover sheets
  - Billing sheets/Encounter forms
  - Medication lists
  - Care plans (preventative)
  - Prescription data
  - Orders (Charlottesville MC only)
  - Referrals

Applicable Medical Center Policies:

- Medical Center Policy 0094 – Documentation of Patient Care (Electronic Medical Record)
- Medical Center Policy 0218 – Definition, Characteristics, Authentication and Maintenance of the Medical Record and Designated Record Set
- Medical Center Policy 0266 – Record Management/Document Retention and Destruction

Record Retention:

- UVA Health patient health documentation
  - Adults – 10 years from the last date of service
  - Minors – 18 years from birth + 10 years from the last date of service
- Outside facility documentation
  - Outside Facility Scan document type* – 2 years from scan date
  - All other Outside Facility document types – 7 years from scan date (as of 9/28/16)

*All approved outside facility documentation is indexed to the Outside Facility Scan document type unless the sender applies a barcode designating an approved UVA Health Outside Facility document type (excluding legal documentation, Advance Directives, etc.)

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