Chapter:	Health Records and Confidentiality	**Effective Date: 3/1/15**
Title:	**Health Records Organization**	Page: 1 of 1
ACA:	4-JCF-4C-32	Replaces: HSP.10.02, 6/1/09

(a) **Standard.**

(1) Youth health records (paper and/or electronic) contain the following items, as applicable, and are filed in a consistent format:

(A) patient identification on each sheet;
(B) receiving screening form;
(C) health appraisal data and examination forms;
(D) record of immunizations;
(E) diagnoses, treatments, and dispositions;
(F) individualized treatment plan;
(G) progress reports;
(H) place, date, and time of health encounters;
(I) record of prescribed medications and their administration records;
(J) laboratory, x-ray, and diagnostic studies;
(K) release of information forms;
(L) consent and refusal forms;
(M) health service reports (e.g., consultations);
(N) discharge summary of hospitalization and other termination summaries; and
(O) legible signatures and the titles of the providers.

(2) The TJJD medical director and UTMB-CMC Youth Services medical director approve the method of recording entries in the records, the form and format of the records, and the procedures for their maintenance and safekeeping. The health record is made available to and is used for documentation by all qualified health care professionals and health care practitioners.

(b) **General Provisions.**

(1) All youth medical records, including items (A)-(O) above, are maintained in the electronic medical record (EMR). Medical information is either documented directly into the EMR or scanned into designated folders.

(2) Requests to revise, add, or delete health services documents must be submitted to the UTMB-CMC Youth Services program manager for nursing and compliance.