DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **RETENTION AND DISPOSITION OF PREHOSPITAL PATIENT CARE RECORDS** (EMT, PARAMEDIC, MICN) REFERENCE NO. 608

PURPOSE: To outline the appropriate procedure for retention and disposition of Prehospital Patient Care Records which includes but is not limited to the following formats: electronic patient care record (ePCR), EMS Report Form, Base Hospital Form, Multiple Casualty Incident (MCI) Base Hospital Form, Base Hospital Form Page 2, Advanced Life Support (ALS) Continuation Form, Triage Tags, base hospital radio contact logs, base hospital medical control audio recordings, and private provider agency patient care records.

AUTHORITY: California Code of Regulations, Title 22, Sections 100128, 100170
California Welfare and Institutions Code Section 14124.1
California Health and Safety Code section 1797.98(e)
Health Insurance Portability and Accountability Act of 1996

PRINCIPLES:

1. Prehospital patient care records contain patient information which is protected under the Health Insurance Portability and Accountability Act (HIPAA) and shall be maintained in accordance with HIPAA regulations.

2. Prehospital care providers and base hospitals have an obligation to ensure the security of confidential patient information.

3. Personnel responsible for all aspects of prehospital patient care record maintenance (including data entry personnel) shall receive appropriate training related to patient care record confidentiality.

4. Prehospital patient care records shall be maintained in a secure location with access limited to authorized personnel.

5. Provider agencies and base hospitals are responsible for maintaining the original copy of prehospital patient care records.

6. Original patient care records of all patients shall be retained for a minimum of seven years. Original patient care records of minors shall be kept for at least one year after such minors have reached the age of 18, but in no event less than seven years following the provision of service.

7. Records shall be accessible for audit review by EMS Agency personnel.

8. All records related to either suspected or pending litigation shall be retained indefinitely.

APPROVED: Richard Tadeo
Director, EMS Agency

Medical Director, EMS Agency

POLICY:

I. Provider Agency Prehospital Patient Care Records:

A. EMS Report Forms and ALS Continuation Forms are utilized only during electronic patient care record (ePCR) system failure and are distributed as follows:

1. White (Original) - Retained by the EMS Provider Agency that initiates the form.

2. Red (Receiving Hospital) - Left with the receiving facility for transported patients. This copy becomes part of the patient's medical record at the receiving facility. If the patient is not transported, disposition is at the discretion of the EMS Provider Agency that initiates the form.

3. Yellow (EMS Agency) - Sent to the EMS Agency within 30 days of the last day of the preceding month. The EMS Agency shall retain until the data has been entered into the Trauma Emergency Medical Information System (TEMIS) database.

B. Private provider agency-specific, non-9-1-1 prehospital patient care records are completed for all patients and are distributed as follows:

1. Original copy - Retained by the private provider agency that initiates the form.

2. Duplicate copy – Left with the receiving facility for patients transported to a healthcare facility. This copy becomes part of the patient's medical record at the receiving facility. If patient is not transported to a healthcare facility, disposition is at the discretion of the private provider agency that initiates the form.

C. Triage Tags - In the event of a multiple casualty incident where triage tags are utilized, the original triage tag will remain with the patient, if transported, the triage tag should become part of the patient's medical record at the receiving facility. If the patient is not transported, the triage tag is to be retained as the original patient care record.

II. Base Hospital Records: Base Hospital Form, MCI Base Hospital Form, and Base Hospital Form Page 2 are utilized, as applicable, for all patients requiring base hospital contact and are distributed as follows:

A. White (Original) - Retained by the Base Hospital that initiates the form.

B. Complimentary - Used at the discretion of the Base Hospital.

C. Complimentary - Used at the discretion of the Base Hospital.

III. Maintenance of Prehospital Care Patient Records

A. Prehospital patient care records shall be delivered to the EMS Agency in a manner that ensures form security and patient confidentiality.

B. Prehospital patient care records in paper format, may be stored electronically upon written approval by the EMS Agency.

IV. Destruction of Prehospital Care Patient Records

A. Prehospital patient care records that are eligible for destruction shall be disposed of in accordance with all applicable laws.

B. Complimentary and supplemental copies of prehospital patient care records shall be disposed of in accordance with all applicable laws.

CROSS REFERENCES:

Prehospital Care Policy Manual:
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 607, **Electronic Submission of Prehospital Data**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**