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MINISTER OF HEALTH
REPUBLIC OF INDONESIA

REGULATION OF THE MINISTER OF HEALTH OF THE REPUBLIC OF INDONESIA NUMBER 269/MENKES/PER/III/2008 ABOUT MEDICAL RECORDS

MINISTER OF HEALTH OF THE REPUBLIC OF INDONESIA,

Considering: whereas as the implementation of Article 47 paragraph (3) of Law Number 29 2004 concerning Medical Practice, it is necessary to reorganize the administration of Medical Records by Regulation of the Minister of Health;

In view of:
1. Law Number 23 of 1992 concerning Health (Gazette of Republic of Indonesia Year 1992 Number 100; Additional Sheets Republic of Indonesia Number 3495);
2. Law Number 29 of 2004 concerning Medical Practice (State Gazette of the Republic of Indonesia Year 2004 Number 116, Supplement State Gazette of the Republic of Indonesia Number 4431);
3. Law Number 32 of 2004 concerning Regional Government (State Gazette of the Republic of Indonesia Year 2004 Number 125. Supplement State Gazette of the Republic of Indonesia Number 4437) as already stated amended by Law Number 8 of 2005 concerning the Stipulation of Government Regulation in Lieu of Law Namer 3 of 2005 concerning Amendments to Law Number 32 of 2004 concerning Regional Government (State Gazette of the Republic of Indonesia Year 2005 Number 108, Supplement to the State Gazette of the Republic of Indonesia Number 4548);
4. Government Regulation Number 10 of 1966 concerning Mandatory Keeping Secrets Medicine (State Gazette of the Republic of Indonesia of 1966 Number 21, Supplement to the State Gazette of the Republic of Indonesia Number 2803):;
5. Government Regulation Number 32 of 1996 concerning Health Workers (State Gazette of the Republic of Indonesia of 1996 Number 39 Supplement) State Gazette of the Republic of Indonesia Number 3637);
6. Government Regulation Number 38 of 2007 concerning Division of Affairs Government Between Governments. Provincial Government and Regency/City Regional Government (State Gazette of the Republic of Indonesia Tether 2007 Namer 82. Supplement to the State Gazette of the Republic of Indonesia number 4737);
7. Regulation of the Minister of Health Number 920/Menkes/Per/XII/1986 concerning Private Health Service Efforts in the Medical Sector;
8. Regulation of the Minister of Health Number 159b/Menkes/Per/II/1985 concerning Hospital;
9. Regulation of the Minister of Health Namer 1575/Menkes/Per/XII/2005 concerning Organization and Work Procedure of the Ministry of Health;

DECIDING:

To stipulate: REGULATION OF THE MINISTER OF HEALTH CONCERNING MEDICAL RECORD.

PIG
GENERAL REQUIREMENTS

article 1

In this Regulation what is meant by:
1. Medical record is a file that contains records and documents regarding identity patients, examinations, treatment, actions and other services that have been provided to the patient.
2. Doctors and dentists are doctors, specialists, dentists, and specialist dentists graduates of medical and dental education both at home and abroad recognized by the Government of the Republic of Indonesia in accordance with the laws and regulations invitation.
3. Health service facilities are places where service efforts are carried out health that can be used for the practice of medicine and dentistry.
4. Certain health workers are health workers who participate in providing services health directly to patients other than doctors and dentists.
5. Patient is any person who consults his health problems for obtain the necessary health services, either directly or indirectly directly to the doctor or dentist.
6. Notes are writings made by a doctor or dentist about all actions made to patients in the context of providing health services.
7. Documents are records of doctors, dentists, and/or certain health workers, reports results of supporting examinations, daily observation and treatment records and all recordings, both in the form of radiology photos, imaging images *(imaging*), and electro-recording diagnostic.
8. Professional Organization is the Indonesian Doctors Association for doctors and the Association of Dentists Indonesia for dentists.

CHAPTER II
TYPE AND CONTENT OF MED1S RECORDS

Section 2

(1) Medical records must be made in writing, complete and clear or electronically.
(2) Organizing medical records using electronic information technology further regulated by separate regulations.

Article 3

(1) Contents of medical records for outpatients at health service facilities at least lack of loading a. patient identity;
- b. date and time;
- c. anamnesis results, including at least complaints and a history of disease;
- d. results of physical examination and medical support;
- e. diagnosis;
- f. management plan;
- g. treatment and/or action;
- h. other services that have been provided to patients;
- i. for dental case patients equipped with a clinical odontogram; and
- j. approval of action when necessary.

(2) Fill in medical records for inpatients and one day care at least load:
- a. patient identity;
- b. date and time;
- c. anamnesis results, including at least complaints and a history of disease;
- d. results of physical examination and medical support;
- e. diagnosis:
- f. management plan;
- g. treatment and/or action;
- h. approval of action when necessary;
- i. records of clinical observations and treatment outcomes.
- j. Summary return *(discharge summary*);
- k. the name and signature of a particular doctor, dentist, or health worker who provide health services;
- l. other services performed by certain health personnel; and
- m. for dental case patients equipped with a clinical odontogram.

(3) Contents of medical records for emergency patients must at least contain:
- a. patient identity;
- b. conditions when the patient arrives at the health care facility;
- c. patient introduction identity;
- d. date and time;
- e. anamnesis results, including at least complaints and a history of disease;
- f. results of physical examination and medical support;
- g. diagnosis;
- h. treatment and/or action;
- i. summary of the patient's condition before leaving the emergency department and follow up plan;
- j. the name and signature of a particular doctor, dentist, or health worker who provide health services;
- k. means of transportation used for patients who will be transferred to the facility other health services; and
- l. other services provided to the patient.

(4) The contents of the patient's medical record in a disaster situation, in addition to fulfilling the provisions as referred to in paragraph (3) shall be added with:
- a. the type of disaster and the location where the patient was found;
- b. emergency category and number of mass disaster patients; and
- c. identity who found the patient;

(5) The contents of the medical record for the services of a specialist doctor or specialist dentist can be developed according to need.
(6) The services provided in the ambulance or mass treatment are recorded in the record medical equipment according to the provisions as regulated in paragraph (3) and stored in health care services.

Article 4

(1) The summary of discharge as regulated in Article 3 paragraph (2) must be made by a doctor or the dentist who treats the patient.
(2) The contents of the return summary as referred to in paragraph (1) shall at least contain:
- a. patient identity;
- b. admission diagnosis and indication of patient being treated;
- c. summary of the results of the physical examination and supporting, final diagnosis, treatment, and follow-up; and
- d. the name and signature of the doctor or dentist providing the service health.

CHAPTER III
PROCEDURE OF ORGANIZATION

Article 5

(1) Every doctor or dentist in carrying out medical practice is obliged to make medical records.
(2) The medical record as referred to in paragraph (1) must be made immediately and completed after the patient receives the service.
(3) The making of medical records as referred to in paragraph (2) is carried out through recording and documenting the results of medical examinations, actions and other services provided to the patient.
(4) Every recording into the medical record must be affixed with the name, time, and signature doctors, dentists, or certain health workers who provide services health directly.
(5) In the event of an error in recording the medical record, it can be correction is made.
(6) Amendments as referred to in paragraph (5) can only be made by: deletion without removing the corrected notes and affixed with the doctor's initials, dentist, or certain health personnel concerned.

Article 6

Doctors, dentists, and/or certain health workers are responsible for records and/or documents made in the medical record.

Article 7

Health service facilities are required to provide the necessary facilities in order to maintenance of medical records.

CHAPTER IV
STORAGE, DESTRUCTION AND CONFIDENTIALITY

Article 8

(1) Medical records of inpatients at a hospital must be kept at least for: a period of 5 (five) years from the last date the patient was treated or repatriated.
(2) After the time limit of 5 (five) years as referred to in paragraph (1) has been exceeded, medical records can be destroyed, except for the summary of discharge and approval of action medical.
(3) Summary of discharge and approval of medical action as referred to in paragraph (2) must be kept for a period of 10 (ten) years from the date of manufacture the summary.
(4) Storage of medical records and summary of discharge as referred to in paragraph (1) and paragraph (3) is carried out by an officer appointed by the head of the service facility health.

Article 9

(1) Medical records at non-hospital health service facilities must be kept at least for a period of 2 (two) years from the last date treatment patient.
(2) After the time limit as referred to in paragraph (1) has been exceeded, the medical record can be destroyed.

Article 10

(1) Information on the identity of the diagnosis, medical history, examination history and history patient's treatment must be kept confidential by doctors, dentists, certain health services, management officers and leaders of health service facilities.
(2) Information on identity, diagnosis, medical history, examination history, and history treatment can be opened in the event of:
- a. for the benefit of the patient's health;
- b. fulfill the request of law enforcement officials in the context of law enforcement court order;
- c. patient's own request and/or consent;
- d. request of institutions/institutions based on statutory provisions; and
- e. for the purposes of research, education, and medical auditing, as long as it does not state the patient's identity;

(3) Requests for medical records for the purpose as referred to in paragraph (2) must be This is done in writing to the head of the health service facility.

Article 11

(1) Explanation of the contents of the medical record may only be made by a doctor or dentist who treats patients with the patient's written permission or based on statutory regulations. invitation.
(2) The head of health service facilities can explain the contents of the medical record in writing or directly to the applicant without the patient's consent based on statutory regulations. invitation.

CHAPTER V
OWNERSHIP, USE AND RESPONSIBILITY

Article 12

(1) Medical record files belonging to health service facilities.
(2) The contents of the medical record are the property of the patient.
(3) The contents of the medical record as referred to in paragraph (2) in the form of a summary of the record medical.
(4) Summary of medical records as referred to in paragraph (3) may be provided. noted, or copied by the patient or authorized person or with written consent patient or patient's family who are entitled to it.

Article 13

(1) Utilization of medical records can be used as:
- a. maintenance of health and treatment of patients;
- b. evidence in the process of law enforcement, medical discipline, and dentistry and enforcement of medical ethics and dental ethics;
- c. educational and research needs;
- d. the basis for paying the cost of health services; and
- e. health statistics.

(2) Utilization of medical records as referred to in paragraph (1) letter c which mentioning the identity of the patient must obtain written consent from the patient or his heirs and must be kept confidential.
(3) The use of medical records for educational and research purposes is not required patient consent, if done in the interest of the state.

Article 14

The head of the health service facility is responsible for lost, damaged, counterfeiting, and/or use by persons or entities who are not entitled to medical records.

CHAPTER VI
ORGANIZING

Article 15

Management of medical records is carried out in accordance with the organization and work procedures of the facility health services.

CHAPTER VII
GUIDANCE AND SUPERVISION

Article 16

(1) Head of Provincial Health Office, Head of Regency/Municipal Health Service, and related professional organizations carry out guidance and supervision of the implementation of regulations This is in accordance with the duties and functions of each.
(2) The guidance and supervision as referred to in paragraph (1) is directed to improve the quality of health services.

Article 17

(1) In the framework of fostering and supervising, the Minister, Head of the Provincial Health Service, Head of District/City Health Office, may take appropriate administrative action with their respective powers.
(2) The administrative action as referred to in paragraph (1) may take the form of a verbal warning, written warning up to license revocation.

CHAPTER VIII
TRANSITIONAL TERMS

Article 18

Doctors, dentists, and health service facilities must comply with the provisions as regulated in this Regulation no later than 1 (one) year from the date of set.

CHAPTER IX
CLOSING

Article 19

At the time this Ministerial Regulation comes into force, Regulation of the Minister of Health No 749a/Menkes/Per/XII/1989 concerning Medical Records, is revoked and declared no longer valid.

Article 20

This regulation comes into force on the date of stipulation.

So that everyone knows it, ordering the promulgation of this Ministerial Regulation by placing it in the State Gazette of the Republic of Indonesia.

Set in Jakarta
on March 12, 2008
MINISTER OF HEALTH,

Dr. SITI FADILAH SUPARI Sp. JP (K)