

# UConn HEALTH

**POLICY NUMBER 2012-07**  
**December 8, 2015**

**POLICY:   LEGAL HEALTH RECORD (LHR)**

It is the policy of UConn Health to create and maintain health records that, in addition to their primary intended purpose of clinical and patient care use, will also serve the business and legal needs of UConn Health. It is the policy of UConn Health to maintain health records that will not be compromised and will support the requirements as listed above.

The legal health record (LHR) is created at the time when services are rendered in the ordinary course of business at or near the time of matter recorded.

The legal medical record is considered a subset of the entire patient database and contains documentation of the healthcare services provided to an individual in any aspect of healthcare delivery by UConn Health.

**PURPOSE:**

To define a patient's legal health record (LHR) for UConn Health in accordance with applicable UConn Health policy, federal, state, accrediting and regulatory requirements.

**INTENT (Of the Legal Health Record):**

1. Provide a broad view of the patient's health history, including observations, measurements, past history and prognosis and preventive measures that serve as the legal document describing the health care services provided to a patient.
2. Provide a method of clinical communication and care planning among the individual healthcare practitioners treating the patient.
3. Serve as legal testimony regarding the patient's illness or injury, response to treatment and caregiver decisions that will be delivered for any legal request.
4. Provide supporting documentation for the reimbursement of services provided to the patient.
5. Document and substantiate the patient's clinical care and serve as a key source of data for outcomes research and public health purposes.
6. Serve as a teaching tool for healthcare practitioner education in clinical settings.
7. Serve to document evidence of the quality of patient care.
8. Serve as the legal business record in support of business decision-making.

**CONTENTS (Of the Legal Health Record):**

The LHR contains sufficient information to identify the patient, support the diagnosis, justify treatments and services, document course of care and results and promote the continuity of care.

The LHR is comprised of individually identifiable data in any medium, paper or electronic, that is collected and directly used in and/or for documenting health care or health status. It also includes records of care in any health related setting used by healthcare professionals while providing patient care services, reviewing patient data or documenting observations, actions or instructions.

Documentation that comprises the LHR may physically exist in separate and multiple paper-based or electronic based formats.

The LHR **DOES NOT** contain the following:

1. Administrative Data – Patient identifiable data used for administrative, regulatory, healthcare operation and payment (financial) purposes, including but not limited to: Administrative data includes abbreviation and do not use abbreviation lists, audit trails related to the electronic medical record, birth and death certificate worksheets, cancer registry data, databases containing patient information, event history and audit trails, financial and insurance forms, incident or patient safety reports, indices such as disease, operation or death, institutional review board lists, logs, including but not limited to patient identifiable data reviewed for quality assurance or utilization management, protocols and clinical pathways, practice guidelines and other knowledge sources that do not imbed patient data, registries, psychotherapy notes, staff roles and access rights and work lists.
2. Derived Data and Documents – Data that is derived from the primary healthcare record and contains selected data elements to aid in the provision, support, evaluation or advancement of patient care. Derived data consists of information aggregated or summarized from patient records but has no means to identify patients. Derived data includes accreditation reports, best practice guidelines created from aggregate patient data, quality indicators, quality measures, public health reports that do not contain patient identifiable data, statistical reports, data transmission reports, and anonymous patient data for research purposes.

#### **LEGAL HEALTH RECORD MAINTENANCE:**

1. A medical record shall be maintained for every individual who is evaluated or treated as an inpatient, outpatient, emergency patient, ambulatory clinical practice patient or dental patient at UConn Health.
2. Currently, the LHR is considered a hybrid record, consisting of both electronic and paper documentation. Documentation that comprises the LHR may physically exist in separate and multiple locations in both paper-based and electronic formats.
3. The medical record contents can be maintained in either paper (hardcopy) or electronic formats, including digital images, and can include patient identifiable source information, such as photographs, films, digital images and fetal monitoring strips and /or a written or dictated summary or interpretation of findings.
4. The current electronic components of the medical record consist of patient information from multiple electronic health record source systems. The intent of UConn Health is to integrate all electronic documents into a permanent legal health record repository.

5. Original medical record documentation must be sent to the designated Health Information Management Department for handling and storage. Whenever possible, the paper chart shall contain original reports.

The documents contained within the Legal Health Record Matrix may be obtained through the HIM Department.

Reference: [Policy #2012-06 Designated Record Set](#)

Elena Albini (Signed)

1/13/16

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**Elena Albini, R.H.I.A**  
**Director of Health Information**

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**Date**

Jeffrey Geoghegan (Signed)

12-14-15

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**Jeffrey Geoghegan**  
**Chief Financial Officer**

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**Date**

Andrew Agwunobi (Signed)

1-22-16

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**Andrew Agwunobi, M.D., M.B.A.**  
**Executive Vice President for Health Affairs**

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**Date**

**New Policy: 11/13/12**

**Reviewed without changes: 12/8/15**