SECOND REGULAR SESSION

[P E R F E C T E D**]**

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 1024

91ST GENERAL ASSEMBLY

Reported from the Committee on Public Health and Welfare, February 25, 2002, with recommendation that the Senate Committee Substitute do pass and be placed on the Consent Calendar.

Senate Committee Substitute adopted March 5, 2002.

Taken up March 5, 2002. Read 3rd time and placed upon its final passage; bill passed.

TERRY L. SPIELER, Secretary.

4267S.02P

AN ACT

To amend chapter 334, RSMo, by adding thereto one new section relating to medical records.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Chapter 334, RSMo, is amended by adding thereto one new section, to be known as section 334.097, to read as follows:

334.097. 1. Physicians shall maintain an adequate and complete patient record for each patient and may maintain electronic records provided the record keeping format is capable of being printed for review by the state board of registration for the healing arts. An adequate and complete patient record shall include documentation of the following information:

(1) Identification of the patient, including name, birthdate, address and telephone number;

(2) The date or dates the patient was seen;

(3) The current status of the patient, including the reason for the visit;

(4) Observation of pertinent physical findings;

(5) Assessment and clinical impression of diagnosis;

(6) Plan for care and treatment, or additional consultations or diagnostic testing, if necessary. If treatment includes medication, the physician shall include in the patient record the medication and dosage of any medication prescribed, dispensed or administered;

(7) Any informed consent for office procedures.

2. Patient records remaining under the care, custody and control of the licensee shall be maintained by the licensee of the board, or the licensee's designee,

for a minimum of seven years from the date of when the last professional service was provided.

3. Any correction, addition or change in any patient record made more than forty-eight hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time and name of the person making the correction, addition or change shall be included, as well as the reason for the correction, addition or change.

4. A consultative report shall be considered an adequate medical record for a radiologist, pathologist or a consulting physician.

5. The board shall not initiate disciplinary action pursuant to subsection 2 of section 334.100 against a licensee solely based on a violation of this section. If the board initiates disciplinary action against the licensee for any reason other than a violation of this section, the board may allege violation of this section as an additional cause for discipline pursuant to subdivision (6) of subsection 2 of section 334.100.

6. The board shall not obtain a patient medical record without written authorization from the patient to obtain the medical record or the issuance of a subpoena for the patient medical record.

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