SECOND REGULAR SESSION

SENATE BILL NO. 1511

103RD GENERAL ASSEMBLY

INTRODUCED BY SENATOR MOSLEY.

3367S.01I KRISTINA MARTIN, Secretary

AN ACT

To repeal section 334.097, RSMo, and to enact in lieu thereof one new section relating to patient records.

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

Section A. Section 334.097, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 334.097, to read as follows: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; **and**

(8) If requested to be documented by the patient, any question asked related to the care and treatment of the patient and the physician's response to such question.

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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