CHAPTER 4642
DEPARTMENT OF HEALTH
MEDICAL RECORDS

4642.1000 INDIVIDUAL PERMANENT MEDICAL RECORD.

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Subpart 1. **Scope.** This part defines the term "individual permanent medical record." It does not outline content requirements for hospital records. Minnesota Statutes, section 145.32 establishes the record retention requirements for hospital records of patients and specifies the conditions under which hospital patient records may be destroyed. Minnesota Statutes, section 145.32 requires permanent retention of those portions of patient's hospital records which have been defined by the commissioner of health as the individual permanent medical record.

Subp. 2. **Elements.** A patient's individual permanent medical record must consist of all of the following elements of the hospital record which are applicable to that patient:

A. Identification data which includes the patient's name, address, date of birth, sex, and if available, the patient's social security number.

B. Medical history which includes details of the present illness, the chief complaint, relevant social and family history, and provisional diagnosis. For obstetrical patients, the medical history shall include prenatal information when available. For newborns, a birth history consisting of a physical examination report and delivery record as it pertains to the newborn must be included.

C. A physical examination report.

D. A report of operations which includes the preoperative diagnosis, the names of all surgeons and assistants, the anesthetic agent, a description of the specimens removed with pathological findings, a description of the surgical findings, the technical procedures used, and the postoperative diagnosis.

E. A discharge summary which includes the reason for hospitalization, summary of clinical observations, procedures performed, treatment rendered, significant findings (for example, pertinent laboratory, X–ray, and test results), and condition at discharge. For newborns or others for whom no discharge summary is available, a final progress note must be included.

F. Autopsy findings.

Statutory Authority: *MS s 145.32*

History: *9 SR 2659*

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