6500.0700 RECORDS.

Subpart 1. **Minimum standards for medical records.** An optometrist licensed in the state must maintain a medical record for each patient. For each encounter with a patient, the medical record must:

A. be legible to someone other than the author, and written in the English language;

B. contain only those terms and abbreviations that are or should be comprehensible to other health care professionals in the same or similar specialties;

C. contain adequate identification of the patient and treating health care professional;

D. specify the date the health care was provided;

E. contain information supporting the decision making, diagnosis, or recommended treatment plan, which may include the chief complaint or reason for the encounter; history of present illness; medical, social, or family history; examinations performed and tests ordered and their findings or interpretations; counseling offered; concurrent care or transfers of care; or consultations requested;

F. specify the prescriptions written or renewed; any medications prescribed, dispensed, or administered; and the quantity and strength of each;

G. document the patient's progress during the course of treatment if applicable; and

H. include all patient records received from other health care providers, if those records formed the basis for a treatment decision by the optometrist.

Subp. 2. [Repealed, 43 SR 5]

Subp. 3. **Storage.** Patient records required by subpart 1 shall be maintained for at least five years. In the event of closure of a practice, all records from patient encounters during the previous five years shall be offered to the individual patients or transferred to another provider after notification of the new location is made to those individuals.

Statutory Authority: *MS s 145.714; 148.53; 214.06*

History: *43 SR 5*

Published Electronically: *July 11, 2018*