13:35-6.5 PREPARATION OF PATIENT RECORDS, COMPUTERIZED RECORDS, ACCESS TO OR RELEASE OF INFORMATION; CONFIDENTIALITY, TRANSFER OR DISPOSAL OF RECORDS

a) The following terms shall have the following meanings unless the context in which they appear indicates otherwise:

"Authorized representative" means, but is not necessarily limited to, a person who has been designated by the patient or a court to exercise rights under this section. An authorized representative may be the patient's attorney or an employee of an insurance carrier with whom the patient has a contract which provides that the carrier be given access to records to assess a claim for monetary benefits or reimbursement. If the patient is a minor, a parent or guardian who has custody (whether sole or joint) will be deemed to be an authorized representative, except where the condition being treated relates to pregnancy, sexually transmitted disease or substance abuse.

"Examinee" means a person who is the subject of professional examination where the purpose of that examination is unrelated to treatment and where a report of the examination is to be supplied to a third party.

"Licensee" means any person licensed or authorized to engage in a health care profession regulated by the Board of Medical Examiners.

"Patient" means any person who is the recipient of a professional service rendered by a licensee for purposes of treatment or a consultation relating to treatment.

b) Licensees shall prepare contemporaneous, permanent professional treatment records. Licensees shall also maintain records relating to billings made to patients and third-party carriers for professional services. All treatment records, bills and claim forms shall accurately reflect the treatment or services rendered. Treatment records shall be maintained for a period of seven years from the date of the most recent entry.

1) To the extent applicable, professional treatment records shall reflect:

i) The dates of all treatments;

ii) The patient complaint;

iii) The history;

iv) Findings on appropriate examination;

v) Progress notes;

vi) Any orders for tests or consultations and the results thereof;

vii) Diagnosis or medical impression;

viii) Treatment ordered, including specific dosages, quantities and strengths of medications including refills if prescribed, administered or dispensed, and recommended follow-up;

ix) The identity of the treatment provider if the service is rendered in a setting in which more than one provider practices;

x) Documentation when, in the reasonable exercise of the physician's judgment, the communication of test results is necessary and action thereon needs to be taken, but reasonable efforts made by the physician responsible for communication have been unsuccessful; and

xi) Documentation of the existence of any advance directive for health care for an adult or emancipated minor, and associated pertinent information. Documented inquiry shall be made on the routine intake history form for a new patient who is a competent adult or emancipated minor. The treating doctor shall also make and document specific inquiry of or regarding a patient in appropriate circumstances, such as when providing treatment for a significant illness, or where an emergency has occurred presenting imminent threat to life, or where surgery is anticipated with use of general anesthesia.

2) Corrections/additions to an existing record can be made, provided that each change is clearly identified as such, dated and initialed by the licensee.

3) A patient record may be prepared and maintained on a personal or other computer only when it meets the following criteria:

i) The patient record shall contain at least two forms of identification, for example, name and record number or any other specific identifying information;

ii) An entry in the patient record shall be made by the physician contemporaneously with the medical service and shall contain the date of service, date of entry, and full printed name of the treatment provider. The physician shall finalize or "sign" the entry by means of a confidential personal code ("CPC") and include date of the "signing";

iii) Alternatively, the physician may dictate a dated entry for later transcription. The transcription shall be dated and identified as "preliminary" until reviewed, finalized and dated by the responsible physician as provided in (b)3ii above;

iv) The system shall contain an internal permanently activated date and time recordation for all entries, and shall automatically prepare a back-up copy of the file;

v) The system shall be designed in such manner that, after "signing" by means of the CPC, the existing entry cannot be changed in any manner. Notwithstanding the permanent status of a prior entry, a new entry may be made at any time and may indicate correction to a prior entry;

vi) Where more than one licensee is authorized to make entries into the computer file of any professional treatment record, the physician responsible for the medical practice shall assure that each such person obtains a CPC and uses the file program in the same manner;

vii) A copy of each day's entry, identified as preliminary or final as applicable, shall be made available promptly:

(1) To a physician responsible for the patient's care;

(2) To a representative of the Board of Medical Examiners, the Attorney General or the Division of Consumer Affairs as soon as practicable and no later than 10 days after notice; and

(3) To a patient as authorized by this rule within 30 days of request (or promptly in the event of emergency); and

viii) A licensee shall maintain, as a permanent part of a patient record, any printout of computerized records maintained by the licensee while he or she modified a computer recordkeeping system, so that it complied with the requirements of (b)3i through vii above.

c) Licensees shall provide access to professional treatment records, including records from other licensees or other health care providers that are part of a patient's record, to a patient or an authorized representative in accordance with the following:

1) No later than 30 days from receipt of a request from a patient or an authorized representative, the licensee shall provide a copy of the professional treatment record,

and/or billing records as may be requested. The record shall include all pertinent objective data including test results and x-ray results, as applicable, and subjective information.

2) Unless otherwise required by law, a licensee may elect to provide a summary of the record in lieu of providing a photocopy of the actual record, so long as that summary adequately reflects the patient's history and treatment. A licensee may charge a reasonable fee for the preparation of a summary which has been provided in lieu of the actual record, which shall not exceed the cost allowed by (c)4 below for that specific record.

3) If, in the exercise of professional judgment, a licensee has reason to believe that the patient's mental or physical condition will be adversely affected upon being made aware of the subjective information contained in the professional treatment record or a summary thereof, with an accompanying notice setting forth the reasons for the original refusal, shall nevertheless be provided upon request and directly to:

i) The patient's attorney;

ii) Another licensed health care professional;

iii) The patient's health insurance carrier through an employee thereof; or

iv) A governmental reimbursement program or an agent thereof, with responsibility to review utilization and/or quality of care.

4) Licensees may require a record request to be in writing and may charge a fee for:

i) The reproduction of records, which shall be no greater than $1.00 per page or $100.00 for the entire record, whichever is less. (If the record requested is less than 10 pages, the licensee may charge up to $10.00 to cover postage and the miscellaneous costs associated with retrieval of the record.) If the licensee is electing to provide a summary in lieu of the actual record, the charge for the summary shall not exceed the cost that would be charged for the actual record; and/or

ii) The reproduction of x-rays or any other material within a patient record which cannot be routinely copied or duplicated on a commercial photocopy machine, which shall be no more than the actual cost of the duplication of the materials, or the fee charged to the licensee for duplication, plus an administrative fee of the

lesser of $10.00 or 10 percent of the cost of reproduction to compensate for office personnel time spent retrieving or reproducing the materials and overhead costs.

5) Licensees shall not charge a patient for a copy of the patient's record when:

i) The licensee has affirmatively terminated a patient from practice in accordance with the requirements of N.J.A.C. 13:35-6.22; or

ii) The licensee leaves a practice that he or she was formerly a member of, or associated with, and the patient requests that his or her medical care continue to be provided by that licensee.

6) If the patient or a subsequent treating health care professional is unable to read the treatment record, either because it is illegible or prepared in a language other than English, the licensee shall provide a transcription at no cost to the patient.

7) The licensee shall not refuse to provide a professional treatment record on the grounds that the patient owes the licensee an unpaid balance if the record is needed by another health care professional for the purpose of rendering care.

d) Licensees shall maintain the confidentiality of professional treatment records, except that:

1) The licensee shall release patient records as directed by a subpoena issued by the Board of Medical Examiners or the Office of the Attorney General, or by a demand for statement in writing under oath, pursuant to N.J.S.A. 45:1-18. Such records shall be originals, unless otherwise specified, and shall be unedited, with full patient names. To the extent that the record is illegible, the licensee, upon request, shall provide a typed transcription of the record. If the record is in a language other than English, the licensee shall also provide a translation. All x-ray films and reports maintained by the licensee, including those prepared by other health care professionals, shall also be provided.

2) The licensee shall release information as required by law or regulation, such as the reporting of communicable diseases or gunshot wounds or suspected child abuse, etc., or when the patient's treatment is the subject of peer review.

3) The licensee, in the exercise of professional judgment and in the best interests of the patient (even absent the patient's request), may release pertinent information about the patient's treatment to another licensed health care professional who is providing

or has been asked to provide treatment to the patient, or whose expertise may assist the licensee in his or her rendition of professional services.

4) The licensee, in the exercise of professional judgment, who has had a good faith belief that the patient because of a mental or physical condition may pose an imminent danger to himself or herself or to others, may release pertinent information to a law enforcement agency or other health care professional in order to minimize the threat of danger. Nothing in this paragraph, however, shall be construed to authorize the release of the content of a record containing identifying information about a person who has AIDS or an HIV infection, without patient consent, for any purpose other than those authorized by N.J.S.A. 26:5C-8. If a licensee, without the consent of the patient, seeks to release information contained in an AIDS/HIV record to a law enforcement agency or other health care professional in order to minimize the threat of danger to others, an application to the court shall be made pursuant to N.J.S.A. 26:5C-5 et seq.

e) Where the patient has requested the release of a professional treatment record or a portion thereof to a specified individual or entity, in order to protect the confidentiality of the records, the licensee shall:

1) Secure and maintain a current written authorization, bearing the signature of the patient or an authorized representative;

2) Assure that the scope of the release is consistent with the request; and

3) Forward the records to the attention of the specific individual identified or mark the material "Confidential."

f) Where a third party or entity has requested examination, or an evaluation of an examinee, the licensee rendering those services shall prepare appropriate records and maintain their confidentiality, except to the extent provided by this section. The licensee's report to the third party relating to the examinee shall be made part of the record. The licensee shall:

1) Assure that the scope of the report is consistent with the request, to avoid the unnecessary disclosure of diagnoses or personal information which is not pertinent;

2) Forward the report to the individual entity making the request, in accordance with the terms of the examinee's authorization; if no specific individual is identified, the report should be marked "Confidential"; and

3) Not provide the examinee with the report of an examination requested by a third party or entity unless the third party or entity consents to its release, except that should the examination disclose abnormalities or conditions not known to the examinee, the licensee shall advise the examinee to consult another health care professional for treatment.

g) (Reserved)

h) If a licensee ceases to engage in practice or it is anticipated that he or she will remain out of practice for more than three months, the licensee or designee shall:

1) Establish a procedure by which patients can obtain a copy of the treatment records or acquiesce in the transfer of those records to another licensee or health care professional who is assuming responsibilities of the practice. However, a licensee shall not charge a patient, pursuant to (c)4 above, for a copy of the records, when the records will be used for purposes of continuing treatment or care.

2) Publish a notice of the cessation and the established procedure for the retrieval of records, and the location at which the records will be permanently maintained, in a newspaper of general circulation in the geographic location of the licensee's practice, at least once each month for the first three months after the cessation. Such notice shall be submitted to the Board after the first publication; and

3) Make reasonable efforts to directly notify any patient treated during the six months preceding the cessation, providing information concerning the established procedure for retrieval of records.

13:35-6.6 STANDARDS FOR JOINT PROTOCOLS BETWEEN ADVANCED PRACTICE NURSES AND COLLABORATING PHYSICIANS

a) The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

"Collaboration" means the ongoing process by which an advanced practice nurse and a physician engage in practice, consistent with agreed upon parameters of their respective practices.

"Device" means an article, other than medication, for use in the diagnosis, cure, mitigation, treatment or prevention of disease, injury, pain or deformity or physical or emotional condition or health problem in humans or intended to affect the structure or function of the human body.