

42 C.F.R. § 485.638

Conditions of participation: Clinical records.

- (a) *Standard: Records system*—(1) The CAH maintains a clinical records system in accordance with written policies and procedures.
- (2) The records are legible, complete, accurately documented, readily accessible, and systematically organized.
- (3) A designated member of the professional staff is responsible for maintaining the records and for ensuring that they are completely and accurately documented, readily accessible, and systematically organized.
- (4) For each patient receiving health care services, the CAH maintains a record that includes, as applicable—
- (i) Identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;
- (ii) Reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings;

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