

Contents of Medical Records

Physicians are required to maintain complete, contemporaneous and legible records for all of their patients.

Each physician entry in a patient's medical record should be dated and signed, initialed or electronically authenticated by the physician. It should also include the patient's subjective complaints or reason for the encounter, any significant objective findings or diagnostic test results, pertinent physical examination findings, the physician's assessment and a plan of care. The note should reflect the overall rationale for the treatment and recommendations.

Patient consent forms, health insurance information, billing correspondence, and the like belong in a patient's medical record as well. The aforementioned components are not an exhaustive list, as the nature and amount of physician documentation will inevitably vary by the type of practice and services provided.

It is important to remember that medical records are legal documents that are required by state and federal law. Thorough and well-organized medical records provide a foundation for good patient care.

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