4. Hazardous behavioral problems;

5. Drug and other allergies; and

6. A copy of the patient's advance directive, where available.

(f) Medical records shall be completed within 30 days of discharge.

(g) Medical records shall be retained and preserved in accordance with N.J.S.A. 26:8–5 et seq.

(h) Original medical records of components of medical records shall not leave hospital premises unless they are under court order or subpoena or in order to safeguard the record in case of a physical plant emergency or natural disaster.

(i) Any consent form for medical treatment that the patient signs shall be printed in an understandable format and the text written in clear, legible, nontechnical language. In the case where someone other than the patient signs the forms, the reason for the patient's not signing it shall be indicated on the face of the form, along with the relationship of the signer to the patient.

(j) The patient's death shall be documented in the patient's medical record upon death.

(k) Recording errors in the medical record shall be corrected by drawing a single line through the incorrect entry. The date of correction and legible signature or initials of the person correcting the error shall be included.

(*l*) All medical records, including outpatient medical records, shall be organized in a uniform format within each clinical service.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Electronic and fax order requirements specified at (b)1–2; outpatient records included at (c).
Amended by R.1992 d.132, effective March 16, 1992.
See: 23 N.J.R. 3256(a), 24 N.J.R. 942(a).
Text on documentation of advance directives added at (d) and (e).
Petition for Rulemaking.
See: 25 N.J.R. 3563(d).

**8:43G–15.3 Medical record patient services**

(a) Health care practitioners who provide clinical services to the patient shall enter clinical/progress notes in the patient's medical record, when the services are rendered.

(b) Notes that provide a full and accurate description of the care provided to the patient shall be made in the medical record at the time clinical services are provided. Notes that provide a description and an evaluation of the patient's response to treatment shall be made in the medical record.

(c) The medical record shall either accompany the patient when he or she leaves the patient care unit for clinical services in other departments of the hospital or shall be retrievable by authorized personnel on a computerized system with a restricted access and entry system.

(d) If a patient or the patient's legally authorized representative requests, in writing a copy of his or her medical record, a legible, written copy of the record shall be furnished at a fee based on actual costs. ("Legally authorized representative" means spouse, immediate next of kin, legal guardian, patient's attorney, or third party insurer where permitted by law.) One copy of the medical record from an individual admission shall be provided to the patient or the patient's legally authorized representative within 30 days of request, in accordance with the following:

1. The fee for copying records shall not exceed $1.00 per page or $100.00 per record for the first 100 pages. For records which contain more than 100 pages, a copying fee of no more than $0.25 per page may be charged for pages in excess of the first 100 pages, up to a maximum of $200.00 for the entire record;

2. In addition to per page costs, the following charges are permitted:

i. A search fee of no more than $10.00 per patient per request;

ii. A postage charge of actual costs for mailing, not to exceed $5.00. No charges shall be assessed other than those permitted in (d)1 and 2 above.

3. The hospital shall establish a policy assuring access to copies of medical records for patients who do not have the ability to pay; and

4. The hospital shall establish a fee policy providing an incentive for use of abstracts or summaries of medical records. The patient or his or her representative, however, has a right to receive a full or certified copy of the medical record.

(e) If the patient or the patient's legally authorized representative subsequently requests additional copies of a medical record which has been furnished in accordance with (d) above, the additional copy(s) shall be furnished at a fee based on actual costs, and in no case shall exceed $1.00 per page.

(f) The Department shall periodically reevaluate the reasonableness of the fee scale contained in (d) above, and shall report to the Health Care Administration Board on or before July 1, 1993 on the need for amendment.

(g) Access to the medical record shall be limited only to the extent necessary to protect the patient. A verbal explanation for any denial of access shall be given to the patient or legal guardian by the physician and there shall be documentation of this in the medical record. In the event that direct access to a copy by the patient is medically contraindi-

cated (as documented by a physician in the patient's medical record), the medical record shall be made available to a legally authorized representative of the patient or the patient's physician.

(h) The patient shall have the right to attach a brief comment or statement to his or her medical record after completion of the medical record.

(i) Incidents, including patient injuries and mishaps, shall be fully documented in the patient's record.

Amended by R.1992 d.72, effective February 18, 1992.
See: 23 N.J.R. 2590(a), 24 N.J.R. 590(a).
Record copying fees and standards specified at (d) through (g).

**8:43G–15.4 Medical records staff qualifications**

There shall be a full-time medical record director who is an accredited record technician or a registered record administrator under a certification program approved by the American Medical Record Association.

**8:43G–15.5 Staff education**

Requirements for the medical record staff education and training program shall be as provided in N.J.A.C. 8:43G–5.9.

**8:43G–15.6 (Reserved)**

**8:43G–15.7 Medical record quality assurance methods**

(a) There shall be a quality assurance program for medical records that is integrated into the hospital quality assurance program and includes regularly collecting and analyzing data to help identify health-service problems and their extent, and recommending, implementing, and monitoring corrective actions on the basis of these data.

(b) Quality assurance activities for the medical record department shall include monitoring medical records for accuracy, completeness, legibility, and accessibility.

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## SUBCHAPTER 16. MEDICAL STAFF

**8:43G–16.1 Medical staff structural organization**

(a) There shall be an organized medical staff that is responsible to the governing body of the hospital. Bylaws governing all medical staff members shall be implemented.

(b) Applications for membership, privileges, or initial appointment to the medical staff shall be processed under a system that includes, at least, the verification of applicants' credentials, periodic review of privileges, and obtaining information about any disciplinary action against the applicant available from the New Jersey Board of Medical Examiners or the Federal Clearinghouse established pursuant to the Health Care Quality Improvement Act, P.L. 99–660; 100 STAT 3743.

(c) Applications for medical staff membership, clinical privileges, or initial appointment submitted by health professionals who are not practitioners, shall be reviewed according to the same established criteria and procedures that govern physicians' applications, including obtaining information about any disciplinary action by New Jersey professional licensing boards.

(d) A committee or mechanism shall be established to be responsible for examining applications for appointment and reappointment to all categories of the medical staff. This committee shall recommend the conferring or withholding of all staff positions. It shall assure that all credentials are documented and verified.

(e) Medical staff privileges shall be specifically delineated and based on the practitioner's training, experience and demonstrations of clinical competence.

(f) The medical staff shall be divided into clinical departments. Each department shall be directed by a director, physician director, chairman or chief who is responsible for its administration and for taking or recommending action in those instances in which staff members fail to meet the department's standards of quality of care.

(g) There shall be an executive committee for the medical staff which performs supervisory functions, including reviewing patient care policies and procedures and serving as a forum for discussing patient care issues identified by the clinical departments.

(h) A medical staff meeting shall be held at least annually for all active staff members.

(i) The hospital and medical staff shall have a formal program addressing impaired practitioners. This program shall include the following components:

i. Policies and a mechanism which encourage the voluntary or informal identification or reporting of practitioner impairment to the hospital;

ii. A mechanism for monitoring physician performance and for the limitation of clinical privileges if appropriate; and

iii. A procedure for the referral of impaired practitioners to appropriate treatment.

(j) The clinical privileges of all individuals shall be fully reviewed periodically. Actions which result in reduction or restriction of staff privileges based on this review shall be reported to the New Jersey Board of Medical Examiners in accordance with N.J.S.A. 26:2H–12.2.

(k) The hospital shall notify the New Jersey State Board of Medical Examiners, or a medical practitioner review panel created by legislation and subordinate to the Board, if a practitioner who is employed by, under contract to render professional services to, or has privileges at the hospital: