Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
In (a)3, inserted "purchasing or" preceding "prescribing".
Repealed by R.1992 d.75, effective February 18, 1992 (operative April 15, 1992).
See: 23 N.J.R. 161(a), 23 N.J.R. 1063(a), 24 N.J.R. 626(a).
Section was "Prohibition of kickbacks, rebates or receiving a payment for services not rendered."
New Rule, R.1997 d.226, effective June 2, 1997.
See: 28 N.J.R. 2317(a), 28 N.J.R. 3512(a), 29 N.J.R. 2564(a).
Amended by R.1998 d.560, effective December 7, 1998.
See: 29 N.J.R. 4740(a), 30 N.J.R. 4247(b).
In (c), deleted former 4 and recodified former 5 and 6 as 4 and 5; and added (d).
Amended by R.1999 d.356, effective October 18, 1999.
See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).
In (a)2, inserted a reference to the National Center for Competency Testing.

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 wishing to continue a system of computerized patient records, which system does not meet the requirements of (b)3i through vii above, shall promptly initiate arrangements for modification of the system which must be completed by October 19, 1993. In the interim, the licensee shall assure that, on the date of the first treatment of each patient treated subsequent to October 19, 1992, the computer entry for that first visit shall be accompanied by a hard copy printout of the entire computer-recorded treatment record. The printout shall be dated and initialed by the attending licensee. Thereafter, a hard copy shall be prepared for each subsequent visit, continuing to the date of the changeover of computer program, with each page initialed by the treating licensee. The initial printout and the subsequent hard copies shall be retained as a permanent part of the patient record.

(c) Licensees shall provide access to professional treatment records 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 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.

5. 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.

6. 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 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; 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.

Repeal and New Rule, R.1990 d.176, effective March 19, 1990.
See: 21 N.J.R. 3253(a), 22 N.J.R. 978(a).
Amended by R.1992 d.429, effective October 19, 1992.
See: 24 N.J.R. 50(a), 24 N.J.R. 3729(d).
Revised (b).
Amended by R.1994 d.119, effective April 4, 1994.
See: 25 N.J.R. 4862(a), 26 N.J.R. 1522(a).
Amended by R.1998 d.184, effective April 6, 1998.
See: 29 N.J.R. 840(b), 30 N.J.R. 1295(a).
In (a), added exception at the end of the sentence; in (c)3, substituted "patient's mental or physical condition will be adversely affected upon being made aware" for "patient may be harmed by release"; in (c)3iii, added "through an employee thereof; or" at the end of the sentence and added a new iv; in (d)4, added the last two sentences; in (h)1, inserted "a copy of the" preceding "treatment records" and added the last sentence.

Case Notes

Board of Medical Examiners neither abused its statutory authority nor mistakenly exercised its discretion when it refused to expunge or otherwise modify consent order disciplining a doctor for failing to keep adequate patient medical records; consent order was legally entered into with doctor's consent, and the Board had authority to file order and fine doctor accordingly. In re D'Aconti, 316 N.J.Super. 1, 719 A.2d 652 (N.J.Super.A.D. 1998).

Verification may be required before personal injury protection benefits are paid. State Farm Mut. Auto. Ins. Co. v. Dalton, 234 N.J.Super. 128, 560 A.2d 683 (A.D.1989) certification denied 117 N.J. 664, 569 A.2d 1356, certiorari denied 110 S.Ct. 1131, 493 U.S. 1078, 107 L.Ed.2d 1037.

Reprimand by Board for failure to prepare patient record noted; transcript of Board proceeding not records within the meaning of the Right to Know Law, but are public records under common law; injury action's plaintiff's right to examine and inspect records superior to Board's interest in confidentiality (citing former N.J.A.C. 13:13–6.12). Beck v. Bluestein, 194 N.J.Super. 247, 476 A.2d 842 (App.Div.1984).

Use of improper procedures at abortion clinics and failure to supervise staff support suspension of doctors operating facility. In the Matter of Miro and Steck, 97 N.J.A.R.2d (BDS) 1.

Revocation of license; psychiatrist who engaged in sexual contact with patients. In the Matter of the Suspension or Revocation of the License of Schermer, 94 N.J.A.R.2d (BDS) 33.

Performing numerous cardiac procedures without sufficient medical justification, failing to maintain accurate patient records, along with other acts of negligence, malpractice and incompetence, warranted license revocation; penalty and costs also assessed. In Matter of Suspension or Revocation of License of Rodriguera, 93 N.J.A.R.2d (BDS) 33.

Surgeon's license revoked; unauthorized prescriptions for controlled dangerous substances, failure to maintain medical records, and prescribing medications in manner deviating from accepted professional standards. In Matter of Suspension or Revocation of License of Makarenko. 92 N.J.A.R.2d (BDS) 1.

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.

"Joint protocol" means an agreement or contract between an advanced practice nurse and a collaborating physician which conforms to the standards established by the Director of the Division of Consumer Affairs pursuant to this rule.

"Medication" means any substance for which a prescription is required which is intended 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.

(b) Advance practice nurses who seek to prescribe or order medications or devices and the collaborating physician(s) with whom they are in collaboration shall develop a joint protocol, which shall be:

1. In writing;

2. Signed by both the advanced practice nurse and the physician, with an acknowledgment that any inappropriate professional behavior or violation of the protocol on the part of either the physician or the advanced practice nurse will be reported to his or her respective licensing board;

3. Maintained on the premises of every office in which the advanced practice nurse practices;

4. Updated on an ongoing basis to reflect changes in the practice, office personnel, skills of the advanced practice nurse, frequency of record review, and reference materials containing practice guidelines or accepted standards of practice; and

5. Reviewed at least on an annual basis.

(c) The content of a joint protocol under (b) above shall address:

1. The nature of the practice, the patient population (for example, pediatric patients) and settings (for example, inpatient, nursing home, patient residences or other alternative care environments);

2. Any particular circumstances for which, prior to prescribing, a specific examination is to be performed or a definitive diagnosis made;

3. The recordkeeping methodology to be used in the practice (for example, the protocol might indicate that records should contain subjective complaints, objective findings, an assessment and a plan of treatment);

4. A list of categories of medications appropriate to the practice;

5. A delineation of specific medications and the specific number of refills, to be prescribed pursuant to the direction of the physician;

6. Specific requirements with respect to the recordation, in the patient record and/or in separate logs, of medications prescribed or dispensed, dosages, frequency, duration, instructions for use and authorizations for refills;

7. Any medical conditions or findings within the nature of the practice which should require direct consultation prior to the prescribing or ordering of medications or devices;

8. The frequency and methodology to be employed to ensure periodic review of patient records;

9. Identification of the means by which the advanced practice nurse and collaborating physician can be in direct communication, as well as a description of arrangements which will assure that the collaborating physician or peer coverage is accessible and available;

10. Procedures for the use of medications in emergency situations; and

11. Identification of reference materials containing practice guidelines or accepted standards of practice.

(d) Failure to establish and implement joint protocols consistent with the standards set forth in this section and any violation of the joint protocol by an advanced practice nurse or physician may be deemed professional misconduct or other grounds for disciplinary sanction within the meaning of N.J.S.A. 45:1–21 by his or her respective licensing board.

New Rule, R.2000 d.274, effective July 3, 2000 (operative September 1, 2000).
See: 31 N.J.R. 1459(a), 32 N.J.R. 2448(a).

13:35–6.7 (Reserved)

Amended by R.1983 d.490, effective November 7, 1983.
See: 15 N.J.R. 785(a), 15 N.J.R. 1866(a).
In (c)2., added "or repeated" malpractice and added section (c) to statutory cite.
Amended by R.1991 d.597, effective December 16, 1991.
See: 23 N.J.R. 2248(a), 23 N.J.R. 3763(a).
Revised (a)1.
Amended by R.1994 d.522, effective October 17, 1994.
See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).
Repealed by R.1997 d.475, effective November 3, 1997.
See: 29 N.J.R. 842(a), 29 N.J.R. 4706(a).
Section was "Prescribing of amphetamines and sympathomimetic amine drugs".

13:35–6.8 Prescribing, administering or dispensing amygdalin (laetrile)

(a) The prescription or administration of amygdalin (laetrile) is a medical procedure which may only be performed by a physician licensed to practice medicine and surgery in the State of New Jersey, or a physician duly licensed to practice medicine and surgery in another state provided the practitioner does not open an office or place for the practice of his profession in this State.

(b) A licensed physician may prescribe, administer or dispense amygdalin (laetrile) to such physician's patient, consistent with the following standards and providing that the patient has signed the "written information request . . . for medical treatment" as set forth herein:

1. Generally:

i. As an adjunct to recognized, customary, or accepted modes of therapy; or

ii. Utilized exclusively in the treatment of any malignancy, disease, illness or physical condition; and

iii. If and when the physician has received a confirmed diagnosis of said malignancy, disease, illness or physical condition;

2. In the course of medically justifiable dietary supplement therapy;

3. As a prophylactic medication.

(c) The informed request for prescription of laetrile for medical treatment must utilize the wording appearing on a form which is available on request from the Board.

1. The form shall be prepared in quadruplicate and distributed as follows:

i. Original copy to State Department of Health;

ii. Copy to be retained by the physician;

iii. Copy to patient or person who signed form for the patient;

iv. Copy to pharmacist.

2. When amygdalin (laetrile) is utilized in the treatment of a malignancy, the diagnosis of malignancy shall be documented by a positive tissue diagnosis rendered by a qualified pathologist which shall include the size, location and type of malignancy. In the absence of tissue for diagnosis, the treating physician shall be required to obtain consultative and/or professional reports to support a positive diagnosis of a malignancy.

3. The alternative medically recognized and accepted form of therapy offered by a physician shall be thoroughly discussed with the patient and documented in writing.

(d) Complete and accurate records shall be maintained and made available to include:

1. Copy of signed informed request.

2. History of previous therapy to be included where indicated.

i. Surgery;

ii. Radiation;

iii. Chemotherapy.

3. Complete record of dates of office visits, examination and evaluation of patient with detailed progress notes.

i. Complications and/or untoward reactions from amygdalin (laetrile) shall be reported immediately to the State Department of Health.

ii. Fee for service: The patient record shall include fee charged per visit which fee shall not be greater than the physician's usual and customary fee for an office visit. When fee includes administering or dispensing amygdalin (laetrile), the change is to be itemized and recorded. When a physician administers or dispenses amygdalin (laetrile), the fee to the patient shall not exceed the cost to the physician of such substance and shall be so itemized in the charge or billing.

iii. Copies of all laboratory and follow-up examinations; and

iv. Periodical clinical measurements of tumor activity.

4. Date or procurement of amygdalin (laetrile), quantity, cost, name and address of manufacturer and supplier, batch number and expiration date when administered or dispensed by a physician.

5. Records are to be readily available without prior notice for inspection by the appropriate official agency, including, but not limited to the New Jersey Board of Medical Examiners and the New Jersey State Department of Health.

6. Copies of records shall be forwarded to State Department of Health at quarterly intervals.

(e) Solicitation is prohibited. Such prohibited activity shall include, but is not limited to, the dissemination of information concerning amygdalin (laetrile) which may be found by the Board of Medical Examiners as:

1. False, fraudulent, deceptive, misleading or flamboyant;

2. Using testimonials;

3. Guaranteeing that satisfaction or cure will result from the use of amygdalin (laetrile);

4. Making claims of professional superiority;

5. Stating fees for professional services which are false, deceptive and/or misleading.

(f) A licensed physician may, in the regular course of medical practice and pursuant to a justifiable medical basis, prescribe, administer, or dispense amygdalin (laetrile) in accordance with the Act concerning Laetrile (Chapter 318, P.L. 1977) and these rules and regulations.

As amended, R.1984 d.67, effective March 19, 1984.
See: 15 N.J.R. 2029(b), 16 N.J.R. 552(a).
Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Deleted reference to specific statute.

13:35–6.9 Referral for radiological services

(a) "Physician" shall mean a physician possessing a plenary license to practice medicine and surgery and practitioners legally licensed to practice chiropractic or podiatry.

(b) A physician possessing a plenary license to practice medicine and surgery who provides diagnostic radiological services for other physicians possessing a plenary license to practice medicine and surgery shall, upon the request of a chiropractic or podiatric physician, provide diagnostic radiological services to such chiropractic or podiatric physician without discrimination on the basis of classification of license, provided the diagnostic radiological services requested pertain to skeletal areas of the body.

(c) Denial of professional diagnostic radiological services, as set forth herein, shall constitute purposeful and intentional discrimination and shall subject the licensee to appropriate disciplinary action by the Board of Medical Examiners.

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Added reference to podiatric services.

Case Notes

Rule valid as within statutory power and duties of Board to regulate practice of medicine, surgery and chiropractic and to secure patients the expert diagnostic radiological services referred to therein (cited as N.J.A.C. 13:35–6.18). Brodie v. New Jersey Bd. of Medical Examiners, 177 N.J.Super. 523, 427 A.2d 104 (App.Div.1981) certification denied 87 N.J. 386, 434 A.2d 1068 (1981).

13:35–6.10 Advertising and solicitation practices

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

1. The term "advertisement" shall mean any attempt directly or indirectly by publication, dissemination, or circulation in print or electronic media which directly or indirectly induces or attempts to induce any person or entity to purchase or enter into an agreement to purchaser services, treatment, or goods related thereto from a Board licensee.

2. "Board licensee" shall mean any individual holding a license issued by the State Board of Medical Examiners.

3. The term "routine professional service" shall refer to a service which a board licensee or professional association routinely performs.