



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Care Safety and Quality
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Circular Letter: DHCQ 09-07-515

TO: Hospital and Clinic CEO's and Medical Record Librarians
FROM: Paul I. Dreyer, PhD, Director
DATE: July 22, 2009
SUBJECT: Notification of Destruction of Medical Records

The purpose of this letter is to clarify for hospitals and clinics the Department's regulations regarding the retention of medical records. As a result of Chapter 305 of the Acts of 2008, and changes to the Department's regulations regarding medical records approved by the Public Health Council at its May 13 and June 24, 2009 meetings, hospitals and clinics: (1) may convert records to an electronic format, (2) must notify patients in writing of their record retention and destruction policies; and, (3) may destroy medical records 20 years after the discharge or the final treatment of the patient to whom a retained medical record relates.

Under the provisions of the revised hospital and clinic regulations, 105 CMR 130.370(F) and 105 CMR 140.302(F), hospitals and clinics must notify the Department of Public Health at least thirty days in advance of their intent to destroy medical records in excess of twenty years old.

The Department has developed a notification form for hospital and clinic medical record administrators to use for this purpose. Attached is a copy of the form.

Please follow these guidelines when completing this form:

- Hospital or clinic name and address should be that under which you are licensed.

- Type of record should reflect the general type of medical records¹ to be destroyed within the date range specified, or if it is records of a particular service or satellite. Please note that providers are not required to provide specific information on the actual content of the medical record.
- The date range of the records to be destroyed should specify either records through a particular period (for example, “All records regarding patients whose discharge or final treatment was between January 1, 1958 and December 31, 1988.”), or prior to a particular date (for example, “Any records created for patients whose discharge or final treatment was prior to December 31, 1988.”).
- The planned date of destruction should reflect the schedule to be followed. Hospitals and clinics may specify one particular date or period during which destruction will occur, or a series of dates for the calendar year (for example “Monthly for records created for patients whose discharge or final treatment was over 20 years ago on the first of the month.”) **Hospitals and clinics may notify the Department once annually of all destruction planned through a calendar year if they choose, as long as the notification is after the expiration of the 20 year retention period.**

Each notification form must be signed and dated by an authorized representative of the hospital or clinic, and include the contact information for that person. Hospitals and clinics may include additional comments as necessary to clarify their notification.

Please note that it is our intent that hospitals and clinics simply fax the form to the Department. There is no requirement to send the original copy to us by mail, or to call the Department to notify us of your intent to destroy records.

A hospital or clinic is not obligated to notify the Department of the destruction of the original document upon converting handwritten, printed or typed records to an electronic digital format or an alternative archival method, so long as converted version will be retained for at least 20 years after the last date of treatment or discharge of the patient to whom the record relates. Hospitals and clinics are reminded of their obligation to provide written notice to each patient of the patient’s right to inspect and to receive a copy of the patient’s medical records, and the hospital or clinic’s medical record retention policy, as specified in M.G.L. c. 111, § 70. Hospitals and clinics may, but are not required to, notify a patient before destroying a particular record.

If you have any questions regarding this matter, please contact Sherman Lohnes, Assistant Director for Complaints and Enforcement, at 617-753-8160.

¹105 CMR 130.370(B) and 105 CMR 140.302(C)(2) specifically provide that hospitals and clinics “... shall not be required to consider the following as part of the medical record subject to the retention requirements in M.G.L. c. 111, § 70: radiological films, scans, other image records, raw psychological testing data, electronic fetal monitoring tracings, electroencephalograph, electrocardiography tracings and the like, provided that any signed narrative reports, interpretations or sample tracings that are generated to report the results of such tests and procedures shall be maintained as part of the record...” and that such records shall be retained for a period of at least five, rather than 20 years following the date of service, but that hospitals and clinics are not precluded from maintaining these records for a longer period of time.

