

Under the *Chiropractic Act, 1991*
Approved by Council: March 23, 1996
Proposed Amendments Circulated August 2002

Note to Readers: In the event of any inconsistency between this document and the legislation that affects chiropractic practice, the legislation governs.

Type of Records to be Maintained

1. (1) A member shall, in relationship to his/her practice, take all reasonable steps necessary to ensure that records are kept in accordance with this regulation.
 - (2) Reasonable steps under subsection (1) shall include the verification by the member, at the request of the College, that the records are kept in accordance with this regulation.
2. A legible daily appointment record shall be kept that sets out the surname and initials of each patient the member examines or treats or to whom the member renders any service.
3. An equipment service record shall be kept that sets out the servicing of:
 - every x-ray machine in accordance with the regulations prescribed under section 22 of the *Healing Arts Radiation Protection Act, 1990*; and
 - every other piece of equipment used to emit a form of energy prescribed under section 43 (1) (a) of the *Regulated Health Professions Act, 1991*.
4. (1) A financial record shall be kept for each patient.
 - (2) The financial record shall contain:
 - date of service;
 - services billed;
 - payment received; and
 - balance of account.

Health Records Information

5. (1) A patient health record shall be kept for each patient.
 - (2) The patient health record shall include the following:
 - the patient's name, address, birth date and gender;
 - the date of each of the patient's visits to the member;

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- the name and address of the treating chiropractor;
 - the names of primary care practitioners and the referring health professional;
 - the history of the patient, including:
 - patient's chief complaint(s) and supporting data;
 - relevant past health history; and
 - family and social history when indicated by the presenting complaint(s);
 - reasonable information about every examination, including but not limited to an x-ray examination performed by the member, and
 - reasonable information about every clinical finding, diagnosis and assessment made by the member;
 - record of therapeutic management of the patient including:
 - reasonable information about every order made by the member for examinations, including but not limited to x-ray examinations, tests, consultations or treatments to be performed by any other person; and
 - every written report received by the member with respect to examinations, tests, consultations or treatments performed by other health professionals;
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- reasonable information about all advice given by the member to the patient; and
 - reasonable information about every treatment involving the performance of a controlled act within the meaning of subsection 27 (2) of the *Regulated Health Professions Act, 1991*, performed by the member;
 - reasonable information about every referral of the patient by the member to another health professional;
 - reasonable information about a procedure that was commenced but not completed, including reasons for non-completion; and

- a copy of every consent, which shall be fully informed, voluntarily given, evidenced in a written form signed by the patient or otherwise documented in the patient's record, and not obtained by fraud or misrepresentation.
- (3) Every part of a patient health record shall have a reference identifying the patient or the patient health record.
- (4) Every entry in a patient health record shall be dated, and the identity of the person who made the entry must be identifiable.

Records Retention

6. Subject to section 7, every patient health record and every financial record shall be retained for at least seven years following,
- the patient's last visit; or
 - if the patient was less than 18 years old at the time of his/her last visit, the day the patient became or would have become 18 years old.

Member Resignation

7. It is an act of professional misconduct for the purpose of clause 51 (1) (c) of the Health Professions Code for a member to fail to take reasonable steps before resigning as a member, to ensure that for each patient health record for which the member has primary responsibility:
- the record is transferred to another member and reasonable efforts are made to obtain the consent of the patient; or
 - the patient is notified that the member intends to resign and the patient can obtain copies from the patient health record.

Confidentiality of Access to Records

8. (1) The following are acts of professional misconduct for the purpose of clause 51 (1) (c) of the Health Professions Procedural Code:
- allowing any person to examine a patient health record or giving any information, copy or thing from a patient health record to any person except as required by law or as required or allowed by this section; and

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- failing to provide copies from or access to a patient health record for which the member has primary responsibility, as required by this section.
- (2) A member shall provide, on request, copies from or access to a patient health record for which the member has primary responsibility to any of the following persons:
- the patient;
 - a personal representative authorized by the patient to obtain copies from or access to the record;
 - if the patient is deceased, the patient's legal representative;
 - if the patient lacks capacity to give an authorization described in paragraph 2, a committee of the patient appointed under the *Mental Incompetency Act*;
 - a person to whom the patient is married and living in a conjugal relationship;
 - a person of the opposite or same sex with whom the patient is living in a conjugal relationship outside marriage if the patient and the person have cohabited for at least one year; are together the parents of a child; or have together entered into a co-habitation agreement under section 53 of the *Family Law Act*;
 - the patient's son or daughter;
 - the patient's parents.
- (3) Despite subsection 2, a member is not required to provide copies from or access to a patient health record if the member is of the opinion that disclosure of the health record would likely result in,
- serious harm to the care of the patient; or
 - serious physical or emotional harm to the patient or another person.

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- (4) Where the member has primary responsibility for a patient health record, the member shall, at the request of the patient, cause a correction to be made to the patient's health record or attach a statement of disagreement reflecting the correction requested but not made.
 - (5) The member shall give notice of every correction made and statement of disagreement attached to a patient health record to every person and organization to whom the record was disclosed during the 12 months preceding the day the correction was requested.
 - (6) It is not an act of professional misconduct under paragraph (b) of subsection (1) for a member to refuse to provide copies from or access to a patient health record until the member is paid a reasonable fee.
 - (7) It is not an act of professional misconduct under paragraph (b) of subsection (1) for a member to provide copies from or access to a patient health record to his/her legal counsel or insurer where the patient health record is relevant to advice being sought by the member or required by the member's policy of insurance.
 - (8) A member may provide copies from or access to a patient health record for which the member has primary responsibility to any person authorized by a person to whom the member is required to provide copies or access under subsection (2).
 - (9) A member may, for the purpose of providing health care or assisting in the provision of health care to a patient, allow a health professional to examine the patient health record or give a health professional any information, copy or thing from the record.
 - (10) A member may provide information or copies from or access to a patient health record to a person if,
 - the information or copies are to be used for health administration, planning, health research or epidemiological studies; or
 - the use of the information or copies is in the public interest as determined by the Minister; and
 - anything that could identify the patient is removed from the information or copies.

Electronic Equipment

9. (1) Where in this Regulation a notation, report, record, order, entry, signature or transcription is required to be entered, prepared, made, written, kept or copied, the entering, preparing, making, writing, keeping or copying may be done by electronic or optical means or a combination thereof.
- (2) The member shall take reasonable steps to ensure that the electronic or optical means referred to in subsection (1) are so designed and operated that the notation, report, record, order, entry, signature or transcription is secure from loss, tampering, interference or unauthorized use or access.