

Chapter DE 8

PATIENT DENTAL RECORD RETENTION

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DE 8.01 Authority and purpose. The provisions in this chapter are adopted pursuant to authority in ss. 15.08 (5) (b) and 227.11 (2) and ch. 447, Stats., to govern the practice of dentists in the maintenance, retention, and destruction of patient dental records.

History: CR 14-011; cr. Register August 2014 No. 704, eff. 9-1-14; correction made under s. 35.17, Stats., Register August 2014 No. 704.

DE 8.02 Definitions. In this chapter:

(1) “Patient” means a person who receives dental services from a licensed dentist or dental hygienist.

(2) “Patient dental record” or “patient health care record” has the meaning given in s. 146.81 (4), Stats.

Note: Section 146.81 (4), 2011 Stats., reads: “Patient health care records” means all records related to the health of a patient prepared by or under the supervision of a health care provider; and all records made by an ambulance service provider, as defined in s. 256.01 (3), an emergency medical technician, as defined in s. 256.01 (5), or a first responder, as defined in s. 256.01 (9), in administering emergency care procedures to and handling and transporting sick, disabled, or injured individuals. “Patient health care records” includes billing statements and invoices for treatment or services provided by a health care provider and includes health summary forms prepared under s. 302.388 (2). “Patient health care records” does not include those records subject to s. 51.30, reports collected under s. 69.186, records of tests administered under s. 252.15 (5g) or (5j), 343.305, 938.296 (4) or (5) or 968.38 (4) or (5), records related to sales of pseudoephedrine products, as defined in s. 961.01 (20c), that are maintained by pharmacies under s. 961.235, fetal monitor tracings, as defined under s. 146.817 (1), or a pupil’s physical health records maintained by a school under s. 118.125.”

History: CR 14-011; cr. Register August 2014 No. 704, eff. 9-1-14.

DE 8.03 Minimum standards for patient health care record retention. Patient health care records on every patient administered shall be maintained for a period of at least 10 years after the date of the last entry, unless otherwise required by state or federal law.

History: CR 14-011; cr. Register August 2014 No. 704, eff. 9-1-14.

DE 8.04 Confidentiality of patient health care records. All patient health care records shall remain confidential as provided in s. 146.82, Stats.

Note: Section 146.82, 2011 Stats., reads: “146.82 (1) CONFIDENTIALITY. All patient health care records shall remain confidential. Patient health care records may be released only to the persons designated in this section or to other persons with the informed consent of the patient or of a person authorized by the patient. This subsection does not prohibit reports made in compliance with s. 253.12 (2), 255.40, or 979.01; records generated or disclosed pursuant to rules promulgated under s. 450.19; testimony authorized under s. 905.04 (4) (h); or releases made for purposes of health care operations, as defined in 45 CFR 164.501, and as authorized under 45 CFR 164, subpart E.”

History: CR 14-011; cr. Register August 2014 No. 704, eff. 9-1-14.

DE 8.05 Preservation or destruction of patient health care records. The preservation or destruction of patient health care records shall be in compliance with s. 146.819, Stats.

Note: Section 146.819, 2011 Stats., reads: “146.819 Preservation or destruction of patient health care records. (1) Except as provided in sub. (4), any health care provider who ceases practice or business as a health care provider or the personal representative of a deceased health care provider who was an independent practitioner shall do one of the following for all patient health care records in the possession of the health care provider when the health care provider ceased business or practice or died:

(a) Provide for the maintenance of the patient health care records by a person who states, in writing, that the records will be maintained in compliance with ss. 146.81 to 146.835.

(b) Provide for the deletion or destruction of the patient health care records.

(c) Provide for the maintenance of some of the patient health care records, as specified in par. (a), and for the deletion or destruction of some of the records, as specified in par. (b).

(2) If the health care provider or personal representative provides for the maintenance of any of the patient health care records under sub. (1), the health care provider or personal representative shall also do at least one of the following:

(a) Provide written notice, by 1st class mail, to each patient or person authorized by the patient whose records will be maintained, at the last-known address of the patient or person, describing where and by whom the records shall be maintained.

(b) Publish, under ch. 985, a class 3 notice in a newspaper that is published in the county in which the health care provider’s or decedent’s health care practice was located, specifying where and by whom the patient health care records shall be maintained.

(3) If the health care provider or personal representative provides for the deletion or destruction of any of the patient health care records under sub. (1), the health care provider or personal representative shall also do at least one of the following:

(a) Provide notice to each patient or person authorized by the patient whose records will be deleted or destroyed, that the records pertaining to the patient will be deleted or destroyed. The notice shall be provided at least 35 days prior to deleting or destroying the records, shall be in writing and shall be sent, by 1st class mail, to the last-known address of the patient to whom the records pertain or the last-known address of the person authorized by the patient. The notice shall inform the patient or person authorized by the patient of the date on which the records will be deleted or destroyed, unless the patient or person retrieves them before that date, and the location where, and the dates and times when, the records may be retrieved by the patient or person.

(b) Publish, under ch. 985, a class 3 notice in a newspaper that is published in the county in which the health care provider’s or decedent’s health care practice was located, specifying the date on which the records will be deleted or destroyed, unless the patient or person authorized by the patient retrieves them before that date, and the location where, and the dates and times when, the records may be retrieved by the patient or person.

(4) This section does not apply to a health care provider that is any of the following:

(a) A community-based residential facility or nursing home licensed under s. 50.03.

(b) A hospital approved under s. 50.35.

(c) A hospice licensed under s. 50.92.

(d) A home health agency licensed under s. 50.49 (4).

(f) A local health department, as defined in s. 250.01 (4), that ceases practice or business and transfers the patient health care records in its possession to a successor local health department.”

History: CR 14-011; cr. Register August 2014 No. 704, eff. 9-1-14.