Chapter Med 21

PATIENT HEALTH CARE RECORDS

Med 21.01 Authority and purpose. The rules in this chapter are adopted by the board under the authority of ss. 15.08 (5) (b), 227.11 (2) and 448.40 (1), Stats., to govern the practice of physicians and physician assistants in the preparation and retention of patient health care records.

History: Cr. Register, April, 1996, No. 484, eff. 5-1-96; am. Register, December, 1999, No. 528, eff. 1-1-00.

Med 21.02 Definitions. As used in this chapter:

(1) "Board" means the medical examining board.

(2) "Patient" means a person who receives health care services from a physician or physician assistant.

(3) "Patient health care record" has the meaning given in s. 146.81 (4), Stats.

History: Cr. Register, April, 1996, No. 484, eff. 5-1-96; am. (2), Register, December, 1999, No. 528, eff. 1-1-00.

Med 21.03 Minimum standards for patient health care records. (1) A physician or physician assistant shall maintain patient health care records on every patient administered to for a period of not less than 5 years after the date of the last entry, or for such longer period as may be otherwise required by law.

(2) A patient health care record prepared by a physician or physician assistant shall contain the following clinical health care information which applies to the patient's medical condition:

(a) Pertinent patient history.

(b) Pertinent objective findings related to examination and test results.

(c) Assessment or diagnosis.

(d) Plan of treatment for the patient.

(3) Each patient health care record entry shall be dated, shall

identify the practitioner, and shall be sufficiently legible to allow interpretation by other practitioners for the benefit of the patient.

History: Cr. Register, April, 1996, No. 484, eff. 5-1-96; am. (1) and (2) (intro.), Register, December, 1999, No. 528, eff. 1-1-00.