

RETENTION OF RECORDS POLICY & RELEASE OF RECORDS POLICY



CDSS RETENTION OF RECORDS POLICY

Updated April 2010

The Dental Professions Act, 1978, stated that dental records should be kept for one (1) year following the termination of services. The College policy, at that time, recommended to the membership that all dental records should be kept for a minimum of seven (7) years to meet the requirements of Revenue Canada legislation.

When *The Dental Disciplines Act* was proclaimed in 1997, the new Act was silent on the subject of limitations with respect to retention of dental records. Accordingly, The Limitations Act was the legislation determining the requirement respecting records retention. Under that Act, records were required to be kept for a minimum of two (2) years from the termination of treatment or a minimum of two years from the time a reasonably prudent patient discovered something was wrong. In consultation with our solicitor, the College basically determined that this time line could be infinity under this legislation.

In the year 2002, the Government established a Law Review Committee to study the issue surrounding the retention of records, and on May 15, 2005, amended *The Limitations Act* wherein it states that health records must now be kept a minimum of fifteen (15) years. When the discoverability principle is applied (2 years), this becomes seventeen (17) years.

At a special meeting of Council held September 13, 2008, the Council passed the following motion: THAT the CDSS develop a Bylaw that states as a general rule that dental patient records must be retained from the date of collection / creation to the longer of 6 years (adults) or the age of majority (age 18) plus 2 years (minors).

Since that time, SK Ministry of Health has advised that the Bylaw is not necessary and that the CDSS may simply establish this as policy.

At Fall Council held October 30, 31, 2008, the Council passed the following motion:

THAT Members of the College of Dental Surgeons of Saskatchewan shall adopt the following policy for retention of personal health information records:

- A member shall retain patient records for **six (6) years** after the date of the last entry in the records.
- A member shall retain the records of pediatric patients until two (2) years past the age of majority (age 18); or six (6) years after the date of the last entry in the records; whichever may be the later date. Age 24 would be the maximum age in this category.
- This policy applies to all patient information including:
 - All radiographs
 - Pretreatment and post treatment models, for major treatment, by specialists or general members, must be kept for 6 years after satisfactory delivery and appropriate adjustment and/or follow up. Major treatment would include but not be limited to the following cases:
 - Multiple veneers (more than 4)
 - Full mouth reconstruction involving most posterior teeth
 - Multiple implants
 - Alteration of posterior vertical dimension
 - Implant supported removable prosthesis
 - Orthognathic surgery
 - Orthodontics – the appropriate models must be kept for the greater of 6 years or the age of majority plus two (2) years after satisfactory completion of treatment and appropriate

retention.

- **Appropriate disposal should ensure compliance with HIPA which states: [17(1) (2)(b)] “personal health information is destroyed in a manner that protects the privacy of the subject individual.”**
- **A member is obligated to retain records of deceased patients for two (2) years from the date of the last entry in the records. (Discoverability Principle – The Limitations Act)**

RELEASE OF RECORDS POLICY

Updated October 2008

Bylaw 9.2(1) (g): states that "members shall provide within a reasonable time any report or certificate requested by a patient or his or her authorized agent in respect of an examination or treatment performed by a member."

The Code of Ethics, Article 12: Records: states that “A dentist must establish and maintain adequate records of medical-dental history, clinical findings, diagnosis and treatment of each patient. Such records or reports of clinical information must be released to the patient or to whomever the patient directs, when requested by the patient. Original records should be retained and a duplicate provided.”

Reference to the patient’s right to obtain copies of their dental records were strengthened following a unanimous ruling of the Supreme Court of Canada wherein the Court found that, due to the patient’s vital interest in the information contained in the records, the patient has the right to inspect the records and obtain copies of the records. Subsequent decisions have been made by dental regulatory bodies stating that to withhold the release or transferring of a patient’s dental records due to an outstanding account is not permissible, as there are alternate methods available to collect such accounts. Upon a written request from a

patient or legal guardian a dental office should:

1. Forward the requested records directly to another dental office or to the patient where so requested.
2. Record the written request and the date of transfer.
3. Receive confirmation, in writing, that the other dental office, or the patient, have received the record.

This protocol respects the patient’s rights, the Bylaws and the Code of Ethics.

The Code of Ethics does state “Original records should be retained and a duplicate provided.”; however, in a situation where a practitioner is retiring or closing a practice there is no need to retain the original record, provided that the original record is forwarded securely to the patient’s dental office of choice and confirmation of this transfer should be sent to the originating dentist. Copying the file is not necessary.

Currently secure, user friendly methods of transfer of electronic records may not be available. To remedy this, electronic transfer of patient information (including radiographs) could be achieved by sending two (2) consecutive emails to the provider of choice (eg. Oral Radiologist). The first email will include very basic information (name of patient) and it will indicate that a second email will follow immediately with the radiographs for that patient attached.

A provider may charge for this service and the following codes in our fee guide relate to this matter:

- 93211 Patient File Management
- 92911 Radiographs, Duplications
- 92912 Radiographs, Duplications
- 92913 Radiographs, Duplications

Currently a draft HIPA (Health Information Protection Act) document that will limit the transfer fee to \$20 plus expenses for duplication is being developed and will be forwarded to dental offices once completed.

Sample Form:

Transfer of Records For: _____ (patient's name)

_____ (patient signature)

From: _____ Date Sent: _____
(Dentist office/signature)

To: _____ Date Received: _____
(Dentist office/signature)

Method of Transfer: In Person _____ Mail _____ Courier _____ Other _____

- 1. Originating dentist keeps copy of this form when record is sent.**
- 2. Receiving dentist returns signed copy of this form when record received**