1.4.E.5 Inmate Medical Records

I Policy Index:

Date Signed: 03/22/2016
Distribution: Public
Replaces Policy: 4E.12
Supersedes Policy Dated: 10/29/2015
Affected Units: All Institutions
Effective Date: 03/23/2016
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Revision Number: 14
Office of Primary Responsibility: DOC Administration

II Policy:

A complete health record will be maintained for each inmate to accurately document medical, dental and mental health needs and care received while the inmate is in the custody of the Department of Corrections.

III Definitions:

Inmate:
For the purposes of this policy, an inmate is any person who has been sentenced or placed in a facility under the control of the Department of Corrections (DOC).

IV Procedures:

1. Establishing Health Records:

A. At the time of admission to a DOC facility, a complete health record will be established for every inmate (See DOC policy 1.4.A.2 Inmate Admission).

B. Paper and electronic medical records will be compiled in a standard format approved by the responsible health care authority (See Attachments 1 and 2). All health records will be organized in a uniform manner and the order of content standardized (See DOH policies P-H-01A Medical Records Chart Order).

C. When an inmate is re-admitted to a DOC facility, any existing DOC health records for the inmate will be pulled from the archives.

   A. To facilitate continuity of care and ensure diagnostic evaluations are current, all inmates will have one (1) health record that contains reports, studies, and all other medical information specific to the inmate.
2. **Location of Health Records:**

   A. Paper health records for an inmate housed in the facility will be retained in a secure area of the facility under the control of health service staff. Inactive paper medical records will be securely maintained separate from the records of inmates currently housed at the facility.

   B. Upon an inmate’s release from DOC custody to parole, suspended sentence, discharge, or in the event of death, all of the inmate’s paper health records will be placed in the health records archives (See DOH policies P-H-04 *Management of Health Records*).

       1. Inactive paper health records for inmates released from DOC custody will be archived at the South Dakota State Penitentiary (SDSP) for male inmates and at the South Dakota Women’s Prison (SDWP) for female inmates.

       2. Paper health records will be kept for a minimum of ten (10) years following the date the record is archived.

       3. All paper health records that exceed the current retention period will be properly destroyed. The South Dakota Department of Health is responsible for coordinating the proper destruction of inmate medical records that meet the destruction criteria.

3. **Transfer of Inmate Health Records:**

   A. Pertinent health information in the form of summaries, originals or copies of health records, as determined by health service staff, will accompany the inmate when/if he/she is transferred to a correctional facility outside the jurisdiction of the South Dakota DOC (See DOH policies P-H-05 *Transfer of Health Records* and ACA 4-4414).

   B. Inmate ERMs stored in Correct Tech™ may be reviewed by authorized health service staff at a SD DOC facility (See DOH policy P-H-04A *Intra System Transfer of Medical Records*).

   C. To avoid delays in continuing medications and/or treatment, authorized health service staff will review each transferred inmate’s EMR or summary. Typically this will occur within twelve (12) hours of the inmate’s admission, unless no health service staff is scheduled.

       1. A computer generated transfer sheet will be completed for inmates transferring outside a DOC facility (See DOH policy Y-E-03 *Transfer Screening*).

       2. Health record confidentiality will be maintained throughout the transfer of inmate records (ACA #4-4414).

4. **Access to Health Records:**

   A. Inmates may review their health records and receive copies of their health records, subject to DOC policy 1.1.E.3 *Inmate Access to Records*, DOC policy 1.4.E.10 *Inmate Medical Co-Pay* and DOH policy P-H-02A *Release of Information From Medical Records*.

       1. A co-pay fee may be charged to an inmate to view their medical record.

       2. Inmates requesting copies of their medical record may be charged a fee for each copy generated.
B. A written request is required prior to privileged information being released/disclosed from the inmate’s medical record. The request must be accompanied by a signed release of information from the inmate or legal representative (See DOH policy P-H-02 Confidentiality of Health Records).

1. Privileged information may be released from an inmate’s health record upon receipt of a subpoena, or through statutory privilege. The Clinical Supervisor will be notified of such requests by the Warden or his/her designee.

C. Any privileged information released regarding an inmate’s behavioral health records must have the approval of the Clinical Director or his/her designee.

Note: Medical staff is not permitted to release behavioral health records. Behavioral health staff is not permitted to release medical records. Prior approval from the respective responsible health authority is required.

D.Privileged medical information from an inmate’s health record may be accessed and/or released in accordance with state and federal law. An inmate’s health records may be accessed and/or released to the following (may require written request/authorization from those authorized to release the records and/or a signed Release of Information from the inmate):

1. Attorneys;
2. Other health care facilities/providers;
3. Regulatory agencies, Center for Disease Control (CDC), DOH and its various Divisions (Vital Statistics, Disease Intervention Office etc.);
4. Welfare organizations, Social Security Administration;
5. Workers Compensation;
6. Disability Determination Services;
7. South Dakota Advocacy Services; and
8. Others, as approved by the responsible health authority.

E. Access to inmate health records is controlled by the responsible health authority. Health records will be stored separate from confinement records and are only accessible to authorized individuals (ACA #4-4396). Only information necessary to preserve the health and safety of the inmate, other inmates or staff may be released by DOH staff to DOC staff (ACA #1-HC-3A-03).

F. DOC staff will not remove an inmate’s paper health records from the designated secure storage area.

G. The confidentiality of each inmate’s health information, including health information contained within paper health records or an EMR, will be maintained at all times.

5. Documentation of Health Records:

A. Laboratory reports, consultant reports, discharge summaries, diagnostics studies, etc. will be maintained in the adult inmate’s medical file.

B. The health care provider will properly maintain a record of any care from an outside health care facility.
V Related Directives:
   DOC policy 1.1.E.3 – Inmate Access to Records
   DOC policy 1.4.A.2 -- Inmate Admission
   DOC policy 1.4.E.10 – Inmate Medical Co-Pay
   DOH policy P-H-01 – Health Record Format and Contents
   DOH policy P-H-01A -- Medical Records Chart Order
   DOH policy P-H-02 – Confidentiality of Health Records and Information
   DOH policy P-H-04 -- Management of Health Records
   DOH policy P-H-04A -- Intra System Transfer of Medical Records
   DOH policy P-H-05 – Transfer of Health Records
   DOH policy P-H-06 – Retention of Health Records

VI Revision Log:
   July 2003: Added references to DOH policies PH 01, PH 02, PH 05 and PH 06. Added reference to policy 1.1.E.3 Changed the wording on disposing of inactive medical files Deleted reference to record retention from the policy statement.
   September 2004: Changed policy reference name from Inmate Access to Records to Offender Access to Records Changed inmate to offender Changed Director of Nursing to Clinical Supervisor. Revised attachment 1.
   September 2005: Expanded policy to include juvenile offenders Added definition of offender. Added attachment 2 Clarified that Health Services will release an offender’s medical records to another state agency/department with a signed release.
   October 2007: Revised attachment 1. Updated the name of DOH policy P-H-02.
   September 2008: Revised formatting of policy and attachments in accordance with DOC policy 1.1.A.2. Added reference to DOC policy in section V.
   September 2009: Added mental health to policy statement. Deleted Medical Director or psychiatrist for Mental Health Records in ss (B), added reference to Clinical Director or designee for release of mental health records within new ss (C), added Note, deleted former ss (C) regarding Health Services being the final authority on who is provided access to offender’s health records and added new ss (G) all within (Access to Records).
   September 2010: Revised formatting of Section I. Revised Note within section (Access to Medical Records) to state prior approval must be granted and copies can be made by either medical or mental health staff once permission is granted.
   October 2010: Deleted former ss (B) stating that any request/release of medical records must receive prior approval from the Clinical Supervisor or designee and replaced with referencing any request/release of medical records must accompany a signed release of information from the offender in new ss (B) both within (Access to Medical Records).
   November 2012: Added “Records should be organized in a uniform manner and the order of content standardized as offenders may be transferred throughout the DOC system” in Section 1 B. Added “provided to the offender to help facilitate continuity of care and ensure diagnostic evaluations are current” to Section 1 C. Added “by the owner(s)” to Section 2 D. Added “Access to medical records is controlled by Health Services” to Section 2 F. Added H. to Section 2.
   September 2013: Added D. to Section 1. Deleted “expiration of the offender’s maximum sentence and Replaced with “the date it is archived” in Section 2 B. 3. Added D. to Section 2. Added 1. and 2. to Section 3 A. Added “or legal representative” to Section 3 B. Added 1. to Section 3 B. Deleted D. “Copies of medical records will be released by court order by the owner of the record upon notification from the Warden, Superintendent or designee, the Clinical Supervisor, Charge Nurse or designee” in Section 3. Deleted “Health Service staff will release the offender’s medical record to other state agencies/departments with an offender’s signed release form” and Replaced with “Privileged medical information may be released from an offender’s medical record to the following (may require written authorization and signed Release of Information from the offender) and added sub items 1-8 to Section 3 E. Deleted “Health Services” and Replaced with “Clinical Supervisor or designee” in
Section 3 F. **Deleted** "The only exception that may allow for an offender’s medical chart to be removed from the medical unit with the correctional facility is when an inmate is being transferred from one DOC institution to another; i.e. from SDSP to MDSP" in Section 3. **Renumbered** section. **Added** G. to Section 3. **Deleted** attachments 1 & 2. Adult and Juvenile Medical Record Contents.

September 2014: Added “Electronic medical records (EMR) will be initiated on all admissions to the facility” in Section 1 C.

**September 2014**: **Replaced** term “medical record” with “health record” throughout policy. **Added** “paper and electronic” to Section 1 B. **Deleted** “incarcerated” and **Replaced** with “admitted to a DOC facility” and **Added** “If previously established, an ERM may be located in COMS for the re-admitted offender” in Section 1 C. **Added** 1. to Section 1 C. **Deleted** D. from Section 1. **Deleted** “Active medical records for offenders currently in custody will be kept in the medical unit in secure open shelf storage” and **Replaced** with “Paper health records for an offender housed in the facility will be retained in a secure area of the facility and under the control of health service staff. Inactive paper medical records will be maintained separately from the records of offenders currently housed at the facility.” In Section 2 A. **Added** “paper” health records in Section 2. **Added** 4. to Section 2 B. **Deleted** “After the 10 year period of retaining inactive medical records, the medical record will be destroyed” and **Replaced** with “Medical records that exceed the retention period will be destroyed” in Section 2 B. 5. **Added** new Section 3 “Transfer of Offender Health Records”. **Deleted** “Clinical Director” and **Replaced** with “responsible health authority” in Section 4. **Added** 2. to Section 4 B. **Added** “mental health and dental” in Section 5 A.

**September 2015**: **Reviewed** with no changes.

**March 2016**: **Deleted** references to juvenile and STAR Academy. Added definition of “inmate”. 

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**Denny Kaemingk (original signature on file)**

03/22/2016

Denny Kaemingk, Secretary of Corrections

Date