

Introduction to Medical Records

Introduction to Medical Records

Key concepts, components, and best practices for handling patient information

1. What Is a Medical Record?

Aspect	Description
Definition	A systematic collection of health-related information about an individual, created and maintained by health-care providers. • Document clinical care • Support decision-making
Purpose	• Facilitate communication among providers • Serve legal and regulatory requirements • Enable billing and reimbursement
Legal Status	Considered a legal document; must be accurate, complete, and retained for a mandated period (varies by jurisdiction).

2. Types of Medical Records

Type	Format	Typical Use
Paper Chart	Physical folders, printed forms	Still common in small practices or low-resource settings
Electronic Health Record (EHR)	Digital platform (cloud-based or on-premises)	Standard in most hospitals, clinics, and health systems
Personal Health Record (PHR)	Patient-controlled digital record (apps, portals)	Empower patients to view and share their data
Hybrid	Combination of paper and electronic components	Transitional environments

3. Core Components of a Medical Record

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1. Administrative Information

- Patient identifiers (name, DOB, MRN)
- Contact details, insurance information
- Consent forms and advance directives

2. Clinical Documentation

- **History & Physical (H&P)** – chief complaint, past medical/surgical history, family/social history, review of systems, physical exam findings.
- **Progress Notes** – SOAP (Subjective, Objective, Assessment, Plan) or narrative entries.
- **Orders & Results** – medication orders, lab/pathology, imaging, procedure reports.

3. Medication & Allergies

- Current medication list (dose, route, frequency)
- Documented drug, food, and environmental allergies

4. Immunizations & Preventive Care

- Vaccination dates, screening test results (e.g., mammography, colonoscopy)

5. Procedures & Interventions

- Surgical reports, anesthesia records, wound care notes

6. Discharge Summaries & Referrals

- Summary of hospitalization, follow-up plan, referral letters

7. Legal & Administrative Entries

- Consent for procedures, do-not-resuscitate (DNR) orders, legal holds

4. Standards & Interoperability

Standard

Scope

Relevance

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HL7 (Health Level 7)	Messaging format for exchanging clinical data	Enables labs, imaging, and EHRs to communicate
FHIR (Fast Healthcare Interoperability Resources)	Modern, web-based API standard	Supports mobile apps, patient portals, and real-time data exchange
CPT/ICD-10-CM	Coding for procedures (CPT) and diagnoses (ICD)	Required for billing, analytics, and quality reporting
LOINC	Lab and clinical observation identifiers	Standardizes test result reporting
SNOMED CT	Clinical terminology for signs, symptoms, diagnoses	Improves data consistency across systems

5. Privacy, Security, and Legal Requirements

Requirement	Key Points
HIPAA (U.S.)	- Safeguards Protected Health Information (PHI) - Minimum necessary rule - Patient right to access and amend records
GDPR (EU)	