

FIRST REGULAR SESSION

SENATE BILL NO. 261

103RD GENERAL ASSEMBLY

INTRODUCED BY SENATOR MOSLEY.

0066S.011

KRISTINA MARTIN, Secretary

AN ACT

To repeal section 334.097, RSMo, and to enact in lieu thereof one new section relating to patient records.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Section 334.097, RSMo, is repealed and one new
2 section enacted in lieu thereof, to be known as section 334.097,
3 to read as follows:

334.097. 1. Physicians shall maintain an adequate and
2 complete patient record for each patient and may maintain
3 electronic records provided the record-keeping format is
4 capable of being printed for review by the state board of
5 registration for the healing arts. An adequate and complete
6 patient record shall include documentation of the following
7 information:

- 8 (1) Identification of the patient, including name,
9 birthdate, address and telephone number;
- 10 (2) The date or dates the patient was seen;
- 11 (3) The current status of the patient, including the
12 reason for the visit;
- 13 (4) Observation of pertinent physical findings;
- 14 (5) Assessment and clinical impression of diagnosis;
- 15 (6) Plan for care and treatment, or additional
16 consultations or diagnostic testing, if necessary. If
17 treatment includes medication, the physician shall include

18 in the patient record the medication and dosage of any
19 medication prescribed, dispensed or administered;

20 (7) Any informed consent for office procedures; **and**

21 **(8) If requested to be documented by the patient, any**
22 **question asked related to the care and treatment of the**
23 **patient and the physician's response to such question.**

24 2. Patient records remaining under the care, custody
25 and control of the licensee shall be maintained by the
26 licensee of the board, or the licensee's designee, for a
27 minimum of seven years from the date of when the last
28 professional service was provided.

29 3. Any correction, addition or change in any patient
30 record made more than forty-eight hours after the final
31 entry is entered in the record and signed by the physician
32 shall be clearly marked and identified as such, and the
33 date, time and name of the person making the correction,
34 addition or change shall be included, as well as the reason
35 for the correction, addition or change.

36 4. A consultative report shall be considered an
37 adequate medical record for a radiologist, pathologist or a
38 consulting physician.

39 5. The board shall not initiate disciplinary action
40 pursuant to subsection 2 of section 334.100 against a
41 licensee solely based on a violation of this section. If
42 the board initiates disciplinary action against the licensee
43 for any reason other than a violation of this section, the
44 board may allege violation of this section as an additional
45 cause for discipline pursuant to subdivision (6) of
46 subsection 2 of section 334.100.

47 6. The board shall not obtain a patient medical record
48 without written authorization from the patient to obtain the

49 medical record or the issuance of a subpoena for the patient
50 medical record.

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