Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
Alabama	Assisted living facilities and abortion/reproductive health centers must retain medical records three years.	ADPH, 420-5-4.06(1)(c) ADPH, 420-5-1.02(5)(h)
	Hospital and sleep disorders facilities must retain medical records five years.	ADPH, 420-5-7-.10 ADPH, 420-5-18-.06(8)
	Hospices, nursing facilities, and rehabilitation centers must retain medical records five years from the date of discharge or three years after the age of majority.	ADPH, 420-5-17-.18(6) ADPH, 420-5-10-.03(33) ADPH, 420-5-11-.02(6)(f)
	End stage renal disease treatment and transplant centers and ambulatory surgical treatment centers must retain medical records six years from the date of discharge or six years after the age of majority.	ADPH, 420-5-5-.02(7)(e)2 ADPH, 420-5-2-.02(6)(g)
	Birthing centers must retain medical records 20 years for adults or seven years after the age of majority for minors.	ADPH, 420-5-13.11(4)
Alaska	Unless otherwise specified by the Department of Health and Social Services, hospitals must preserve records that relate directly to the care and treatment of a patient for seven years following discharge. However, records of a patient under 19 years of age shall be kept at least two years after the patient reaches 19 or seven years following discharge of the patient, whichever is longer. X-ray film must be retained for five years.	Alaska Stat. Section 18.20.085 (1992)
	Facilities providing healthcare to Medicaid recipients must retain fiscal, patient care, and related records for three years following the year in which services were provided, unless the Department of Health and Social Services requests retention for a longer period.	Alaska Admin. Code tit. 7 Section 43.030 (Apr. 1984)
Arizona	There is no state statute specific to retention of health information. However, the statute of limitations for medical malpractice claims is two years from the time the patient discovers or should have discovered an injury. The statute of limitations for minors is two years past the age of 18. Providers must keep adult patient records for a minimum of two years and minor patient records for a minimum of two years past the age of 18 to comply with statute of limitations.	ARS 12-502 (1996) ARS 12-542 (1985) ARS 12-550 (1994)
	Any institution that provides inpatient medical, surgical, diagnostic, nursing, custodial, or domiciliary care must retain the information necessary to complete birth, death, and fetal death registration forms, and records of disposal of remains for at least 10 years.	ARS Section 36-343 (1992)
	For licensing purposes, hospital medical records must be retrievable for a period of not less than three years, except for vital records (birth and death) and statistics, which must be retained for 10 years.	ARS Section 36-343 (1992)
	Arizona requires that duplicate lab reports be retained in the laboratory area for at least one year after the date results are reported.	Arizona Comp. Admin. Rules & Regs. Section 9-10-222 (1982)
Arkansas	All medical records shall be retained in either the original form or microfilm or other acceptable methods for ten years after the last discharge. After ten years a medical record may be destroyed provided the facility permanently maintains the information contained in the master patient index. Complete medical records of minors shall be retained for a period of two years after the age of majority.	Arkansas Regs. 0601

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
California	Hospitals must maintain medical records for a minimum of seven years following patient discharge, except for minors. Records of minors must be maintained for at least one year after a minor has reached age 18, but in no event for less than seven years.	California Code Regs. tit. 22 Section 70751 (c) (1993) California Code Regs. tit. 22 Section 71551(c) (1993)
	Acute psychiatric hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, primary care clinics, psychology clinics, and psychiatric facilities must maintain medical records and exposed x-rays for a minimum of seven years following patient discharge, except for minors. Records of minors must be maintained for at least one year after a minor has reached age 18, but in no event for less than seven years.	California Code Regs. tit. 22 Section 73543(a) (1993) California Code Regs. tit. 22 Section 74731(a) (1993) California Code Regs. tit. 22 Section 75055(a) (1993) California Code Regs. tit. 22 Section 75343(a) (1993) California Code Regs. tit. 22 Section 77143(a) (1993)
Colorado	Hospitals must preserve medical records as originals or on microfilm for not less than 10 years after the most recent patient care use, except that records of minors must be preserved for the period of minority plus 10 years.	6 Colorado Code Regs Section 1011-1, Section 4.2 (1977)
Connecticut	Medical records, other than nurses' notes, must be kept for a minimum of 25 years after patient discharge, but may be destroyed sooner if microfilmed by a process approved by the Department of Health.	Connecticut Agencies Regs. Section 19-13-D4(b)(1979)
	Homes for the aged and rest homes must maintain information on forms approved by the state Department of Health at least 10 years following patient death or discharge.	Connecticut Agencies Regs. Section 19-13-D6(e)(1988)
Delaware	Nursing home records should be retained five years before being destroyed.	Delaware State Board of Health, Nursing Home Regs. for Skilled Care Section 810 (1986)
District of Columbia	Regulations require a medical record to be kept for not less than 10 years following the date of the patient's discharge.	DC Mun. Regs. tit. 22 Section 2216.3 (1986)
Florida	Hospital shall retain inpatient medical records, emergency room records, and outpatient/clinical records for seven years after the last entry. X-ray films are to be retained for seven years.	General Records Schedule for Hospital Records GS4 (1997)
	Nursing homes must retain medical records a minimum of seven years after the last entry or retain until 24 years of age, whichever is longer.	Florida Admin. Code Annotated r. 59A-4.118(8)(1992)
	Physicians are required to maintain records for at least seven years.	Florida Admin. Code Annotated r. 59A-3.214
	Dentists must maintain written dental records for four years after the patient is last examined or treated.	Florida Admin. Code Annotated r. 61FS 17.005
Georgia	Hospitals must preserve medical records as originals, microfilms, or other useable forms until the sixth anniversary of the patient's discharge or longer. Hospitals must keep a minor's records until the patient's 27th birthday. (This regulation was promulgated at a time when the age of majority in Georgia was 21. Since that time, the age of majority has been lowered to 18.)	Georgia Comp. Rules & Regs. r. 290-5-6-.11(1991)

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
Hawaii	Healthcare medical records must be retained for a minimum of seven years after the last data entry. Medical records for minors shall be retained during the period of minority plus seven years after the minor reaches the age of majority. X-ray films, electro-encephalogram tracings, and similar imaging records shall be retained for at least seven years, after which they may be presented to the patient or destroyed. The healthcare provider or the healthcare provider's successor shall be responsible for the retention of basic information from the medical records for 25 years from the last entry, or in the case of a minor, for the duration of minority plus 25 years after reaching the age of majority. Basic information from a physician or surgeon's record includes the patient's name and birthdate, a list of dated diagnoses and intrusive treatments, and a record of all drugs prescribed or given. Basic information from a healthcare facility shall include the patient's name and birthdate, dates of admission and discharge, names of attending physicians, final diagnoses, major procedures performed, operative reports, pathology reports, and discharge summaries.	Hawaii Rev. Stat. Section 622-58
Idaho	Clinical laboratory test records and reports may be destroyed three years after the date of the test.	Idaho Code Section 39-1394 (1992)
	Long term care facilities are required to preserve records for a period of time not less than seven years. If the patient/resident is a minor, the record shall be preserved for a period of not less than seven years following his 18th birthday.	IDAPA 16.03.02203,04b
	X-ray films may be destroyed five years after the date of exposure or five years after the patient reaches the age of majority, whichever is later, if the hospital has written findings of a physician who has read such films.	Idaho Code Section 39-1394 (1992)
	Skilled nursing and intermediate care facilities must keep records not less than seven years. If the patient is a minor, the facility must preserve the records for not less than seven years following the patient's 18th birthday. Proprietary home health agencies must maintain clinical records for six years from the date of discharge or in the case of minors, three years after the patient becomes of age.	Licensing and Certification Section, Bureau of Welfare Medical Programs, Division of Welfare, Idaho Dept. of Health and Welfare, Statutes and Regs. Dealing with Medical Record Retention 5 (1992)
	Health maintenance organizations must keep medical records for six years after the termination of the enrollee's contract.	Idaho Code Section 41-3909 (1992)
Illinois	All original medical records or photographs of such records shall be preserved in accordance with a hospital policy based on American Hospital Association recommendations and legal opinion.	Illinois Admin. Rules, Title 77, Subpart L, §250.1510
	Home health agencies shall retain records for a minimum of five years beyond the last date of service provided. Agencies that are subject to the Local Records Act should note that "except as otherwise provided by law, no public record shall be disposed of by an officer or agency unless the written approval of the appropriate Local Records commission is first obtained."	50 ILCS (Illinois Compiled Statutes) 205/1

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
Illinois (cont.)	Hospitals that produce photographs of the human anatomy by the x-ray or roentgen process on the request of licensed physicians for use by them in the diagnosis or treatment of a patient's illness or condition shall retain such photographs or films as part of their regularly maintained records for a period of five years provided that retention of said photographs or film may be by microfilm or other recognized means of minification that does not adversely affect their use for diagnostic purposes. However, if the hospital has been notified in writing by an attorney-at-law before the expiration of the five-year period that there is a litigation pending in court involving a particular x-ray or roentgen photograph in their records as possible evidence, and that the subject person of such photograph is his client, or is the person who has instituted such litigation against his client, then the hospital shall keep such photograph or film or minified copy thereof in its regular records until notified in writing by the plaintiff's attorney with the approval thereon of the defendant's attorney of record that the case in court involving such photograph has been concluded, or for a period of 12 years from the date that the x-ray photograph film was produced, whichever comes first in time.	210 ILCS (Illinois Compiled Statutes) 90/1
Indiana	Physicians, dentists, nurses, optometrists, podiatrists, chiropractors, physical therapists, psychologists, audiologists, speech-language pathologists, home health agencies, and hospitals must maintain the original health records or microfilms of the records for at least seven years. They must maintain patient x-ray film, scans, and diagnostic images for at least five years.	IC 16-39-7-1(b)(1993) IC16-39-7-2 (b) and (d) (1993) 410 IAC 15-1.5-9 (e)
	Ambulatory outpatient surgical centers must retain medical records or microfilms for at least 25 years. Microfilms may be substituted for original records that are three years or more of age. A center may submit a request to the Licensing Council for approval to microfilm earlier.	410 IAC 15-2-8
	Comprehensive care facilities and residential care facilities must preserve medical records in the facility for a minimum of one year after discharge of the resident or in accordance with applicable federal and state laws.	410 IAC 16-2-3-13(f)(2) (1984) 410 IAC 16.2-5-8 (1984) 431 IAC 2-2-6(a)
	In facilities for the mentally ill, medical records must be retained at least 10 years after the resident leaves the program, or in the case of minors, 10 years after discharge or until the child's 23rd birthday, whichever is the longer period. Patient registers shall be maintained within the facility for the period required by statutes of limitations.	410 IAC 15-2-7 (1976)
	Any such photographic, photostatic, miniature photographic, or optical image copy or reproduction shall be deemed to be an original record for all purposes and shall be treated as an original record in all courts or administrative agencies for the purpose of its admissibility in evidence.	IC34-3-15-2 (1995)

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
Iowa	Hospitals must keep admission records, death records, birth records, and narcotic records. Medical records must be filed and kept in an accessible manner in the hospital in accordance with the statute of limitations.	Iowa Admin. Code r. 481-51.6(1) (1987)
	The hospital pharmacy must keep records of transactions for the control and accountability of drugs, as well as records of all medications and prescriptions dispensed.	Iowa Admin. Code r. 481-51.25(2)(135B)
	Nursing facilities must keep a resident's medical record for three years.	Iowa Admin. Code 4.441-81.9(2)
Kansas	Kansas hospitals must maintain medical records 10 years after the last discharge of the patient or one year beyond the date that patients who are minors reach their majority, whichever is longer.	Kansas Hospital Regs. 28-34-9(d)(1)
Kentucky	Hospitals must maintain inpatient and outpatient records a minimum of five years from the date of discharge, or in the case of a minor, three years after the patient reaches the age of majority under state law, whichever is longer.	902 Kentucky Admin. Regs. 20:016 Section 3(11)(a)(1991)
Louisiana	Hospitals must retain hospital records in their original, microfilmed or similarly reproduced form for a minimum of 10 years after the patient is discharged. Hospitals must retain graphic matter, images, x-ray films, and the like necessary to produce a diagnostic or therapeutic report in their original, microfilmed, or similarly reproduced form for three years from the date the patient was discharged. The hospital must retain records for a longer period when the patient's physician, the patient, or legal representative requests so in writing.	Louisiana Rev. Stat. Annotated Section 40:2144 (West 1992)
	Physicians must retain medical records in their original, microfilmed, or similarly reproduced form for a minimum of six years from the date the physician last treats the patient. Graphic matter, images, x-ray films, and the like necessary to produce a diagnostic or therapeutic report must be retained in the original, microfilmed, or similarly reproduced form for a minimum of three years from the date the patient is last treated by the physician and must be kept longer when requested in writing by the patient.	Louisiana Rev. Stat. Annotated Section 40:1299.96 (West 1992)
Maine	Hospital records shall be preserved on paper or by other electronic/optical means for a period of seven years. If the patient is a minor, the record must be retained for at least six years past the age of majority. Hospital x-ray films will be retained in the original or electronic form for five years, or in the case of a minor, five years past the age of majority. Patient logs and written x-ray report will be retained permanently.	State of Maine, Regs. for the Licensure of General and Specialty Hospitals, ch. VI: XII B.1. State of Maine, Regs. for the Licensure of General and Specialty Hospitals, ch. VI: XV.C.5.
	Maine regulations do not apply to healthcare providers other than hospitals. In particular, there is no state law or regulation covering retention of physicians' office records.	State of Maine, Regs. for the Licensure of General and Specialty Hospitals, ch. VI: XII B.
Maryland	"Healthcare provider" means: an acupuncturist, audiologist, chiropractor, dietitian, dentist, electrologist, massage therapist, mortician, nurse, nutritionist, occupational therapist, optometrist, physical therapist, physician, podiatrist, professional counselor, psychologist, social worker, or speech-language pathologist.	Maryland Health-General Code Annotated Section 4-403

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
Maryland (cont.)	Except for a minor patient, unless a patient is notified, a health-care provider may not destroy a medical record or laboratory or x-ray report about a patient for five years after the record or report is made. In the case of a minor patient, a medical record, or laboratory or x-ray report about a minor patient may not be destroyed until the patient attains the age of majority plus three years or for five years after the record or report is made, whichever is later, unless the parent or guardian of the minor patient is notified or if the medical care documented in the record was provided under 20-102 (c) or 20-103(c) of the Health-General Article, the minor patient is notified.	
Massachusetts	Hospitals: All hospitals and clinics licensed by the Department of Public Health or supported in whole or in part by the Commonwealth shall keep records of the treatment of cases under their care, including the medical history and nurses notes for 30 years following discharge or final treatment. Hospitals or clinics licensed by the Department of Mental Health shall maintain patient records for at least 30 years after discharge or last contact of patient.	Massachusetts Gen. Laws c. 111, s. 70 Massachusetts Gen. Laws c. 123 CMR 104
	Long term care: All clinical records of discharged patients or residents shall be completed within two weeks of discharges and filed and retained for at least five years.	Massachusetts Gen. Laws c. 105 CMR 150.013(E)
	Ambulatory services: For patients' records existing on or after January 1, 1990, the patient medical record must be maintained for a minimum of seven years from the date of the last patient encounter.	Massachusetts Gen. Laws c. 243 CMR 2.07(13)
Michigan	Nursing homes must maintain clinical records for a minimum of six years from discharge or, in the case of a minor, three years after the individual comes of age under state law, whichever is longer.	Michigan Admin. Code r. 325.21102 (1987)
	Medicaid providers must maintain records substantiating the medical necessity, appropriateness, and quality of services rendered for which a Medicaid claim is made for a period of six years.	MCL 400-111b (6) and (8)
	Clinical laboratories shall preserve original or duplicate laboratory reports at least one year.	MDPH R325.2353(1)
	Dentists must retain their records of treatment for a period of not less than 10 years after the performance of last service upon the patient.	MCL 333.16644
	Outpatient and residential substance abuse records are required to be maintained for a minimum of three years after services are discontinued.	OSAS R 325.14711(4) OSAS R. 325.14910(4)
Minnesota	Hospitals must maintain the original medical record in its entirety for a minimum of three years. The medical record may be destroyed after three years if it has been microfilmed in its entirety. The hospital governing body must approve destruction of records. After seven years, only the portion of the entire record defined by statute as the "individual permanent medical record" must be retained. For minors, the entire record must be retained for seven years past the age of majority.	Minnesota Statute 145.32, 145.30 Minnesota Rule 4642.1000
	Long term care facility medical records must be retained for a period of at least five years following discharge or death.	Minnesota Rules 4658.0470 Section 1

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
Minnesota (cont.)	Supervised living facilities are required to maintain records for three years following discharge or death.	Minnesota Rules 4665.4100, Section 4
Mississippi	Hospitals must maintain records for such period of reasonable duration as may be prescribed by the rules and regulations of the licensing authority. Such rules may provide for different retention periods for the various parts of the record or for various medical conditions and may require that the hospital make an abstract of the record. However, hospitals must retain complete medical records for a period of at least seven years for patients discharged at death, 10 years for adult patients of sound mind at the time of discharge, and for the period of minority or other disability plus seven years, but not to exceed 28 years for minors or disabled adults. If a patient dies in a hospital or within 30 days of discharge and the hospital knows or has reason to know that the patient left one or more disabled survivors who are or claim to be entitled to damages for wrongful death of the patient, the hospital must maintain the patient's record for the period of the disability of the survivors plus seven years, but not to exceed 28 years. The facility may destroy x-ray films four years after the date of exposure provided the radiologist has documented and authenticated findings in the patient's medical record. Before x-rays or graphic data can be destroyed, the facility must notify the patient or patient's legal representative by certified letter. The patient or his representative has 60 days to request the facility retain the material for the same retention period as hospital records and the hospital must abide by such a request.	Mississippi Code Annotated Section 41-9-69 (1991)
Missouri	Hospitals must maintain medical records for a period of time not less than that required by the statute of limitations. In no event can action for damages for malpractice be commenced more than 10 years from the date of the complained of act of neglect.	19 CSR 30-20.021 (3)(D)(15) (1993)
	Special record retention rules apply to Missouri hospital districts, county hospitals, and public hospitals. Those rules are published in the *Missouri Hospital District Records Manual* available through the Office of the Secretary of State. Skilled nursing, intermediate care, and residential care facilities must maintain medical records for five years after the resident leaves the facility, or until the resident reaches the age of 26, whichever is longer.	RS Missouri Section 198.052.7 (1983)
	Abortion records must be retained at the abortion facility for a period of seven years from the time of discharge. Patient records for minors must be kept for seven years after discharge, or until the patient reaches age 25, whichever is longer.	RS Missouri Section 188.060 (1983); 19 C.S.R. 30-30.060(2)(D)(1990)
	Vital records (birth and death information) must be maintained for at least five years.	RS Missouri Section 193.275 (1995 Supp.)
Montana	Hospitals must retain the patient's entire medical record for at least 10 years following the patient's discharge or death, or, in the case of a patient who is a minor, for not less than 10 years following the date the patient either attains the age of majority or dies, whichever occurs earlier. After the expiration of the applicable 10-year period, the patient's medical record may be abridged to "core records." Core records should be retained permanently, but are required to be retained for an additional 10 years following the patient's discharge or death.	ARM 16.32.328 (1990)

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
Montana (cont.)	Diagnostic imaging film and electrodiagnostic tracings must be retained for at least five years; their interpretations must be retained for the length of time required for other medical records.	ARM 16.32.328 (1990)
	Other healthcare facilities must retain patient or resident medical records for no less than five years following the patient's or resident's discharge or death.	ARM 16.32.308 (1990)
Nebraska	Hospitals must keep medical records in original, microfilm, or other approved copy form for at least 10 years following discharge. In the case of minors, hospitals must keep the record until three years after the age of majority.	Nebraska Admin. Rules & Regs. 775-9-003.04A6 (1979)
	Intermediate care facilities must keep medical records for at least as long as the resident remains at the facility and five years thereafter, or in the case of a minor, five years after the resident reaches the age of majority.	Nebraska Admin. Rules & Regs. 175-8-003.04A3 (1987)
	Health clinics must maintain client records for not less than five years.	Nebraska Admin. Rules & Regs. 175-7-004.04 (1975)
	Substance abuse treatment centers (which includes alcohol and drug—inpatient and outpatient) rules and regulations are pending at this time due to a statute change.	Pending
	Home health agencies must retain records in retrievable form for at least five years after last discharge. The home health agency must keep records of minors at least five years after the patient reaches the age of majority.	Nebraska Admin. Rules & Regs. 175-14-006.01I (1988)
Nevada	Healthcare providers must retain health records for five years after their receipt or production.	Nevada Rev. Stat. Annotated Section 629.051 (Michie 1991)
New Hampshire	Both hospitals and health facilities must retain medical records of adults for a period of seven years from discharge. Children's records must be retained to the age of majority plus seven years.	New Hampshire Code Admin. R. Dept. of Health and Human Services Reg. 802.11, 803.06 (1986)
	X-ray film must be stored at least seven years.	New Hampshire Code Admin. R. Dept. of Health and Human Services Reg. 802.08(b)(5)(1986)
New Jersey	Hospitals must preserve medical records for a period of not less than 10 years following the most recent discharge of the patient or until the discharged patient reaches age 23, whichever is the longer period. In addition, a discharge summary sheet shall be retained for a period of 20 years following the most recent discharge of the patient. X-ray films shall be retained for a period of five years.	N.J.A.C. Title 26 §26:8-5
New Mexico	Hospitals must retain all records that relate directly to the care and treatment of a patient for 10 years following the patient's last discharge. X-ray films may be destroyed four years after exposure. After three years, a patient may recover the x-rays.	New Mexico Stat. Annotated Section 14-6-2 (Michie 1992)
New York	Hospital: Medical records shall be retained in their original or legally reproduced form for a period of at least six years from the date of discharge or three years after the patient's age of majority (18 years), whichever is longer, or at least six years after death.	Title 10 NYCRR §405.10(a)(4)

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
New York (cont.)	Long-term care facility: Clinical records shall be retained for six years from the date of discharge or death, or for residents who are minors, for three years after the resident reaches the age of majority (18).	Title 10 NYCRR §415.22(b)
	HMO: The HMO shall require and assure that the medical records of enrollees be retained for six years after the date of service rendered to enrollees or cessation of HMO operation, and in the case of a minor, for six years after majority.	Title 10 NYCRR §98.12(j)
	Clinical laboratory or blood bank: All records and reports of tests performed, including the original or duplicates of original reports received from another laboratory, shall be kept on the premises of both laboratories and shall be exhibited to representatives of the department on request. Records listed below shall be retained by the laboratory for at least the period specified. If other New York state or federal regulations or statutes require retention for different periods of time, the laboratory shall retain the appropriate record for the longest period applicable. Records shall be retained in their original form for a period of three months and may thereafter be stored on microfilm, microfiche, or other photographic record, or as magnetic tapes or other media in an electronic processing system. Such record shall be adequately protected against destruction, either by archival storage of duplicated photographic or electronic medium or by other suitable means providing equivalent protection. Records that are required to be retained for more than two years may, after two years, be stored off the immediate laboratory premises, provided they can be available to the laboratory staff or other authorized persons in the laboratory within 24 hours of a request for records. Request for tests shall be retained for the same period of time as required for the test results or seven years, whichever is less, except that referral information for cytogenetic cases shall be retained for six years. Accession records shall be retained for seven years. Records of quality control results shall be retained for two years. Preventative maintenance, service, and repair records shall be retained for as long as the instrument remains in use, except that records of monitoring of temperature-controlled spaces shall be kept for one year.	Title 10 NYCRR §58-1.11(c)
	The following types of laboratory reports shall be retained for at least the period specified: tissue pathology including exfoliative cytology—20 years; syphilis serology—negative report—two years; cytogenetics—25 years; all others—seven years. Worksheets containing instrument readings and/or personal observations upon which the outcome is based shall be retained for one year. Specimens shall be retained so as to be accessible to the laboratory within 24 hours for at least the period set forth below: blood film—other than routine—one year; blood film—routine—six months; bacteriology slide on which a diagnosis depends—one year; cytology slide showing any abnormality—seven years; cytology slide showing no abnormality—three	Title 10 NYCRR §58-1.11(c)

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
New York (cont.)	years; tissue block—20 years; histopathology block—20 years; histopathology slide—20 years; bone marrow biopsy—20 years; cytogenetic slide—six years; photographic slide of cytogenetic karyotype—25 years; and recipient blood specimens—one week stoppered at 6~C.	
North Carolina	Hospitals must maintain medical records, whether original, computer media, or microfilm for a minimum of 11 years following the discharge of an adult patient. Hospitals must maintain the medical records of minors until the patient's 30th birthday.	T10:03C:3903(1996)
	Hospice medical records must be retained for a period of not less than three years from the date of discharge of the patient, unless the patient is a minor, in which case the record must be retained until five years after the patient's 18th birthday. If a minor patient dies, as opposed to being discharged for other reasons, the minor's records must be retained at least five years after the minor's death.	T10:03T:0900 (1996)
	Nursing homes must maintain medical records, whether original, computer media, or microfilm for a minimum of five years following the discharge of an adult patient. Nursing homes must maintain the medical records of minors until the patient's 19th birthday and then for five years.	T10:03H:2402 (1996)
North Dakota	Hospital records must be preserved in original or any other method of preservation, such as by microfilm, for a period of at least the 10th anniversary of the date on which the patient who is the subject of the record was last treated in the hospital. If a patient was less than 18 years of age at the time of last treatment, the hospital may authorize the disposal of medical records relating to the patient on or after the date of the patient's 21st birthday or on or after the 10th anniversary of the date on which the patient was last treated, whichever is later. The hospital may not destroy medical records that relate to any matter that is involved in litigation if the hospital knows the litigation has not been finally resolved. It is the governing body's responsibility to determine which records have research, legal, or medical value and to preserve such records beyond the above-identified time frames until such time in the governing body's determination the record no longer has a research, legal, or medical value. Long term facilities must retain their records as original or any other method of preservation for 10 years after discharge or seven years after death. Records of minors must be retained for the period of minority, plus 10 years after discharge.	North Dakota Admin. Code Section 33-07-01-20 (1994)
Ohio	Maternity hospitals and homes must keep medical records of each maternity patient and infant for not less than two years.	Ohio Admin. Code Section 3701-7-35 (1989)
	Resident records of alcoholism inpatient/emergency care facilities must be kept for at least three years after patient discharge.	Ohio Admin. Code Section 3701-55-15 (1989)
	All facilities participating in the Title XIX program must keep medical records for the longer of seven years or six years after the fiscal audit.	Ohio Admin. Code Section 5101: 3-3-26 (1992)
Oklahoma	Healthcare facilities must retain medical records for a minimum of five years beyond the date the patient was last seen or a minimum of three years beyond the date of the patient's death.	Oklahoma Dept. of Health Reg. ch. 13, Section 13.13A

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
Oklahoma (cont.)	Hospitals in which abortions are performed must keep records not less than seven years.	Oklahoma Stat. Annotated tit. 63, Section 1-739 (West 1991)
	Medicaid providers must maintain at their principal place of Medicaid business all required records for at least six years from the date of claimed provision of any goods or services to the Medicaid recipient and to make these records accessible to the attorney general for investigation concerning whether any person may have committed welfare fraud.	Oklahoma Stat. Annotated tit. 56, Section 1004 (West 1991)
Oregon	Hospital inpatient records must be preserved 10 years from last discharge.	OAR 333-505-050(1)
	Long term care records must be maintained five years from last discharge.	OAR 411-86-300(6)
	Home healthcare records must be maintained 10 years from last discharge.	OAR 333-27-060(2)
	All clinical records or photographic records not incorporated into the records, such as x-rays, EKGs, EEGs, and radiological isotope scans, shall be retained for seven years.	ORS 333-505-050(16)
	Patient delivery, death, operation registers, and the master patient index must be retained permanently. Outpatient registers for acute care facilities and emergency room registers must be retained seven years. Blood bank registers must be retained 20 years.	ORS 333-505-050(8)
Pennsylvania	Hospitals and ambulatory surgical facilities must maintain medical records—whether original, reproductions, or microfilm—for a minimum of seven years following the discharge of a patient. If the patient is a minor, records shall be kept on file until his majority and then for seven years or as long as the records of adult patients are maintained.	28 Pennsylvania Code Section 115.23 28 Pennsylvania Code Section 563.6
	Physicians shall retain medical records for at least seven years from the date of the last medical service for which a medical record entry is required. The medical record for a minor patient shall be retained until one year after the minor patient reaches majority, even if this means that the physician retains the record for a period of more than seven years.	49 Pennsylvania Code Section 16.95
Puerto Rico	Medical records shall be conserved in their original form or in any medium that utilizes the advances of recognized technology such as microfilm, or computerized or electronic forms, among others, for a minimum of five years. The medical records of patients under 21 years of age shall be conserved until the patient (minor) reaches his/her 22nd birthday. Those medical records that because of the needs or particular interests of the health facility are retained for a period of time greater than that stated here, shall be retained for the duration of the need as expressed in writing in its internal statutes. After the five years or once the minor reaches the age of 22 or after the additional time in the cases of particular interest, the facility shall conserve for at least five additional years the following documents in their original form or in a recognized technology medium (microfilm or computerized or electronic forms, among others):	Puerto Rico Health Information Regulations #99

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
Puerto Rico (cont.)	• Inpatient records: Admission and discharge records, discharge summary, operative reports, pathology reports, labor room and newborn reports, and autopsy report. • Outpatient record: Problem list (summary list); clinical history and report of significant findings of the basic or clinical services such as dental, social, psychiatric, psychological, or nutritional services, adolescent or prenatal clinics, post-partum, family planning, and WIC among others; operative/procedure reports (ambulatory surgery); and pathology/cytology reports. • Emergency room record: Emergency room evaluation and procedure reports. • Mental health/physical disability records: In addition to the previously mentioned list, the following documents shall be conserved—psychological, social services, and psychiatric evaluations. • The facility may also conserve any other document it deems pertinent according to its particular needs.	
Rhode Island	Medical records must be kept for five years following discharge of the patient. Records may be kept in either original or accurately reproduced form. Hospitals must maintain a minor's record for at least five years after the minor reaches 18 years of age.	Rhode Island General Laws Section 23-3-26 (1990) 1991 Rhode Island Acts & Resolves R23-17-Hosp. 25.9
South Carolina	Hospital records must be retained for 10 years. The records of minors are retained until after the expiration of the period of election following achievement of majority prescribed by statute (one year).	South Carolina Code Regs. Section 601.7(a)(1982)
	Nursing homes must store medical records for 10 years from discharge or death.	South Carolina Code Regs. 61.13 Section 503 (1980)
South Dakota	Except for resident assessment records, a healthcare facility must retain medical records for at least 10 years after the last date of patient or resident care. Records of minors must be retained until the minor reaches the age of majority plus an additional two years or 10 years—whichever is longer.	ARSD 44:04:09:08 (1995)
	The nursing facility must retain the original resident assessment instrument together with the supporting documentation for at least six years following the date of the assessment.	ARSD 44:04:09:12 (1995)
Tennessee	Healthcare facilities are required to keep medical records as originals or reproductions for 10 years following discharge or death of the patient. In cases involving minors or patients with mental disabilities, the hospital must keep records for the period of disability or minority plus one year, or 10 years following discharge of the patient, whichever is longer.	Tennessee Code Annotated Section 68-11-305(a) (1998)
	Healthcare facilities may retire x-ray film four years after the date of exposure.	Tennessee Code Annotated Section 68-11-305 (b)(1998)
Texas	Hospitals may dispose of medical records on or after the 10th anniversary of the date on which the patient was last treated in the hospital. If the patient was under age 18 when last treated, the hosital may dispose of the records on or after the	Texas Health and Safety Code Section 241.103 (West 1993)

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
Texas (cont.)	20th birthday or on or after the 10th anniversary of the date on which the patient was last treated, whichever is later. The hospital may not destroy medical records that relate to any matter that is involved in litigation if the hospital knows the litigation has not been resolved.	
Utah	Hospitals must retain medical records for seven years after the last date of patient care, or three years after a minor reaches the age of 18, whichever is first.	Utah Admin. R. 432-100-35 (6)(a)
	Intermediate care, nursing care, and mental disease facilities must retain medical records for at least five years after the last date of resident care. The records of minors, including newborns, must be retained for three years after the minor reaches legal age, but in no case less than five years.	Utah Admin. R. 432-149-33 Utah Admin. R. 432-150-27 (2)(c) Utah Admin. R. 432-151-21
	Mental retardation facilities and small healthcare facilities must retain medical records for at least seven years after the last date of client care. Records of minors must be retained at least two years after the minor reaches age 18 or the age of majority, but in no case less than seven years.	Utah Admin. R. 432-152-30 Utah Admin. R. 432-201-28 Utah Admin. R. 432-200-28
	Limited capacity/type N residential healthcare facilities shall retain medical records for at least seven years following discharge.	Utah Admin R. 432-300-10
	Residential healthcare facilities and assisted living facilities must retain resident records for at least three years following discharge.	Utah Admin. R. 432-250-11 Utah Admin. R. 432-270-25 Utah Admin. R. 432-500-21
	Free-standing ambulatory surgical centers shall retain medical records at least seven years after the last date of patient care. Records of minors shall be retained until the minor reaches age 18 or the age of majority plus an additional three years. Birthing centers must retain medical records at least five years after the last date of patient care. Records of minors, including records of newborn infants, shall be retained for three years after the minor reaches legal age under Utah law, but in no case less than five years.	Utah Admin. R. 432-550-22
	Abortion clinics shall retain medical records for at least seven years after the last date of patient care. Records of minors shall be retained until the minor reaches age 18 or the age of majority plus an additional two years, but in no case less than seven years.	Utah Admin. R. 432-600-24
	End stage renal disease facilities must retain medical records at least seven years after the last date of patient care. Records of minors must be retained until the minor reaches the age of majority plus an additional two years, but in no case less than seven years.	Utah Admin. R. 432-650-12
	Hospices must retain medical records at least seven years after the last date of patient care.	Utah Admin. R. 432-750-12
	Home health agencies must retain medical records seven years after the last date of patient care. Records of minors must be retained until the minor reaches the age of majority plus two years, but in no case less than seven years.	Utah Admin. R. 432-700-18

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
Vermont	Hospitals must maintain medical records for 10 years following patient discharge.	18 VSA Section 1905 (8); 4 CVR 13140019, Section 3-946 (a)(1989)
	Residential care homes must keep residents' records on file for at least seven years after the date of discharge or death of the resident, whichever occurs first.	Residential Care Home Licensing Regs., 4 CVR 13162004, Section 5.11(c)(1993)
	Nursing homes must keep residents' records for at least six years following discharge or death.	State of Vermont Nursing Home Regs., 4 CVR 13140025 (1989)
Virginia	Hospitals and nursing homes must preserve medical records, either as originals or accurate reproductions for a minimum of five years following patient discharge, except for minors. Records of minors must be kept for at least five years after the patient reaches 18 years of age.	Virginia Reg. Regs. Hosp. & Nursing Home Licensure of and Inspection, part II Section 208 and 24.5 (1985)
Washington	Acute care medical records and master patient index (MPI) will be retained as follows: Adult patients: No less than 10 years following most recent discharge. Minors: Three years following the date upon which the minor attained the age of eighteen years or 10 years following the most recent discharge, whichever is longer. Outpatient diagnostic service reports: At least two years. Data in emergency services register: No less than 10 years following most recent discharge or only three years after last entry if hospital includes all outpatient emergency care in the MPI. Data on inpatient and outpatient registers: for at least three years.	Washington Admin. Code Section 248-318-440 RCW 70.41.190
	Physicians: No code addressing retention of records.	
	Behavioral health medical records will be retained a minimum of 10 years following most recent discharge for adults, and for minors, no less than three years following date upon which client obtained age of 18 years or five years following most recent discharge, whichever is longer.	Washington Admin. Code Section 246-322-200
	Substance abuse medical records will be retained 10 years following most recent discharge for adults, and for minors, a minimum of three years following patient's 18th birthday or 10 years following most recent discharge, whichever is longer.	Washington Admin. Code Section 246-322-200
	Rehabilitation medical records will be retained no less than five years following the resident's most recent discharge.	Washington Admin. Code Section 246-325-060
	Nursing home medical records will be retained eight years following discharge for adults, and for minors, a minimum of three years following patient's 18th birthday or 10 years following most recent discharge, whichever is longer.	RCW 18.51.300
	Hospice medical records will be retained 10 years following discharge for adults, and for minors, 10 years or until the patient attains age of 21, whichever is longer.	Washington Admin. Code Section 246-321-045
	Home health medical records will be retained three years following date of termination of services for adults and, for minors, no less than three years after attaining age of 18 or five years following discharge, whichever is longer.	Washington Admin. Code Section 246-327-165

Table 4: State Laws or Regulations Pertaining to Retention of Health Information

State	Summary of Law/Regulation	Citation
West Virginia	Regulations for hospital licensure state that records must be preserved in the original form, microfilm, or electronic data process, without specifying a retention period, implying that retention must be permanent.	West Virginia Acts, tit. 64 West Virginia Leg. Rules, Dept. of Health; Hospital Licensure Series 12 Section 10.3.1, 10.3.1(e)(1987)
Wisconsin	Hospitals must retain medical records at least five years after discharge.	Wisconsin Admin. Code HFS 124.14(2)(c)
	Hospitals must maintain authenticated laboratory reports in the patient's medical record. Duplicate records shall be maintained by the laboratory for at least two years.	Wisconsin Admin. Code HFS 124.17(l)(f)
	Hospitals must keep copies of tracings, reports, printouts, films, scans, and other image records at least five years.	Wisconsin Admin. Code HFS 124.18(l)(e)(4) Wisconsin Statute 146.817
	Skilled nursing/long term care facilities must retain medical records five years following death or discharge. Registers of resident identification, final diagnosis, physician, and dates of admission and discharge shall be kept permanently.	Wisconsin Admin. Code HFS 132.45 (4) (f) (1-5) Wisconsin Admin. Code HFS 132.45 (4)
	Mental health records must be maintained at least seven years after treatment is completed or until minor turns 19, whichever is longer.	Wisconsin Admin. Code Alcohol, Drug Abuse, Developmental Disabilities, and Mental Health Services HFS 92.12 Wisconsin Statute Section 51.01(19)
Wyoming	Hospital administrative and discharge records, diagnoses of operations, operative reports, pathology reports, and discharge summaries must be kept permanently. Nursing histories and care plans must be kept for three years. Facilities must keep emergency care records and outpatient records for 10 years. Other medical records must be maintained for 30 years, then destroyed.	Wyoming State Archives & Historical Dept., Records Disposal Manual for Wyoming, County Hospitals (1987)