4770.4017 RECORDS MAINTAINED BY THE CERTIFYING HEALTH CARE PRACTITIONER.

Subpart 1. **Health records maintained.** The health care practitioner must maintain a health record for each patient for whom the health care practitioner has certified a qualifying medical condition. These records need not be maintained separately from the health care practitioner's established records for the ongoing medical relationship with the patient.

Subp. 2. **Contents.** The records must be legible, accurately reflect the patient's evaluation and treatment, and must include the following:

A. the patient's name and dates of visits and treatments;

B. the patient's case history as it relates to the qualifying condition;

C. the patient's health condition as determined by the health care practitioner's examination and assessment;

D. the results of all diagnostic tests and examinations as they relate to the qualifying condition; and any diagnosis resulting from the examination;

E. the patient's plan of care, which must state with specificity the patient's condition, functional level, treatment objectives, medical orders, plans for continuing care, and modifications to that plan; and

F. a list of drugs prescribed, administered and dispensed, and the quantity of the drugs.

Subp. 3. **Retention.** The health care practitioner must keep records for each qualifying patient for at least three years after the last patient visit, or seven years, whichever is greater.

Statutory Authority: *MS s 14.389; 152.26; 152.261*

History: *39 SR 1760; 40 SR 1599*

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