

**RECORDS RETENTION AND DISPOSAL SCHEDULE**

DEPARTMENT OF HEALTH AND MENTAL HYGIENE		County Health Department
AGENCY		DIVISION
Item No.	Description	Retention
1.	<p><u>PEDIATRIC CASE FILES</u></p> <p>Pediatric Clinic records are maintained on forms supplied by the Division of Material and Child Health, in family folders which also contain the treatment records of other members of a patient's family. The records include:</p> <p>A. Pediatric Health Records and Continuation Sheets B. Head and Body Measurements C. Tests of Child Physical Coordination D. Vaccination Cards DHMH-2101; 2102; 2097 E. Chisis Data Forms DHMH-1021 F. Local Health Eligibility Interviews</p>	Retain for ten (10) years after last entry or until patient reaches twenty-four (24) years old, whichever is earlier, then destroy.
2.	<p><u>IMMUNIZATION RECORDS</u></p> <p>This file series includes such records as child medical health histories, type of immunization and dates of inoculations, and consent forms.</p>	Retain for three (3) years after graduation from high school or until twenty-one (21) years old, then destroy.
3.	<p><u>CRIPPLED CHILDREN PROGRAM X-RAY FILES</u></p> <p>X-ray studies completed on patients in cardiac clinic, seizure clinic, E.N.T. clinic, and orthopedic clinic.</p>	Retain for five (5) years after last visit, then destroy.
4.	<p><u>CRIPPLED CHILDREN CASE FILES</u></p> <p>These comprehensive files usually contain:</p> <p>A. Medical and Nursing Records B. Eligibility Interviews (copies) C. Physician's request for clinic consultations D. Correspondence, authorization and memos E. Weight charts, dental records and progress records</p>	Retain until patient reaches twenty-four (24) years old, then destroy.

Schedule Approved by Department,  
Agency, or Division Representative

Schedule Authorized by  
Hall of Records Commission

12-17-79 *James Rose* *John. J. H. M. A.*  
Date Signature Title

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Date State Archivist

**RECORDS RETENTION AND DISPOSAL SCHEDULE**  
(CONTINUATION SHEET)

SCHEDULE  
NO. **774**

PAGE  
NO. 2 of 6

Item No.	Description	Retention
5.	<p><u>DENTAL CASE RECORDS</u></p> <p>These files contain:</p> <ul style="list-style-type: none"> <li>A. Dental treatment and examination records, and dental charts</li> <li>B. Medical history records</li> <li>C. Eligibility interviews</li> <li>D. Consent for dental X-ray forms</li> <li>E. Examination notes, correspondence and progress records</li> </ul>	<p>Retain for three (3) years after last entry, then destroy.</p>
6.	<p><u>MATERNAL HEALTH CASE FILES</u></p> <p>Maternal and gynecological case files contain:</p> <ul style="list-style-type: none"> <li>A. Exfoliative cytology examination reports</li> <li>B. Cancer screening program examination reports</li> <li>C. Gonorrhea culture reports</li> <li>D. Urinalysis or pregnancy test reports</li> <li>E. Colposcopy consent forms and examination reports</li> <li>F. Gynecology medical record, DHMH 569 and 643</li> <li>G. Parental consent forms, if under 18 years</li> <li>H. CHISIS medical forms</li> <li>I. Eligibility interview forms</li> <li>J. Progress notes on revisits and consultations</li> </ul>	<p>Retain for ten (10) years after last entry, then destroy. (Test results that show positive reactions are recorded in a permanent Johns Hopkins Tumor Registry.)</p>
7.	<p><u>WOMAN, INFANT AND CHILD CERTIFICATION RECORDS</u></p> <p>This file series includes:</p> <ul style="list-style-type: none"> <li>A. Certification/Recertification Records <ul style="list-style-type: none"> <li>1. Evaluation of nutritional risk</li> <li>2. Economic status determination</li> <li>3. Affirmation of residency in Health Service Area</li> <li>4. Dietary intake records</li> </ul> </li> <li>B. Nutrition education contact records</li> <li>C. Health History forms</li> </ul>	<p>Retain for five (5) years or until audit, whichever is later, then destroy.</p>
8.	<p><u>FAMILY PLANNING CASE FILES</u></p> <p>These case folders contain the following:</p> <ul style="list-style-type: none"> <li>A. Laboratory tests for cytology, hematology, gonorrhea and syphilis</li> <li>B. Family planning record and revisit reports</li> <li>C. Special confidentiality consent forms DHMH 1269</li> <li>D. Routine laboratory consent forms</li> </ul>	<p>Retain for ten (10) years after last entry, then destroy. Positive results of cancer tests are recorded in the Johns Hopkins Tumor Registry.</p>

(continued on next page)

**RECORDS RETENTION AND DISPOSAL SCHEDULE**  
(CONTINUATION SHEET)

Item No.	Description	Retention
	<ul style="list-style-type: none"> <li>E. Contraceptive information and consent forms</li> <li>F. Cancer screening tests and consent forms</li> <li>G. CHISIS - visit data forms</li> <li>H. Cloposcopy tests and consent forms</li> <li>I. Eligibility interview - referral information reports.</li> </ul>	
9.	<p><u>HYPERTENSION CASE FILES</u></p> <p>File series contains all the medical history and examination forms for the treatment of hypertension, (DHMH-1271 A.B.C. for Hypertension).</p>	<p>Retain for ten (10) years after last entry, then destroy.</p>
10.	<p><u>GERIATRICS CASE FILES</u></p> <p>Files contain the following records:</p> <ul style="list-style-type: none"> <li>A. Geriatric evaluation - pre-admission applications GES 11/72</li> <li>B. Applications for nursing homes</li> <li>C. Laboratory tests, chest x-ray and physical reports</li> <li>D. Clinic medical records</li> <li>E. Eligibility interview records</li> </ul>	<p>Retain for three (3) years after last entry, then destroy.</p>
11.	<p><u>HEARING, VISION, ORTHOPEDIC, CARDIAC AND PLASTIC CASE RECORDS</u></p> <p>File series contains the following forms and records:</p> <ul style="list-style-type: none"> <li>A. Personal and hearing history forms SCC-13 and SCC-18</li> <li>B. Hearing, etc., clinic examination reports</li> <li>C. Results of eye examinations</li> <li>D. Orthopedic examination, cardiac and plastic examinations</li> <li>E. Physicians and nurses notes and follow-up examination reports</li> <li>F. Authorization and financial questionnaires</li> </ul>	<p>Retain for ten (10) years after last entry, or until patient reaches twenty-four (24) years old, then destroy.</p>
12.	<p><u>COMMUNITY MENTAL HEALTH FILES</u></p> <p>This file series includes the following:</p> <ul style="list-style-type: none"> <li>A. General questionnaires to new applicants</li> <li>B. Progress notes by physicians</li> <li>C. Release of information statements</li> <li>D. Patient service record, DHMH-50</li> <li>E. Social Service Application, DHR-248-A</li> <li>F. Income eligibility and financial determination MAC-215(HO)</li> <li>G. Medication records, correspondence and notes</li> </ul>	<p>Retain inactive files for ten (10) years, then destroy.</p>

**RECORDS RETENTION AND DISPOSAL SCHEDULE**  
(CONTINUATION SHEET)

Item No.	Description	Retention
13.	<p><u>LABORATORY REPORTS</u> All laboratory tests (cytology, blood analysis, urinalysis, etc.) are done in the various clinics.</p>	<p>Retain negatives for one (1) year; retain positives with patient records and destroy when case file is destroyed.</p>
14.	<p><u>TUBERCULOSIS CONTROL RECORDS</u> These are examination reports which depend on nonreactor or reactor status as recorded on DHMH-TB-14 and 14-A. The following classifications exist:</p> <ul style="list-style-type: none"> <li>A. Nonreactor or negative x-rays</li> <li>B. Reactors including contacts and recent converters, (INH taken in tests)</li> <li>C. Tuberculosis cases - chemotherapy completed</li> <li>D. Tuberculosis cases - chemotherapy incomplete</li> <li>E. Abnormal, but nontuberculosis x-rays</li> <li>F. Atypical mycobacterium results</li> </ul>	<p>Retain nonreactors for three (3) years, then destroy. Tuberculosis positive cases are retained for ten (10) years. Abnormal or Atypical x-rays are retained for five (5) years after last entry, then destroy.</p>
15.	<p><u>TUBERCULOSIS REGISTERS</u> All counties maintain a tuberculosis register on a form similar to the TB card TB-14. Also maintained is a contact card similar to TB-14-A, showing names of individuals with whom a tubercular patient is closely associated.</p>	<p>Retain permanently.</p>
16.	<p><u>COMMUNICABLE DISEASE RECORDS</u> Every doctor is required to report communicable disease cases to the Local Health Officer on forms similar to U.S. Public Health Service 1407 and DHMH-CD-1. Records of typhoid carriers are also maintained. Copies are kept in Local Health Departments and originals sent to DHMH Headquarters in Baltimore.</p>	<p>Retain original records on typhoid carriers until death, then destroy. Retain copies at local level until no longer necessary.</p>
17	<p><u>VENEREAL DISEASE RECORDS</u> The following records are maintained as case files on individuals having this infection:</p> <ul style="list-style-type: none"> <li>A. Venereal disease registration and preliminary examination record, such as DHMH-227 and VD-25D</li> <li>B. Venereal disease history chart and treatment card CO-25</li> <li>C. Consent forms for tests</li> <li>D. Morbidity card - syphilis DHMH-1140</li> </ul>	<p>Retain for five (5) years after last entry, then destroy. Retain laboratory reports and correspondence for three (3) years, then destroy.</p>

**RECORDS RETENTION AND DISPOSAL SCHEDULE**  
(CONTINUATION SHEET)

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18.	<p><u>MENTAL RETARDATION RECORDS</u></p> <p>The following authorization forms are used in mental retardation:</p> <p>A. DHMH-898 - Authorization for Day Care Services for Mentally Retarded Children</p> <p>B. DHMH-898-A - Authorization for Day Care Services for Mentally Retarded Adults</p>	<p>Retain for three (3) years after last entry and after fiscal audit, then destroy.</p>
19.	<p><u>CHRONIC DISEASE PATIENT RECORDS</u></p> <p>These records include the following items:</p> <p>A. DHMH-50 - Chronic Disease Hospital patient data (copy)</p> <p>B. Discharge summary from hospital (copy)</p> <p>C. Predischarge home visit report (copy)</p> <p>D. Postdischarge home visit report (copy)</p> <p>E. AADH-222 - Interagency Preferral (original)</p> <p>F. Nurse's notes and continuation sheet (original)</p> <p>G. Correspondence, application for program and other documents pertaining to chronic disease patients</p>	<p>Retain for three (3) years after last service entry, then destroy.</p>
20.	<p><u>VETERINARY MEDICINE FILES</u></p> <p>A. Records dealing with investigation of animal bites.</p> <p>B. Animal Rabies Vaccination records and psittacosis records</p> <p>C. Records dealing with pre-exposure rabies immunization and anti-rabies treatment of humans</p> <p>D. Records of the investigation of zoonotic diseases.</p>	<p>A. Retain for three (3) years then destroy.</p> <p>B. Retain for three (3) years then destroy.</p> <p>C. Retain for five (5) years, then destroy.</p> <p>D. Retain for three (3) years and destroy unless outbreak of unusual or continuing importance, then retain ten (10) years and destroy.</p>
21.	<p><u>HOME HEALTH PROGRAM RECORDS</u></p> <p>Home Health Program records include the following:</p> <p>A. Assessment of the Patient's Needs AADH-352 A&amp;B</p> <p>B. Progress Notes</p> <p>C. Financial Assessment - billing records</p>	<p>Retain for five (5) years after the last yearly cost report, then destroy. Retain financial records for three (3) years after notice of settlement of cost report has been issued, then destroy.</p>

**RECORDS RETENTION AND DISPOSAL SCHEDULE**  
(CONTINUATION SHEET)

SCHEDULE  
NO. 774

PAGE  
NO. 6 of 6

Item No.	Description	Retention
22.	<p><u>COPIES OF BIRTH AND DEATH CERTIFICATES</u> These are maintained by the local health departments for issuing statement of age cards, obtaining passports or licenses, etc.</p>	<p>Retain copies of death certificates for three (3) years and then destroy. Retain copies of birth certificates for ten (10) years, then offer to the Hall of Records.</p>
23.	<p><u>METHADONE AND OTHER DRUG ABUSE CASE FILES</u> File series includes the following: A. CODAP - Client oriented data acquisition processing forms B. Instate forms and charts C. Title XX financial support forms D. Release of information forms E. Federal and State consent forms F. Urine surveillance reports G. Follow-up charts and progress notes</p>	<p>Retain inactive files for twelve (12) years after last entry, then destroy.</p>
24.	<p><u>ABSTINENCE COUNSELING FILES</u> Similar files as those described in Item 23 in addition to: A. Counseling interviews B. Alcoholism control forms C. Intake forms D. Treatment documents</p>	<p>Retain inactive files for twelve (12) years after last entry, then destroy.</p>
25.	<p><u>BRIEF SERVICE CARD FILES</u> Cards containing a description of each client and a digest of the problems of the client.</p>	<p>Retain for three (3) years, then destroy.</p>
26.	<p><u>DRUG ABUSE CENTER STATISTICAL FILES AND CORRESPONDENCE</u> Files include statistical reports such as AADH-529-530 and general correspondence to and from patients, staff and State officials related to the business of the center.</p>	<p>Retain for five (5) years, then destroy.</p>