DGS-550-1
REV. 6/78

DEPARTMENT OF GENERAL SERVICES
Records Management Division

SCHEDULE NO. 1043

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RECORDS RETENTION AND DISPOSAL SCHEDULE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE — AGENCY

COUNTY HEALTH DEPARTMENTS — DIVISION

Item No.	Description	Retention
	SUPERSEDES SCHEDULE NO. 774 This records retention schedule, established by the Local Health Administration, is in compliance with the State Government Article, Title 10-633, of the Annotated Code of Maryland, whereby each unit of the State government is required to have a program for the continual, economical, and efficient management of the records of the unit. Each local health department is authorized to implement this schedule; however, due to a non-standardized filing system, some records series may vary as to content in each local health department. Procedures describing the destruction and/or storage of records may be obtained from the State Records Management Center, 7275 Waterloo Road, P.O.Box 275, Jessup, MD 20794, Telephone 799-1930. Records which have been or will be microfilmed should be retained for one (1) year or until film has been verified and a security copy has been made, then destroyed. Permanent paper records which have been microfilmed must be offered to the State Archives before destroying. The retentions established by this schedule also apply to record copies of microfilm. Requests for changes to this schedule should be directed to the Local Health Administration through each local Health Officer.	

Schedule Approved by Department, Agency, or Division Representative

11/20/85 — Date
Ruth Singer — Signature
DIRECTOR — Title

Schedule Authorized by Hall of Records Commission

12/12/85 — Date
Edward J. Gerwin — State Archivist

Ruth Singer Local Health Admin.

Item No.	Description	Retention
1.	PEDIATRIC CASE FILES Pediatric Clinic records are maintained on forms supplied by the Division of Maternal and Child Health, in folders which may also contain the treatment records of other members of a patient's family. The records include: 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. Local Health Eligibility Interviews F. CHSIS/EPSDT Form 1022; 1022A; 1023	Retain until twenty-four (24) years of age or death, if earlier, then destroy. CHSIS forms (F) for medical assistance patients may be destroyed after five (5) years.
2.	IMMUNIZATION RECORDS This file series includes such reports as child medical health histories, type of immunization and dates of innoculations, and consent forms as well as adult influenza and adult overseas immunization records.	Retain until twenty-four (24) years of age or death, if earlier, then destroy. Retain adult records for ten (10) years, then destroy.
3.	DENTAL CASE RECORDS These files contain: A. Dental treatment and examination records, and dental charts B. Medical history records C. Eligibility interviews D. Consent for dental X-ray forms E. Examination notes, correspondence and progress records	Retain until twenty-four (24) years of age or death, if earlier, then destroy. Retain adult dental records for six (6) years after the last service, then destroy.
4.	MATERNAL HEALTH CASE FILES Maternal and gynecological case files contain: A. Exfeliative cytology examination reports B. Cancer screening program examination reports C. Gonorrhea culture reports D. Urinalysis and pregnancy test reports E. Colposcopy consent forms and examination reports F. Gynecology medical record, DHMH 569 and 643 G. Parental consent forms, if under 18 years H. Maternity record DHMH 3782 I. Eligibility interview forms J. Progress notes on revisits and consultations	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.)

Item No.	Description	Retention
	K. CHSIS medical forms DHMH 1022 or 1022A	Retain for five (5) years for medical assistance patients, then destroy. There is no requirement for non-medicaid population as long as the information is contained in the records described in F and J.
5.	WOMAN, INFANT AND CHILD CERTIFICATION RECORDS This file series includes: A. Certification/Recertification Records 1. Evaluation of nutritional risk 2. Economic status determination 3. Affirmation of residency in Health Service Area 4. Dietary intake records B. Nutrition education contact records C. Health History forms D. All Financial Records	Retain for three (3) years after the date of submission of the final expenditure report, then destroy.
6.	FAMILY PLANNING CASE FILES These case folders contain the following: A. Laboratory tests for cytology, hematology, gonerrhea and syphilis B. Family planning record and revisit reports C. Special confidentiality consent forms D. Routine laboratory consent forms E. Contraceptive information and consent forms F. Cancer screening tests and consent forms G. Cloposcopy tests and consent forms H. Eligibility interview - referral information reports	Retain for ten (10) years after last entry, then destroy. Positive results of cancer tests are recorded in the Johns Hopkins Tumor Registry. Retain records of children for ten (10) years or until age twenty-four (24) whichever is greater, then destroy.
	I. CHSIS- visit data forms	Retain for five (5) years for medical assistance patients. There are no requirements for non-medicaid population as long as the information is contained in the records described in B and H.

Item No.	Description	Retention
7.	HYPERTENSION CASE FILES File series contains all the medical history and examination forms for the treatment of hypertension. (DHMH-1271 A.B.C. for Hypertension).	Retain for ten (10) years after last entry, then destroy.
8.	GERIATRICS CASE FILES Files contain the following records: Geriatric evaluation - pre-admission applications GES 11/72	Retain for five (5) years after last entry, then destroy.
9.	HEARING, VISION, ORTHOPEDIC, CARDIAC, PLASTIC AND CRIPPLED CHILDREN CASE RECORDS File series contains the following forms and records: A. Personal and hearing history forms MCH 9/69 (IM) and SCC 25A-5M B. Hearing, etc., clinic examination reports C. Results of eye examinations D. Orthopedic examination, cardiac and plastic examinations E. Physicians and nurses' notes and follow-up examination reports F. Authorization and financial questionnaires G. Crippled Children Program X-Ray Files X-ray studies completed on patients in cardiac clinic, seizure clinic, E.N.T. clinic, and orthopedic clinic H. Crippled Children Case Files These comprehensive files usually contain: 1. Medical and Nursing Records 2. Eligibility Interviews (copies) 3. Physician's request for clinic consultations 4. Correspondence, authorization and memos 5. Weight charts, dental records and progress records I. Adult Speech and Audiology Clinic Files Contains diagnostic evaluations and speech and audiology treatment notes and updates. J. Adult Seizure Case Files Contains seizure clinic visit reports, EEG reports, skull X-ray reports, and release of information statements.	Retain until twenty-four (24) years of age or death, if earlier, then destroy. Retain for five (5) years, then destroy. Retain for ten (10) years, then destroy.

Item No.	Description	Retention
10.	COMMUNITY MENTAL HEALTH FILES This file series includes the following: A. General questionnaires to new applicants B. Progress notes by physicians and clinical staff C. Release of information statements D. Patient service record, DHMH-500 E. Social Service Application, DHR-248-A F. Income eligibility and financial determination MAC-215 (HO) G. Medication records, correspondence and notes H. Psychiatric, Psychological and Psychosocial evaluations	Retain for five (5) years after age eighteen (18) for children and five (5) years for adults. Hospital Mental Health files are retained for ten (10) years after death or twenty-five (25) years after discharge according to schedule for hospital centers.
11.	LABORATORY REPORTS All laboratory tests (cytology, blood analysis, urinalysis, etc.) are done in the various clinics.	Retain for three (3) years, then destroy.
12.	TUBERCULOSIS CONTROL RECORDS These are examination reports which depend on non-reactor or reactor status as recorded on DHMH-TB-14 and 14A. The following classifications exist: A. Nonreactor or negative X-rays B. Reactors including contacts and recent converters, (INH taken in tests) C. Tuberculosis cases - chemotherapy completed D. Tuberculosis cases - chemotherapy incomplete E. Abnormal, but nontuberculosis X-rays F. Atypical mycobacterium results G. Tuberculosis test records	Retain nonreactors for five (5) years, then destroy. Retain records of children for five (5) years or until age twenty-four (24), whichever is greater, then destroy. Tuberculosis positive cases are retained until death. Abnormal or atypical X-rays are retained until death, then destroyed.
13.	TUBERCULOSIS REGISTERS 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.	Retain permanently.

Item No.	Description	Retention
14.	COMMUNICABLE DISEASE RECORDS 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.	Retain original records on typhoid carriers until death, then destroy. Local level copies are non-record and may be disposed of when administrative value ceases.
15.	SEXUALLY TRANSMITTED DISEASE RECORDS The following records are maintained as case files on individuals having these infections: A. Venereal disease registration and preliminary examination record, such as DHMH-227 and VD-25D B. Venereal disease history chart and treatment card CO-25 C. Consent forms for tests D. Morbidity card - syphillis DHMH-1140 E. Morbidity card - gonorrhea DHMH-3954	Retain for three (3) years, then destroy. Retain positive syphillis treatment cards until death, then destroy.
16.	MENTAL RETARDATION RECORDS The following authorization form is used in mental retardation: DHMH-898-A - Authorization for Day Care Services for Mentally Retarded Adults	Retain until client leaves program and for three (3) years or audit thereafter, then destroy.
17.	CHRONIC DISEASE PATIENT RECORDS These records include the following items: A. DHMH-50 - Chronic Disease Hospital patient data (copy) B. Discharge summary from hospital (copy) C. Predischarge home visit report (copy) D. Postdischarge home visit report (copy) E. AADH-222 - Interagency Preferral (original) F. Nurse's notes and continuation sheet (original) G. Correspondence, application for program and other documents pertaining to chronic disease patients	Retain for three (3) years after last service entry, then destroy.

Item No.	Description	Retention
18.	VETERINARY MEDICINE FILES	
	A. Records dealing with investigation of animal bites	Retain until twenty-four (24) years of age or death, if earlier, then destroy. Retain adult records as follows:
	B. Animal Rabies Vaccination records and psittacosis records	A. Retain for three (3) years, then destroy.
		B. Retain for three (3) years, then destroy.
	C. Records dealing with pre-exposure rabies immunization and anti-rabies treatment of humans	C. Retain for five (5) years, then destroy.
	D. Records of the investigation of zoonotic diseases	D. Retain for three (3) years, and destroy unless outbreak of unusual or continuing importance, then retain for ten (10) years and destroy.
19.	HOME HEALTH PROGRAM RECORDS	
	Home Health Program records include the following: A. Billing material B. Cost reporting material C. Medical record material - physician's certification and recertification, clinical and other medical records relating to health insurance claims D. Home health agency physician material	Retain for five (5) years after the cost report is filed with the intermediary, then destroy. Retain financial records for the same length of time, then destroy.
20.	COPIES OF BIRTH AND DEATH CERTIFICATES	
	These are maintained by the local health departments for issuing statement of age cards or licenses, etc.	Retain copies of death certificates for three (3) years and then destroy. Retain copies of birth certificates permanently.
21.	METHADONE AND OTHER DRUG ABUSE CASE FILES	
	File series includes the following A. CODAP - Client oriented data acquisition processing forms B. Intake 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	Retain inactive files for five (5) years after last entry, then destroy.
22.	ABSTINENCE COUNSELING FILES	
	Similar files as those described in Item 21 in addition to: A. Counseling interviews B. Alcoholism control forms C. Intake forms D. Drug Abuse treatment documents E. Alcohol Abuse treatment documents F. Other alcohol abuse treatment records	Retain inactive files for three (3) years after last entry, then destroy.

Item No.	Description	Retention
23.	BRIEF SERVICE CARD FILES Cards containing a description of each client and a digest of the problems of the client.	Retain for three (3) years, then destroy.
24.	DRUG ABUSE CENTER STATISTICAL FILES AND CORRESPONDENCE 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.	Retain for five (5) years, then destroy.
25.	GRANT AWARDS Includes DHMH 432, the DHMH Standard Grant Agreement Form (4133) and any modifications or supplements to the original agreement.	Retain until completion of grant and for three (3) years thereafter or until all audit requirements have been fulfilled, then destroy.
26.	GENERAL CORRESPONDENCE Included in this series are original incoming letters, copies of outgoing letters, memoranda, reports, studies, surveys, investigations, press releases, newspaper clippings, and other miscelleaneous papers relating to the administration of the local health department which are not filed as part of another record series.	Screen annually. Destroy that material no longer needed for current business. Directives and other material relating to planning and policy that illustrate the development of the local health department, retain permanently for eventual transfer to the State Archives.
27.	PERSONNEL RECORDS Consisting of case files which contain employment applications, probation reports, annual efficiency reports, letters of commendation, reprimands, disciplinary suspense forms, and other documents.	Retain for four (4) years after termination of employment, then destroy.
28.	SIGNED RELEASE OF INFORMATION STATEMENTS Includes all documents submitted to obtain official release of patient information.	Retain for ten (10) years or the length of the retention schedule for the information released, whichever is longer, then destroy.