DGS-550-1
REV. 6/78

DEPARTMENT OF GENERAL SERVICES
Records Management Division

SCHEDULE NO. 1402

PAGE NO. 1 of 9

RECORDS RETENTION AND DISPOSAL SCHEDULE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE — AGENCY

COUNTY HEALTH DEPARTMENTS — DIVISION

Item No.	Description	Retention
	SUPERSEDES SCHEDULE NO. 1043 (#1043 Superseded #774) This records retention schedule, established by the Local and Family Health Administration, is in compliance with the State Government Article, Title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 the 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 the microfilm. Requests for changes to this schedule should be directed to the Local and Family Health Administration through each local Health Officer.	

Schedule Approved by Department, Agency, or Division Representative

11/14/41 — Date

Signature

Dep-Dir — Title

Schedule Authorized by Hall of Records Commission

JAN 20 19[illegible] — Date

Edward C. Papenfuse — State Archivist

No.	Description	Retention
1.	PEDIATRIC CASE FILES	
	Pediatric Clinic records are maintained on forms in folders which may also contain the treatment records of other members of a patient's family. The records include:	Retain until twenty-four (24) years of age or death, if earlier, then destroy.
	A. Pediatric Examination, Assessment, and Continuation Sheets. B. Growth Charts. C. Assessment of Child Development D. Record of Immunizations E. Financial Eligibility Forms F. CHSIS/EPSDT Form 1022; 1022A; 1023 G. Parental Consent Forms	CHSIS forms (F) for medical assistance patients may be destroyed after six (6) 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. Cervical 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 G. All consent forms H. Maternity record I. Eligibility interview forms J. Progress notes on revisits and consulations K. All other maternity laboratory reports and results	Retain for twenty-four (24) years after last entry, then destroy.

No.	Description	Retention
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 closeout report for the federal fiscal period to which the report pertains.
6.	FAMILY PLANNING CASE FILES These case folders contain the following: A. Laboratory tests for cervical cytology, hematology, gonorrhea and syphilis B. Family planning records, revisit reports, and consultations C. Special confidentiality consent forms D. Routine laboratory consent forms E. Contraceptive information and consent forms F. Cancer screening tests, consent forms, and reports G. Colposcopy tests, consent forms and reports H. Eligibility interviews and referral information reports I. All other family planning laboratory results and reports J. All other consent forms	Retain for ten (10) years after last entry, then destroy. Retain records of children (under age 18) for ten (10) years or until age twenty-four (24) whichever is greater, then destroy.
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: A. Geriatric evaluation - pre-admission applications GES 11/72 B. STEPS C. PASARR	Retain for six (6) years after last entry, then destroy.

No.	Description	Retention
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.	Retain until twenty-four (24) years of age or death, if earlier, then destroy.
	I. Adult Speech and Audiology Clinic Files Contains diagnostic evaluations and speech and audiology treatment notes and updates.	Retain for five (5) years, then destroy.
	J. Adult Seizure Case Files Contains seizure clinic visit reports, EEG reports, skull x-ray reports, and release of information statements.	Retain for ten (10) years, then destroy.
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 records, 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, (six (6) years for medical assistance patients). Hospital Mental Health files are retained for ten (10) years after death or twenty-five (25) years after discharge according to schedule for hospital center.

No.	Description	Retention
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. The following classifications exist: A. Nonreactor or negative x-rays B. Reactors including contacts and recent converters C. Tuberculosis cases - chemotherapy completed D. Tuberculosis cases - chemotherapy incomplete E. Abnormal, but nontuberculosis x-rays F. Atypical mycobacterium results G. Tuberculosis test records H. INH chemoprophyllaxis records (DHMH 851)	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.	Retain permanently. Transfer periodically to the State Archive
14.	COMMUNICABLE DISEASE RECORDS	
	A. Maryland Confidential Morbidity Report (DHMH-1140). The originals are sent to DHMH Headquarters and the copies are kept in the local health department.	Retain for ten (10) years, then destroy.
	B. S. typhi carries records (DHMH-1140, laboratory results, copies of written instructions concerning occupational restrictions, etc.)	Retain until death of carrier, then destroy.
	C. Confidential Report: Laboratory Evidence of Certain Communicable Diseases (DHMH-1281), and any other laboratory report indicating communicable disease.	Retain for three (3) years, then destroy.
	D. CDC Case Investigation Report	Retain for ten (10) years, then destroy.
15.	SEXUALLY TRANSMITTED DISEASE RECORDS	
	The following records are maintained as case files on individuals having these infections: A. Sexually transmitted disease registration, examination and treatment record. B. STD interview records and epidemiology records 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.

No.	Description	Retention
16.	DEVELOPMENTALLY DISABLED PATIENT RECORDS The following authorization form is used for the developmentally disabled: DHMH-2075-A - Authorization for Day Care Services for the Developmentally Disabled Adults This was a city/county form. City/county files are retained on diskettes/computer, and each region has implemented their own in-house form.	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. Post discharge 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.
18.	VETERINARY MEDICINE FILES A. Records dealing with investigation of animal bites B. Animal Rabies Vaccination records and psittacosis records C. Records dealing with pre-exposure rabies immunization and anti-rabies treatment of humans D. Records of investigation of zoonotic diseases	Retain until twenty-four (24) years of age or death, if earlier, then destroy. Retain adult records as follows: A. Retain for three (3) years, then destroy. B. Retain for three (3) years, then destroy. C. Retain for five (5) years, then destroy. D. Retain for three (3) years, then destroy unless outbreak of unusual or continuing importance, then retain ten (10) years, then destroy.

Item No.	Description	Retention
19.	HOME HEALTH PROGRAM RECORDS Home Health Program records include the following: A. Billing material B. Cost reporting material C. Medical records 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, then destroy. Retain copies of birth certificates permanently. Transfer periodically to the Maryland State Archives.
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 (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.
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.

Item No.	Description	Retention
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.	HIV POSITIVE/AIDS RECORDS	
	In general, medical information concerning HIV test results and treatment are part of the patient's regular medical record and should be so handled. The following categories of records, if maintained separately, should have the indicated retention/ disposal schedule:	
	A. Diagnostic Evaluation Services includes care plans, intake forms	Pediatric (under 19), retain until age 24 or six (6) years after death, if sooner. Adults (over 18), retain for ten (10) years after last entry.
	B. Case Management Record includes registration and demographic, medical/psychological intake forms, progress notes and care plans	
	C. HIV Seropositive Follow-up Clinic Records (same as for B.)	
	D. HIV CTS Forms	
	1. All site's HIV/CTS Questionnaires and anonymous sites' HIV consent forms	Retain twelve (12) months, then discard.
	2. Confidential CTS or clinic site HIV consent forms	Retain five (5) years, then discard.
	E. HIV Positive/AIDS Case Records	Retain twenty (20) years, then discard.
	F. Partner notification interview records	Retain for three (3) years, then destroy.
26.	REFUGEE RECORDS	
	Includes refugee health screening records and CDC Class A and B waiver records.	Retain for three (3) years, then destroy.
27.	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.

Item No.	Description	Retention
28.	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 miscellaneous 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.
29.	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.
30.	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.