ARTICLE 20:43

DENTISTS

CHAPTER 20:43:11

MEDICAL RECORDS

Section

20:43:11:01. Content. A dentist who treats patients shall maintain legible, complete, and accurate medical records. The medical record must contain the patient's clinical and financial record. The clinical record must contain the following information:

(1) For each clinical record entry note:

(a) The signature, initials, or electronic verification of the individual that made the entry note; and

(b) If treatment was provided, the name and the signature, initials, or electronic verification of the individual that provided treatment;

(2) The date of each patient record entry, document, radiograph or model;

(3) The examination findings documented by subjective complaints, objective findings, an assessment or diagnosis of the patient's condition, and proposed treatment options;

(4) Current dental and medical history that may affect dental treatment;

(5) Any images, radiographs, test results or other diagnostic aid used to aid in the diagnosis. All film or digital radiographs must be of diagnostic quality. Retention of molds or study models is at the discretion of the dentist, except for molds or study models for orthodontia or full mouth reconstruction that must be retained as part of the clinical record;

(6) An agreed upon treatment plan based on the assessment or diagnosis of the patient's condition;

(7) A complete description of all treatment or procedures administered to the patient at each visit;

(8) A record of any medication administered or dispensed in office, or prescribed, including:

(a) The date administered, dispensed, or prescribed;

(b) The name of the patient to which the medication was administered, dispensed, or prescribed;

(c) The name of the medication; and

(d) The dosage and amount of the medication administered, dispensed, or prescribed, including refills;

(9) Referrals, patient response to referrals, and any communication to and from any health care provider regarding the patient;

(10) Notation of communication to and from the patient or patient's parent or guardian, including:

(a) Notation of informed consent, including communication of potential risks and benefits of proposed treatment, recommended tests, and alternatives to treatment, including no treatment or tests;

(b) Notation of post-treatment instructions or reference to an instruction pamphlet given to the patient;

(c) Notation regarding patient complaints or concerns associated with treatment, including complaints or concerns obtained in person, by phone call, mail, electronic communication, or digital communication; and

(d) Termination of the doctor-patient relationship; and

(11) A copy of, or notation regarding, each laboratory order.

Source:

General Authority: SDCL 36-6A-14(20).

Law Implemented: SDCL 36-6A-1(6), 36-6A-14(1).

20:43:11:02. Editing. Clinical record entries may not be erased or deleted from the record, and may only be edited or corrected as follows:

(1) If the medical record is a written record, entries must be edited with a single line drawn through the incorrect information. New or corrected information must be initialed and dated. The individual initialing the record shall identify who the individual is on the written medical record; or

(2) If the medical record is an electronic record, a record audit trail must be maintained with the medical record that includes a time and date history of deletions, edits, and corrections to electronically signed or locked medical records.

Source:

General Authority: SDCL 36-6A-14(20).

Law Implemented: SDCL 36-6A-1(6), 36-6A-14(1).

20:43:11:03. Retention and destruction. The following applies to medical records subject to this chapter:

(1) If a patient is an adult, the dentist must retain the medical records for seven years from the date of the last treatment, examination, or prescription;

(2) If a patient is a minor, the dentist must retain the medical records for one year after the patient reaches the age of eighteen or seven years from the date of the last treatment, examination, or prescription, whichever is longer;

(3) If medical records are part of an investigation by the State Board of Dentistry, the dentist must extend retention of medical records until the dentist is notified that the investigation is complete;

(4) If a dentist is employed by a dental entity or another dentist, the dental entity or employing dentist is responsible for maintaining the medical records as outlined in this section; and

(5) When medical records are destroyed, confidentiality must be preserved.

Source:

General Authority: SDCL 36-6A-14(20).

Law Implemented: SDCL 36-6A-1(6), 36-6A-14(1), 36-6A-21.1.

20:43:11:04. Furnishing and transfer. The following applies to medical records subject to this chapter:

(1) Upon receiving an authorization for release of a medical record, pursuant to SDCL 36-2-16.2, the dentist or dental entity responsible for the medical records shall furnish copies of the medical records within ten business days. The copies must be legible and include copies of radiographs that are of diagnostic quality;

(2) When closing a dental practice, a dentist or dental entity responsible for the medical records may not transfer the medical records until the dentist or dental entity has attempted to provide notice of the pending transfer to patients that received treatment from the dentist or dental entity within the five years preceding the date of the notice. The notice must be sent electronically or by mail to the patient's last-known address. The notice must read that, at the written request of the patient or an authorized representative, the medical records or copies will be sent to another provider of the patient's choice or provided to the patient. The notice must also disclose whether any charges will be billed to the patient for supplying the patient or the provider chosen by the patient with the originals or copies of the patient's medical records; and

(3) When medical records are transferred to a dentist or dental entity as part of a sale of a dental practice, the dentist or dental entity receiving the medical records is responsible for maintaining the patient records as outlined in § 20:43:11:03.

Source:

General Authority: SDCL 36-6A-14(20).

Law Implemented: SDCL 36-6A-1(6), 36-6A-14(1), 36-2-16.2.