**Section 265.2200 Clinical Records**

a) Each birth center shall adopt, implement, enforce and maintain a clinical record system to assure that the care and services provided to each client are completely and accurately documented and systematically organized to facilitate the compilation and retrieval of information.

b) Each birth center shall maintain accurate and complete clinical records for each client, and all entries in the clinical record shall be made at the time when care, treatment, medications, consultations or other medical services are given. The record shall include, but not be limited to, the following:

1) Client-identifying information;

2) Name of the client's birth attendants, and the name of all other birth assistants;

3) Initial risk assessment in accordance with Section 265.1550;

4) A disclosure statement and informed consent that is signed by the client that explains the benefits, limitations, and risks of the services available at the center, and that describes the collaborative arrangements that the center has with physicians and with referral hospitals;

5) Record of antepartum (prenatal) care;

6) History and physical examination of the client;

7) Laboratory tests, procedures and results;

8) Written progress notes, signed and dated by the person rendering the service on the day service is rendered, and incorporated into the client record on a timely basis;

9) Medication list and medication administration record, if applicable;

10) Intrapartum care;

11) Newborn assessment and care, including:

A) Apgar scores;

B) Maternal-newborn interaction;

C) Prophylactic procedures;

D) Accommodation to extra-uterine life;

E) Blood glucose when clinically indicated;

12) Postpartum care;

13) Allergies and medication reactions;

14) Documentation of consultation;

15) Refusal of the client to comply with advice or treatment;

16) Discharge summary, to include mother and infant;

17) Discharge plan and instructions to the client;

18) Authentication of entries by the physician or physicians, birth attendants and birth assistants who treated or cared for the client and newborn;

19) A copy of the transfer form if the client or newborn was transferred to a hospital; and

20) Documentation that a birth certificate was filed or, if applicable, a death certificate was filed.

c) The birth center shall maintain all original medical records for a period of at least 10 years, or 12 years for records involved in pending litigation. The birth center shall not destroy client records that relate to any matter that is involved in litigation if the birth center knows that the litigation has not been finally resolved.

d) Records shall be stored in a manner that will assure safety from water, fire or other sources of damage and will safeguard the records from unauthorized access.

e) The birth center shall develop a policy for maintenance and confidentiality of all original records or copies of those records, in accordance with State and federal laws.

f) If a birth center closes, inactive records shall be preserved to ensure compliance with this Section. The birth center shall send the Department written notification of the reason for closure, the location of the client records, and the name and address of the client record custodian. If a birth center closes with an active client roster, a copy of the active client record shall be transferred with the client to the receiving birth center or other health care facility to assure continuity of care and services to the client.