**Section 641.100 Data, Medical Record Keeping, Exchange and Confidentiality**

a) The Center will develop a health record system that provides for consistency, confidentiality, storage and security of records for documenting significant student health information and the delivery of health care services. (See Problem-Oriented Medical Record System and Medical Record Management Guidance in Section 2200.50(c).)

1) The Center must maintain a single confidential medical record for each student receiving services. The medical record must be kept in a physically secure manner that protects it from unauthorized use.

2) The Center's health records must be maintained in a manner that is current, detailed, confidential and organized, and promotes effective student care.

3) The Center may separately maintain medical records needing a higher level of confidentiality, including, but not limited to, mental health, substance abuse, family planning and HIV testing records, provided that there is an effective cross referencing system. Access to such records must be restricted to authorized personnel.

4) The Center must have written policies that address exchange of health information verbally and/or faxed to insurers, managed care entities and the student's primary care physician.

5) The Center's health records must contain sufficient information to justify the diagnosis and treatment and to accurately document all health assessments and services provided to the student, including:

A) a signed consent for treatment identifying services that may be provided in the Center;

B) the student's name and ID number on each page in the record;

C) personal/biographical data including address, home telephone, work phone for parent(s), type of insurance, managed care entity's name/telephone number and emergency contact;

D) health care provider identification;

E) dated entries;

F) legible records (errors in charting shall have a single line drawn through, with the date and practitioner's initials written above);

G) significant illnesses and medical conditions;

H) medication allergies and adverse reactions prominently noted in the record; if no known allergies or history, note appropriately;

I) appropriate notations concerning use of cigarettes, alcohol and illegal substances, and other high-risk behaviors;

J) written history and physical documents with appropriate subjective and objective information for presenting complaints;

K) laboratory and other studies ordered, as appropriate, with documented results/findings;

L) working diagnoses consistent with findings;

M) treatment plans consistent with diagnoses;

N) encounter forms or notes with specifics regarding referrals, release of information, follow-up care, calls or visits;

O) student's refusal of recommended treatment;

P) notation of unresolved problems from previous office visits addressed in subsequent visit;

Q) record of after-hours care (e.g., emergency room utilization);

R) if a consultation is requested, a note regarding the results of the consultation;

S) consultation, lab and imaging reports filed and initialed by primary care provider;

T) evidence that potential risk to the student from diagnostic or therapeutic procedure has been discussed and student's response;

U) evidence that preventive screening and education services are offered in accordance with the Center's or its sponsoring agency(ies);

V) a record of prescriptions obtained from and/or provided by the Center;

W) signed release of information forms, as appropriate, that are dated, identify what is to be released and to whom, and length of time consent covers and/or is valid;

X) restricted release information practices (i.e., family planning, STDs, substance abuse, mental health) conforming to federal governing laws. (See 325 ILCS 10/1, 410 ILCS 210/1, 2, 3, 4 and 5, 410 ILCS 70/5 410 ILCS 305/9k, 410 ILCS 325/3, 405 ILCS 5/3-500-510.)

6) The Center will request information regarding previous health history at the time of enrollment to be included in the health record, including:

A) past medical and psychological history, including serious accidents, operations, illnesses, prenatal care, births, substance abuse and mental health needs;

B) immunization records.

7) Records shall not be removed from the Center.

b) The Center shall protect the confidentiality of student information and records in the following ways:

1) Written confidentiality policies and procedures shall be implemented to protect the student's and his/her family's right to privacy;

2) Students shall be afforded the opportunity to approve or refuse the release of identifiable personal information by the Center, except when such release is required by law; and

3) The Center's contracts with practitioners and health plans shall explicitly state expectations about the confidentiality of student information and records.

c) The Center must implement procedures ensuring that cross-referencing of medical records within the medical record system is possible at all times.

d) The Center shall ensure that its health records are compatible with the medical record system of its sponsoring provider agency(ies).

e) The Center must lock and otherwise maintain records and copies of records in a secure manner that protects them from unauthorized use. The Center must have policies for identifying who shall have access to health records. The Center health records must be maintained separately from school records.