

A COMPARATIVE STUDY OF LAWS AND PROCEDURES PERTAINING TO THE MEDICAL RECORDS RETENTION IN SELECTED COUNTRIES

Nahid Tavakoli, Sakineh Saghaiannejad, Mohammad Reza Habibi
Isfahan University of Medical Sciences, Isfahan, Iran

Corresponding author: Nahid Tavakoli, MD. Isfahan University of Medical Sciences, Isfahan, Iran. E-mail: tavakoli@mng.mui.ac.ir

Original paper

ABSTRACT

Introduction: The health record serves several purposes and must be retained to meet those purposes. These varied purposes influence how long health records must be kept, or their retention period. **Aim:** Present study aimed to recognize laws and procedures pertaining to retention of health records in selected countries and provide a proposed guideline for Iran.

Methods: This was an applied and descriptive-comparative research on laws and procedures pertaining to retention of medical records in USA, United Kingdom, Australia and Iran that

performed in 2011. The data were collected via library sources, websites, and consultation with specialists in and out of the country. The validity of the data was confirmed by experts. Finally, the recommendations were provided for medical record retention in Iran. **Results:** The study revealed that, there are complete and transparent record retention schedules in selected counties so that retention situation for adults, minors, emergency, outpatients and deaths records is clearly recommended. But in Iran, either there aren't specific laws and procedures for medical record or they are unspecified. **Conclusion:** The lack of a com-

plete, transparent and update medical record retention schedule in Iran, lead to confusion for hospitals. Some of hospitals maintain medical records more than of determined retention period and some of them destruct them before expiring of essential retention period. In order to optimize the situation of health records retention in Iran, it is necessary to review, correction and completion of medical records retention schedule on the provided recommendations for kinds of medical record.

Key words: Medical Record; retention schedule; Laws; Procedures.

1. INTRODUCTION

The health record serves several purposes and must be retained to meet those purposes. The purposes for which the health records are to be retained affect their retention time (1). The length of the time that health records should be archived and their selected formats (e.g. original, microfilm, optical CD-ROM, or other) are very complex issues (2). Although the major concern of the health information professionals is how to retain the health data in a way accessible for future users (3), no health records department throughout the world has endless space for the storage of health records. Therefore, careful planning of record retention schedules is necessary in order to avoid overcrowded files (4).

Health information professionals frequently pose questions about how long to keep patients records. There is no universal answer to this

question and multiple factors need to be considered (5, 6).

Retention of health information has long been influenced by both external and internal forces. Certain statutes and laws provide specific requirements on record retention. The laws and laws, continuous patient care needs, defense of professional liability actions, education and research all influence how long health information will be retained. Furthermore, storage constraints, new technology and fiscal concerns play a role in reaching a decision on this issue (6).

According to *Medical Records Manual: A Guide for Developing Countries* issued by the Health World Organization, there is no general retention policy and individual hospitals/health care facilities or governments should determine how long medical records will be kept (7).

Different countries adopt unique

and different strategies and laws with respect to the retention time of health records (8). For instance, in the USA, most states have laws that mandate how long a facility must maintain health information (9). Similarly, in Australia, each state imposes its own specific legal requirements on the retention of medical records, subject to implementation by health-care facilities (10).

Despite the availability of varied laws on the retention of different records in England, its National Health Service (NHS) has published a general guideline covering all the existing laws and binding upon all the states (11). Corn (2009) in an article entitled *Clinical Records Deserve Long-term Preservation* states:

Many health care organizations hold records longer than mandated, but over time much clinical data are discharged or become difficult to access. He believed that clinical infor-

mation, both paper and electronic, constitutes a valuable asset that deserves long-term storage in the archives that preserve both the records and access to the information (12).

Tavakoli et al (2007) in one study on the retention and destruction process of medical records in the hospitals situated in the city of Isfahan, Iran found that hospitals seem to be still confused about the required time for the retention of files and other medical records. This has led to a complicated situation. Some hospitals have to deal with the lack of space and confusion of their medical records department's personnel due to the records' long retention time, while some others are forced to destruct and discharge the records prematurely (13).

In another study entitled *A Comparative study of Medical Records Standards in Iran and Selected countries*, Ebadifar (2004) concluded that there is no special organization for devising a body of standards on the medical records in terms of various aspects including their documentation, privacy, security, retention time and destruction. He also pointed out the lack of a regular and united approach in Iran's hospitals as far as the important tasks of medical records retention and destruction are concerned (14).

Based on the author's information, apart from hospitals' evaluation instructions, Iran's Country Councils By-laws and several detached instructions published by the Ministry of Health with some general hints on the retention time of health records aside, no practical, similar, complete and clear country plan clarifying the type of the records to be retained and their retention time is available in Iran at the present time. This, in turn, has entailed some difficulties, namely the retention of the records for an overdue time and wasting unnecessary money and space, premature destruction of the records and the violation of the patients' rights and the emergence of multiple legal complexities. Taking these into consideration, this study aims to identify and compare the laws and procedures pertaining to medical record reten-

tion in Iran, USA, England and Australia and propose some recommendations for Iran to improve its present situation.

2. METHODOLOGY

This study is of applied type in terms of goal and of comparative-descriptive type in terms of methodology. The population under study included all printed and electronic documents and records covering the laws and procedures related to medical records retention in USA, England, Australia and Iran. The criteria applied for the selection of these countries were as follows: a) their pioneer role or long history in establishing the medical records field, b) having the oldest and the most active health information management associations in their own geographical region and finally c) their development in varied areas such as information management and, hence, the researcher's better access to their information. The instruments used for data collection was note taking (library note cards). Furthermore, the data related to the countries under study were collected by using library sources such as articles and journals, websites and other written documents. This stage of gathering data lasted from 2010 up to 2011. Simultaneously, the data related to Iran were collected from the publications and notifications issued by formal bodies such as Medical Education and Care ministry, Iran's Country Records Organization, Iran's Legal Medical Organization and Isfahan's Medical University's Assistance Department. To analyze the data, they were firstly categorized based on the research questions. Thereafter, the findings were explained both within the text and in the comparative tables.

3. RESULTS

Although providers and facilities currently in USA often retain records longer than required (e.g. for educational and research purposes) (15), state and federal laws clarify mandatory record retention time frames (6).

According to the federal record retention laws, the hospitals ought

to retain the inpatients records for a minimally 5-year period. However, this law just applies when a longer time for records retention is not mandated by the state. In the absence of specific requirements for record retention, record retention providers should keep health information for at least the period specified by the statutes of limitations or for a sufficient length of time to prove compliance with laws and regulations (16).

In most states, the period of the applicable statute of limitations is less than 10 years (2). Unless longer periods of time are required by state or federal law, the American Health Information Management Association (AHIMA) recommends that adults' medical records be retained for 10 years after the most recent encounter and if the patient was a minor, until age of majority i.e. when he/she reaches 25 plus statute of limitations (16).

Presently, the mandatory time for the retention of health records varies from 5 to 10 years in different states of U.S.A. In Western Virginia, retention for a perpetual period is being practiced (16).

In England, under the Limitation Act 1980, the limitation period for bringing up a claim is 3 years. This period runs from when it is realized by a person that he has suffered a significant injury that may be attributable to the negligence of a third party. For a minor, the limitation period runs from the time he/she attains the age of 18 years (11).

Following the England's Health Department' laws, the retention time of the health records depends on both the patient's age and the type of the health problem. Child health records, for instance, are retained until the patient's 25th birthday or mental health records 20 years after the last visit (17).

In Australia, each state practices its own legal requirements on the retention of the health record [10]. For instance, in New State Wels, the obligatory retention time for the adult's and child's health record is 10-15 years (depending on the kind of the hospital) and 10-20 years or the 25th birthday (the longer one

	U.S.A	England	Australia	Iran
Adults	-varied in different states: ranging from 5 years after discharge to permanent (with some exceptions) AHIMA: 10 years after the last discharge	-8 years (with some exceptions)	-Varied in different states. AHS: -Educational hospitals: 15 years after the last -Other hospitals: 10 years after the last discharge (with some exceptions)	-Retention time length for all the ages: 15 years after the last discharge (with some exceptions)
Minors	-Varied in different states, ranging from 1 year after majority to 30 th birthday -AHIMA: majority plus Statutes of Limitation	-Until 25 th or 26 th birthday (if the adolescent has been 17 years old at the end of his/her treatment) -NHS: if the illness could have potential relevance to adult conditions, the advice of clinicians should be sought as to whether to retain the records for a longer period.	-AHS: 15 years after majority -Varied in different states: - NSW: 15 years after the last visit or until patient's 25 th birthday (the longer one applies) -WA: 15 years after the 25 th birthday	-Regardless of age, Time retention is 15 years after the last discharge (with some exceptions)
Dead patients	-Most states do not practice distinct time retention for this type of records with two states having a shorter time: -Mississippi: 7 years -Oklahoma: 3 years -AHIMA: no recommendation	-8 years after death (for all age groups and all diseases except murder, suicide and Creutzfeldt–Jakob disease) - NHS: if death has potential genetically relevance to the deed's family, clinicians' advice should be sought as to whether the records should be retained for a longer period.	-Varied in different states, e.g. in NSW the dead patients' records retention time does not differ from others. -WA: up to 10 years after the patient's death (5 years less than the retention time practiced for the alive discharged) -AHS: no recommendation	-Retention time does not depend on the condition of discharge i.e. alive or dead.
Emergency patients & out-patients	-Records' retention based on the inpatients' files	-Records retention based on the inpatients' files (in terms of patient or specialty)	-AHS: 7 years after the last visit -NSW: 7 years after the last visit or until the 25 th birthday, the longer one will be considered. -WA: 15 years after the last discharge (if the patient is already 25 years of old)	-Emergency records: 3 years unless there is legal cases. Otherwise, retention time will be the same as the inpatients' records retention (i.e. 15 years) -outpatients' records in medical centers: 5 years after the last entry

Table 1. A comparison of laws and procedures pertaining to the retention of different types of health records in Iran and the selected countries

will be considered), respectively (18). Iran following the time schedule for health records retention passed by its Country Records Council maintains the patients' records until 15 years following patient's discharge (19) without having a country instruction or law pertaining to the retention of minor's health records. Just, in some universities' internal bulletins (e.g. the University of Isfahan and Hormozgan) retention of such records until 2 years after the patient reaches his majority has been emphasized (20, 21). The remaining laws and procedures adopted by the above-mentioned countries have been comparatively summarized in Table 1. The recommendations given by some formal bodies e.g. AHIMA, AHS, NHS have also been clarified.

In the countries divided into states, in addition, specific schedules have been proposed for some patients or illnesses differing from the ones allocated to other health records (for the details, see Table 2).

4. DISCUSSION

4.1. Adult inpatients' records and their retention

The retention time for this type of records ranges from 5 (the minimum period determined by federal laws) to 30 years with permanent retention being practiced in the Western Virginia. AHIMA recommends retaining the adults' health records for 10 years after the last visit. Thompson in a study entitled *Record Retention Practices among the Country's "most Wired" Hospitals* revealed that only 4.9 percent retained adult records for 5 to 9 years and showed that professional guidance from AHIMA is being used currently by facilities (22).

In Australia, each state may have unique medical record retention laws (10). Health Services Organization suggests in terms of the type of hospital (Educational vs. Non-educational), the retention time should be 15 or 10 years after the last entry

[23] similar to that mentioned in the NSW's laws (17). Under the NHS guidance, the records retention time for the adult inpatients is 8 years after the conclusion of the treatment in England, of course with numerous exceptions based on the type of the illness (17).

Inpatients records retention time in Iran has been subject to some changes and different authorities in this country have issued various requirements in this regard. At last, under the Country Records Council's resolution no. 1530/166/3001/sh dated 1990 the time required for the retention of inpatients' records was increased to 15 years after the patient's discharge (19).

Iran's Hospitals' Evaluation Instruction mandates the same time. The only difference is that it is 15 years after the last entry or visit (not the last discharge) (24).

Besides the foregoing disparities, there does not seem to be conformity and coordination in the Hospitals' Evaluation Instruction and

	U.S.A	England	Australia	Iran
Exceptions about retention time	-Being a highly developed country and having a variety of medical institutes, U.S.A tends to practice records retention requirements mostly not based on the type of illness but on the type of institute.	- joint change, Suicide or attempted suicide and job illnesses records up to <u>10</u> years; - Human fertility and delivery records up to <u>25</u> years; - Blood or organ donations, murder or serious criminal events, radiotherapy treatments, Creutzfeldt–Jakob disease and Genetics records up to <u>30</u> years; - and at last, mental diseases up to <u>20</u> years	- Rapes' records until <u>30</u> years after reaching majority; - human fertility up to <u>35</u> after the baby's birth; - Radiotherapy treatments <u>10</u> years after the 70 th birthday or <u>10</u> years after the last discharge; - Genetics records: a) diagnostics records: permanently b) medical records: the same as other records; - Delivery records: permanently; -Mental disorders: a) NSW: up to <u>15</u> years or 15 years after the 25 th birthday b) WA: <u>7</u> years after death	- Heart diseases, burns , the war injuries and mental problems records up to <u>25</u> years -Natural/ caesarean labor records up to <u>10</u> years - Cataract surgery records up to <u>5</u> years

Table 2. The comparison of exceptions pertaining to health records retention periods in Iran and the selected countries under study

Country's National Literature resolutions in terms of retention time exceptions (e.g. mental patients, heart diseases, burns etc.) stipulated in them. Furthermore, there are numerous ambiguities regarding how to destruct the records entailing hospitals personnel's confusion and misunderstandings.

The previous studies carried out in this field have confirmed this fact. Tavakoli et al (2007) in one study titled *An Investigation of Retention and Destruction of Health Records in City of Isfahan's Hospitals* found that not having a comprehensive and clear policy on records retention, hospitals are still puzzled about how long they should maintain patient's files and other records (13).

According to Ebadifar's study (2004), *A Comparative Study of Medical Records Standards in Iran and Some Selected Country*, no organized and similar procedure for the important task of health records' retention and destruction governs Iran's hospitals (14). Finally, it is worth mentioning that according to Daniali (1998), despite the large number of records potentially transformable to passive, stagnant as well as destructible records, Iran still has not been provided with a compiled instruction determining the time retention required for active, passive and stagnant files on the one hand, and the methods appropriate for their destruction on the other. The fact that many of these records, as old as 30 years, are not usable anymore illuminates the importance of this finding (25).

4.2. Minor inpatients' records and their retention

The possibility of future patient's litigations is another factor significant in determining the records' retention time (2). The statute of limitations begins at the time of the event or at the age of majority if the patient was treated as a minor (5).

Hence, USA's different states tend to retain minors' health records until several years after the majority, ranging from 1 to 10 years. Following AHIMA's recommendation, minors' medical records must be maintained until majority plus statute of limitations. Similarly, both Australia and England regard a specific period after the majority as the necessary time for the minors' record retention which is not less than patient's 25th birthday. According to England's National Health Service, if the illness could have potential relevance to adult conditions, the advice of clinicians should be sought as to whether to retain the records for a longer period.

Iran still has not imposed any separate legal policy on the minors' health records retention, therefore, they are currently being retained based on procedures adopted for the other records. However, it is noteworthy that some academic centers e.g. University of Isfahan and University of Hormozgan have mentioned a period of 2 years after majority in their internal bulletins as the required retention time of minors' records (20, 21). No executive guarantee supports such internal instructions making

the adoption of a national policy as to how long to retain minors' health records inevitable.

4.3. The dead patients' health records and their retention

As far as the retention of the dead' records is concerned, it can be said that in several states of USA, e.g. Oklahoma and Mississippi a shorter period is adopted for records of this type compared with the discharged alive patients'. However, these exceptions were just limited to the two foregoing states. In England, the retention period of these records is the same as other records i.e. an 8 year period. In addition, age or type of illness do not play any role in the time length of the dead' records retention. Mental patients' records tend to be retained for 20 years, unless they die, in this case the period will similarly be 8 years. NHS recommends considering a longer period for the retention of the dead' medical records, if based on physicians' advice it has potentially genetics relevance to the patient's family members. A similar condition dominates Australia, in other words various approaches are followed by its different states. For instance, in New South Wales State the retention time is the same regardless of the discharge status (i.e. dead or alive), while in the Western Australia State the retention time of dead patients' records is 5 years less than the others'. Neither a law nor an instruction was found in Iran clarifying a different retention time for the dead' medical information. Main-

taining the dead' files as long as other patients (15 years) can be deemed as a precautionary measure, but it must be confessed that unless there are legal issues, storing medical records pertaining to those patients who have passed away due to heart disease, burn and mental illnesses is quite unnecessary.

4.4. Emergency patients' medical records and their retention

If the patient was in a serious condition, the emergency department's record should become part of the patient's medical record after admission to the hospital and thus is to be kept as long as the medical records (26).

If a patient has passed all of his/her treatment process in the emergency department, countries such as USA and England treat him/her as an inpatient. On the other hand, different approaches are taken by Australia' different states as to how long to retain this type of records e.g. in Western Australia State, there is no difference between emergency patients' and inpatients' medical records in terms of length of retention time (27), but in New South Wales, compared to inpatients' medical records, a shorter period is required for emergency departments'. In Iran, under resolution no. 2459/51/301/ dated 1998 issued by Country's National Literature, the medical files related to the emergency's regular patients without any serious problem must be maintained until 3 years after discharge. This law is binding upon hospitals throughout the country (19). Despite this permit's superficial openness, there are many questions and ambiguous points regarding how to identify the emergency department's problematic medical records. The guideline related to scanning and destructing the records notified by the Medical Universities of Isfahan and Hormozgan enumerates car accidents, physical injuries, suicide, etc as the examples of problematic medical records. These medical records have legal implications, hence should be retained for 15 years after patient's discharge (20, 21). Unfortunately, due to the difficulties of the process of detecting and dis-

tinguishing the problematic records and occasional influence of personal tastes on this process, most Iran's hospitals embark upon obliterating emergency department's records after 3 years without any effort to separate problematic ones. Accordingly, given the existing ambiguities and considering this reality that the retention time for the emergency department's medical records is not less than 7 years in the three selected countries, namely USA, England and Australia, it can be claimed that Iran needs to revise and modify its approach as to how to determine the retention time for this type of medical records adopting a longer period for them.

4.4. Outpatients' medical records and their retention

In USA, the retention time of this type records has clearly been defined some states like Kentucky and Florida, while in others it has indirectly been addressed. For instance, New Mexico's laws have stipulated that "hospitals must retain all records that relate directly to the care and treatment of a patient for 10 years following the patient's last discharge (16). It can indirectly be inferred that the retention time does not differ per the type of records i.e. inpatients, outpatients and emergency patients. Similarly, in England, outpatients' records have not been referred to by NHS's instruction. However, when this instruction addresses the retention of health care records, firstly, makes no exceptions and secondly, asserts that "all hospital records not mentioned in the retention timetable should be kept as long as 8 years following the conclusion of care or treatment (i.e. exactly the same as the inpatients' health records). In Australia, pursuant to the Southern Australia state's laws, the discharged inpatients and outpatients' medical information are to be retained for 15 years after their last admission (if the patient is 25 years of old). Nevertheless, this period in NSW is up to 7 years. Under the Iran's Country's National Literature permit no. 2753/62/3001/sh approved on 2000, the *ordinary outpatients' medical records* in all the med-

ical centers throughout Iran should be retained for 5 years following the patient's last visit to the hospital (19). Notwithstanding, this permit has neither clearly defined ordinary outpatients and retention schedules necessary for them, nor has presented a specified policy as far as records related to outpatient surgeries or other types of outpatient treatments (e.g. chemotherapy, Angiography, Dialysis,...) are concerned. Hence, viewing the existing legal deficiencies and ambiguities regarding the retention time of outpatient treatments, the authorities must take the necessary measures to determine an appropriate timetable for such records. Unfortunately, referring to the above-mentioned permit, the majority of Iran's hospitals currently tend to obliterate their outpatient surgeries and treatments (maybe wrongly) after 5 years!

5. CONCLUSION

An ambiguous condition governs medical records' retention in Iran. On the one hand, discrepancies exist in the existing instructions. On the other, the instructions are incomplete, non-expert and non-technical in need of revision and modification. The absence of a complete, clear and up-to-date schedule for the retention of health records has led to many difficulties and ambiguities for the medical centers so that some centers are experiencing lack of space due to the accumulation of destructible records, while some others are annihilating the records prematurely. It is hoped that the existing challenges and difficulties can be conquered by applying the recommendations presented in the following section.

Recommendations

Considering the recent advances and changes in different fields of disease diagnostics, treatment methods and their respective legal issues, it is suggested that the Ministry of Health with the cooperation of related professional associations revise the retention time assigned for some records including HIV, pregnancy and delivery, child abuse, organ transplant, artificial fertility techniques, work-related or occupational

illnesses, radiotherapy, chemotherapy records, to name but a few. For some of them, longer retention periods must be adopted.

To prevent the minors' rights infringement and the possibility of legal claims, a national policy must be compiled for the retention time of minors' records. These records need to be maintained at least for 2-7 years following the majority.

Reviewing all legal, medical, research, educational etc., the Ministry of Health shall embark upon determining a clear period for the retention of dead patients' medical records. Apparently, with the exceptions clearly determined, there is no need to keep the records of the dead as long as other types of records.

It is suggested that the authorities shall express their viewpoints regarding the retention time frames, the conditions for destructing the outpatients, outpatient surgeries and treatments files. The results of the study revealed that the retention time for the outpatient surgeries is not much less than inpatients medical records.

Some revisions must be made as to how long to retain the medical records related to the emergency department applying a longer period for them (a minimum period of 7 years). Furthermore, some appropriate criteria as well as a formal authority should be specified for identifying and separating the so-called problematic records in an open and logical way.

Finally, it is recommended that to obviate the existing ambiguities and create unity throughout the country, the responsible bodies within the Ministry of Health shall take necessary measures as to complete, revise and modernize the time tables for records retention. Having acquired the Country's National Literature approval, they should be notified to all medical centers to be implemented. Following the mentioned timetables and considering their own characteristics and requirements, the academic centers and medical facilities should try to make clear their adopted procedures on retention and destruction in written forms and to organize their acts accordingly.

Conflict of interest: none declared

REFERENCES

1. Latour K, Eichenwald Sh. Health Information Management Concepts, Principles and Practice. USA: AHIMA; 2002: 204.
2. Skurka M. Health Information Management Principles and Organization for Health Record Services. USA: AHA Press, 1998: 157-158.
3. Sadoughi F, Ahmadi M, Asadi F, Jalalifard B. Health Information Management of a Strategic Resource. Tehran: vajepardaz; 2003: 352.
4. Education Module for Health Record Practice. 2005: 24-25. available at: www.ifhro.org/ed_modules/Education_Module3.doc
5. Abdelhak M, Gostick S, Hanken M, Jacobs E. Health Information Management of Strategic Resource. second edition. USA: WB Saunders Company, 2001: 198.
6. McWay D. Legal Aspects of Health Information Management. Second Edition. USA: Thompson Delmar Learning, 2002: 78: 75-76.
7. Medical Record Manual: A Guide for Developing Countries. 2001: [24]. wavailable at: www.wpro.who.int.
8. Arabzadeh A, Azizi A, Alimadadi E. Storage And Retrieval System. In: Health Information Management. Iran: TOHIDE GHOM; 1999: 173.
9. Davis N, Lacour M. Introduction to Health Information Technology. USA: WB Saunders Company, 2002: 155.
10. Mennillo A. Retention and destruction of medical records. Medical Insurance Group Australia Bulletin. 2006; 1. [cited 2006 August]. Available at: www.miga.com.au.
11. Department of Health. Record Management : National Health Services Code of Practice , Part1. London; 2008: 1-78. Available at: www.dh.gov.uk/publications
12. Corn M. Archiving the Phenome: Clinical Records Deserve Long-term Preservation. Journal of American Medical Informatics Association 2009 jan-feb; 16(1): 1-6. Available at: <http://www.ncbi.nlm.nih.gov>.
13. Tavakoli N. Investigation of retention and destruction process of medical record and provide guidelines in hospitals in Isfahan [In Persian]. Isfahan University of Medical Science, Faculty of Medical Informatics & Management, 2007.
14. Ebadifar F, Hajavi A, Maidani Z. A Comparative Study of Medical Record Standards in Selected Countries. Management and Medical Information Journal. 2004; 7(17): 37-41. [Article in Persian]
15. Green MA. Jo Bowie M. Essentials of Health Information Management: Principles and Practices. USA: Thompson Delmar Learning; 2005: 96.
16. AHIMA. Practice Brief: Retention of Health Information (updated). 2002: 1-6 available at: <http://library.ahima.org>. [cited 2010 August 11]
17. Department of Health. Record Management: National Health Services Code of Practice Part2. London; 2008:9-66. Available at: www.dh.gov.uk/
18. The General Retention and Disposal Authority (GDA17)- Public Health Services: Patient/Client Records. MAY 2004 Sydney: 228. Australia; State Records Authority of New South Wales. Available at: www.records.nsw.gov.au/recordkeeping/
19. National Documents Organization of Iran, approved retention schedule for medical record by The National Archive council of Iran, 2003. [In Persian]
20. Guidelines for destruction and scanning paper medical records, Isfahan Province Medical Records Committee, University of Medical Sciences, Isfahan, 2009. [In Persian]
21. Destruction Guidelines in Hormozgan university. available at: http://him.hums.ac.ir/emha_dastorolamal.pdf. [2011 sep 22] . [In Persian]
22. Thompson L. Record Retention Practices among the Nation's "Most Weird" Hospitals. Journal Perspectives in Health Information Management 2008; 5:8. [cited 2008 June 10]. Available at: <http://www.ncbi.nlm.gov/>.
23. Tabibi S, Ebadi F, Azar F, Safdari R, Hajavi A, Meidani. Health Information Management Standard. Tehran: Ebadifar; 2004: 164 [In Persian].
24. Ministry of Health and Medical Education, Standard Guidelines and criteria for evaluation of public hospitals. Tehran: Ministry of Health, Treatment Evaluation Office; 1996. [In Persian].
25. Daniali A. Study on medical record filing unit in educational hospitals in Shiraz University of Medical Science [Thesis]. Iran University of Medical Sciences, School of Management and Medical Information; 1998 [Thesis in Persian].
26. Huffman E. Medical Record Management. Ninth Edition. USA: Physicians Record Company, 1990: 321.
27. Patient Information Retention and Disposal Schedule Version 3, 2008. Information Management and Reporting Department of Health, Western Australia. Available at: www.docpdf.info/