

## Patient/Parent/Legal Guardian Access to Medical Records

Patients, parents, and legal guardians have legal right to information about a patient's care. Federal and state laws provide for the ability to obtain copies of medical records for a reasonable fee. Children's Hospitals and Clinics of Minnesota supports your legal rights and gives you access to the medical record free of charge.

- If you have questions about our care, or the care of your child, please contact your/your child's physicians, nurse practitioners, and nurses. They can help you understand your/your child's condition, the medications given, and the treatments used.
- Nurses can show you the medical record. This can be done if the nurse has time, and the nurse must remain with you while you are looking at the record. Children's medical record is primarily electronic but some information remains on paper. Please ask a nurse to help explain this information and what it means.
- If your child is in the hospital for a long time, you can receive access to view your/your child's Electronic Medical Record (EMR) on the computer. Visit a Health Information Management (HIM) office to request this access. In Saint Paul, the HIM office is located on the first floor of the Garden View Medical Building (Suite 1052) between the Red Parking Ramp and the coffee shop.
- In Minneapolis it is located on the lower level of the hospital immediately south of the visitor elevators (B701). You can generally receive access within one hour. Your access will automatically end after one year. Once your access is granted, you can look at the Electronic Medical Record (EMR) in these locations:
  - Computers in HIM Offices between 7am – 4:30pm Monday – Friday.
- For paper copies of medical records, visit an HIM office Monday – Friday, 8am – 4:30pm.
- The medical record contains a lot of documents. The back of this page lists documents that would be most helpful to patients, parents, and legal guardians.
- We provide interpreters to help you communicate with staff about the medical record. Please ask your nurse whenever you need an interpreter.

Document Name	Document Content
<b>Discharge Summary</b>	This report is created for patients who have stayed in the hospital for more than 2 days. It is completed after the patient is discharged from the hospital. The report is a summary of the reason for admission to the hospital, significant care, the diagnosis, procedures, medications, any problems, and the plan for care after discharge from the hospital. The attending physician is responsible for this report, although sometimes a resident will do the report with review by the attending physician.
<b>History and Physical (H&amp;P)</b>	The History and Physical report is completed within 24 hours of every hospital admission. It gives a detailed physical examination of the patient, the history of the present illness, the family medical history, the social history, and a summary of the suspected causes of the patient's illness. Your primary or referring physician, a nurse practitioner, a resident, and the attending or admitting physician can complete the history and physical.
<b>Operative Report (Op Report)</b>	This report is created for every major surgical procedure for a patient. It includes the diagnosis before and after surgery as well as a detailed summary of the actual procedure. This report should be in the medical record within 24 hours of a surgery. The surgeon is responsible for this report.
<b>Immediate Post-Op Note</b>	This handwritten report is completed immediately after surgery. It is created by the surgeon and goes with the patient back to the room. It is a brief summary of what took place during surgery.
<b>Pathology Report</b>	If the patient had something removed during an operation, the laboratory produces an evaluation of the tissue. This report often takes some time to get into the medical record because the evaluation can take several days. A physician working in the lab (pathologist) produces this report.
<b>Medication Reconciliation</b>	This form is required both at admission to the hospital and discharge from the hospital. It lists all the medications the patient takes or needs to take at home. A nurse generally completes this report.
<b>Consultations</b>	Often, a patient will require the advice of an expert physician, called a consultant. The consultant must complete a report within 24 hours of the visit and examination. This report is a specialized history and physical examination that focuses on a particular problem or diagnosis.
<b>Discharge Instructions</b>	This form is completed for every patient who has stayed in the hospital. It lists diagnosis, diet, activity limitations, and follow-up visit instructions. A nurse who documents the attending physician orders generally completes this report.

## Questions?

For more reading material about this and other health topics, please call or visit the Family Resource Center library, or visit our Web site: [www.childrensmn.org](http://www.childrensmn.org).