College of
COMPLEMENTARY HEALTH
PROFESSIONALS OF BC

FAQ

Professional Standard: Record Keeping

Introduction

The Professional Standard: Record Keeping sets out the *minimum* expectations for professionalism and ethical conduct that licensees must meet when creating and maintaining all records related to their practice. A patient's health care record is a legal document that reflects a licensee's clinical reasoning, decision-making and professional activities pertaining to patient care.

Licensees are responsible for ensuring that patient health care records comply with all applicable laws and regulations including those governing:

- The collection, use and disclosure of personal information.
- The retention, storage, transfer and disposal of the patient health records.

Below are frequently asked questions by licensees.

Q: Has the requirement for the retention of patient health care records changed? If so, why?

For some professions the period of time that health care records must be retained has changed. Professional Standard: Record-Keeping, Principle 2.1 states licensees must:

> 2.1 *Retain patient health care records, appointment logs, billing records, and receipts for a minimum of 16 years from either the date of the last entry, or from the age of majority, whichever is later, except as otherwise required under the Limitation Act or any other applicable legislation.*

The 16-year retention requirement for patient health care records is based on BC's *Limitation Act*.

The *Limitation Act* sets a 15-year ultimate limitation period. The additional year functions as an operational safeguard to ensure that health care records are not destroyed before all potential legal risks have fully expired.

Q: Do patient health care records created before April 1st, 2026 fall under the previous College bylaw retention period?

No. Health care records in a licensee's possession that did not meet the destruction requirements under the previous bylaws are now subject to the 16-year retention period.

Q: Does the 16-year retention period still apply if a patient is deceased?

Yes. Health care records of a deceased patient should be retained for the entirety of the retention period.

Q: Who is responsible for fees associated with obtaining certified translations of health care records into English?

Professional Standard: Record-Keeping, Principle 1.4 states:

> 1.4 *Ensure that entries are produced in English upon request by a patient or third-party, by:*
>
> 1.4.1 *Creating the record entries in English, or in relation to entries for the practice of traditional Chinese medicine and acupuncture only, having certified translated copies prepared and produced.*

If a licensee in the profession of traditional Chinese medicine and acupuncture *does not* maintain patient health care records in English, the licensee is responsible for providing certified translated copies upon request by either a patient or third-party (ex: the College, lawyers, insurance companies, etc.), including covering all associated fees.

Q: Does the College set fees or fee guidelines for licensees to charge for the transfer and/or copy of patient health care records?

No. The determination of specific fees is a *business decision of the licensee*. Licensees may charge a reasonable administrative fee to cover costs including, but not limited to: photocopying, courier services, staff time, etc. However, any fees charged by a licensee must be disclosed in advance (see Professional Standard: Communication and Professionalism, Principle 5).

Professional Standard: Record-Keeping, Principle 3.3 states licensees must:

3.3 *Ensure that any fees charged for health care record transfers or production of copies of patient health care records are reasonable.*

Q: Can a patient have a shared health care record in a multidisciplinary practice?

Licensees must ensure that only individuals for whom the patient has provided consent are permitted to access the patient's health care records. The majority of electronic medical record systems that use a shared clinical patient health care record have privacy and permission settings that can be applied so that only authorized health care practitioners can view specific entries. These settings should always be used when a patient has not consented to the sharing of information between practitioners.

Professional Standard: Record-Keeping, Principle 4 states licensees must:

> 4. *CCHPBC licensees are responsible for handling personal health information carefully and lawfully, ensuring it is only collected, used, and disclosed with proper consent and/or legal authority.*

Q: What are a licensee's responsibilities regarding patient health care records when they retire?

When a licensee retires, they can either:

- Transfer health care records that are subject to the retention period to another regulated health care professional, or
- Retain the health care records until they can be properly disposed.

Licensees must notify patients, in writing, if their health care records are transferred to another regulated health care professional upon their retirement.

Professional Standard: Record-Keeping, Principle 2.7 states licensees must:

> 2.7 *Ensure the proper retention, transfer or disposal of patient health care records when ceasing to practice by:*
>
> > 2.7.1 *Ensuring that health care records subject to retention requirements are either securely transferred or retained until the expiry of the retention period.*

Q: Should billing records and receipts be included in a patient's health care record?

No. Billing records and receipts should be maintained separately.

Professional Standard: Record Keeping, Principle 1.5 states licensees must:

> 1.5 *Maintain separately both of the following:*
>
> > 1.5.1 *A daily appointment log that records the date and time of each appointment, the name of each patient, and the treatment and service provided.*
> >
> > 1.5.2 *Billing records and receipts that clearly identify the patient's name, date of service, nature of the service provided, products supplied and their descriptions, location of the service, fees charged, and licensee name and license number.*

Q: Are appointment logs and billing records subject to the same retention period as patient health care records?

Yes. Professional Standard: Record Keeping, Principle 2.1 states licensees must:

> 2.1 *Retain patient health care records, appointment logs, billing records, and receipts for a minimum of 16 years from either the date of the last entry, or from the age of majority, whichever is later, except as otherwise required under the Limitation Act or any other applicable legislation.*