STANDARD OPERATING PROCEDURE

Medical Records Management SOP

Document no.	SOP-HLC-010
Revision	1.0
Owner	Health Information Manager
Effective date	September 15, 2026
Review cycle	Every 12 months

1. Purpose

To keep patient records complete, accurate, secure and available to authorized staff, while releasing information only to properly verified and authorized requesters.

2. Scope

Applies to the management of paper and electronic patient records, including release of information requests. Clinical documentation content standards are covered by separate department SOPs.

Definitions

Release of information (ROI)	A request from a patient, provider or third party for a copy of some or all of a patient's medical record.
Authorization form	A signed document from the patient or their legal representative permitting release of specific records to a named recipient.
Retention schedule	The facility's documented policy for how long different types of records must be kept before they can be destroyed.
Chart deficiency	A missing signature, order or required entry that must be completed before a record is considered complete.

3. Responsibilities

Health Information Clerk	Files and scans records, tracks chart deficiencies and processes routine release of information requests.
Health Information Manager	Oversees the department, approves complex or sensitive release requests, and manages the retention schedule.
Provider	Completes and signs documentation and clears assigned chart deficiencies within the required timeframe.
Privacy Officer	Reviews unusual or disputed release requests and investigates any suspected privacy breach.

RACI matrix

Activity	Health Information Clerk	Health Information Manager	Provider	Privacy Officer
Track and clear chart deficiencies	R	A	R	-

Activity	Health Information Clerk	Health Information Manager	Provider	Privacy Officer
Verify and process a release of information request	R/A	C	I	C
Approve a sensitive or disputed release request	I	R/A	I	R
Apply and execute the retention schedule	R	R/A	I	C

R = Responsible, A = Accountable, C = Consulted, I = Informed

4. Materials and PPE

Materials, tools and systems

- EHR and document management system
- Chart deficiency tracking report
- Release of information authorization forms
- Retention schedule policy document
- Secure shredding or destruction service log
- Photo ID verification process for in-person requests

5. Procedure

Step	Task	Owner	Done
5.1	**Scan and file incoming documents** Scan paper documents and file them into the correct patient record in the document management system within the timeframe set by department policy.	Health Information Clerk	☐
5.2	**Run the chart deficiency report** Run the deficiency report on the schedule set by the department, identifying missing signatures, orders or required entries by provider.	Health Information Clerk	☐
5.3	**Notify providers of deficiencies** Send deficiency notices to the responsible provider with a due date, and escalate to the medical staff office for repeated overdue deficiencies.	Health Information Clerk	☐
5.4	**Complete assigned deficiencies** Review and complete assigned chart deficiencies, such as missing signatures or dictated notes, within the timeframe required by facility policy. **Checkpoint:** Charts are marked complete only after every required signature and entry is present.	Provider	☐
5.5	**Receive a release of information request** Log the incoming request, whether from the patient, another provider or a third party, and identify the specific records and date range requested.	Health Information Clerk	☐
5.6	**Verify the requester's identity and authority** Confirm the requester's identity with photo ID or an equivalent verification method, and confirm they are legally entitled to receive the records requested. **Checkpoint:** Requester identity and legal authority are verified before any record is released.	Health Information Clerk	☐

Step	Task	Owner	Done
5.7	**Confirm a valid authorization** Check that the signed authorization form covers the specific records, date range and recipient requested, and that it has not expired. **Warning:** Never release records based on a verbal request alone or an authorization form that does not match the request.	Health Information Clerk	☐
5.8	**Escalate sensitive or unclear requests** Route requests involving sensitive record categories, minors, deceased patients or legal disputes to the health information manager or privacy officer for review before release.	Health Information Manager	☐
5.9	**Compile and release the records** Compile only the records covered by the authorization, redact any information outside its scope, and send them through an approved secure method.	Health Information Clerk	☐
5.10	**Log the disclosure** Record what was released, to whom, when and by what method in the disclosure tracking log required for accounting of disclosures.	Health Information Clerk	☐
5.11	**Apply the retention schedule** Review records approaching the end of their retention period against the facility's retention schedule before scheduling destruction.	Health Information Manager	☐
5.12	**Destroy records securely** Destroy eligible records using an approved secure method, such as shredding or certified electronic destruction, and log the destruction with date and method.	Health Information Manager	☐

6. Quality checks

- Chart deficiency rate stays below the facility's target for overdue items.
- Every release of information request has a verified requester identity on file.
- Disclosure log entries match the volume of processed release requests.
- No record is destroyed before its retention period has expired.

7. Records

- Chart deficiency tracking report
- Release of information authorization forms
- Accounting of disclosures log
- Record destruction log

8. KPIs

- Average chart deficiency completion time
- Release of information turnaround time
- Percentage of requests verified before release
- Records destroyed on schedule versus overdue

9. Common mistakes

- Releasing records based on a phone request without written authorization.
- Filing a document into the wrong patient's record.
- Letting chart deficiencies go untracked past the required completion window.
- Destroying records without checking the retention schedule first.

10. Revision history

Revision	Date	Description	Reviewed by
1.0	September 15, 2026	Initial release	Ilia Pirozhenko

Approval

Prepared by	Approved by	Date

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