

Keeping prescription and patient records – How long is long enough?

The retention of information is controlled by federal legislation, our provincial standards of practice, and *the Health Information Act*. You can find these documents on the ACP website (abpharmacy.ca) if you need further clarification. Here is an overview of the major requirements.

Record	What is it?	Retention period?	Reference
Prescription	A record of a prescription (hard copy or scanned) from any authorized prescriber. For example, a prescription from a physician, pharmacist, or nurse practitioner.	Generally 42 months (3.5 years). However, the more precise answer is 2 years past the completion of therapy with regard to the prescription or 42 months, whichever is greater.	Standard 8.3 of <i>Standards for the Operation of Licensed Pharmacies; Food and Drug Act</i>
Patient record	A patient record must contain: <ul style="list-style-type: none"> ☒ demographic information about the patient, ☒ a profile of drugs provided, and ☒ a record of care provided. 	10 years past the last date of pharmacy service provided or for 2 years past the age of majority of the patient if the patient is a child, whichever is greater	Standard 8.8 of <i>Standards for the Operation of Licensed Pharmacies</i> ; Standard 18.3 and Appendix A of <i>Standards of Practice for Pharmacists and Pharmacy Technicians</i>
Record of care	Part of the patient record. Includes: <ul style="list-style-type: none"> ☒ records of drug therapy problems identified and/or interventions, the actions taken or monitoring plans created to deal with them, ☒ a record of any prescriptions adapted and other drugs prescribed, ☒ a record of drugs administered by injection, and ☒ other information such as prescriptions that were not filled or summaries of consultations with the patient or other health care providers. 		
Drug error ¹	A drug error means: <ul style="list-style-type: none"> ☒ drug incident (any preventable event that may cause or lead to inappropriate drug use or patient harm) where the drug was released to the patient, or ☒ an adverse drug event (an unexpected or undesired incident that results in patient injury or death or an adverse outcome for a patient including injury or complication). 	10 years after the error is discovered	Standards 6(c) & 6.4(c) of <i>Standards for the Operation of Licensed Pharmacies</i>
Disclosure of health information without [signed] consent of the patient	A record of the disclosed diagnostic, treatment and care information which is provided to another health care provider. ² For example, faxing a patient's drug profile to a physician's office.	10 years following the date of disclosure	Section 41(2) of the <i>Health Information Act</i>
Narcotic Receipts	A record of narcotics received at a pharmacy from a licensed dealer, such as a wholesaler.	2 years from the date of the receipt ³	Sections 30 & 40(2) of the <i>Narcotic Control Regulations</i>

Frequently asked questions

1. Why do patient records have to be retained for so long?

The 10-year requirement is consistent with retention of medical records by all other health professionals and health care facilities.

2. Does the patient record need to be active in my software system for the whole time?

No, the records may be archived. However, you do need to be able to access the record if necessary for 10 years past the last date of service, or until the patient's twentieth birthday if the patient is a child.

3. Do I have to retain a copy of all faxes sent to doctor's offices?

No, you do not have to keep a copy of the fax, but you must keep a record that you have disclosed the information. You may keep a copy of the fax or you may make a note in the patient's profile or create a written "disclosure log." Regardless of the method or recording the disclosure, the record must be kept for 10 years.

4. What if I have verbal consent from a patient to disclose health information?

Verbal consent is not recognized in the *Health Information Act*. Section 34(2) describes the requirements for consent and lists the information that *must* be included. This includes information about what information may be disclosed, to whom, for what purpose(s), the date the consent becomes effective and when the consent expires. It also indicates that the consent or the revocation of consent must be signed by the person providing it. A sample consent form is included in the appendix to *Health Information Act Guidelines and Practices Manual* which was distributed to all pharmacists and is available [on the Alberta Health website](#).

5. Do I need to keep a record of disclosure of health information if I have written consent?

The *Health Information Act* does not indicate that a record of disclosure must be retained if written consent has been provided, and it does not specify whether a copy of the consent must be retained or, if so, for how long. However, it is good practice to retain a record of the disclosure for 10 years in the same way you do for other disclosures. It is also good practice to retain the signed consent form.

6. Is the information in this chart all I need to know?

Not at all; this is only a summary for quick reference compiled for you by ACP. You should refer to all applicable pharmacy standards and federal and provincial Acts and Regulations for a full understanding of your professional responsibilities as they relate to record retention. Sources of information include the *Health Information Act*, *Personal Information Protection Act*, the *Health Professions Act*, Standards for Pharmacist Practice and Standards for Operating Licensed Pharmacies. All of these resources are available on ACP's website (abpharmacy.ca) under the *Pharmacist Resources* heading.

¹ A licensee must ensure that a quality assurance process is implemented and maintained in a licensed pharmacy. The quality assurance process must provide for reporting, investigating, and evaluating drug errors.

² When a custodian discloses a record containing individually identifying diagnostic, treatment and care information without consent, the disclosing custodian must make a notation of the name of the recipient, the date and purpose of the disclosure and a description of the information disclosed. The disclosure notation may be in paper or electronic form, may be put on the individual's health or drug record or in a book or "disclosure log."

³ Retention requirements for other business-related purposes, such as income tax, may also apply to these records.