



The Legal Health Record Companion:
A case study approach

By Deborah Adair, MPH, MS, RHIA, and Karen B. Griffin

Practical advice and policy guidance to manage patient records for legal scrutiny

By most definitions, a health record is the set of documents used to provide optimum patient care and document the patient’s progress across the continuum of care, generate a bill for appropriate reimbursement, and conduct audits and research.

Ultimately, it is your organization’s responsibility to define its legal health record. That definition will change and you will continue to update the definition as long as you have to—especially as you convert to electronic health records—to maintain the integrity of information you keep. Find out how Adair and Griffin successfully managed the legal health records process—from defining the term to training staff—at both Massachusetts General and Brigham and Women’s Hospital in Boston, respectively.

The Legal Health Record Companion: A case-study approach is a hands-on resource tool that shows you how to define and develop health records that meet legal requirements. You’ll learn how to use the health record appropriately and efficiently—from the legal point of view—as well as from the more familiar patient safety and common-sense perspective.

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