

Retention Schedule for Personal Health Information

SERVICE TYPE	MINIMUM RETENTION PERIOD
ACUTE/TRANSITIONAL CARE (includes inpatients, outpatients, specialist clinics, cancer care records at the facility)	
Adults/Minors	20 years from the discharge date of an encounter.
Death Records	10 years from date of death (not date of last encounter)
Fetal Monitor Strips	20 years from the discharge date of an encounter.
Forms – Slating	1 year
Manual Ledgers/Logs: OR, ER, Inpt, etc.	12 years
Master Patient Index (electronic)	Under review
Master Patient Index Cards	20 years after the implementation of an electronic Admission/Discharge/Transfer (ADT) system
Photocopies of Personal Health Information	When no longer required
Requests for info–client never presented/record destroyed	2 years
Requests for info – College/Production Orders	20 years
Records - Destruction Log	Permanent
Reports – Audit (including clinical)/Quality Assurance	5 years
Reports – fax confirmation sheets stored separately	1 year
Sexual Assault/Legal Action/Risk Management	30 years from date of occurrence or as determined in consultation with Risk
Telephone Triage Forms	2 years
Transitory/Working Documents (as per policy definition)	Upon discharge of client
COMMUNITY SERVICES: Mental Health, Public Health-Healthy-Living, Home Care, and Palliative Care	
Adults	10 years from the discharge date of last encounter
Minors	10 years plus the age of majority
Palliative Community records	7 years after date of death
Public Health/Families First Family Record	10 years plus the age of majority
Communicable Disease Reports/Animal Exposure Reports	5 years
Immunization – Consent forms	Adults: 7 years after date of last immunization Minors: 7 years past the age of majority
Immunization Records – Occupational Health	7 years after the last immunization
Immunization Inputting Form	Upon entry into electronic system
Flu Vaccine and other mass Immunization Clinic (including school-based) Consent forms	7 years after last immunization
Mental Health Crisis Service/One-time contacts (unidentifiable i.e. only first name)	1 year after contact
EMERGENCY MEDICAL SERVICES (EMS) for billing purposes only. PCR's related to facility visits are retained in client records	
Ambulance Patient Call Report (PCR)	Adults: 7 years after date of last entry in the record Minors: 7 years past the age of majority
LONG TERM CARE	
PCH Register	Permanent
After death, discharge, or transfer	7 years from the date of separation
REHAB SERVICES	
Audiology, Speech Pathology (College of Audiologists and Speech Language Pathologists of MB Record Keeping)	Adults: 10 years after date of last entry in the record Minors: 10 years past the age of majority
Physiotherapy, Occupational Therapy, School Records/Home Care Records	Adults: 7 years after date of last entry in the record Minors: 7 years past the age of majority
PRIMARY CARE (based on College guidelines)	
Adults (includes deaths)	10 years from date of last service
Minors	10 years past the age of majority
Appointment Diary/Book	2 years
Triplicate Prescription Pads	1 year
MIDWIFERY	
Adult/Minors	20 years from the discharge date of an encounter
Intake forms – client not accepted	1 year