SOP: Secure Creation, Labeling, and Filing of New Patient Records

This SOP ensures the **secure creation, labeling, and filing of new patient records**, including guidelines for accurate data entry, confidentiality protocols, standardized labeling practices, and proper storage methods. The objective is to maintain the integrity and privacy of patient information, facilitate easy retrieval, and comply with legal and regulatory requirements.

1. Purpose

To establish standardized procedures for the secure creation, accurate labeling, and systematic filing of new patient records, ensuring confidentiality and regulatory compliance.

2. Scope

This SOP applies to all staff responsible for creating, labeling, and filing patient records in any format (paper or electronic) within the healthcare facility.

3. Responsibilities

- **Front Desk/Admin Staff:** Collects initial patient data and initiates the record creation process.
- **Medical Records Personnel:** Completes record creation, verifies accuracy, applies labeling, and securely files records.
- **Supervisors/Managers:** Oversees compliance and addresses discrepancies or breaches.

4. Procedure

1. **Patient Information Collection**
    - Obtain required documents and demographic/medical information from the patient per facility policy.
    - Verify identity using government-issued ID.
2. **Record Creation**
    - Enter patient data into the Electronic Health Record (EHR) system or use official paper charts if EHR is unavailable.
    - Use only authorized and secure systems or documents.
3. **Labeling of Records**
    - Assign a unique patient identifier (e.g., medical record number).
    - Label each record (physical or electronic) with:
        - Full name (as per ID)
        - Date of birth
        - Unique patient identifier
        - Date of record creation
    - Ensure labels are clear, legible, and comply with facility standards.
4. **Confidentiality Protocols**
    - Access only by authorized personnel.
    - Do not leave records unattended or accessible to unauthorized persons.
    - Follow HIPAA and applicable privacy laws.
5. **Filing and Storage**
    - File records promptly in the designated, secure location.
    - Use locked cabinets/rooms for paper records; ensure EHR systems have controlled access and audit trails.
    - Adhere to standardized filing system (e.g., alphabetical or numerical order).
6. **Quality Assurance**
    - Supervisors review newly created records for completeness and accuracy on a regular basis.
    - Report and address discrepancies promptly.

5. Documentation

- Maintain an access log for record creation and modifications.
- Retain documentation per record retention policies.

6. Related Policies & References

- HIPAA Privacy Rule
- Organization's Data Protection & Privacy Policy
- Record Retention and Disposal SOP
- Electronic Health Record (EHR) System User Guide

7. Revision & Review

Version	Date	Author	Description
1.0	2024-06-15	Medical Records Supervisor	Initial SOP creation.

This SOP will be reviewed annually or when regulatory requirements change.