MINISTRY OF HEALTH
SINGAPORE

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PHMC Licensees

2015 NATIONAL GUIDELINES FOR RETENTION PERIODS OF MEDICAL RECORDS

The objective of this circular is to inform healthcare institutions of the updated national guidelines (2015) for retention periods of medical records. The updated guidelines seek to standardise best practices and ensure that medical records retention practices meet all current medical and legal requirements. Please refer to **Annex A** for the updated guidelines; **Annex B** for the relevant legislation in relation to the retention periods for medical records; and **Annex C** for the Table of Amendments and Rationales of the Updated Guidelines.

2. Healthcare institutions will still need to develop your own internal processes applicable to your requirements, with these updated guidelines as a reference. This entails having appropriate retention protocols and guidelines which include the development of:

a. **Retention schedules** appropriate to your internal requirements and in consultation with your legal counsel and senior management, **for periods not shorter** than those set out in the revised guidelines;

b. **Risk management strategies** to stratify patients and/or cases by risk of requiring their medical records for clinical or medico-legal investigation at a later date;

c. **Archival strategies** for the storage of medical records of inactive patients; and,

d. **Electronic or computerised format** of medical records.

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3 The guidelines will be made available from the MOH internet website. (https://www.moh.gov.sg/content/moh_web/home/Publications/guidelines.html)

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Enclosures

Annex A: 2015 Guidelines for the Retention Periods of Medical Records

Annex B: Relevant Legislation in relation to the Retention Periods for Medical Records

Annex C: Table of Amendments and Rationales of the Updated Guidelines

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ANNEX A

2015 GUIDELINES FOR THE RETENTION PERIODS OF MEDICAL RECORDS

Category	Medical Record[1] Retention Period[2]
1. Computerised/ electronic medical records[3]	
	Lifetime[4] +6 years
2. Paper Hospital / Inpatient records[5] (includes private & community hospitals)	
a) Adults	15 years
b) Minors	Until the patient is 24 years of age[6]
c) Lacks Mental Capacity[7]	Lifetime +6 years
3. Paper Intermediate & Long Term Care records	
Includes all residential ILTC institutions	15 years
4. Paper Ambulatory / Outpatient records (includes polyclinics, GPs & private specialists)	
a) Outpatient including A&E[8] and non-residential ILTC institutions	6 years or longer for "high risk" [10] patients
b) Primary health care (PHC)	
c) Dental outpatient [9]	
5. Others (includes video recordings)	
a) Electronic Patient registers	Lifetime + 6 years
b) Diagnostic images [11]	6 years
c) Assisted Reproduction [12]	Child's Lifetime +6 years

EXPLANATORY NOTES

1. Medical Records	a. The medical record covers all clinical encounters and original inpatient and outpatient records generated at the time of admission or outpatient attendance.
2. Retention Period	a. **Retention period refers to the period of time that the medical records should be kept for, following:** i. the date of the last discharge from hospital or last attendance at a clinic; ii. the patient being considered "inactive" (e.g. not having been to the HCI in the last 3 years); iii. the patient's death. b. **It is advised that the retention periods "kick in" only after patients have turned inactive, or have passed away. This ensures that the majority of patients who have chronic medical conditions, or are likely to require their medical records in the future, will have access to them.**
3. Computerised / Electronic Medical Records	a. Computerised and/or electronic medical records include all records produced by electronic systems and paper medical records which have been digitised into an electronic format. b. **HCIs are encouraged to convert and store all paper medical records in a computerised or electronic format for a period of "lifetime +6 years".** c. HCIs are encouraged to develop an archival strategy for medical records of "inactive patients" (HCIs to decide on definition of "inactive patients"). d. If HCIs keep records for longer than the period of "lifetime+6 years", records should be de-identified, unless otherwise permitted under law.
4. Definition of "lifetime"	a. As HCIs may not always be aware of time of death of patients, HCIs may choose to substitute "lifetime" with a "safe number" based on maximum life expectancy e.g. 110. Thus for medical records which are required to be stored for "lifetime+ 6 years", HCIs could store the medical records for either of the following periods (where information is available, and whichever is sooner): i. Actual lifetime + 6 years, or; ii. 116 years

5. Paper Medical Records	a. When original paper medical records are converted into a digitised form through processes such as scanning or microfilming, the digitised records should be retained for the remainder of the retention period of "lifetime + 6 years". b. Original paper records may be destroyed upon digitisation of medical records, as long as the copies are accurate and satisfy the legal requirements for admission as secondary evidence in court. c. Due to the importance of medical records in resolving medico-legal cases, and the sizeable impact (including consequence to individuals and/or monetary costs) that such disputes may have, HCIs are encouraged to digitise paper records using processes that are compliant with applicable legislation (e.g. the Evidence Act), where necessary. d. **In developing appropriate retention and archival strategies for the storage of medical records, HCIs (e.g. ITLC sector) may after a specified period of retention, cull the medical records, and retain at least the records proposed below as part of the secondary medical records, to be stored for the remainder of the retention period.** ii. Inpatient/ outpatient discharge summary iii. Operation reports iv. All consent forms v. X-ray reports vi. Histopathology investigation reports vii. Maternity records viii. Neonatal records which are enclosed in the mother's case notes ix. Labour records x. Workman's compensation reports xi. Insurance forms xii. Medical and other medico-legal forms xiii. Treatment and progress notes (including doctors, nurses and allied health professionals) xiv. Inpatient medication charts xv. Prescription orders xvi. Blood transfusion records e. HCIs are encouraged to refrain from culling records until at least 4 years have passed, as patients can commence proceedings in Court on the 3rd year and have a further 12 months to inform the

	HCIs of the proceedings
6. Inpatient records (Minors)	a. Inpatient medical records of minors should be retained until the patient has reached 24 years of age. However, where the patient is still active, the medical records should continue to be maintained. b. Maternity records, relating to a child, should be retained as per guidelines for records for that child.
7. Mental Incapacity	c. Under the Mental Capacity Act, a person lacks mental capacity in relation to a matter if, at the material time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the function of, the mind or brain. (Please refer to Section (4) of the Mental Capacity Act). d. Mental capacity can be determined by a SMC registered psychiatrist or a medical practitioner who is accredited by the Public Guardian. (Please refer to Section 7(1) under the Mental Capacity Regulations)
8. Outpatient Medical Records	a. Outpatient medical records include those for visits at HCIs, polyclinics, GPs, specialists, non-residential ILTC institutions etc. b. A&E records should only be treated as outpatient medical records if the patient is not admitted for inpatient treatment. c. Patients, who are admitted into the same institution for inpatient treatment, should have both sets of medical records retained together, for the retention period recommended under the inpatient medical records. d. The retention period for outpatient medical records have been lengthened to 6 years as a precautionary measure. While this is shorter than the 15 year general overriding time limit under the Limitation Act, (i) many outpatients may not require their medical records past this timeframe and (ii) some outpatient healthcare providers may experience difficulties in storing medical records longer than 6 years. However, healthcare providers are advised to retain the complete outpatient medical records for up to 15 years, in cases which are (i) deemed as “high risk”, (ii) may require internal investigations, or where (iii) legal action has been or might be taken against the healthcare provider.

9. Dental Medical Records	a. Inpatient primary dental records should be retained as per inpatient records guidelines. b. Outpatient primary dental records should be retained for a minimum of 6 years. c. HCIs are encouraged to apply appropriate risk management strategies, and high risk cases should be retained following inpatient secondary medical records retention guidelines, based on age i.e. adult or minor. d. After this retention period, records should be stored for as long as possible by scanning or digitising them, and destroying the originals. e. Dental primary records consist of a variety of material in both paper and electronic format, and include but are not limited to the following: i. Database information e.g. name, birth date, address, contact information, medical and dental histories, notes and updates ii. Treatment notes made by clinicians and staff iii. Diagnostic records, including reports, charts, casts, photographs, radiographs, tracings and measurements iv. Treatment plan notes v. Consent forms vi. Laboratory work order forms vii. Referral letters and correspondence with referring or referral dentists and/or physicians viii. Patient complaints and resolutions
10. "High risk" Patients and/or cases	a. HCIs may identify "high risk patients/cases", e.g. patients who suffered complications during treatment, pending complaint cases, patients who underwent procedures to remove foreign bodies, or patients whose mental capacity was an issue. b. These medical records should be kept for a longer duration, such as 15 years which is the general overriding time limit stipulated by the Limitation Act. c. Where a decision is made to retain records for longer than the periods prescribed, it is important that this is supported by clear reasons, which should be explicitly noted in the records. It may also be prudent to include the reasons for identifying these "high risk patients/cases" in the HCIs' data protection and retention policies.

11. Diagnostic Images	a. Diagnostic images in this instance refer to film based images. b. HCIs need not retain diagnostic images where images are released to the patient.
12. Assisted Reproduction Records	a. The following Assisted Reproduction (AR)[1] records should be retained for the child's lifetime + 6 years: i. Registers of children conceived through IVF or other AR procedures, and delivered in Singapore, identified by their birth certificate numbers. ii. Medical records[2] of IVF or other Assisted Reproduction procedures. [1] *AR includes clinical treatments and laboratory procedures that involve:* i. The removal or attempted removal of oocytes from a woman for any purpose; and ii. The handling of human oocytes or embryos for the purpose of procreation iii. This includes In-vitro fertilisation; gamete intrafallopian transfer; zygote intrafallopian transfer; intra-cytoplasmic sperm injection; gamete/embryo/ovarian tissue cryopreservation; gamete/embryo donation (for any purpose); and embryo biopsy for preimplantation genetic diagnosis. [2] Records should include the investigations carried out before the start of AR treatment, indications for undergoing AR, treatment protocols, data captured from the start of the cycle till the end (e.g. in the case of a fresh cycle: from the date of ovarian stimulation till the confirmation of clinical pregnancy) as well as the outcome and complications of AR treatment.
13. Cancer Records	a. Retention periods applied to cancer records should follow those of the relevant patient care settings. b. At hospital level, cancer records need not be kept indefinitely. Separately, relevant information should be reported to and reside in the National Cancer Registry.
14. Medico-Legal Cases	a. Where HCIs are aware that legal action has been initiated or is imminent, the complete medical records of the patient should be retained until the conclusion of legal proceedings. b. Operationally, HCIs may choose to tag these records e.g. electronically, by stamping the words " Medico-Legal case", or otherwise appropriate, prominently on the case folder/records

ANNEX B

RELEVANT LEGISLATION IN RELATION TO THE RETENTION PERIODS FOR MEDICAL RECORDS

Act	Provision	Legal Requirements
Coroners Act	Section 8 (read with the Coroners (Records Retention) Regulation 2012)	If a patient dies in a healthcare institution (HCI), the HCI must retain the patient's medical records for **at least 6 years after the patient passes away.** **Enforcement:** any person in breach of the Coroners Act is liable to a maximum fine of $10,000 or to imprisonment of not more than 12 months or both.
Infectious Diseases Act	Section 48(2) (read with regulations 22 and 24(2) of the Infectious Diseases (Diphtheria and Measles) Regulations)	Medical practitioners must keep vaccination records (for diphtheria and measles) for at least **3 years**. **Enforcement**: A breach of the Infectious Diseases (Diphtheria and Measles) Regulations may be punished with a fine of up to $500 for a first offence, or up to $1,000 for second and subsequent offences.
Limitation Act	Section 6(1)	Under the rubric of "actions founded on a contract and tort and certain other actions", the following actions shall not be brought after the expiration of **6 years** from the date on which the cause of action accrued: • Actions founded on a contract or on tort • Actions to enforce a recognizance • Actions to enforce an award • Actions to recover and sum recoverable by virtue of any written law other than a penalty or forfeiture or sum by way of penalty or forfeiture.
	Sections 24A, 24B	In the case of an action for damages for medical negligence resulting in personal injuries, lawsuits must be filed within : • **3 years** from the date on which the cause of action accrued, or • **3 years** from the earliest date on which the plaintiff has the knowledge required to bring legal proceedings in court • Overriding time limit: **15 years** from the date of injury
	Section 24 (read with s2(2), as well as common law)	There is an extension of the limitation period in cases of disability: • Patient is a minor (and therefore is unable to bring legal proceedings in his own capacity until the **age of 21**) • Patient lacks mental capacity (as defined in the Mental Capacity Act)., in which case the relevant period in the Limitation Act does not come into effect until the disability ceases or the patient has died (whichever comes first)

Act	Provision	Legal Requirements
Medicines Act (Clinical Trials Regulations)	Regulation 19	Clinical trial records are to be kept up to date and at least for whichever period is longer: • Until there are no pending marketing applications of the test material in Singapore • 2 years after the last approval of a marketing application for the test material in Singapore • 2 years after the licensing authority has been informed of the discontinuation of the clinical trial • **6 years** after the completion of the clinical trial
Personal Data Protection Act	Section 25, read with section 56	Retention limitation obligation requires that personal information should not be kept any longer than is necessary for the original, business or legal purpose e.g. patient care. **Enforcement**: Any person in breach of the act is liable to a maximum fine of $10,000 or up to 3 years' imprisonment or both, and if the offence is continuing, a further fine of up to $1,000 per day that the offence continues.
Private Hospitals and Medical Clinics Act	Para 7 Licensing Terms and conditions for Assisted Reproduction Services imposed under Section 6(5) (issued on 26 Apr 2011)	AR centers shall ensure that a register of children conceived through IVF and other AR procedures and delivered in Singapore, identified by their birth certificate numbers is maintained.

ANNEX C

TABLE OF AMENDMENTS AND RATIONALS OF THE UPDATED GUIDELINES

Category	1996 Guidelines	Proposed Guidelines	Legal requirement / Rationale
Computerised Records	Indefinitely	Lifetime + 6 years	Legal requirement Retention limitation obligation under the PDPA requires that personal information should not be kept any longer than is necessary for the original, business or legal purpose e.g. patient care. Rationale To reduce cost and aid compliance with PDPA requirements, healthcare institutions are encouraged to retain medical records in an electronic format. It is recognised that medical records are a valuable store of information for primary patient care and secondary uses. Thus, HCIs are encouraged to store all medical records in a computerised or electronic format, and subsequently may retain de-identified electronic medical records beyond this timeframe, unless otherwise provided for by the law.
Hospital Inpatient Paper records			
a. Adults	Medical and surgical records Primary medical record: 3 years Secondary medical record: 17 years	15 years	Legal requirement The revised retention periods are in line with the Limitation Act's over-riding limit of **15 years** for cases involving negligence (section 24B).

	<u>Cancer records</u> Till death		<u>Rationale</u> In order to reduce cost and facilitate easy operational housekeeping, the category of secondary medical records has been removed. As part of their internal archival strategy, HCIs may perform the culling of medical records after a specified period of retention. The secondary medical record should contain the proposed list of records described in the supplementary notes (Annex A) and be stored for the remainder of the retention period. Cancer records will be retained for based on the patient type category. At the hospital level, cancer records need not be kept indefinitely. Separately, the relevant information should be reported to and reside in the National Cancer Registry.
b. Minors	<u>Medical and surgical records</u> Primary medical record: 5 years Secondary medical record: 17 years	Till the patient is 24 years of age	<u>Legal requirement</u> There is an extension of the limitation period in cases where the patient is a <u>minor</u> (and therefore is unable to bring legal proceedings in his own capacity until he turns **21**) (see section 24 read with section 2(2) [definition of "disability"] of the Limitation Act) <u>Rationale</u> The "paediatric" category was reclassified as "minor" to be in line with the law, including the Limitation Act, Patients are provided a further

			3 years to file legal proceedings after they reach maturity.
c. Lacks mental capacity	<u>Psychiatric records</u> 7 years after death	Lifetime + 6 years	<u>Legal requirement</u> There is an extension of the limitation period in cases where the patient lacks mental capacity, in which case the relevant period in the Limitation Act does not come into effect until the disability ceases or the patient has died (whichever comes first). (see section 24 read with section 2(2) [definition of "disability"] of the Limitation Act) <u>Rationale</u> In alignment with legal requirements, the category of "psychiatric" has been reclassified as those who "lack mental capacity", and the retention period has been extended.
ILTC Paper records			
a. All residential patients in ILTC institutions	NIL	15 years	<u>Legal requirement</u> The revised retention period is in line with the Limitation Act's over-riding limit of **15 years** for cases involving negligence (section 24B).
Ambulatory / Outpatient Paper records			
a. Outpatient	<u>Adult medical and surgical patients</u> Primary medical record: 3 years Secondary medical record: 17 years	6 years or longer for "high risk" patients * inclusive of A&E and non-	<u>Legal requirement</u> This is in line with the general rule in law that civil cases have to be brought within 6 years from the date on which the cause of action accrued (see section 6(1) of the Limitation Act).

	<u>Paediatric medical and surgical records</u> Primary medical record: 5 years Secondary medical record: 17 years <u>Cancer records</u> Till death <u>Psychiatric records</u> 7 years after death <u>A&E records</u> Accident/ Police cases : 5 years Medical cases: 3 years	residential ILTC patients.	<u>Rationale</u> The retention period of 6 years or longer for "high risk patients" has been recommended: a. To be in alignment with the retention period of the other outpatient care settings and with legal requirements. b. To take into account the space and logistic limitations of outpatient healthcare practitioners, in particular stand-alone private specialists. Healthcare providers are encouraged to develop a risk management strategy to stratify patients and/or cases by "risk" of requiring their medical records for clinical or medico-legal investigation at a later date.
b. Primary health care	<u>Outpatient records</u> Primary medical record: 5 years Secondary medical record: 17 years <u>School health records</u> Primary medical record: 3 years Secondary medical record: up to age 21	6 years or longer for "high risk" patients	<u>Legal requirement</u> This is in line with the general rule that civil court cases have to be brought within 6 years from the date on which the cause of action accrued (see section 6(1) of the Limitation Act). <u>Rationale</u> The retention period of 6 years has been recommended as: a. The incidence of legal cases filed more than '3 years after the date of injury' is understood to be low. However, the retention period has been lengthened as a precautionary measure.

			b. To be in alignment with the retention period of the other outpatient care settings and with legal requirements. c. To take into account the space and logistic limitations of primary healthcare practitioners, in particular stand-alone private GPs. Healthcare providers are encouraged to develop an appropriate risk management strategy.
c. Dental outpatient	3 years	6 years or longer for "high risk" patients	<u>Legal requirement</u> This is in line with the general rule that civil court cases have to be brought within 6 years from the date on which the cause of action accrued (see section 6(1) of the Limitation Act). <u>Rationale</u> The retention period of 6 years has been recommended as: a. The Singapore Dental Council had advised that dental outpatient medical records be retained for 5 years. b. To be in alignment with the other outpatient care settings, legal requirements. c. To take into account the space and logistic limitations of dental outpatient clinics and private dental practitioners.

			Healthcare providers are encouraged to develop an appropriate risk management strategy.
Others			
a. Patient registers	3 year retention period applies to paper records including their computer generated hard copies	Electronic patient registers : lifetime + 6 years	<u>Legal requirement</u> Retention limitation obligation under the PDPA requires that personal information should not be kept any longer than is necessary for the original purpose, and there is no business or legal purpose for retention e.g. patient care. <u>Update</u> Paper patient registers have been removed from the guidelines, and HCIs may retain these registers as per Institution protocol. Electronic patient registers will be retained as per retention periods of all electronic medical records.
b. Diagnostic images	NIL	6 years *diagnostic images refer to film based images.	<u>Legal requirement</u> This is in line with the general rule that civil court cases have to be brought within 6 years from the date on which the cause of action accrued (see section 6(1) of the Limitation Act). <u>Rationale</u> The retention period of 6 years has been recommended as: a. The College of Radiology had advised that diagnostic images be retained for a

			minimum of 5 years. b. To be in alignment with the other retention periods, and with legal requirements.
c. Assisted reproduction	NIL	Child's Lifetime + 6 years	<u>Licensing requirements</u> AR centers shall ensure that a register of children conceived through IVF and other AR procedures and delivered in Singapore is maintained. <u>Rationale</u> The guidelines have been amended based on recommendations from MOH Regulatory, Policy and Legislation Division, and the licensing terms and conditions on AR services imposed under section 6(5) of the PHMC Act.