



## PERMANENT ADMINISTRATIVE ORDER

### PH 6-2021

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PUBLIC HEALTH DIVISION

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#### RULES:

333-501-0055, 333-505-0030, 333-505-0033, 333-505-0050

AMEND: 333-501-0055

REPEAL: Temporary 333-501-0055 from PH 59-2020

NOTICE FILED DATE: 11/16/2020

RULE SUMMARY: Amend OAR 333-501-0055 – Adds reference to Oregon Laws 2020, chapter 20 for purposes of issuing civil penalties for violations.

#### CHANGES TO RULE:

333-501-0055

Civil Penalties, Generally ¶

- (1) This rule does not apply to civil penalties for violations of ORS 441.155, 441.166, 441.815, or 435.254 or rules adopted to implement these statutes.¶
- (2) A person that violates a health care facility licensing law, including OAR 333-501-0020 (violations), is subject to the imposition of a civil penalty not to exceed \$500 per day per violation.¶
- (3) In addition to the penalties under section (2) of this rule, civil penalties may be imposed for violations of ORS 441.030-~~or~~, 441.015(1), and Oregon Laws 2020, chapter 20, sections 1 and 2 (Special Session).¶
- (4) In determining the amount of a civil penalty, the Division shall consider whether:¶
  - (a) The Division made repeated attempts to obtain compliance;¶
  - (b) The licensee has a history of noncompliance with health care facility licensing laws;¶
  - (c) The violation poses a serious risk to the public's health;¶
  - (d) The licensee gained financially from the noncompliance; and¶
  - (e) There are mitigating factors, such as a licensee's cooperation with an investigation or actions to come into compliance.¶
- (5) The Division shall document its consideration of the factors in section (4) of this rule.¶

(6) Each day a violation continues is an additional violation.¶¶

(7) A civil penalty imposed under this rule shall comply with ORS 183.745.

Statutory/Other Authority: ORS 441.025

Statutes/Other Implemented: ORS 441.990, OL (2020) Chapter 20, ¶1-3 (Spec Sess)

AMEND: 333-505-0030

REPEAL: Temporary 333-505-0030 from PH 59-2020

NOTICE FILED DATE: 11/16/2020

RULE SUMMARY: Amend OAR 333-505-0030 – Removes language that is already identified in statute and summarizes the requirement that a hospital develops and maintains a policy regarding a patient's right to accept or refuse medical or surgical treatment and right to formulate an advance directive or appoint a health care representative. Clarifies that a hospital may not condition the provision of treatment on a patient having a POLST, an advance directive, a form appointing a health care representative or any instruction relating to the administration, withholding or withdrawal of life-sustaining measures.

CHANGES TO RULE:

333-505-0030

Organization, Hospital Policies ¶¶

- (1) A hospital's internal organization shall be structured to include appropriate departments and services consistent with the needs of its defined community.¶¶
- (2) A hospital shall adopt and maintain clearly written definitions of its organization, authority, responsibility and relationships.¶¶
- (3) A hospital shall adopt, maintain and follow written patient care policies that include but are not limited to:¶¶
  - (a) Admission and transfer policies that address:¶¶
    - (A) Types of clinical conditions not acceptable for admission;¶¶
    - (B) Constraints imposed by limitations of services, physical facilities or staff coverage;¶¶
    - (C) Emergency admissions;¶¶
    - (D) Requirements for informed consent signed by the patient or legal representative of the patient for diagnostic and treatment procedures; such policies and procedures shall address informed consent of minors in accordance with provisions in ORS 109.610, 109.640, 109.670, and 109.675;¶¶
    - (E) Requirements for identifying persons responsible for obtaining informed consent and other appropriate disclosures and ensuring that the information provided is accurate and documented appropriately in accordance with these rules and ORS 441.098; and¶¶
    - (F) A process for the internal transfer of patients from one level or type of care to another;¶¶
  - (b) Discharge, termination of services, and release from emergency department policies in accordance with OAR 333-505-0055 and OAR 333-520-0070;¶¶
  - (c) Patient rights, including but not limited to compliance with OAR 333-505-0033;¶¶
  - (d) Housekeeping;¶¶
  - (e) All patient care services provided by the hospital;¶¶
  - (f) Maintenance of the hospital's physical plant, equipment used in patient care and patient environment;¶¶
  - (g) Treatment or referral of acute sexual assault patients in accordance with ORS 147.403; and¶¶
  - (h) Identification of patients who could benefit from palliative care in order to provide information and facilitate access to appropriate palliative care in accordance with ORS 413.273.¶¶
- (4) In addition to the policies described in section (3) of this rule, a hospital shall, in accordance with ~~the Patient Self-Determination Act, 42 CFR 489.102, adopt policies and procedures that require (applicable to all capable individuals 18 years of age or older who are receiving health care in the hospital):~~ ¶¶
  - (a) ~~Providing to each adult patient, including emancipated minors, not later than five days after an individual is admitted as an inpatient, but in any event before discharge, the following in written form, without recommendation:~~ ¶¶
    - (A) ~~Information on the rights of the individual under Oregon law to make health care decisions, including the~~ 42 CFR 489.102, ORS 127.649, and ORS 127.652, adopt and maintain written policies and procedures concerning a patient's right to accept or refuse medical or surgical treatment and the right to execute directives and powers of

attorney for health care; ¶

~~(B) Information on the policies of the hospital with respect to the implementation of formulate an advance directive or appoint a health care representative.~~ ¶

~~(5) A hospital may not condition of the rights of the individual under Oregon law to make health care decisions;~~ ¶

~~(C) A copy of the directive form set forth provision of treatment on a patient having a POLST as that term is defined in ORS 127.531, along with a disclaimer attached to each form in at least 16-point bold type stating "You do not have to fill out and sign this form."; and~~ ¶

~~(D) The name of a person who can provide additional information concerning the forms for directives.~~ ¶

~~(b) Documenting in a prominent place in the individual's medical record whether the individual has executed a directive.~~ ¶

~~(c) Compliance with Oregon law relating to directives for health care.~~ ¶

~~(d) Educating the staff and the community on issues relating to directives 663, an advance directive as defined in ORS 127.505, a form appointing a health care representative under ORS 127.510, or any instruction relating to the administration, withholding or withdrawing of life-sustaining procedures or artificially administered nutrition and hydration.~~ ¶

~~(56) A hospital's transfer agreements or contracts shall clearly delineate the responsibilities of parties involved.~~ ¶

~~(67) Patient care policies shall be evaluated triennially and rewritten as needed; and presented to the governing body or a designated administrative body for approval triennially. Documentation of the evaluation is required.~~ ¶

~~(78) A hospital shall have a system, described in writing, for the periodic evaluation of programs and services, including contracted services.~~

Statutory/Other Authority: ORS 441.025

Statutes/Other Implemented: ORS 413.273, 441.025, 441.196051, 441.198054, OL (2020) Chapter 20 (Spec Sess)

AMEND: 333-505-0033

REPEAL: Temporary 333-505-0033 from PH 59-2020

NOTICE FILED DATE: 11/16/2020

RULE SUMMARY: Amend OAR 333-505-0033 – Moves definitions to the beginning of the rule and adds a definition for support care conference. Aligns language with the statutory provisions. Specifies requirements necessary in the hospital's policy about a patient's right to designate support persons and a hospital's obligation to allow support persons to be physically present. Clarifies that the decision to have a support person present during discussions about withholding or withdrawing life sustaining measures resides with the patient. Clarifies that all patients are notified orally and in writing of right to support person(s), and that treatment cannot be conditioned upon having an advance directive, POLST, or an order withdrawing or withholding life-sustaining measures. Requires notices to be available in an alternate format. Clarifies that a hospital may impose conditions for any support person(s) present at the hospital to ensure the safety of the patient, support person and staff, and requires that the hospital conduct a support care conference if the hospital denies a patient's request for a support person's physical presence. Requires a hospital to take reasonable steps to ensure that a patient understands his or her rights to designate support persons if the patient did not designate a support person(s) and it is determined that the patient has a communication barrier or other disability.

CHANGES TO RULE:

333-505-0033

Patient Rights ¶¶

(1) A hospital shall comply with the requirements for patients' rights as set forth in 42 CFR 482.13.¶¶

(2) As used in sections (3) through (9) of this rule: ¶¶

(a) "Patient" means a patient admitted to a hospital or seeking medical evaluation and care in an emergency department who needs assistance to effectively communicate with hospital staff, make health care decisions, understand health care information, or engage in activities of daily living due to a disability, including but not limited to:¶¶

(A) A physical, intellectual, behavioral or cognitive impairment:¶¶

(B) Deafness, being hard of hearing or other communication barrier:¶¶

(C) Blindness:¶¶

(D) Autism; or¶¶

(E) Dementia:¶¶

(b) "Support care conference" means a meeting in person, by telephone, or electronic media, that includes a representative from the patient's hospital care team, the patient, the patient's legal representative (if applicable), and the patient's designated support person(s). The support care conference must include discussion of denial and any parameters for permitting a support person to be physically present with the patient including but not limited to any limitations, restrictions, or additional precautions that may be implemented for the safety of the patient, support person, and hospital staff.¶¶

(c) "Support person" means a family member, guardian, personal care assistant or other paid or unpaid attendant selected by the patient to physically or emotionally assist the patient or ensure effective communication with the patient.¶¶

(3) A patient has the right, and a hospital must allow a patient, to designate at least three support persons and to have at least one support person physically present with the patient at all times in the emergency department and during the patient's stay at the hospital if necessary to facilitate the patient's care including but not limited to when the patient:¶¶

(a) Has a cognitive, intellectual or mental health disability that affects the patient's ability to make or communicate medical decisions or understand medical advice:¶¶

(b) Needs assistance with activities of daily living and the hospital staff are unable to provide the same level of care

or are less effective at providing the assistance;¶

(c) Is deaf, is hard of hearing or has other communication barriers and requires the assistance of a support person to ensure effective communication with hospital staff; or¶

(d) Has behavioral health needs that the support person can address more effectively than the hospital staff.¶

(4) Unless a patient requests otherwise, a hospital must ensure that a support person designated by the patient, or patient's legal representative, is physically present for any discussion in which the patient is asked to:¶

(a) Elect hospice care;¶

(b) Sign an advance directive; or¶

(c) Sign any other document allowing the withholding or withdrawing of life-sustaining procedures or artificially administered nutrition or hydration.¶

(5) A hospital shall develop and implement a policy regarding a patient's rights and the hospital's obligations in sections (3) and (4) of this rule. The policy shall recognize at a minimum:¶

(a) The notification requirements described in sections (6) and (7) of this rule;¶

(b) That either the patient or a patient's legal representative in collaboration with the patient, may designate support persons;¶

(c) That the hospital shall post the hospital's policy on its website and post a summary of the policy, with instructions on how to obtain the full policy, at entry points to the hospital. The posting at each entry shall be clearly visible to the public and the full policy will include contact information for a person, position, or a department at the hospital where the policy may be requested in an alternate format; and¶

(d) That the hospital may not condition the provision of treatment to a patient in accordance with Oregon Laws 2020, chapter 20, section 1 (Special Session).¶

(6) A hospital shall provide all patients orally and in writing notice of their right to support persons as described in section (3) of this rule. In addition:¶

(a) Notice to patients shall include that treatment cannot be conditioned upon having an advance directive, POLST, or an order withdrawing or withholding life support such as a Do Not Resuscitate order.¶

(b) Notice must be made available in alternate formats at the request of the patient or the patient's legal representative. ¶

(7) As specified in section (3) of this rule, a hospital must allow at least one support person to be physically present with a patient at all times in the emergency department and during the patient's stay at the hospital. This includes, but is not limited to, an operating room, a procedure room, or other area where generally only patients and hospital staff are allowed.¶

(a) Consistent with other state and federal requirements, a hospital may impose conditions for any support person(s) present at the hospital to ensure the safety of the patient, support person(s) and staff as specified in Oregon Laws 2020, chapter 20, section 2 (Special Session).¶

(b) If a hospital denies a patient's request for a support person's physical presence with the patient, or a portion of such a request, the hospital shall:¶

(A) Immediately notify the patient and the patient's designated support person(s) orally and in writing of the opportunity to request a support care conference to discuss the denial and any parameters for permitting a support person to be physically present.¶

(B) Upon request for a support care conference, conduct a support care conference as soon as possible but not later than 24 hours after admission or prior to a procedure or operation.¶

(C) Following a support care conference, the hospital shall document the decision and any reasons for the limitation, restriction, additional precautions or prohibition in the treatment plan. If a support care conference does not occur, the hospital shall document in the treatment plan why the support care conference did not occur.¶

(8)(a) A hospital may refuse to allow the presence of a designated support person who refuses or fails to comply with conditions imposed by the hospital or remove a designated support person from a procedure room, operating room, or other area where generally only patients and hospital staff are allowed, if necessary to ensure the safety of the patient, support person or staff. ¶

(b) The hospital shall ensure that another designated support person is permitted to be physically present with the

patient if otherwise consistent with this rule.¶

(9) If a patient, or a patient's legal representative does not designate a support person(s) and a hospital determines that a patient has a communication barrier or other disability, the hospital shall take reasonable steps to further communicate the patient's right to support persons to the patient, patient's family or patient's legal representative.

Statutory/Other Authority: ORS 441.025

Statutes/Other Implemented: ORS 441.025, OL (2020) Chapter 20 (Spec Sess)

AMEND: 333-505-0050

REPEAL: Temporary 333-505-0050 from PH 59-2020

NOTICE FILED DATE: 11/16/2020

RULE SUMMARY: Amend OAR 333-505-0050 – Since OAR 333-505-0033 requires notification to all patients, removes requirement to document in the medical record whether a patient has a disability and is subject to notification. Removes requirement to document the reason why a support person is needed to assist.

CHANGES TO RULE:

333-505-0050

Medical Records ¶¶

- (1) A medical record shall be maintained for every patient admitted for care in a hospital.¶¶
- (2) A legible reproducible medical record shall include, but is not limited to (as applicable):¶¶
  - (a) Admitting identification data including date of admission.¶¶
  - (b) Chief complaint.¶¶
  - (c) Pertinent family and personal history.¶¶
  - (d) Medical history, physical examination report and provisional diagnosis as required by OAR 333-510-0010.¶¶
  - (e) Admission notes outlining information crucial to patient care.¶¶
  - (f) All patient admission, treatment, and discharge orders:¶¶
    - (A) All patient orders shall be initiated, dated, timed and authenticated by a licensed health care practitioner in accordance with section (7) of this rule.¶¶
    - (B) Documentation of verbal orders shall include:¶¶
      - (i) The date and time the order was received;¶¶
      - (ii) The name and title of the health care practitioner who gave the order; and¶¶
      - (iii) Authentication by the authorized individual who accepted the order, including the individual's title.¶¶
    - (C) Verbal orders shall be dated, timed, and authenticated promptly by the ordering health care practitioner or another health care practitioner who is responsible for the care of the patient.¶¶
    - (D) For purposes of this rule, a verbal order includes but is not limited to an order given over the telephone.¶¶
  - (g) Clinical laboratory reports as well as reports on any special examinations. The original report shall be recorded in the patient's medical record.¶¶
  - (h) X-ray reports bearing the identification of the originator of the interpretation.¶¶
  - (i) Consultation reports when such services have been obtained.¶¶
  - (j) Records of assessment and intervention, including graphic charts and medication records and appropriate personnel notes.¶¶
  - (k) Discharge planning documentation in accordance with OAR 333-505-0055.¶¶
  - (l) Discharge summary including final diagnosis.¶¶
  - (m) Autopsy report if applicable.¶¶
  - (n) Such signed documents as may be required by law.¶¶
  - (o) Informed consent forms that document:¶¶
    - (A) The name of the hospital where the procedure or treatment was undertaken;¶¶
    - (B) The specific procedure or treatment for which consent was given;¶¶
    - (C) The name of the health care practitioner performing the procedure or administering the treatment;¶¶
    - (D) That the procedure or treatment, including the anticipated benefits, material risks, and alternatives was explained to the patient or the patient's representative or why it would have been materially detrimental to the patient to do so, giving due consideration to the appropriate standards of practice of reasonable health care practitioners in the same or a similar community under the same or similar circumstances;¶¶
    - (E) The manner in which care will be provided in the event that complications occur that require health services beyond what the hospital has the capability to provide;¶¶



- (F) The signature of the patient or the patient's legal representative; and¶
- (G) The date and time the informed consent was signed by the patient or the patient's legal representative;¶
- (p) Documentation of the disclosures required in ORS 441.098; and¶
- (g) Documentation of support persons designated by a patient, or a patient's legal representative, in collaboration with the patient, pursuant to OAR 333-505-0033. The following information shall be documented:¶
  - (A) The name and contact information for each designated support person;¶
  - (B) The date and time the patient was informed of their rights in OAR 333-505-0033(3) to designate support persons and have one support person present at all times to assist the patient when the patient is receiving hospital services; and¶
  - (C) Any conditions imposed on the support person(s). ¶
- (3) A medical record of a surgical patient shall include, in addition to other record requirements, but is not limited to:¶
  - (a) Preoperative history, physical examination and diagnosis documented prior to operation.¶
  - (b) Anesthesia record including preanesthesia assessment and plan for anesthesia, records of anesthesia, analgesia and medications given in the course of the operation and postanesthetic condition.¶
  - (c) A record of operation dictated or written immediately following surgery and including a complete description of the operation procedures and findings, postoperative diagnostic impression, and a description of the tissues and appliances, if any, removed. When the dictated operative report is not placed in the medical record immediately after surgery, an operative progress note shall be entered in the medical record after surgery to provide pertinent information for any individual required to provide care to the patient.¶
  - (d) Postanesthesia recovery progress notes.¶
  - (e) Pathology report on tissues and appliances, if any, removed at the operation.¶
- (4) An obstetrical record for a patient, in addition to the requirements for medical records, shall include but is not limited to:¶
  - (a) The prenatal care record containing at least a serologic test result for syphilis, Rh factor determination, and past obstetrical history and physical examination.¶
  - (b) The labor and delivery record, including reasons for induction and operative procedures, if any.¶
  - (c) Records of anesthesia, analgesia, and medications given in the course of delivery.¶
- (5) A medical record of a newborn or stillborn infant, in addition to the requirement for medical records, shall include but is not limited to:¶
  - (a) Date and hour of birth; birth weight and length; period of gestation; sex; and condition of infant on delivery (Apgar rating is recommended).¶
  - (b) Mother's name and hospital number.¶
  - (c) Record of ophthalmic prophylaxis or refusal of same.¶
  - (d) Physical examination at birth and at discharge.¶
  - (e) Progress and nurse's notes including temperature; weight and feeding data; number, consistency and color of stools; urinary output; condition of eyes and umbilical cord; condition and color of skin; and motor behavior.¶
  - (f) Type of identification placed on infant in delivery room.¶
  - (g) Newborn hearing screening tests conducted in accordance with OAR chapter 333, division 20.¶
- (6) A patient's emergency room, outpatient and clinic records, in addition to the requirements for medical records, shall be maintained and available to the other professional services of the hospital and shall include but are not limited to:¶
  - (a) Patient identification.¶
  - (b) Admitting diagnosis, chief complaint and brief history of the disease or injury.¶
  - (c) Physical findings.¶
  - (d) Laboratory and X-ray reports (if performed), as well as reports on any special examinations. The original report shall be authenticated and recorded in the patient's medical record.¶
  - (e) Diagnosis.¶
  - (f) Record of treatment, including medications.¶

- (g) Disposition of case with instructions to the patient.-¶
- (h) Signature or authentication of attending physician.-¶
- (i) A record of the pre-hospital report form (when patient is brought in by ambulance) shall be attached to the emergency room record.-¶
- (7) All entries in a patient's medical record shall be dated, timed and authenticated.-¶
  - (a) Authentication of an entry requires the use of a unique identifier, including but not limited to a written signature or initials, code, password, or by other computer or electronic means that allows identification of the individual responsible for the entry.-¶
  - (b) Systems for authentication of dictated, computer, or electronically generated documents must ensure that the author of the entry has verified the accuracy of the document after it has been transcribed or generated.-¶
- (8) The following records shall be maintained in written or computerized form for the time period specified:-¶
  - (a) Permanent:-¶
    - (A) Patient's register, containing admissions and discharges;-¶
    - (B) Patient's master index;-¶
    - (C) Register of all deliveries, including live births and stillbirths;-¶
    - (D) Register of all deaths; and-¶
    - (E) Register of operations.-¶
  - (b) Seven years:-¶
    - (A) Register of outpatients; and-¶
    - (B) Emergency room register.-¶
  - (c) Blood banking register shall be retained for 20 years.-¶
- (9) The completion of the medical record shall be the responsibility of the attending qualified member of the medical staff. Any licensed health care practitioner responsible for providing or evaluating the service provided shall complete and authenticate those portions of the record that pertain to their portion of the patient's care. The appropriate individual shall authenticate the history and physical examination, operative report, progress notes, orders and the summary. In a hospital using interns, such orders must be according to policies and protocols established and approved by the medical staff. An authentication of a licensed health care practitioner on the face sheet of the medical record does not suffice to cover the entire content of the record:-¶
  - (a) Medical records shall be completed by a licensed health care practitioner and closed within four weeks following the patient's discharge.-¶
  - (b) If a patient is transferred to another health care facility, transfer information shall accompany the patient. Transfer information shall include but is not limited to:-¶
    - (A) The name of the hospital from which they were transferred;-¶
    - (B) The name of physician or other health care practitioner to assume care at the receiving facility;-¶
    - (C) The date and time of discharge;-¶
    - (D) The current medical findings;-¶
    - (E) The current nursing assessment;-¶
    - (F) Current medical history and physical information;-¶
    - (G) Current diagnosis;-¶
    - (H) Orders from a physician or other licensed health care practitioner for immediate care of the patient;-¶
    - (I) Operative report, if applicable;-¶
    - (J) TB test, if applicable; and-¶
    - (K) Other information germane to patient's condition.-¶
  - (c) If the discharge summary is not available at time of transfer, it shall be transmitted to the new facility as soon as it is available.-¶
- (10) Diagnoses and operations shall be expressed in standard terminology. Only abbreviations approved by the medical staff may be used in the medical records.-¶
- (11) Medical records shall be filed and indexed. Filing shall consist of an alphabetical master file with a number cross-file. Indexing is to be done according to diagnosis, operation, and qualified member of the medical staff,

using a system such as the International or Standard nomenclature systems.-¶

(12) Medical records are the property of the hospital. The medical record, either in original, electronic or microfilm form, shall not be removed from the hospital except where necessary for a judicial or administrative proceeding. Treating and attending physicians shall have access to medical records. When a hospital uses off-site storage for medical records, arrangements must be made for delivery of these records to the hospital when needed for patient care or other hospital activities. Precautions must be taken to protect patient confidentiality.-¶

(13) Authorized personnel of the Division shall be permitted to review medical records and patient registers as necessary to determine compliance with health care facility licensing laws.-¶

(14) Medical records shall be kept for a period of at least 10 years after discharge. Original medical records may be retained on paper, microfilm, electronic or other media.-¶

(15) Medical records shall be protected against unauthorized access, fire, water and theft.-¶

(16) If a hospital changes ownership, all medical records in original, electronic or microfilm form shall remain in the hospital and it shall be the responsibility of the new owner to protect and maintain these records.-¶

(17) If a hospital closes, its medical records and the registers required under section (8) of this rule may be delivered and turned over to any other hospital in the vicinity willing to accept and retain the same as provided in section (12) of this rule. A hospital which closes permanently shall follow the procedure for Division and public notice regarding disposal of medical records under OAR 333-500-0060.-¶

(18) All original clinical records or photographic or electronic facsimile thereof, not otherwise incorporated in the medical record, such as X-rays, electrocardiograms, electroencephalograms, and radiological isotope scans shall be retained for seven years after a patient's last exam date if professional interpretations of such graphics are included in the medical records. Mammography images shall be retained for 10 years after a patient's last exam date.-¶

(19) If a qualified medical record practitioner, RHIT (Registered Health Information Technician) or RHIA (Registered Health Information Administrator) is not the Director of the Medical Records Department, periodic and at least annual consultation must be provided by a qualified medical records consultant, RHIT or RHIA. The visits of the medical records consultant shall be of sufficient duration and frequency to review medical record systems and assure quality records of the patients. The contract for such services shall be made available to the Division.-¶

(20) A current written policy on the release of medical record information including a patient's access to his or her medical record shall be maintained in the medical records department.-¶

(21) A hospital is not required to keep a medical record in accordance with this rule for a person referred to a hospital ancillary department for a diagnostic procedure or health screening by a private physician, dentist, or other licensed health care practitioner acting within his or her scope of practice.-¶

(22) Pursuant to ORS 441.059, the rules of a hospital that govern patient access to previously performed X-rays or diagnostic laboratory reports shall not discriminate between patients of chiropractic physicians and patients of other licensed health care practitioners permitted access to such X-rays and diagnostic laboratory reports.-¶

(23) Nothing in this rule is meant to prohibit or discourage a hospital from maintaining its records in electronic form.

Statutory/Other Authority: ORS 441.025

Statutes/Other Implemented: ORS 441.025, 433.321, OL (2020) Chapter 20 (Spec Sess)