RECORDS RETENTION AND HEALTHCARE RECORDS
NRS 629.051 Health care records: Retention; disclosure to patients concerning destruction of records; exceptions; regulations.

1. Except as otherwise provided in this section and in regulations adopted by the State Board of Health pursuant to NRS 652.135 with regard to the records of a medical laboratory and unless a longer period is provided by federal law, each provider of health care shall retain the health care records of his or her patients as part of his or her regularly maintained records for 5 years after their receipt or production. Health care records may be retained in written form, or by microfilm or any other recognized form of size reduction, including, without limitation, microfiche, computer disc, magnetic tape and optical disc, which does not adversely affect their use for the purposes of NRS 629.061. Health care records may be created, authenticated and stored in a computer system which meets the requirements of NRS 439.581 to 439.595, inclusive, and the regulations adopted pursuant thereto.

2. A provider of health care shall post, in a conspicuous place in each location at which the provider of health care performs health care services, a sign which discloses to patients that their health care records may be destroyed after the period set forth in subsection 1.

3. When a provider of health care performs health care services for a patient for the first time, the provider of health care shall deliver to the patient a written statement which discloses to the patient that the health care records of the patient may be destroyed after the period set forth in subsection 1.

4. If a provider of health care fails to deliver the written statement to the patient pursuant to subsection 3, the provider of health care shall deliver to the patient the written statement described in subsection 3 when the provider of health care next performs health care services for the patient.

5. In addition to delivering a written statement pursuant to subsection 3 or 4, a provider of health care may deliver such a written statement to a patient at any other time.

6. A written statement delivered to a patient pursuant to this section may be included with other written information delivered to the patient by a provider of health care.

7. A provider of health care shall not destroy the health care records of a person who is less than 23 years of age on the date of the proposed destruction of the records. The health care records of a person who has attained the age of 23 years may be destroyed in accordance with this section for those records which have been retained for at least 5 years or for any longer period provided by federal law.

8. The provisions of this section do not apply to a pharmacist.

9. The State Board of Health shall adopt:
   (a) Regulations prescribing the form, size, contents and placement of the signs and written statements required pursuant to this section; and
   (b) Any other regulations necessary to carry out the provisions of this section.

NRS 629.053 Health care records: Disclosure on Internet by State Board of Health and certain regulatory boards concerning destruction of records; regulations.

1. The State Board of Health and each board created pursuant to chapter 630, 630A, 631, 632, 633, 634, 634A, 635, 636, 637, 637A, 637B, 640, 640A, 640B, 640C, 641, 641A, 641B or 641C of NRS shall post on its website on the Internet, if any, a statement which discloses that:
(a) Pursuant to the provisions of subsection 7 of NRS 629.051:
   (1) The health care records of a person who is less than 23 years of age may not be destroyed; and
   (2) The health care records of a person who has attained the age of 23 years may be destroyed for those records which have been retained for at least 5 years or for any longer period provided by federal law; and
(b) Except as otherwise provided in subsection 7 of NRS 629.051 and unless a longer period is provided by federal law, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051.

2. The State Board of Health shall adopt regulations prescribing the contents of the statements required pursuant to this section.

Healthcare Records Inspection; Copies-NRS 629.061

NRS 629.061 Health care records: Inspection; copies; use in public hearing; immunity of certain persons from civil action for disclosure.
   1. Each provider of health care shall make the health care records of a patient available for physical inspection by:
      (a) The patient or a representative with written authorization from the patient;
      (b) The personal representative of the estate of a deceased patient;
      (c) Any trustee of a living trust created by a deceased patient;
      (d) The parent or guardian of a deceased patient who died before reaching the age of majority;
      (e) An investigator for the Attorney General or a grand jury investigating an alleged violation of NRS 200.495, 200.5091 to 200.50995, inclusive, or 422.540 to 422.570, inclusive;
      (f) An investigator for the Attorney General investigating an alleged violation of NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440, inclusive, or any fraud in the administration of chapter 616A, 616B, 616C, 616D or 617 of NRS or in the provision of benefits for industrial insurance; or
      (g) Any authorized representative or investigator of a state licensing board during the course of any investigation authorized by law.
   2. The records described in subsection 1 must be made available at a place within the depository convenient for physical inspection. Except as otherwise provided in subsection 3, if the records are located:
      (a) Within this State, the provider shall make any records requested pursuant to this section available for inspection within 10 working days after the request.
      (b) Outside this State, the provider shall make any records requested pursuant to this section available in this State for inspection within 20 working days after the request.
   3. If the records described in subsection 1 are requested pursuant to paragraph (e), (f) or (g) of subsection 1 and the investigator, grand jury or authorized representative, as applicable, declares that exigent circumstances exist which require the immediate production of the records, the provider shall make any records which are located:
      (a) Within this State available for inspection within 5 working days after the request.
      (b) Outside this State available for inspection within 10 working days after the request.
4. Except as otherwise provided in subsection 5, the provider of health care shall also furnish a copy of the records to each person described in subsection 1 who requests it and pays the actual cost of postage, if any, the costs of making the copy, not to exceed 60 cents per page for photocopies and a reasonable cost for copies of X-ray photographs and other health care records produced by similar processes. No administrative fee or additional service fee of any kind may be charged for furnishing such a copy.

5. The provider of health care shall also furnish a copy of any records that are necessary to support a claim or appeal under any provision of the Social Security Act, 42 U.S.C. §§ 301 et seq., or under any federal or state financial needs-based benefit program, without charge, to a patient, or a representative with written authorization from the patient, who requests it, if the request is accompanied by documentation of the claim or appeal. A copying fee, not to exceed 60 cents per page for photocopies and a reasonable cost for copies of X-ray photographs and other health care records produced by similar processes, may be charged by the provider of health care for furnishing a second copy of the records to support the same claim or appeal. No administrative fee or additional service fee of any kind may be charged for furnishing such a copy. The provider of health care shall furnish the copy of the records requested pursuant to this subsection within 30 days after the date of receipt of the request, and the provider of health care shall not deny the furnishing of a copy of the records pursuant to this subsection solely because the patient is unable to pay the fees established in this subsection.

6. Each person who owns or operates an ambulance in this State shall make the records regarding a sick or injured patient available for physical inspection by:
   (a) The patient or a representative with written authorization from the patient;
   (b) The personal representative of the estate of a deceased patient;
   (c) Any trustee of a living trust created by a deceased patient;
   (d) The parent or guardian of a deceased patient who died before reaching the age of majority; or
   (e) Any authorized representative or investigator of a state licensing board during the course of any investigation authorized by law.

   The records must be made available at a place within the depository convenient for physical inspection, and inspection must be permitted at all reasonable office hours and for a reasonable length of time. The person who owns or operates an ambulance shall also furnish a copy of the records to each person described in this subsection who requests it and pays the actual cost of postage, if any, and the costs of making the copy, not to exceed 60 cents per page for photocopies. No administrative fee or additional service fee of any kind may be charged for furnishing a copy of the records.

7. Records made available to a representative or investigator must not be used at any public hearing unless:
   (a) The patient named in the records has consented in writing to their use; or
   (b) Appropriate procedures are utilized to protect the identity of the patient from public disclosure.

8. Subsection 7 does not prohibit:
   (a) A state licensing board from providing to a provider of health care or owner or operator of an ambulance against whom a complaint or written allegation has been filed, or to his or her attorney, information on the identity of a patient whose records may be used in a public
hearing relating to the complaint or allegation, but the provider of health care or owner or operator of an ambulance and the attorney shall keep the information confidential.

(b) The Attorney General from using health care records in the course of a civil or criminal action against the patient or provider of health care.

9. A provider of health care or owner or operator of an ambulance and his or her agents and employees are immune from any civil action for any disclosures made in accordance with the provisions of this section or any consequential damages.

10. For the purposes of this section:
(a) “Guardian” means a person who has qualified as the guardian of a minor pursuant to testamentary or judicial appointment, but does not include a guardian ad litem.
(b) “Living trust” means an inter vivos trust created by a natural person:
   (1) Which was revocable by the person during the lifetime of the person; and
   (2) Who was one of the beneficiaries of the trust during the lifetime of the person.
(c) “Parent” means a natural or adoptive parent whose parental rights have not been terminated.
(d) “Personal representative” has the meaning ascribed to it in NRS 132.265.