

This is the Records Regulation, 2015, which has been approved by the provincial government and is **now in effect**. This new regulation replaces the Proposed Records Regulation, 2011.

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## ONTARIO REGULATION 164/15

made under the

### AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY ACT, 1991

Made: April 17, 2014

Approved: June 17, 2015

Filed: June 19, 2015

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Amending O. Reg. 21/12

(REGISTRATION)

1. The title of Ontario Regulation 21/12 is revoked and the following substituted:

#### GENERAL

2. The Regulation is amended by adding the following heading before section 1:

#### PART I REGISTRATION

3. Section 29 of the Regulation is revoked and the following substituted:

#### PART II RECORDS

##### Interpretation, "record"

29. In this Regulation, a record includes a record in electronic or paper format.

##### Duty to keep records up to date, etc.

30. (1) Every member shall, in relation to his or her practice, ensure that his or her records are up to date and made, used, maintained, retained and disclosed in accordance with this Regulation.

(2) However, if a member is practising the profession in collaboration with any other person, the member shall take reasonable steps to ensure that the records are up to date and made, used, maintained, retained and disclosed in accordance with this Regulation.

##### Records to be in English or French

31. Every record must be legible and must be written in English or French.

##### Patient health records

32. (1) In this section,

"screening process" means a process where a member applies certain measures that are designed to identify a patient who may have hearing, balance, communication, swallowing or other similar disorders, for the sole purpose of determining the patient's need for a speech-language pathology assessment, an audiological assessment or both.

(2) For every patient who is not part of a screening process, a member shall maintain a patient health record that contains the following information:

1. The patient's name, address, telephone number and date of birth.
2. The date and purpose of each professional contact with the patient and whether the contact was made in person, by telephone or electronically.
3. The name and address of any person who referred the patient to the member, if available.
4. The patient's health history, including any educational, developmental or other relevant issues concerning the patient.

5. The nature and, if known, the result of,
    - i. each assessment relating to the patient,
    - ii. each clinical finding relating to the patient,
    - iii. any recommendation made by the member to the patient,
    - iv. each treatment performed, and
    - v. any advice given to the patient, including any pre-treatment or post-treatment advice, and the identity of the person who gave the advice if that person was not the member.
  6. The identity of the person who provided any service to the patient, if that person was not the member.
  7. Every referral of the patient by the member to any other person.
  8. Every written report received by the member relating to an assessment, test, consultation or treatment performed by any other person concerning the patient.
  9. Every controlled act, within the meaning of subsection 27 (2) of the *Regulated Health Professions Act, 1991*, performed by the member on the patient.
  10. If a controlled act has been delegated to the member by a member of a regulated health profession, the name of the other member, the nature of the controlled act and whether the delegated act was performed on the patient.
  11. Every professional service that was commenced but not completed, including the reasons for non-completion.
  12. Every cancellation of an appointment by the patient and, if available, the reason for the cancellation.
  13. Every refusal of a treatment or procedure by the patient or by the patient's authorized representative.
  14. A record of every consent provided by the patient or by the patient's authorized representative.
  15. A copy of or, if a copy is not available, the details about any report concerning the patient that was required to be made under the Act, the *Regulated Health Professions Act, 1991* or any other law of Ontario or Canada.
  16. A copy of or, if a copy is not available, the details about any legal requirement that compelled the member to disclose any information concerning the patient or the patient's records, including the name of the person or official to whom the disclosure was made and the nature of the legal requirement.
  17. A report of any adverse outcome relating to the provision of health care services to the patient by the member, including any injury to the patient, the member or any person assisting the member.
- (3) For every patient who is part of a screening process, a member shall maintain a patient health record that contains the following information:
1. If the patient is not part of a group screening process, the patient's name and either,
    - i. the patient's address, telephone number and date of birth, or
    - ii. a notation of the patient's refusal to provide some or all of the information described in subparagraph i.
  2. If the patient is part of a group screening process, the patient's name and a reference to the group with whom the patient is identified.
  3. The date, nature and result of every screening process performed by the member on the patient.
  4. Any action taken by the member as a result of the screening process.
  5. A record of every consent provided by the patient or by the patient's authorized representative.
- (4) Despite subsections (2) and (3), a member is not required to maintain a patient health record in either of the following circumstances:
1. The member is part of a multi-disciplinary team whose purpose is to provide a treatment plan, a report or ongoing services to a patient and the patient's health record is maintained by a person who is part of the team and who is a member of a College under the *Regulated Health Professions Act, 1991*.
  2. The member provides information to a member of the College or a member of another College under the *Regulated Health Professions Act, 1991* in the nature of a consultation.
- (5) Every member shall ensure that,
- (a) every part of a patient health record has a reference identifying the patient; and
  - (b) every entry in a patient health record is dated and includes the identity of the person who made or dictated the entry.

- (6) Every member shall retain a patient's health record for at least 10 years following,
- (a) the date of the member's last professional contact with the patient, if the patient was 18 years or older on that date; or
  - (b) the date that the patient became or would have become 18 years old, if the patient was younger than 18 years on the date of the member's last professional contact with the patient.

**Patient financial records**

**33.** (1) Subject to subsection (2), every member shall maintain a financial record for each patient that contains the following information regardless of whether the member bills the patient directly for professional products or services provided to the patient or bills a third party:

1. The patient's name.
2. The member's name.
3. If the person who provided the professional product or service was not the member, the name of that person.
4. Each professional product or service provided to the patient and the date it was provided.
5. The fee charged or received that relates to each professional product or service provided to the patient.
6. The total fee charged or received for all of the professional products or services.
7. A record of the receipt given by or on behalf of the member, if available.

(2) A member is not required to maintain a financial record for a patient if the patient is part of a group screening process referred to in paragraph 2 of subsection 32 (3).

- (3) Every member shall retain a patient's financial record for at least 10 years following,
- (a) the date of the member's last professional contact with the patient, if the patient was 18 years or older on that date; or
  - (b) the date that the patient became or would have become 18 years old, if the patient was younger than 18 years on the date of the member's last professional contact with the patient.

**Equipment service records**

**34.** (1) Every member shall maintain an equipment service record that contains servicing information, including the date of every service, for any instrument or equipment that requires servicing and that is used by the member in the practice of the profession.

(2) Every member shall retain each equipment service record for 10 years from the date of the last servicing entry relating to the instrument or equipment.

**Closure of practice**

**35.** If a member intends to close his or her practice, he or she shall do both of the following:

1. Take reasonable steps to give appropriate notice of the intended closure to each patient for whom the member has primary responsibility.
2. Ensure that each patient's health and financial records are,
  - i. transferred to the member's successor or another member, if the patient so requests,
  - ii. retained in a secure manner, or
  - iii. disposed of in a secure manner, subject to the requirements to retain the records as set out in subsections 32 (6) and 33 (3).

**Commencement**

**4. This Regulation comes into force on the day it is filed.**

Made by:

COUNCIL OF THE COLLEGE OF AUDIOLOGISTS AND SPEECH-LANGUAGE PATHOLOGISTS OF ONTARIO:

NANCY BLAKE  
*President*

BRIAN O'RIORDAN  
*Registrar*

Date made: April 17, 2014.

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