The American College of Emergency Physicians (ACEP) believes that high-quality emergency department (ED) medical records promote improved patient care. Many types of medical records are currently used including handwritten, dictated/transcribed, scribed, templated, and electronic medical records. Emergency physicians should play a lead role in the selection of all medical record documentation aspects for the health care system.

An effective ED medical record assists with:

- documentation of clinically relevant aspects of the patient encounter including laboratory, radiologic, and other testing results
- efficiency in the patient encounter continuum
- legibility
- communication with other health care professionals
- coordination of follow-up care
- identification of who entered data into the record
- discharge instruction communication
- ease of data collection and data reporting
- sharing and obtaining patient health information with and from outside care centers

When implemented successfully, a high-quality ED medical record should accurately capture the process of evaluation, management, medical decision making, and disposition related to a patient encounter. It should facilitate quality assessment, quality improvement, meaningful use, and risk management activities and not interfere with physician productivity. The ED medical record should be promptly available after the patient encounter. For EMR systems, technological assistance should be available immediately 24/7 and plans should be in place to manage records in the event of an EMR system failure.

Hospitals should provide a plan for appropriate and timely review of technology and software updates.

Hospitals should provide emergency physicians the same access to dictation and transcription services as is provided to other hospital medical staff.
ED medical records should be managed in compliance with applicable state and federal regulations, including the Health Insurance Portability and Accountability Act (HIPAA) of 1996.