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AUDIT AND DISCOVERY PREPARATION

Medical matter data gathering package

Locate clinical records, EMR audit histories, billing, imaging and portal sources. Organize questions for counsel and authorized health IT.

Help a legal and technical team identify relevant clinical, administrative and audit records for a medical matter and prepare a lawful, precise specialist handoff.

Attorneys, paralegals, business/medical contacts, project coordinators and client IT

Medical treatment, documentation, privacy and related disputes. It organizes the request, and medical opinion, any question of record alteration, vendor extraction steps and authority to access patient data rest with the clinician, the examiner, the vendor and counsel respectively.

Before you gather

Use the clinical episode, the relevant issues, the patient identifiers and the date range selected by counsel. The EHR or EMR may be one of several systems, so ask about separate imaging, laboratory, pharmacy, practice management, claims, portal, interface, legacy and backup sources and record each one with its owner. Distinguish a chart rendering, the underlying clinical record, the version and amendment information, the audit events and the billing records; they answer different questions, and the examiner will ask for each by name. Ask what the actual export includes, and compare it with the full electronic record alongside any printed chart.

HIPAA audit control requirements and health IT certification guidance support asking about logging; request the vendor and version, the enabled events, the field definitions, the clock information and the earliest and latest available dates, because the examiner works from the audit trail as configured at the site, which can differ from the vendor description.

HIPAA treats a subpoena differently from a court order, so counsel and the covered entity settle the lawful disclosure route and its conditions first, and the records move after that. Additional protections can apply to substance use disorder records, psychotherapy notes and other state protected categories. The 2024 Part 2 final rule has a February 16 2026 compliance date according to HHS; use specialist review for Part 2 records and their use in proceedings against a patient, and confirm the specific authority for litigation use alongside the treatment, payment or operations permission. Patient chart retention periods come from state law, provider and licensure rules, payer and contract terms and preservation duties rather than from HIPAA, so determine the current obligations for the actual record type and patient circumstances; the six year HIPAA period applies to certain HIPAA documentation.

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Give each request to the suggested owner. Record each answer, including the items awaiting confirmation, in the editable CSV checklist. Keep the records themselves in a secure evidence location agreed with the recipient and use the checklist as the index that points to them; passwords stay with their owners, and real patient data and controlled technical information stay in the secure location.

Records to find

CSV files hold plain records, and your spreadsheet sets the layout. Import as UTF-8, keep IDs as text, wrap text and widen columns before use. Blank client fields are intentional.

MED-R01 Matter scope and legal authority

Ask
Legal and privacy officer

Gather
Issues, relevant care episodes/periods, providers, jurisdiction, proper patient/representative authority and applicable authorization, order or other approved process.

Where to ask
Counsel and privacy/HIM files

Why it may be needed
Defines the lawful, proportionate request and recipients.

If missing or uncertain
Obtain counsel approved route.

Reference: HE02 164.512(e); HE03; LG01

HE02 HE03 LG01

MED-R02 Patient and encounter crosswalk

Ask
HIM and registration owner

Gather
Approved patient identifiers, historical/merged IDs, encounter/account numbers, facilities, aliases as relevant and matching limitations.

Where to ask
Master patient index and registration

Why it may be needed
Keeps each request on the right patient and the full set of encounters.

If missing or uncertain
Use masked IDs in general coordination; maintain the actual crosswalk in the restricted workspace.

Reference: HE01; NI04

HE01 NI04

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MED-R03 System and vendor map

Ask
Clinical IT and department owners

Gather
EHR vendor/version/modules, hosting, facilities, departmental systems, portal/HIE, practice management, billing, dictation, devices/interfaces, legacy and backup services.

Where to ask
Clinical architecture, application inventory and providers

Why it may be needed
Identifies actual systems that may contain relevant records or logs.

If missing or uncertain
Every candidate needs an owner response.

Reference: HE01; HE06; NI04

HE01 HE06 NI04

MED-R04 Clinical record export description

Ask
HIM and application owner

Gather
Available chart components, signed/unsigned status, notes, orders/results, attachments, flowsheets, medication/administration and export format/options for the selected episode.

Where to ask
Clinical record system and departmental records

Why it may be needed
Allows the recipient to specify what is needed beyond a routine printout.

If missing or uncertain
Ask for a component list, data dictionary and stated exclusions, which describe the export precisely.

Reference: HE01; HE06

HE01 HE06

MED-R05 Documentation history and amendments

Ask
Clinical application owner

Gather
Existing addenda, corrections, amendment records, signature/cosignature history and available earlier versions relevant to the issue.

Where to ask
EHR audit/version functions and provider

Why it may be needed
Supports later professional interpretation of documentation chronology.

If missing or uncertain
Record the event definition and possible workflow explanation.

Reference: HE06; NI04

HE06 NI04

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MED-R06 Audit and access records

Ask
Clinical security and vendor

Gather
Event types, actor/patient/encounter IDs, actions, source workstation/session/IP where available, emergency/proxy access, configuration changes, retention and report parameters.

Where to ask
Clinical audit system, vendor and security

Why it may be needed
Helps the specialist understand what actions can actually be examined.

If missing or uncertain
Mark which fields are recorded, which periods are covered and whether logging was enabled. The examiner confirms log completeness from the site's own records, with certification as background.

Reference: HE01 164.312(b); HE06

HE01 HE06

MED-R07 Timestamp and identity explanations

Ask
Clinical IT and HIM

Gather
Meaning of entered/service/event/signed/imported/modified times; local/UTC/time zone/DST rules; clock sources; shared/delegated/service users and ID mappings.

Where to ask
Application data dictionary and administrators

Why it may be needed
Keeps sequences and attribution accurate.

If missing or uncertain
Ask vendor for a written explanation where needed.

Reference: NI04; HE06

NI04 HE06

MED-R08 Imaging and diagnostic sources

Ask
Radiology laboratory and pathology owners

Gather
Relevant source images/reports, diagnostic results, amendments, accession/order IDs and exchange/interface records from actual systems.

Where to ask
PACS/RIS, laboratory/pathology and interfaces if used

Why it may be needed
Underlying diagnostic objects can sit in imaging, laboratory and pathology systems beyond the chart report.

If missing or uncertain
Specialist defines needed native objects and format.

Reference: HE01; NI04

HE01 NI04

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MED-R09 Medication and treatment operations

Ask
Pharmacy and clinical operations

Gather
Relevant prescription/dispense/administration records, order changes, medication reconciliation and connected device records where actually kept.

Where to ask
Pharmacy, eMAR and relevant devices/providers

Why it may be needed
Identifies distinct clinical record sources.

If missing or uncertain
Separate scheduled, ordered, dispensed, charted and administered meanings for a qualified clinician/expert to interpret.

Reference: HE01; NI04

HE01 NI04

MED-R10 Portal referral and exchange

Ask
Portal/HIE/telehealth owners

Gather
Relevant messages, uploads, referrals, exchanged documents, telehealth material if recorded, proxy permissions and interface error/status records.

Where to ask
D32 and communications providers

Why it may be needed
Surfaces patient facing and interorganization information.

If missing or uncertain
Confirm recording and retention, and send patient proxy activity and imports to the specialist for interpretation.

Reference: HE01; HE03; HE06

HE01 HE03 HE06

MED-R11 Practice administration and claims

Ask
Practice manager and billing

Gather
Scheduling/check in, calls if recorded, referrals, eligibility/authorizations, coding, claims/remittances and corrections for relevant episodes.

Where to ask
Practice management, clearinghouse, payer and phone systems

Why it may be needed
Links clinical and administrative events while keeping each in its own category.

If missing or uncertain
Ask for unique IDs and what each export includes; care is corroborated from the clinical record alongside any claim or charge.

Reference: HE01; HE03; NI04

HE01 HE03 NI04

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MED-R12 Relevant communications and external copies

Ask
Custodians and legal

Gather
Permitted relevant internal/provider messages, secure texting, mail, incident communications, outside care records and legal/practice management files.

Where to ask
Clinical communication tools, D04 to D12, D28 and D35

Why it may be needed
Finds sources outside the clinical chart.

If missing or uncertain
Counsel separates privilege, patient protections and third party authority.

Reference: LG01; HE02; CL01

LG01 HE02 CL01

MED-R13 Preservation retention and historical data

Ask
Records, IT and legal

Gather
Actual retention schedules, holds, overwrite dates, former systems, migration reconciliation, backups/catalogs and access/restoration constraints.

Where to ask
HIM, records manager, migration and backup providers

Why it may be needed
Supports a time sensitive, realistic collection plan.

If missing or uncertain
Identify the actual state, provider, record and patient circumstances for specialist review, which set the retention period.

Reference: HE04; HE01 164.316; LG01 37(e)

HE04 HE01 LG01

MED-R14 Sensitive record segmentation

Ask
Privacy officer and counsel

Gather
Whether Part 2, psychotherapy or other specially protected records are involved; relevant consents/orders and release restrictions.

Where to ask
Privacy/HIM and counsel restricted file

Why it may be needed
Allows lawful limited disclosure and separate handling.

If missing or uncertain
Pending authority stays visible.

Reference: HE05; HE07; HE02

HE05 HE07 HE02

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MED-R15 Export quality and transfer

Ask
Collector and receiving specialist

Gather
Export method, account/role, dates/time zone, parameters, counts by component, metadata/attachments, errors, field legend, hashes where used and transfer receipt.

Where to ask
Collection reports and approved evidence repository

Why it may be needed
Makes completeness and limitations reviewable.

If missing or uncertain
Specialist chooses any additional export.

Reference: NI04; HE06

NI04 HE06

Questions for client IT and owners

A useful answer names the actual system, period, supporting record and its coverage. Where the answer sits with someone else, name the person or provider who can give it.

1. Which systems contain the selected patient episodes and which system owns each component?

Suggested responder
HIM, privacy officer and clinical IT as appropriate

Useful supporting record
System/module/owner and identifier map.

2. What does your routine chart export include, and what sits outside it?

Suggested responder
HIM, privacy officer and clinical IT as appropriate

Useful supporting record
Written component/format description and a permitted masked sample.

3. Can earlier note versions, addenda, signatures and corrections be separately retrieved?

Suggested responder
HIM, privacy officer and clinical IT as appropriate

Useful supporting record
Vendor/site specific capability and actual availability statement.

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4. Which events does the audit export include, and which event types are enabled?

Suggested responder
HIM, privacy officer and clinical IT as appropriate

Useful supporting record
Event dictionary, enabled settings, query scope and retention dates.

5. What do the different timestamps and user identifiers mean?

Suggested responder
HIM, privacy officer and clinical IT as appropriate

Useful supporting record
Data dictionary, time zone/DST rules and identity/proxy mappings.

6. What records remain in old systems, departmental platforms, exchanges or backups?

Suggested responder
HIM, privacy officer and clinical IT as appropriate

Useful supporting record
Historical system and retention inventory with owners.

7. Which requested records carry their own authority or segregation rules?

Suggested responder
HIM, privacy officer and clinical IT as appropriate

Useful supporting record
Privacy/counsel approved release route and restrictions.

8. What errors, patient matching questions, interval breaks or excluded components bear on the response?

Suggested responder
HIM, privacy officer and clinical IT as appropriate

Useful supporting record
Exception report linked to the record request IDs.

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Sample questions for the legal team

Sample questions are drafting prompts for counsel, who shapes them into requests that fit the matter. Define the event, source, period and parties. Check relevance, proportionality, privilege, privacy, possession/custody/control, current local rules and case orders. Federal Rule 33 ordinarily allows up to 25 interrogatories, including discrete subparts, unless a stipulation or court order sets another number. New York uniform and Commercial Division rules and CPLR 3130 set their own conditions on interrogatories; especially check the interrogatory/deposition choice in negligence personal injury, property or wrongful death actions. Split or narrow prompts as the rules permit, and use a document request, interview or deposition topic where that is the appropriate device. Counsel decides what is served; these packages prepare the facts behind it.

Supporting procedural sources: LG01, NY05, NY06, NY07 and NY08. These questions are separate from the internal IT interview.

LG01 NY05 NY06 NY07 NY08

1. Identify the systems and responsible custodians maintaining records of [defined patient episode] during [period], subject to the authorized disclosure scope.
2. Identify the patient, encounter, accession and account identifiers used to link the responsive components, under the agreed privacy protections.
3. Describe the components included in and excluded from [identified chart export] and the export parameters used.
4. Identify available records of amendments, addenda and signature events for [defined documentation], without assuming those records establish improper alteration.
5. Identify the recorded audit event types, retained periods and person able to explain the fields for [specified system and period].
6. Describe the meanings and time zone conventions of the date/time fields in [identified export].
7. Identify relevant predecessor/departmental systems or migration limitations affecting [defined record category].
8. Identify the factual preservation/collection steps and known omissions for [defined source], excluding privileged legal advice and respecting protected record restrictions.

Worked gathering example

Example only: The chart printout shows a note signed two days after the visit. The coordinator asks HIM for definitions of service, entry and signature times and any available amendment/audit records. The specialist reviews workflow and evidence before interpreting the sequence, and treats the signing time as one data point among the workflow records.

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Facts to confirm and specialist decisions

These are explicit handoff questions, and each one closes with the specialist's written answer, drawing on the records marked Received. Add client specific questions and a responsible person.

MED-Q01 What legal authority permits each disclosure and recipient, including specially protected material?

Ask
Counsel and privacy officer

Gather
Actual process/consent/order, case purpose and record categories

Resolution needed
Written release instructions from counsel and the privacy officer that authorize each disclosure.

MED-Q02 Which record components, event types and versions exist in this deployment?

Ask
HIM, vendor and clinical forensic specialist

Gather
Vendor/version, configuration, dictionary, masked sample and actual retention

Resolution needed
A scoped export plan with stated coverage for this deployment.

MED-Q03 Which retention and preservation requirements apply to these records?

Ask
Records specialist and legal

Gather
Jurisdiction, provider/license, patient/record facts, schedules and case holds

Resolution needed
Record specific schedule and preservation instructions for these records.

Preparing the handoff

The handoff is ready when counsel and privacy authority and the sensitive record restrictions are recorded before any disclosure; when clinical, audit, diagnostic, portal and administrative records are requested as separate components where relevant; when timestamps, identities, system versions, formats and interval breaks have explanations or named questions; and when restricted evidence is delivered only through the agreed route while the ordinary index uses masked identifiers.

Sources for this package

Official laws/rules establish duties within their scope. Guidance explains programs; NIST supplies methods; vendor documentation describes possible product behavior. The package works alongside the actual contracts, facts, configuration and case orders.

- New York Commercial Division rules (NY05)

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- New York Uniform Civil Rules Part 202 (NY06)
- New York CPLR 3130 (NY07)
- NIST SP 800-86 (NI04)
- Federal Rules of Civil Procedure December 2025 (LG01)
- Federal Rules of Evidence (LG02)
- HIPAA Security Rule (HE01)
- HIPAA judicial proceedings provision (HE02)
- HHS court orders and subpoenas (HE03)
- HHS medical record retention FAQ (HE04)
- HHS Part 2 confidentiality (HE05)
- ONC auditable events certification guidance (HE06)
- Substance use disorder record regulation (HE07)
- Clio matter export scope (CL01)

Bring the completed pack to a free scoping call and a senior examiner sets the scope from it. Call (800) 868-8189.

Source review date: October 18 2026.

Reviewed by Joseph Caruso, Founder, CEO and CTO, CISSP. Last reviewed November 3, 2026.

Start With a Free Consultation

The initial consultation is free, and requests are handled in confidence. On the first call a senior member of our team listens to the question you need answered, identifies the records and systems involved, and recommends the next step.

Call (800) 868-8189, answered 24/7, request a consultation at evestigate.com/contact, or email info@evestigate.com.

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