INFORMATION RETENTION AND ACCESS PRACTICE TEST (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

1. **Which filing system would provide the most convenient method for the record retrieval of 200 patients consecutively admitted to the hospital?**

   A. Alphabetic

   B. Straight numeric

   C. Color-coded patient ID

   D. Geographic zoning

2. **Which term describes a centralized data store designed to retrieve clinical information from multiple sources?**

   A. Electronic Health Record

   B. Clinical Data Repository

   C. Health Information Exchange

   D. Master Patient Index

3. **Which of the following is NOT a factor to consider when developing a record retention program?**

   A. Reimbursement guidelines

   B. Legal requirements

   C. Privacy considerations

   D. Data access needs

4. **A department plans to file 1,000 records, with each record 1 inch thick, using six-shelf open filing units where each shelf is 33 inches long. How many filing units should be purchased?**

   A. 6

   B. 5

   C. 7

   D. 8

5. **What unit of measurement is used to describe filing storage in this example?**

   A. Linear filing inches

   B. Cubic feet

   C. Square meters

   D. Pages

6. Which data type is typically excluded from long-term retention planning under the HIM duties described?

A. Audit logs

B. Administrative metadata

C. Clinical data

D. Financial data

7. What is the linear inches provided by a single six-shelf unit if each shelf is 36 inches long?

A. 216 inches

B. 206 inches

C. 240 inches

D. 180 inches

8. Which of the following is NOT considered a challenge in the adoption of an electronic health record system?

A. Interoperability across systems

B. Security concerns

C. Cost of implementation

D. Contribution to the quality of patient care

9. What type of numbering/filing system is used when two patient records with the same base number are filed under a new, later number (e.g., 54-47-53 and 54-88-42 both under 54-88-42)?

A. Serial-unit

B. Purely unit

C. File-interactive

D. Alphabetic-by-name

10. Which of the following best describes the function of an information system that tracks surgical procedures by physician and date?

A. To store patient demographics

B. To summarize discharge instructions

C. To track surgical procedures by physician and date

D. To index medication orders

Answers

1. B
2. B
3. A
4. A
5. A
6. D
7. A
8. D
9. A
10. C

Explanations

1. Which filing system would provide the most convenient method for the record retrieval of 200 patients consecutively admitted to the hospital?

A. Alphabetic

B. Straight numeric

C. Color-coded patient ID

D. Geographic zoning

When you need to retrieve records quickly for a large stream of admissions, a straight numeric filing system makes the most sense. Each patient gets a unique, consecutive number, so locating a chart is a simple matter of following a predictable numeric index or path. There's no ambiguity even if names are common or spellings vary, and this system scales cleanly as more patients are admitted, keeping retrieval fast and consistent for hundreds of records. Alphabetic filing, by contrast, relies on patient names. Names can be shared, changed, or misspelled, which can slow retrieval and increase the chance of selecting the wrong chart in a busy setting. Color-coded IDs introduce potential confusion if colors are misread or if color codes aren't perfectly maintained, and they add an extra layer of lookup to map colors to specific patients. Geographic zoning groups records by location, which disperses records and makes it harder to pull a chart quickly when you're dealing with many admissions in sequence. So a straight numeric system offers the most efficient, unambiguous, and scalable way to access records for a large number of consecutively admitted patients.

2. Which term describes a centralized data store designed to retrieve clinical information from multiple sources?

A. Electronic Health Record

B. Clinical Data Repository

C. Health Information Exchange

D. Master Patient Index

A centralized data store that brings together clinical information from multiple source systems is the Clinical Data Repository. This kind of repository collects data from various places—electronic health records, lab systems, radiology, medications, and more—then stores it in a unified structure so clinicians can pull up a complete, longitudinal view of a patient from one place. The key idea is integration and accessible retrieval across different care settings, which supports better care coordination, analytics, and decision-making. In contrast, an Electronic Health Record is typically the digital chart used within a single organization, focusing on the patient's record in that setting rather than aggregating data across multiple sources. A Health Information Exchange refers to the network and processes that move data between organizations to enable sharing, rather than being the central store itself. A Master Patient Index handles consistent patient identification across systems, ensuring the right patient's data are matched, but it does not serve as the centralized clinical data store.

3. Which of the following is NOT a factor to consider when developing a record retention program?

A. Reimbursement guidelines

B. Legal requirements

C. Privacy considerations

D. Data access needs

When you build a record retention program, the main things you prioritize are compliance with laws and regulations, protecting privacy, and ensuring records are available for legitimate business needs and audits. Legal requirements tell you how long to keep records and when to dispose of them. Privacy considerations govern how sensitive information should be stored, who may access it, and how long it can be retained. Data access needs determine the retention horizon based on who needs the records and for what purposes, ensuring authorized retrieval when required. Reimbursement guidelines, while important for how billing and payments are handled, do not dictate how long records must be kept. They influence what data is captured for billing, but they aren't the primary driver of the retention timeline. So the factor that doesn't fit as a core consideration for a retention program is the reimbursement guidelines.

4. A department plans to file 1,000 records, with each record 1 inch thick, using six-shelf open filing units where each shelf is 33 inches long. How many filing units should be purchased?

A. 6

B. 5

C. 7

D. 8

When planning filing space, you compare the total thickness of the records to the capacity of each storage unit. A single shelf is 33 inches long, and each record is 1 inch thick, so you can fit 33 records on one shelf. A unit has six shelves, so it can hold 6 × 33 = 198 records. To store 1,000 records, you need 1,000 ÷ 198 ≈ 5.05 units, which means you must round up to 6 units. Five units would hold 5 × 198 = 990 records, which is not enough. Therefore, six filing units should be purchased.

5. What unit of measurement is used to describe filing storage in this example?

A. Linear filing inches

B. Cubic feet

C. Square meters

D. Pages

In filing storage, the space is described using a linear measurement that captures how long the storage area runs along a row of folders or rails. This unit, linear inches, reflects the length of filing space used, making it easy to estimate how many drawers or shelves are needed. It focuses on length along the storage line rather than volume, area, or quantity. Volume would describe how much space something occupies in three dimensions (cubic feet), area would describe the footprint on a surface (square meters), and pages describe the number of sheets, not the length of storage space. So the correct concept is that filing storage is measured in linear inches.

6. Which data type is typically excluded from long-term retention planning under the HIM duties described?

A. Audit logs

B. Administrative metadata

C. Clinical data

D. Financial data

The main idea here is about what kinds of information health information management (HIM) plans to preserve over the long term. HIM focuses on preserving data that makes up the patient's health record and supports ongoing care, accountability, and regulatory compliance. That means preserving clinical data—the actual patient health information clinicians rely on for diagnosis and treatment—and the surrounding record-keeping details like administrative metadata that track who created or modified records and when, as well as audit logs that show who accessed or changed information. These elements are essential to maintain the integrity of the health record and to meet legal and regulatory requirements. Financial data, while important for the organization's budgeting and billing, follows separate retention policies managed by the finance side of the organization. It's not typically part of the health information management long-term retention planning because it isn't a health record component and doesn't directly pertain to patient care or regulatory health-record requirements.

7. What is the linear inches provided by a single six-shelf unit if each shelf is 36 inches long?

A. 216 inches

B. 206 inches

C. 240 inches

D. 180 inches

Linear inches are the total length when you add up all the shelves' lengths. If there are six shelves and each is 36 inches long, you multiply 36 by 6: 36 × 6 = 216. So the unit provides 216 linear inches. The other numbers would come from different shelf lengths (for example, longer or shorter shelves) or counting differently, but with six shelves at 36 inches each, the total is 216.

8. Which of the following is NOT considered a challenge in the adoption of an electronic health record system?

A. Interoperability across systems

B. Security concerns

C. Cost of implementation

D. Contribution to the quality of patient care

The main idea here is distinguishing between real obstacles to adopting electronic health records and the benefits those systems are meant to deliver. Interoperability across systems is a challenge because different vendors and health IT environments often use varied data standards and formats, making seamless sharing of information difficult. Security concerns are another major hurdle, since protecting patient privacy requires strong access controls, auditing, encryption, and ongoing compliance with regulations. The cost of implementation includes not just the software, but hardware, data migration, training, workflow changes, and potential downtime during the switch. In contrast, contributing to the quality of patient care is a positive outcome of using electronic health records rather than a challenge. When implemented well, EHRs can improve legibility of notes, support clinical decision-making with alerts and evidence-based guidelines, reduce medication errors, and enhance care coordination across providers. So the statement about improving quality of care is not a challenge, but a goal and benefit of adopting EHR systems.

9. What type of numbering/filing system is used when two patient records with the same base number are filed under a new, later number (e.g., 54-47-53 and 54-88-42 both under 54-88-42)?

A. Serial-unit

B. Purely unit

C. File-interactive

D. Alphabetic-by-name

In this scenario, the idea being tested is how to group more than one record that shares a base number using a serial-unit filing approach. In serial-unit filing, when there are multiple records tied to the same base identifier, they're collected under a newer, later serial number that acts as the overarching file for those related records. So two records with the same base (like 54-47-53 and 54-88-42) can be filed under a single later number (54-88-42), linking them together under one serial while still recognizing the individual units of information within that series. This setup helps keep all records for the same patient or case accessible under one umbrella number and preserves the sequence of records over time. If you were using purely unit numbering, each record would have its own distinct number with no common serial to group them. Alphabetic-by-name would file by the patient's name rather than by numbers, and file-interactive isn't the standard method described for this kind of base-number grouping.

10. Which of the following best describes the function of an information system that tracks surgical procedures by physician and date?

A. To store patient demographics

B. To summarize discharge instructions

C. To track surgical procedures by physician and date

D. To index medication orders

This is about logging procedural activity so you can search and report on who performed a surgical procedure and when it happened. An information system that tracks procedures by physician and date stores each event with fields like the physician identifier, the date, the patient, and the procedure type. This makes it easy to pull up records for credentialing, workload analysis, scheduling, quality improvement, and auditing—because the data are organized around the specific procedure event and who did it, on what date. Other data like patient demographics, discharge instructions, or medication orders serve different purposes in their respective areas (identification, care communication, pharmacy management). They aren't the primary function described here, which is specifically to capture and retrieve surgical events by who performed them and when.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://inforetentionandaccess.examzify.com

We wish you the very best on your exam journey. You've got this!