HAS 104F AIR FORCE MEDICAL RECORDS MANAGEMENT PRACTICE EXAM (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.

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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!

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Questions

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1. **Which standard ensures that a record's content has not been altered after creation?**

   A. Authentication

   B. Audit trail

   C. Version control

   D. Record locking

2. **How should late entries be documented in a military record?**

   A. Do not mark, just add the note retroactively without stating it's late.

   B. Mark as a late entry, include actual date/time of care, author credentials, and justification; follow policy for late entries.

   C. Delete the late entry and re-enter.

   D. File a separate late-entry form instead of editing the chart.

3. **Which elements are commonly used for indexing scanned records to support retrieval?**

   A. MRN, name, DOB, encounter date

   B. Address, phone, email, employer

   C. Service code, room number, bed type, physician name

   D. Insurance ID, next of kin, nationality, marital status

4. **What does the Service Treatment Record refer to?**

   A. The outpatient medical record for patients serving in the military.

   B. The inpatient hospital record for veterans.

   C. The dental record of service members.

   D. The medical board file.

5. **What governs the retention and destruction timing of records?**

   A. Retention policies

   B. Encryption standards

   C. Access control lists

   D. Data formats

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6. Which item is NOT listed on the Medical Document block?

A. DOB

B. Facility providing treatment

C. Patients Name

D. Name of the MTF maintaining the records

7. When are inventories completed?

A. by 31st of March each year

B. by 31st of December each year

C. quarterly

D. monthly

8. How are electronic signatures used in Air Force health records and what policies govern them?

A. Used to authorize routine administrative tasks.

B. Used to authenticate authors and transactions and must be linked to user authentication per DoD/AF policies.

C. They replace the need for physician signatures.

D. They are optional for all records.

9. Why is indexing of scanned documents critical for retrieval?

A. Increases file size only

B. Provides metadata (MRN, name, DOB, encounter date) that enables accurate, efficient search and retrieval

C. Is optional and not important

D. Eliminates need for encryption

10. What is a terminal digit roster?

A. A listing of all retirees

B. A listing of base assets

C. A listing of all active duty personnel currently assigned to the base

D. A listing of all patients

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Answers

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

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Explanations

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1. Which standard ensures that a record's content has not been altered after creation?

A. Authentication

B. Audit trail

C. Version control

D. Record locking

Auditing trails provide a detailed, time-stamped record of every action on a record—who accessed it and what changes were made. This creates an evidentiary path that allows you to verify whether the content remained unchanged after creation. If any modification occurs later, the audit trail shows the exact user, date, and nature of the change, enabling detection and accountability. Authentication only confirms identities, not changes to content. Version control tracks revisions but doesn't by itself guarantee integrity; it's about managing edits and history. Record locking prevents edits but doesn't document whether changes occurred. The audit trail is the mechanism that lets you confirm and demonstrate whether content stayed intact after creation.

2. How should late entries be documented in a military record?

A. Do not mark, just add the note retroactively without stating it's late.

B. Mark as a late entry, include actual date/time of care, author credentials, and justification; follow policy for late entries.

C. Delete the late entry and re-enter.

D. File a separate late-entry form instead of editing the chart.

Proper documentation of late entries in a military medical record requires transparency and an auditable trail. When care occurs but is entered after the fact, the entry must be marked as a late entry, include the actual date and time of care, identify the author's credentials, and provide a justification, all in accordance with policy for late entries. This approach preserves the accuracy of the patient's timeline and shows who documented the care and why the entry was made late, making the record trustworthy during audits or legal reviews. It prevents the record from being misinterpreted as having occurred on a different date and maintains the integrity of the chart's chronology. Adding the entry without indicating it's late hides the delay and raises integrity concerns. Deleting the entry or re-entering it would alter the record and break the audit trail. Filing a separate late-entry form would fragment the documentation rather than keeping it integrated with the chart, which is not the standard method.

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3. Which elements are commonly used for indexing scanned records to support retrieval?

A. MRN, name, DOB, encounter date

B. Address, phone, email, employer

C. Service code, room number, bed type, physician name

D. Insurance ID, next of kin, nationality, marital status

Indexing scanned records effectively hinges on stable, unique identifiers that tie a record to the correct patient and the specific visit. The combination of a medical record number, the patient's name, date of birth, and the encounter date provides a precise, unambiguous key to retrieve the exact record. The MRN uniquely identifies the patient within the system; the name and date of birth help confirm identity and assist if the MRN isn't readily available; and the encounter date points to the particular visit, which is essential when a patient has multiple encounters. Elements like address, phone, or employer aren't reliable for indexing because they can change and aren't unique to a single patient. Service code, room number, bed type, and physician name are tied to the care episode but aren't stable identifiers across the system and can apply to different patients or visits. Insurance ID and demographic details such as nationality or marital status are either not unique or sensitive and not efficient for retrieval. So the best indexing set for scanned records is MRN, name, DOB, and encounter date.

4. What does the Service Treatment Record refer to?

A. The outpatient medical record for patients serving in the military.

B. The inpatient hospital record for veterans.

C. The dental record of service members.

D. The medical board file.

The Service Treatment Record is the outpatient medical record for service members. It contains routine medical encounters, treatments, immunizations, and health assessments while a person is on active duty, serving to track medical history and readiness for deployment. It's distinct from inpatient hospital records, veterans' records, the dental record, and the medical board file, which are separate records or files.

5. What governs the retention and destruction timing of records?

A. Retention policies

B. Encryption standards

C. Access control lists

D. Data formats

Retention policies govern how long records are kept and when they are destroyed. They provide the official rules that define the lifecycle of each record series, tying retention to legal, regulatory, and organizational needs. A retention policy is usually implemented through a retention schedule that lists each record type with its required retention period and the approved disposition action (destroy, archive, or transfer). This ensures records remain available for the necessary time for operations, audits, and compliance, and are then disposed of securely when the retention period ends. Encryption standards, access control lists, and data formats all play important roles in protection, access, and storage, but they do not set or govern the timing of retention and destruction.

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6. Which item is NOT listed on the Medical Document block?

A. DOB

B. Facility providing treatment

C. Patients Name

D. Name of the MTF maintaining the records

The Medical Document block is used to identify the document's source and ownership within the record. It lists the patient's name, the facility where treatment occurred, and the name of the MTF maintaining the records to ensure proper linking and custody of the document. The date of birth is part of the patient's demographic data in the record, not a detail tagged in the Medical Document block, so it isn't listed there. That's why the item not listed on the Medical Document block is the date of birth. The other items fit because they establish who the patient is and where and by whom the record is maintained.

7. When are inventories completed?

A. by 31st of March each year

B. by 31st of December each year

C. quarterly

D. monthly

Inventories are completed by March 31 each year. This timing sits at the end of the first quarter, which supports timely reconciliation of physical assets with the records and aligns with the Air Force annual reporting and audit cycle. Doing inventories monthly or quarterly adds unnecessary workload, and completing at the end of December would miss the standard first-quarter deadline used for official accountability and year-start processes.

8. How are electronic signatures used in Air Force health records and what policies govern them?

A. Used to authorize routine administrative tasks.

B. Used to authenticate authors and transactions and must be linked to user authentication per DoD/AF policies.

C. They replace the need for physician signatures.

D. They are optional for all records.

Electronic signatures in Air Force health records are used to verify who created or changed a record and to bind that action to a specific, authenticated user. The signature accompanies the action—such as data entry, authorization, or releasing information—and is tied to the user's authenticated identity through DoD/AF security controls (like PKI or smart-card logon). This creates an auditable trail with a timestamp, the signer's identity, and the exact action taken, which preserves integrity, accountability, and non-repudiation. They're part of the official workflow and support proper documentation without replacing clinicians' required attestations where those are mandated. They are not optional; DoD/AF policies require electronic signatures to be linked to user authentication and to be auditable across the health record.

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9. Why is indexing of scanned documents critical for retrieval?

A. Increases file size only

B. Provides metadata (MRN, name, DOB, encounter date) that enables accurate, efficient search and retrieval

C. Is optional and not important

D. Eliminates need for encryption

Indexing scanned documents is crucial because it attaches a structured set of searchable identifiers to the image, making retrieval fast and precise. By capturing metadata such as the medical record number, patient name, date of birth, and encounter date, the system can locate the exact document within a patient's chart and link it to the correct encounter. This means staff can search using multiple, reliable fields rather than guessing or opening many files, which saves time and reduces the chance of pulling the wrong record. Without indexing, a scan is just an image that may be difficult to locate, even if OCR later extracts text. Retrieval would rely on manual searching or rudimentary text extraction, which is slow and prone to errors. Indexing supports efficient search, proper chart linkage, and auditability, all of which are essential for patient safety and compliance. It's not primarily about increasing file size, and it isn't optional or about encryption—encryption remains a separate, necessary protection for privacy.

10. What is a terminal digit roster?

A. A listing of all retirees

B. A listing of base assets

C. A listing of all active duty personnel currently assigned to the base

D. A listing of all patients

A terminal digit roster is a current listing of all active duty personnel assigned to the base. It's used by medical records and base command to maintain accountability and ensure medical readiness—knowing who is on base and has up-to-date medical status, records, and readiness requirements. It isn't about retirees, base assets, or patients, which is why the other options don't fit.

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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://has104f.examzify.com

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

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