

ACCESS TO MEDICAL RECORDS POLICY

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**ACCESS TO HEALTH RECORDS
PROCEDURE
for
GP PRACTICES**

(under the Data Protection Act (DPA) 1998 and the Access to Health Records Act 1990)

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1 INTRODUCTION

1.1 BACKGROUND

The Access to Health Records Act 1990 gave individuals the right of access, subject to certain exceptions, to health information recorded about themselves, and, in certain circumstances, about others, within manual records. The Data Protection Act (DPA) 1998 came into force in March 2000 and repealed most of the 1990 Access to Health Records Act. All applications for access to records, whether paper based or electronic, of living persons are now made under the DPA 1998. For deceased persons, applications are made under sections of the 1990 Access to Health Records Act which have been retained. These sections provide the right of access to the health records of deceased individuals for their personal representative and others having a claim under the estate of the deceased.

1.2 THE RIGHT OF ACCESS

Under section seven of the DPA, patients have the right to apply for access to their health records. Provided that the fee has been paid and a written application is made by one of the individuals referred to below, the Practice is obliged to comply with a request for access subject to certain exceptions (see the procedure in section 2). However, the Practice also has a duty to maintain the confidentiality of patient information and to satisfy itself that the applicant is entitled to have access before releasing information.

1.3 APPLICATIONS

An application for access to health records may be made in any of the circumstances explained below.

1.3.1 The Patient

Rectory Meadow Surgery has a policy of openness with regard to health records and health professionals are encouraged to allow patients to access their health records on an informal basis. This should be recorded in the health record itself. The Department of Health's Code of Practice on Openness in the NHS as referred to in HSG (96) 18 Protection and Use of Patient Information will still apply to informal requests.

Such requests are usually made for a reason. The patient may have concerns about treatment that they have received, how they have been dealt with or may be worried that something they have said has been mis-interpreted. Staff are encouraged to try to understand and allay any underlying concerns that may have contributed to the request being made and offer an opportunity of early resolution.

1.3.2 Parental Responsibility

"Children of 16 years or Over"

If a mentally competent child is 16 years or over then they are entitled to request or refuse access to their records. If any other individual requests access to these the Practice should first check with the patient that he or she is happy for them to be released.

"Children Under 16 Years"

Individuals with parental responsibility for an under 16 year old will have a right to request access to those medical records. A person with parental responsibility is either:

- i the birth mother; or
- ii the birth father (if married to the mother at the time of child's birth or subsequently) or;
- iii an individual given parental responsibility by a court.

(This is not an exhaustive list but contains the most common circumstances).

If the appropriate health professional considers that a child patient is Gillick competent (i.e. has sufficient maturity and understanding to make decisions about disclosure of their records) then the child should be asked for his or her consent before disclosure is given to someone with parental responsibility.

If the child is not Gillick competent and there is more than one person with parental responsibility, each may independently exercise their right of access. Technically, if a child lives with, for example, its mother and the father applies for access to the child's records, there is no "obligation" to inform the mother. In practical terms, however, this may not be possible and both parents should be made aware of access requests unless there is a good reason not to do so.

In all circumstances good practice dictates that a Gillick competent child should be encouraged to involve parents or other legal guardians in any treatment/disclosure decisions. Again medical records should not be disclosed unless the process set out in Section 2 is adhered to.

1.3.3 Patient Representatives

A patient can give written authorisation for a person (for example a solicitor or relative) to make an application on their behalf. The Practice may withhold access if it is of the view that the patient authorising the access has not understood the meaning of the authorisation. Records should not be disclosed unless the process set out in Section 2 is adhered to.

1.3.4 Court Representatives

A person appointed by the court to manage the affairs of a patient who is incapable of managing his or her own affairs may make an application. Access may be denied where the GP is of the opinion that the patient underwent relevant examinations or investigations in the expectation that the information would not be disclosed to the applicant.

1.3.5 Access to a Deceased Patient's Medical Records

Where the patient has died, the patient's personal representative or any person who may have a claim arising out of the patient's death may make an application. Access shall not be given (even to the personal representative) to any part of the record which, in the GP's opinion, would disclose information which is not relevant to any claim which may arise out of the patient's death. The effect of this is that those requesting a deceased person's records should be asked to confirm the nature of the claim which they say they may have arising out of the person's death. If the person requesting the records was not the deceased's spouse or parent (where the deceased was unmarried) and if they were not a dependant of the deceased, it is unlikely that they will have a claim arising out of the death.

1.3.6 Children and Family Court Advisory and Support Service (CAFCASS)

Where CAFCASS has been appointed to write a report to advise a judge in relation to child welfare issues, Rectory Meadow Surgery would attempt to comply by providing factual information as requested.

Before records are disclosed, the patient or parents consent (as set out above) should be obtained. If this is not possible, and in the absence of a court order, the Practice will need to balance its duty of confidentiality against the need for disclosure without consent where this is necessary:

- i to protect the vital interests of the patient or others, or
- ii to prevent or detect any unlawful act where disclosure is in the substantial public interest (e.g. serious crime); and
- iii because seeking consent would prejudice those purposes.

The relevant health professional should provide factual information and their response should be forward to a member of the Child Protection Team who will approve the report.

1.3.7 Chapter 8 Review

All Chapter 8 Review requests for information should be immediately directed to the Primary Care Trust (PCT) Child Protection Manager who will co-ordinate the Chapter 8 Review in accordance with national and local Area Child Protection Committee Guidance.

1.4 Amendments to or Deletions from Records

If a patient feels information recorded on their health record is incorrect then they should firstly make an informal approach to the health professional concerned to discuss the situation in an attempt to have the records amended. If this avenue is unsuccessful then they may pursue a complaint under the NHS Complaints procedure in an attempt to have the information corrected or erased. The patient has a 'right' under the DPA to request that personal information contained within the medical records is rectified, blocked, erased or destroyed if this has been inaccurately recorded.

He or she may apply to the Information Commissioner but they could also apply for rectification through the courts. The GP Practice as the data controller should take reasonable steps to ensure that the notes are accurate and if the patient believes these to be inaccurate, that this is noted in the records. Each situation will be decided upon the facts and the Practice will not be taken to have contravened the DPA if those reasonable steps were taken. In the normal course of events, however, it is most likely that these issues will be resolved amicably.

2 PROCESS

2.1 Co-ordination

GP Practices receive applications for access to records via a number of different sources, for example:

- Medical Insurance Companies
- Patient's solicitors
- Patients
- Patient Carers
- Parents of under 16 year old patients

2.2 Notification of requests

Keep a record of a request for a patient's records in that patient's records.

2.3 Inspecting and withholding of records

2.3.1 Requirement to consult appropriate health professional

It is the GP's responsibility to consider an access request and to disclose the records if the correct procedure has been followed. Before the Practice discloses medical records the patient's GP must have been consulted and he/she happy for the records to be disclosed. This consent to disclose by the GP should be recorded in the Patient's records.

2.3.2 Grounds for refusing disclosure to health records

The GP should refuse to disclose all or part of the health record if the he / she is of the view that:

- disclosure would be likely to cause serious harm to the physical or mental health of the patient or any other person;
- the records refer to another individual who can be identified from that information (apart from a health professional). This is unless that other individual's consent is obtained or the records can be anonymised or it is reasonable in all the circumstances to comply with the request without that individual's consent, taking into account any duty of confidentiality owed to the third party; or if
- the request is being made for a child's records by someone with parental responsibility or for an incapacitated person's record by someone with power to manage their affairs, and the:

- i information was given by the patient in the expectation that it would not be disclosed to the person making the request; or
- ii the patient has expressly indicated it should not be disclosed to that person.

2.3.3 Informing of the decision not to disclose

If a decision is taken that the record should not be disclosed, a letter must be sent by recorded delivery to the patient or their representative stating that disclosure would be likely to cause serious harm to the physical or mental health of the patient, or to any other person. The general position is that the Practice should inform the patient if records are to be withheld on the above basis. If however, the appropriate health professional thinks that telling the patient:

- i will effectively amount to divulging that information; or this
- ii is likely to cause serious physical or mental harm to the patient or another individual

then the GP could decide not to inform the patient, in which case an explanatory note should be made in the file.

That decision can only be taken by the GP and an explanatory note should be made in the file. Although there is no right of appeal to such a decision, it is the Practice's policy to give a patient the opportunity to have their case investigated by invoking the complaints procedure. The patient must be informed in writing that every assistance will be offered to them if they wish to do this. In addition, the patient may complain to the Information Commissioner for an independent ruling on whether non-disclosure is proper.

2.3.4 Disclosure of a Deceased Patient's Medical Records

The same procedure used for disclosing a living patient's records should be followed when there is a request for access to a deceased patient's records. Access should not be given if:

- the appropriate health professional is of the view that this information is likely to cause serious harm to the physical or mental health of any individual; or
- the records contain information relating to or provided by an individual (other than the patient or a health professional) who could be identified from that information (unless that individual has consented or can be anonymised); or
- the record contains a note made at the request of the patient before his/her death that he/she did not wish access to be given on application. (If while still alive, the patient asks for information about his/her right to restrict access after death, this should be provided together with an opportunity to express this wish in the notes.);
- the holder is of the opinion that the deceased person gave information or underwent investigations with the expectation that the information would not be disclosed to the applicant.
- the Practice considers that any part of the record is not relevant to any claim arising from the death of the patient.

2.4 Disclosure of the record

Disclosure may only be made to a third party eg. a solicitor, upon receipt of a signed consent from the patient, indicating that they acknowledge that the whole of their medical record will be sent to the third party. This consent should be scanned into the medical record together with the request for disclosure. Upon confirmation by the Patient's GP and receipt of the appropriate fee (see below), the health record may then be sent to the patient or their representative in a sealed envelope by recorded delivery, for a period of seven working days. The record should be sent to a named individual, marked confidential, for addressee only and the sender's name should be written on the reverse of the envelope. ***Confidential information should not be sent by fax and never by email unless via an encrypted service such as NHS Mail account to another NHS Mail account.***

A note should be made in the medical record of what has been disclosed to whom and on what grounds.

2.5 Charges and Timescales

Timescales

For patients currently undergoing care or whose records were updated within the last 40 days, it is assumed such records are more readily available and a response within 21 days from receipt of the written request is required. In respect of patients whose care is completed and whose records have not been updated in the last 40 days, 40 days is allowed from receipt of the written request.

Costs

A letter should be sent to the Third Party advising of the costs of allowing access to the patient's health records and requesting the appropriate fee prior to disclosure (see shared folders).

To provide copies of electronic patient health records (to accompany the patient's manual file) a maximum charge of £10 can be requested to cover photocopying. Rectory Meadow will also charge £10 administration plus the cost of recorded delivery at £10, making a total of £30.00.

If providing copies of health records, for manual records or a mixture of electronic and manual there can be a maximum charge of £50 but Rectory Meadow Surgery will charge a standard fee of £10.00 administration plus 0.33 pence per sheet up to a maximum of £50.00 unless there are exceptional circumstances, such as when a GP is asked to formally inspect a record that does not belong to him, where a fee of £50 will be charged.

No fee can be charged for allowing a patient to directly inspect their record where no copy is requested. The Practice is not required to provide all the information requested if this would involve disproportionate effort and can refuse to provide copies if no fee is paid. At the same time, however, the GP has discretion not to charge for copies should it choose to do so.

2.6 Patients living abroad

For former patients living outside of the UK and whom once had treatment for their stay here, under the DPA 1998 they still have the same rights to apply for access to their UK health records. Such a request should be dealt with as someone making an access request from within the UK.

2.8 Requests made by telephone

No patient information may be disclosed to third parties by telephone. However, it is sometimes necessary to give patient information to another NHS employee over the telephone. Before doing so, the identity of the person requesting the information must be confirmed. This may best be achieved by telephoning the person's official office and asking to be put through to their extension.

2.9 Requests made by the police

In all cases the GP Practice can release confidential information if the patient has given their consent (preferably in writing) and understands the consequences of making that decision. There is, however, no legal obligation to disclose information to the police unless there is a court order or this is required under statute (e.g. Road Traffic Act).

The Practice does, however, have a power under the DPA and Crime Disorder Act to release confidential health records without consent for the purposes of the prevention or detection of crime or the apprehension or prosecution of offenders. The release of the information must be necessary for the administration of justice and is only lawful if this is necessary:

- i to protect the patient or another persons vital interests; or
- ii for the purposes of the prevention or detection of any unlawful act where seeking consent would prejudice those purposes and disclosure is in the substantial public interest (e.g. where the seriousness of the crime means there is a pressing social need for disclosure).

Only information, which is strictly relevant to a specific police investigation, should be considered for release and only then if the police investigation would be seriously prejudiced or delayed without it. The police should be asked to provide written reasons why this information is relevant and essential for them to conclude their investigations.

2.10 Requests from Solicitors

Solicitors who are acting in civil litigation cases for patients should obtain consent from the patient.

2.11 Court Proceedings

You may be ordered by a court of law to disclose all or part of the health record if it is relevant to a court case (for example by a Guardian ad litem).