



# Access to Medical Records Policy

Author	Heather Carrigan
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## **INTRODUCTION**

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 The Data Protection Act (DPA) 1998 came into force in March 2000 and repealed most of the 1990 Access to Health Records Act.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.

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 below). 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.

## **APPLICATIONS FROM DIFFERENT SOURCES**

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

### ***THE PATIENT***

Pembroke Road 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 must 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, and will always be in writing. There is no requirement to allow immediate access to a record of any type. A valid written request must be accompanied by the appropriate fee. 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 misinterpreted. 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.

### ***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 will 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 will 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 must 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 will be encouraged to involve parents or other legal guardians in any treatment/disclosure decisions.

## **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.

## **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.

## **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 will 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.

## **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, Pembroke Road Surgery would attempt to comply by providing factual information as requested.

Before records are disclosed, the patient or parents' consent (as set out above) must 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 will provide factual information and their response must be forwarded to a member of the Child Protection Team who will approve the report.

## **CHAPTER 8 REVIEW**

All Chapter 8 Review requests for information must 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.

## **AMENDMENTS TO OR DELETIONS FROM RECORDS**

If a patient feels information recorded on their health record is incorrect then they must 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, they may then 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 must 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.

Further information can be obtained from the Commissioner at Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF, telephone number 01625 545700.

## **PROCESSING REQUESTS**

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

Requests must be in writing, with a patient signature. Where a solicitor or other representative is making the request, ensure that you have patient signed consent, and sufficient information to clearly identify the patient.

## ***NOTIFICATION OF REQUESTS***

Pembroke Road Surgery treats all requests as potential claims for negligence. A central record of all requests is kept in order to ensure that requests are cross-referenced with any complaints or incidents and that the deadlines for response are monitored and adhered to.

## ***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 or provides copies of medical records the patient's GP must have been consulted and he / she checked the records and authorised the release, or part-release.

## ***GROUNDINGS FOR REFUSING DISCLOSURE TO HEALTH RECORDS***

The GP will refuse to disclose all or part of the health record if 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 will not be disclosed to that person.

## ***INFORMING OF THE DECISION NOT TO DISCLOSE***

If a decision is taken that the record will 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 will 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 will be made in the file.

The decision can only be taken by the GP and an explanatory note must 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.

## ***DISCLOSURE OF A DECEASED PATIENT'S MEDICAL RECORDS***

The same procedure used for disclosing a living patient's records must be followed when there is a request for access to a deceased patient's records. Access must 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 must 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.

## ***DISCLOSURE OF THE RECORD***

Once the appropriate documentation has been received and disclosure approved, the copy of the health record may be sent to the patient or their representative in a sealed envelope by recorded delivery. The record will be sent to a named individual, marked confidential, for addressee only and the sender's name will be written on the reverse of the envelope. Originals must not be sent.

Confidential information must 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 will be made in the file of what has been disclosed to whom and on what grounds. Where information is not readily intelligible an explanation (e.g. of abbreviations or medical terminology) must be given.

## **CHARGES AND TIMESCALES**

Copies of records must be supplied within 21 days of receiving a valid and complete access request. In exceptional circumstances, it may take longer. The original Access to Health Records Act 1990 required requests to be complied with within 21 days where the record had been amended within 40 days, however the new Data Protection Act which replaced this required 40 days for all requests. Ministers gave a commitment to Parliament that 21 days would be retained for the NHS. 21 days is therefore the required standard, 40 days may apply in some exceptional circumstances, and if this is to be the case the patient will be advised prior to expiry of the initial 21 day period.

Where further information is required by the Practice to enable it to identify the record required or validate the request, this must be requested within 14 days of receipt of the application and the timescale for responding begins on receipt of the full information.

To provide copies of electronic patient health records a maximum charge of £10 can be requested to cover photocopying. For manual records or a mixture of electronic and manual there can be a maximum charge of £50 but Pembroke Road Surgery will charge a standard fee 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.

Inspection of records of any type without copies, including those held only in electronic form, will incur a £10 charge. It is normal for inspection to be supervised.

The Practice is not required to provide all the information requested if this would involve disproportionate effort. This however would only apply in very exceptional circumstances and may need to be justified to the Information Commissioner in the event of a dispute. At the same time, however, the GP has discretion not to charge for copies should it choose to do so.

## **SAFE HAVEN**

Confidential medical records must not be sent by fax unless there is no alternative. If a fax must be sent, it will include the minimum information and names must be removed and telephoned through separately.

All staff are aware that safe haven procedures apply to the sending of confidential information by fax, for whatever reason (**see Safe Haven Requirements policy on Intranet**). That is, the intended recipient must be alerted to the fact that confidential information is being sent. The recipient then makes a return telephone call to confirm safe and complete receipt. A suitable disclaimer, advising any unintentional recipient to contact the sender and to either send back or destroy the document, must accompany all such faxes. A suitable disclaimer is shown below.

Warning: The information in this fax is confidential and may be subject to legal professional privilege. It is intended solely for the attention and use of the named addressee(s). If you are not the intended recipient, please notify the sender immediately. Unless you are the intended recipient or his/her representative you are not authorised to, and must not, read, copy, distribute, use or retain this message or any part of it.

## ***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 will be dealt with as someone making an access request from within the UK.

## ***REQUESTS MADE BY TELEPHONE***

No patient information may be disclosed to members of the public 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. Requests from patients must be made in writing.

## ***REQUESTS MADE BY THE POLICE***

In all cases the Practice can release confidential information if the patient has given his/her 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, will be considered for release and only then if the police investigation would be seriously prejudiced or delayed without it. The police will be asked to provide written reasons why this information is relevant and essential for them to conclude their investigations.

## ***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).

## ***REQUESTS FROM SOLICITORS***

Solicitors who are acting in civil litigation cases for patients must obtain consent from the patient using the form below (based on the BMA/Law Society drafted model form):

# PATIENT AUTHORITY FORM

## ACCESS TO HEALTH RECORDS AND X-RAYS UNDER THE DATA PROTECTION ACT 1998 (Subject access request)

Patient's authority for release of health records and x-rays to solicitors or medical experts for the purpose of litigation. (Manual or computerised health records)

To:

**Dr Rossdale and Partners**  
**111 Pembroke Road**  
**Clifton**  
**Bristol**  
**BS8 3EU**

**Tel: 0117 9733790**

1. **Full name of patient:**

Surname \_\_\_\_\_ (Mr/Mrs/Miss/Ms)

Forenames \_\_\_\_\_

Any former names \_\_\_\_\_

2. **Date of Birth:**

\_\_\_\_\_

3. **Current Address:**

\_\_\_\_\_

\_\_\_\_\_

Postcode \_\_\_\_\_

4. **Previous Address:** *(if in current property for less than 3 years)*

\_\_\_\_\_

\_\_\_\_\_

Postcode \_\_\_\_\_

5. **Is clinical negligence alleged? Yes/No?**

If yes, against whom? \_\_\_\_\_

**CONSENT**

1. I consent to my clinical notes and records\* being disclosed to:

\_\_\_\_\_ **Name of solicitor or expert to whom disclosure is sought**

2. I consent to the release of copies of **either**:

- Health records dated from/to: \_\_\_\_\_
- Health records relating to the following injury/condition \_\_\_\_\_
- All health records except those relating to the following condition \_\_\_\_\_
- All information contained on my health records from birth

**\* PLEASE TICK ONE OF THE ABOVE BOXES, AND READ POINTS 3 – 6 BELOW CAREFULLY**

- 1. I understand that all or part of my health records may be made available to my opponent and/or my opponent's solicitor or experts. I also understand that my solicitor may be required to make my health records available to the court. I understand that this may include details from birth if I decide to consent to the release of all my record.
- 2. I understand that this request for copies of my health record will be used in connection with this specific accident/incident only and that if further information is required my solicitor will approach me again for my consent.
- 3. I understand that my GP/health professional will have no control over any information that has been sent to my solicitor once it has arrived at the solicitor's office.
- 4. I understand a fee will be charged for the work performed in releasing notes as governed by the Data Protection Act 1998.
- 5. I understand it is a criminal offence to mislead the courts by failing to disclose details in my past health records that may be relevant to this specific incident.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Request for Access to Health Records

### Section 1 – Details of the patient:

*Mr/Mrs/Miss/Ms    * delete as appropriate	Surname:
Forenames:	Any former names:
Date of Birth:	Address:
<b>Section 2 – Details of the record to be accessed:</b>	
<input type="checkbox"/> Health records dated from/to:	<input type="checkbox"/> Health records relating to the following injury/condition:
<input type="checkbox"/> All health records except those relating to the following condition:	<input type="checkbox"/> All information contained in my health records from birth

### Section 3 – Declaration:

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health record referred to above, under the terms of the Access to Health Records Act (1990)/Data Protection Act (1998)

- I am the patient
- I have been asked to act by the patient and the attach the patient's written consent
- I have parental responsibility/legal guardianship for the patient, who is under the age of 16 and \*is incapable of understanding the request/has consented to me making this request (*\*please delete as appropriate*)
- I have been appointed the guardian for the patient, who is over 16, under a guardianship order
- I am the deceased patient's personal representative and attach confirmation of my appointment
- I have a claim arising from the patient's death and wish to access information relevant to my claim – the information will support my claim for the following reasons:

.....  
 .....

I am aware that a charge may be payable (£10.00 for an electronic copy, £50.00 for a copy of manual records, or a combination of electronic and manual records) Note: the maximum charge is £50.00, and NO fee will be payable if the record is being viewed and copies are not made.

Signed ..... Date .....

*Please note:*

- *It may be necessary to provide evidence of identity (i.e. Driving Licence, Passport)*
- *If there is any doubt about the applicant's identity or entitlement, information may not be released*
- *You will be informed if this is the case.*

For official use only:

**PRE-PROCESSING CHECK**

- Sufficient details to process application Initials ..... Date .....
- Insufficient details, letter sent requesting further info Initials ..... Date .....

NOTE: Information must be provided within 40 days (21 for access to records of the deceased) of receipt of the completed application.

**ADMINISTRATION FEE**

- £10.00 for computerised records – received/not appropriate/to be charged
  - £50.00 max for manual accessible records – received/not appropriate/to be charged
- Initials ..... Date .....

**PROCESSING OF REQUEST**

Name of Lead Health Professional .....

- Correspondence sent/contacted Initials ..... Date .....

Outcome:

- Appointment to be made with Lead Health Professional  
Made for (date) ..... at ..... Initials .....
- Supervised appointment to be made with .....  
on ..... at ..... Initials .....
- Copies of notes to be sent
- Applicant advised of outcome on ..... Initials .....

**PROCESSING APPLICATION**

Access provided on ..... (date)

Further Action:	Corrections requested	Yes/No		
	Copies provided	Yes/No	Copying Fee £	Yes/No

Comments:

Copies of notes:

- Made on ..... Initials .....
- Copying fee: £ ..... P&P: £..... Total: £.....
- Sent on ..... Initials .....
- Finance Advised on ..... Initials .....
- Fee received on ..... Initials .....