OAKLEY HEALTH GROUP	
ACCESS TO MEDICAL RECORDS POLICY	
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REVIEWED BY:	**Dr N Bhatia**
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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The Data Protection Act (DPA) 1998 came into force in March 2000 and repealed most of the 1990 Access to Health Records Act.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

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

The Patient

Oakley Health Group (hereby referred to as "the Practice") 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 will still apply to informal requests.

A request for access to health records in accordance with the DPA (The DPA refers to these as a subject access request) should be made in writing, which includes by email, to the data controller, i.e. the Practice. However, where an individual is unable to make a written request it is the Department of Health view that in serving the interest of patients it can be made verbally, with the details recorded on the individual's file.

The requester should provide enough proof to satisfy the Practice of their identity and to enable the Practice to locate the information required. If this information is not contained in the original request the Practice should seek proof as required. Where requests are made on behalf of the individual patient the Practice should be satisfied that the individual has given consent to the release of their information.

As good practice the Practice may check with the applicant whether all or just some of the information contained in the health record is required before processing the request. This may decrease the cost for the applicant and eliminate unnecessary work by NHS staff. However, there is no requirement under the Act for the applicant to inform the Practice of which parts of their health record they require.

Where an access request has previously been met the Act permits that a subsequent identical or similar request does not have to be fulfilled unless a reasonable time interval has elapsed between.

A request does not have to use the term "subject access" or "data protection" for it to be valid.

A patient, or their representative, is under no obligation to provide a reason for the request, even if asked by the Practice.

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:

- the birth mother, or
- the birth father (if married to the mother at the time of child's birth
  or subsequently) or,
- 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 <u>not</u> 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.

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.

Next of kin

Despite the widespread use of the phrase 'next of kin' this is not defined, nor does it have formal legal status. A next of kin cannot give or withhold

their consent to the sharing of information on a patient's behalf. A next of kin has no rights of access to medical records.

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 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.

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, the Practice 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:

- to protect the vital interests of the patient or others, or
- to prevent or detect any unlawful act where disclosure is in the substantial public interest (e.g. serious crime), and
- 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.

Chapter 8 Review
(Serious Case Review or Critical Incident Child Protection 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.

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 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.

Further information can be obtained from the Information Commissioner.

PROCESS

Notification of requests

The Practice will keep a central record of all requests 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.

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; or
- 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
- 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:

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

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:

- will effectively amount to divulging that information; or
- 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.

The 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.

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); or
- 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; or
- 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, or given to, the patient or their representative.

There should be no circumstances in which it would not be possible to supply permanent copies of health records.

If sent by post:

- the record should be sent to a named individual
- by recorded delivery

- marked "private and confidential"
- "for addressee only"
- and the Practice details should be written on the reverse of the envelope.

Originals should not be sent.

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

All staff should be aware that safe haven procedures apply to the sending of confidential information by fax, for whatever reason. 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 would be:

"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."

Confidential information should not be sent by email unless:

- the email address of the recipient is absolutely verified
- the data is via an encrypted service such as one NHS Mail account to another NHS Mail account; or
- the data is fully encrypted via *at least* 128-bit AES and preferably 256-bit AES. In such circumstances, the password must be *at least* 32 characters and contain a mixture of letters (upper and lower case), digits, and punctuation. The password must be conveyed to the patient separately from the encrypted file and preferably not by email at all (i.e. in person, by SMS, telephone or post)

Confidential information can be burnt onto a practice-provided blank CD-ROM as long as:

- the data is fully encrypted via *at least* 128-bit AES and preferably 256-bit AES. In such circumstances, the password must be *at least* 32

characters and contain a mixture of letters (upper and lower case), digits, and punctuation
- the password must be conveyed to the patient separately from the encrypted file

If the information requested is handed directly to the patient (whether on paper or CD-ROM) then the patient must provide verifiable identification at the time of collection.

A note should 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 should 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 should 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.

The Practice has discretion not to charge for copies or for viewing should it choose to do so.

The DPA states that fees for a subject access should be paid in advance, but in the interest of providing a helpful service to patients, the Practice will request the fee at the release stage of the access request.

The fees a patient may be charged to view their records or to be provided with a copy of them are summarised below:

To provide copies of patient health records the maximum costs are:

- Health records held purely on computer: up to a maximum £10 charge.
- Health records held in part on computer and in part on paper: up to a maximum £50 charge.

All these maximum charges include postage and packaging costs.

Any charges for access requests will not be made by the Practice in order to make a financial gain.

To allow patients to view their health records (where no copy is required) the maximum costs are:

- Health records, whether held purely on computer in part on computer and in part on paper: up to a maximum £10 charge.
- However, if the records have been added to in the last 40 days, no charge will be made

Note: if a person wishes to view their health records and then wants to be provided with copies this would still come under the one access request. The £10 maximum fee for viewing would be included within the £50 maximum fee for copies of health records, held in part on computer and in part on paper.

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.

If it is agreed that the patient or their representative may directly inspect their health records, it should be considered whether access should be supervised by a health professional or a lay administrator. A lay administrator is a neutral person who can oversee the viewing and ensure that the record remains safe. In these circumstances the lay administrator must not comment or advise on the content of the record. If the applicant raises queries an appointment with a health professional should be offered.

Fees for access to deceased patients' health records

- Where an applicant is permitted to view a record which is held wholly or partially on computer a fee of £10 may be charged.
- Where an applicant is permitted to view a record which is held wholly on paper and has been added to in the forty days preceding the application, access is free of charge. Where the record has not been added to in the preceding forty days a charge of £10 may be charged to view the record.

If an applicant wishes to obtain a copy of the record, they may be charged a fee. There is no limit on this charge, but it should not result in a profit for the Practice. This fee is over and above the £10 for the initial access.

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.

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:

- to protect the patient or another person's vital interests, or
- 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.

Requests from solicitors

Solicitors who are acting in civil litigation cases for patients should obtain consent from the patient using the form that has been agreed with the BMA and the Law Society.

Court Proceedings

The Practice 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).

FOI and Access to Health Records

The FOI is not intended to allow people to gain access to private sensitive information about themselves or others, such as information held in health records. Those wishing to access personal information about themselves should apply under the DPA. The Information Commissioner has provided guidance to the effect that health records of the deceased are exempt from the provisions of FOI due to their sensitive and confidential content.