ACCESS TO MEDICAL RECORDS POLICY

The practices of Central Bournemouth locality have adopted a library of standard policies with relevant practice-specific information as detailed in the box below:

Practice / Data Controller	St Alban's Medical Centre
Practice Manager	Colette Kiernander
Related policies	Subject Access Request Process (SAR flowchart) Online Access to Medical Records Protocol Patient Privacy Notice

INTRODUCTION

Patients are entitled to access their medical records under the auspices of the General Data Protection Regulation (GDPR) 2018 and the Data Protection Act (DPA) 2018. Access to the records of a deceased person is covered by the Access to Health Records Act 1990.

Patients have the right to apply for access to their health records, either directly or via a third party. This is known as a Subject Access Request (SAR). Provided a written or verbal application is made by the patient or a written application received by a third party acting with the consent of the patient, the Practice is obliged to comply with a request for access subject to certain exceptions. 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.

This policy should be read alongside the Subject Access Request process (see SAR flowchart).

APPLICATIONS

An application for access to health records may be made in any of the circumstances explained below. Access to the record may be refused where the information contained in it could cause serious harm to the patient or another person.

The Patient

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 patient should be offered online access to either the Detailed Coded Record or to the Full Record, as per information included in the Online Access to Medical Records protocol. If this is not suitable or sufficient for their needs, they may apply for copies of records.

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. The timeframe for processing is 30 days, unless the records are very complex in which case the time limit can be extended

to 90 days maximum. 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 members 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 and Young People

Children over the age of 13 are generally considered to have the capacity to give or withhold consent to release medical records. Where the child is considered to be capable, then their consent must be sought before access is given to a third party, including a parent / guardian. Access can be agreed or refused by the health professional where they consider that the child does not have capacity to make this decision.

Individuals with parental responsibility for an individual under 18 years of age will have a right to request access to those medical records. Access may be granted if this is not against the wishes of the competent child.

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) if named on the birth certificate, or,
iii an individual given parental responsibility by a court.

Parental responsibility is not lost on divorce. If parents have never been married only the mother has automatic parental responsibility, however the father may subsequently "acquire" it.

If the appropriate health professional considers that a child patient has sufficient maturity and understanding to make decisions about disclosure of their records (Gillick competent), 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. It is not essential that the other parent be informed of such a request – disclosure of this is at the discretion of the GP.

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 in full or in part 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. If medical records have been returned to the NHS Medical Records central depot, the patient should be given contact details to make their request direct to them.

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.

Where a deceased patient has indicated that they would not wish disclosure of their records then this should be the case after death, unless there is an overriding public interest in disclosure.

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, consent should be obtained from the patient or parent. 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, if deemed necessary, the data should be reviewed by the Safeguarding lead prior to release of records.

PROCESS

GP Practices receive applications for access to records via a number of different sources, such as Medical Insurance Companies, Solicitors, Patients, Carers and Parents of patients under the age of 18. Requests to view or have copies of medical records by the patient or their representative directly are usually handled by the Practice Manager. Other routine requests are handled by the Secretaries.

Requests should be made in writing, with a patient signature. Where requests are made by a third party, there should be a signed consent from the patient and sufficient information to identify the patient. Consent is only valid if dated within 6 months of the request.

Notification of requests
Practices should treat all requests as potential claims for negligence.

It is the GP's responsibility to consider an access request and to disclose the records if the correct procedure has been followed. The GP authorises the request, copies are produced in line with the request, third party information is redacted, the GP checks the remaining information for any inappropriate disclosure. NB - Some professionals outside the practice do not allow disclosure of their letters without their explicit consent.

Grounds for refusing disclosure to health records

The GP should 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 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 this 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 medical record.

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.

Disclosure of the record

Once the appropriate documentation has been received and sufficient identification has been produced to satisfy the data controller that disclosure may be made, the records are reproduced by printing / photocopying as necessary. References to third parties are redacted in accordance with the principles outlined in this document. A checklist is completed for each set of notes requested, outlining various checks and processes such as request, consent, payment, who has produced copies, and so on.

The copy of the health record is sent to the requestor in a sealed envelope by recorded delivery (unless they have provided a prepaid envelope). 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. Some individuals may wish to collect the copy by hand. In this case, they are asked to provide photographic proof of identify in the form of a driving licence, ID card or passport.

Where viewing is requested, a date may be set for the patient to view by supervised appointment. Where parts of the record are not to be released or to be viewed (i.e. they are restricted) an explanation does not have to be given; however the reasons for withholding should be documented. An explanation of terminology must be given if requested. Where the viewing is supervised by a non-medical member of staff, a note should be made of any medical queries for the GP to clarify.

A note should be made in the file of what has been disclosed to whom and on what grounds. Where an access request has been fulfilled a subsequent identical or similar request does not have to be again fulfilled unless a "reasonable" time interval has elapsed.

Charges and Timescales

The General Data Protection Regulations allow that a copy of records be provided free of charge. The practice is permitted to charge if they are asked to provide a second copy of the same information or if requests are considered to be spurious.

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

Patient ID should be confirmed in the case of allowing a patient to view medical records or to obtain copies direct from the practice – unless the patient is already known to the clinician concerned, this should be in the form of official photo ID such as driving licence or passport.

Fax

Confidential medical records should not be sent by fax unless there is no alternative. The recipient should be expecting to receive the fax, and where possible, a pre-programmed fax number is used to send the information. If a pre-programmed number is not available, the recipient should be contacted to ensure that the fax has been safely received.

Patients living abroad

Under data protection law, former patients treated by the practice but no longer living in the UK 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. Original records should not be given to a patient to take outside the UK. The GP may agree to provide a summary, or otherwise the request is treated as any other SAR. The same applies to patients who are moving abroad and wish to take a copy of their records.

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 or social care worker 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; email is acceptable as long as the person is able to provide sufficient information to prove identity and entitlement to the records.

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 right under data protection law and the 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 person's 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.

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

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.

AMENDMENTS TO OR DELETIONS FROM RECORDS

The rights of patients are laid out in the Patient Privacy Notice. 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.

It is not possible for a clinician to amend a consultation or letter produced by another clinician. In such a case, it is possible to record the patient's views on the record in question and what they feel is an accurate record of the consultation.

If the patient is not satisfied with review of the records, 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 current legislation 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 correction 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 GDPR / DPA if those reasonable steps were taken.

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