

MEDICAL RECORDS – YOUR QUESTIONS ANSWERED

Who owns medical records?

Ownership of medical records largely depends on the business and contractual arrangements associated with the operation of the medical practice, and the doctor concerned:

1. Employee Doctor and Employer Medical Practice

The appeal case of *Health Services for Men Pty Ltd v D'Souza (2000) 48 NSWLR 448* provides that ownership of medical records in private clinics resides with the clinic and not the doctor or health worker. In this case, the employee doctor wanted to take the medical records of his patients when he left his employment at Health Services for Men.

The case went before the NSW Court of Appeal, which decided the clinic owned the records. It is important to note that the clinic was a company, *Health Services for Men Pty Ltd* and the doctor was an employee.

2. Independent Contractor Doctor and Principal Medical Practice

Where a doctor or a doctor's company is engaged as an independent contractor by the principal medical practice to provide medical services, ownership of the medical records would generally reside with the independent contractor and possibly the Principal, subject to any written contract or mutual understanding of the parties.

In determining ownership of medical records, the courts will examine the nature of the services the principal medical practice offered to patients and the part the independent contractor played in providing those services.

3. Partnerships and Medical Records

In a partnership, each partner has ownership of the medical records unless the partnership agreement states otherwise. Medical records created by a partner will generally remain with the partnership if a partner leaves unless the partnership agreement states otherwise. Where a partnership is terminated, the records should be distributed in accordance with the terms of the partnership agreement.

4. Associateships and Medical Records

An Associateship is an industry specific term for a business relationship where two or more doctors operate their medical practices from a single site and agree to share the costs of their practices, for example, staff, rent, utilities etc.

Each Associate would have their own patients and patient records. The ownership of the patient's records would generally reside with the respective Associate, subject to any written contract of mutual understanding of the parties.

In the event a doctor leaves the practice:

1. If the doctor is part of an associateship or partnership, then they can inform patients of the new place of practice

2. If the doctor is an employee of the practice, then they cannot inform their patients, unless arrangements have been made with the previous practice informing patients.

How should medical records be kept?

Privacy and the manner in which medical records are stored are governed by the national *Privacy Act*, under National Privacy Principle No. 4, *Data Security*. Section 4.1 of NPP No. 4 states:

“an organisation must take reasonable steps to protect the personal information it holds from misuse and loss and from unauthorised access, modification or disclosure”.

Medical records may be kept in the form of paper files or electronically, as long as the records are stored in accordance with the above mentioned NPP.

For example, if medical records are kept electronically, it is recommended:

1. The records should only be accessible by authorised staff
2. The records are protected by a security password (this ensures patient and practice confidentiality)
3. To keep a back-up copy of all records at the end of each day and store these in a fireproof safe on or off site
4. Any converting of medical records to electronic format must be done by way of accurate direct imaging of the original document
5. You should be able, if required, to demonstrate or provide satisfactory evidence of the integrity and inability to modify the electronic document.

How long should medical records be kept?

There is no specific legislation in Queensland that stipulates how long medical records are required to be kept. The *AMA Code of Ethics* recommends a doctor must “maintain accurate contemporaneous clinical records”. AMA Queensland recommends, in line with the *Code of Ethics*, medical records be kept as long as necessary to ensure appropriate standard of care for the patient.

Further, AMA recommends records be retained for 10 years from the date of the last consultation. In the case of minors, the 10 year count starts from the date the patient attains 18 years of age.

Patient x-ray reports form part of the medical record; therefore AMA Queensland recommends these are kept for seven years from the date of the x-ray. After that time period they may be disposed.

How should medical records be disposed?

It is important to ensure medical records are destroyed in a manner which maintains patient confidentiality.

A number of organisations specialise in the disposal of confidential information. You should:

1. Obtain information from such organisations about their disposal methods so that you can be sure appropriate confidentiality is maintained
2. View their confidentiality policy or have them sign a confidentiality agreement with the practice. Pro-forma confidentiality agreements, between a practice and contracting organisation, are available in the *AMA Queensland Privacy Information Kit*.

CLOSING DOWN A MEDICAL PRACTICE and MEDICAL RECORDS

Patients should be notified at least six (6) months in advance, (where practicable), of the date of practice closure by:

1. A sign being placed in a conspicuous place in the practice providing details of the practice closure such as date of closure and the option to transfer medical records
2. Practice staff advising patients of the practice closure. This may be when a patient rings to make an appointment, or before or after the patient's consultation.
3. The doctor/s sending a letter to all patients to advise them of the practice's impending closure, (including the date of closure), and asking each patient to contact the practice about the medical records kept about them.

In such a letter:

- (i) Patients must be given the option to transfer their medical records and if this is requested, the medical records should be forwarded accordingly. The patient should be requested to notify the practice in writing of a new treating doctor to whom they would like the medical records to be forwarded.
- (ii) A reasonable fee may be charged for the costs incurred for transferring patient records. Patients must be advised up-front if there is a fee involved for the transfer of their medical records.
- (iii) Patients should be informed of what will happen to the medical records if no reply/contact is made by the patient prior to the practice closing. This may be that you elect to forward those remaining medical records to a specific doctor, for example, a doctor practicing in your area, or you store them yourself.
- (iv) A record being kept detailing where the records have been transferred to and the date that this occurred.
- (v) Storing in accordance with National Privacy Principle No. 4, *Data Security*, any medical records that are required to be kept (i.e. they have not been transferred at the request of a patient).

Can medical records be transferred via email?

AMA Queensland recommends patient records are **not** transferred via email, as email is not always reliable and the records may be lost. They should either be sent via registered post or courier, or personally delivered to the new doctor.

1. Storage Information

It is also prudent to keep a record of to whom and/or where all patient files are transferred and the date which this occurred. Any records which are not out-of-date and have not been provided to other practitioners or the patients concerned, must be stored and kept.

As an alternative, you may wish to retain the medical records and place them in a storage facility. The *AMA Code of Ethics* recommends that a doctor “maintain accurate contemporaneous clinical records”.

Further, AMA recommends records be retained for 10 years from the date of the last consultation. In the case of minors, the 10 years starts from the date the patient attains 18 years of age.

AMA Queensland recommends, in line with the *Code of Ethics*, medical records are kept for as long as necessary to ensure the appropriate standard of care for the patient.

- i. It is important your patients know where the medical records will be, whether in storage, or at another medical centre. This allows patients to make contact with the appropriate person should they wish for a new treating doctor to receive a copy of the records.
- ii. Scanning records onto a computer or CD is a simple method of storing patient files. Only patient files that are out-of-date, (see above), may be disposed of - all other records must either be transferred or stored.
- iii. You may also wish to consider placing an advertisement in the local community newspaper advising that your practice will be closing as of a certain date.

AMA Queensland can assist you to draft a letter to patients advising of the practice closure.

2. Access At a Later Date

Where you are going to provide new treating doctors with the medical records of a patient, it is advisable to seek written confirmation from that practitioner clearly indicating that in the event you need to access those records for medico-legal reasons, the new doctor consents to you accessing the necessary records.

Stemming from this is a need to maintain a record of where you forwarded patient records.

For a copy of the AMA Queensland Fact Sheet on Medical Records, members are welcome to contact the Member Services Department on (07) 3872 2258