The Medical Record

Rights and obligations

The rights of patients and obligations of medical practitioners, regarding medical records, are extensive. Rights and obligations are covered in The Privacy Act 1993, The Health Act 1956, The Health Information Privacy Code 1994 and The Health (Retention of Health Information) Regulations 1996. The following is a list of frequently asked questions that the NZMA Advisory Service is often asked about medical records.

Who owns the medical record?
Physical and electronic medical records are the property of the medical practitioner but the health information contained in the records belonging to the patient. Therefore access to the information must be available to the patient if they request it.

How long must medical records be kept?
The minimum retention period is ten years, measured from the day after the most recent date shown in the patient's health information on which health services were provided to the patient. However, providers must retain all health information relating to an individual if any of the information relates to the provision of health services within the last ten years. This means that for medical practitioners who are providing ongoing services to patients, then they must retain all health information relating to them irrespective of how old that information is.

Providers should consider retaining copies of all health information to assist in defending future legal or disciplinary matters. This reflects the view of the Medical Protection Society.

How should medical records be kept?
The Regulations do not require that health information be retained in any particular form. However, if the health information is recorded in a form which may deteriorate before the expiry of the ten (10) year period, an accurate summary or interpretation of the health information should be made and retained for the balance of the minimum retention period.

Are there any rules or obligations when disposing of medical records?
The Regulations do not stipulate how health information is to be disposed. However, disposal of health information is referred to in Rule 5 of the Health Information Privacy Code 1994, which suggests that consideration may be given to offering individuals the choice of having the records transferred to them or disposed of in accordance with their wishes. If the medical practitioner is to dispose of the health information, it must be completed in a manner which maintains the confidentiality of the patient, for example, shredding or incineration, or the rendering unreadable of computerised records.

Is there a set procedure for transferring records?
No. However, if a patient requests their medical records to be transferred to another practice, you are required to comply with their wishes, regardless of the circumstances bring about the change of doctor. You should, if possible, transfer the patient's full notes, but as a minimum it can be a brief factual summary of the content of the doctor's personal case notes along with a note of the present state of the patient's health. Once you have

transferred the medical records, you have also transferred the obligation to retain these records under The Health (Retention of Health Information) Regulations. However, as stated earlier, Medical Protection Society advise that you should also retain a copy of these notes.

You cannot withhold medical records because the patient owes the practice money. Doing this is a breach of the Health Information Privacy Code.

Who is responsible for medical records in a partnership or company situation?
Where a partner leaves the practice or a locum finishes, medical records cannot be removed without the other partners approval. A break up of partnership requires special care and doctors involved in partnership disputes should seek legal advice.

Where the medical records are the property of the employer or company, the doctor still has an obligation to transfer medical records on request by the patient.

What happens to medical records if a doctor retires or dies?
Meeting all the requirements for the retention of medical records can be difficult, especially for sole practitioners. Before retirement, doctors should:

- make prior arrangements for another practitioner to accept responsibility for them, and/or
- arrange for patients to pick up their own records.

In the situation where arrangements have not been made for the retention of patient records and the doctor dies, the Executor of the Estate or Power of Attorney should endeavor to return the records to the patient (the patient's family if the patient is dead), or another doctor.

Who has the rights to access a patient's medical records?
Access and disclosure of medical information is covered in the Privacy Act, The Health Act and the Health Information Privacy Code. Further Information on this legislation is available in the following NZMA member resources:

- Advice to Practice Staff on Confidentiality and Privacy
- Privacy and the Law – Part One
- Privacy and the Law – Part Two

Can I charge patients or third parties for access to their medical records?
You cannot charge patients for access to their health information. This applies if the patient is requesting the information directly or the request comes on behalf of the individual.

Charges may be made for providing a copy of a x-ray, a video recording or a CAT scan photograph. The charge should only be the actual cost of reproducing the copy to the patient. If the charge for any of these things is likely to exceed $30, you should give the patient an estimate before dealing with the request.

You can charge for giving health information to some third parties unless the providing of information is a statutory requirement. Third parties are such agencies as insurance companies, WINZ, or the Department of Statistics.

Lawyers requesting information while acting for a patient cannot be charged. The Privacy Commission considers that lawyers are not third parties, they are requesting information on behalf of the individual. If a lawyer was charged, the lawyer would then pass the charge directly on to their client. In effect, any charge by the doctor would ultimately be met by the patient, who was simply seeking a copy of his/her own records.

The only time you can charge patients for access to their medical records is if they have previously requested the information within the past year. If this is the case, the charge should only be the actual costs incurred.

Need more help?

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