FACTSHEET

MEDISEC

We look after you

FAQs- Access to Medical Records/ Information

At Medisec, we regularly receive queries from our members regarding access to medical records. The following is an overview of some of the frequently asked questions and our advice, which you may find useful.

Q. Is a patient entitled to a copy of their medical records?

A: In general, a patient is entitled to a copy of their medical records, except where this is likely to cause serious harm to their physical or mental health. Information relating to third parties must be redacted from the records prior to releasing, unless the third party has consented to the disclosure of their information.

The request should be responded to as soon as possible, and no later than 30 days after the request is made. No fee is chargeable for providing a copy of the medical record. However, GDPR outlines that a "reasonable fee" may be charged when a request is "manifestly unfounded or excessive", particularly if it is repetitive.

For detailed guidance on managing patient requests for records, please see our factsheet on our website: *Patient Access to Medical Records*.

Q. Should letters or notes from other healthcare professionals, such as hospital consultants, be included when releasing a copy of a patient's clinical records?

A. Yes, they should, they form part of the patient's medical records held by you as treating GP and data controller. While you do not need consent from the authors of those letters or notes (with the exception of certain mental health records – see below), it is open to you as a matter of courtesy, to let them know that the patient records have been requested and released.

In the event another healthcare professional expressly gave an opinion on the understanding that it would be treated as confidential, then their consent should be obtained before releasing written confirmation of that opinion.

In appropriate cases (some psychiatric illnesses for example) the views of the consultants/secondary care providers should be sought where the GP is unsure as to whether releasing such records could cause serious harm to the patient's physical or mental health.

Q. How long should I keep patients' records?

A. Please refer to the table below and to Medisec's factsheet: *Storage and Retention of Medical Records*, available on our website, which provides details of retention periods for specific categories of patient records.

Type of Patient Record	Retention Period
Adult/General	8 years after last contact.
Deceased patients	8 years after date of death.
Children and young people	Retain until the patient's 25th birthday or 26th if young person was 17 at the conclusion of treatment, or eight years after death. If the illness or death had potential relevance to adult conditions or genetic implications, specific advice should be sought as to whether to retain the records for a longer period.

Maternity (all obstetric and midwifery records, including those of episodes of maternity care that end in stillbirth or where the child later dies)	25 years after the birth of the last child.
Mentally disordered persons (within the meaning of the Mental Health Acts 1945 to 2001)	20 years after the date of last contact between the patient and the doctor, or eight years after the death of the patient if sooner.
Patients included in clinical trials	20 years.
Suicide - notes of patients having committed suicide	10 years.
Cause of Death Certificate Counterfoils	2 years.
Records/documents related to any litigation	National Hospital Office recommends that the records are reviewed 10 years after the file is closed. Note however, if the litigation related to a child, this should not be used to lessen the retention period set out above.

Q. One of my private patients died recently and his son is requesting access to his father's medical records. Can I provide him with a copy?

A. According to the Medical Council's Guide to Professional Conduct and Ethics, (available on the Medical Council website) your duty of confidentiality continues after a patient's death. This is an ethical requirement and not a legal one, as the right to sue for a breach of confidentiality dies with the patient. Also, data protection legislation such as GDPR refers to living persons only.

If during his lifetime, your patient expressed that information contained within his records should remain confidential, you should respect his wishes. If the deceased patient had not given any instructions regarding his clinical information, you should consider the purpose of the disclosure and explore why the patient's son is seeking a copy of the records. You should also consider how disclosure of that information might benefit or cause distress to the deceased's family and the effect of disclosure on the reputation of the deceased.

In general, prior to releasing the requested information, you should seek written consent from the Legal Personal Representative, e.g., the executor, of the deceased patient's estate. It is important to inform the LPR of the nature and extent of any disclosure.

We advise contacting your indemnifier/insurer on receipt of such requests should you have any queries/concerns arising from the request.

Please refer to Medisec's factsheet; *Request for Medical Records/Information of a Deceased Patient*, available on our website, for further guidance.

Q. I have often been asked to prepare medical reports by insurance companies. Some patients do not want particular details of their clincial history disclosed to the insurance company. What should I do?

A. Before disclosing any personal information to an insurance company, it is important that you have full, valid and informed consent from the patient to disclose their information. You should take steps to satisfy yourself that the patient fully understands the nature and extent of the disclosure.

Sometimes patients are naturally anxious that nothing prejudicial is disclosed unless absolutely necessary. Patients may need to be reminded that it is important that they are honest in their disclosure to insurance companies and they should not omit anything of significance. It is important that the patient fully understands your obligations in completing a PMA report. You should highlight to patients that any non-disclosure, misleading or untruthful information on a form may render the policy void and cause an application/ claim to be rejected.

As a practical step, we recommend you review completed PMA reports with patients prior to submission to the insurance company. This allows an opportunity to explain to patients the nature and extent of the consent provided and will help to ensure the patient understands the information that is being disclosed and the scope and purpose of the report. It also provides an opportunity to spot any errors / inaccurate information included in the report.

If following a discussion with the patient, they object to any necessary or relevant information being provided in the report, they are effectively not consenting to disclosure of that information. You should not compromise your position by omitting any relevant details from the report and you should simply write on the relevant section of the form "*no consent from the patient to disclose*" or decline to submit the form entirely in such circumstances. You should make patients aware that failing to disclose details may mean the insurance company cannot process the application/claim. You should carefully document any discussions with the patient in their medical records.

Please see our factsheet *Private Medical Attendant (PMA) Reports*, available on our website, for further guidance.

Q. A GP undertakes some occupational health work for a company. One of the employees is taking legal action against the company. The company is requesting a medical report on the patient. The patient previously consented to attending the GP for GP services, but is not willing to give consent to release the report to their employer.

A. It would appear that the original consent signed by the patient for GP services would not apply in this case. Bearing in mind that litigation may be imminent against the employer, further specific written consent should be sought from the patient to release the report.

At the outset of each consultation with the patient, it is important to clarify on whose behalf the GP is providing a service; i.e., the patient or the company. Should there be any perceived conflict of interest, it may be in the best interests of both the patient and the GP to request that the company seek an independent medical review of the patient and an independent medical report in the context of the litigation.

Q. Is the above patient entitled to a copy of the report?

A. In the above scenario, where the report is prepared for the company in the context of litigation, the patient cannot be furnished with a copy of the report without the consent of the company, as the company may claim litigation privilege over the report in those circumstances.

Q. One of my patient's had genetic testing recently and does not want his family to know the results. What should I do?

A. The Medical Council's *Guide to Professional Conduct and Ethics,* states that anyone who wishes to have genetic testing must be counselled beforehand about the possible consequences the results from the testing may have not only on them, but on their relatives. You should encourage the patient to speak with family members and offer, if possible, to facilitate a meeting or a telephone call with the patient and their family members to discuss the results of the test. If the patient is not agreeable to a meeting and does not consent to disclosure to relatives, disclosure may be permitted in the public interest, in limited

circumstances which must be considered on a case by case basis. These can be difficult legal scenarios and we recommend that you contact your indemnifier/insurer for specific advice if such a situation arises.

Q. I have received a request from a solicitor seeking records under Data Protection legislation in respect of an elderly patient who is in long-term residential care. I am not sure if the patient has capacity to sign the form of authority received. What should I do?

A. The patient is entitled to a copy of their records under Data Protection legislation (except where it is likely to cause serious harm to their physical or mental health) and it is presumed that an adult patient has capacity to consent to disclosure. You are however entitled to clarify whether your patient has capacity. You may, either directly by reviewing your patient or from the residential centre's doctor, and/ or through discussion with their solicitor, seek evidence of your patient's capacity.

In circumstances where the patient does not have capacity, you may wish to ask the solicitor to explain in detail the reasons why access to the records is required. As the records are going to be reviewed by third parties, you should consider if the purpose of release can properly be made by the disclosure of certain parts of the patient's records only. Document carefully your decision-making process separate to the consultation records, retaining these notes in the patient's file.

If the patient is a Ward of Court for example, or if an Enduring Power of Attorney has been registered, the "Committee" (person/s appointed by the Court to act on behalf of someone who is made a Ward of Court) or the Attorney (person/s nominated under the EPA to make decisions on behalf of the patient), will have the authority to discuss the request and provide appropriate written consent.

If the patient does not have capacity, did not execute an EPA and has not been made a Ward of Court, you may still consider the request from the patient's solicitor acting on behalf of the next-of-kin (e.g., spouse, child, niece, nephew, sibling etc.), provided you are satisfied that the patient's best interests require disclosure of their clinical information. We advise that you contact your indemnifier/insurer for specific advice in such circumstances.