Criterion 4.2.1 – Confidentiality and Privacy of Health Information

Practice Policy – Practice Privacy Policy

This practice is bound by the Federal Privacy Act (1988) and Australian Privacy Principles (APPs), and also complies with the Victorian Health Records Act (2001).

'Personal information' is information that identifies you or could reasonably identify you. 'Personal health information' a particular subset of personal information can include any information collected and held to provide a health service.

This information includes medical details, family information, name, address, employment and other demographic data, past medical and social history, current health issues and future medical care, Medicare number, accounts details and any health information such as a medical or personal opinion about a person's health, disability or health status.

It includes the formal medical record whether written or electronic and information held or recorded on any other medium eg letter, fax, electronically or information conveyed verbally.

Our practice has a designated person Kellie Adam with primary responsibility for the practice's electronic systems, computer security and adherence to protocols as outlined in our computer information security policy (Criterion 4.2.2). This responsibility is documented in the position description. Tasks may be delegated to others and this person works in consultation with the privacy officer.

Our security policies and procedures regarding the confidentiality of patient health records and information are documented and our practice team are informed about these at induction and when updates or changes occur.

The practice team can describe how we correctly identify our patients using 3 patient identifiers, name, date of birth, address or gender to ascertain we have the correct patient record before entering or actioning anything from that record.

For each patient we have an individual patient health record, electronic containing all clinical information held by our practice relating to that patient. The practice ensures the protection of all information contained therein. Our patient health records can be accessed by an appropriate team member when required. We also ensure information held about the patient in different records (eg at a residential aged care facility) is available when required.

Practice Procedure – Practice Privacy Policy

Doctors, allied health practitioners and all other staff and contractors associated with this practice have a responsibility to maintain the privacy of personal health information and related financial information. The privacy of this information is every patient's right.

The maintenance of privacy requires that any information regarding individual patients, including staff members who may be patients, may not be disclosed either verbally, in writing, in electronic form, by copying either at the practice or outside it, during or outside work hours, except for strictly authorised use within the patient care context at the practice or as legally directed.

There are no degrees of privacy, all patient information must be considered private and confidential, even that which is seen or heard and therefore is not to be disclosed to family, friends, staff or others without the patient's approval. Sometimes details about a person's medical history or other contextual information such as details of an appointment can identify them, even if no name is attached to that information and as such it must be protected under the Privacy Act.

Any information given to unauthorised personnel will result in disciplinary action and possible dismissal. Each staff member is bound by his/her privacy clause contained with the employment agreement which is signed upon commencement of employment at this practice.

Personal health information should be kept where staff supervision is easily provided and kept out of view and access by the public eg not left exposed on the reception desk, in waiting room or other public areas or left unattended in consulting or treatment rooms.

Practice computers and servers comply with the RACGP computer security checklist and we have a sound back up system and a contingency plan to protect the practice from loss of data (See Criterion 4.2.2 – Computer information security).

Care should be taken that the general public cannot see or access computer screens that display information about other individuals. To minimise the risk automated screen savers should be engaged.

Members of the practice team have different levels of access to patient health information (See Criterion 4.2.2 – Computer information security). To protect the security of health information, GPs and other practice staff do not give their computer passwords to others in the team.

Reception and other practice staff should be aware that conversations in the main reception area can often be overheard in the waiting room and as such staff should avoid discussing confidential and sensitive patient information in this area.

Whenever sensitive documentation is discarded the practice uses an appropriate method of destruction shredding and security bin or computer drive, memory sticks etc are reformatted.

Correspondence

Electronic information is transmitted over the public network in an encrypted format using secure messaging software. Where medical information is sent by post, the use of secure postage or a courier service is determine on a case by case basis.

Incoming patient correspondence and diagnostic results are opening by a designated staff member.

Items for collection or postage are left in a secure area not in view of the public.

Facsimile

Facsimile, printers and other electronic communication devices in the practice are located in areas that are only accessible to the general practitioners and other authorised staff. Faxing is point to point and will therefore usually only be transmitted to one location.

All faxes containing confidential information are sent to fax numbers ensuring the recipient is the designated receiver.

- Confidential information sent by fax has date, patient name, description and destination recorded in a log on the Fuji Xerox machine.
- Write "Confidential" on the fax coversheet
- Check the number dialled before pressing SEND
- Keep the transmission report produced by the fax as evidence that the fax was sent
- Also confirm the correct fax number on the report.

Faxes received are managed according to incoming correspondence protocols.

The practice uses a fax disclaimer notice on outgoing faxes that affiliates with the practice.

Emails

Emails are sent via various nodes and are at risk of being intercepted. Patient information may only be sent via email if it is securely encrypted according to industry and best practice standards.

Patient Consultations

Patient privacy and security of health information is maximised during consultations by closing consulting room doors. All examination couches, including those in the treatment room, have curtains or privacy screens.

When consulting, treatment or administration office doors are closed, prior to entering, staff should either knock and wait for a response or alternatively contact the relevant person by internal phone or email.

Where locks are present on individual rooms these should not be engaged except when the room is not in use.

It is the doctor's / health care professional's responsibility to ensure that prescription paper, sample medications, medical records and related persona patient information is kept secure, if they leave the room during a consultation or whenever they are not in attendance in their consulting/treatment room.

Medical Records

The physical medical records and related information created and maintained for the continuing management of each patient are the property of this practice. This information is deemed a personal health record and while the practice does not have ownership of the record he/she has the right to access under the provisions of the Commonwealth Privacy and State Health Records Act/ Requests for access to the medical record will be acted upon only if received in written format.

Our patient health records can be accessed by an appropriate team member when required.

Practix stores medical records, Practix is password protected per user and access to the record assigned per user to ensure the protection of all information contained in medical records e.g. passwords, access details, storage and how you ensure information held about the patient in different records (e.g. at a residential aged care facility) is available when required.

Both active and inactive patient health records are kept and stored securely.

A patient health record may by solely electronic based.

Computerised Records

Our practice is considered paperless and has systems in place to protect the privacy, security, quality and integrity of the personal health information held electronically. Appropriate staff members are trained in computer security policies and procedures.

NOTE The RACGP Standards define an "active health record" as a record of a patient who has attended the practice three or more times in the past 2 years.

Practice Policy – Patients Request for Access to Personal Health Information

Patients at this practice have the right to access their personal health information (medical record) under legislation; Commonwealth Privacy Amendment (Private Sector) Act 2000 and the Health Records Act 2001 (Victoria). The HRA gives individuals a right of access to their personal health information held by any organisation in the private sector in Victoria in accordance with Health Privacy Principle 6 (HPP 6). The principle obliges health service providers and other organisations that hold health information about a person to give them access to their health information on request, subject to certain expectations and the payment of fees (if any).

Public sector organisations continue to be subject to the Freedom of Information Act 1982.

This practice complies with both laws and the Australian and Health Privacy Principles (APPs & HPPs) adopted therein. See summary headings of principles in this section. Both Acts give individuals the right to know what information a private sector organisation holds about them, the right to access this information and to also make corrections if they consider data is incorrect. Compliance with the access provisions in the Health Records Act 2001 (Victoria) will generally ensure compliance with the Commonwealth Privacy Act.

Australian Privacy Principles (APPs)	
APP 1	Open and transparent management of personal information
APP 2	Anonymity and pseudonymity
APP 3	Collection of solicited personal information
APP 4	Dealing with unsolicited personal information
APP 5	Notification of the collection of personal information
APP 6	Use or disclosure of personal information
APP 7	Direct marketing
APP 8	Cross-border disclosure of personal information
APP 9	Adoption, use or disclosure of government related identifiers
APP 10	Quality of personal information
APP 11	Security of personal information
APP 12	Access to personal information
APP 13	Correction of personal information

As adopted within the Commonwealth Privacy Amendment (Private Sector) Act 2000. We have a privacy policy in place that sets out how to manage health information and the steps an individual must take to obtain access to their health information. This includes the different forms of access and the applicable time frames and fees.

Reports by Specialists

This information forms part of the patient's medical record, hence access is permitted under privacy law.

Diagnostic Results

This information forms part of the patient's medical record, hence access is permitted under privacy law.

NOTE: Amendments to the Privacy Act apply to information collected after 21st December 2001, however they also apply to data collected prior to this date provided it is still in use and readily accessible.

We respect individual's privacy and allow access to information via personal viewing in a secure private area. The patient may take notes of the content of their record or may be given a photocopy of the requested information. A GP may explain the contents of the record to the patient if required. An administrative charge may be applied, at the GPs discretion and in consultation with the Privacy Officer e.g. for photocopying record, x-rays and for staff time involved in processing the request.

Practice Procedure – Patients Request for Access to Personal Health Information

A notice is displayed in our waiting room advising patients and others of their rights of access and of our commitment to privacy legislation compliance. An information brochure is also available that provides further details if required.

Release of information is an issue between the patient and the doctor. Information will only be released according to privacy laws and at doctor's discretion. Requested records are reviewed by the medical practitioner prior to their release and written authorisation is obtained.

Request Received

When our patients request access to their medical record and related personal information held at this practice, we document each request and endeavour to assist patients in granting access where possible and according to the privacy legislation. Exemptions to access will be noted and each patient or legally nominated representative will have their identification checked prior to access being granted. A patient may make a request verbally at the practice, via telephone or in writing eg fax, email or letter. No reason is required to be given. The request is referred to the patient's doctor or delegated privacy officer.

A request for personal health information is completed to ensure correct processing.

Once completed a record of the request is logged in the access register and the form filed/scanned in the patient record.

Request by another (not patient)

An individual may authorise another person to be given access, if they have the right eg legal guardian, and if they have a signed authority. Under NPP 2 Use and Disclosure, a 'person responsible' for the patient (including a partner, family member, carer, guardian or close friend), if that patient is incapable of giving or communicating consent, may apply for and be given access for appropriate care and treatment or for compassionate reasons. Identity validation applies.

The Privacy Act defines 'a person responsible' as a parent of the individual, a child or sibling of the individual, who is at least 18 years old, a spouse or de facto spouse, a relative (at least 18 years old) and a member of the household, a guardian or a person exercising an enduring power of attorney granted by the individual that can be exercised for that person's health, a person who has an intimate relationship with the individual or a person nominated by the individual in a case of emergency.

Children

Where a young person is capable of making their own decisions regarding their privacy, they should be allowed to do so according to Federal Privacy Commissioner's Privacy Guidelines. The doctor could discuss the child's record with their parent. Each case is dealt with subject to the individual's circumstances. A parent will not necessarily have the right to their child's information.

Deceased Persons

A request for access may be allowed for a deceased patient's legal representative if the patient has been deceased for 30 years or less and all other privacy law requirements have been met. Ref: Sec 28 Health Records Act. No mention is made of deceased patient's access in Commonwealth privacy legislation.

Acknowledge Request

Each request is acknowledged with a letter sent to the patient, confirming request has been received. Send the letter within 14 days or sooner as recommended by the National Privacy Commissioner. Acknowledgement will include a statement concerning charges involved in processing the request.

Fees Charged

Discuss with the individual what information they want access to, and the likely fees, before undertaking their request for access.

The fees which an organisation can charge for providing access must not be excessive and must not apply to the mere lodgement of a request for access. National Privacy Principle (NPP) 6.4 aims to prevent

prevent organisations for using excessive charges to discourage individuals from making requests for access to their medical records. If an organisation incurs substantial costs in meeting a request for access, then the organisation could charge a reasonable fee to meet the administrative costs involved. For example, an organisation could recover some of the costs of photocopying or of the staff time involved.

Collate and Assess Information

Retrieve patient's hardcopy medical record or arrange for the treating doctor or practice principle to access the computer record. Refer to the patient request form to help identify what information is to be given to the patient.

Data may be withheld under privacy legislation NPP 6 – Access and Correction for the following reasons:

- Where access would pose a serious threat to the life or health of any individual
- Where the privacy of others may be affected
- If a request is frivolous or vexatious
- If information relates to existing or anticipated legal proceedings
- If access would prejudice negotiations with the individual
- If access would be unlawful
- Where denying access is required or authorised by law.

See National Privacy Principles in full for a comprehensive list of exclusions available at: http://www.privacy.gov.au/materials/types/infosheets/view/6583

Access Denied

Reasons for denied access must be given to the patient in writing. Note these on the request form. In some cases refusal of access may be in part or full.

Use of Intermediary when Access Denied

If request for access is denied an intermediary may operate as facilitator to provide sufficient access to meet the needs of both the patient and the doctor.

Provide Access

Personal health information may be accessed in the following ways:

- View and inspect information
- View, inspect and talk through contents with the doctor
- Take notes
- Obtain a copy (can be photocopy or electronic printout from computer)
- Listen to audio tape or view video

- Information may be faxed to patient

Check Identity of Patient

- Ensure a visible form of ID is presented by the person seeking access eg driver's licence, passport or other photo identification. Note details on request form
- Does the person have the authority to gain access? Check age, legal guardian documents; is person authorised representative?

If the patient is viewing the data, supervise each viewing so that patient is not disturbed and no data goes missing.

If a copy is to be given to the patient ensure all pages are checked and this is noted in the request form.

If the doctor is to explain the contents to a patient then ensure an appointment time is made.

Request to Correct Information

A patient may ask to have their personal health information amended if he/she considers that is not up to date, accurate and complete (NPP 6.5/6.6).

Our practice must try to correct this information. Corrections are attached to the original health record.

Where there is a disagreement about whether the information is indeed correct, our practice attaches a statement to the original record outlining the patient's claim.

Time Frames

Acknowledge request – within 14 days. Complete the request – within 30 days.

Practice Policy – 3rd Party Request for Access to Personal Health Information

Requests for 3rd party access to the medical record should be initiated by either receipt of correspondence from a solicitor or government agency or by the patient completing a patient request for personal health information form. Where a patient request form and signed authorisation is not obtained the practice is not legally obliged to release.

Where requests for access are refused the patient or third party may seek access under relevant privacy laws.

An organisation 'holds' health information if it is in their possession or control. If you have received reports or other health information from another organisation such as a medical specialists, you are required to provide access in the same manner as for the records you create. If the specialist has

written ‘not to be disclosed to a third party’ or ‘confidentiality’ on their report, this has no legal effect in relation to requests for access under the Health Records Act. You are also required to provide access to records which have been transferred to you from another health service provider.

Requests for access to the medical record and associated financial details may be received from various 3rd parties including:

1. Subpoena / court order / coroner / search warrant
2. Relatives / friends / carers
3. External doctors and health care institutions
4. Police / solicitors
5. Health insurance companies / worker’s compensation / social welfare agencies
6. Employers
7. Government agencies
8. Accounts / debt collection
9. Students (medical and nursing)
10. Research / quality assurance programs
11. Media
12. International
13. Disease registers
14. Telephone calls

We only transfer or release patient information to a third party once the consent to share information has been signed and in specific cases informed patient consent has may be sought. Where possible de-identified information is sent.

Our practice team can describe the procedures for timely, authorised and secure transfer of patient health information in relation to valid requests.

Practice Procedure - 3rd Party Request for Access to Personal Health Information

The practice team can describe how we correctly identify our patients using 3 patient identifiers, name, and date of birth, address or gender to ascertain we have the correct patient record before entering, actioning or releasing anything from that record.

Patient consent for the transfer of health information to other providers or agencies is obtained on the first visit and trained on file in anticipation of when this may be required.

As a rule no patient information is to be released to a 3rd party unless the request I made in writing and provides evidence of a signed authority to release the requested information, to either the patient directly or a third party (where possible de-identified data is released).

Written requests should be noted in the patient’s medical record and also documented in the practice’s request register. Requests should be forwarded to the designated person within the practice for follow-up.

Requested records are to be reviewed by the treating medical practitioner or principal doctor prior to their release to a third party. Where a report or medical record is documented for release to a third party, having satisfied criteria for release (including the patients written consent and where appropriate written authorisation from the treating doctor), then the practice may specify a charge to be incurred by the patient or third party, to meet the cost of time spent preparing the report or photocopying the record.

The practice retains a record of all requests for access to medical information including transfers to other medical practitioners.

Where hard copy medical records are sent to patients or 3rd parties, copies are forwarded not original documentation wherever possible. If originals are required copies are made in case of loss.

Security of any health information requested is maintained when transferring requested records and electronic data transmission of patient health information from our practice is in a secure format.

Subpoena, court order or coroner search warrant

Note the date of the court case and date request received in the medical record. Depending on whether a physical or electronic copy of the record is required follow procedures as described above.

On occasions a member of staff is required to accompany the medical record to court or alternatively a secure courier service may be adequate. If the original is to be transported, ensure a copy is made in case of loss of the original during transport. Ensure that the record is returned after review by the court.

Relatives / Friends

A patient may authorise another person to be given access if they have the legal right and a signed authority.

In 2008 the Australian Law Reform Commission recognised that disclosure of information to 'a person responsible for an individual' can occur within current privacy law. If a situation arises where a carer is seeking access to a patient's health information, practices are encouraged to contact their medical defence organisation for advice before such access is granted.

Individual records are advised for all family members but especially for children whose parents have separated where care must be taken that sensitive demographic information relating to rather partner is not recorded on the demographic sheet. Significant court orders relating to custody and guardianship should be recorded as an alert on the children's records.

External Doctors and Health Care Institutions

Direct the query to the patient's doctor and or the practice manager/principle doctor

Police / Solicitors

Police and solicitors must obtain a case specific signed patient consent (or subpoena, court order or search warrant) for release of information. The request is directed to the doctor.

Health Insurance Companies / Workers Compensation / Social Welfare Agencies

Depending on the specific circumstances information may need to be provided. It is recommended that these requests are referred to the doctor.

It is important that organisations tell individuals what could be done with their personal health information and if it is within the reasonable expectation of the patient then personal health information may be disclosed. Doctors may need to discuss such requests with the patient and perhaps their medical defence organisation.

Employers

If the patient has signed consent to release information for a pre-employment questionnaire or similar report then direct the request to the treating doctor.

Government Agencies

Medicare / Department of Veterans Affairs - depending on the specific circumstances information may need to be provided. It is recommended that doctors discuss such issues with the medical defence organisations.

State Register or Births, Deaths and Marriages – death certificates are usually issued by the treating doctor

Centrelink – There are a large number of Centrelink forms (treating doctor's reports) which are usually completed in conjunction with the patient consultation.

Accounts / Debt Collection

The practice must maintain privacy of patient's financial accounts. Accounts are not stored or left visible in areas where members of the public have unrestricted access.

Accounts must not contain any clinical information. Invoices and statements should be reviewed prior to forwarding to third parties such as insurance companies or debt collection agencies.

Outstanding account queries or disputes should be directed to the practice manager / bookkeeper or principal.

Students (Medical and Nursing)

This practice does not participate in medical / nursing student education. The practice acknowledges that some patients may not wish to have their personal health information accessed for educational purposes. The practice always advises patients of impending student involvement in practice activities and seeks to obtain patient consent accordingly. The practice respects the patient's right to privacy.

Researchers / Quality Assurance Programs

Where the practice seeks to participate in human research activities and/or continuous quality improvement (CQI) activities, patient anonymity will be protected. The practice will also seek and retain a copy of patient consent to any specific data collection for research purposes. Research requests are to be approved by the practice principal, practice partners and must have approval from a Human Research Ethics Committee (HREC) constituted under the NH&MRC guidelines. A copy of this approval will be retained by the practice.

Practice accreditation is a recognised peer review process and the reviewing of medical records for accreditation purposes has been deemed as a 'secondary purpose' by the Office of the Federal Privacy Commissioner. As a consequence patients are not required to provide consent.

Patients should be advised of the ways in which their health information may be used (including for accreditation purposes) via a sign in the waiting room and the practice information brochure.

Media

Please direct all enquiries to the practice manager / principal. Staff must not release any information unless it has been authorised by the practice manager / principal and patient consent has been obtained.

International

Where patient consent is provided then information may be sent overseas however the practice is under no obligation to supply any patient information on receipt of an international subpoena (NPP 9 – Transborder Data Flows).

Disease Registers

This practice submits patient data to various disease specific registers (cervical, breast, bowel screening etc) to assist with preventative health management. Consent is required from the patient with the option of opting in or opting out. Patients are advised of this via a sign in the waiting area and in the practice's information leaflet.

Telephone Calls

Requests for patient information are to be treated with care and no information is to be given out without adherence to the following procedure:

1. Take the telephone number, name and address of the person calling
2. Forward this onto the treating doctor / principal or the practice manager where appropriate.

Practice Policy – Collection and Management of Personal Health Information

Australian Privacy Principle 1 requires our practice to have a document that clearly sets out its policies on handling personal information, including health information.

This document, commonly called a privacy policy, outlines how we handle personal information collected (including health information) and how we protect the security of this information. It must be made available to anyone who asks for it and patients are made aware of this.

The collection statement informs patients about how their health information will be used including other organisations to which the practice usually discloses patient health information and any law that requires the particular information to be collected. Patient consent to the handling and sharing of patient health information should be provided at an early stage in the process of clinical care and patients should be made aware of the collection statement when giving consent to share health information.

In general, quality improvement or clinical audit activities for the purpose of seeking to improve the delivery of a particular treatment or service would be considered a directly related secondary purpose for information use or disclosure so we do not need to seek specific consent for this use of patients' health information, however we include information about quality improvement activities and clinical audits in the practice policy on managing health information.

Practice Procedure – Collection and Management of Personal Health Information

We inform our patients about our practice's policies regarding the collection and management of their personal health information via:

- A sign at reception
- Brochure/s in the waiting area
- Our patient information sheet

- New patient forms – "Consent to share information"
- Verbally if appropriate
- The practice website.

The privacy policy should outline:

- The practice's contact details
- What information is collected
- Why information is collected
- How the practice maintains the security of information held at the practice
- The range of people within the practice team (eg GPs, practice nurses, GP Registrars, students and allied health professionals), who may have access to patient health records and the scope of the access
- The procedures for patients to gain access to their own health information on request
- The way the practice gains patient consent before disclosing their personal health information to third parties
- The process of providing health information to another medical practice should patients request that
- The use of patient health information for quality assurance, research and professional development
- The procedures for informing new patients about privacy arrangements
- The way the practice addresses complaints about privacy related matters
- The practice's policy for retaining patient health records.

A 'collection statement' sets out the following information:

- The identity of the practice and how to contact it
- The fact that patients can access their own health information
- The purpose for which the information is collected
- Other organisations to which the practice usually discloses patient health information
- Any law that requires the particular information to be collected (eg notifiable diseases)
- The main consequence for the individual if important health information is not provided.

Prior to a patient signing consent to the release of their health information patients are made aware they can request a full copy of our privacy policy and collection statement.

Patient consent for the transfer of health information to other providers or agencies is obtained on the first visit. A copy of our consent form is included below. Once signed this form is scanned into the patient's record and its completion noted.

NOTE: Consent for transfer of information differs from procedural consent.

Practice Policy – Transfer of Health Information

Transfer of medical records from this practice can occur in the following instances:

- For medico-legal reasons eg record is subpoenaed to court
- When a patient asks for their medical record to be transferred to another practice, due to moving residence or for other reasons
- Where an individual medical record report is requested from another source
- Where the doctor is retiring and the practice is closing.

Our practice team can describe the procedures for timely, authorised and secure transfer of patient health information to other providers and in relation to valid requests.

Practice Procedure – Transfer of Health Information

Requests for Transfer of Medical Records for Medico-legal Reasons

Refer to 3rd Party requests for access to medical records / health information above.

Receiving a Request to Transfer Medical Records to a Patient's New Clinic

In accordance with state and federal privacy regulations, a request to transfer medical records must be signed by the patient giving us authority to transfer their records.

The request form should contain:

- The name of the receiving practitioner or practice
- The name, address (both current and former if applicable) and date of birth the patient whose record is required
- The reason for the request.

When fulfilling a request, this practice may choose to either:

- Prepare a summary letter (manually or via clinical software) and include copies of relevant correspondence and results pertinent to the ongoing management of the patient
- Make a copy of the medical record and dispatch the copy to the new practice, retaining the original on site for a minimum of 7 years.

The requesting clinic is advised if we propose to transfer a summary or a copy of the full medical record. If they have a preference the format can be negotiated or they can choose not to proceed with the transfer and seek a copy through a separate access request.

If there is going to be any expenses related to the transfer the requesting clinic is advised prior to sending the medical records and once the fee has been paid we process the request as soon as possible. Any charges must not exceed the prescribed maximum fee.

The patient's signed request letter/form and a notation that the patient has transferred is made on the medical record. Include the name and address of the new practice and the dispatch details (eg via priority mail or confidential courier or in an electronic form).

Electronic data transmission of patient health information from our practice is in a secure format.

NOTE: There are a number of ways the information can be transferred, depending on the request from the patient and clinic: via secure post; encrypted email (if computerised records) or, if the practice is releasing copies of the entire record and the patient requests access (Health Records Act), the practice may wish to make an appointment time with the patient to offer an appropriate explanation and counsel from the GP or as an alternative may choose to supply a summary of the history.

All reasonable steps are taken to protect the health information from loss and unauthorised disclosure during the transfer.

This practice does not allow individuals to collect the file and take it to their new provider.

Making a Request for a Patient Medical Record from another Source

Access to a new patient's previous record can assist with maintaining the continuity of care of the patient.

When requesting records from another clinic a standard request for transfer of medical records template (see sample below) should be used.

This should contain:

- The patient's details, the patient should be identified by name, address (both current and former if applicable) and date of birth
- The reason for request including the name of the doctor making the request
- The request for transfer of patient files should be authorised by the patient

If the files will be requested electronically, specific details of the format needs to be included such as HTML or XML.

If the clinic advises you that the patients are likely to incur out of pocket expenses related to transfer, please advise the patient prior to accepting the transferred medical records.

When a doctor is retiring and the practice is closing

The correct process for handling patient health information on the closure of a practice is available in the OFPC Guidelines at www.privacy.gov.au/materials/types/guidelines/view/6517.

The following factsheet may be useful: Transfer / closure of a practice or business of a health service provider http://www.health.vic.gov.au/hsc/infosheets/closure.pdf

NOTE: A health service provider who has a dispute with an organisation in relation to a request to access health information cannot complain on behalf of the patient.

A complaint must be ledged in writing, by the patient with the Health Services Commissioner (HSC). A sample complaint form can be found below. A detailed letter is also required.

Practice Policy – Research

Research activity, both within the practice and through reputable external bodies is encouraged.

Patients consent is essential for involvement in research projects. Whenever any member of our practice team is conducting research involving our patients, we can demonstrate that the research has appropriate approval from an ethics committee. The research protocol, consent procedures and process for resolving problems should be retained by the practice.

Research activities are distinct from audits undertaken by the practice as part of quality improvement activities. Research projects require approval from an Ethics committee but "in house" practice audits do not.

When we collect patient health information for quality improvement audits or professional development activities, we only transfer deidentified patient health information to a third party once informed patient consent has been obtained.

Privacy and confidentiality is particularly important especially when considering involvement in commercial market research activities.

Our practice considers how identifiable their patient information will be using the following:

- Identifiable patient information – by which individual patients can be identified
- De-identified patient information – which cannot be traced back to the individual
- Potentially identifiable information – could possibly be traced back to individuals or groups of individuals

Practice Procedure – Research

Research projects involving patient care

- Must have the explicit and documented written consent of the patient
- The patient must receive a written and oral explanation about the research and be able to withdraw consent at any time
- The project must be approved by a relevant human research ethics committee (HREC) established under the NH&MRC guidelines
- Privacy laws must be adhered to.

Research projects involving research or clinical audits using de-identified data should ideally have patients consent. This can be in more general terms such as by waiting room notice or practice information sheet.

- Extreme care must be taken not to allow patient identification from small and/or unusual cohorts

For QI&CPD activities that require the transfer of patient information outside the practice (eg NPS activities) we need to:

- Ensure the activity complies with relevant guidelines on QI&CPD (issued by an appropriate specialist medical college)
- Ensure the activity is approved by that college
- Retain a copy of the QI&CPD approval for the activity
- Obtain patient consent if transferring identifiable patient information

The practice should retain a record of the request for participation in any research project, including the research protocol, consent procedures and process for resolving problems should be retained by the practice.

Narre Warren Medical Centre Consent Form for the Collection of Personal Health Information

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2 Malcolm Court
Narre Warren
Phone 9704 6812 Fax 9704 0509
admin@nwmc.com.au

Narre Warren Medical Centre

Require your consent to collect person information about you. Please read this consent form carefully, and sign where indicated below.

Narre Warren medical Centre collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals
- Disclosure to other doctors in the practice, locums etc attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will not in your record accordingly
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management, all information in these instances is un-identified. You will be informed when such activities are being conducted and given the opportunity to “opt out” of any involvement

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling Patient Information.

I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of healthcare and treatment given to me.

I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.

Name…… Signed……

Name of Guardian (for child)…….. Signed……..

Date……

NWMC Request for Personal Health Information

Narre Warren Medical Centre
2 Malcolm Court
Narre Warren
Phone 9704 6812 Fax 9704 0509
admin@nwmc.com.au

Patient Details

Family name…….. Given Name/s……..

Address……

Date of Birth ……../……../……..

Applicant if not the patient…… Relationship to patient……

Health Information Requested

☐ Pathology results — Specify date/s ……..
☐ X-ray results — Specify date/s……..
☐ Other test results — Please specify……
☐ A summary of my health record
☐ Health Record - detailed
☐ Current Medications

☐ Correspondence on file
☐ Other, please give details ……..
……
……

How would you like to receive this information?

☐ View and inspect information. I will make a time at reception
☐ View, inspect and discuss contents with my doctor. I will make an appointment at reception
☐ Obtain a copy - collect
☐ Obtain a copy – send via mail
☐ Obtain a copy – via Fax No ……..
☐ Obtain a copy – via Email ……

Note: Privacy requirements allow the doctor in certain circumstances to restrict the release of medical records.

Charging policy – fees may be charged for access. Please request information about your charging policy.

Signature of Applicant…… Date ……/……/……

Office Use Only – Staff to Initial and Date Each Entry

☐ Date request received ……/……/……. ☐ Acknowledgement Date ……/……/……..
☐ Identification verified known to staff / license / passport / other ……..
☐ Appointment made with doctor ☐ Yes ☐ No Date ……/……/……. Time :
☐ Patient to collect? Expected Date ……/……/…….
☐ Doctor advised prior to release ☐ Noted in patient record
☐ Record checked and ready for patient ☐ Data removed / deleted ☐ Yes ☐ No
☐ Method of access: view / view & Dr / copy & collect / copy & send ……..
☐ Fees Charged ☐ Yes ☐ No Amount $..... (exclude GST) Fees Received $ ……..
☐ Access process completed (record viewed / sent) Date ……/……/…….

Request for Medical Records Transfer

Narre Warren Medical Centre
2 Malcolm Court
Narre Warren
Phone 9704 6812 Fax 9704 0509
admin@nwmc.com.au

Date ……/……/…….

Dear Dr……..,

Practice Details……..

Patients Full
Name……DOB……/……/……..

Other Family Members (if under 18 years of age)

Patient Full Name…….. DOB ……/……/……..

Address……..

Patient Full Name…….. DOB ……/……/……..

Address……..

Patient Full Name…….. DOB ……/……/……..

Address……..

The above mentioned now attends this practice. To assist in their future medical management would you please kindly forward (tick option):

☐ Their clinical records

☐ An accurate health summary, with relevant correspondence and results

☐ Details of any CDM or PIP items claimed within the last 2 years (GPMP)

These records can be forwarded by mail, fax, encrypted email (PKI), non-rewriteable CD. Electronic version should be ☐ HTML ☐ XML

Yours Sincerely,

Doctor ……(Name of GP)

Patient's Signed Authority

I, ……..(Patients full name)

Of ……
(Patients current address and date of birth)

Formerly of …….
(Patients former address if applicable)

Authorise the release of my / my families medical records to the forwarded to <Insert Clinic Name>

Signed …….. Date ……/……/…….