Fact Sheet

Ownership of personal health information

What is personal health information?

The Royal Australian College of General Practitioners (RACGP) and the Committee of Presidents of Medical Colleges defines personal health information as:

- Information about a patient or a third party obtained by a health service provider from a patient or a third party in the course of providing a health service; or
- An opinion formed by a health service provider about a patient (whether true or not) which is in a form whereby the identity of the person is apparent, or can reasonably be ascertained (1).

This includes information on the person’s:

- Name, address and contact details
- Medical history
- Medicare number
- Social circumstances
- Health services requested or provided
- Expressed wishes about the future provision of health services.

Active and inactive patients

The RACGP definition of active and inactive patients is as follows:

‘An inactive patient health record is generally considered to be the record of a patient who has not attended the practice three or more times in the past two years’ (2)

Retention of personal health information

Private medical practice

There is currently no legislation in Western Australia mandating the retention or destruction of private medical practice health information.

However, it is essential for medical practitioners to collect, use and disclose personal health information in accordance with the National Privacy Act 1988 (3).

Victoria (4), New South Wales (5) and the Australian Capital Territory (6) legislation requires health information collected from adults be retained for 7 years after their last health service. Health information collected from children (i.e. under 18 years of age) should to be retained until they reach 25 years of age or for 7 years after their last health service whichever is the later.

This standard is also recognised nationally by the RACGP Standards for General Practice (2) and can also be applied to the retention and destruction of radiology x-ray films.

State health facilities

Under the Western Australian State Records Act 2000 (7) (the Act), health records of discharged patients and outpatients from acute hospitals are generally allowed to be disposed of 15 years after the date of last attendance or last access (provided the patient has reached the age of 25 years). The medical records of any patient treated in a state health facility for psychiatric illness are to be retained for a minimum of seven years following death (8).

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**Personally Controlled Electronic Health Record**

The introduction of the Personally Controlled Electronic Health Record (PCEHR) does not reduce the responsibility of a medical practitioner to maintain their usual standard of clinical records in accordance with relevant best practice, national and state legislation.

A medical practitioner will require authority from a patient or carer to update a PCEHR personal health summary and the information to include should be discussed at the time of consultation.

**Ownership of medical records**

In general, the medical practitioner who creates a health record owns that record. However under the National Privacy Act, (3) a patient or carer may have rights to access the record.

It is important to note that ownership and access rights are separate. There are also circumstances where a medical practitioner can refuse access to medical records under National Privacy Principle 6. When providing access to medical records, the Federal Privacy Commissioner considers that “access should be given in the form requested by the individual, such as a copy or an accurate summary” (9).

**If your practice is closing due to the relocation or retirement of the practice principal(s) – what happens to the medical records?**

If the practice is bought out or taken over by another medical practitioner or entity then ideally the medical records will remain with the practice.

If the practice is closing its doors permanently, ownership and storage of the medical records remains the responsibility of the medical practitioner. In this case medical records should be securely stored yet accessible in a reputable archival facility.

Patients should be advised and given sufficient time to make arrangements for the transfer of medical records to another medical practitioner in the same field of practice.

If you have chronic or high care patients, detailed arrangements may be required for the handover of their health management.

It is also a good idea to advise relevant stakeholders in your patient care such as pathology and radiology providers, specialists and allied health professionals.

**Other recommendations**

- When deleting or disposing of health information, keep a record of the patient’s name, the period of which the records relate and the date of deletion or disposal
- When transferring health information to another organisation keep a record of the date, contents, name and address of the organisation to whom it was transferred
- If records are held in electronic form, i.e. a medical report scanned to a patient health record, it must remain able to be reprinted on paper so as to be useable for subsequent reference

**More information**

- Rural Health West Fact Sheet: National Privacy Act
- Health Information Policy Consultant
- Information Management and Reporting Department of Health, Western Australia Telephone: (08) 9222 4228

Contact your medical indemnity organisation:

- AVANT – Telephone 1800 128 268
- INVIVO – Telephone 1800 103 779
- MDA – Telephone 1800 011 255
- MIGA – Telephone 1800 777 156
- MIPS – Telephone 1800 061 113
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