



Retention and Destruction of Medical Records

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.

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

Ownership of medical records

In general, the medical practitioner who creates a health record owns that record. However, under the National Privacy Act, a patient or guardian 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'.

Retention and storage of personal health information

It is essential that medical practitioners collect, use and disclose personal health information in accordance with the National Privacy Act 1988 and the associated Australian Privacy Principles. In addition, personal information must be kept and stored securely, until otherwise destroyed.

In the Handbook for the management of health information in general practice: 2nd edition, the RACGP recommends that records for both active and inactive patients be retained indefinitely or as stipulated by the relevant national, state or territory legislation.

An active patient is defined as one who has attended the practice three or more times in the previous two years.

Electronic health records

The introduction of the My Health Record (ehealth record) 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 guardian to upload an electronic health record with shared health summaries and what information to include should be discussed at the time of the consultation.

Whilst all care has been taken in preparing this document, this information is a guide only and subject to change without notice.

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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, ie, a medical report scanned to a patient health record, it must remain able to be reprinted on paper to be useable for subsequent reference.

Other considerations

When a 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 stored securely yet accessible in a reputable archival facility.

Patients should be advised and given sufficient time to plan 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.

When can we dispose of medical records?

There is currently no legislation in Western Australia mandating the retention or destruction of private medical practice health information, however, in general, the RACGP recommendations are in line with legislation held in Victoria, New South Wales and the Australian Capital Territory which requires health information collected from adults to be retained for seven years after their last health service, and health information collected from children (under 18 years of age) should to be retained until they reach 25 years of age, or for seven years after their last health service, whichever is the later.

Under the Western Australian State Records Act 2000, health records of discharged patients and outpatients from state run 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 a psychiatric illness are to be retained for a minimum of seven years following death, and records pertaining to Aboriginal patients must be retained indefinitely for patients with a date of birth prior to and including 1970. Additionally, all remote clinic patient records from the Kimberley or Pilbara Health Regions must be retained indefinitely due to their complex nature and sensitivity.

More information

Practice Assist Fact Sheet: National Privacy Principles

www.practiceassist.com.au

Western Australian State Records Act 2000

https://www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtitle_924_homepage.html

Western Australian Department of Health

Patient Information Retention and Disposal Schedule, Version 4.

<http://www.health.wa.gov.au/circularsnew/pdfs/13308.pdf>

Royal Australian College of General Practitioners

The Handbook for the Management of Health Information in Private Medical Practice (2nd edition)

<http://library.racgp.org.au/amlibweb/images/Handbook%20for%20the%20management%20of%20health%20information%20in%20general%20practice%20-%20July%202012.pdf>

Royal Australian College of General Practitioners

RACGP Standards for general practice (4th edition)

<http://www.racgp.org.au/your-practice/standards/standards4thedition/>

Commonwealth Government of Australia. Privacy Act. 1988.

http://www.austlii.edu.au/au/legis/cth/consol_act/pa1988108

Victorian State Government. Health Records Act 2001.

[http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/LTObject_Store/LTObjSt6.nsf/DDE300B846EED9C7CA257616000A3571/77FAA53ECD C0DA44CA2579030015D701/\\$FILE/01-2aa023%20authorised.pdf](http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/LTObject_Store/LTObjSt6.nsf/DDE300B846EED9C7CA257616000A3571/77FAA53ECD C0DA44CA2579030015D701/$FILE/01-2aa023%20authorised.pdf)

New South Wales State Government. Health Records and Information Privacy Act 2002.

<http://www.legislation.nsw.gov.au/fullhtml/inforce/act+71+2002+FIRST+0+N#pt.4-div.2-sec.25>