



Managing patient records

Introduction

Patient records reflect a doctor's reasoning and are an important source of information about a patient's care.

Patient records are a crucial part of medical practice. They help ensure good care of patients and clear communication between doctors and other health practitioners.

Health information is confidential and sensitive. This statement refers to the Health Information Privacy Code 2020,¹ which sets out how health information, including patient records, should be handled. Health agencies (including doctors)² must comply with the 13 rules of the Code.

This statement also sets out the legal requirements for maintaining, storing and destroying patient records. It applies to any patient records you make whether that is on paper or electronically.

Maintaining clear and accurate patient records³

- 1 You must maintain clear and accurate patient records that note:
 - a clinical history including allergies
 - b relevant clinical findings
 - c results of tests and investigations ordered
 - d information given to, and options discussed with, patients (and their family or whānau⁴ where appropriate)
 - e decisions made and the reasons for them
 - f consent given⁵
 - g requests or concerns discussed during the consultation
 - h the proposed management plan including any follow-up
 - i medication or treatment prescribed including adverse reactions.
- 2 It is good practice to record information that may be relevant during the patient's health-care journey. Relevant information could include their next of kin, donor status, and whether the patient has a disability, health passport,⁶ advance care plan, or an enduring power of attorney.

¹ The Health Information Privacy Code 2020 is a regulation under the Privacy Act 2020. The 13 rules of the Code are consistent with the Privacy Act.

² Refer to clause 3(1) of the Health Information Privacy Code for a full definition of 'health agency'.

³ Refer to *Good medical practice. Cole's medical practice in New Zealand* contains further guidance on record management and patient access to information.

⁴ Whānau refers to the extended family and family group.

⁵ See Right 7(6) of the Code of Health and Disability Services Consumers' Rights which outlines several instances where the patient's consent must be in writing.

⁶ A Health Passport is a booklet the patient brings to hospital or when they use a health or disability service. It is intended to guide health and disability providers on communicating with and supporting the patient. See the Ministry of Health's website (<https://www.health.govt.nz/your-health/services-and-support/health-care-services/health-passport>) for more information.

- 3 Records must be completed at the time of the events you are recording, or as soon as possible afterwards.
- 4 Your record about the patient must be accurate and respectful. Consider the impact on the patient when they read what is written about them.
- 5 Your records must be easy to understand and sufficient for other doctors and health practitioners to follow up.
- 6 If you need to correct or add notes to your patient's records sometime after an event, these must be clearly identified as corrections or additions. The notes must be initialled or signed, and accurately dated as to when the changes were made. The earlier entry must not be changed or deleted as that might raise suspicion about covering up an error in treatment or diagnosis.

Audio or video recording of clinical consultations with patients

- 7 The Health Information Privacy Code applies to information about a patient that a doctor records in writing, and by audio or video recording. If you record a clinical interaction using audio or video recording, check that your patient agrees to that form of recording, and that your actions comply with the Health Information Privacy Code. This includes telling patients that information about them is being recorded by audio or video recording, and that they can request a copy of the recording.⁷
- 8 The principles in the Health Information Privacy Code do not apply where it is the patient who asks to make an audio or video recording of the patient's own consultation. If your workplace has a policy on patients recording their consultations, you should highlight this to your patient. If you are concerned that your patient's recording will have a negative effect on the consultation, you should explain this to the patient and consider asking them to see another doctor.⁸

When a patient is referred for a test or to another doctor or health provider

- 9 Sometimes, you may need to refer your patient to another doctor or health provider, or to request a test or investigation. This information must be documented in your patient's records. We recommend that you use a system for recalling patients who need regular checks, investigations, or treatment.

If you are a doctor making a referral or request

- 10 You should have systems in place to follow up:
 - a test results promptly including informing the patient about the results
 - b referrals that are not actioned, or if there is an unreasonable delay for the patient to see the health provider you have referred them to.

If you are a doctor receiving a referral or request

- 11 You should have systems in place to:
 - a acknowledge that you have received referrals
 - b process referrals within a reasonable timeframe
 - c communicate with the referring doctor about the referral.⁹

⁷ The New Zealand Medical Association and New Zealand Private Surgical Hospitals Association have issued a guide on key ethical and legal issues to be aware of before using a personal mobile device to take or transmit clinical images of patients. See *Clinical images and the use of personal mobile devices: A guide for medical students and doctors* for more information.

⁸ See also the statement on *Non-treating doctors performing medical assessments of patients for third parties*.

⁹ See also the statement on *Safe practice in an environment of resource limitation* that discusses assessing referrals and assigning priority to patients.

Guidance on handling a patient's records

- 12 As a doctor, you are responsible for what you record about your patient. If you are in sole practice, you maintain and hold the clinical records about your patients. If you work for a health agency, they hold the clinical records.

When a patient requests their records

- 13 Legally, patients can request access to any health information that a doctor or another health agency holds about them because the information concerns the patient.¹⁰
- 14 There is no prescribed format for requesting access to clinical records. Encouraging patients to put their request in writing creates a record of the request. It also helps the health agency receiving the request to know what information the patient is seeking.
- 15 Access to or transfer of patient records cannot be refused because of conflicting commercial interests or because the patient owes the practice money.¹¹
- 16 A patient or representative of the patient¹² can only be charged for copies of their records if they have requested the same information within the past year. Exceptions to this rule¹³ include video recordings, and radiography imaging such as X-rays, CT, PET, and MRI scans.
- 17 Before providing information to the requester, you must be satisfied with their identity, and that they are entitled to the information requested.¹⁴
- 18 Message services and emails are not always secure. When sending information to patients, ask them how they would like to receive their information.

When patient records are transferred

- 19 Patients' records should be transferred by secure electronic systems or by registered mail. These secure methods create an audit trail so that the records can be tracked if they go missing.
- 20 We recommend that doctors keep a copy or summary of the patient records that are transferred.

How long patient records should be retained

- 21 Doctors in private practice:
- Must retain health information for a minimum of 10 years and 1 day from the date of the last consultation with the patient.¹⁵
 - Should consider retaining the records for longer than the minimum 10-year and 1-day period in some situations. Examples include children with significant health problems, or patients with long-term medical conditions.
- 22 Doctors working in District Health Boards
- Under the Public Records Act 2005, most records held by government agencies, including patient records held by DHBs, are public records. These records may not be disposed of without the Chief Archivist's authorisation. DHBs should contact Archives New Zealand for authority to dispose of records that are more than 25 years old.¹⁶

¹⁰ See Rule 6 of the Health Information Privacy Code (Access to personal health information). Note that Rule 6 is subject to Part 4 of the Privacy Act 2020 (Access to and correction of personal information).

¹¹ Section 22F of the Health Act 1956.

¹² 'Representative' is defined in Part 3(1) of the Health Information Privacy Code 2020. It includes a parent or guardian of a child under the age of 16 years, an executor or administrator of a deceased individual's estate, or the person who has an activated enduring power of attorney for the individual or someone acting in the individual's best interests.

¹³ Part 3(6) Health Information Privacy Code 2020.

¹⁴ See Part 4 of the Privacy Act 2020 on access to and correction of personal information.

¹⁵ Clause 5 of Health (Retention of Health Information) Regulations 1996.

¹⁶ Section 21 of the Public Records Act 2005.

How patient records should be stored

23 Patient records should be stored securely and away from public areas. They should be easy to retrieve when there are requests for copies.¹⁷ Computer files must be protected by password and have backups in case of technical difficulties. You should access patient records only when there is an appropriate reason, for example, if that patient is under your care.

When patient records are destroyed

24 Patient records must be destroyed in a way that preserves the patient's privacy. Burning or shredding records is acceptable. You can also contract a document destruction company to securely destroy the records.

Leaving a practice or planning for retirement

25 Well before you leave a practice or retire from it, you should:

- a arrange with another doctor to accept responsibility for your patients' records (for example, through a power of attorney)
- b let your patients know if they need to collect their records from the practice
- c inform the practitioners who have referred patients to you (if you are a specialist in private practice).

26 If you are leaving a group practice, you need to discuss and agree within the practice how your patients' records will be managed.

27 When a patient dies, a doctor may transfer the patient's records to the personal representative of the deceased.¹⁸

28 Where a doctor dies without making any arrangements about their patients' records, the doctor's executor or power of attorney should return the records to the patient (or the patient's family if the patient is dead), or to another doctor.

29 If you work for a District Health Board or a Primary Health Organisation, refer to your workplace's policy for guidance on how patient records should be dealt with before you leave.

This statement was updated in December 2020. It replaces the August 2008 statement on *The maintenance and retention of patient records*. It is scheduled for another review in December 2025. Any changes to the law before our next review date may make parts of this statement obsolete.

¹⁷ See Rule 5: Storage and security of the Health Information Privacy Code 2020 for more information.

¹⁸ Clause 6(2)(c) of Health (Retention of Health Information) Regulations 1996.
