Managing Patient Records & Confidentiality

Reading time:
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I've had a request to provide a patient's records.

This question has a varied response based on your state. Generally speaking patients have a right under Commonwealth or State/Territory legislation to request access to their health records, or can authorise others to receive them on their behalf (for example, lawyers, and insurance companies).

Access to medical record requests should be done in writing, signed and dated by the patient. There are some limited circumstance in which health records can be withheld from patients, if you are unsure about disclosure we recommend contacting MIPS for advice

When should I not disclose information?

You should not disclose health information from a deceased patient's medical records if you know the patient would have objected to the disclosure when he/she was alive. Such objection should have been noted in the medical records. It may not be that the patient has explicitly stated it but if you form a reasonable belief that the deceased would have objected to the disclosure, this is sufficient to refuse disclosure.

I need to prepare a death certificate

The death certificate is a legal document, and one that you need to ensure you are the appropriate person to sign before doing so eg a Dr responsible for the patient's care immediately prior to death or one who saw the deceased after the death.

Only sign the death certificate if the cause of death is known and the death is not reportable to the Coroner. Whilst it is not legally necessary to view the deceased, it is advised to do so prior to signing the death certificate

When is the death reportable to the Coroner? The legislation on this differs between states, the following are general inclusions:

- If the deceased person was a child or person in care or custody
- Follwing an accident that contributed to the death
- Any violent or unnatural death
- Any sudden death of unknown cause
- A death under suspicious or unusual circumstances
- When the deceased had not been seen by a Doctor recently
- During or following an anaesthetic and / or a medical procedure

If a healthcare practitioner has died, who can provide authority to release medical records?

If a doctor of other healthcare practitioner is deceased, his/her estate may still receive a request from a patient to release medical records. In these situations, the authority rests with the Executor or Administrator of the deceased doctor's Estate. A power of attorney does not have authority to release the records because a power of attorney is no longer valid after a person dies.

If a patient has died, who can provide authority to release medical records?

If a patient dies you must still maintain their healthcare records. The person authorised to access the deceased patient's medical records is the executor or administrator of the deceased patient's estate. A power of attorney does not have the authority to request/release the deceased patient's records because a power of attorney is no longer valid after a person dies.

You should always sight the will or the grant of probate (if available) and ascertain the identity of the person before releasing the

information. Always attach a copy of the relevant documentation to the medical records of the patient.

What if a relative of the deceased patient requests medical records?

It depends on the purpose of the request. Doctors may be able to disclose limited information to immediate family members for compassionate reasons.

It is important to be cautious about releasing information where there may be disputes amongst family members.

How do I destroy patient records?

Having maintained the patient records as defined by the practice state (as general guideline consider maintaining adult records for seven years from last provision of health care and children until the child is 25), records should be destroyed securely. Paper based records may be scanned into a computer based system and destroyed within this timeframe.

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