



**Queensland
Government**
Queensland **Health**

Health Information: Disclosure and Access Policy

Further details concerning the interpretation and application of the policy principles discussed in this document are available in the accompanying
Health Information: Disclosure and Access Guidelines

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Health Information: Disclosure and Access Guidelines

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FOREWORD

As a matter of policy, Queensland Health supports the right of an individual to see what information is held about him or her by a Queensland public sector health facility. It is also recognised that confidentiality of health records is paramount, and that all Queensland Health employees are under legal and ethical obligations to maintain the confidentiality of patients' health information.

In 1990, in anticipation of the enactment of Queensland's *Freedom of Information Act 1992* (the FOI Act), Queensland Health determined that it would be appropriate to establish a mechanism whereby individuals could request access to their own health records without the necessity of utilising the formal processes of the FOI Act. Queensland Health subsequently implemented an "Administrative Access to Health Records Policy", which set out the framework for individuals seeking access to their own health records, and circumstances in which patient-identifying information could be disclosed to third parties, either with or without the consent of the individual concerned.

This policy is a restatement and updating of the general principles set out in that original policy, and is consistent with the principles of the FOI Act and of Information Standard 42A "Information Privacy for the Queensland Department of Health". It is intended to assist and ensure consistency in the access to and management of health information across Queensland Health's health service districts.

The policy recognises that an individual seeking access to their own health records should, in most cases, be given such access through an informal, administrative release process. It also recognises, however, that there are certain circumstances in which health records will not be appropriate for administrative release, and that applications for such records should instead be processed under the FOI Act.

The policy also recognises that as a general rule, and subject to circumstances outlined in this policy, no information concerning a patient should be released to another person without the consent of the patient. Access in such circumstances should be provided strictly in accordance with the duty of confidentiality that the relevant provisions of the *Health Services Act 1991*, and other confidentiality provisions in health legislation impose on all Queensland Health employees, as well as the privacy principles set out in Information Standard No 42A.

Administrative access applications must be in writing and forwarded to the office of the Medical Superintendent of the hospital or senior health professional of any other health service where the record is held. Where access is provided to an individual's own health record under this policy, the individual is to be provided with full access to the requested record (or requested part thereof).

I am pleased to endorse the revised Health Information: Disclosure and Access Policy. I encourage all staff to practice within these policy principles.

DR STEVE BUCKLAND
Director-General

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1. INTRODUCTION

1.1 OUTLINE

This policy is presented in three sections:

Section 1 provides the general principles for the policy, including definitions, scope and confidentiality issues.

Section 2 (Administrative access) deals with applications to access health records made by:

- the patient to whom the records relate; or
- a third party **acting on behalf of the patient**, and with the patient's valid written consent to such access.

Section 3 (Other disclosure/access mechanisms) deals with other mechanisms for access to health records, or disclosure of patient-related information held by Queensland Health.

The accompanying **Health Information: Disclosure and Access Guidelines** are intended to provide assistance in interpreting and applying this policy.

1.2 DEFINITIONS

In this policy–

"health facility" includes any Queensland hospital or other facility which provides a public sector health service.

"health information", in relation to a patient, includes clinical information about that patient held in any material form by a health facility. This includes health records, or information contained in health records, of both public and private patients who are receiving, or have received, a public sector health service.

"medical practitioner" means a doctor, (registered under the *Medical Practitioners Registration Act 2001*).

"patient" may be interchanged with "client" as appropriate, and includes any person who is receiving or has received a public sector health service from a health facility.

"personal information" means information which relates to the private aspects of an individual's life, and which is held by a public body on the understanding that it would be treated as confidential.

"public interest" means something that is of serious concern or benefit to the public not merely of individual interest.

"senior health professional" means the Medical Superintendent or other supervising senior health care provider, where appropriate.

"treating health care provider" means the person in charge of a patient's care, including:–

- a medical practitioner; or
- other health care provider, where appropriate.

1.3 SCOPE

Who is bound by the policy?

The policy applies to all permanent, temporary, full time, part time and casual staff of Queensland Health

What information does the policy cover?

The policy covers health information about individuals who are receiving, or have received, public sector health services. It applies regardless of the format of the information (i.e., electronic as well as paper-based records).

What is not covered?

As indicated above, the scope of the policy is limited to health information about identifiable individuals. It does not cover, for example:

- information that is not identifiable, or potentially identifiable, such as statistical or aggregated data
- staff, personnel or payroll records.

1.4 CONFIDENTIALITY AND SECURITY

Health records held by health facilities are the property of the department, and must be kept under adequate security to ensure their confidentiality is maintained.

Health records, or identifying information concerning a patient, must be handled at all times in accordance with relevant legal and policy requirements, such as:

- **statutory confidentiality obligations** under health legislation (eg. *Health Services Act 1991* and *Health Act 1937*)
- **Queensland Health's:**
 - Information Security Policy
 - Information Security Standards
 - Code of Conduct 2000.
- **Queensland Government's:**
 - Information Standard 18: Information Security
 - Information Standard 42A: Information Privacy for the Queensland Department of Health
 - Information Standard 42A: Information Privacy Guidelines

Health records should only be removed from the agency in response to:

- a judicial process (eg. court subpoena; search warrant; coronial summons);
- a valid request from an individual or body having specific statutory authority to require production of such records (see **Section 3**).
- approval by the senior health professional, where the records are to accompany a patient transferred from one health facility to another.

When the original of a health facility's health record leaves the premises, a copy of the record should, where possible, be made beforehand and kept in the relevant health facility.

Faxing or e-mailing health information

The transmission of patient information by facsimile or e-mail is a "disclosure" for the purposes of the statutory obligation of confidentiality that is imposed on all officers, employees and agents of Queensland Health by relevant sections of the *Health Services Act 1991*.

Such disclosure should only be made where it can properly be done without breaching the strict duty of confidentiality (i.e., the situation comes within one of the specific exceptions listed in the relevant sections of the *Health Services Act 1991*).

Facsimile transmission of a patient's health information should only be used where:

- the information is required to facilitate the patient's further treatment; and
- approval has been given by the treating practitioner or appropriate senior manager.

Patient information that is being faxed should **not** be de-identified. Although intended to protect patient privacy, de-identification carries significant risks which may compromise patient care if the intended recipient cannot safely identify the individual to whom the de-identified information relates.

When transmitting patient information by fax appropriate safeguards must be established to ensure that the information is protected from unauthorised, inappropriate or unnecessary access.

Patient information sent or received by facsimile forms part of the public record and must be managed accordingly.

E-mail transmission of patient identifying information over public networks (i.e. internet email) is prohibited unless appropriate encryption processes are in place. (see Queensland Health's **Information Security Standard 6: Operational Security Management**).

1.5 AMENDING HEALTH INFORMATION

Administrative (informal) correction

While the FOI Act provides a formal mechanism for seeking correction of an individual's personal information held by Queensland government (see below), that does not preclude the amendment of health information administratively, where appropriate.

For example, personal data (eg. incorrect date of birth, address details etc) may simply be replaced with the correct data upon verification with the patient. However, except for such readily verifiable information, the contents of a patient's clinical record (eg. progress notes) **should be amended by notation only**.

Formal application under the FOI Act

Under Part 4 of the FOI Act, an individual who has had access to a record (whether administratively or under the FOI Act), has the right to apply for amendment of information in the record that relates to the individual's personal affairs (or the personal affairs of a deceased person to whom the individual is next of kin).

Amendment may be sought on the basis that information is "inaccurate, incomplete, out-of-date or misleading". The applicant must explain why they believe the information in question satisfies one or more of those requirements, and must specify the amendments they want made.

If a patient wishes to make an FOI application for amendment of their health information, assistance should be offered to the patient to indicate the records they wish to amend and the reasons for seeking amendment. The amendment application should then be forwarded to the relevant FOI decision-maker **within 2 working days** of receipt.

Destruction / disposal of health records

As specified in the FOI Act, the methods of amending information include alteration or addition of notations. Destruction or disposal of records is not contemplated as a method of amendment, and may only be done in accordance with the *Public Records Act 2002* and relevant Queensland Health record retention and disposal policies and guidelines. (See Queensland Health's **Retention, Storage and Disposal of Clinical Records Policy Statement** and the related **Disposal and Retention Schedule for Clinical Records**).

2. ADMINISTRATIVE ACCESS TO HEALTH RECORDS

(application by a patient or by a third party with the patient's written consent)

2.1 INTRODUCTION

As a matter of policy, Queensland Health supports the right of patients to see what information is held about them by a health facility. Generally, access to an individual's own health record should be provided administratively. The exceptions to this policy are discussed below (see **Section 2.5**).

Access to health records is to be provided strictly in accordance with relevant legal and policy confidentiality and privacy requirements (see **Section 1.4**).

2.2 FORM & CONTENT OF APPLICATION

An application by a patient for administrative access to their health record must be in writing and should be forwarded to the office of the health facility's senior health professional.

While the use of an application form is not mandatory, a suggested form is included which may help applicants set out relevant details of the records sought, and assist staff in locating such records (see **Appendix 1**).

The following information will assist in locating relevant records:-

- the patient's full name and date of birth
- the patient's present address and, if different, address at the time of the public sector health service in question
- the date, place and nature of the public sector health service to which the requested health records relate
- the patient's contact details, in case clarification or more information is needed.

2.3 THIRD PARTY APPLICATIONS

Patient's written consent is required

Where possible, patients should be encouraged to apply personally for their health record. This will improve the therapeutic relationship between the patient and the treating health professional. However, a patient may give consent **in writing** for a third party, who is acting on the patient's behalf, to have access to the patient's health information.

The third party to whom a patient gives such consent may include, but is not limited to, a relative, interpreter, medical practitioner or a legal representative.

A patient's consent to access by a third party must be in writing, an **original** (not a photocopy or facsimile), be signed and dated by the patient, and specify the information that the patient consents to being released to the third party. To ensure that a consent represents the patient's current wishes in relation to the content of their health record, it should be **recent (no more than six (6) months old)**.

If there is any uncertainty about the validity, or scope, of a patient's written consent to release of their health information to a third party, the patient should be contacted to verify their agreement to such release. In some cases, it may be appropriate to query requests by third parties for "a complete copy", "all notes and records" or other similar broad, non-specific requests, pending receipt of details of the specific information required, and confirmation of the patient's consent to the release of such information to the third party.

Access by patient's insurer

Where a request for information relates to an insurance application or claim, it must be accompanied by a photocopy of the insurance application or claim form and an original, recent signed patient consent that authorises the release of relevant health information.

If the insured person whose information is sought is deceased (and thus no patient consent can be obtained), the access request should be referred for processing under the FOI Act.

Access by patient's lawyer

As with any other third party, legal practitioners who seek access to records on behalf of a client must provide their client's written authority for the release of records. It is not sufficient authority to rely on a letter from the lawyer saying that they are acting on behalf of their client. While it is acknowledged that a lawyer acting on a client's instructions is the agent of the client, the confidentiality provisions in the *Health Services Act 1991* clearly indicate that the "consent exception" which permits disclosure of information only applies where the consent of the person to whom the information relates has been obtained.

Medical reports (as an alternative to access)

Where a solicitor or other third party, acting with a patient's written consent, requests access to the patient's health information, the option of a medical report summarising the relevant health information may be offered (where appropriate). Normal fees for such reports would apply (see **Section 2.7**).

2.4 PROCESSING THE APPLICATION

Delegated responsibility

The senior health professional of the health facility may delegate responsibility for processing administrative access applications to the treating health care provider or other appropriate officer.

Where possible, the treating health care provider should be involved in processing such applications to ensure that only information relevant to the application is released. Consultation with the patient is encouraged, particularly to aid in identifying the actual documents to which access is sought or to narrow the field of inquiry (for example, to a particular admission if possible).

If the treating health care provider is not processing the application, he/she should (where possible) be advised that an application has been received, and informed which officer has been assigned to process the application.

Checking the record

The officer processing the application should retrieve and examine the requested record **within 2 working days** of receiving the application, to determine whether administrative access can appropriately be given.

In examining the record, the responsible officer must have regard to the exceptions to this policy (see **Section 2.5**). If any doubt exists about release of the record, or part of the record, the officer should consult with the relevant FOI decision-maker **no later than 3 working days** after receipt of the application.

If an administrative access application is to be referred for processing under the FOI Act, it must be forwarded to the FOI decision-maker **within 5 working days** of receipt. This short time-frame is necessary because of the statutory time limits imposed by the FOI Act for determining applications.

2.5 EXCEPTIONS TO ADMINISTRATIVE ACCESS

NOTE: The matters discussed below are applicable to administrative access applications only. They cannot be relied upon as grounds for refusing to provide access to information under any of the mechanisms discussed in **Section 3** of this policy.

Birth-related information sought by an adopted person

Any application by an adopted person, seeking birth-related information contained within health records held by Queensland Health facilities, must be processed under the FOI Act.

Children's health records

Queensland Health recognises that children have a right to privacy in relation to information about their health care which should be respected in the same way as any other individual.

Children can apply for access to their own health records, or can give written consent to a third party having access to their health records, provided they have attained a sufficient level of intelligence and maturity to understand the nature of the application, and the implications of giving or refusing consent to the release of their health records.

Third parties may also seek the release of children's health records, without the child's written consent, under specific statutory schemes (eg. under the *Personal Injuries Proceedings Act 2002*) that authorise the third party to act in a representative capacity on behalf of a child, or which authorise the third party to consent, on a child's behalf, to the release of the child's health information. Such situations, and the specific requirements for their application, are discussed in **Section 3** of this policy.

Apart from the specific circumstances of such statutory schemes, all other applications for access to children's health records must be processed under the FOI Act, in accordance with guidelines issued by the Legal and Administrative Law Unit, Corporate Office. This process permits appropriate consideration of the specific content of the record in issue, and whether the application is being made in the child's best interests, or for some other reason.

Deceased persons' health records

Applications for access to deceased persons' health records cannot be processed under administrative access (**Section 2** of this policy).

Given the sensitivity of information contained in health records, and the inability to consult with the deceased patient, **all** applications for access to deceased persons' health records (except those validly made under specific statutory authority, as discussed in **Section 3** of this policy), **must** be processed under the FOI Act. This process facilitates detailed consideration of the health record and appropriate public interest arguments for and against release.

The situations in which third parties may be able to obtain access to deceased persons' health records without making an FOI application are limited to those where disclosure is required or permitted under various statutory mechanisms that apply in specified circumstances (eg. subpoenas, Centrelink or WorkCover investigations, PIPA claims). Such situations are discussed in **Section 3** of this policy and the accompanying **Health Information: Disclosure and Access Guidelines**.

Information subject to special confidentiality & disclosure requirements

Administrative access does not apply to health information that is subject to specific statutory confidentiality requirements and mechanisms for disclosure. Such information can only be disclosed in accordance with the relevant legislation:

Eg: **Queensland Cancer Register**
Health Act 1937 (Part 3, Division 10)

Pap Smear Register
Health Act 1937 (Part 3, Division 11)

Disease Test Orders
Police Powers and Responsibilities Act 2000
(Chapter 8B)

(*see: **Guidelines for Blood and Urine Testing on the Alleged Perpetrator of an Assault**, which deal with all aspects of Queensland Health's involvement in the process, including the disclosure of results of analysis).

If access to information sought cannot be provided by persons authorised to deal with such matters under the relevant statutory scheme, then the request should be referred to the delegated FOI decision-maker for processing under FOI, and the applicant should be notified accordingly.

Information concerning controlled and restricted drugs

Unless validly made under specific statutory authority, as discussed in **Section 3** of this policy, requests for access to documents that contain information concerning the enforcement of the statutory regime for the prescribing, dispensing and use of controlled and restricted drugs under the *Health (Drugs and Poisons) Regulation 1996* whether or not held by the Drugs of Dependence Unit, **must** be processed under the FOI Act by the Legal and Administrative Law Unit, Corporate Office except in a number of limited circumstances. Contact the Legal and Administrative Law Unit for further details of such circumstances.

NOTE: This exception is not intended to apply to records that simply record the administration of controlled and restricted drugs as part of an individual patient's treatment. It is intended to apply to records containing details of the investigative methods used in ensuring compliance with the *Health (Drugs and Poisons) Regulation 1996*, that may be seriously compromised if such information is released inappropriately.

Other situations involving sensitive matter

If the officer processing an administrative access application believes, after consultation with the FOI decision-maker, that access should not be provided to the requested health record, or to certain information contained in that record, the application must be processed under the FOI Act, and the applicant should be notified accordingly.

None of the matters listed below **automatically** excludes health information from administrative release. However, they represent situations involving sensitive issues where extra care must be taken in deciding whether full release is appropriate:

- (i) documents relating to suspected or actual child abuse
- (ii) documents revealing the involvement and deliberations of a SCAN (Suspected Child Abuse and Neglect) Team in relation to a particular patient
- (iii) documents containing information in relation to testing for and / or treatment of HIV/AIDS (including statements regarding HIV status) or other notifiable diseases under the *Health Act 1937*

- (iv) in circumstances where it is considered that granting a patient full access to their health record could be prejudicial to their physical or mental health or wellbeing
- (v) in circumstances where the health record contains matter that it is considered may reasonably be expected to be of substantial concern to another agency or person, if disclosed
- (vi) any other sensitive matter - eg. documents revealing confidential sources of information, or containing information relating to the personal affairs of a person other than the applicant (whether that other person is alive or dead).

2.6 PROVIDING ACCESS TO HEALTH RECORDS

Time frame

As indicated previously, administrative access is available only where the requested content of a health record is suitable for **full release** to the applicant. In such cases, access should be given **within 15 working days of receipt of the application**.

Where a decision cannot be reached within the **15 working days** deadline, the applicant should be informed in writing of the reasons for the delay and the approximate date when a decision will be made.

Evidence of identity

Due to the sensitive nature of health records, evidence of identity will be required in all cases before access can be granted.

- **If the access application is made by the patient** - they must provide acceptable evidence of their identity (to establish that they are the individual to whom the requested records relate).
- **If the access application is made by a third party** - they must provide the patient's written consent (as discussed above in **Section 2**), as well as evidence of identity.

The evidence of identity requirements employed for processing applications under the FOI Act also apply to applications made under this policy. It is the responsibility of the officer processing the application to obtain appropriate evidence of the patient's identity before access is provided.

Assistance of health care provider

Where requested by the patient, and subject to availability, a suitable health care provider should be made available to assist the patient in interpreting the record. (If the health care provider who recorded information the patient seeks to have clarified no longer works for Queensland Health or is otherwise unavailable, the matter should be referred to the senior health professional of the health facility so that suitable arrangements can be made.)

Delivery by post

In view of the confidential, and often very sensitive nature of health records, they should be posted to an applicant or authorised third party by "Registered Post - Acknowledgment of Receipt" (which is confirmed by the signature of any person at the delivery address).

Depending on the sensitivity of a record's contents and the applicant's wishes, It may be appropriate to use the "Registered Post - Person to Person" delivery option, where the item must be signed for by the person named in the address, and evidence of identity is required before the item to be delivered is handed over. (This delivery option incurs an additional fee.)

Access at health facility

Where a patient is granted access to their health record within the premises of the health service, such access should be supervised by an appropriate officer. If the patient wishes, they may bring a support person with them.

It is the responsibility of the officer processing the application to arrange an appointment time that is convenient for the applicant and the supervising officer/assisting health care provider, taking into account the applicant's circumstances (eg. a patient who is able to travel to the health facility only on a particular day).

2.7 ACCESS CHARGES

Copies of health records released under administrative access (**Section 2** of this policy) are to be provided to the patient, or a third party holding valid written authority from the patient, **free of charge**, subject to the special considerations discussed below.

Colour photocopies

The copies of records that will be provided free of charge under this policy are standard A4 size black and white copies, made using the copying equipment normally available within the relevant health facility.

Although there is no obligation to provide colour photocopies, there may be situations in which a compelling reason for requiring colour copies is given by the applicant. For example, a request for colour copies simply for the purpose of ease of distinguishing between different clinical entries will not normally justify the provision of colour copies.

By contrast, where a record contains machine tracings generated in different colours, it may be appropriate to comply with a request for colour copies of such tracings.

Such requests must be determined on a case-by-case basis, taking into account the:

- content of the record in question
- reason given for requiring colour copies
- on-site availability of colour copier facilities.

It may be appropriate, considering the nature of the documents and volume of material copied, to require the applicant to pay the reasonable costs of providing colour copies (over and above the cost that would have been incurred to provide black and white copies).

Copies of X-rays, photos, tapes, CD-ROMs

Requests for copies of non-paper formats of health records (x-rays, photographs, video or audio tapes, CD-ROMs) will attract the charges that have been administratively set by Queensland Health. Details of the applicable charges for such records are set out in the Fees and Charges Register, maintained by the Veterans' Affairs and Revenue Unit, Health Funding and Systems Development Branch.

Medical reports

Where a request requires the creation of a medical report, the charges that have been set administratively by Queensland Health for the production of such reports will apply. Details of the applicable charges for medical reports are set out in the Fees and Charges Register, maintained by the Veterans' Affairs and Revenue Unit, Health Funding and Systems Development Branch.

Exceptions

The access charges set out above do not apply to medical reports or copies of health records provided to WorkCover Queensland (or a self-insurer), or to copies of health records provided to Compulsory Third Party (CTP) insurers under the *Motor Accident Insurance Act 1994*. Special arrangements have been made in respect of these matters, as discussed in **Section 3** of this policy.

3. OTHER DISCLOSURE / ACCESS MECHANISMS (for health information held by Queensland Health)

3.1 INTRODUCTION

Scope of this section

This section of the policy is intended to address situations which cannot be dealt with under **Section 2** (Administrative Access) - that is, applications for access to health records or information:

- made by, or with the consent of, the patient concerned, but which come within one or more of the exceptions to administrative access
- made with the consent of the patient concerned, but made by a person not acting on the patient's behalf (eg. applications made under statutory claims processes in the *Motor Accident Insurance Act 1994*, the *Personal Injuries Proceedings Act 2002* or the *Workers' Compensation and Rehabilitation Act 2003*)
- made by someone other than the patient concerned, without the patient's valid written consent.

Confidentiality

Before health records or information are disclosed under a statutory mechanism, it is essential to ensure that each element of the applicable mechanism has been satisfied, so that disclosure can be made without contravening the strict statutory and ethical obligations of confidentiality owed by Queensland Health staff to its patients.

To avoid a breach of confidentiality, it is essential to confirm the validity of the statutory authority under which a right of access is claimed. The nature and scope of the access requested should also be checked to ensure that only material coming within the terms of the statutory demand is released.

Obtaining legal advice

The accompanying **Health Information: Disclosure and Access Guidelines** provide further details concerning the interpretation and application of the principles discussed in this policy statement, and the general requirements for individual disclosure/access mechanisms discussed below.

However, if there is any question about the validity of a specific disclosure/access request or demand under these mechanisms, or any other basis for concern, it may be necessary to seek legal advice before responding to the request or demand.

Requests for legal advice in such matters should be directed, in the first instance, to one of the nominated legal panel firms for the relevant health service district. The District Manager's office can advise on local arrangements.

3.2 COURT-ORDERED / LITIGATION RELATED ACCESS

Subpoena / summons to produce documents

A subpoena is an order issued by a court, which directs a person to produce to the court certain documents for use in ongoing legal proceedings, or to attend at court on a particular date to produce documents and/or give evidence. Subpoenas may be used in either civil or criminal proceedings as a means of presenting evidence to the court. Some courts or tribunals (eg. the Magistrates Court) issue a "summons to produce documents", which is subject to the same general principles as for a subpoena.

A subpoena or summons must not be ignored. It must be dealt with promptly. Failure to comply is a serious matter, which could lead to a charge of contempt of court, or even arrest.

The senior health professional and the treating health care provider should be advised (where possible) of the receipt of a subpoena for health records, if neither they nor the health facility are parties to the proceeding.

Where a patient whose health record has been subpoenaed is not named on the subpoena as a party to the proceeding, they should also be notified that the subpoena has been received, and advised of the "return date" on the subpoena (by which the documents are to be produced to the court). This should be done in sufficient time to allow the patient to attend court if they wish. There are exceptions to this general principle in cases where the records relate to monitoring activities which the patient may be unaware of (eg. subpoenas for records held by the Drugs of Dependence Unit).

Upon the production of a subpoena or summons to produce documents, the health records should be forwarded under adequate security to the Registrar or the court or tribunal from which the subpoena or summons was issued, and a receipt obtained from the person accepting delivery.

"**Adequate security**" should involve hand delivery of health records direct to the Registrar of the court or tribunal by an employee of the health facility, or by registered post or courier service.

Before health records leave the health facility, the senior health professional's authorisation for such release should be obtained.

When the original of a health facility's health record leaves the premises, a copy of the record should, where possible, be made beforehand and kept in the relevant health facility.

Search warrant

A search warrant provides lawful authority for a police officer to enter a place and exercise certain powers. Section 444 of the *Police Powers and Responsibilities Act 2000* (PPRA) makes it an offence to obstruct a police officer in the performance of his/her duties.

Compliance with a search warrant is required by law. The senior health professional should be advised immediately when a search warrant is executed, or notice is received of an intention to execute a search warrant.

There are specific statutory requirements regarding the contents of search warrants, and the circumstances of their execution.

Section 134A of the Evidence Act 1977

Section 134A of the *Evidence Act 1977* provides an administrative mechanism under which a party to a civil proceeding may obtain discovery of documents held by an agency (which is not a party to the proceeding). However, as the documents sought must be relevant to an issue in the proceedings, it may be appropriate to seek legal advice before responding to s.134A notices.

The Director-General, Queensland Health has executed written instruments of delegation and authorisation to positions within Corporate Office and the Health Service Districts, for the purpose of managing requests for access to Queensland Health documents under s.134A.

Notice of non-party disclosure

Parties to civil proceedings in Queensland courts may serve a notice of non-party disclosure for the production of a patient's health record. Courts or tribunals in other jurisdictions have similar powers. Such notices must be complied with within strict time limits.

Legal advice may be required, in order to determine whether it is appropriate to resist production (eg. on grounds of privilege, or that the Notice is oppressive).

NOTE: Although neither the s.134A Evidence Act or the notice of non-party disclosure mechanisms described above requires the consent of the patient whose health records are sought, they should be notified by the health facility that such access has been given (unless they are a party to the proceeding), as they may have a basis for objection to release.

Solicitors acting for the State of Queensland

Health records may be released to Crown Law or the panel of private legal firms who are representing Queensland Health or any other department or body that makes up the legal entity the "State of Queensland", on receipt of written confirmation that the State of Queensland is their client, and that the records are required for litigation.

Litigation guardian

Under the *Uniform Civil Procedure Rules 1999*, a "person under a legal incapacity" may start or defend a legal proceeding only by the person's litigation guardian. A party's litigation guardian who is not a solicitor may act only by a solicitor.

Where a person seeks access to documents in the capacity of litigation guardian, and has filed in court their consent to act as litigation guardian, or has been appointed litigation guardian by the court, they should be asked to produce the relevant document:

- Form 13 (Consent of litigation guardian)
- Court order

(See also **Section 2.5** re: the requirements for processing applications to access children's records.)

3.3 DISCLOSURE OR ACCESS REQUIRED, AUTHORISED OR PERMITTED BY STATUTE (OTHER THAN FOI)

A number of individuals or bodies have statutory means of access to certain types of information. In addition, there are numerous legislative provisions that confer a discretion to release health-related information in certain specific circumstances.

Each individual situation must be carefully assessed, to establish whether all of the requirements of a specific statutory mechanism for access / disclosure have been satisfied, so that health information is not disclosed in breach of the legal and policy obligations of confidentiality, and privacy principles, that bind all Queensland Health employees (see **Section 1.4**).

Mandatory notifications

There are a number of statutory provisions under which specific categories of health care providers are **required** to provide information to relevant authorities; for example:

- Reporting notifiable diseases (s.32A, *Health Act 1937*)
- Reporting suspected child maltreatment / neglect (s.76K, *Health Act 1937*)
- Furnishing Cancer Registry returns (s.100C, *Health Act 1937*)
- Furnishing perinatal statistical returns (s.100H, *Health Act 1937*)
- Reporting births (s.5, *Births, Deaths and Marriages Registration Act 2003*)
- Reporting certain types of deaths (ss.7-8, *Coroners Act 2003*)

As long as information is disclosed in strict compliance with the relevant statutory scheme, no breach of confidentiality is involved.

Statutory demands

Numerous bodies that conduct investigations or process health or injury-related compensation claims have statutory powers to issue written notices requiring the production of documents or information necessary for the performance of their functions.

The statutory schemes vary in terms of the formal and procedural requirements for the making of such demands. The terms of a statutory demand must be assessed to determine whether it complies with all relevant requirements.

As most statutory schemes granting power to require production of documents prescribe penalties for non-compliance with such requirements without lawful excuse, statutory demands that are **validly** made under the relevant legislative scheme must be dealt with in a timely fashion. If it is not possible to comply with a valid statutory demand for production of documents within the prescribed time period, the individual or body concerned should be contacted to see if an extension of time can be negotiated.

Discretionary disclosures

In some cases, legislation that **permits** the disclosure of health-related information specifies the categories of persons who may make such disclosures and/or the categories of entities or persons to whom disclosure may be made. Prior to the disclosure of health records or information under such a discretionary power, it is essential to confirm that every element of the relevant statutory scheme is satisfied, or the disclosure may constitute a breach of applicable statutory and policy obligations of confidentiality (see **Section 1.4**).

Special consent requirements for certain statutory claims processes

The normal requirements set out above (in **Section 2.3**), for a patient's consent to be an original, and to be no more than 6 months old, do not apply where the patient's consent to the release of information or records has been given as part of a statutory claims process under the following legislation:

Motor Accident Insurance Act 1994

Personal Injuries Proceedings Act 2002

Workers' Compensation and Rehabilitation Act 2003

In such cases, the original form bearing the patient's consent must be kept by the agency or party concerned for its claims file. As a result, in these specific circumstances, a **photocopy** of the form signed by the patient is acceptable as evidence of the patient's consent; and the patient's consent is considered **valid for the life of the claim**, if all of the following requirements are met:

- the patient's consent to the release of information or records is set out on the relevant prescribed claim / consent form;
- the form has been signed by the patient him/herself*, and
- the copy of the signed form is received directly from the agency or party that the patient has authorised to have access to their information or records.

*The *Personal Injuries Proceedings Act 2002* provides (in s.9(4)) that where the claimant is a minor, their parent / guardian may sign the relevant claim forms on the minor's behalf.

3.4 HEALTH CARE PROVIDERS

NOTE: Health care providers who are not directly involved in a patient's treatment have no greater right of access to the patient's health records than any other person.

Information required for further treatment

A patient's consent is not necessary for the release of information that is required in connection with their further treatment.

Where a patient has been transferred or discharged to another public health facility, private health facility or medical practitioner for continuing treatment, information from the patient's health record of direct relevance to the further treatment of the patient (for example, in the form of a discharge summary) may generally be released, in accordance with the relevant exception to the statutory duty of confidentiality prescribed in the *Health Services Act 1991*):

- on written request by the public health facility, private health facility or medical practitioner; or
- on confirmation by the receiving facility or practitioner of transfer arrangements.

(See **Section 1.4** re: the faxing or e-mailing of health information or records.)

Requests for information made by telephone

Where a request for information is made by telephone, information should only be given to the treating health care provider or senior health professional, if urgently required for treatment of the patient.

Care should be taken to establish the identity of the recipient of the information. The recipient's telephone number and authority to receive the information should be checked and the call returned before information is given. (Refer to the confidentiality provisions in the *Health Services Act 1991* re: release of information required in connection with the further treatment of a patient.)

Access to other family members' records

Requests by health care providers for access to health records of members of a patient's family must not be treated as exceptions to the general rules regarding confidentiality. Such requests must be accompanied by the written consent of the relevant person. Such requests should, where practicable, be referred to the treating health care provider or senior health professional.

3.5 OTHER DISCLOSURE / ACCESS

The accompanying **Health Information: Disclosure and Access Guidelines** contain specific information and references to relevant Queensland Health policy documents concerning issues such as:

- research activities
- media inquiries
- inquiries from patients' relatives or visitors
- Members of Parliament
- pastoral care services.

Prior to the disclosure of health records or information in such circumstances, the relevant Guidelines and related material referred to therein should be checked to ensure that the disclosure of information will not breach applicable statutory and policy obligations of confidentiality (see **Section 1.4**).



APPLICATION FOR ADMINISTRATIVE ACCESS TO HEALTH RECORDS

*For office use only
(Attach Patient ID Label)*

DETAILS OF APPLICANT (Please print)

Full Name	Title (Mr/Mrs/Ms etc)	Surname/ Family Name		
	Given Names		Date of Birth (dd/mm/yy)	
Name used in records (If records requested are under a different name than above, please provide details):				
Postal Address	Suburb/Town			Postcode
Tel (Home)	(Work)	(Mobile)	E-Mail	

DETAILS OF REQUEST

It will help us locate the documents without unnecessary delays if you can provide as many details about the documents as possible, including: in what name they are held (eg. under a maiden name); the hospital or health facility where they are held; the date(s) of treatment to which the application applies.

I REQUEST ACCESS TO THE FOLLOWING DOCUMENTS:

<input type="checkbox"/> IN-PATIENT HOSPITAL NOTES	<input type="checkbox"/> OUT-PATIENT NOTES	<input type="checkbox"/> COMMUNITY HEALTH SERVICE NOTES	<input type="checkbox"/> X-RAYS; MRI SCANS, ETC	<input type="checkbox"/> LABORATORY REPORTS
(Approximate dates of records requested): _____				
<input type="checkbox"/> RECORDS OF TREATMENT ARISING OUT OF MOTOR VEHICLE ACCIDENT ON _____ (Date)				
<input type="checkbox"/> OTHER (Please specify): _____				

EVIDENCE OF IDENTITY

<p>Before access to personal information can be given, you must provide suitable evidence of your identity (see over for acceptable forms of documentation)</p> <p>Evidence of identity documentation accompanies this form</p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>If you are requesting personal information in respect of another person, <u>the written consent of that person is also required</u></p> <p>A copy of the person's written consent accompanies this form</p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
--	---

SIGNED: _____

DATE: _____

**NOTE: DOCUMENTS WILL NORMALLY BE AVAILABLE WITHIN 15 WORKING DAYS AFTER
RECEIPT OF COMPLETED APPLICATION AND CONFIRMATION OF IDENTITY/CONSENT.
YOU WILL BE NOTIFIED IF THAT DEADLINE CANNOT BE MET.**

EVIDENCE OF IDENTITY

To protect patient privacy, satisfactory evidence of identity is required before you can be given access to health information. This can be established by providing one of the following identity documents:

- | | |
|--|---|
| <input type="checkbox"/> Driver's licence
<input type="checkbox"/> Medicare or health benefits card
<input type="checkbox"/> Birth certificate or certified extract from birth register
<input type="checkbox"/> Marriage certificate | <input type="checkbox"/> Identifying page of current passport
<input type="checkbox"/> Naturalisation certificate or citizenship certificate
<input type="checkbox"/> Immigration papers or other documents issued by the Commonwealth Department of Immigration. |
|--|---|

IF APPLYING IN PERSON: Bring an **original** identity document, for sighting/verification by a departmental officer.

IF APPLYING BY MAIL: Send with your application a photocopy of one of the identity documents listed above.

NOTE: The photocopy must bear the **original** signature of a Commissioner for Declarations or a Justice of the Peace (JP), certifying the photocopy to be a true copy of the original document, which they have sighted. Documents that bear a photocopied or facsimile copy of the certification/signature will not be accepted.

DO NOT SEND ORIGINAL IDENTITY DOCUMENTS THROUGH THE MAIL.

FOR OFFICE USE ONLY

Date received		Officer's Signature
Identity confirmed	<input type="checkbox"/> YES Officer's Signature	Date <input type="checkbox"/> NO
Consent verified	<input type="checkbox"/> YES Officer's Signature	Date <input type="checkbox"/> NO

← If "NO", application is refused

PROCESSED UNDER ADMINISTRATIVE ACCESS:

Release authorised by	Officer's Name	Officer's Signature	Date
Documents released by	Officer's Name	Officer's Signature	Date
Method of release	<input type="checkbox"/> Personal attendance		<input type="checkbox"/> Registered Mail - Acknowledgment of receipt
	(Applicant's Signature) _____		

OR

REFERRED FOR PROCESSING UNDER FOI:

Referred by	Officer's Name	Officer's Signature	Date
Reason for referral			

This completed form should be placed on the patient's file as a record confirming the details of access granted

ADMINISTRATIVE ACCESS FLOWCHART

INITIAL STEPS

WRITTEN APPLICATION RECEIVED

APPLICATION FORWARDED TO MEDICAL SUPERINTENDENT OF HOSPITAL OR SENIOR HEALTH PROFESSIONAL IN ANY OTHER HEALTH SERVICE

RECORDS CHECKED BY DELEGATED OFFICER AS SOON AS POSSIBLE, BUT **WITHIN 2 WORKING DAYS**

CAN APPLICATION BE PROCESSED UNDER ADMINISTRATIVE ACCESS?

APPLICATION FOR ACCESS TO

- DECEASED PERSON'S RECORDS?
- CHILDREN'S RECORDS?
- RECORDS WITH SPECIAL ACCESS REGIMES or RE: CONTROLLED DRUGS?

YES

APPLICATION TO BE REFERRED FOR PROCESSING UNDER *FREEDOM OF INFORMATION* OR UNDER RELEVANT STATUTORY SCHEME (where available and done in accordance with applicable requirements - see **Section 3** of the Policy)

NO

THIRD PARTY APPLICATION?
DOES APPLICATION INCLUDE PROOF OF AUTHORITY OF THE PERSON WHOSE RECORDS HAVE BEEN REQUESTED?

NO

YES

DOES RECORD CONTAIN SENSITIVE INFORMATION TO WHICH ACCESS SHOULD NOT BE PROVIDED ADMINISTRATIVELY?
(REFER TO EXCEPTIONS LISTED IN **SECTION 2** OF THE HEALTH INFORMATION: DISCLOSURE AND ACCESS POLICY)

YES

NO

ADMINISTRATIVE ACCESS PROCEDURE

SATISFACTORY EVIDENCE OF IDENTITY MUST BE RECEIVED BEFORE ACCESS IS GIVEN

ACCESS BY RELEASE OF COPIES
(access to be provided as soon as possible, but **within 15 working days** of application being received)

ACCESS BY INSPECTION
(supervised access to be provided as soon as possible, but **within 15 working days** of application being received)

IF THE **15 WORKING DAYS** TIME LIMIT FOR ACCESS IS NOT MET, THE APPLICANT IS TO BE NOTIFIED IN WRITING OF THE INABILITY TO MEET THE DEADLINE AND ADVISED OF THE DATE WHEN ACCESS WILL BE PROVIDED

BLACK AND WHITE PHOTOCOPIES OF HEALTH RECORDS ARE TO BE PROVIDED FREE OF CHARGE
(charges apply for specific types of records - x-rays etc - see **Section 2.7** of this policy)