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Managing external requests for patient information

Purpose

This document is a guide for general practices to advise which data elements should be extracted from a patient's electronic medical record when responding to external requests for their record. This document is for use once the decision has been made to provide a third party a copy of (or part of) a patient's medical record.

It is recommended that data sets developed by the OPTIMUS group be adopted by medical software vendors for integration into their systems to ensure the safe and accurate extraction of a patient's comprehensive medical record.

Introduction

General Practitioners often receive requests from lawyers and other third parties for information on or a comprehensive record of a specific patient. As such, GPs may be obliged to disclose patient health information in certain circumstances and requested to do so in others. Providing records to facilitate resolution of legal disputes is usually in the interest of patients (unless the patient has claimed things that are untrue) and in the public interest.

Data elements of a patient's comprehensive medical record

As part of the OPTIMUS project, the collaborative has developed a recommended data set of what should be contained as part of a patient's comprehensive medical record and how it should be presented. Not all requests for patient information will require a comprehensive medical record. When this request should be reciprocated is out of scope of this document, however, there is discussion and guidance below.

The OPTIMUS collaborative has developed recommended pathways for the provision of extracting and releasing a patient's medical record for three separate circumstances of medical record requests:

- legislative requirements such as subpoena
- request from a third party, and
- the transfer of care when a patient moves to a different practice.

Types of requests for medical records

1. Under a Subpoena/Legislative requirement

GPs may receive requests for medical records as part of legal proceedings. A subpoena, a court order, or summons, has the authority to compel production of medical records. Failure to do so may result in a penalty, fine or legal action. These order are exceptions to principles of patient confidentiality and privacy. If a doctor is unsure about compliance with the subpoena, advice should be sought from their medical defence organisation.

When a GP is requested to provide a patient's complete medical record under a subpoena or legislative requirement, the GP is generally obligated to comply. However, the various clinical systems interpret what constitutes a comprehensive medical record data set differently.

The collaborative has developed a data set that a comprehensive medical record should contain.

Table A - Comprehensive medical record data set.

Medical Record Data Set – Comprehensive Medical Record	
Demographic information	Name
	Date of birth
	Current address
	Medicare name
	Contact details
	Ethnicity (if captured in the system)
	Interpreter needed (only if captured in the system)
	Aboriginal Torres Strait Islander status
	Gender
	Employment status (occupation)
	All patient identifiers (except Individual Healthcare Identifiers (IHI))
Health summary	Allergies & adverse reactions
	Current medicines list
	Medical history (current and past active and inactive)as recorded
	Family history as recorded
	Social history as recorded
	Health risk factors • identified health risk factors as outlined in the RACGP SNAP guide: smoking nutrition, alcohol and physical activity • weight (overweight/obesity) assessment • indicate grade for confidentiality by inclusion on non-inclusion in the GP e-health summary
	Immunisations as recorded
Progress notes (including action notes)	All entries including 'non visit' entries dated, timed & author identified
	Data entered in other section of notes such as obstetrics, acupuncture
	All actions entered in a transaction
	All prescribing information including quantity & repeats, old scripts
	All documents generated by the provider including pathology and DI requests (care plans, management plans, ECGs, spirometry and photos)
Letters and reports	Sent and received (include all scanned material), all test results and documents from third parties

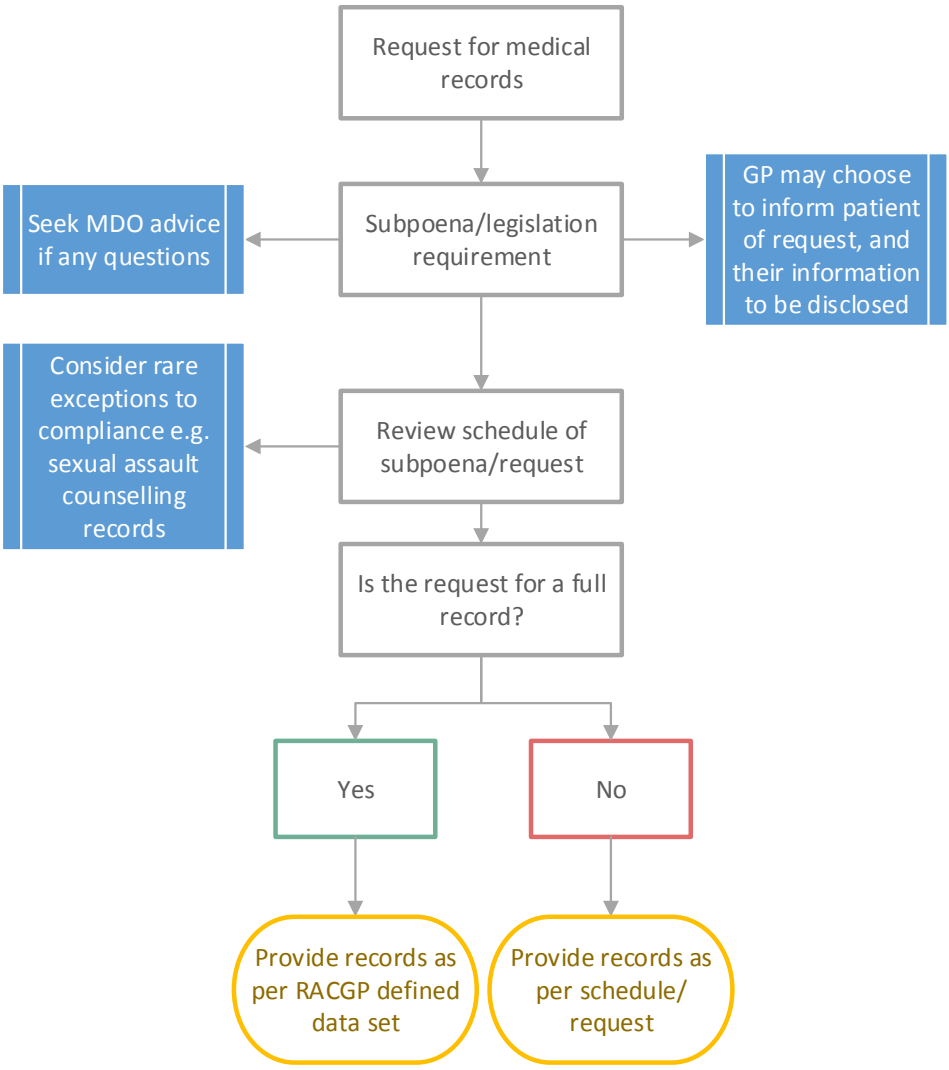
Additional administrative and clinical data useful in some cases but not essential in all cases (forensic data):

- Sign off audit trail for letters, scanned material and results
- Appointment history including cancelled/moved appointments
- Claims and payments history
- Tracking and tracing logs
- Clinical support material viewed (e.g. Travel immunisation information – if not already recorded in the progress notes)
- Alerts, recalls and reminders

It is important to note that the printed version of electronic records will not necessarily be indicative of how the medical record appeared in real time, as not all elements of the software can be produced on paper, e.g. metadata, audit trails, alerts, recalls. It is also important to note that any extraction of a comprehensive medical record is as it appears in its current state and cannot be produced retrospectively.

The OPTIMUS collaborative has developed the following procedure to aid practices to generate a patient's record in accordance with this type of request.

Figure A – Flow chart: Request for medical record - Under a Subpoena/Legislative requirement



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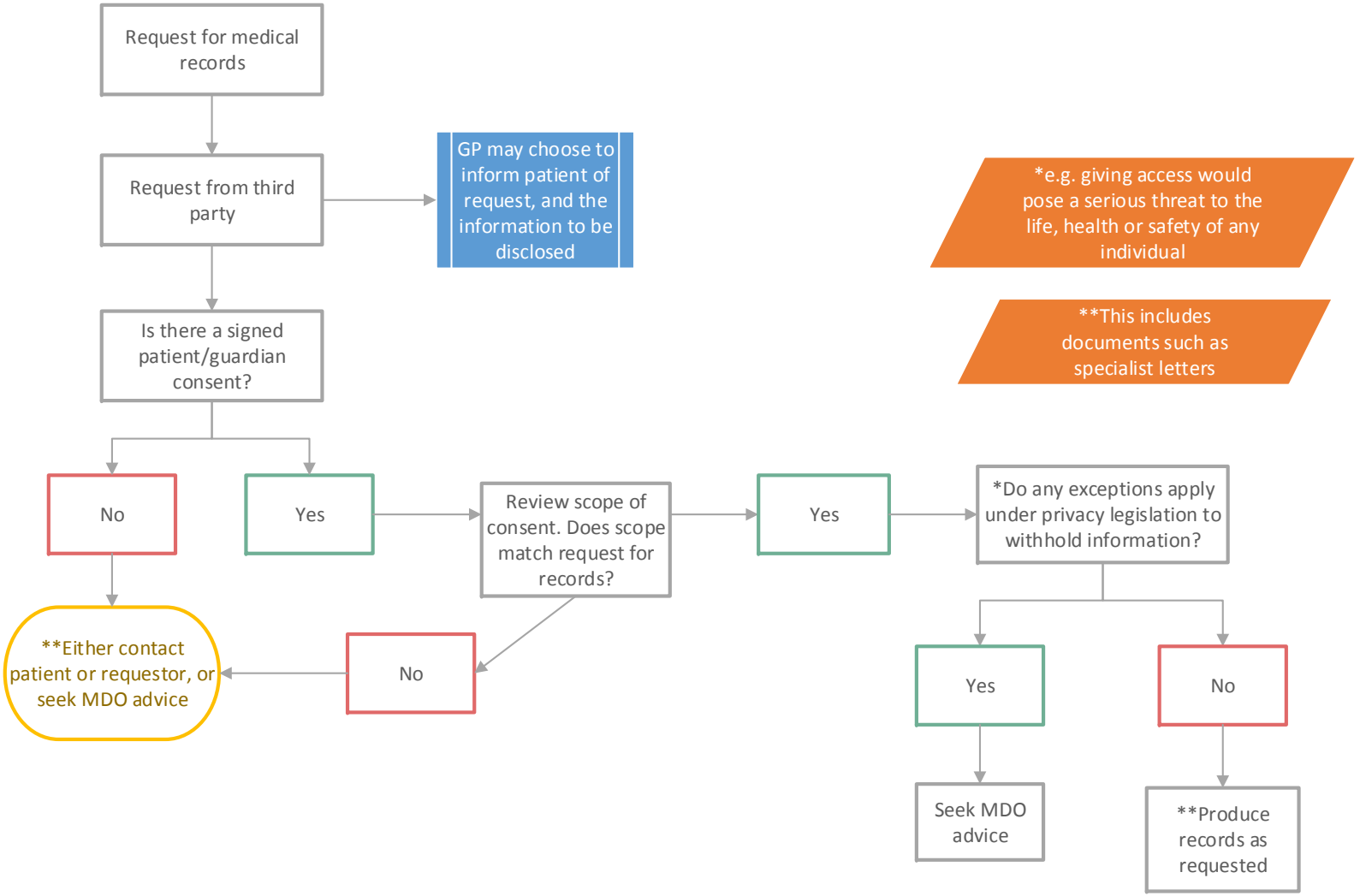
2. Request from a Third Party

From time to time GPs will receive requests for patient records from third parties such as requests from WorkCover or insurance groups. Before providing patient information to a third party, patient consent must be provided. The OPTIMUS collaborative has developed the following procedure to aid practices with the process for provision of a patient records in accordance with this type of request.



3. Transfer of care between practices

When patients move to a new practice either the new GP or the patient may request to have their existing records transferred. As the patient's complete medical history could be quite extensive, it is recommended that a succinct data set of relevant information could be provided. The OPTIMUS collaborative has developed a list of the types of patient information you may wish to receive and/or send as part of transferring care of a patient.

Table B - Transfer of care medical record data elements

Transfer of care medical record data elements	
Demographic information	Name
	Date of birth
	Medicare name
	Ethnicity (if captured in the system)
	Interpreter needed (only if captured in the system)
	Aboriginal Torres Strait Islander status
	Gender
	Employment status (occupation)
	All patient identifiers (except Individual Healthcare Identifiers (IHI))
Health summary	Allergies & adverse reactions • record of allergies and adverse events • known substance (drug and non-drug), reaction and date of occurrence • review of allergy and adverse reaction at the point of prescribing any new medications or at periodic health review (e.g. referrals) is recommended
	Current medicines list
	• Medical history (current and past active and inactive)as recorded
	• Family history as recorded
	Social history as recorded
	Health risk factors • identified health risk factors as outlines in the RACGP SNAP guide: smoking nutrition, alcohol and physical activity • weight (overweight/obesity) assessment • indicate grade for confidentiality by inclusion on non-inclusion in the GP e-health summary
	• Immunisations as recorded

The OPTIMUS collaborative has developed the following procedure to aid practices in the process for provision of a patient record in accordance with a transfer of care.

Figure C - Flowchart - Request for medical record - Transfer of care