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Kibworth, Market Harborough and Fleckney

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Rights of access to clinical records

Records ownership

Patients do not own their medical records and are not entitled to keep the originals but under the Data Protection Act 1998, they do have the right to view their records and have copies of them.

Who makes the request?

In most cases this will be the patient but we need to confirm their identity to ensure we do not breach patient confidentiality.

If a third party submits an access request on behalf of a patient (such as a solicitor), they should be asked for evidence of their authority to act for the patient. This includes the patient's written consent or the necessary legal authority, for example a certificate of Lasting Power of Attorney. Where someone with parental responsibility submits a request for the records of a competent child, the child's consent should be sought.

Access limitations

Access can be limited or denied if it would be likely to cause serious harm to the physical or mental health or condition of the patient or any other person, unless it is information of which the patient is already aware. In such cases, there must first be an assessment by the doctor responsible for the person's clinical care and the doctor should make a record of this in the patient’s medical records.

Timescales

We must respond to subject access requests within 40 days of receiving them or sooner if possible.

Charges

We can charge a maximum of £50 for copies of paper records or £10 for electronic records (including postage). Patients must be informed of the charges and payment must be received before proceeding. However, it should be free for patients to inspect medical records which are held manually if they have been updated in the last 40 days.

Confidentiality

If a copy of the record is requested, this should be sent by special delivery unless collected in person by the patient.

If the patient or their representative wants to directly inspect the records, this event should be supervised by a health professional or administrator to protect the confidentiality of other records.

The extent of disclosure

We can 'black-out' part of the record or withhold specific documents which relate to third parties, unless we are able to get consent from the person named. Information about the patient written by other healthcare professionals involved in their treatment may be disclosed.

Assistance

We may need to make a reasonable adjustment for disabled patients who find it impossible or unreasonably difficult to make a subject access request in writing, for example, by accepting their verbal request, as long as this is documented in their medical records.

The Information Commissioner's Office also expects us to help patients understand the contents of their records. For example, we may need to spell out acronyms and be prepared to explain diagnoses and treatments in more detail.

Correcting factual errors

Patients can question the content of their records but an entry should not be amended simply because they do not agree with or like it. If factual corrections are made, it should be immediately obvious who made the amendment and the time and date it was changed.

Requests relating to deceased patients

These usually relate to concerns about the treatment the patient received (if this is suspected then contact our medico-legal advice line), an insurance company investigation or where there is a dispute about the patient's will and their testamentary capacity.

Rights of access to the records of deceased patients are covered by the Access to Health Records Act 1990 rather than the Data Protection Act 1998. The right to make a request under the Act applies to the deceased's personal representative, the executor or

administrator of their estate, or any person who may have a claim resulting from their death. Applicants should be required to make their request in writing, providing evidence of their identity and in support of their claim.

Other access requests will need to be considered on a case-by-case basis, bearing in mind the patient's right to confidentiality extends beyond their death. If the patient had previously asked that access should not be given, a note should have been made on their records and their wishes should usually be respected. However, in many cases the patient will not have left any indication of their wishes and we will need to make a judgement based on the content of the record, the reason and source of the request, and our knowledge of the patient's wishes. It's also important to consider the extent of the disclosure. For example, where the applicant has a claim arising from the patient's death, access should be limited to relevant information. As with other medical records, we may need to withhold information if it might cause serious harm to an individual or if it relates to a third party other than a health professional who has not consented.