West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

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4 February 2021

9(2)(a) [redacted]

[redacted]

[redacted]

[redacted]

RE Official information request WCDHB 9507

I refer to your email dated 14 December 2020, requesting the following information under the Official Information Act from West Coast DHB regarding data sharing at DHBs and PHOs. Specifically:

1. Do you have a privacy officer and at what level of DHB leadership do they sit?

West Coast DHB has a shared privacy officer with Canterbury DHB. This is a senior leadership position.

2. Do you have a chief data officer and if so, what is their responsibility in the organisation?

West Coast DHB has a Chief Digital Officer, which as part of their role involves ensuring patient management systems have the appropriate technical security relating to access to patient identifiable data (e.g. passwords, firewalls, etc), their role also requires ensuring that for DHB staff that have access to systems containing patent identifiable data that before access is granted they sign a form agreeing to abide by the policy of the DHB around access and release of data.

3. How do you gain patient consent for data sharing - i.e. via a consent form? (please provide a copy of the form or statement that explains how patient data is shared)

A variety of forms are used in various clinical settings that include collection of patient consent as appropriate to the nature of service being provided. Statement on our policies on the gaining of patient consents, including data capture and sharing, is jointly covered by the West Coast DHB's Informed Consent Policy (copy attached as **Appendix 1**), Disclosure of Personal Health Information Procedure (copy attached as **Appendix 2**), and the Collection, Collation, Correction & Alteration of Personal Information Procedure (copy attached as **Appendix 3**).

Other supporting DHB policy, national guidelines and legislation relevant to the West Coast DHB in regard to the capture, holding and sharing of information to individual persons include:

- Guidelines for Informed Consent of Children
- Health Information Privacy Code 2020
- On the Record - A Practical Guide to Health Information Privacy
- Privacy Act 2020
- Official Information Act (OIA) 1982
- Health Act 1956
- Health and Disability Standards 2008
- WCDHB Official Information Request Procedure
- WCDHB Guidelines for Informed Consent of Children

Depending of the level and purpose of the information patient consent may not be gained if you are sharing information due to safety concerns, for example: under provisions of the Family Violence Act. The Ministry of Health has produced guidance in this regard in their publication Information Sharing Guidance for Health Professionals from 1 July 2019 Wellington: Ministry of Health.
https://www.health.govt.nz/system/files/documents/publications/health-professional-guidance-information-sharing-from-1-july-2019.pdf

Further, we share information with a patient's other health providers/caregivers under section 22F Health Act 1956. This would generally involve a discussion with the patient, or if they lack capacity, appropriate others.

4. For what purposes are you sharing patient identifiable health information within the DHB?

- ***a. Clinical care***
- ***b. Analytics***
- ***c. Quality improvement***
- ***d. Planning***
- ***e. Research***

Data that identifies individuals is primarily shared between directly inter-related health care services for the purposes of clinical care for the individual patients concerned. This includes clinical care interactions with patient identifiable information commonly shared as National Health Identifiers (NHI) through administrative and national data collections. Information relating to individual persons may also be shared with other agencies involved in the care and/or protection of those people as outlined in the answer to Question 5 below. All staff and contractors who work within the DHB are subject to strict confidentiality clauses as part of their employment engagement with respect to all and any patient information that they may view or hear and/or have to share or work with as part of their daily work within our health services. Any breaches of this confidence that may occur in relation to patient information are subject to being dealt with accordingly as an employment matter or as otherwise befits the nature and scope of the breach.

With the exception of information mandatorily supplied to national data collections held by the Ministry of Health, no individual patient identifiable data is released externally to any other agencies for the specific purposes of analytics, quality improvement, planning or research outside of established policy.

Where internal planning, analytics, quality improvement work, surveys, or research is undertaken, any resultant data or reporting is only released with anonymised information, such that individual persons cannot be identified.

5. Do you share patient identifiable information outside of the DHB and if so, with what other entities? I.e. other DHBs, PHOs, GPs, NGOs, social services. If so, what agreements do you have in place to support this?

Contractual Agreements are in operation with service providers and government agencies where data sharing of relevant identifiable individual patient health information is required, including agencies such as ACC, Oranga Tamariki, Tamariki Ora, Police, other DHBs, General Practices, Ministry of Social Development, and to third party NGOs as outlined in the answer to Question 8 below.

See answer to 3 above regarding the sharing of data with other agencies. Please also refer to Section 22F of the 1956 Health Act which outlines the mandate to share information between healthcare providers who are providing diagnostic and other health care to the same patients. This may be found at the following website address:
https://www.legislation.govt.nz/act/public/1956/0065/latest/DLM306662.html

6. Do you share any personal data directly with patients? (appointment and discharge letters/ emails to patients should not be included in this definition of 'sharing personal data')

- ***a. If yes, what data do you share and via what method?***

Yes, release of health information to patients of current or historic nature is provided on request. West Coast DHB is required to safeguard a patient's personal health information by ensuring compliance with the Health and Disability Standards 2008, and respecting their right to have confidential information pertaining to your care. Requestors of personal health information must therefore personally identify themselves as that person by signing the Release of Patient Information request form (copy attached as **Appendix 4**) and attaching proof of identity. If someone wishes to access the health records of someone other than themselves, they must also complete the Release of Patient Information Form and provide proof of identity and supporting information. The same process applies where someone asks West Coast DHB to release their patient information to someone other than themselves. We refer to these requests as "third party access requests".

Method of information delivery may be in printed, electronic, or other physical formats, as is pertinent to the type and nature of information requested.

7. Do you plan to let consumers access and contribute to their own health information online, via something like a patient portal, in the future?

a. ***If so: when do you plan to implement and what info will be shared first*?**

Canterbury and West Coast DHBs plan to implement a consumer engagement solution that will allow patients to better manage their own care. We are still in the preliminary stages of investigation.

8. How does your organisation govern data sharing?

There is no specific governance group, but there is a recently formed Privacy Governance Group which will promote the DHB's compliance with the Information Privacy Principles, including principles 10-12, which relate to sharing of information.

As per question 5 above, please refer to Section 22F of the 1956 Health Act which outlines the mandate to share information between healthcare providers who are providing diagnostic and other health care to the same patients. Governance of data sharing across agencies is otherwise provided through a formal agreement with specific purpose of intent of use of information, timeframe and roles, and a limitation of the data shared with and between vendors, health service providers and other Government agencies if not cover by the provision of legislation. Examples of this include view of near real time data of St John Ambulance or Health Line services of patients accessing our Emergency Department services.

Non-identifiable aggregate data is shared based on need and request. In general, we operate on the principle of sharing the least identifiable data at all times when we receive external requests for data.

I trust this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the West Coast DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Acting Executive Director
Planning, Funding & Decision Support

Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Informed Consent

Purpose

To ensure CDHB and WCDHB follow an approach to informed consent which:

- is patient-centred and supports people to make an informed and voluntary choice about their care; and
- complies with relevant legal, ethical and professional standards regarding informed consent.

Policy

Informed consent is part of all clinical service and must be obtained from a patient before any treatment is provided, except where:

- specific legislation allows the treatment to be provided without consent;
- the common law allows services to be provided without consent (for example, in an emergency); or
- the patient is incompetent.

The informed consent process involves four elements including:

- checking to ensure the person is **competent** to make the decision to undergo or refuse the proposed treatment;
- effective communication;
- providing the person with **sufficient information** to enable to them to make an informed decision about the proposed treatment; and
- the person giving consent **voluntarily.**

Informed consent is not the act of filling out a form, but rather a process of exchange of information so that an informed decision can be made by that person.

Competence

Every person is presumed competent unless there are reasonable grounds for believing that the person is not competent.

The person must be capable of understanding the essential nature of their condition along with the treatment proposed, its intended benefits, risks and possible side effects.

A competent person has the right to refuse treatment or services, even if it is not in their best interests, results in significant harm, or even death.

Medication, intellectual disability, mental illness, the influence of alcohol or other substances or physical injuries all may affect the informed consent process, and may amount to reasonable grounds for believing the person is not competent. In each case reasoning outlining why the person is not considered competent must be documented.

A decision which seems unwise to others is not reasonable grounds for believing the person is incompetent.

Information about Capacity, and assessing Capacity, can be found on Hospital HealthPathways under *'Legal and Ethical'*.

Treatment of an incompetent person

Except in case of emergency, if the patient is rendered temporarily incompetent, the planned health care procedure should be delayed until the patient is able to provide informed consent. See pages 5 and 6 regarding treatment of an incompetent patient.

Competence and children

The health professional must assess competence of a child as with an adult. Capacity includes the ability to understand and to make a decision in relation to the particular treatment. The assessment and the child's decision must be documented in the clinical notes.

Children 16 years and over: Under the Care of Children Act 2004, a child who is 16 years or over, or is or has been married, in a civil union, or living in a de facto relationship can consent, assuming he or she is competent, to any medical procedure (including blood donation and surgical and dental procedures). Consent to medical treatment and procedures expressly includes the right to refuse consent.

Children under 16 years: It is generally agreed that children under 16 years of age can consent to their own treatment if they are competent to make a decision about the particular treatment.

Incompetent children: If a child is incompetent to make an informed choice and give informed consent, services may be provided:

- With the consent of the child's legal representative; or
- In an emergency, to save the child's life or prevent serious risk to his or her health;
- Without consent, provided the treatment is in the child's best interests and the requirements set out in Right 7 (4) of the Code have been satisfied.

Effective communication

Information is to be provided in a form, language and manner that enables the person to understand the information provided to them. Where necessary and reasonably practicable, this must involve arranging for an independent interpreter to be present in person or by phone. Interpretation by family members or other personal support persons should not be relied upon. This is because the lack of independence creates an inherent risk to the accurate exchange of information.

The Booking and Requesting Interpreters procedure gives information on the limited circumstances when family, friends and untrained staff members can interpret.

The environment must be one in which the person and the provider of the health and disability services feels that they are able to communicate openly, honestly, and effectively.

Sufficient information

Every person has the right to information that a reasonable person, in that person's circumstances, would expect to receive, including:

- An explanation of their condition;
- An explanation of the options available, including an assessment of the expected risks, side effects, benefits and cost of each option (including no treatment);
- The estimated duration for the service
- The possibility of additional treatments or procedures that can be anticipated,
- Any proposed participation in teaching or research, including whether the research requires and has received ethical approval;
- Any other information required by legal, professional, ethical and other relevant standards;
- The results of tests; and
- The results of procedures.

Other relevant information may include private treatment options, the option of a second opinion, implications of existing advance directives, issues related to the use of blood products, issues related to body parts, precautions following the procedure, recovery and planned follow-up.

In many situations, a patient would expect to be informed of which clinician will be performing or leading their treatment. For example, in some cases a patient will consent to a procedure at a pre-admission clinic but enter a pooled waiting list for a theatre booking with the next available surgeon. In this situation, the patient should be informed of the process for allocating theatre bookings and advised who their surgeon will be prior to their procedure.

The discussion should include an opportunity for the individual to ask questions and have their questions answered.

The discussion must take place with a person who is suitably qualified and experienced and has sufficient knowledge of the individual's condition and the proposed services.

Voluntary choice

The individual must be allowed to make a decision (either to accept or decline healthcare services) freely, without any form of coercion or constraint.

Documentation of consent

Consent (oral or written), must always be recorded in the patient's clinical notes. If written consent is required, it must be obtained using one of the forms associated with this policy or another form which has been approved as an exception by the legal team and the Chief Medical Officer.

Written consent

Consent must be obtained in writing if:

- General anaesthetic or conscious sedation is to be used;
- There is a significant risk of adverse effects;

- The patient is to participate in any research;
- The procedure is experimental.

Recordings and imaging

Where recordings and imaging are made as part of patient treatment or management, informed consent is required.

These recordings and imaging may only be used for education and research purposes if appropriate consent is given *(see Agreement to Clinical Imaging form).*

Refusal or withdrawal of consent

Every competent patient has the right to refuse service and withdraw consent for service for any reason (including religious beliefs).

- This decision must be respected (noting the few exceptions regarding decisions on behalf of children and incompetent persons).
- The person should be informed of the implications their refusal may have on their clinical outcome.
- The best standard of care and support possible in the circumstances is to be offered to that patient.
- No undue influence or pressure is to be brought to bear on that patient.

Appropriate members of the clinical team must be informed of the decision.

The following should be documented in the patient's clinical notes;

- A full account of what happened (including date and time);
- What the patient was told, his or her response;
- Whether any relatives or witnesses were present;
- An assessment of the patient's competence.

It may sometimes be appropriate, if the risks are unusually high, to ask the patient to provide a written acknowledgment of their refusal and their acceptance of the risks involved. This record is not to be framed as a waiver of responsibility or liability by CDHB or WCDHB. CDHB and WCDHB remain responsible for the quality of care we provide and our actions.

When this decision is made by one or more people on behalf of a child or incompetent person, there may be provision for the decision to be legally challenged. For example, a person holding an enduring power of attorney for an incompetent adult cannot refuse treatment intended to save the person's life or prevent serious damage to their health. When situations such as this occur, advice should be sought from the Clinical Director / Corporate / Legal.

How long is the consent valid for?

The validity of consent is variable. If any of the following situations are fulfilled the patient's consent should be considered invalid and retaken:

- The nature of the procedure changes

- There is progression of the condition
- Change in the health status of the individual (prognosis)
- Change in the individual's competence
- Change in the expected outcome or side effects
- Change in treatment options
- Elapse of more than 3 months between consent and the beginning of the treatment.

Advance directives

Every person has the right to use an advance directive under Right 7 (5) of the Code of Rights.

An advance directive is made by the person, while they are competent, about a possible future health care service that is intended to be used only when the person is incompetent. An advance directive can be made orally or in writing but for clear communication and evidentiary purposes a written advance directive is preferred.

A valid advance directive is binding on health professionals and should be followed unless there are reasonable grounds for believing it is not valid.

An advance directive is valid when the person:

- Was competent;
- Anticipated and intended his or her decision to apply to the prevailing circumstances;
- Had been sufficiently informed to make the decision; and
- Reached their decision without undue influence or coercion.

Persons legally entitled to give consent on a person's behalf

A welfare guardian or an Enduring Power of Attorney (EPOA) for personal care and welfare can consent on behalf of an incompetent adult.

- They cannot refuse treatment intended to save a person's life or prevent serious damage to a person's health.
- An EPOA is activated when a health practitioner has certified that the patient is mentally incapable. This "activation" must occur before an attorney can act in respect of a "significant matter".
- An EPOA for property cannot consent to personal care or treatment decisions.

A person cannot consent on behalf of an incompetent adult simply because they are that person's next of kin, a member of their family or a close friend.

Treatment without consent under Right 7(4)

Where a person is not competent to make an informed choice and give informed consent, and no person who is legally entitled to consent on the patient's behalf is available (and it may not be an emergency), right 7(4) allows a health professional to administer treatment without consent where:

- It is in the best interests of the person;
- Reasonable steps have been taken to ascertain the views of the person; and

Either:

a) If the person's views have been ascertained, and having regard to those views, the health professional believes, on reasonable grounds, that the provision of services is consistent with the informed choice the patient would make if he or she were competent; or

b) If the patient's views have not been ascertained, the health professional takes into account the views of other suitable persons who are interested in the welfare of the patient and available to advise the health professional. The suitable persons are not being asked to give informed consent. Rather it is a matter of taking their views into account in deciding whether the proposed treatment is in the patient's best interests and the patient would have consented.

Treatment without consent where permitted by legislation

Some specific legislation overrides an individual's right to refuse treatment. This includes:

- *The Mental Health (Compulsory Assessment and Treatment)* Act 1992, where statutory criteria are met for treatment of mental disorder.
- *The Substance Addiction (Compulsory Assessment and Treatment)* Act 2017, where a court has ordered detention for the treatment of alcohol or drug dependence.
- *The Health Act 1956* provides for compulsory treatment in specified circumstances, e.g. some Infectious Diseases.

Students and teaching

Informed consent must be gained for the presence or involvement of students or other staff who do not have a direct role in the treatment team during the health care procedure. The reasons for the presence or involvement must be explained to the patient.

The clinician is expected to exclude any students during the discussion to allow the patient to make a decision without undue pressure (real or perceived).

Additional treatments or procedures

If an unexpected event occurs and the person has not given their prior informed consent to any additional treatments, no further treatment can be undertaken without first pausing to obtain consent, unless those treatments are required in an emergency situation or immediately for the preservation of life.

Applicability

Applies to all CDHB or WCDHB staff (permanent or casual/temporary), including contractors, visiting health professionals and students working in any CDHB or WCDHB facility and to all organisations providing services and treatment on behalf of CDHB or WCDHB.

Roles and Responsibilities

Obtaining consent

The registered health professional who is responsible for the service/treatment being proposed has duty of care to enable an informed choice to be made about that treatment before any treatment begins.

This responsibility may be delegated provided that delegated person is suitably qualified and experienced and has sufficient knowledge of the individual's circumstances, condition and the proposed service/treatment.

Legal advice

The legal team is responsible for advising on informed consent when requested.

The legal team will oversee legal obligations and potential concerns and complaints relating to consent for CDHB and WCDHB.

Training

Education on informed consent is professionally and clinically based. CDHB and WCDHB's informed consent processes and divisional practice will be included as part of clinical staff induction and ongoing training within their department as required.

Governance

Divisional quality teams monitor informed consent processes through customer feedback and regular reporting processes, escalating concerns to clinical governance committees when necessary.

Clinical governance committees will ensure that compliance with this policy is monitored. The focus of monitoring is to verify that the:

- Informed consent process occurs.
- A written consent is obtained when appropriate.
- Consent and the discussions between the health professional and person are recorded in the clinical notes.

Policy measurement

Incidents and complaints relating to poor compliance with the policy are reported using the Incident Management Reporting System.

Patient experience feedback will provide data about informed consent.

Area or topic specific audit will occur as per local audit schedules.

Associated material (inclusive)

Related documents

- Agreement to Treatment form
- Request for Treatment form
- Treatment without consent form
- Agreement to Clinical Imaging Form
- General photography/ Video Filming consent
- Electronic Interpreter Booking form
- Interpreter Services Patient Information

Legislation and standards

- Code of Health and Disability Services Consumers' Rights 1996 Rights 5, 6 and 7.
- Health and Disability Services Standard 2008: 1.10
- Medical Council of New Zealand Statement on information, choice of treatment and informed consent, March 2011

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Disclosure of Personal Health Information Policy and Procedure

Please note: This Procedure is currently under review by Legal Services as part of a Transalpine approach to policy alignment with the CDHB. If you have any questions regarding this document please contact the ***Senior Corporate Solicitor*** *in the first instance.*

1. Purpose

This Procedure outlines the process to be followed when disclosing personal health information, while maintaining the patient's right to privacy, confidentiality, and to meet the relevant statutory requirements.

2. Application

This Procedure is to be followed by all staff, inclusive of Secondary, Tertiary and General Practice services throughout the West Coast District Health Board (WCDHB).

This Procedure does not apply to:

- Pathology results – these can be provided to the patient without a request to release patient information
- Radiology results – these can be provided to the patient without a request to release patient information
- Dispensing Scrip Record, including Script charges paid by patient
- Print out of hospital visits for travel claims
- Release of personal health information to another health provider directly involved in the individual's care, including other District Health Boards

3. Definitions

For the purposes of this Procedure:

Release of Personal Health Information (PHI) is taken to mean:

- Information provided in both verbal, electronic and / or paper clinical records

Personal Health Information (PHI) is taken to mean:

- Information about the health of an individual/patient
- Information about the disabilities of an individual/patient
- Information about any health or disability services that are being or have been provided by the WCDHB to an individual / patient
- Health information communicated verbally and electronic and paper clinical records

- Diagnostic images taken by specialist services within the WCDHB e.g. X-rays, diagnostic scans or photographs of pathological specimens

- Information derived from the testing or examination of any body part or bodily substance of an individual/patient

- Information provided by an individual in relation to the donation by that individual of any body
  part or bodily substance

- Information about an individual which is collected before or in the course of, and incidental to the provision of any health or disability service to the individual.

An individual's ***Representative*** is taken to mean the following:

- When an individual has died – it is the person in charge of their estate;

- Where an individual has authorised someone to act on their behalf;

- When an individual is under the age of 16 years – it is their parent or guardian; Please use the following link for more information in relation to release of patient information under the Guardianship Procedure – Guidelines for Informed Consent of Children

- When an individual is unable to give their consent or exercise their rights – it is someone who is seen to be acting lawfully on the individual's behalf.

4. Responsibilities

For the purposes of this Procedure:

Quarantined Files:

- The release of any information from a quarantined file (refer to the WCDHB Serious and Adverse Event Review Procedure) **can only take place after the request has been considered by the Patient Safety Officer, including where the request is by the Police.**

Privacy Officer /Patient Safety Officer/Quality and Patient Safety Manager are responsible for:

- Ensuring compliance by WCDHB staff with the requirements of this Procedure, and for providing advice and information to staff relating to the releasing of personal health information (PHI).

Medical Records Staff and/or Reception Staff are responsible for:

- Confirming identification of individual/patient requesting information for each individual request –
- Photocopying of identified documentation to whom the information relates, or their representative

- Recording of authority box details on page 5 of the request to Release Patient Information Form (ROPI)
- Recording request details on the electronic register (shared drive medical records ROPI)
- Health Authority Release stamp on photocopy
- Filing of request to release patient information form
- Providing, by post (registered mail/courier) or another agreed mode of communication, the requested material to the person once it has been confirmed that they are authorised to receive the material.
- Provision of the complete clinical record to a statutory agency upon receipt of a written request and after complying with the relevant legislation.

Chaplains / Clergy / Church Visitors

- The Hospital Chaplain, members of the Clergy or Church Visitors are to report to the Reception Desk at each Hospital and request to be provided with a list of those patients who wish to receive a visit. This information is to be provided after Reception staff have correctly identified the Hospital Chaplain members of the Clergy or Church Visitors, and had them complete the relevant sign-in procedure.

Clinical Staff are responsible for:

- The checking and removal of any 3rd party information and/or information that is deemed to be inappropriate for release and /or would be harmful for the patient and / or third parties to receive

Mandatory for Mental Health staff only:

- Where necessary, the relevant clinical staff member should be consulted to determine if there are any concerns that the likelihood of releasing the information would prejudice the physical or mental health of the requestor.

- No mental health PHI is to be released without first being authorised by the current Psychiatrist and /or Case Manager. Even in this situation, the only reasons available to refuse a patient's request to access his or her own PHI are contained in sections 27 to 29 of the Privacy Act 1993 as shown below.

The only reasons available to refuse a patient's request to access his or her own PHI are contained in sections 27 to 29 of the Privacy Act 1993. The key reasons are if releasing the information would:

i) Prejudice any laws; or[1]
ii) Endanger the safety of any person; or[2]
iii) Involve releasing information about a 3rd person; or[3]
iv) Prejudice the physical or mental health of the individual.[4]

[1] Here after will be referenced as sections 27 to 29 of the Privacy Act 1993
[2] Here after will be referenced as sections 27 to 29 of the Privacy Act 1993
[3] Here after will be referenced as sections 27 to 29 of the Privacy Act 1993
[4] Here after will be referenced as sections 27 to 29 of the Privacy Act 1993

- **If none of the withholding grounds apply then the information must be released**.

However, even if the withholding grounds do apply, then the information may still be released. For example, Section 22F(2) of the Health Act 1956 permits this to occur where the information is being released to a patient or their representative. (**Section 22F (2) states that reliance on the withholding grounds is discretionary - (may) as opposed to mandatory (shall)**).

5. Resources Required

- WCDHB Request For The Release Of Personal Health Information Form

6. Process

Introduction

- WCDHB has the legal responsibility to ensure that a patient's privacy is protected by taking all reasonable steps to prevent the unauthorised disclosure of PHI.

- The physical medical record that contains the PHI remains the property of WCDHB, while the PHI itself belongs to the individual (or their representative) to whom the information relates.

Releasing Information to Patients and/or a third party

- Individuals who wish to be provided with copies of their PHI must complete a WCDHB Request for the Release of Personal Health Information Form, and provide verification of identification, such as:
  - i) community services card;
  - ii) drivers license;
  - iii) bank card;
  - iv) or other suitable forms of identification;
  - or be known personally by the Medical Records/Reception and / or Clinical Staff

- The requested information shall not be released until an accepted form of identity and proof of authorisation has been provided

- Representatives must have documented authorization from the patient that indicates the patient has agreed to the representative having access to their PHI, and the representative must also provide some form of verification of their identification (as identified above) before the PHI will be released to them

- Page 2 of the release of patient information form should clearly identify the clinical documentation requested for release

- Medical Records and/or Reception staff are required to take a photocopy of the verification of identification and attach it to the completed WCDHB Request for the Release of Personal Health Information Form, which is to be filed in the relevant clinical record e.g. RAGP, Mental Health or Ziman House

- The request for release of PHI is to be processed within 20 working days. However, if the request is for a large quantity of information, or there is a need for consultations to occur before a decision on the request can be made, an extension can be made. Where this occurs, the requester is to be informed in writing of this and:

  i) the period of the extension; and
  ii) the reason for the extension; and
  iii) their right of complaint to the Privacy Commissioner

- The PHI requested is then to be photocopied. Once photocopied it is to be checked by another staff member to ensure that the information copied is correct and in accordance with the request

- Where necessary, the relevant clinical staff should be consulted to determine if there are any concerns that the likelihood of releasing the information would prejudice the physical or mental health of the requester. For mental health clients this requirement is mandatory
  (NOTE: No Mental Health PHI Is To Be Released Without First Being Authorised By The Current Psychiatrist Or Case Manager)
- **Consideration is then required to be given to the possibility of any reason for the withholding the PHI. The only reasons available to refuse a patient's request to access his or her own PHI are contained in <u>sections 27 to 29 of the Privacy Act 1993</u>**

- **If none of the withholding grounds apply then the information <u>must be</u> released**

- However, even if the withholding grounds do apply, then the information may still be released. For example, Section 22F(2) of the Health Act 1956 permits this to occur where the information is being released to a patient or their representative. (**Section 22F (2) states that reliance on the withholding grounds is discretionary - (may) as opposed to mandatory (shall)**)

- Any decision to withhold PHI must be recorded on the WCDHB Withholding of Personal Health Information Form (which is to be forwarded to the Privacy Officer). It is advisable for staff to contact the Privacy Officer to discuss any concerns that they have regarding the withholding of PHI

- Once a decision has been made to release the PHI, it is to be stamped to indicate that it has been released in response to a request from a person entitled to receive it

- If any PHI has been withheld, the requester is to be informed of this in writing, as well as:
  i) the reasons for withholding the information;
  ii) their right of complaint to the Privacy Commissioner

- The release of patient information log must be updated at all stages of the process by the relevant medical records and/or reception staff member

- Where patients have requested access to their personal health information, it may be appropriate for a suitable person to be available to assist in interpreting the information and to answer any questions from the patient

- The WCDHB must ensure that only the patient making the request, or their authorised representative, receives the PHI being sought by the patient. This may involve the patient collecting the information in person and providing proof of identity, or **sending it by registered mail/courier**

Disclosure of Deceased Patient Personal Health Information Procedure:

- An individual's right to privacy of their health information continue following their death with some modification of the privacy rights they had while they were alive

- With recently deceased patients, a registered health professional, or other WCDHB staff member authorised by the relevant General Manager, may disclose the facts relating to the death of the patient to the patients' spouse partner, next of kin, whanau, close relative, principal caregiver, or other person whom in the circumstances it is reasonable to inform. (see WCDHB Immediate Care of Relatives Following Patient Death/Serious Incident)

- If immediate family/whanau members request information regarding the circumstances surrounding the death, it will usually be appropriate for a registered health professional to discuss the circumstances of the death with the immediate family. The registered health professional should satisfy themselves that the request is a genuine one. The registered health professional may wish to refer to the clinical records and may allow family/whanau members to sight these records in the presence of the registered health professional. (see WCDHB Immediate Care of Relatives Following Patient Death/Serious Incident)

- Access to the PHI of a deceased patient is restricted to the deceased patient's:
  - i) Estate executor or
  - ii) Estate administrator or
  - iii) Individual who inherited the deceased person's estate or
  - iv) Another agency that has a lawful reason for requesting the information

Requests From Individuals Who Are Inpatients

- Requests by patients who are currently residing in a ward to view their PHI are first to be cleared with the relevant responsible clinician, to ensure that this would not prejudice the physical or mental health of the patient

  (No mental health PHI is to be released without first being authorised by the current psychiatrist and / or case manager).
- **The only reasons available to refuse a patient's request to access his or her own PHI are contained in sections 27 to 29 of the Privacy Act 1993**

- **If none of the withholding grounds apply then the information must be released**

- However, even if the withholding grounds do apply, then the information may still be released. For example, Section 22F(2) of the Health Act 1956 permits this to occur where the information

is being released to a patient or their representative. (**Section 22F (2) states that reliance on the withholding grounds is discretionary - (may) as opposed to mandatory (shall)**)

- Nursing/medical staff are to provide the patient/representative access to their PHI, and are to offer to provide any explanation or interpretation that the patient/representative may require

- Nursing/medical staff are to record all such requests by patients/representatives in the patient's medical record, and all actions taken

Requests From a Statutory Agency i.e. Police, CYFS and/or ACC

Requests Made By NZ Police

- All requests for information from Police Officers are to be directed to the Medical Records Department, Privacy Officer and / or Patient Safety Officer to handle in accordance with WCDHB's legal obligations

- Before any information is released to the NZ Police, they must provide one of the following types of authorisation:

    i. A written requests made under Section 22C of the Health Act; or
    ii. A written request made under the Official Information Act; or
    iii. Signed authorisation from the patient – if appropriate / applicable; or
    iv. A search warrant

- All requests pertaining to a quarantined file must be directed through the Patient Safety Officer

Requests Made by Child, Youth and Family Services

- All requests for information from Child, Youth, and Family Services are to be directed to the Medical Records Department, Privacy Officer and / or Patient Safety Officer to handle in accordance with WCDHB's legal obligations

- Before any information is released to Child, Youth and Family Services, they must provide one of the following types of authorisation:

    i. For children - a written requests made under Section 66 of child, Young Persons and their Families Act; or
    ii. For adults – a written request made under Section 22C of the Health Act

Requests Made by Accident Compensation Corporation

- All requests for information, including treatment injury, from Accident Compensation Corporation are to be directed to the Medical Records Department, Privacy Officer and / or Patient Safety Officer to handle in accordance with WCDHB's legal obligations
- When a patient completes an application for Accident Compensation Corporation they are requested to sign an authorisation allowing Accident Compensation Corporation to access information about their care for the purpose of the patient's management. Therefore, Accident Compensation Corporation requests for information about the patient's care may be released without WCDHB seeking the patient's separate, express permission

Requests Made by Ministry of Social Development, Housing New Zealand Corporation, Lawyers/Insurance Companies

- All requests for information from any of the above organisations are to be directed to the Quality and Patient Safety Manager, Privacy Officer and / or Patient Safety Officer to handle in accordance with WCDHB's legal obligations

Requests Made by the Coroner and/or the Health and Disability Commissioner/Privacy Commissioner

- All requests for information from the Coroner are to be directed to the Patient Safety Officer and/or the Quality and Patient Safety Manager to handle in accordance with WCDHB's legal obligations

Ministerial Inquiries

- Inquiries for the Minister of Health are to be referred to the General Manager and/or the Quality and Patient Safety Manager

Requests by Professional Bodies

- All requests for information from any Professional Body are to be directed to the relevant WCDHB Professional Advisor:
  - i. Chief Medical Officer; or
  - ii. Director of Nursing and Midwifery; or
  - iii. Associate Director of Allied Health

Requests From News Media Representative (NMR)

- All requests from a NMR for information, including PHI, are considered requests under the Official Information Act. Although WCDHB must always comply with the Official Information Act 1982, the way in which WCDHB handles these NMR requests will depend on the specific nature and circumstances of the request

- During normal working hours, all requests from a NMR for PHI are to be directed to the relevant General Manager and Senior Communications Adviser. After normal working hours, such requests are to be directed to the After Hours Coordinator

- If a Patient has consented to the release of PHI to a NMR then the following information can be released:
  - i) Presence of the patient
  - ii) Location of the patient
  - iii) Condition[5] and progress of the patient

  NB: no other[6] PHI shall be released

- If the Patient has not consented to their release of PHI to a NMR (nominated 3rd party), then no PHI is to be released. The NMR is to be informed that the patient does not wish any details of their condition to be released to the news media

[5] **Condition is not the diagnosis;**

[6] **Includes diagnosis**

- If a NMR makes a request for PHI about a person who has been a patient of WCDHB, but is not currently admitted to a WCDHB hospital, then the request is to be considered as having been made under the Official Information Act, which requires that in this circumstance, the prior written consent of the patient has to be provided before any information is to be released. This written consent is also to include the specific information that is to be released

- A record of all PHI released to a NMR is to be kept by the relevant General Manager and/or Senior Communications Advisor

Requests for External Audit and Research

- **No records are to be released** for research or audit purposes unless the appropriate authorisation has been received

Requests For PHI That Is Held By The National Archives

- **Where** a request for PHI by a patient has been received, considered and approved, and the PHI has previously been transferred to the National Archives (under the Archives Act 1956) a letter granting the patient or their representative access to the PHI has to be sent to the patient or their representative and to the National Archives. This is undertaken by the Privacy Officer

7. Precautions and Considerations

➔ The identity of requester, and where applicable third party/representative, is to be checked before any PHI is released

The WCDHB has a legal responsibility to ensure that a patient's privacy is protected by taking all reasonable steps to prevent the unauthorized disclosure of PHI

➔ Whenever possible the requested PHI **must be** sent by courier

While recognising that there will be circumstances when PHI is required to be sent by either by fax or email, WCDHB staff members must be mindful of the limitations of these communication systems with regards to protecting the privacy of patients PHI. Confirmation of the fax and/or email address must be achieved prior to sending PHI

➔ PHI may only be sent by email after reasonable steps have been taken to confirm the authenticity of the email address provided

PHI sent by fax, must:

i. Where possible use pre-programmed fax numbers
ii. Ensure the correct fax number correlates with the number displayed
iii. If sent to the wrong fax number, contact the recipient and request that they either return the information in person or vial mail, or destroy the information

- **If PHI is sent to an incorrect recipient, the WCDHB staff member is required to complete a WCDHB Safety 1st Incident Report and report the incident to the WCDHB Privacy Officer**

- Requests for PHI are to be processed within 20 working days
- Consideration is to be given to withholding any PHI if any of the withholding criteria applies
- Only the names of those patients who have indicated a desire to receive a visit are to be disclosed to the Hospital Chaplain, members of the Clergy or Church Visitor
- Rights to health information privacy of deceased persons continue after their death with some modification of the privacy rights they had while they were alive
- Access to the PHI of a deceased person is restricted to their estate executor, administrator or person who inherited their estate
- A request for access to the PHI of deceased patients is to be processed as per the normal request process

8. References

- Health Information Privacy Code 1994
- On The Record – A Practical Guide to Health Information Privacy
- Privacy Act 1993
- Official Information Act (OIA) 1982

9. Related Documents

- WCDHB Official Information Request Procedure
- WCDHB Guidelines for Informed Consent of children
- WCDHB Collection, Collation, Correction & Alteration Of Personal Health Information Procedure
- WCDHB Staff Access to Personal Health Information Procedure
- WCDHB Storage Of Personal Health Information Procedure
- WCDHB Immediate Care of Relatives Following Patient Death/Serious Incident
- WCDHB Withholding of Personal Health Information Form
- WCDHB Serious and Adverse Event Reporting and Review Procedure

10. Key Words

Access	Disclosure	Inpatient	Patient	Mental Health
Clergy	Health information	Media	Information	Official Information
ROPI	Health Record	Release of	Privacy	request
OIA	Deceased	Medical Records	Third Party	Clinical Records / File
				General Practitioner - GP

11. Glossary

PHI	Personal Health Information
ACC	Accident Compensation Company
WCDHB	West Coast District Health Board
NMR	News Media Release
CYFS	Child, Youth and Family Services

Revision History		
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West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Collection, Collation, Correction & Alteration Of Personal Health Information/Medical Records Procedure

Please note: This Procedure is currently under review by Legal Services as part of a Transalpine approach to policy alignment with the CDHB. If you have any questions regarding this document please contact the ***Senior Corporate Solicitor*** *in the first instance.*

1. Purpose

This Procedure outlines the process to be followed when collecting, collating, correcting and altering personal health information, in order to maintaining the patient's right to privacy, confidentiality, and to meet the relevant statutory requirements.

2. Application

This Procedure is to be followed by all staff throughout West Coast District Health Board (WCDHB).

3. Definitions

For the purposes of this Procedure:

Personal Health Information (PHI) is taken to mean:

- information about the health of an individual;
- information about the disabilities of an individual;
- information about any health or disability services that are being or have been provided by WCDHB to an individual;
- information derived from the testing or examination of any body part or bodily substance of an individual;
- information provided by an individual in relation to the donation by that individual of any body part or bodily substance;
- information about an individual which is collected before or in the course of, and incidental to the provision of any health or disability service to the individual

When collated together is called a *patient's medical record*.

Representative is taken to mean the following:

- when an individual has died – it is the person in charge of their estate;
- where an individual has authorised someone to act on their behalf;
- when an individual is under the age of 16 years – it is their parent or guardian;
- when an individual is unable to give their consent or exercise their rights – it is someone who seems to be
  acting lawfully on the individual's behalf

4. Responsibilities

For the purposes of this Procedure:
The ***Privacy Officer*** is responsible for encouraging compliance by WCDHB staff with the requirements of this Procedure, and for providing advice and information to staff.

WCDHB Staff are responsible for collating PHI in accordance with the requirements of this Procedure.

5. Resources Required

This Procedure requires:

i) WCDHB Guide to Managing Personal Health Information

ii) Various WCDHB PHI Forms

iii) WCDHB Medical Records File Cover

6. Process

1.00 Introduction

1.01 WCDHB has the legal responsibility to ensure that a patient's privacy is protected by taking all reasonable steps to prevent the unauthorised disclosure of PHI.

1.01 The collated medical record that contains the PHI remains the property of WCDHB, while the PHI itself belongs to the person (or their representative) to whom the information relates.

2.00 Collecting Personal Health Information (PHI)

2.01 Personal health information is to be obtained and used for the purpose of providing ongoing care and treatment to the patients of WCDHB, which includes sharing relevant information with other providers of health services.

2.02 Other purposes for which PHI may be obtained include:

i) Service planning and other administrative functions; and/or

ii) Training and education; and/or

iii) Auditing and monitoring of the quality of services; and/or

iv) Ministry of Health and other agencies' (e.g. ACC, Enable NZ) funding and statistical reporting requirements; and/or

v) Research.

2.03 If a staff member wishes to obtain or use personal health information for a purpose other than those outlined above, they must first seek the advice of their Service Manager or the Privacy Officer.

2.04 Health information must not be collected by unlawful or unfair means or if it will intrude unreasonably into the affairs of the patient. However, if health information is being collected without the knowledge of the patient, (e.g. by the use of one-way mirrors etc), the justifications for using this method of collecting information must be documented in the patient's medical record.

2.05 PHI should be collected directly from the individual patient concerned. Exceptions to this include where:

i) The patient has authorised someone else to provide the information; and/or
ii) The patient's representative has authorised someone else to provide the information if the patient is unable to give their authorisation; and/or
iii) Compliance with this directive would prejudice the patient's interests, for example, in an emergency situation; and/or
iv) Compliance with this directive is not practical, for example, if a patient is unconscious or unable to provide the information; and/or
v) Ethics Committee approval for research has been obtained; and/or
vi) Compliance with legislation is required, e.g. Mental Health (Compulsory Assessment and Treatment) Act 1992.

2.06 When information is not collected directly from the patient the source of this information and the identity of the person providing the information must be documented in the patient's medical record.

2.07 When collecting PHI, staff must ensure that patients are aware:

i) That the information is being collected; and
ii) Why it is being collected; and
iii) Who will receive the information, e.g. ACC, GP etc; and
iv) Whether it is mandatory or voluntary to provide the information; and
v) What the consequences of not providing the information are; and
vi) What their rights to access and alter the information are.

2.08 Staff should avoid collecting PHI from patients in public waiting areas where members of the public or unauthorised staff could overhear the discussion.

3.00 Collated Personal Health Information (The Medical Record)

3.01 All collated medical records are to be stored (when not in use) in the specific secure storage areas allocated within the WCDHB Medical Records Department, or within individual WCDHB Departments.

3.02 Medical records will be collated by WCDHB Medical Records Staff or WCDHB Administration staff at WCDHB Hospital Reception, in the Department where the patient is being treated, or in the WCDHB Medical Records Department.

3.03 Presentation of the collated medical records is to be neat and tidy at all times.

3.04 Collated medical records are to be created in the following circumstances:

i) for new patients being admitted to a WCDHB Hospital, Department or Service; or
ii) when a current medical record becomes too large to be managed effectively (as per Section 1.11)

3.05 Medical/surgical PHI is to be collated into the following order in a medical record (*starting at the back and working to the front)*:

i) admission form
ii) property sheet
iii) fluid balance chart
iv) ventilatory function
v) doctors request/referral form
vi) pulse and BP chart
vii) coma record
viii) peak flow meter chart
ix) hourly recording chart
x) diabetic chart
xi) nursing history
xii) patient care plan
xiii) nursing care plan
xiv) pre-op checklist
xv) operation note
xvi) anaesthesia record
xvii) ECG
xviii) waiting list card
xix) radiology report mount
xx) pathology report mount
xxi) histology reports
xxii) anticoagulant chart
xxiii) IV fluid chart
xxiv) medication chart

xxv) clinical notes
xxvi) temperature, pulse and BP chart
xxvii) discharge note
xxviii) discharge summary
xxix) clinical coding printout
xxx) outpatient records
xxxi) correspondence

3.06 Mental Health PHI is to be collated into the following order in a medical record (*starting at the back and working to the front)*:

i) Miscellaneous (case studies, observation summaries and accident/incident reports;
ii) Correspondence;
iii) Medic-legal (Mental Health Act, Alcohol and Drug Act, Tribunals and Reviews);
iv) Special Education Service Reports (CAMHS only);
v) Psychometric Assessments (CAMHS only) *****NB: Must be as per the New Zealand Psychologists Board Guidelines on the use of Psychometric Tests, March 2015 in a sealed and labelled envelope.
v) Psychologists Reports;
vi) Medical Investigations;
vii) Radiology Reports;
viii) Pathology Reports;
ix) ECT Treatments;
x) Prescription Sheet;
xi) Discharge Checklist;
xii) Summary of Care Form;
xiii) Clinical Notes;
xiv) Nutrition Screening Form;
xv) Sleep Pattern and Medication Chart;
xvi) Physical Examination Form;
xvii) Care Plan For Persistently High Risk Consumer Form;
xviii) Wellness Maintenance and Relapse Prevention Form;
xix) Recovery Plan Progress Notes;
xx) Recovery Plan Form;
xxi) Crisis/Respite Care
xxii) MDT Clinical Review/Evaluation Form
xxiii) MDT Management Plan Form
xxiv) Discharge Plan Form
xxv) Initial Care Plan Form
xxvi) Comprehensive Assessment Form
xxvii) Limitations on Movement Form
xxviii) Risk Assessment Form
xxix) Referral, Triage and Emergency Assessment Form
xxx) Case Note Alert Form

xxxi) Property Sheet
xxxii) Privacy and Consent Form
xxxiii) Registration and Admission Forms

*****<u>Keeping psychometric records</u>
Psychometric test results, consisting of both the raw data and the interpreted results, should be safeguarded to preserve confidentiality and to avoid those who are not trained to use them in a manner that could be misleading. Raw data arising from psychometric assessment should be retained in a secure file. In an organisation or health service setting this is likely to require that the Psychologist keep psychometric

assessment records in separate, securing filing systems rather than including them in a client's main personal or health records (which may be accessed by other professional and non-professional). In some settings it may be appropriate to keep the psychometric records on the main file in a sealed and labelled envelope.

3.07 All PHI collated into the medical record must contain either a Bradmar (patient label) affixed to the top right corner of the PHI, or the patient's name, NHI and DOB written on the PHI.

3.08 Medical alerts (for medication allergies etc) are to be indicated on the front cover of the medical record file.

3.09 A case note alert for persistently high risk mental health patients is to be attached to the front cover of the medical record form (*as per the WCDHB MHS Case Note Alert Procedure*).

3.10 If the medical record has become too large to be managed effectively, a second medical record is to be started. The medical record with the oldest PHI is to be marked "Volume 1", and the new medical record is to be marked "Volume 2". The volume 2 medical record must always retain the correspondence and outpatients PHI (medical/surgical patients only).

4.00 Correction Of Collected & Collated Personal Health Information

4.01 All health information in the medical record must be accurate. However, from time-to-time inaccuracies are identified, and these must be corrected to ensure the records remain accurate.

4.02 Inaccuracies in the health information contained in the medical record must be corrected as soon as they are identified.

4.03 The original information, which is being corrected, must not be deleted from the medical record. The changes must be tracked so that it is clear to all users that the correction has been made.

4.04 Prior to making any corrections, the medical record must be checked for subsequent references to this information, so that these can be corrected as well, if appropriate.

4.05 The information that is being corrected may appear in both paper and electronic format. Both the electronic and paper copy must be corrected:

i. Corrections to Electronically Generated Records:
   a. If the inaccuracy is in a typed report, the author of the report must be notified and a request to correct made
   b. The date the correction is made, name of the person making the corrections, and on whose authority the corrections have been made, should be noted on the document.

c. The document should be marked "amended" on the top right hand corner, an amended copy sent to the GP or any other third party recipient of the information, and filed in the medical record.
d. The incorrect paper copy should be removed when the amended copy is filed in the medical record.

ii. Corrections to Paper Records:
a. All inaccuracies in the paper should be corrected by crossing out the original entry with a single line, initialed, dated.
b. Use a different coloured pen from the original entry to ensure that it is clearly identified as a correction.
c. Correction fluid or other products which obliterate the original entry must not be used to make corrections.

5.00 Alteration Of Personal Health Information

5.01 The Health Information Privacy Code (Rule 7) provides that patients may request a correction or alteration to their health information. If a request to make an alteration is declined, a "statement of alteration" should be attached to the information in their record.

5.02 Patients should be offered the opportunity to meet and discuss the request with the author of the information.

5.03 The identity of the person making the request must be verified before any alteration takes place. The West Coast DHB is required to provide a reasonable assistance to any individual wishing to record a statement of correction.

5.04 The person making the request must be informed of any action taken in respect of the request.

5.05 The alterations may be made in the following way:
i. Electronically Generated Records:
a. Electronic information should be altered using the same method for correcting inaccuracies in the electronically generated records.
b. Alterations to the information need to be clearly tracked without deleting the original record. The date the alteration was made, the name of the person making the alteration, and on whose authority the alterations have been made should be included on the document.
ii. Paper Records:
a. Hand written information in the paper record should be altered using the same method for correcting inaccuracies in the paper records. If the alterations are too complex to change in the paper record, a separate document outlining the alterations should be filed alongside the original entry.
b. An annotation next to the original entry to alert users of the record that an alteration has been made, and where it is located, must be included.

5.06 The original information, which is being altered, must not be deleted from the clinical record. The changes must be tracked so that it is clear to all users that the alteration has been made.

5.07 Prior to making any alterations, the clinical record should be checked for subsequent references to this information, so that these can be altered as well, if appropriate.

5.08 The Privacy Act does not specify grounds for denying or refusing requests for alteration. However, Health Information Privacy code suggests that valid reasons might be:

- If the agency believes the original information is correct; and/or
- When the original information is clearly identified as an opinion and correctly represents the opinion held at the time (e.g. an assessment of a patient's risk of suicide) ; and/or
- Where it is believed that the original information was correct at the time the assessment was made, but there is no means of verifying its correctness now.

5.09 Where a request for alteration is refused, the person making the request must:

- Be advised of the reasons for the refusal; and
- Be advised of their right to complain to the Privacy Commissioner to seek an investigation and review of the decision; and
- Seek a "statement of correction/ alteration" from the patient. This will be either a letter or note written by the patient, signed and dated. This will be placed in the paper record in close proximity to the information in question.

7. Precautions and Considerations

➔ Personal health information is to be obtained and used for the purpose of providing ongoing care and treatment to the patients of WCDHB

➔ When information is not collected directly from the patient the source of this information and the identity of the person providing the information must be documented in the patient's medical record

➔ All health information in the medical record must be accurate. However, from time-to-time inaccuracies are identified, and these must be corrected to ensure the records remain accurate

➔ If a request to make an alteration is declined, a "statement of alteration" should be attached to the information in their record

8. References

Health Information Privacy Code 1994.

On The Record – A Practical Guide to Health Information Privacy.
New Zealand Psychologists Board Guidelines on the use of Psychometric Tests, March 2015

9. Related Documents

- WCDHB Guide To Managing Personal Health Information
- WCDHB Access By Chaplains/Clergy/Church Visitors To Personal Health Information Procedure
- WCDHB Disclosure Of Personal Health Information (Of Deceased Patient) Procedure
- WCDHB Disclosure Of Personal Health Information (To Government Agencies) Procedure
- WCDHB Disclosure Of Personal Health Information (To Another Health Provider) Procedure
- WCDHB Disclosure Of Personal Health Information (To Patient) Procedure
- WCDHB Disclosure Of Personal Health Information (To The Media) Procedure
- WCDHB Disclosure of Personal Health Information (To Parents, Family, Friends) Procedure
- WCDHB Official Information Request Procedure
- WCDHB Requesting Personal Health Information From Another Health Provider Procedure
- WCDHB Sending Personal Health Information By Fax and Email Procedure
- WCDHB Staff Access To Personal Health Information Procedure
- WCDHB Storage & Disposal Of Personal Health Information Procedure

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	Authorised By:	Chief Executive Officer
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	Date of Next Review:	July 2019

RELEASE OF HEALTH INFORMATION

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Requests to access medical records/ health information held by West Coast District Health Board

Please read the following information before completing the request form.

The West Coast District Health Board (WCDHB) is required to safeguard your personal information by ensuring compliance with the Health and Disability Standards 2008, and respecting ***your*** right to have confidential information pertaining to your care. You must therefore personally identify yourself as that person by signing the request form **and attaching proof of identity**.

If you wish to access the health records of someone other than you, you must also complete this form and **provide proof of identity and supporting information**. The same process applies where you ask WCDHB to release your patient information to someone other than you. We refer to these requests as "third party access requests".

You can access your clinical records in three ways:

- Viewing in person
  - If you wish to view your clinical records, there may be a staff member with you when you do so. You must not alter, deface or remove any information.
- Receiving a photocopy of your information
  - If you wish you may have a clinician present to ask questions and explain specific procedures
- Verbal communication

Your request may take up to 20 working days to complete. We will inform you if an extension to this timeframe is required.

WCDHB may refuse you access or disclosure of certain parts of your clinical record under the provisions of the Health Information Privacy Code 1994. We will state the reason for such a refusal and you do have the right of review of the decision through the Privacy Commissioner.

You also have the right to seek a correction of your health information. You can do so by writing to the WCDHB Privacy Officer at PO Box 387, Greymouth 7840 or emailing on clinicalrecords@westcoastdhb.health.nz .

Please be aware, if your medical clinical record has been inactive for more than 10 years or your mental health record has been inactive for more than 20 years, it may have been destroyed.

WHAT WE NEED FROM YOU

1. COMPLETE THE FORM

Part 1: The details of the patient and the records or health information which is being requested
Part 2: Ensuring there is consent or proper authority to release the requested information

Please complete BOTH sections.

2. PROOF OF IDENTITY

Proof of identity is required with **ALL** requests for patient information. We require proofs of identity for:

- The patient whose records are being requested (unless the request is for the records of a child under 16 years of age or the patient is incapacitated or deceased); **AND**
- Any person who is requesting the records of someone other than themselves (for example, a child's parent or legal guardian, a person's enduring power of attorney or executor).

WCDHB will accept one of the following as proof of identity: Drivers Licence, or photo/signature page from valid passport OR other form of ID, e.g., Community Services Card.

3. SUPPORTING INFORMATION

If you are requesting the health information of someone for whom you are the legal representative, we require evidence of this relationship. For example, we require a copy of the Enduring Power of Attorney document, Welfare Guardian Court order, the patient's Will, or the Letters of Administration.

4. GIVE THE FORM TO US

Please post completed from to:

Medical Records Supervisor
Medical Records
Greymouth Hospital
PO Box 387
Greymouth 7840

OR

Hand-deliver the form to the relevant area your clinical documentation is held *e.g.*

Rural Academic General Practice, Buller Hospital or Mental Health Service

5. WE'LL RESPOND

In accordance with section 40 of the Privacy Act 1993, we will respond to your request no later than 20 working days after date of receipt. Every effort will be made to meet required timeframes, but this will not always be possible.

This form and the health information it relates to are subject to the Privacy Act 1993, Health Information Privacy Code 1994 and/or Official Information Act 1982. Further information about the relevant law is available from the Office of the Privacy Commissioner 0800 803 909 or www.privacy.org.nz.

PART 1 – *please complete in full*

PATIENT'S DETAILS (RECORDS TO BE ACCESSED)

Full Name of Patient:_____ **NHI:**_____

Other Names known by:_____

Full Residential or Postal Address: _____

Date of Birth:_____/____/_____Contact Number: Home/Work: _____ Cell:_____

Date information requested by if urgent: (NOT ASAP) ___/___/___ *(Please see notes on previous pages about response timeframes)*

Reason for request for urgency: _____

INFORMATION REQUESTED

Clinical Record

- ☐ Greymouth Hospital
- ☐ Reefton Hospital
- ☐ Buller Hospital
- ☐ Kynnersley (pre Sept 2015)
- ☐ Ziman House
- ☐ Emergency Department
- ☐ Mental Health
- ☐ Kahurangi
- ☐ District Nursing
- ☐ Radiology

WCDHB General Practitioner:

- ☐ **Buller Medical Service**
- ☐ **Ngakawau**
- ☐ **Karamea**
- ☐ **Reefton**
- ☐ **Grey Medical Centre**
- ☐ **RAGP**
- ☐ **Moana**
- ☐ **South Westland**

Outpatient Clinic *(Specify)*_____ Date of injury / medical treatment ……/……/……

Allied Health Therapy Services: Dates of treatment: from ……/……/…… to ……/……/……

- ☐ Physiotherapy
- ☐ Speech Language Therapy
- ☐ Dietetics/Nutrition
- ☐ Pharmacy
- ☐ Occupational Therapy
- ☐ Social Work
- ☐ Medical Technical

Documentation Requested

- ☐ Assessment
- ☐ Clinical Notes, includes care plans
- ☐ Correspondence and/or Referrals
- ☐ Discharge Summary
- ☐ Monitoring Charts (eg medication, temperature)
- ☐ Operation Notes/Report
- ☐ Report
- ☐ Investigations (e.g. laboratory tests)
- ☐ Radiology - please include date of injury / body location_____
- ☐ Images *(e.g. X-Ray, CT) there is a charge for imaging on CD/DVD*
- ☐ Complete record from ……/……/…… to ……/……/……
- ☐ Other (specify e.g. Mental Health Act documentation, chemotherapy treatment charts) _____

Please give any specific details about the documentation you are requesting

Manner in which Information is Requested

☐ Verbal ☐ View personally ☐ Photocopy ☐ Collect ☐ Post ☐ Email (not secure)

PART 2 – *please complete relevant section/s*

REQUEST BY THE PATIENT

A. REQUEST BY PATIENT TO ACCESS OWN INFORMATION

I, _____ [full name], request access to my health information as outlined in Part 1 of this form.

Signature: _____

Date: _____

❑ I have **attached proof of ID** for me as the patient

THIRD PARTY ACCESS REQUESTS

B. PATIENT'S CONSENT AND REQUEST TO RELEASE OF INFORMATION TO A THIRD PARTY

I, _____ [full name], request and consent to the following person receiving my health information as outlined in Part 1 of this form.

Full name of person (the third party) to receive my health information: _____

Third party's address: _____

Third party's daytime contact phone number: _____

Patient's signature: _____

Date: _____

❑ The third party who is to receive my information has **completed section E** of this form

❑ I have **attached proof of ID** for me as the patient

❑ I have **attached proof of ID** for the third party who is to receive my information

C. LEGAL GUARDIAN'S REQUEST TO ACCESS INFORMATION ABOUT A CHILD UNDER 16 YEARS OF AGE

Legal guardian's full name: _____

Relationship to child patient: _____

Address: _____

Daytime Contact Number: _____

Is there a Counsel for the Child: Yes / No

If yes, Counsel's name: _____ Contact number: _____

Is there a Protection Order issued against you by the Courts relating to this child or anyone involved with this child's care? Yes/No

If yes, please **attach** a copy of the Protection Order for us to assess its impact on your information request.

I request access to the child's health information as outlined in Part 1 of this form.

Legal guardian's signature: _____

Date: _____

❑ I have **attached proof of ID** for me as the third party requesting information

D. REQUEST BY PATIENT'S ENDURING POWER OF ATTORNEY / WELFARE GUARDIAN / ADMINISTRATOR / EXECUTOR

❑ *I hold an enduring power of attorney relating to health or have been appointed as welfare guardian for the patient*

❑ *The individual is deceased and I am the trustee/executor/administrator of his or her estate.*

Name: _____ Date: _____

Address: _____

Daytime Contact Number: _____

I request and consent to the following person receiving the patient's health information as outlined in Part 1 of this form.

Name of person receiving information: _____

Relationship to patient: _____

Address of person receiving information:

_____

Daytime contact number of person receiving information: _____

Signature of patient's representative: _____

❑ I have **attached** a copy of the **Enduring Power of Attorney document / Welfare Guardian Order / Will** OR **Letters of Administration** confirming I am the patient's representative

❑ I have **attached proof of ID** for me as the third party requesting the release of information

❑ I have **attached proof of ID** for the person who will receive the information

E. OTHER THIRD PARTY REQUESTS

I wish to receive the patient's health information as outlined in Part 1 of this form and do not fall within any of the previous categories.

Name: _____ Date: _____

Relationship to patient: _____

Reason for request: _____

Address: _____

Daytime Contact Number: _____

Signature: _____

❑ I have **attached proof of ID** as the third party who is to receive information

❑ If the patient has consented to the release of information to me, the patient has **completed section B** of this form and **attached his or her ID**.

FOR WCDHB OFFICE STAFF USE ONLY

(WCDHB-PRIV1 V1 Issued: August 2016)

Name and signature of staff member processing request:……Date……/……/…….

ID Verified: Yes / No **Form of ID:** Driver's Licence / Passport / Other ID - Specify:……

Request is AUTHORISED Yes / No Specify reason if No: (OR see attached letter)……

Date Information Released: ……/……/…… OR if information delivered to applicant in person:

Data Base Entry Completed Yes / No