CATEGORY:	**ORGANIZATIONAL: INFORMATION MANAGEMENT**
SUB-CATEGORY:	**DISCLOSURE OF INFORMATION**
GROUP:	
DISTRIBUTION:	**ALL EMPLOYEES / PHYSICIANS**
TITLE:	**CLIENT/PATIENT/RESIDENT ACCESS TO RECORDS**

PURPOSE

To provide a consistent approach to providing a client/patient/resident access to the personal health information contained in his/her record(s) containing personal health information.

POLICY

A. Right of Access

The client/patient/resident record of personal health information constitutes all records regarding a client/patient/resident that are prepared by employees of Western Health. The record may also include information received from other organizations (outside consultations, hospitals, etc.) for the purpose of continued client/patient/resident treatment and care.

The physical record is the property of Western Health; however, the information in it belongs to the client/patient/resident.

Unless certain exceptions outlined in this policy apply, an individual has a right of access to a record containing their personal health information that is in the custody or under the control of Western Health.

B. Where to Obtain Access to Records

To request access to their paper and/or electronic record(s) of personal health information, clients/patients/residents, parents/legal guardians and their representatives (see definitions) must be directed as follows:

Only the electronic version of this policy is to be considered current. Paper copies may be outdated. This policy is uncontrolled when printed.

i) Inpatients /Outpatients - Acute Care

- Health Records Department for outpatients;
- Manager or designate for the particular acute care unit or the Health Records Department in the acute care facility.

All outpatient requests for access to his/her record must be directed to the Health Records Department at the facility where the record is located. In consultation with the Regional Manager Health Information or designate as needed, a patient (or where applicable his/her substitute decision maker) will be provided access to his/her record of personal health information during his/her stay on the acute care unit, in particular where the request for access consists of a limited amount of information (e.g. a lab result). If the request concerns access to the entire record, the request must be directed to the Health Records Department at the acute care facility where the record is located.

ii) Long Term Care

- Manager or designate in the long term care facility or the Health Records Department at the acute care facility where the record is located;
- Health Records Department at rural sites.

In consultation with the Regional Manager Health Information or designate as needed, a resident (or where applicable his/her substitute decision maker) will be provided access to his/her record of personal health information at the long term care facility, in particular where the request for access is to information pertaining to his/her stay in long term care. If the request concerns access to the entire record, the request may be directed to the Health Records Department at the acute care facility, if that is where the record is located.

iii) Population Health Branch

- The service provider or designate in the Population Health Branch.

Please note that designated Health Information Management employees will arrange for retrieval of records that are located in inactive storage areas such that the request for access may be processed. In preparing the record for access/disclosure, employees must notify their immediate manager who may further consult with the Regional Manager Information Access and Privacy as necessary.

C. Employee Responsibilities – Client/Patient/Resident Viewing the Record

When the client/patient/resident has asked to view (see definitions) his/her record, an employee must remain with the client/patient/resident while the record is being viewed to ensure that information is not altered, removed or destroyed. If the employee is unable to meet with the client/patient/resident to review his/her record or the client/patient/resident does not wish to review the information with his/her service provider present, an appropriate designate employee must meet with the client/patient/resident while he or she reviews the record, again to ensure that information contained in the record is not altered, removed or destroyed.

Please note that clients/patients/residents are also entitled to obtain copies of their record as outlined in this policy.

D. Accepting and Processing the Request

i) Accepting Written and Verbal/Telephone Requests

Whenever possible, requests for client/patient/resident access to his/her record of personal health information must be made in writing through either a:

- signed and dated written request from the client/patient/resident;
- a completed form requesting access to the record Form # 12 - 484 *Request for Access to Personal Health Information.*

At the discretion of the designated manager/director, a verbal request may be made either in person or by telephone where the client/patient/resident has limited ability to read or write English or has a disability or a condition that impairs his or her ability to make a request in writing.

The reason(s) for accepting a verbal request must be documented in the client/patient/resident record.

Note that clients/patients/residents must not be refused access to their clinical record if they do not wish to provide a reason for the request. However, employees are permitted and encouraged to request a reason for accessing the information if doing so will assist in clarifying the request.

ii) Exception

An exception to this policy exists as it relates to immunization records. The current provincial policy states that within the province of Newfoundland and Labrador, individuals are entitled to a copy of their own immunization record without submitting a written request for this information.

iii) Mandatory and Discretionary Refusal to Disclose Access to the Record

In reviewing the client/patient/resident request to access his/her record, the employee and respective manager may discuss the request and information to be disclosed, particularly in cases that are not routine disclosures of information in that particular unit/department/program/service.

Where the client/patient/resident is refused access to his/her record of personal health information as outlined in this section of the policy, in consultation with the Regional Manager Information Access and Privacy or designate, employees must inform the individual in writing that the request is refused as well as the reason for the refusal.

a) Mandatory

In consultation with the manager/director who further consults with the Regional Manager, Information Access and Privacy or designate as necessary, employees must refuse to permit an individual to view or receive a copy of a record of their personal health information:

- Where a provincial or federal law prohibits disclosure of the record or the information contained in the record;

- Where granting access would reveal personal health information about an individual who has not consented to disclosure; or

- Where the information was created or compiled for the purpose of:
    - The *Evidence Act*;
    - Studying or evaluating health care practice by a standards or quality assurance committee; or
    - The disciplinary process of health care professionals by a statutory body or for the quality or standards of professional services provided by health care professionals.

b) Discretionary

In consultation with the manager/director who further consults with the Regional Manager, Information Access and Privacy or designate as necessary, employees may refuse to permit an individual to examine or receive a copy of a record of his or her personal health information where:

- The record or the information in the record is subject to a legal privilege (e.g., solicitor-client privilege) that restricts disclosure of the record or the information;

- The information in the record was collected or created for use in a proceeding and the proceeding, together with all appeals or processes resulting from it, has not been concluded;

- The following conditions are met:
    - the information was collected or created during an inspection, investigation or similar procedure authorized by law or for detecting, monitoring or preventing the receipt of a service or benefit under an Act or program operated by the minister, or a payment for that service or benefit, and
    - the inspection, investigation or all proceedings, appeals or processes resulting from it, have not been concluded; or

- Granting access could reasonably be expected to:
    - result in a risk of serious harm to the mental or physical health or safety of the individual who is the subject of the information or another individual,
    - lead to the identification of a person who was required by law to provide information in the record to the custodian, or

- lead to the identification of a person who provided information in the record to the custodian in confidence under circumstances in which confidentiality was reasonably expected.

In cases where there is concern about the client/patient/resident having access to his/her clinical record, the decision to provide or temporarily withhold access to the record is reached in consultation with the most responsible physician or most responsible care provider and manager / director. If a decision is reached to refuse a client/patient/resident (or where applicable his/her substitute decision maker) access to his/her own record at a particular time, the decision to refuse access must be reviewed to determine if access may be provided, for example, as the client's/patient's/resident's health status improves.

In consultation with the manager/leader who further consults with the Regional Manager, Information Access and Privacy or designate as necessary, employees may further refuse to grant a request for access to a record of personal health information where it is believed on reasonable grounds that the request for access to the record is:

- frivolous or vexatious;
- made in bad faith; or
- for information already provided to the individual.

Please note that in situations where a request to access a record of personal health information is determined to be in violation of legal or policy requirements and the client/patient/resident is still insistent upon the information being released, the client may be directed to the manager / director who may further consult with the Regional Manager, Information Access and Privacy.

iv) Time Limits

Employees are required to respond to an access request from an individual in a prompt manner and within sixty days of receiving the request. An extension of thirty (30) days is available when the request meets the following criteria and the custodian has informed the individual in writing of the reasons for the extension:

- Meeting the sixty (60) day time limit would unreasonably interfere with the operations of Western Health; or
- The information consists of numerous records or locating the information cannot be completed within the time limit.

In consultation with the manager/director as appropriate, employees may grant or refuse the individual's request as soon as possible. This must not take place any later than the expiration of the extended time limit.

Where an employee of Western Health fails to respond to a request for access within the sixty (60) or ninety (90) day time period, he or she will be considered to have refused the request for access and the individual requesting access may appeal that refusal to the Supreme Court Trial Division or request a review of the refusal by the Information and Privacy Commissioner.

v) Third Party Information in the Record

Prior to disclosure, an employee must review the record to ensure accuracy of the information, e.g. misfiled information. As appropriate, remove or redact any such information from the record prior to disclosure, taking care not to alter or inadvertently disclose the original information. Consult with the Regional Manager Information Access and Privacy or designate as needed in such instances.

vi) Fees and Proof of Identification

Payment of a fee is required to access and/or obtain copies of one's record of personal health information. A copy of the *Fee Schedule for Disclosure of Personal Health Information* is found in Appendix A. However, at the discretion of the program Director or designate, a portion or all applicable fees may be waived in situations where it is deemed that charging a fee would result in undue financial or other hardship to the client/patient/resident. Please note that during the course of providing care to the client/patient/resident (e.g. during an admission to acute care or an ambulatory care visit), a fee will not be charged to provide access to up to ten pages of copies of personal health information pertaining to the current, ongoing episode of care. At the discretion of the program Director or designate, requests for personal health information beyond the current, ongoing episode of care or for copies in excess of ten pages may be subject to the applicable fee as outlined in the Fee Schedule (Appendix A).

Before access is provided to any written or verbal personal health information contained in a record of personal health information, the client/patient/resident must provide proof of identification by presenting of two pieces of identification, e.g. a driver's license or photo identification and MCP card (when in person). Alternatively, when receiving and processing requests by telephone, verification of the telephone number and returning the call to the client/patient/resident may serve as one means of proof of identity in addition to requesting other identifying information from the client/patient/resident such as his/her date of birth and MCP number. Please also refer to section D of this policy titled *Accepting Written and Verbal/Telephone Requests*.

vii) Where Information is Located in Other Records or Record Does Not Exist

Employees may provide personal health information to an individual from a record that is not a record dedicated primarily to personal health information about the individual who is requesting access by removing or redacting (see definitions) all additional information from the record prior to providing access. The Regional Manager information Access and Privacy must be consulted in these instances.

If reasonable efforts have taken place to locate a requested record and it cannot be located or does not exist, the employee who is responding to the request must inform the individual in writing. The manager/leader and Regional Manager, Information Access and Privacy or designate must be informed of this fact.

viii) Documentation

The request for access to the record of personal health information (letter or form) and details of the information released must be documented and filed in the client/patient/resident record. If the client/patient/resident does not wish to view the record with his/her service provider present, this fact must also be documented in the record.

DEFINITIONS

Access: For the purpose of this policy, this term refers to the client's/patient's/resident's right to view and/or obtain copies of their clinical records.

Disclose: In relation to personal health information in the custody or control of a custodian or other person, disclose means to make the information available or to release it and "disclosure" has a corresponding meaning.

Personal Health Information: Identifying information in oral or recorded form about an individual that relates to:

- information concerning the physical or mental health of the individual, including information respecting the individual's health care status and history and the health history of the individual's family;
- the provision of health care to the individual, including information respecting the person providing the health care;
- the donation by an individual of a body part or any bodily substance, including information derived from the testing or examination of a body part or bodily substance;
- registration information;
- payments or eligibility for a health care program or service in respect of the individual, including eligibility for coverage under an insurance or payment arrangement with respect to health care;
- an individual's entitlement to benefits under or participation in a health care program or service;
- information about the individual that is collected in the course of, and is incidental to, the provision of a health care program or service or payment of a health care program or service;
- a drug as defined in the *Pharmacy Act*, a health care aid, device, product, equipment or other item provided to an individual under a prescription or other authorization issued by a health care professional; or
- the identity of a person's representative as defined in Section 7 of the *Personal Health Information Act*.

Redact: To censor or obscure (part of a text) for legal or security purpose, e.g. using a black permanent marker or dry line liquid paper.

Representative: In keeping with the *Personal Health Information Act* (PHIA), a right or power of an individual may be exercised

(a) by a person with written authorization from the individual to act on the individual's behalf;
(b) where the individual lacks the competency to exercise the right or power or is unable to communicate, and where the collection, use or disclosure of his or her personal health information is necessary for or ancillary to a "health care decision", as defined in the *Advance Health Care Directives Act*, by a substitute decision maker appointed by the individual in accordance with that Act or, where a substitute decision maker has not been appointed, a substitute decision maker determined in accordance with section 10 of that Act;
(c) by a court appointed guardian of a mentally disabled person, where the exercise of the right or power relates to the powers and duties of the guardian;
(d) by the parent or guardian of a minor where, in the opinion of the custodian, the minor does not understand the nature of the right or power and the consequences of exercising the right or power;
(e) where the individual is deceased, by the individual's personal representative or, where there is no personal representative, by the deceased's nearest relative, and for this purpose, the identity of the nearest relative may be determined by reference to section 10 of the *Advance Health Care Directives Act*;
(f) where the individual is a neglected adult within the meaning of the *Neglected Adults Welfare Act*, by the Director of Neglected Adults appointed under that Act; or
(g) where an individual has been certified as an involuntary patient under the *Mental Health Care and Treatment Act*, by a representative as defined in that Act, except as otherwise provided in this Act.

Third party: This refers to information that is contained in a record that pertains to other individuals (e.g. other clients/patients/residents). It also refers to information that has been included in the record that has been prepared or provided by other sources that are external to Western Health (e.g. RCMP). In these cases, the legal authority to release any such documents contained in the record may have to be validated.

View: For the purpose of this policy, to review or examine the record without, or prior to, requesting copies of the information.

LEGISLATIVE CONTEXT

Access to Information and Protection of Privacy Act (2015). Available at:
http://www.assembly.nl.ca/legislation/sr/statutes/a01-2.htm

Personal Health Information Act (2008). Available at:
http://www.assembly.nl.ca/legislation/sr/statutes/p07-01.htm

REFERENCES

Government of Newfoundland and Labrador Department of Health and Community Services. *Newfoundland and Labrador Immunization Manual*. Available at: http://www.health.gov.nl.ca/health/publichealth/cdc/im_section1.pdf

APPENDICES

Regional Health Authority Fee Schedule – Appendix A

KEY WORDS

Access to records
Client access to records
Patient access to records
Resident access to records

FORMS

Request for Access to Personal Health Information Form # 12 – 484

TO BE COMPLETED BY STAFF IN QUALITY DEPARTMENT

Approved By: Chief Executive Officer	Maintained By: Regional Manager, Information Access & Privacy
Effective Date: 14/June/2012	☑ Reviewed: 16/July/2018 ☑ Revised: 12/September/2018
Review Date: 12/September/2021	☑ Replaces: (HCSW) 9-a-90 Client Viewing of Record (HCSW)15-1-500 Client Ownership of Records (WHCC) AD-R-200 Release of Information from Clinical Records (WHCC) Patient Access to View Medical Records-Standard ☐ New

Appendix A

RHA FEE SCHEDULE	
Client / Executor / Next-of-Kin Requests	
→ Standard Fee (includes up to 10 pages)	$10.00
→ Copy fee (more than 10 pages)	$0.25 per page
→ Viewing of Health Record	No charge (1 hr.)
→ Viewing of Health Record (**after 1st hour**)	$25/hr.
→ Hospital Visits (per request/per client)	$10.00
→ Time of Birth	$10.00
→ Immunization Records	No charge
→ Verification of Birth or Death	No charge
***Note: There is a $250 maximum charge to a patient/client.**	
Workplace NL Request	
→ Standard Fee (up to 25 pages)	$25.00
→ Copy fee (more than 25 pages)	$0.25 per page
→ Additional costs for photocopying external records from outside of RHA (e.g. fetal heart monitor strips, ICU/CCU notes)	As applicable
Third-Party Request ***(excluding Workplace NL)***	
→ Standard Fee (up to 25 pages)	$50.00
→ Copy Fee (more than 25 pages)	$0.25 per page
→ Additional Costs for photocopying outside of RHA (e.g. fetal heart monitor strips, ICU/CCU notes)	As applicable

NOTES:

- There may be extenuating circumstances where it is appropriate to waive fee(s). The program Director or designate has the right to waive charges due to special circumstances. Please refer to the *Fees and Proof of Identification* section of the policy.
- Copies of Health Records must be provided without charge to physician offices, hospitals, health care facilities, Legal Aid, RCMP/RNC/Police, Veterans and Professional Regulatory Bodies.
- All fees include HST.