

Access to health records

Guidance for health professionals in the
United Kingdom

December 2008

■ What is a health record?

■ Record-keeping

■ Living patients

■ Deceased patients

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1. Introduction

Health professionals often receive requests from people who wish to view or obtain copies of their own health records or those of others. Sometimes these requests come directly from the patient and at other times the requests may be from third parties such as solicitors. Health professionals may also receive requests for access to the records of deceased patients. The purpose of this guidance is to set out the circumstances in which health professionals may receive, and respond to, requests for access to health records.

2. What is a health record?

A health record is any record which consists of information relating to the physical or mental health or condition of an individual made by a health professional in connection with the care of that individual. It can be recorded in a computerised form, in a manual form or a mixture of both. Information covers expression of opinion about individuals as well as fact. Health records may include notes made during consultations, correspondence between health professionals such as referral and discharge letters, results of tests and their interpretation, X-ray films, videotapes, audiotapes, photographs, and tissue samples taken for diagnostic purposes. They may also include internal memoranda, reports written for third parties such as insurance companies, as well as theatre lists, booking-in registers and clinical audit data, if the patient is identifiable from these.

3. Advice on record-keeping

Health records must be clear, accurate, factual, legible and should be contemporaneous. They must include all relevant clinical findings, the decisions made, information given to patients, and drugs or treatment prescribed. Personal views about the patient's behaviour or temperament should not be included unless they have a potential bearing on treatment. Health records should not be altered or tampered with, other than to remove inaccurate or misleading information. Any such amendments must be made in a way that makes it clear that they have been altered and when.

Doctors should ensure that their manner of keeping records facilitates access by patients if requested. It may be helpful to order, flag or highlight records so that when access is given, any information which should not be disclosed, (such as those which identify third parties) is readily identifiable.

If patients express views about future disclosure to third parties, this should be documented in the records. Doctors may wish to initiate discussion about future disclosure with some patients if it seems foreseeable that controversial or sensitive data may be the issue of a future dilemma, for example after the patient's death.

The health departments give detailed advice about the minimum retention periods applicable to NHS records. The recommendations apply to both electronic and manual records, and the BMA advises private practitioners to follow the same rules. Hospital records should be kept for a minimum of eight years following the end of treatment, and GP records for 10 years, although certain types of records, such as children's records, obstetric records, and mental health records are kept for longer. When health professionals are responsible for destroying health records, they must ensure that the method of destruction is effective, and does not compromise confidentiality. Incineration, pulping, and shredding are appropriate methods of destroying manual records. Electronic data should be destroyed using appropriate data destruction software.

4. Living patients

The Data Protection Act 1998 (DPA) governs access to the health records of living people. The DPA is not confined to health records held by NHS bodies. It applies equally to the private health sector and to health professionals' private practice records. It also applies to employers who hold information relating to the physical or mental health of their employees if the record has been made by, or on behalf of, a health professional in connection with the care of the employee. The Act applies to all of the UK. Subject to the conditions explained in this guidance, individuals have a right to apply for access to health records irrespective of when they were compiled.

4.1 Who may apply for access?

4.1.1 Competent patients

Subject to the exemptions listed below, competent patients may apply for access to their own records, or may authorise third parties such as lawyers, employers, or insurance companies to do so on their behalf. Competent young people may also seek access to their own health records. It is not necessary for competent patients to give reasons as to why they wish to access their records.

4.1.2 Children and young people

Legally, there is no automatic presumption of capacity for people under 16 in England, Wales and Northern Ireland, and those under that age must demonstrate they have sufficient understanding of what is proposed. However, children who are aged 12 or over are generally expected to have the capacity to give or withhold their consent to the release of information from their health records. In Scotland, anyone aged 12 or over is legally presumed to have such capacity. When assessing a child's capacity it is important to explain the issues in a way that is suitable for their age. Where a child is considered capable of making decisions about his or her medical treatment, the consent of the child must be sought before a parent or other third party can be given access. Where, in the view of the appropriate health professional, the child is not capable of understanding the nature of the application for access, the holder of the record is entitled to refuse access.

4.1.3 Parents

Parents may have access to their children's records if this is not contrary to a competent child's wishes. For children under 18 or, in Scotland under 16, any person with parental responsibility may apply for access to the records. Not all parents have parental responsibility. In relation to children born after 1 December 2003 (England and Wales), 15 April 2002 (Northern Ireland) and 4 May 2006 (Scotland), both biological parents have parental responsibility if they are registered on a child's birth certificate. In relation to children born before these dates, a child's biological father will only automatically acquire parental responsibility if the parents were married at the time of the child's birth or at some time thereafter. If the parents have never been married, only the mother automatically has parental responsibility, but the father may acquire that status by order or agreement. Neither parent loses parental responsibility on divorce. Where more than one person has parental responsibility, each may independently exercise rights of access. A common enquiry to the BMA concerns a child who lives with his or her mother and whose father applies for access to the child's records. In such circumstances there is no obligation to inform the child's mother that access has been sought. Where a child has been formally adopted, the adoptive parents are the child's legal parents and automatically acquire parental responsibility. In some circumstances people other than parents acquire parental responsibility, for example by the appointment of a guardian or on the order of a court. A

local authority acquires parental responsibility (shared with the parents) while the child is the subject of a care or supervision order. If there is doubt about whether the person giving or withholding consent to access has parental responsibility, legal advice should be sought.

The holder of the record is entitled to refuse access to a parent, or an individual with parental responsibility where the information contained in the child's records is likely to cause serious harm to the child, or another person (see paragraph 4.9).

4.1.4 Individuals on behalf of adults who lack capacity

Patients with mental disorders or learning disabilities should not automatically be regarded as lacking the capacity to give or withhold consent to disclosure of confidential information. Unless unconscious, most people suffering from a mental impairment can make valid decisions about some matters that affect them. An individual's mental capacity must be judged in relation to the particular decision being made. If therefore a patient has the requisite capacity, requests for access by relatives or third parties require patient consent.

When patients lack mental capacity, health professionals are likely to need to share information with any individual authorised to make proxy decisions. Both the Mental Capacity Act in England and Wales and the Adults with Incapacity (Scotland) Act contain powers to nominate individuals to make health and welfare decisions on behalf of incapacitated adults. The Court of Protection in England and Wales, and the Sheriff's Court in Scotland, can also appoint deputies to do so. This may entail giving access to relevant parts of the incapacitated person's medical record, unless health professionals can demonstrate that it would not be in the patient's best interests. These individuals can also be asked to consent to requests for access to records from third parties. Where there are no nominated individuals, requests for access to information relating to incapacitated adults should be granted if it is in the best interests of the patient. In all cases, only relevant information should be provided.

4.1.5 Next of kin

Despite the widespread use of the phrase 'next of kin' this is not defined, nor does it have formal legal status. A next of kin cannot give or withhold their consent to the sharing of information on a patient's behalf. A next of kin has no rights of access to medical records.

4.1.6 Police

If the police do not have a court order or warrant they may request voluntary disclosure of a patient's health records under section 29 of the DPA. However, while health professionals have the power to disclose the records to the police, there is no obligation to do so. In such cases health professionals may only disclose information where the patient has given consent, or there is an overriding public interest. Disclosures in the public interest based on the common law are made where disclosure is essential to prevent a serious threat to public health, national security, the life of the individual or a third party, or to prevent or detect serious crime. This includes crimes such as murder, manslaughter, rape, treason, kidnapping and abuse of children or other vulnerable people. Serious harm to the security of the state or to public order and serious fraud will also fall into this category. In contrast, theft, minor fraud or damage to property where loss or damage is less substantial would generally not warrant breach of confidence. Health professionals should be aware that they risk criticism, and even legal liability, if they fail to take action to avoid serious harm. Guidance should be sought from the Caldicott guardian, or defence body where there is any doubt as to whether disclosure should take place in the public interest.

4.1.7 Solicitors

Health professionals releasing information to solicitors acting for their patients should ensure that they have the patient's written consent to disclosure and, where there is any doubt, confirm that the patient understands the nature and extent of the information disclosed. In practice, most solicitors will provide the patient's signed consent when requesting confidential information. Standard consent forms have been issued by the BMA and The Law Society (Appendix 1) and by the BMA and The Law Society of Scotland (Appendix 2). While it is not compulsory for solicitors to use these forms, it is hoped they will improve the process of seeking consent. If a solicitor acting for someone else seeks information about a patient, the patient's consent to the release of the information must be obtained. Should the patient refuse, the solicitor may apply for a court order requiring disclosure of the information.

The arrangements for charging for access to health records are no different for solicitors (see paragraph 4.6). A common enquiry to the BMA is whether a patient's original medical records can be sent to a solicitor. While the DPA allows the applicant to be supplied with a copy of the health record it does not require health professionals to provide access to the original record. The BMA strongly recommends that original notes are not sent to solicitors because of the potential detriment to patient care should the records be lost.

4.2 When should access be given?

There is nothing in the law that prevents health professionals from informally showing patients (or proxies) their records as long as no other provisions of the Act are breached. However, health professionals may supply copies of records only if a formal application for access to the records has been made.

Requests for access must be made in writing on a form or letter or electronically and is known as a Subject Access Request (SAR). Once the written request has been received, the individual must be advised of the relevant fee and copies supplied to them promptly and, in any event, within 40 days. Sometimes, additional information is needed before copies can be supplied. In such cases, the 40-day time limit will begin as soon as the additional information has been received.

4.3 For how long is a patient's written consent valid?

There is no time limit after which consent for disclosure of information becomes invalid. However, if there has been a significant interval between the time the patient signed the letter or form and its receipt, it would be good practice for the health professional to contact the patient to confirm that he or she is still willing to agree to the disclosure, particularly if it is to a third party such as a solicitor or insurance company.

4.4 Who must give access?

Under the DPA responsibility for providing access to records lies with the 'data controller'. This is usually the health professional responsible for the patient's care, but in some circumstances it may be another health professional, or a member of the records management staff.

4.5 Is there a minimum period that must elapse between requests for access?

Where an access request has previously been complied with, there is no obligation to give access again until a reasonable interval has elapsed. What is reasonable depends on the nature of the information and how often it is altered. The reason for the request(s) may also be relevant.

4.6 Can a fee be charged?

The maximum fees which may be charged are prescribed by the Secretary of State. The following charges apply.

- For records held totally on the computer: £10 for providing access to and/or copies of the records.
- For records held manually in part or full: £50 for providing access to and/or supplying copies.

These are the maximum fees, and cover all costs associated with labour, copying, postage or other forms of delivery. Charges must be proportionate and justifiable, and should reflect the actual costs incurred. They should not result in a profit for the data controller. There is no obligation to comply with a request for access unless the required fee has been paid.

4.7 Should permanent copies always be supplied?

The BMA does not expect there to be any circumstances in which it would not be possible to supply permanent copies. However, the Act does not require that permanent copies be supplied if 'disproportionate effort' is involved in doing so.

4.8 What constitutes 'disproportionate effort'?

The Act does not define 'disproportionate effort' but health professionals are advised to consider more than cost when determining whether a request falls into this category. Other factors to consider include the length of time it will take to provide the information, how difficult it might be to provide it, whether extra staff need to be employed to carry out the request, and the size of the organisation in relation to these factors. The effect on the person making the request should also be considered when determining 'disproportionate effort'.

A common enquiry to the BMA is whether X-rays form part of health records and, if not, whether additional charges can be made for supplying them over and above the maximum £50 limit. X-rays are part of health records and case law has suggested that these be considered in the same way as other health records, unless disproportionate effort is involved in supplying them. Decisions as to what is disproportionate must be made on a case-by-case basis. For a request to involve disproportionate effort it is important that the effort rather than the cost be disproportionate regardless of whether the request for copies is for X-rays or other types of health records. Disproportionate effort can also apply to searching for information and searches can be limited on these grounds as long as similar factors are taken into consideration when deciding whether a case involves disproportionate effort.

4.9 When should information not be disclosed?

Information should not be disclosed if:

- it is likely to cause serious physical or mental harm to the patient or another person; or
- it relates to a third party who has not given consent for disclosure (where that third party is not a health professional who has cared for the patient); or
- it is requested by a third party and the patient had asked that the information be kept confidential; or
- the records are subject to legal professional privilege or, in Scotland, to confidentiality as between client and professional legal advisor. This may arise in the case of an independent medical report written for the purpose of litigation; or
- it is restricted by order of the courts; or
- it relates to the keeping or using of gametes or embryos or pertains to an individual being born as a result of in vitro fertilisation; or
- in the case of children's records, disclosure is prohibited by law, eg adoption records.

The data controller should redact, or block out any withheld information, and must be prepared to justify the decision to do so. The data controller may advise patients of the grounds on which information has been withheld, but is not obliged to do so. There is still an obligation to disclose the remainder of the records.

While the responsibility for the decision, as to whether or not to disclose information, rests with the data controller, advice about serious harm must be taken by the data controller from the appropriate health professional. If the data controller is not the appropriate health professional, then the appropriate health professional needs to be consulted before the records are disclosed. This is usually the health professional currently or most recently responsible for the clinical care of the patient in respect of the matters which are the subject of the request. If there is more than one, it should be the person most suitable to advise. If there is none, advice should be sought from another health professional who has suitable qualifications and experience. Circumstances in which information may be withheld on the grounds of serious harm are extremely rare, and this exemption does not justify withholding comments in the records because patients may find them upsetting. Where there is any doubt as to whether disclosure would cause serious harm, the BMA recommends that the appropriate health professional discusses the matter anonymously with an experienced colleague, the Caldicott guardian, or defence body.

4.10 Can patients read their records if they do not request copies?

The DPA does not expressly allow patients to read their records where no copy is required although they are permitted to do so with the agreement of the data controller. Similarly, the DPA does not expressly allow the data controller to charge fees in these circumstances. However, where the data controller agrees to a request to read records the BMA recommends a maximum charge of £10 unless the records have been added to in the last 40 days, in which case no charge should be made.

Patients sometimes become distressed when reading their records. It is therefore advisable for a member of staff to be present with them to provide support, as well as to explain any clinical terms (see paragraph 4.11). It is also important for staff to be present to ensure that records are not altered.

4.11 Should medical terms be explained?

The DPA requires that copies are accompanied by an explanation of any terms that might be unintelligible to the patient or the person requesting access to the records. Even in cases where permanent copies cannot be supplied, an explanation of such terms must be given.

4.12 Can records be amended?

Records should not be amended because of a request for access. If amendments are made between the time that the request for access was received and the time at which the records were supplied, these must only be amendments that would have been made regardless of the request for access.

Amendments to records must be made in a way which indicates why the alteration was made so that it is clear that records have not been tampered with for any underhand reason. Patients may also seek correction of information they believe is inaccurate. The health professional is not obliged to accept the patient's opinion, but must ensure that the notes indicate the patient's view. Health professionals are advised to provide the patient with a copy of the correction or appended note.

Patients also have the right to apply to the Information Commissioner to have inaccurate records amended or destroyed.

5. Deceased patients

The ethical obligation to respect a patient's confidentiality extends beyond death. The Information Tribunal in England and Wales has also held that a duty of confidence attaches to the medical records of the deceased under section 41 of the Freedom of Information Act. The Freedom of Information Act in Scotland contains an exemption to the disclosure of medical records of deceased patients. However, this duty of confidentiality needs to be balanced with other considerations, such as the interests of justice and of people close to the deceased person. Health professionals should therefore counsel their patients about the possibility of disclosure after death and solicit views about disclosure where it is obvious that there may be some sensitivity. Such discussions should be recorded in the records.

5.1 Are there any rights of access to a deceased patient's records?

Statutory rights of access are set out in the Access to Health Records Act 1990 or Access to Health Records (Northern Ireland) Order 1993. The Access to Health Records Act 1990 covers manual health records made since 1 November 1991. In Northern Ireland the corresponding legislation, the Access to Health Records (Northern Ireland) Order 1993, covers manual records from 30 May 1994. Access must also be given to information recorded before these dates if this is necessary to make any later part of the records intelligible.

5.2 Who can apply for access?

Unless they requested confidentiality while alive, a patient's personal representative and any other person who may have a claim arising out of the patient's death has a right of access to information in the deceased person's records directly relevant to a claim. It is the BMA's opinion that under section 5(4) of the Access to Health Records Act, no information which is not directly relevant to a claim should be disclosed to either the personal representative or any other person who may have a claim arising out of the patient's death.

5.3 Who must give access?

After a patient's death, GP health records may be held by the Primary Care Trust, and hospital records may have been retained at the hospital the patient attended or they may have been sent to a local archive for storage. Applications for access should be made to the records manager of these bodies.

These bodies are required to take advice before making a decision about disclosure. This is usually from the patient's last GP or, if several health professionals have contributed to the care of the patient, the health professional who was responsible for the patient's care during the period to which the application refers. If no appropriate health professional who has cared for the patient is available, a suitably qualified and experienced health professional must provide advice.

Once the person holding the records is satisfied that the person requesting the information is entitled to it, access must then be given within specified time limits. Access can be given either by allowing the applicant to inspect the records or extract, or by supplying a copy if this is requested.

Where the application concerns access to records or parts of records that were made in the 40-day period immediately preceding the date of application, access must be given within 21 days. Where the access concerns information all of which was recorded more than 40 days before the date of application, access must be given within 40 days. If the records are held by a health service body access cannot be given before advice has been obtained. The courts may enforce compliance with the legislation if access is not given within the required time limits. The court may also require that the records be made available for its own inspection in order to come to a decision.

There is no statutory right of access to records of deceased patients which fall outside of the time period covered by the legislation. If access to these records is being granted, the BMA advises that doctors should apply the safeguards and restrictions of the legislation to prevent harm or breach of confidence.

5.4 Can a fee be charged?

The following maximum fees apply.

- For access to the information where records were made more than 40 days before the date of the application for access, a maximum of £10.
- For providing access to information if the records have been amended or added to in the last 40 days, no fee may be charged.
- For supplying a copy, a fee not exceeding the cost of making the copy and postal costs may be charged. Charges should be reasonable and justifiable.
- Health professionals may charge a professional fee to cover the costs of giving access to the records of deceased patients that is not covered by legislation.

5.5 What information should not be disclosed?

Information should not be disclosed if:

- it identifies a third party without that person's consent unless that person is a health professional who has cared for the patient; or

- in the opinion of the relevant health professional, it is likely to cause serious harm to a third party's physical or mental health; or
- the patient gave it in the past on the understanding that it would be kept confidential. No information at all can be revealed if the patient requested non-disclosure.

5.6 Are relatives entitled to information about the deceased's last illness?

While there is no legal entitlement other than the limited circumstances covered under the Access to Health Records legislation, health professionals have always had discretion to disclose information to a deceased person's relatives or others when there is a clear justification. A common example is when the family requests details of the terminal illness because of an anxiety that the patient might have been misdiagnosed or there might have been negligence. Disclosure in such cases is likely to be what the deceased person would have wanted and may also be in the interests of justice. Refusal to disclose in the absence of some evidence that this was the deceased patient's known wish exacerbates suspicion and can result in unnecessary litigation. In other cases, the balance of benefit to be gained by the disclosure to the family, for example of a hereditary or infectious condition, may outweigh the obligation of confidentiality to the deceased.

6. Further information

For further information about these guidelines BMA members may contact: askBMA on 0300 123 123 3 or

British Medical Association
Department of Medical Ethics, BMA House
Tavistock Square, London, WC1H 9JP
Tel: 020 7383 6286
Fax: 020 7383 6233
Email: ethics@bma.org.uk

Further information for BMA members about fees is available from the BMA's website and askBMA 0300 123 123 3.

Non-members may contact:
British Medical Association
Public Affairs Department, BMA House
Tavistock Square, London, WC1H 9JP
Tel: 020 7387 4499
Fax: 020 7383 6400
Email: info.public@bma.org.uk

Appendix 1

BMA/The Law Society consent form

Consent form (Releasing health records under the Data Protection Act 1998)

About this form

In order to proceed with your claim, your solicitor may need to see your health records. Solicitors usually need to see all your records as they need to assess which parts are relevant to your case. (Past medical history is often relevant to a claim for compensation.) Also, if your claim goes ahead, the person you are making the claim against will ask for copies of important documents. Under court rules, they may see all your health records. So your solicitor needs to be familiar with all your records.

Part a – your, the health professionals' and your solicitor's or agent's details

Your full name:	
Your address:	
Date of birth:	
Date of incident:	
Solicitor's or agent's name and address:	
GP's name and address (and phone number if known):	
Name (and address if known) of the hospitals you went to in relation to this incident :	
If you have seen any other person or organisation about your injuries (for example, a physiotherapist) or have had any investigations (for example, x-rays) please provide details.	

Part b – your declaration and signature

Please see the 'Notes for the client' over the page before you sign this form.

To health professionals

I understand that filling in and signing this form gives you permission to give copies of all my GP records, and any hospital records relating to this incident, to my solicitor or agent whose details are given above.

Please give my solicitor or agent copies of my health records, in line with the Data Protection Act 1998, within 40 days.

Your signature:

Date:

 / /

Part c – your solicitor's or agent's declaration and signature

Please see the 'Notes for the solicitor or agent' over the page before you sign this form.

To health professionals

I have told my client the implications of giving me access to his or her health records. I confirm that I need the full records in this case. I enclose the authorised fee for getting access to records.

Solicitor's or agent's signature:

Date:

 / /

Notes for the client

Your health records contain information from almost all consultations you have had with health professionals. The information they contain usually includes:

- why you saw a health professional;
- details of clinical findings and diagnoses;
- any options for care and treatment the health professional discussed with you;
- the decisions made about your care and treatment, including evidence that you agreed; and
- details of action health professionals have taken and the outcomes.

By signing this form, you are agreeing to the health professional or hospital named on this form releasing copies of your health records to your solicitor or agent. During the process your records may be seen by people who are not health professionals, but they will keep the information confidential.

If you are making, or considering making, a legal claim against someone, your solicitor will need to see copies of all your GP records, and any hospital records made in connection with this incident, so he or she can see if there is anything in your records that may affect your claim. Once you start your claim, the court can order you to give copies of your health records to the solicitor of the person you are making a claim against so he or she can see if any of the information in your records can be used to defend his or her claim.

If you decide to go ahead with your claim, your records may be passed to a number of people including:

- the expert who your solicitor or agent instructs to produce a medical report as evidence for the case;
- the person you are making a claim against and their solicitors;
- the insurance company for the person you are making a claim against;
- any insurance company or other organisation paying your legal costs; and
- any other person or company officially involved with the claim.

You do not have to give permission for your health records to be released but if you don't, the court may not let you go ahead with your claim and, in some circumstances, your solicitor may refuse to represent you.

If there is very sensitive information in the records, that is not connected to the claim, you should tell your solicitor. They will then consider whether this information needs to be revealed.

Notes for the solicitor or agent

Before you ask your client to fill in and sign this form you should explain that this will involve his or her full health records being released and how the information in them may be used. You should also tell your client to read the notes above.

If your client is not capable of giving his or her permission in this form, this form should be signed by:

- your client's litigation friend;
- someone who has enduring power of attorney to act for your client; or
- your client's receiver appointed by the Court of Protection.

When you send this form to the appropriate records controller please also enclose the authorised fees for getting access to records.

If you find out at any stage that the medical records contain information that the client does not know about (for example, being diagnosed with a serious illness), you should discuss this with the health professional who provided the records.

Unless your client agrees otherwise, you must use his or her health records only for the purpose for which the client signed this form (that is, making his or her claim). Under the Data Protection Act you have responsibilities relating to sensitive information. The entire health record should not be automatically revealed without the client's permission and you should not keep health records for any longer than you need them. You should return them to the client at the end of the claim if they want them. Otherwise, you are responsible for destroying them.

Notes for the medical records controller

This form shows your patient's permission for you to give copies of his or her full GP record, and any hospital records relating to this incident, to his or her solicitor or agent. You must give the solicitor or agent copies of these health records unless any of the exemptions set out in The Data Protection (Subject Access Modification) (Health) Order 2000 apply. The main exemptions are that you must not release information that:

- is likely to cause serious physical or mental harm to the patient or another person; or
- relates to someone who would normally need to give their permission (where that person is not a health professional who has cared for the patient).

Your patient's permission for you to release information is valid only if that patient understands the consequences of his or her records being released, and how the information will be used. The solicitor or agent named on this form must explain these issues to the patient. If you have any doubt about whether this has happened, contact the solicitor or agent, or your patient.

If your patient is not capable of giving his or her permission, this form should be signed by:

- a 'litigation friend' acting for your patient;
- someone with 'enduring power of attorney' to act for your patient; or
- a receiver appointed by the Court of Protection.

You may charge the usual fees authorised under the Data Protection Act for providing the records.

The BMA publishes detailed advice for doctors on giving access to health records, including the fees that you may charge. You can view that advice by visiting www.bma.org.uk/ap.nsf/Content/accesshealthrecords.

This form is published by the Law Society and British Medical Association. (2nd edition, October 2004)



The Law Society



Appendix 2

BMA/The Law Society of Scotland consent form

Consent form
(Releasing health records under the Data Protection Act 1998)

About this form

In order to proceed with your claim, your solicitor may need to see your health records. Solicitors usually need to see all your records as they need to assess which parts are relevant to your case. (Past medical history is often relevant to a claim for compensation.) Also, if your claim goes ahead, the person you are making the claim against will ask for copies of important documents. Under court rules, they may see all your health records. So your solicitor needs to be familiar with all your records.

Part a – your, the health professionals' and your solicitor's or agent's details

Your full name <small>Include forename, middle name, surname, previous surname when attended hospital</small>	
Sex	
Hospital number or CHI (community health index) number (if known)	
Your address / address when you attended hospital (if different):	
Date of birth:	
Date of incident:	
Solicitor's or agent's name and address:	
GP's name and address (and phone number if known):	
Name (and address if known) of hospital(s) you went to in relation to this incident :	
If you have seen any other person or organisation about your injuries (for example, a physiotherapist) or have had any investigations (for example, Xrays) please provide details:	

Part b – your declaration and signature

Please see the 'Notes for the client' over the page before you sign this form.

To health professionals

I understand that filling in and signing this form gives you permission to give copies of all my GP records, and/or any hospital records (delete words which do not apply) relating to this incident, to my solicitor or agent whose details are given above.

Please give my solicitor or agent copies of my health records, in line with the Data Protection Act 1998, within 40 days.

Your signature: Date: / /

Part c – your solicitor's or agent's declaration and signature

Please see the 'Notes for the solicitor or agent' over the page before you sign this form.

To health professionals

I have told my client why particular parts of his or her health records are needed. I confirm that I need the full/part (specify which) records in this case from (specify dates.....). I enclose the authorised fee for getting access to records.

Solicitor's or Agent's signature: Date: / /

Notes for the client

Your health records contain information from almost all consultations you have had with health professionals. The information they contain usually includes:

- why you saw a health professional;
- details of clinical findings and diagnoses;
- any options for care and treatment the health professional discussed with you;
- the decisions made about your care and treatment, including evidence that you agreed; and
- details of action health professionals have taken and the outcomes.

By signing this form, you are agreeing to the health professional or health establishment named on this form releasing copies of your health records to your solicitor or agent. During the process your records may be seen by people who are not health professionals but they will keep the information confidential. If you are making, or considering making, a legal claim against someone, your solicitor will need to see copies of all your GP records, and any hospital records made in connection with this incident, so he or she can see if there is anything in your records that may affect your claim. Once you start your claim, the court can order you to give copies of your health records to the solicitor of the person you are making a claim against so he or she can see if any of the information in your records can be used to defend his or her client.

If you decide to go ahead with your claim, your records may be passed to a number of people including:

- the expert who your solicitor or agent instructs to produce a medical report as evidence for the case;
- the person you are making a claim against and their solicitors;
- the insurance company for the person you are making a claim against;
- any insurance company or other organisation paying your legal costs; and
- any other person or company officially involved with the claim.

You do not have to give permission for your health records to be released but if you don't, the court may not let you go ahead with your claim and, in some circumstances, your solicitor may refuse to represent you. Once your solicitor has received your records it is wise for you to check your records yourself both to remind yourself of their content and to check accuracy. You can do this by arranging to view them at the solicitor's office. If there is very sensitive information in the records, that is not connected to the claim, you should tell your solicitor. They will then consider whether this information needs to be revealed. The solicitor will destroy any copies of the record apart from the file copy. If you wish to retain a copy you will need to make arrangements with your solicitor. If you change solicitor you should arrange for the copies to be passed to your next solicitor.

Notes for the solicitor or agent

Before you ask your client to fill in and sign this form you should explain that this will involve his or her full health records being released and how the information in them may be used. You should also tell your client to read the notes above.

If your client is not capable of giving his or her permission in this form, this form should be signed by someone who has: Welfare power of attorney to act for your client; or has a Guardianship Order.

When you send this form to the appropriate medical records controller please also enclose the authorised fees for getting access to records.

If you find out at any stage that the medical records contain information that the client does not know about (for example, being diagnosed with a serious illness), you should discuss this with the health professional who provided the records.

Unless your client agrees otherwise, you must use his or her health records only for the purpose for which the client signed this form (that is, making his or her claim). Under the Data Protection Act you have responsibilities relating to sensitive information. The entire record should not be automatically revealed without the client's permission. You should not keep health records for any longer than you need them. You should return copies to the client at the end of the claim if they want them. Otherwise you are responsible for destroying copies securely.

Notes for the medical records controller

This form shows your patient's permission for you to give copies of his or her full GP record, and/or any hospital records relating to this incident, to his or her solicitor or agent. You must give the solicitor or agent copies of these health records unless any of the exemptions set out in The Data Protection (Subject Access Modification) (Health) Order 2000 apply. The main exemptions are that you must not release information that:

- is likely to cause serious physical or mental harm to the patient or another person; or
- relates to someone who would normally need to give their permission (where that person is not a health professional who has cared for the patient).

Your patient's permission for you to release information is valid only if that patient understands the consequences of his or her records being released, and how the information will be used. The solicitor or agent named on this form must explain these issues to the patient. If you have any doubt about whether this has happened, contact the solicitor, agent, or your patient.

If your patient is not capable of giving his or her permission, this form should be signed by someone with: 'Welfare power of attorney' to act for your patient; or a Guardianship order.

Originals should only be sent if required by a Court Order. In all other circumstances photocopies should be sent.

You may charge the usual fees authorised under the Data Protection Act for providing the records.

The BMA publishes detailed advice for doctors on giving access to health records, including the fees that you may charge. You can view that advice by visiting www.bma.org.uk/ap.nsf/Content/accesshealthrecords.

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