

# University Health Network Policy & Procedure Manual Administrative: Patient Access to the Medical Record

## Policy

In accordance with the Ontario Public Hospitals Act, the Mental Health Act, the Vital Statistics Act, Personal Health Information Protection Act, 2004 and other relevant legal and statutory requirements, University Health Network (UHN) provides assistance to patients seeking to understand the contents of their record of [personal health information](#) (medical record, health record) where reasonable and practical. This may mean answering questions, clarifying content (not interpretation) or providing explanations of medical terminology or acronyms used in the record.

This and other UHN policies related to confidentiality and patient personal and health information should be referred to whenever release of any patient information is under consideration. In particular, refer to:

- [UHN Medical Record of Personal Health Information](#) policy 1.40.009
- [Release of Patient Information](#) policy 1.40.002
- [Patient Requests for Correction to Medical Record](#) policy 1.40.010
- [Privacy](#) policy 1.40.007

## Discharged Patients

Where a request is received from a discharged patient to examine or photocopy his/her medical record, the request must be in writing either on the [Authorization for Disclosure of Personal Health Information](#) (Form 2323) or in a letter from the patient.

The physician may object to disclosure on the grounds that access to the patient record would be detrimental to the health of the patient. This refusal must be in writing and filed in the patient's chart.

If the physician [refuses](#) disclosure, the patient must be advised of this and instructed to contact the physician. The physician is responsible for notifying the patient of the reasons for refusal.

The patient is entitled to request that the information in the record be corrected or amended where the patient believes there is an error or omission. Refer to [Patient Requests for Correction to Medical Record](#) policy 1.40.010.

## Inpatients

Any patient in the Hospital (including psychiatric patients) may have access to his/her chart under the supervision of his/her clinician. Documentation must be included within

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Section	<b>Privacy &amp; Information Security</b>	Revision Dates	<b>11/16</b>
Issued By	<b>Shared Information Management Services</b>	Review Dates	
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the record when a patient reviews his/her chart with specific reference to what was reviewed and/or copied/printed for the patient.

Even if the current chart is incomplete, it must still be made available to the patient. It should be made clear to the patient that the chart is incomplete. It may not be made available for photocopying until after discharge, if it is believed that to do so would hinder the care of the patient.

## UHN Agents who are Patients

UHN [agents](#) (including employees, physicians, contractors, consultants, volunteers, students, and other workers at UHN) may not access their own paper and/or electronic records outside of the processes detailed in this policy and, by extension, may not directly view their own records in electronic systems.

## Refusal of Access

All patients (including psychiatric patients) have the right to access their medical records under the supervision of the attending physician(s) but access may be refused under any of the following circumstances:

- the record contains quality of care information (as defined in the Quality of Care Information Protection Act)
- the record contains information collected/created to comply with the requirements of a quality assurance program under the Health Professions Procedural Code that is Schedule 2 to the Regulated Health Professions Act
- the record contains raw data from standardized psychological tests or assessments
- the record (or information in the record) is subject to a legal privilege that restricts disclosure to the requestor
- other legislation or court order prohibits disclosure to the requestor
- the information in the record was collected/created in anticipation of or use in a proceeding that has not concluded
- the information in the record was collected/created for an inspection/investigation/similar procedure authorized by law that has not concluded
- granting access could reasonably be expected to result in a risk of serious harm to the patient or to others. (Where this is suspected a physician or psychologist may be consulted before deciding to refuse access.)
- granting access could lead to the identification of a person who was required by law to provide the information in the record
- granting access could lead to the identification of a person who provided the information in the record in confidence (either explicitly or implicitly) and it is considered appropriate to keep the name of this person confidential
- the request for access is frivolous, vexatious or made in bad faith
- the identity or authority of the requestor cannot be proven by the requestor

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Every effort should be made to grant an individual access to his/her chart. Therefore, in the circumstances where harm could ensue or the identity of a person who provided confidential information revealed, consideration should be given to granting the patient access to an appropriately severed or circumscribed chart.

Appeals of refusals for access should be made to the Privacy Office. In the event the patient is not satisfied with the result of the appeal, the patient shall be informed of his/her right to complain to the Information and Privacy Commissioner of Ontario.

## Disclosure to Other Parties at the Request of the Patient

Should the patient wish his/her physician, attorney, insurance company and other such persons or agencies to have access to the patient chart, the patient must provide a written statement of authorization to this effect. Refer to [Release of Patient Information](#) policy 1.40.002.

## Fees

The fees that may be charged for releasing [personal health information](#) are set by Health Records Services on a reasonable cost recovery basis. Departments or clinics providing copies of information from the patient's medical record may independently set fees consistent with those set by Health Records Services and the principle of reasonable cost recovery as required by law.

If in the judgment of a clinic or department it is in the best interests of the patient's care or well-being, all or part of this fee may be waived.

Patients must be advised of the fee schedule (if applicable) at the time the request is submitted, prior to completion of the request.

## Definitions

**Agent:** A person that, with the authorization of UHN, acts for or on behalf of the organization in respect of personal health information for the purposes of UHN and not the agent's own purposes, whether or not the agent has the authority to bind the custodian, whether or not the agent is employed by UHN, and whether or not the agent is being remunerated. Examples of agents of UHN include, but are not limited to, employees, volunteers, students, physicians, residents, fellows, consultants, researchers, vendors.

**Personal health information:** Information about an individual whether living or deceased and whether in oral or recorded form. It is information that can identify an individual and that relates to matters such as the individual's physical or mental health, the providing of health care to the individual, payments or eligibility for health care in respect of the individual, the donation by the individual of a body part or bodily

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substance and the individual's health number (Personal Health Information Protection Act, 2004, section 4.1).

1. Personal health information can be information about a physician or other care provider, a Hospital staff person, a patient, or a patient's family member. Examples of personal health information include a name, medical record number, health insurance number, address, telephone number, and personal health information related to a patient's care such as blood type, x-rays, consultation notes, etc.
2. Personal health information includes all that is written, verbal, in hard copy, on microfilm, in computerized or any machine-readable form and electronically stored or transmitted. (Includes the medical record, clinical and non-clinical data.)

## Procedures

### Discharged Patients

1. Upon receipt of the written request, ask the patient to provide proof of identification with a picture and signature.
2. If a photocopy of the chart is requested, obtain the [fee](#) prior to processing the request.
3. Health Record Services consults with the Privacy Office or Legal Affairs if any unusual circumstances exist.
4. If the patient is reviewing his/her medical record and not a copy, sit with the patient to ensure that alterations are not made and that documents are not removed.
5. Assist the patient with locating desired information/document(s), but do not make any interpretations.
6. Document the patient's access to the chart either in the patients record or on the release of information authorization form and include what areas/aspects of the record access was granted,

### Inpatients

1. Any patient in the Hospital (including psychiatric patients) may have access to his/her chart under the supervision of his/her clinician unless one of the criteria for [refusal of access](#) listed above applies.
2. Even if the current chart is incomplete, it must still be made available to the patient. It should be made clear to the patient that the chart is incomplete.
3. If any unusual circumstances exist, notify the Privacy Office or Legal Affairs.

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4. The chart may not be made available for photocopying until after discharge as this may pose a safety risk to the patient if the chart is removed from the area of his/her care to be photocopied. The reasons for this must be explained to the patient.
5. Sit with the patient to ensure that alterations are not made and that documents are not removed.
6. Assist the patient with locating desired information/document(s), but interpretation may only be made by the patient's clinical team.
7. Document the patient's access to the chart, either in the patient's record or on the release of information form (if review is conducted within Health Records Services), and include what areas/aspects of the record access was granted and what information was printed for the patient (if relevant).

### Telephone Requests

1. When patients telephone for information such as dates of hospitalization or the name of their doctor, verify the patient's identity by requesting that the patient provide:
  - full name
  - date of birth
  - health card number (OHIP) or medical record number (MRN)
  - date of last visit
2. If the patient requires information of a medical nature, refer the patient to the attending physician.
  - Only information of a non-medical nature, such as, dates of hospitalization or the name of the attending doctor, is to be released to the patient over the telephone.

### Walk-in Requests (not for the use of the patient)

1. If a patient comes to UHN with a request for information for a physician, follow the steps outlined under [Discharged Patients](#) to prepare the information for the appropriate authorized person identified in the request. Consult the [Release of Patient Information](#) policy 1.40.002 for further information.
2. If the patient is seeing a physician that day or the next, and the physician requires the information immediately, either release the information directly to the patient in a sealed envelope, stamped "Confidential" and addressed to the physician or fax the information to the physician directly.

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## Reference

1. Mount Sinai Hospital. *Confidentiality and Release of Information policy*. Mar 2005. Toronto, Canada.

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