Privacy & Confidentiality of Client Health Information Policy

To ensure the privacy and confidentiality of Danila Dilba Health Service and its clients through the appropriate management of client health information.

Category	**Clinical**	**Policy number:** PRIV001
Related forms, policies, and procedures	• Information for clients brochure • Complaints Policy • Duty Doctor Policy • Recalls Policy	
Key words	Privacy; Health & Sensitive information; Confidentiality; Client Health Records	
Relevant legislation	• *Privacy Act 1988 (Cth)* • *Privacy Amendment (Enhancing Privacy Protection) Act 2012; Australian Privacy Principles* • *Information Act 2002 (NT)* • *National Health Act 1953 (Cth)* • *Healthcare Identifiers Act 2010 (Cth)* • *My Health Records Act 2012 (Cth)* • *Care and Protection of Children Act 2007 (NT)* • *Notifiable Diseases Act 1981 (NT)*	

References and resources	• RACGP standards for general practice, 2017, 5th edition:
	  ○ Criterion C6.3 – Confidentiality and privacy of health and other information;
	  ○ Criterion C6.1 – Patient identification;
	  ○ Criterion C6.4 – Information security;
	  ○ Criterion C6.2 – Patient health record systems;
	  ○ Criterion QI2.1 – Health summaries;
	  ○ Criterion C7.1 – Content of patient health records;
	  ○ Criterion C3.6 – Research
	• Handbook for the Management of Health Information in General Practice, 3rd edition, 2014	

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Approved by	Chief Executive Officer	April 2021

Version	Date	Author	Summary of changes
1.0	May 2014	Manager Health Systems	Initial policy.
2.0	Nov 2018	EO	Amend formatting and reference to Clinical Director.
3.0	Jan 2019	CEO	Amend provisions for clarity.
4.0	April 2021	HoCG	Review

PRIVACY & CONFIDENTIALITY OF CLIENT HEALTH INFORMATION POLICY

1. Purpose

Danila Dilba Health Service (DDHS) is committed to ensuring that all information regarding DDHS clients, individuals, groups, or communities remains confidential and private at all times. This includes verbal information (telephone, between staff and client) and written information (notes, pathology, results etc). This policy addresses the management of 'personal health information' and 'sensitive information' at DDHS clinics.

For each client, DDHS has an individual client health record (electronic; *Communicare*) containing all clinical information held by our practice relating to that client. DDHS ensures the protection of all information contained therein (see also Information Security policy).

2. Scope

This policy applies to everyone performing work controlled by DDHS, unless an exemption to specific sections has been issued in writing. This policy applies to all 'staff' including all full time and casual paid staff, work placement students, work experience students and training scheme participants.

The policy covers the following areas:

1. Privacy
2. Informing new clients
3. Client access to their personal health information
4. Maintaining confidentiality of health information
5. Access to personal health information by clinic staff for the purposes of research, professional development, and quality improvement
6. Staff confidentiality agreements
7. Use & Disclosure to third parties
8. Requests for transfer of personal health information
9. Physical privacy & confidentiality
10. Complaints about privacy related matters
11. Management of health information
12. Collection of health information

13. Recording and storage of health information

14. My Health Record (MyHR)

3. Definitions & Principles

DDHS is bound by the Federal Privacy Act 1988 and Australian Privacy Principles (Privacy Amendment (Enhancing Privacy Protection) Act 2012), and complies with the NT Information Act 2002.

Personal information is a particular subset of personal information and can include any information collected to provide a health service. The Privacy Act 1988 defines personal information as:

> *…information or an opinion, whether true or not, and whether recorded in a material form or not, about an identified individual, or an individual who is reasonably identifiable.*

This information includes an individual's name, signature, address, date of birth, telephone number, medical records, Medicare number, and account details.

'Sensitive' information is a type of personal information and includes information about:

- an individual's racial or ethnic origin
- health information
- political opinions
- membership of a political association, professional or trade association or trade union
- religious beliefs or affiliations
- philosophical beliefs
- sexual orientation or practices
- criminal record
- genetic information
- biometric information that is to be used for certain purposes
- biometric templates

'Health records' include the formal medical record whether written or electronic, and information held or recorded on any other medium e.g. letter, fax, or electronically, or information conveyed verbally.

4. Procedure

Privacy

All health practitioners and clinic staff will ensure that clients can discuss issues relating to their health, and that the health practitioner can record relevant personal health information, in a setting that provides visual privacy and protects against any conversation being overheard by a third party.

Staff will not enter a consultation room during a consultation without knocking or otherwise communicating with the practitioner. Staff, GP Registrars, and students will not be present during the consultation without the prior permission of the client.

Informing new clients (Client Consent)

Staff will discuss the clinic's privacy policy with clients who are new to the clinic at their first visit. New clients will be given the DDHS brochure titled "*Client Privacy & Confidentiality*", and *"Information for Clients".* These brochures are also available in waiting areas, consulting rooms, and clinic reception, and includes information for clients about:

- Personal health information and medical records
- Providing health information to other health practitioners
- Using health information for quality improvement and research
- Security of information in the clinic
- Client access to their health information
- Resolving concerns re privacy of health information, including details about DDHS and how it can be contacted

In addition, DDHS's privacy and health information policy is available to clients upon request.

DDHS tries to make sure that the information on privacy available to clients is appropriate for the range of people who access DDHS services.

New clients will be asked to sign a Registration Form to ensure we have information required to provide services. This includes informed consent to share information with relevant NT Diseases Register such as Immunisations and RHD.

Clients will be made aware that our clinic bulk bills all medical consultations, but fees may apply if a client is referred by one of our health practitioners to external services.

The clinic staff, including its health practitioners will endeavour to ensure that continuing clients of the clinic are informed about the impact of changes to privacy legislation, by bringing relevant materials to the attention of continuing clients.

Access to clinical records

Information provided to clients, both by practitioners and staff verbally, and in writing through clinic leaflets will advise that, for the purpose of client care and teaching, DDHS restricts access to client clinical records to:

- Medical practitioners in the clinic, including locums
- GP Registrars attached to the clinic for training
- Clinicians including Registered Nurses and Aboriginal & Torres Strait Islander Health Practitioners

The health practitioner will provide the client with opportunity to limit access to their record and will note any requirements in relation to the client's consent to the collection and use of personal and sensitive information in red font in the 'alert' section of the client individual record on *Communicare*.

Client access to their personal health information

Clients of DDHS have the right to access their personal health information under the Privacy Amendment (Private Sector) Act 2000, and the Australian Privacy Principle: Access to personal information; where *If an entity holds personal information about an individual, the entity must, on request by the individual, give the individual access to the information.*

On written request for access to personal health information, DDHS documents each request and endeavours to assist clients in granting access where possible and according to the privacy legislation. The client request is forwarded to the client's GP to check for exemptions. Exemptions to access must be noted and the client must have their identification checked prior to access being granted.

The GP will provide an up to date and accurate summary of their health information on request or whenever appropriate. The treating GP will consider all requests made by a client for access to their medical record. In doing so the GP will need to consider the risk of any physical or mental harm resulting from the disclosure of health information.

If the GP is satisfied that the client may safely obtain the record then he/she will either show the client the summary page, or arrange for provision of a printed summary page, and explain the contents to the client.

Any information that is provided by others (such as information provided by a referring medical practitioner or another medical specialist) is not the property of DDHS and cannot be accessed directly by the client. The client should be referred to the owner of such information (referring medical practitioner or a medical specialist) to request access to that information.

Maintaining the confidentiality of information held

The maintenance of privacy requires that any information regarding individual clients, including staff members who may be clients, must not be disclosed (verbally, in writing, in electronic form, or by copying), except for strictly authorised use within the client care context at DDHS or as legally directed.

Medical practitioners, allied health practitioners and all other staff and contractors associated with DDHS have a responsibility to maintain the privacy of personal health and sensitive information.

All client information must be considered private and confidential, even that which is seen or heard and therefore is not to be disclosed to family, friends, staff, or others without the client's approval. Sometimes details about a person's medical history or other contextual information such as details of an appointment can identify them, even if no name is attached to that information.

To ensure privacy and confidentiality of DDHS Client Health Records, all DDHS staff must:

1. Sign the DDHS Privacy and Confidentiality Agreement at the commencement of employment with special mention of the importance of maintaining confidentiality of information about clients. Breaches of privacy and/or confidentiality including unauthorised or inappropriate access of client records may result in disciplinary action, including termination of employment.
2. Ensure that all client and personal health information is kept out of view and not be accessible by the public.
3. Limit access to sensitive clinical client records to qualified clinicians *(see 4.2 Informing new clients: Access to clinical records)*
4. Ensure that all client health information and records are kept under constant staff supervision
5. Ensure that individuals cannot see computer screens showing information about other individuals.
6. Ensure that screensavers or other methods of protecting information are engaged.
7. Ensure that access to computerised client information is strictly controlled with personal logins/passwords. Staff must not disclose passwords to unauthorised persons.
8. Ensure that screens are left cleared when information is not being used and that terminals are logged off when the computer is left unattended for a significant period of time.
9. Not disclose any client health information to family, friends, staff, or others without the client's consent. This includes medical details, family information, address, employment and other demographic and accounts data obtained via reception. Any information given to unauthorised personnel will result in disciplinary action, including termination of employment and other legal consequences.

10. Ensure that any items for pathology couriers or other results and pickups not be left in public view. Further detailed information regarding test results and other clinical correspondenceis provided under DDHS Test Result Recalls and Clinical Reminder System policy and Duty Doctor Policy.

11. Ensure that results of pathology test are only given over the phone by prior arrangements with the client. They may only be given out by the person who arranged the test or by one of the GP's. Should any results be given out, then the person giving them is responsible for ensuring that the information given is given only to the client or the person caring for them. Instances where there is complexity, the client should be asked to come into the clinic.

12. Under no circumstances are HIV results ever given over the phone. Clients must attend the clinic to receive the result of HIV testing.

Emails and Faxes *(Refer also to "Information Security" Policy)*

DDHS does not transfer client information via email unless it is encrypted. Communication with clients via electronic means (e.g. email) is conducted with appropriate regard to the privacy and confidentiality of the client's health information.

DDHS configures software so that the confidentiality and privilege notice is automatically added to each outgoing email.

DDHS uses the following confidentiality and privilege notice on outgoing emails:

> *'This message is confidential and should only be used by the intended addressee. If you were sent this email by mistake, please inform us by reply email and then destroy this message. The contents of this email are the opinions of the author and do not necessarily represent the views of DDHS'.*

DDHS fax cover sheets are to be used when sending a fax correspondence. Electronic faxing ensures a log of transmission to ensure that the data has been received and is secure.

Referrals

Referral documents (i.e. letters and pre-printed forms) to other health care providers must contain only relevant and sufficient information to facilitate optimal Client care. Clients must be made aware and

informed consent must be obtained as client health information is being disclosed in the referral documents.

The client must be given information about the purpose, importance, benefits, and risks associated with investigations, referrals or treatments proposed by their practitioner to enable the Client to make informed decisions.

Letters of referral at DDHS are computer based and in the case of an emergency or other unusual circumstance, a telephone referral may be appropriate.

Referral letters are to be documented in the Client's health record and where appropriate must:

- be legible,
- include the purpose of the referral,
- include the relevant history, examination, findings, and current management, and
- include the list of allergies and current medicines.

For medico-legal and clinical reasons, copies of significant (non-routine) referral letters are kept in the Client's health record.

In DDHS, referral letters are computer based (*Communicare*).

Referrals to internal staff by email are NOT secure when using the address @ddhs.org.au. External email transmission is not secure unless identified as encrypted.

In DDHS, the procedure for informing clients that client health information is disclosed in referral documents is via:

- the GPs
- the *DDHS Information for Clients* brochure
- DDHS Client Privacy and Confidentiality Policy
- DDHS Client Registration and Consent Form

Client Records

DDHS client health records are created and maintained in the *Communicare* Client Information System. All DDHS staff have personal passwords to authorise appropriate levels of access to health information. Screensavers or other automated privacy protection devices are enabled, backups of electronic information are stored in a secure offsite environment, antivirus software is installed and updated, and all internet connected computers have hardware/software firewalls installed *(See Information Security Policy).*

Consultation Notes

In DDHS, all staff that are responsible for entering client health information into client health records are responsible for:

- updating the clients address at every opportunity
- checking that they are making an entry in the right clients file by confirming their identity using three (3) identifiers (such as name, DOB and address or phone number)
- reading client notes before making an entry
- recording phone calls or conversations relating to the client in their client record and recording reason for being in the file on all occasions. If the file is opened accidentally, staff should note that the file was “opened in error”
- ensuring all entries are accurate, factual, and complete
- entering notes into the client health record in a timely manner
- ensuring that no notes are removed or pasted over after they have been made

Consultations including those that occur outside normal opening hours, during a home or other visits and any clinically significant telephone or electronic consultations are recorded in the client health record. These consultation/progress notes must include the following information:

- date of consultation/visit
- reason for consultation/visit
- relevant clinical/health assessment findings
- diagnosis
- recommended management plan and where appropriate expected process of review
- prescribed medicine via prescription tab (including medicine name, strength, directions for use/dose frequency, number of repeats, and date medicine started/ceased/changed)
- any relevant preventive care undertaken
- documentation of referral to other health care providers or health service via letters function on *Communicare*
- any special advice or other instructions

- identification of who conducted the consultation, e.g. by initial in the notes, or audit trail in electronic record
- Evidence that problems raised in previous consultations are followed up.

DDHS Client health records also show evidence that problems raised in previous consultations are followed up and this is detailed in the Reminder and Recall Policy.

To ensure that quality consultations continue in the event of computer failure, DDHS uses handwritten progress notes. These notes are then entered into the clinical software when the computers come online, and subsequently shredded via the secure shredding bins.

DDHS also maintains five (5) synchronised laptops for use in emergency situations. Maintenance and upgrades are undertaken on a regular basis by IT Coordinator.

Results, reports and clinical correspondence

All tests and results (including pathology results, diagnostic imaging reports, investigation reports and clinical correspondence received) are to be reviewed on *Communicare*, signed or initialled (or the electronic equivalent), indicated with an action statement and acted on in a timely manner by the medicalpractitioner who ordered the test or in the event that the practitioner is not available, the Duty Doctor will review. If the result, report, or clinical correspondence is a hardcopy, it is then scanned into the client's health record and securely shredded (refer to Duty Doctor Policy).

DDHS staff follow the recall and reminder policy in relation to tests and results, reports, and clinical correspondence where there is concern about the significance of the test or result, and this also includes tests or referrals ordered for the client.

In DDHS, incoming pathology results, diagnostic imaging reports, investigation reports and clinical correspondence is managed through the Recall and Reminder Policy and Duty Doctor Policy.

All urgent pathology results, diagnostic imaging, investigative or clinical correspondence, are:

- Automatically delivered to *Communicare* via secure network.
- Urgency is also able to be marked on the request form and the medical practitioner can ring the laboratory if needed.
- After the results, test, investigation has been checked by the relevant practitioner or Duty Doctor on *Communicare* (under Documents & Results tab), the result is automatically uploaded to the client health record on *Communicare*.

Clients are advised of the usual policy for notifying Clients of results and other correspondence. This is through:

- the GP and clinical staff verbally informing Clients at the time of request the Clinic information sheet

Access to personal health information by clinic staff for the purposes of research, professional development, and quality improvement

New clients will be informed that the clinic undertakes research, professional development, and quality assurance/improvement (QA) activities from time to time, to improve individual and community health care and practice management.

When research projects are conducted in the clinic under the approval of an institutional ethics committee, staff will be made aware of the requirements to obtain consent specified in the research protocol and ensure that consent is properly obtained.

DDHS recognises the role research can play in improving Aboriginal health and health service delivery. However, research should be conducted substantially for and by Aboriginal people and not on Aboriginal people and must reflect the interest and needs of the community rather than those of the researcher. It is preferable that research develops from Aboriginal people's perceived needs. Research should be non-invasive and thereby conducted within culturally intelligible and acceptable frames of reference. It must not disrupt or upset the community and must be conducted only after approval by the local formal Ethics Committee and the health board.

Researchers should respect the parameters pertaining to Aboriginal knowledge and not publish material which violates Aboriginal Law, namely that which is regarded as sacred or exclusively women's or men's business. Issues of body parts and tissue are of particular sensitive nature to many Aboriginal people.

Research that involves DDHS clients wherever possible should ensure that client data be de-identified and aggregated, however where this is not possible, DDHS ensures:

- the Client provides explicit and documented written consent
- the Client receives a written and verbal explanation about the research
- the Client can withdraw their consent at any time
- Internal staff accessing personal health information are aware that they are under an obligation of confidentiality not to disclose the information. Breaches of that obligation may result in instant dismissal.

- the project is approved by a relevant Human Research Ethics Committee (HREC) established under the National Health and Medical Research Council guidelines
- Privacy laws are followed, and the responsible clinician will ensure that any external researchers are also under an explicit written obligation of confidentiality with appropriate penalties for disclosure

DDHS retains a record of the request for participation in any research project, including the research protocol, consent and withdrawal procedures and process for resolving problems with the research involved. All research matters involving DDHS programs and or clients are only undertaken following diligent adherence to relevant research and ethical protocols and processes. These include the following:

- Institutional Ethics Committee approval from the relevant local processes of the day
- Approval and recommendation of the DDHS Research Working Group
- Approval of the CEO and acceptance of the DDHS Board

Quality Improvement

Quality improvement activities are undertaken at DDHS to inform best practice and ensure safe and quality care is provided to clients and communities. Where information is used to monitor, evaluate or improve service delivery, ethics approval is not required. When client data is utilised, data is de-identified and aggregated in order to protect the privacy and confidentiality rights of the client.

If quality improvement activities are in collaboration with an external provider, a written agreement must be documented and recorded ensuring the external providers strict adherence to agreed protocols and processes, and an explicit written obligation of confidentiality with appropriate penalties for disclosure.

Confidentiality agreements

In order to protect personal privacy, all staff, including temporary or casual staff; sub-contractors (e.g. software providers etc) and medical students must sign a confidentiality agreement.

Disclosure to third parties

GPs and staff will ensure that personal health information is disclosed to third parties only where consent of the client has been obtained. Exceptions to this rule occur when the disclosure is necessary to manage a serious and imminent threat to the client's health or welfare or is required by law. This is considered Mandatory Reporting.

Mandatory Reporting

Where a medical practitioner or clinician believes on reasonable grounds that a child has suffered or is likely to suffer harm or exploitation, or on reasonable grounds to believe a child aged 14 or 15 years has been or is likely to be a victim of a sexual offence and the age difference between the child and offender is greater than 2 years, that practitioner or clinician is in his/her rights to mandatory report this information to the NT Department of Children and Families reporting authority under Sections 15, 16 and 26(2) *of the Care and Protection of Children Act 2007 (NT).*

Under the *NT Notifiable Diseases Act,* a Medical Practitioner must make notification to NT Department of Health Communicable Disease Control, when a client is diagnosed with a notifiable disease (as listed on notifiable disease schedule) and must provide the relevant information in relation to the notifiable disease.

Consent

The medical practitioner will refer to relevant legislation and the maturity of the client before deciding whether the client (in this case a minor) can make decisions about the use and disclosure of information independently (i.e. without the consent of a parent or guardian). For example, for the client to consent to treatment, the GP must be satisfied that the client (a minor) is aware and able to understand the nature, consequences, and risks of the proposed treatment. This client is then also able to make decisions on the use and disclosure of his or her health information.

Referrals

Medical practitioners will explain the nature of any information about the client to be provided to other people, for example, in referral letters to hospitals or specialists. The client consents to the provision of this information by agreeing to take the letter to the hospital or specialist, or by agreeing for the clinic to send it.

Medical practitioners and staff will disclose to third parties only that information which is required to fulfil the needs of the client.

These principles apply to the personal information provided to a treating team (for example, a physiotherapist or consultant physician also involved in a person's care). The principles also apply where the information is transferred by other means, for example, via *Communicare*.

Other (Medicare, Medical Defence, Accreditation, Court Orders)

Information classified by a client as restricted will not be disclosed to third parties without the explicit consent of the client. medical practitioners will make a contemporaneous note when such permission is given.

Information disclosed to Medicare or other health insurers will be limited to the minimum required to obtain insurance rebates.

Information supplied in response to a court order will be limited to the matter under consideration by the court.

From time to time, General Practitioners will provide their medical defence organisation or insurer with information, in order to meet their insurance obligations.

DDHS participates in practice accreditation, which assists in in improving the quality of its services. Practice accreditation may involve the 'surveyors' who visit the clinic reviewing client records to ensure that appropriate standards are being met.

Transfer of health records

When a Client requests for their health records to be transferred to a practitioner and/or health service outside of DDHS, the clinic has an obligation to provide a copy or summary of the Client health record in a timely manner to facilitate care of the Client. Transfer of health records from DDHS can occur in the following instances:

- when a Client asks for their health record to be transferred to another Clinic
- for legal reasons, e.g. record is subpoenaed to court
- where an individual health record report is requested from another source.

DDHS staff must notify the Senior Medical Officer about all requests for Client health information. DDHS records the request by the Client on the health record, and this needs to include details as to the date, where and when the information was sent and who authorised the transfer.

The Client must provide written consent to the transfer. A Client consent form is available in the letters tab within the client health record on *Communicare*. The letter is called *Client Consent for Transfer of Health Records*.

For medico-legal reasons, DDHS retains the original record and provides the new Health Service with a summary or a copy. If a summary of the Client's health record is provided to the new health practitioner, a copy of the summary should be kept on file for record purposes.

DDHS does not charge a fee to the Clinic or the Client for transferring the Client's health record to another Clinic.

DDHS follows this procedure when transferring health records to another practice:

1. ensure that the client has provided written consent and this is incorporated into the client's health record. There is a letter template in *Communicare* titled *Client Consent for Transfer of Health Records.* Please complete this letter and get client to sign.

2. send the health record to the requesting practice via registered post / client / courier.

3. select the clinical item *Transfer of Health Information* in the clients file in *Communicare* and record the date and destination of the records transferred.

Transfer from another practice

It is necessary for a health practitioner to become familiar with a new client's medical history via their health record from a previous practice. If a copy or summary of a health record is required, written client consent must be provided to the former practice by the client. Our clinic assists new clients by providing a consent form and posting it to the former practice.

DDHS follows this procedure when transferring health records from another practice:

- ask the client to write a letter / sign a form indicating consent for their previous practice to forward a copy or summary of their health record
- send a letter to the previous practice requesting that they provide a copy or summary of the client's health record and enclose the original copy of the client's consent.

Physical Privacy and Confidentiality

Clients' privacy and confidentiality is also protected at two levels, physically and in practice during client and staff interactions.

Visual privacy during consultations shows respect for clients and can be aided by the use of gowns, curtains and screens. Members of the clinical team need to be sensitive to client dignity when clients are required to undress/dress in the presence of the doctor, nurse or health worker. Different clients may respond differently to these situations, and sometimes gender differences matter, so health professionals need to be sensitive to varying client needs.

Auditory privacy ensures that conversations with clients or conversations with other staff about client health information cannot be overhead by others. Auditory privacy can be ensured when discussions and conversations between staff and between staff and clients are masked by background music, or held in a private room.

A client should never be put in the situation where discussions about their health situation can be overheard by others. If there is the risk that this will happen during consultations, the client needs to be offered a private room or space.

When documenting and using client health information: client health information must only be visible to the GP or clinician (and, if they choose, their client) but not to any unauthorised person. The positioning of

computers and computer screens and the use of screen savers should be carefully considered to hide information from the view of the general public.

Complaints about privacy-related matters

Complaints about privacy-related matters will be addressed in the same way as other complaints. This process is outlined in the Complaints Policy, and the complaints procedure and complaint form are readily available to clients on the DDHS website.

Management of health information

DDHS is considered paperless, utilising *Communicare* Client Information Management System at all DDHS sites, and has systems in place to protect the privacy, security, quality, and integrity of the personal health information held electronically (refer to Information Security Policy).

DDHS is committed to enhancing the continuity and coordination of client care, through effectively recording client health information into their health record in the *Communicare* Client Information Management System. This record is a detailed, confidential and legal document about a particular person over a period of time, where its primary purpose is to:

- identify a person accurately
- record symptoms and signs
- support diagnosis
- justify management decisions.

Individual client health information must be legible, up to date and routinely include:

- client identification, contact details and demographic information including self-identified cultural background such as Aboriginal, Torres Strait Islander, language and/or clan affiliations
- medical history
- consultation notes, including notes from out-of-hours care providers and home visits
- letters and correspondence from hospitals, consultants and health and allied health professionals
- clinical correspondence, investigations, referrals and test results
- reports, correspondence and information relating to each client that may have a bearing on their emotional and physical well-being. This includes Work Cover and legal reports.

Collection of health information

Active client health records must include, at a minimum, the following client identification and contact information:

- client name (family and given, and/or cultural, skin, clan or bush name)
- date of birth
- gender
- address (may be recorded as community, outstation or homeland)
- hospital record number (HRN) or equivalent
- Medicare number
- Emergency contact information
- Allergies and/or adverse reactions

At DDHS our client health records are created and maintained in the *Communicare* Client Information System. In *Communicare*, all client health records have a main health summary that includes:

- adverse reactions summary
- alerts and other information
- active problem/significant history
- social and family history
- risk factors
- medication summary
- care plan
- progress notes
- details

DDHS seeks to ensure that:

- 90% of active health records contain a record of allergies in the health summary
- significant face-to-face, telephone or electronic communication is recorded in the Client record

- health records are updated to show recent important events including immunisations, births and family history changes

Recording and storage of health information

DDHS ensures compliance with the appropriate and adequate retention of records and archiving in accordance with the required Australian Privacy Principles and the Federal Privacy Act 1988.

Retention of Client Health Record

In DDHS, the length of time inactive medical records are kept is indefinite given the use of an electronic client information service. If a client does not present within 3 years, the file then changes from being 'current' file to a 'past client' file.

Individual medical records of Indigenous Australians born before 1980 shall not be destroyed and should be kept in secondary storage. Medical records of Indigenous Australian born after 1980 are dealt with according to the Client Medical Records guidelines.

In DDHS, authority must be obtained from the treating GP or the authorised Senior Medical Officer prior to any information being destroyed.

Archiving

Electronic Records are retained in the *Communicare* Client Information System indefinitely.

All Archived Files are stored in a safe and secure location with the Archiving Body, Iron Mountain, 2887 Stuart Highway, Berrimah, NT.

Destruction of Client Health Records

No Client health record will be destroyed at any time without the permission of the treating GP or the authorised health practitioner in the Service. In the event of closure, clients will be contacted individually or, if not practical, a public notice will be placed in the local newspaper indicating how clients may arrange for their health record to be transferred to another GP or health clinic. In the event of closure, arrangements have been made that any medical records not transferred will be stored securely under the supervision of the Practice Manager.

My Health Record (MyHR)

DDHS is a registered health provider organization under the *My Health Records Act 2012.* If the client has a registered MyHR record, DDHS is authorized to collect, use and disclose information for the purpose of providing healthcare to the registered consumer (client). This is in accordance with the access controls set

by the client, or if no access controls have been set by the client, then in accordance with My Health Record Rules.

DDHS recognizes exceptions where collection, use and disclosure of health information is other than in accordance with access controls. This includes:

- At the request of the System Operator for the purpose of the management or operation of the MyHR system
- In the case of a serious threat to the registered consumer's (client) life, health or safety; or is unreasonable or impracticable to obtain the clients consent
- Authorised and required by Commonwealth, State or Territory law
- With consumer's (client) consent
- For purposes relating to the provision of indemnity cover for a health care provider
- At the order of a court, tribunal or coroner
- For law enforcement purposes carried out by an enforcement body

Assisted Client Registration (Assisted Registration Tool Software)

Assisted registration allows a healthcare provider to help register for an eHealth record. DDHS staff utilizes *Communicare* ART Software for this process and provides the client the essential information regarding MyHR to obtain informed consent.