The College of Physicians and Surgeons of Prince Edward Island

14 Paramount Dr.
Charlottetown, PE C1E 0C7
Phone: 902-566-3861 **Fax**: 902-566-3986
Website: www.cpspei.ca

POLICY NAME	**Retention, Access and Transfer of Medical Records**
DESCRIPTION	This Policy sets out the standard expected of physicians with regard to the retention of medical records (including security and storage), access to medical records and denial of access, transfer of medical records and destruction/disposal of medical records. The Policy also references applicable legislation regarding medical record information. A standard is the minimum professional and ethical behavior, conduct or practice expected by the College of Physicians and Surgeons of PEI (CPSPEI). Physicians licensed with the CPSPEI are required to be familiar with the College standards. **CMA Code of Ethics**: Section 16. "In determining professional fees to patients for non-insured services, consider both the nature of the service provided and the ability of the patient to pay, and be prepared to discuss the fee with the patient." Section 19. "Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given reasonable notice that you intend to terminate the relationship." Section 25. "Respect the need to balance the developing competency of minors and the role of families in medical decision making. Respect the autonomy of those minors who are authorized to consent to treatment." Section 31. "Protect the personal health information of your patients." Section 32. "Provide information reasonable in the circumstances to patients about the reasons for the collection, use and disclosure of their personal health information." Section 33. "Be aware of your patient's rights with respect to the collection, use, disclosure and access to their personal health information; ensure that such information is recorded accurately." Section 34. "Avoid public discussions or comments about patients that could reasonably be seen as revealing confidential or identifying information." Section 35. "Disclose your patients' personal health information to third parties only with their consent, or as provided for by law such as when the maintenance of confidentiality would result in a significant risk of substantial harm to others, or in the case of incompetent patients, to the patients themselves. In such cases take all reasonable steps to inform the patients that the usual requirements for confidentiality will be breached." Section 36. "When acting on behalf of a third party, take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to the third party." Section 37. "Upon a patient's request, provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others." Section 42. "Recognize the profession's responsibility to society in matters relating to public health, health education, environmental protection, legislation affecting the health or well-being of the community and the need for testimony at judicial proceedings."

Statutory Obligations:
Physicians need to be familiar with the various pieces of legislation that deal with the health information contained in a medical record and require compliance by physicians.

Provincial:
Custody, Jurisdiction and Enforcement Act of PEI 2015
Freedom of Information and Protection of Privacy Act of PEI (FOIPPA) 2018;
Health Information Act of PEI 2018

Federal:
Personal Information Protection & Electronic Documents Act (PIPEDA) 2000.
Privacy Act of Canada 1985
Access to Information Act of Canada 1985

Other Important Resources:
Guide to the HI Act PEI, May, 2017
http://www.princeedwardisland.ca/en/information/health-and-wellness/guide-new-health-information-act
CMPA Electronic Records Handbook
https://www.cmpa-acpm.ca/static-assets/pdf/advice-and-publications/handbooks/com_electronic_records_handbook-e.pdf
CMPA-Electronic Records 10 Tips to Improve Safety
https://www.cmpa-acpm.ca/static-assets/pdf/advice-and-publications/risk-management-toolbox/com_electronic_records_poster_letter_size-e.pdf
CMPA- A matter of records: Retention and transfer of clinical records
http://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2003/a-matter-of-records-retention-and-transfer-of-clinical-records
CMPA-Winding Down Your Practice
https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2013/winding-down-your-practice

Custody:
Paper records created in a private office are owned by the physician who created them. When a physician is creating medical records in a group or shared medical record environment, a data-sharing agreement must be in place which addresses how issues of ownership, custody and enduring access by individual physicians and patients will be addressed, including following relocation, retirement or death of the physician.
In situations where a physician creating the medical record is not the owner of the clinic and/or of the EMR license, issues of custody, confidentiality and enduring access by individual physicians and patients must be documented in a formal contract with the owners and/or EMR service providers. Where these issues have not been clearly addressed, physicians are advised to consult CMPA or appropriate legal counsel before contracting to provide medical services.

Retention of Records:
CPSPEI endorses the Canadian Medical Protective Association's recommendation on

	the retention of medical records. See the CMPA document 'A matter of records: Retention and transfer of medical records (updated 2019)'. CPSPEI recommends physicians retain their original patient medical records for **at least 10 years** from the date of last entry, or in the case of minors, 10 years from the time the patient would have reached the age of majority (age 18 years in PEI). Should a physician transfer medical records to another custodian, the physician should ensure enduring access to the medical records they created for these time periods at a minimum. CMPA recommends that you not let the original files out of your control. Records may be required to assist in the defense of a physician, or his/her estate, if medical-legal difficulty should arise at a later date. Failure to provide records in these situations can have significant consequences. A physician defending allegations of malpractice and/or negligence after disposing of a medical record will be left to rely primarily on memory, which may be affected by the passage of time. Should a physician's estate be sued in connection with the physician's professional work, the records often contain the best evidence of the deceased physician's interaction with the patient. Although the statute of limitation in PEI is 2 years after the patient knew or ought to have known that there might be an issue, the court may be reluctant to deprive an individual of the right to have an issue adjudicated despite the apparent expiry of the limitation period. Also, there is no statute of limitation in the case of sexual assault. Physicians may also be required to retain records longer than the above time periods when a request for access to personal health information is made before the retention period ends. Where such a request has been made, physicians should retain the personal health information for as long as necessary to allow for an individual to take any recourse that is available to them. The obligation to securely retain medical records and make copies available as appropriate is a professional obligation that extends well beyond the date that a physician ceases to practice. When transitioning to an EMR, it is only necessary to retain one original medical record. Once the information has been fully transitioned to an EMR, it is not necessary to retain the original paper medical record. The original paper records may be destroyed (by cross-shredding or incineration). If only part of the paper record is transitioned to the EMR, then the remainder of the paper record must be retained as part of the original medical record. Scanned copies of the paper medical record must be saved in "read only" format. Physicians who wish to use optical character recognition (OCR) technology to convert medical records into searchable and editable files may do so, but they must retain the original medical record or a scanned copy. **<u>Security</u>** Clinical records must be properly secured and protected. There must be protocols in place to address physical security, data sharing with other health-care professionals, backup of electronic data and user-based levels of access. Paper records should be kept in a restricted access area or in locked cabinets with limited access. Electronic record security is more complex. It should ensure the medical record is only

	accessible to the patient's caregivers, or for other purposes authorized by law or with express patient consent. This can be achieved through the use of user identification and passwords for logging in. Controls that restrict access based on the user's role and responsibilities should also be used. Physicians should document protocols about who in their office has access to which records and should ensure that the system being used restricts access to those entitled to access. Encryption technology on all computer systems and portable electronic devices containing patient information is recommended. If there is electronic/technological transmission of information contained in a medical record, the physician shall use methods, devices or systems to protect the confidentiality of the information. If patient records are electronically transmitted, physicians must take reasonable steps to ensure that documents sent are indeed received. Emails and web servers are not secure. Physicians should not send personal health information by email without express consent to do so from the patient. There are systems that provide an acceptable level of security; those physicians who wish to send personal health information by email should use an encrypted or otherwise secure system. Wireless Internet access can also be insecure. It is possible for others to "eavesdrop" on information being accessed. Document and system passwords can delay or prevent unauthorized access, but physicians using wireless Internet must be aware of security risk. All hard drives eventually fail and so it is mandatory for physicians using electronic records to ensure that they are using an effective backup system that is updated frequently. An offsite back-up system is highly recommended. This will protect patient records in the event that the physician's computer or office has been destroyed. Physicians who take records out of the office or access their electronic records from a location other than their own office, must take the appropriate measures to restrict access and maintain privacy of patients' personal health information. **Storage** Medical records which are still within the legal retention period may be transferred to the custody of another physician, service provider, medical clinic, public hospital or health authority, or placed in a safe storage facility if they remain in the custody of the original physician. Physicians must ensure that records are stored in a safe and secure place, in accordance with ethical, professional and legal requirements, whether the records are paper or electronic. The physician must ensure that the privacy of patient records will be adequately protected whether the information is stored in premises within the physician's control or otherwise. Where a physician has engaged a service provider to manage medical records, the physician is still responsible for maintaining the security of the records. There are a number of commercial companies who will securely store confidential records and assist in releasing information in the record to other parties as directed. Physicians are encouraged to document medical records transfer arrangements in a written agreement with any storage provider.

Patients should be notified of the location of their records and how they may be accessed.
The physician must ensure that no copy is left with the storage provider when the physician ceases to use the storage system.

Access to Medical Record/ Denial of Access

Patients own the information in their medical records, as affirmed by the Supreme Court of Canada decision McInerney v. MacDonald, 1992. The physical medical records are the property of the physician. Patients are entitled to examine their medical record with appropriate supervision and receive a complete copy of their medical record, which includes any records created by other physicians. Any information forwarded to the physician from any source regarding a patient becomes part of the patient's medical record. Notations which preclude copying or forwarding of any particular document are of no force or effect.
Physicians should be familiar with the applicable legislation with respect to a patient's right of access found in the Health Information Act of PEI, 2018. Physicians are encouraged to seek the guidance of the CMPA, or appropriate legal counsel, if unsure about how to respond to a request for access.
Access to the medical record should be provided to the patient upon request within 30 days. An extension may be granted by the Information and Privacy Commissioner appointed under the FOIPP Act of PEI. Allowable fees for the copying of medical records are listed in the Regulations for the Health Information Act of PEI 2018. If a fee is to be charged and if the record is not immediately required for patient care or for some other pressing reason, it is reasonable for the physician to ask for some assurance of payment before a copy of the requested record is made.
All of the principles discussed in this Policy apply equally to electronic records. Physicians have an obligation to provide printed copies of electronic records when asked to do so, or an electronic version if the patient prefers. Physicians should consider providing a dictated summary to provide an overview of the patient's medical record.

A patient's general right to access medical records is not absolute; the physician may use discretion not to disclose information which the physician reasonably believes is likely to cause an adverse effect on the physical, mental or emotional health of the patient, harm to another person, or if the disclosure would reveal personal health information about another person who has not consented to the disclosure. Access does not extend to information arising outside the doctor/patient relationship. For example, information given to the physician by a friend or family member of the patient does not have to be shared with the patient.
Under the above circumstances, when providing access, or a copy, the physician should sever such information from the rest of the record.
A patient should have access to the medical record unless there are compelling reasons not to disclose. The onus is on the physician to justify denying access. A patient may apply to the Information and Privacy Commissioner appointed under the FOIPP Act of PEI for a review of any refusal by a physician to disclose all or part of the medical record. Refusal to disclosure of personal health information is found in Section 10 of

	the Health Information Act. A patient's right of access does not include medical records compiled and used solely for Quality Assurance activities, Risk Management activities or Regulatory Investigations. If in doubt, a physician should consult CMPA or appropriate legal counsel regarding denial of access to a medical record by a patient. Disclosure of health information to parents or guardians is complex and the interrelationship between different pieces of legislation is not always clear. The College's interpretation is that if the child has sufficient understanding to be able to make informed decisions about the confidentiality of their health information, the child will determine whether the physician can provide their health information to a parent. The child has the right to confidentiality of their health information; disclosing their health information to their parent without their consent will generally be considered an "unreasonable invasion of privacy." If the child does not have sufficient understanding to be able to make informed decisions about the confidentiality of their health information, the custodial parent can access the child's health information. The non-custodial parent who has been granted access rights would also have the right to make reasonable inquiries as to the child's health information. The Custody, Jurisdiction and Enforcement Act 2015 is the applicable legislation. Physicians who find themselves in a position of having a noncustodial parent seeking personal health information of a child are advised to contact CMPA or appropriate legal counsel on such matters. When a physician receives a request to provide a copy of a medical record to a third party, the physician should confirm that the disclosure of the record has been consented to in writing by the patient, or that he/she is required by law to disclose the information. Physicians should be aware of and comply with their legal, professional and ethical reporting obligations. Section 24 of the Health Information Act of PEI deals with permitted disclosure. Patient consent is not required under mandatory reporting, which includes: child abuse or neglect, child sexual abuse, communicable diseases, patient death, fitness to drive, workers' compensation claims, patients who are pilots or members of flight crews, railway workers, loss or theft of narcotics or other controlled drugs, and reporting colleagues. Physicians may disclose personal health information to police without the consent of the individual to whom it relates if the physician reasonably believes that disclosure is required to prevent or reduce a risk of serious harm to the health or safety of the individual to whom it relates or another individual, or to prevent or reduce a risk of significant harm to the health or safety of the public or a group of people. Physicians shall disclose personal health information without consent to a person (including police) carrying out an inspection, investigation or similar procedure that is authorized by law for the purpose of facilitating the inspection, investigation or procedure. Physicians may disclose personal health information without consent for the purpose of a proceeding or a contemplated proceeding in which the physician is or is expected to

	be a party or a witness, if the personal health information relates to or is a matter in issue in the proceeding or contemplated proceeding. In circumstances where a police officer or legal authority is seeking personal health information or private health records, physicians are advised to contact CMPA or appropriate legal counsel before disclosing. In circumstances of mandatory reporting or even where a physician feels there is a need to report, unless clear, legal advice first is the recommended course of action. A physician has an obligation of confidentiality to deceased patients and should only disclose personal health information regarding a deceased patient with the consent of the executor for the patient's estate or the person who has assumed that responsibility if the estate does not have an executor. As a general rule, information about a patient should be disclosed only: 1) on the written authority of the patient, 2) on the written authority of the patient's authorized legal representative, 3) on receipt of a summons, subpoena, warrant or court order, or 4) when the request comes from an agency or individual entitled by legislation to a copy of the records. Coroners have the responsibility and authority under the Coroners Act to obtain copies of the complete medical record of the deceased patient. Physicians are advised to consider seeking legal advice when involved in a coroner's case. In addition, physicians are permitted to disclose information about a deceased patient for the purpose of identifying the individual; for informing anyone it is reasonable to inform of the patient's death and where appropriate, the circumstances of the patient's death; and to the patient's spouse, partner, sibling or child, if they reasonably require the information to make decisions about their own health care or the health care of their children. When in doubt regarding disclosure, the physician should consult CMPA or appropriate legal counsel for advice. **Transfer of Records** When transferring a patient's medical record to another physician, or providing them to a patient, it is recommended that only copies be provided, and that the original medical record be retained by the physician. Patients should be advised that relevant records will be forwarded to a new physician upon written request. Physicians who are employees should satisfy themselves that there is an agreement with the employer about patient medical record retention and transfer. Physicians can transfer original medical records to another physician, service provider, medical clinic, public hospital, health authority, or other commercial storage provider if the receiving party has agreed to take custody of the medical records and provide enduring access to the transferring physician and the patients. Transfer of a medical record to another physician or party should be documented in a written contract that includes: 1) the location of the records; 2) safe custody and protection of confidentiality of the medical record; 3) a requirement that the receiving physician or storage provider notify the transferring

	physician if the records are transferred to a different physician or moved to a different location; 4) the transferring physician's right of enduring access, including copying of any records, for the purpose of transferring the record, preparing medico-legal reports, defending legal actions, or participating in a complaint investigation; 5) the patient's right of access to the records; 6) the duration of retention of the records; 7) the appropriate destruction of the records. Before patient records are transferred to another custodian, the physician must make reasonable efforts to give notice to patients, or where this is not reasonably possible, notify patients as soon as possible after the transfer has occurred. Notification may be done by letter, email, handout, visible signage, telephone answering machine, notice in a newspaper or in person, and should detail how a patient can access a copy of their medical record. Patients should be advised that copies of their medical records will be available and provided upon written request, at a reasonable cost as outlined in the Health Information Act of PEI, 2018. Newspaper publication of notice should be made in three separate editions of the newspaper (one being a weekend edition if one is published) over a 2 week period. When a patient requests transfer of their medical records to another physician or other health-care practitioner against the advice of the treating physician, it may be appropriate to provide the copies of those records directly to the patient who can then dispose of them as they wish. A physician must provide a copy of the medical record to lawyers, insurance providers or other third parties when provided with a written, dated authorization from the patient or the patient's legal representative specifying the records that are to be provided. Any uncertainty should be clarified with the patient or the person entitled to act on their behalf. Physicians are strongly encouraged to discuss these issues directly with the patient whenever possible. If there is no valid authorization, advise that you have received the request but cannot provide the copy of the medical record until you have received the written, dated authorization. The transfer of a medical record should be done in a timely manner in order to facilitate continuity of care and in a manner that protects the confidentiality of the record. Transfer of relevant information among physicians and others directly involved in the patient's care, must always be expedited in the patient's best interest. To expedite the transfer of information, and to limit the costs involved, physicians are encouraged to avoid copying the entire record, but instead, to forward only necessary information regarding significant issues and current status. In some cases it will be more efficient for the transferring physician to prepare a summary of the medical record rather than to provide a copy of the entire record. This is acceptable to the CPSPEI as long as it is acceptable to the patient and the receiving physician. The transferring physician is still expected to retain the entire original record for the time period recommended by this policy. Requests for transfer of patient information should generally be honored within six weeks, or less if circumstances require. The physician is entitled to invoice the patient

for this service as long as such is done on a fair and reasonable basis. See section 26, CMA Code of Ethics and Professionalism (2018). Transfer must not be delayed pending payment.

In the normal course of health care delivery, transfer of patient information should occur without the need for express consent from the patient or their personal representative. Information relevant to the patient's wellbeing should, thus, be shared among all health care providers caring for the patient.

When transferring a medical record because you are ending the physician-patient relationship, consider providing the patient with a copy of their medical record without a fee.

Closure of a Practice

When a physician temporarily closes a practice, he/she should give notice to the public and patients as soon as possible. When a physician permanently closes a practice (relocates or retires) he/she should give at least ninety days notice to the public and patients.

It is recommended that physicians in a group practice should have an agreement that establishes responsibility for maintaining and transferring patient records upon dissolution of the group and closure of the practice. The agreement should address:

1) notification of the public and patients;
2) the method for division of medical records;
3) the method of identifying custody of the medical records;
4) how records will be safely stored;
5) how records will be transferred;
6) how patients can access their records;
7) associated costs to patients;
8) physician access to the content of the record to allow for the preparation of medico-legal reports, defense of legal actions or response to a complaint investigation.

If no such agreement exists, physicians dissolving a group practice must agree upon a strategy for informing the public and patients, and a system to determine who is the 'most responsible physician' for each record and how records will be dealt with. In the case of a sudden departure of a partner, records should be kept at the original location until the patient directs where he or she wishes the records to be sent to for ongoing healthcare.

If a group practice dissolves, and if the patient is following a physician to a different practice location, the records should be transferred and physicians should agree how the cost of copying, transferring and access to records will be handled by the group. Reasonable access to medical records must be given to all former partners and associates.

Upon the death of a physician, the executor of the estate of the physician is deemed to be the custodian of the medical records until custody and control of the records passes on to another physician, service provider, medical clinic, public hospital, health authority, or commercial storage provider who is legally authorized to hold them. Should there be no named executor for the physician's estate, the courts may appoint an administrator to manage the medical records. In writing a will and naming an estate

	executor, a physician has a responsibility to advise the executor that they will be responsible for managing any medical records remaining in the custody of the physician upon the physician's death. It is necessary to provide to a patient the opportunity to access the medical record, either through a formal custody agreement or through the executor of the estate for the physician. Hopefully colleagues will be willing to assist the family or the executor of the estate with these tasks. Where uncertainty arises over the responsibilities with regard to the medical records of a deceased physician, the CPSPEI suggests seeking legal advice and/or contacting the CMPA. Regardless of how a practice closes, the physician (or the estate executor) is still responsible for retention of the medical record. Those physicians who wish to transfer custody of patient medical records to another physician, service provider, medical clinic, public hospital, health agency, or other commercial storage provider, are encouraged to obtain legal advice regarding the arrangement. In all cases of practice closure, notice should also be given to the CPSPEI as soon as possible, and should include a contact mailing address, telephone number and email address by which the physician (or estate executor) can be reached after the closing of the practice, and how medical records will be accessed. **Theft, Loss, or Disclosure** When, despite reasonable efforts, theft, loss or the potential for disclosure does occur, physicians should advise all patients potentially affected of the potential for disclosure of their information. **Destruction/Disposal of Medical Records** When the obligation to store medical records comes to an end, after the legal retention period has expired, the records should be destroyed in a way that is in keeping with the obligation of maintaining confidentiality. The College recommends that physicians destroy medical records by supervised cross-shredding or incineration of all paper medical records. If patient records are stored on a computer hard drive, the hard drive itself should be either crushed or wiped clean with a commercial disk wiping utility and any back-up copies and other storage means also destroyed at the same time. Physicians should maintain a list of each record that is destroyed, with a description of the time period covered in the record. Physicians must not dispose of a record of personal health information unless his or her obligation to retain the record has come to an end. **The CPSPEI acknowledges CMPA, CPSNS, CPSNB, CPSNL, CPSS, CPSBC and CPSO whose policies re: medical records were reviewed and used in writing this Policy.**
APPLICABLE LEGISLATION	Provincial: Custody, Jurisdiction and Enforcement Act of PEI 2015 Freedom of Information and Protection of Privacy Act of PEI (FOIPPA) 2018 Health Information Act of PEI 2018 Federal: Personal Information Protection & Electronic Documents Act (PIPEDA) 2000 Privacy Act of Canada 1985 Access to Information Act of Canada 1985
APPROVED BY:	Council, April 9, 2018, June 3, 2019
REVIEWED:	Council, November 4, 2019