



# Managing health records



## Practitioners' obligations

**Maintaining clear and accurate health records is essential for the continuing good care of patients.**

National Boards expectations about maintaining health records are set out in your profession's code of conduct. This is a summary of those expectations.

### 1. You must keep good health records

- This means accurate, up-to-date, factual and legible records.
- They must be objective and show respect for patients, be non-judgemental and not include remarks that may be interpreted as prejudiced, demeaning, derogatory, discriminatory, racist or culturally unsafe.
- Good health records include all relevant clinical history, diagnostic, treatment and services information and advice – including correspondence with other treating practitioners. If you're not sure, refer to your code of conduct or use our self-reflective tool.
- Each record should clearly identify the date and time that the service was provided as well as who provided the service and when relevant, where the service was provided.
- It is important to document informed consent for treatment, examinations and services provided. You may need to include written consent for some procedures which are considered higher risk or that may result in serious injury or death.

### 2. Good processes support good health records

- Make records at the time of events or as soon as possible afterwards to help ensure your records are accurate and include all necessary information.
- Checking available electronic records such as My Health Record should be part of your process in taking the patient's history.
- Keep billing information accurate and up to date.

### 3. Continuity of care is an important part of making and keeping good health records

- Ensure that the health records you keep are in a form that can be understood by other health practitioners. It is important to include your management plan and any other details necessary to facilitate continuity of care.
- When you take a patient's history, you should record all relevant psychological, social and cultural aspects and access available electronic records such as My Health Record where appropriate.

### 4. Health records must be kept private and confidential

- Be aware of the privacy requirements that apply to your practice and hold health records securely and prevent unauthorised access. This includes protecting the privacy and integrity of electronic records.
- Comply with the health records legislation in the states or territory where you are practising.
- Only access health records when you are involved in the person's care and/or are authorised to do so.

### 5. Patients have a right to access information in their health records

- Recognise the right of patients to access information contained in their health records and facilitate that access in a timely manner.
- You must promptly facilitate the transfer or management (including disposal) of records by following your local requirements for privacy of health records when requested by patients, when closing or relocating a practice, or when you retire.

## Other resources to help you

Some National Boards have specific guidelines in relation to records that you should familiarise yourself with.

You should also familiarise yourself with any state, territory or Commonwealth legislation about health records and privacy that may apply to health records you create. Useful resources for practitioners include:

- Resources published by your professional association and professional indemnity provider
- [Office of the Australian Information Commissioner \(OAIC\) – Privacy for health service providers](#)
- [OAIC – Guide to health privacy](#)
- [OAIC – Links to state and territory legislation](#)
- [My Health Record – Legislation and governance information](#)

For useful information about cultural safety, see the Australian Commission on Safety and Quality in Health Care's [User Guide for Aboriginal and Torres Strait Islander Health](#).