Responsible clinician approval for the release of health records:

Data Protection Act 2018 (living individuals)

Access to Health Records Act 1990 (deceased individuals)

**Re:**

**Service user name: XXX**

Address: XXX

Date of birth: XXX

NHS no: XXX

Dear XXX

I am writing to you to ask you to review and scrutinise the attached clinical records, complete the table below and return, via email, to elft.accesstorecords@nhs.net by no later than XXX insert date required by XXX.

We have received a request from XXX insert requester name / organisation XXX under the Data Protection Act 2018 / Access to Health Records Act 1990, to be supplied with a copy of the health records for the above named patient.

I can confirm that we have obtained and reviewed the following:

* Consent from the patient (Living patients only)
* Consent from the patient’s appropriate parent / guardian (Living patients only)
* Appropriate proof of Authority to act on behalf of the patient, i.e, LPoA (Living patients only)
* Identification for the patient / requester
* Confirmation from the Solicitors that due diligence has been completed
* Proof of personal representation (Deceased patients only)
* Evidence of a claim arising out of the patient’s death (Deceased patients only)

We have reviewed the records and made suggested redactions as per below:

|  |  |
| --- | --- |
| **Page / section** | **Reason for redaction** |
|  | i.e the information referred to a 3rd party / the information was provided in confidence by a 3rd party / the information related to a different data subject / the information was provided by another agency who has not authorised the disclosure of the information etc. |

We require you to complete the below table, sign and return as indicated above.

|  |  |
| --- | --- |
| I agree with the proposed redactions | Yes / No |
| I believe some redactions are not necessary | Yes / NoIf Yes, please indicate page / section number here and reason: |
| I believe further redactions are necessary | Yes / NoIf Yes, please add to the table above indicating page / section and reason for redaction. |
| I believe it is in the patient’s best interests to disclose the records subject to redactions as stated above. | Yes / NoIf No, explain why here: |
| I have no reason to believe the disclosure of the records would go against the wishes of the patient.(We ask this, as the patient’s most appropriate clinician, to provide further assurance that the patient has not been forced into requesting the records, forced into consenting or that the request is fraudulent) | True / False / Unable to answerIf False, explain why here: |
| **Name of Clinician completing the review** |  |
| **Signature of Clinician completing the review** |  |
| **Date**  |  |

**NOTES TO CONSIDER WHEN REVIEWING RECORDS FOR REDACTION:**

* Ensure you know **who the requester is**, i.e patient, family member, solicitor police and tailor the redactions accordingly.
* Ensure you know the **scope of the request**. Whose records are being requested, i.e, a patient’s records or perhaps a family member of a patient asking for information held about them rather than the patient. Ensure only records and information relating to that person are disclosed. Any references to 3rd parties should be redacted as per below:
* **Names of 3rd parties** - Is it reasonable that the patient (or the requester if a family member / friend) is aware of any third party reference.
	+ i.e record states patient attended appointment with their brother John. In this case it is reasonable to assume the patient knows his brother is called John and therefore this doesn’t need to be removed.
	+ Staff members names should not usually be redacted as they are staff names acting in their professional capacity and as such, if they are referenced within a patients record, it is reasonable to assume that the patient is aware or has been advised of that staff members name.
* **Information provided by 3rd parties** – Is it reasonable to assume that the patient (or the requester if a family member / friend) is aware of references made by a person who is not a clinician involved in the patients care.
	+ i.e record states patients sister contacted the service to raise concerns about the patients mental health, they feel the patient is not coping and requests an appointment for the patient. In this case it would be reasonable (unless otherwise obvious) that the patient is not aware that their sister has contacted the service. It should be assumed that the sister contacted the service in confidence and therefore the full reference should be redacted.
	+ Patient attends clinic with their mother who advises she believes the patient would benefit from a review of medication. In this case, the patient was present when the mother made this reference and therefore does not need to be redacted.
	+ Clinician discusses patient’s current mental health status with Dr Smith to agree if a referral to talking therapies would be appropriate. In this case, the discussion, is with another clinician and relates to the patient’s health care and treatment and is unlikely to require redaction.
* **Personal data about a 3rd party** - any information personal to a third party should be redacted.
	+ Patient had a violent episode on the ward and attacked Nurse Rachel who subsequently required sick leave and counselling. In this case the face that Rachel required sick leave and counselling is personal to her and should not, under any circumstances, be disclosed as part of the patients record.
	+ Patient attended clinic with their brother Mike. Following the appointment, Mike stayed behind to talk to the clinician to advise that he is struggling to cope with the patient’s behaviour and asked for any coping strategies he can use to help himself. Again, this information is personal to Mike and should not be disclosed as part of the patients records.
* Health records can be very complex and often contain information about a patient’s family member such as a CAMHS patient’s parent. Understanding the patient’s family environment can be essential to treating the patient appropriately, however, any information obtained about any person (non-professional) that is NOT the patient **MUST NOT BE** disclosed with the patient’s record. Disclosure of this nature is a breach of confidentiality and must be reported as a Data Breach via Datix.
* It is also important to consider if releasing any of the information could have a **detrimental effect on the physical or mental health of the patient or the requester**. If disclosure of physical or mental health information is likely to cause significant harm to either the individual or another person it may be withheld and redacted (unless they are already aware). This can only ever be a clinical decision and must be considered in the context of significant harm or distress (not just discomfort or something in the records they may not like).

For any advice and guidance that may be required when reviewing records, please do not hesitate to contact the Information Rights Manager at elft.accesstorecords@nhs.net