

INDEX NO: **Practice Direction
16.17**

SUBJECT: **Health Records – Responsibilities
of the Custodian of Health
Records**

APPROVAL BY COUNCIL: June 1, 2016
UPDATED:

Background

Manitoba Health has outlined in legislation, responsibilities of a custodian of health records. These responsibilities apply whether the custodian has been appointed by a Registered Dietitian, the College or the court.

Practice Direction

Responsibilities of custodian

1. Taking custody of records:
 - a. If the records must be moved, the custodian must ensure that:
 - i. The records are only handled by authorized persons
 - ii. The records must be transported in a secure manner
 - iii. There must be a tracking system in place to ensure that the number of records removed from the original location matches the number of records in the new storage location (temporary or permanent).
2. The custodian must notify:
 - a. The patients/clients to whom the records relate of how they may obtain a copy or request a transfer of their personal health information, using such means as is reasonable in the circumstances, but including at a minimum notification via:
 - i. a publication in a daily or weekly circulation in the geographic area in which the patients were treated; and
 - ii. posting a written notice on the premises from which the records were removed, if possible

Additionally, the College must post on its website, notice of the custodian of the health records, and information respecting how patients/clients may request a copy of or the transfer of their personal health information to another regulated health professional.

3. Indexing of health records

As soon as is reasonably possible, the custodian shall create, or have created, an index of the records, so that the records are readily and accurately searchable. The index will include the client's

- name and
- date of birth

INDEX NO: **Practice Direction
16.17**

SUBJECT: **Health Records – Responsibilities
of the Custodian of Health
Records**

APPROVAL BY COUNCIL: June 1, 2016
UPDATED:

4. Security of Stored Records

When storing records, whether temporarily or permanently, the custodian must:

- ensure that the records are stored in a designated area and are subject to appropriate security safeguards, in accordance with *The Personal Health Information Act (PHIA)*;
- limit physical access to designated areas containing records to authorized persons;
- take reasonable precautions to protect records from fire, theft, vandalism, deterioration, accidental destruction or loss and other hazards; and
- establish a measure to ensure security of a record if it is removed from the secure designated area.

5. Record of access

- a. A custodian shall create and maintain or have created and maintained a record of access for any system it uses to maintain the records.
- b. A record of access may be generated manually or electronically, and at a minimum should include:
 - i. which record has been accessed
 - ii. persons who accessed the record
 - iii. when the record was accessed
 - iv. whether the record, or any part of the record, that has been accessed was subsequently provided to the individual the record was about, or disclosed to another person or organization, and if they were shared or disclosed:
 1. to whom they were shared or disclosed
 2. what parts(s) of the record were shared or disclosed
 3. when the record was shared or disclosed
 4. how the record was shared or disclosed
 5. for what purpose, or under what authorization, the record was shared or disclosed

6. Providing access to records

As soon as is reasonably possible after taking possession of the records, the custodian shall establish policies and procedures regarding:

- a. how requests for access can be made
- b. how the identity of the requesting individual will be confirmed
- c. how the record will be located, reviewed and severed (where required)
- d. how the record will be copied and provided, forwarded or transferred

INDEX NO: **Practice Direction
16.17**

SUBJECT: **Health Records – Responsibilities
of the Custodian of Health
Records**

APPROVAL BY COUNCIL: June 1, 2016
UPDATED:

- e. the method by which records copied and provided will be logged, including, at a minimum:
 - i. who copied them
 - ii. when they were copied
 - iii. to whom or what organization the records were sent
 - iv. how they were provided, forwarded or transferred
 - v. for what purpose or under what authorization they were provided, forwarded or transferred
- f. fees that will be charged for providing a copy of or transferring a copy of an abandoned record at the request of the patient the record is about.

7. Fees

The custodian may charge a reasonable fee for providing a copy of a record, but the fee must not exceed:

- 20 cents for each page for paper copies made by a photocopier or computer printer
- 50 cents for each page for paper copies made from a micro printer or
- the actual costs for any method of providing copies

No fee is payable by an applicant for:

- making an application for access to a record
- using any file list, file plan or similar record used to identify, locate or describe records, unless the applicant requires a copy, in which case, 20 cents is payable for each page
- locating, reviewing or severing records or
- regular mailing costs, other than special courier delivery which may be charged to the applicant at actual cost

8. The custodian is responsible for the health records until they are transferred to another regulated health professional or have met CDM requirements for records retention, outlined below.

- Records should be retained for a minimum of 10 years from the date of the last entry.
- Records for pediatric clients should be retained for a minimum of 10 years and 2 years past the date the client becomes 18 years old.