Standard of Practice

Maintenance of Patient Records in All Settings

Initial Approval: December 8, 2021 **Effective Date: February 15, 2022**

Standards of Practice of Medicine set out the requirements related to specific aspects for the quality of the practice of medicine. Standards of Practice of Medicine provide more detailed information than contained in *The Regulated Health Professions Act*, Regulations, and Bylaws. All registrants must comply with Standards of Practice of Medicine, per section 86 of *The Regulated Health Professions Act*.

This Standard of Practice of Medicine is made under the authority of section 82 of *The Regulated Health Professions Act* and section 15 of the CPSM Standards of Practice Regulation.

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PREAMBLE

This Standard sets out CPSM's requirements for maintaining patient records. It applies to paper based and digitally stored patient records, whether care is provided in-person or virtually. The requirements in this Standard are in addition to those at sections 10, 11, 13, and 14 of the *College of Physicians and Surgeons of Manitoba Standards of Practice Regulation* **("Standards Regulation"),** *The Personal Health Information Act*, CCSM c. P33.5 **("PHIA"),** and regulations made under PHIA.

Note: CPSM requirements for documentation in patient records are dealt with in CPSM's **Standard for Documentation in Patient Records**.

Notice to the profession

The health care system shifts the standard of care in the practice of medicine over time. With this in mind, CPSM recognizes the adoption by registrants of Electronic Medical Records (EMRs) compatible with the provincial government's electronic medical records systems (e.g., eChart, eHealth_Hub/Digital Health)[1] significantly contributes to the provision of good patient care. While working with an EMR compatible with provincial systems has not yet been made a requirement in this Standard, CPSM considers this arrangement the current standard of care and it is expected that it will become a requirement pursuant to this Standard for all registrants when the Standard is reviewed again in or around 2026. In the interim, it is expected that all registrants will make efforts to adopt an EMR and establish links with provincial systems as soon as reasonably possible, if they have not already done so.

1. DEFINITIONS

For the purposes of this Standard:

1.1. **"Maintain"** has the same meaning as it does in *The Personal Health and Information Act*, which is, "*in relation to personal health information, […] to have **custody** or **control** of the information.*" Respecting this Standard and relating to patient records, this meaning is expanded to include having custody or control of patient records.

1.1.1. **"Control"** means having full or partial authority and directorship over a patient record, including relating to how it is maintained. A patient record is under the control of a registrant when they have the authority to restrict, regulate (e.g., policy making), or otherwise administer its use, disclosure, or disposition.

[1] See Shared Health's website for details regarding services offered: HERE

1.1.2. **"Custody"** means having the protective care or guardianship of a patient record. Not to limit the foregoing, this includes having possession of a physical or virtual patient record. A person who has custody of a patient record will inherently have a degree of control over the patient record.

1.2. **"Abandoned"** or **"abandonment"**, with respect to a patient record, means that a trustee, as the term is defined in PHIA, has ceased maintaining the patient record in accordance with PHIA requirements without having transferred maintenance responsibilities to another PHIA trustee (e.g., the trustee is unwilling or unable to maintain the patient record).

1.3. **"Information manager"** has the same meaning as it does in PHIA, which is, "*a person or body that (a) processes, stores or destroys personal health information for a trustee, or (b) provides information management or information technology services to a trustee*".

1.4. **"Medical clinic"** means a health care facility that is primarily focused on providing medical services to outpatients, including non-institutional sole and group medical practice settings, whether incorporated or unincorporated (e.g., family doctor's office, cardiologist's office, etc.).

1.5. **"Ownership"** means, respecting a patient record, having certain proprietary rights to that patient record, including rights to possession and control.[2, 3]

1.6. **"Trustee"** has the same meaning as it does in *The Personal Health and Information Act*, which is, "*a health professional, health care facility, public body, or health services agency that collects or maintains personal health information.*"

1.6.1. As health professionals, registrants of CPSM are considered trustees pursuant to PHIA respecting any personal health information they collect and/or maintain in patient records or appointment records.

1.6.2. Medical clinics fall under the definition of '*health care facility*' established at subsection 1(1) of PHIA and, therefore, are considered trustees respecting any personal health information collected and/or maintained.

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[2] While a registrant may own or maintain a patient record, the patient has a legal interest in the personal health information contained in the record (see PHIA, *McInerney v. MacDonald*, [1992] 2 SCR 138), including certain rights to examine the record and obtain copies.

[3] Subsection 27(1) of PHIA states that, "*No trustee shall sell or otherwise dispose of or disclose for consideration personal health information unless (a) it is essential to facilitate the sale or disposition of the practice of a health professional or the business of a health care facility or health services agency as a going concern; and (b) subject to subsection (2), the sale or disposition is to another trustee.*"

2. OTHER APPLICABLE AUTHORITIES

This Standard forms only one part of the overall regulatory framework for patient records, personal health information, and other personal information in Manitoba and Canada. This Standard is not intended to comprehensively reference all enactments or rules applicable to patient records, personal health information, or other personal information established by government or institutional settings.[4]

The Personal Health Information Act

Patient records contain the personal health information of patients and the legal requirements of *The Personal Health Information Act*, CCSM c. P33.5 **("PHIA")** are applicable to that information.[5] Provisions of PHIA are referenced and incorporated several times throughout this Standard; however, this Standard does not comprehensively describe all requirements of PHIA.

2.1. It is a professional obligation that registrants be aware of, keep current with, and comply with PHIA's requirements for maintaining personal health information.[6, 7]

Institutional (e.g., hospital) legislation, rules, and by-laws

Institutions have legislation, rules, by-laws, and administrative services established by or for the institution to regulate and manage how personal health information and patient records are maintained. As a result, registrants who practice in institutional settings will generally have a limited role, on an individual level, in the maintenance of patient records within the institutional practice setting.

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[4] The federal ***Privacy Act*** will have application respecting personal health information collected and maintained in federal institutions (e.g., federal prisons, military bases). The federal ***Personal Information Protection and Electronic Documents Act*** ("PIPEDA") may apply with respect to the requirement to notify the Privacy Commissioner of Canada and affected individuals of any privacy breach in a private clinic that creates a real risk of significant harm to individuals. PIPEDA may also apply should personal health information fall into the custody of a commercial enterprise not defined as a trustee under PHIA. PIPEDA applies to access, use, or disclosure of personal health information over provincial or national boarders. For more information about federal legislation, registrants may contact the federal privacy commissioner.

[5] Manitoba Health, Seniors and Active Living provides useful and comprehensive information and resources, including educational materials and templates, on its website: HERE

[6] PHIA is engaged when three elements are present: (1) information is considered personal health information, (2) a trustee as the term is defined under PHIA is involved, and (3) the personal health information was created, used, disclosed, or maintained by the trustee.

[7] Manitoba Health, Seniors & Active Living have made training materials available online: HERE

2.2. Registrants who provide either outpatient or inpatient care in an institutional setting must comply with all legislation, rules and by-laws established by or for the institution respecting maintenance of patient records.

3. CUSTODY AND CONTROL OF PATIENT RECORDS

Registrants are required to create patient records for the medical care they provide in accordance with the **Standard for Documentation in Patient Records**. Once created, the patient record must be maintained in accordance with this Standard, either by the registrant who created the record or an appropriately entrusted transferee (see below).

Responsibility for maintenance in institutional settings

3.1. Registrants who practice in an institutional setting must comply with institutional legislation, rules and bylaws respecting the control and custody of patient records that they create while practicing in that setting (see paragraph 2.2., above). Institutional settings usually take ownership of and assume responsibility for maintaining the patient records created by registrants who practice within the institution, though this must be confirmed by individual registrants.

Presumption of responsibility for maintenance

3.2. Registrants who practice in non-institutional settings (e.g., private medical clinics) are presumptively responsible for maintaining (i.e., custody and control) the patient records that they create and their record of appointments. Paragraph 1.2.3. of CPSM's **Standard of Practice - Practice Environment** establishes that:

> *If a member engages in medical care in a non-institutional setting, the member **must maintain full direction and control** of his or her medical practice, including:*
>
> > *… **documentation in, access to and security of patient records**, including documenting medical care provided to a patient, patient appointment schedules, patient billing and payment records for the medical care of a patient …*

3.3. Notwithstanding paragraph 3.2. of this Standard, above, subject to a written agreement to the contrary, a registrant practicing as *locum tenens* is not presumptively responsible

for maintaining the patient records that they create in their *locum tenens* capacity, rather the registrant for whom they are covering remains presumptively responsible.[8]

Transferring maintenance responsibilities

3.4. Maintenance responsibilities for patient records that are created in a registrant's professional practice, including those set out at Parts 4 and 5 of this Standard, may only be transferred by a registrant to another trustee (e.g., to another registrant or to a medical clinic where they practice) in accordance with subsection 11(5) of the **Standards Regulation**, which establishes that:[9, 10, 11]

> *11(5) A member **must retain control** of all of his or her patient records unless they are maintained*
>
> *(a) by **another member**; or*
>
> *(b) by **a person or organization that employed, engaged or granted privileges to the member and is a trustee** under* [PHIA].[12]

3.5. For this Standard, subsection 11(5) of the **Standards Regulation** shall be read to include the record of appointments.

3.6. For institutional settings, transfer of maintenance responsibilities will typically be dealt with contractually or in the institution's legislation, rules, and by-laws. Registrants working within institutional settings are expected to be familiar with these authorities.

3.6.1. If institutional maintenance responsibilities respecting patient records are not clear, the registrant must negotiate an agreement that makes them clear, including rules about access to and custody of the patient records.

[8] Issues respecting creation and maintenance of records should be dealt with in a *locum tenens* agreement.

[9] Accordingly, registrants are prohibited from entering an arrangement in their professional practice that would violate this regulatory requirement.

[10] This restriction applies to succession arrangements (see paragraph 4.29 regarding, 'Preparedness for unforeseen absence or termination of practice').

[11] Registrants are strongly discouraged from transferring ownership of or maintenance responsibilities respecting the patient records they create to non-institutional health care facilities that are not controlled by another registrant who is also subject to this Standard.

[12] As an example, this may include a health care facility (e.g., medical clinic) which is considered a trustee under PHIA that has employed or engaged the registrant.

Requirement for Maintenance Agreement[13]

3.7. For non-institutional practice settings, any transfer of maintenance responsibilities by a registrant respecting the patient records they will create in their practice, or their record of appointments, must be in writing ("Maintenance Agreement")[14] and must be PHIA compliant. A Maintenance Agreement transferring maintenance responsibilities must be in place before responsibilities are transferred and must have the following components:

- 3.7.1. Pertinent details regarding who has ownership, control, and custodianship relating to the subject patient records.
- 3.7.2. Details about authority to access patient records in the practice setting (e.g., individuals who will be able to use the patient record).
- 3.7.3. Provisions to ensure reasonable enduring access related to both:
  - 3.7.3.i. continuity of care, including access to discrete or limited information needed for immediate care[15], and
  - 3.7.3.ii. patient access and copying rights.
- 3.7.4. Provisions stating that:[16]
  - 3.7.4.i. the recipient trustee must give the registrant who created the patient record reasonable access to it to allow them to prepare medico-legal reports, defend legal actions, or respond to an investigation or review, when necessary, and
  - 3.7.4.ii. if relevant, the transferring registrant will always have reasonable access to their record of appointments and authority to copy same for the applicable retention period.
- 3.7.5. Details respecting:
  - 3.7.5.i. security measures established by the recipient trustee that accord with Part 4 of this Standard, and
  - 3.7.5.ii. storage arrangements, including policies and procedures for the appropriate retention and destruction of patient records, that accord with Part 4 of this Standard.

[13] This may, for example, form a schedule to a group practice agreement.

[14] CPSM has developed sample provisions for Maintenance Agreements. These are available on CPSM's website: HERE

[15] This is to survive termination of a practice arrangement, keeping in mind that subsection 22(2)(a) of PHIA states, "*A trustee may disclose personal health information without the consent of the individual the information is about if the disclosure is … to a person who is or will be providing or has provided health care to the individual, to the extent necessary to provide health care to the individual, unless the individual has instructed the trustee not to make the disclosure*". This provision contrasts with requests for a copy of the patient record, which are dealt with at Part 5 of this Standard.

[16] This is to survive termination of a practice arrangement.

3.7.6. Reasonable plans to ensure compliance with this Standard, the **Standards Regulation** and the **Standard of Practice - Practice Management** for the following situations:

3.7.6.i. The transferring registrant temporarily or permanently ceases practice or changes practice locations, including plans to notify patients how they can access and obtain copies of their patient record.

3.7.6.ii. The recipient trustee becomes unwilling or unable to continue to maintain the patient records (e.g., death, incarceration, etc.; see also paragraph 4.29., below).

3.7.7. Any custody and control implications upon termination of the Maintenance Agreement, if applicable, or termination of the employment, engagement, business, or practice arrangement, including implications respecting the transfer of copies of patient records (see Part 5 under the heading 'Transfer of patient records at patient's request').

3.8. Regardless of whether maintenance responsibilities are transferred or not, all registrants who practice in a non-institutional practice setting must have a written Maintenance Agreement in place that includes the components listed at paragraph 3.7., above, respecting patient records that are created in the practice setting if one or more of the following apply:

3.8.1. The registrant is practicing in a setting where there are multiple contributors to a patient record (e.g., a group or interdisciplinary practice setting with a shared digital record system or electronic medical record ("EMR")).

3.8.2. The registrant is not the sole owner of the practice setting.[17]

3.8.3. The practice setting is considered a group medical practice (i.e., multiple registrants practicing in association, in which case a Medical Director is required).

3.8.4. The registrant is not the sole digital record system (e.g., EMR) licensee relating to the patient records they create in the practice setting.

3.9. When a Maintenance Agreement is required under paragraphs 3.7. or 3.8, it must be in place prior to the establishment of the practice, business, or employment arrangement, or as soon as possible afterward.

3.10. For transfers of maintenance responsibilities that pre-dated this Standard or situations when a Maintenance Agreement is required under paragraph 3.8., a Maintenance

[17] This applies to a health care facility or practice setting that is owned by someone who is not a registrant of CPSM. A practice setting may include more than one location or involve an association that provides virtual care or home visits.

Agreement that complies with this Standard must be put in place within one year of the coming into force of this Standard.

General requirements for all maintenance arrangements

3.11. The following requirements apply to **all** patient records maintenance arrangements:

3.11.1. Registrants who maintain patient records, including those responsible for the operation of a medical clinic that maintains patient records (e.g., Medical Director), must give the registrant who created the patient record reasonable access to it to allow them to prepare medico-legal reports, defend legal actions, or respond to an investigation or review, when necessary.[18]

3.11.2. Registrants moving to a new practice setting who do not have custody or control of the patient records[19] of patients who choose to follow them from the former practice setting must obtain written consent from the effected patients or their legal representatives to transfer copies of patient records to the new location. The transfer must comply with the requirements set out under Part 5, below) ('Patient Access Rights And Transferring Patient Records').[20, 21]

3.11.3. In all situations, registrants must prevent conflict from compromising patient care related to difficulties imposed by one registrant or medical clinic on another related to accessing patient records.

4. REQUIREMENTS FOR MAINTAINING PATIENT RECORDS

The requirements in this part relate to how patient records must be stored, secured, and retained over time by registrants who are responsible for their maintenance (i.e., trustees who have custody and control).

4.1. Registrants have a fiduciary obligation to hold patient information in confidence. It is an ethical requirement in the practice of medicine that registrants protect the personal

[18] PHIA provides that trustee should disclosure no more information that what is necessary to defend the action or respond to the complaint.

[19] This occurs where maintenance responsibilities have been transferred by the relocating registrant to another trustee, for example the medical clinic. It is noted that a transfer of maintenance responsibilities is commonly associated with a transfer of ownership.

[20] In this scenario, the registrant would obtain, personally or through their staff, written consent from the patient to transfer the patient record. The written consent would then be provided to the trustee responsible for maintaining the patient record. The process at Part 5 would be followed. When moving, it is prudent to make such arrangements before relocating.

[21] Registrants relocating practice must comply with all requirements set out in CPSM's **Standard of Practice - Practice Management**.

information and personal health information of their patients. There is a corollary ethical duty to make proper disclosure of information to patients, including by ensuring appropriate access and copying rights.

4.1. Respecting sharing personal health information in providing good continuity of care:

4.1.1. Section 18 of CPSM's Code of Ethics provides:

> *Fulfill your duty of confidentiality to the patient by keeping identifiable patient information confidential; collecting, using, and disclosing only as much health information as necessary to benefit the patient; and sharing information only to benefit the patient and within the patient's circle of care. Exceptions include situations where the informed consent of the patient has been obtained for disclosure or as provided for by law.*

4.1.2. Subsection 22(2)(a) of PHIA states that:

> *A trustee may disclose personal health information without the consent of the individual the information is about if the disclosure is … to a person who is or will be providing or has provided health care to the individual, to the extent necessary to provide health care to the individual, unless the individual has instructed the trustee not to make the disclosure.*

4.2. Registrants who are trustees respecting patient records often rely on others such as staff, EMR service providers, or information managers to assist with maintenance responsibilities. When that occurs, the registrant retains primary responsibility, and the expectation is that the registrant will reasonably satisfy themselves that the requirements of this Standard are being met.

4.3. Registrants responsible for the operations of a medical clinic that is a trustee (e.g., directors, officers, sole proprietor), including Medical Directors, share jointly with the clinic all maintenance responsibilities established under this Standard respecting the patient records that the medical clinic maintains.

Security and storage measures

4.4. A registrant who is responsible for maintaining patient records (*i.e., sole, or joint responsibility*) must reasonably satisfy themselves that reasonable administrative, technical, and physical safeguards are in place to protect against:[22, 23, 24, 25]

4.4.1. reasonably anticipated threats to the security of patient records, including unauthorized use, disclosure, modification, or access, or any other breach of confidentiality, and

4.4.2. reasonably foreseeable events or errors that may compromise the accuracy or integrity of patient records.

4.5. Part of safeguarding patient records will include ensuring they are stored in a safe location. Section 3 of PHIA's *Personal Health Information Regulation* establishes that trustees of personal health information are required to:[26]

4.5.1. Take reasonable precautions to protect it from fire, theft, vandalism, deterioration, accidental destruction, accidental deletion, loss, and other hazards.

4.5.2. Ensure that it is maintained in a designated area or areas subject to appropriate security safeguards.

4.5.3. Limit physical access to designated areas containing personal health information to authorized persons.

4.5.4. Ensure that removable media used to record personal health information is stored securely when not in use.

4.6. A registrant who is responsible for maintaining patient records must ensure that record management protocols are in place that regulate who may gain access to patient records and what they may do according to their role, responsibilities, and authority. Protocols must include:

[22] Guidance in this regard is provided on the Manitoba Health, Seniors and Active Living website: HERE

[23] See section 8 of the PHIA Regulation, which sets out requirements for periodic audit of safeguards.

[24] See section 18 of PHIA which sets out specific safeguards that must be in place.

[25] Section 6 of the PHIA Regulation requires, "*A trustee shall provide orientation and ongoing training for its employees and agents about the trustee's policy and procedures referred to in section 2 of the regulation (re security).*"

[26] See 'Examples of Commonly Used Security Safeguards' on the Manitoba Health, Seniors and Active Living website: HERE

4.6.1. Confidentiality pledges for all individuals who have access to patient records.[27, 28]

4.6.2. Controls that limit who may access and use information contained in the patient records.

4.6.3. Controls to ensure that patient records cannot be used unless the identity of the person seeking to use the information is verified as a person the registrant has authorized to use it, and the proposed use is verified as being authorized under PHIA.

4.7. Registrants must ensure the patient records they maintain (i.e., patient records for which the registrant is trustee) are readily available and producible when access is required (i.e., for PHIA authorized use). When an EMR system is used to maintain patient records, the system must:

4.7.1. Be capable of visually displaying and printing the recorded information for each patient promptly and in chronological order.

4.7.2. Be capable of displaying and creating a printed record in a format that is readily understandable to patients seeking access to their records.

4.7.3. Provide a way to access the record of each patient using the patient's name and health number, if applicable.

4.8. Where registrants choose to store patient record content that is no longer relevant to a patient's current care separately from the rest of the patient record, they must include a notation in the record indicating that information has been removed from the active patient record and the location where it is stored.[29]

4.9. Section 2 of PHIA's *Personal Health Information Regulation* establishes that trustees of personal health information must establish and comply with a written policy and procedures containing the following:[30, 31]

4.9.1. Provisions for the security of personal health information during its collection, use, disclosure, storage, and destruction, including measures

4.9.1.i. to ensure the security of the personal health information when a record of the information is removed from a secure designated area, and

4.9.1.ii. to ensure the security of personal health information in electronic form when the computer hardware or removable electronic storage media on which it has been recorded is being disposed of or used for another purpose.

[27] Sample PHIA Pledge of Confidentiality available HERE

[28] See section 7 of the PHIA regulation.

[29] This usually only occurs with the use of paper records.

[30] Sample written policy available: HERE

[31] See 'PHIA Policy and Procedure Requirements' on the Manitoba Health, Seniors and Active Living website: HERE

4.9.2. Provisions for the recording of security breaches and corrective procedures to address security breaches, including respecting reporting obligations under applicable legislation.

Specific EMR system requirements

4.10. Registrants must use due diligence when selecting an EMR system or engaging EMR service providers (i.e., EMR vendor) (see also paragraph 4.26, below, respecting Information Managers when applicable) and must only use electronic patient record keeping systems that:[32]

4.10.1. comply with requirements set out in **PHIA**,

4.10.2. comply with the requirements of the **Standards Regulation**, and

4.10.3. can fulfill the requirements set out in this Standard and the **Standard of Practice - Documentation in Patient Records**.

4.11. When patient records are maintained electronically, a registrant responsible for maintaining them must ensure that (see also 4.6., above):

4.11.1. Each authorized user has a private and unique login identity and password.

4.11.2. Robust security features, including encryption, use of passwords, and access controls, are in place to protect against unauthorized access.

4.12. When an EMR system is used to maintain patient records, the system must have comprehensive audit capability that:

4.12.1. Records user activity onto a permanent log, including:

4.12.1.i. the date, time, and identity of the user when patient records are accessed, and

4.12.1.ii. the date and time of each information entry for every patient and the identity of the user making the entry.

4.12.2. Indicates, in a permanent log, any changes in the recorded information and the identity of the user making the change.

4.12.3. Preserves, in a permanent log, the original content of the recorded information when changed or updated.[33]

4.12.4. Can print the permanent log separately from the recorded information for each patient.

4.13. Subsection 4(4) to 4(6) of PHIA's *Personal Health Information Regulation* establish that trustees of personal health information must:[34]

[32] This can be satisfied contractually between the trustee and the service provider.

[33] Requirements for corrections and alterations are found in the Documentation in Patient Records standard.

[34] 'Guidelines for Records of User Activity' are provided on the Manitoba Health, Seniors and Active Living website: HERE

4.13.1. Audit records of user activity to detect security breaches, in accordance with guidelines set by government.
4.13.2. Maintain a record of user activity.
4.13.3. Ensure that at least one audit of a record of user activity is conducted before the record is destroyed.

4.14. Backing-up EMRs on a routine basis and storing back-up copies in a secure environment separate from where the original data is stored is required when patient records are stored electronically.

Transitioning patient records management systems

4.15. When transitioning from one patient record keeping system to another (i.e., a paper-based to electronic system, or from one electronic system to another), registrants must:
4.15.1. maintain continuity and quality of patient care,
4.15.2. continue appropriate patient record keeping practices without interruption,
4.15.3. protect the privacy of patients' personal health information, and
4.15.4. maintain the integrity of the data in the patient record.

4.16. To ensure the integrity of the patient record is maintained, registrants who are transitioning from one patient record keeping system to another must have a quality assurance process in place that includes:
4.16.1. written procedures that are consistently followed, and
4.16.2. verification that the entire medical record has remained intact upon conversion (e.g., comparing scanned copies to originals to ensure that they have been properly scanned or converted).

4.17. Registrants who wish to destroy original paper patient records following conversion into a digital format must:
4.17.1. use appropriate safeguards to ensure reliability of digital copies,
4.17.2. save scanned copies in "read-only" format, and
4.17.3. destroy patient records in accordance with the expectations set out in this Standard.[35]

4.18. Registrants who use voice recognition software or Optical Character Recognition (OCR) technology to convert records into searchable, editable files must retain either the original record or a scanned copy for the retention periods set out above.

4.19. So that complete and up to date information is contained in one central location, a registrant who maintains patient records and is overseeing a transition must:
4.19.1. Set a date whereby the new system becomes the official record.

[35] This must be considered as part of the policy trustees are required to have under section 2 of the PHIA regulation.

4.19.2. Inform all health care professionals who would reasonably be expected to contribute or rely on the record of this date.
4.19.3. And ensure contributors only document in the new system from the official date onward.

Retention and destruction of patient records and appointment records

4.20. In accordance with subsection 11(3) of the **Standards Regulation**, registrants who are responsible for maintaining patient records must ensure patient records are retained for a minimum of the following time periods:
4.20.1. Respecting adult patients, 10 years from the date of the last entry in the record.
4.20.2. Respecting patients who are children (*i.e., minors*), 10 years after the day on which the patient reached or would have reached 18 years of age.

4.21. In accordance with subsection 10(2) of the **Standards Regulation**, registrants responsible for maintaining patient records must ensure the record of appointments kept for their practice is retained for at least 10 years after the date the record was made.

4.22. Registrants responsible for maintaining patient records must reasonably ensure that patient records and the record of appointments are maintained for the retention period in a manner that ensures these records remain reasonably accessible[36] and reproducible.

4.23. Registrants must only destroy patient records once their obligation to retain the record has come to an end.

4.24. When destroying patient records, registrants must do so in a secure and confidential manner and in such a way that they cannot be reconstructed or retrieved. As such, registrants must, where applicable:
4.24.1. cross-shred all paper medical records,
4.24.2. permanently delete electronic records by physically destroying the storage media or overwriting the information stored on the media, and
4.24.3. appropriately destroy any back-up copies of records.

4.25. Registrants who maintain patient records must ensure compliance with section 17 of PHIA, which establishes that:[37, 38]

[36] For use and access that is permitted under PHIA.
[37] Sample written policy available: HERE
[38] See also section 2 of the PHIA regulation.

17(1) A trustee shall establish a written policy concerning the retention and destruction of personal health information and shall comply with that policy.

Information managers (see Definition, above)

4.26. Section 25 of PHIA permits trustees, including registrants and medical clinics, to retain an information manager to assist in maintaining patient records. Many information managers are also EMR service providers. Pursuant to subsection 25(5) of PHIA, when this occurs the patient record is deemed to be maintained by the trustee (e.g., the registrant, the medical clinic). Arrangements with an information manager must be in writing and accord with section 25 of PHIA:[39]

4.26.1. A trustee may provide personal health information to an information manager for the purpose of processing, storing, or destroying it or providing the trustee with information management or information technology services.

4.26.2. A trustee who wishes to provide personal health information to an information manager under section 25 of PHIA must enter into a written agreement with the information manager that provides for the protection of the personal health information against such risks as unauthorized access, use, disclosure, destruction, or alteration, in accordance with PHIA regulations.

Closing, leaving, or moving a medical practice

4.27. The **Standards Regulation** and the **Standard of Practice for Practice Management** set out important requirements for closing, leaving, or moving a medical practice. Respecting patient records, subsection 13(2)(b) of the **Standards Regulation** establishes that when a registrant intends to close their medical practice, take a leave of absence, relocate, or otherwise cease practice, they must notify patients, or their legal representatives, "*about where patient records are to be located, and how the records can be transferred to another member or how copies can be obtained*". **Note:** This notice requirement is obligatory regardless of whether the registrant is the trustee or not.

4.27.1. Per subsection 13(3) of the **Standards Regulation**, the requirements at subsection 13(2)(b) do not apply if the registrant's patient records are

[39] 'PHIA - A Trustee's Guide to Information Manager Agreements Required by *The Personal Health Information Act*' is provided on the Manitoba Health, Seniors and Active Living website: HERE

maintained by, "*a person or organization that employed, engaged or granted privileges to the member and is a trustee under [PHIA]"* (e.g., a hospital).

4.28. A registrant who closes their medical practice, relocates their medical practice, or takes a leave of absence, or otherwise ceases active practice must:[40]

4.28.1. ensure the appropriate and secure storage of any patient records and record of appointments respecting which they are responsible to maintain for the remainder of the applicable retention period, and

4.28.2. must ensure subsequent destruction in accordance with this Standard.

Preparedness for unforeseen absence or termination of practice

4.29. A registrant who owns or is responsible for maintaining patient records or a record of appointments must have a written plan in place to ensure the ongoing maintenance of those records in accordance with this Standard that accommodates for situations where the registrant becomes unwilling or unable to continue to maintain those patient records (*e.g., death, incarceration, etc.*). Plans under this paragraph must be sufficient to avoid abandonment, or the risk of abandonment, of patient records or appointment records. An appropriate successor trustee must be named in the plan.[41] To be appropriate, the successor trustee must be:

4.29.1. another registrant; or

4.29.2. a person or organization that employed, engaged, or granted privileges to the registrant and is a trustee under PHIA (e.g., a hospital).

5. PATIENT ACCESS RIGHTS AND TRANSFERRING PATIENT RECORDS

Patients' right to examine and copy information

5.1. Paragraph 19 of CPSM's Code of Ethics provides:

> *Provide the patient or a third party with a copy of their medical record upon the patient's request, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.*

[40] See also subsection 14(1) of the **Standards Regulation**.

[41] An acceptable plan would include a legal instrument appointing an appropriate trustee for the registrant's patient records in the event the registrant becomes incapable of managing and maintaining the records and a legal instrument ensuring an appropriate trustee is appointed respecting the registrant's patient records in the event of death.

5.2. When a registrant creates a patient record, the personal health information contained in the record belongs to the patient, regardless of who owns or maintains the patient record. Subsection 5(1) of PHIA establishes that, "*an individual has a right, on request, to examine and receive a copy of his or her personal health information maintained by a trustee*" subject to exceptions under which a registrant may refuse to provide certain information that are set out at section 11 of PHIA.[42] Respecting such requests:

5.2.1. Registrants shall make every reasonable effort to assist a patient, or their legal representative, making the request and respond to it openly, accurately, and completely.

5.2.2. Upon receiving a request, registrants must, to the extent they are authorized to do so (i.e., per access rights established for the patient record), facilitate lawful access to all requested portions of a patient record, unless an exception applies, and provide copies upon request.

5.3. In accordance with sections 6 through 7 of PHIA, registrants shall respond[43] to a request from a patient, or their legal representative, to examine their patient record or receive a copy of it as promptly as required in the circumstances but not later than:

5.3.1. 24 hours after receiving it, if facilitating the response on behalf of a hospital and the information is about health care currently being provided to an inpatient,

5.3.2. 72 hours after receiving it, if the information is about health care the registrant is currently providing to a person who is not a hospital inpatient, and

5.3.3. 30 days after receiving it in any other case unless the request is transferred to another trustee (see paragraph 5.3., below).

5.3.4. In the circumstance mentioned in paragraph 5.2.1. (i.e., hospital inpatient), the registrant is required only to make the information available for examination and need not provide a copy or an explanation.

5.4. A registrant may transfer a request to examine or copy a patient record to another trustee if the information sought is maintained by the other trustee, or the other trustee was the first to collect the information. A registrant who transfers a request shall notify the individual who made the request of the transfer as soon as possible.

5.5. Subject to paragraph 5.3., in responding to a request from a patient or their legal representative, registrants shall do one of the following:

5.5.1. Make the patient record available for examination and provide a copy, if requested, to the individual.

[42] See 'Your Personal Health Information – Access and Privacy Rights at our Location' on the Manitoba Health, Seniors and Active Living website: HERE

[43] This would include information about whether the relevant patient record is maintained by another person, in which case the recipient of the request may not be authorized to access or copy the patient record. When this occurs, the recipient should facilitate transfer of the request to the trustee.

5.5.2. Inform the individual in writing if the information does not exist or cannot be found.

5.5.3. Inform the individual in writing that the request is refused, in whole or in part, for a specified reason described in section 11 of PHIA and advise the individual of the right to make a complaint about the refusal under Part 5 of PHIA.

5.5.4. On request, a registrant shall provide an explanation of any term, code or abbreviation used in the patient record.

5.6. When a request is made for a patient record that is maintained in electronic form, the registrant shall produce a record of the information for the individual in a form usable by the individual, if it can be produced using the registrant's normal computer hardware and software and technical expertise.

5.7. A registrant may charge a fee as permitted under section 10 of PHIA relating to a request from a patient or their legal representative to examine or copy a patient record unless the registrant terminated the respective patient from an ongoing practice, in which case no fee may be charged. This exception does not prohibit a registrant from charging a fee when the registrant is closing, leaving, or moving a medical practice. The fee must be reasonable and should not exceed cost recovery.

5.8. For greater certainty, a registrant who provides a copy of a patient record to a patient or their legal representative must retain the original for the duration of the applicable retention period.

Transfer of a copy of patient records to third party (e.g., to another registrant)[44]

5.9. Registrants must only transfer copies of patient records that they maintain to a third party, for example another registrant (e.g., a registrant who has relocated practice), when they have consent of the patient or the patient's legal representative or when they are otherwise permitted or required by law to do so. The following requirements apply to such transfers:

5.9.1. Registrants who have custody or control of patient records must transfer copies in a timely manner, urgently, if necessary, but no later than 30 days after a request is made. What is timely will depend on whether there is any risk to the patient if there is a delay in transferring the records (e.g., exposure to any adverse clinical outcomes).

5.9.2. In the context of a request for a copy of the patient record (e.g., the patient is seeing another registrant for primary care and wants their record transferred),

[44] This part relates to the transfer of a copy of the patient record and may be distinguished from requirements related to requests for a limited or discretion portion of the record for immediate care (e.g., a lab report, or pertinent encounter note).

registrants must transfer copies of the entire patient record, unless providing a summary or a partial copy of the medical record is acceptable to the receiving person or the patient.

5.9.3. Registrants must transfer copies of patient records in a secure manner and document the date and method of transfer in the medical record.

5.9.4. For greater clarity, a registrant who provides a copy of a patient record to a third party must retain the original for the duration of the applicable retention period, unless maintenance responsibilities are expressly transferred in accordance with an appropriate Maintenance Agreement.

5.10. Fulfilling a request for copying and transferring patient records to a third party is an uninsured service. As such, registrants are entitled to charge a fee. When a fee is levied, the follow rules must be followed:

5.10.1. When charging for copying and transferring medical records, registrants must:

5.10.1.i. provide a fee estimate prior to providing copies or summaries,

5.10.1.ii. provide an itemized bill that provides a breakdown of the cost, upon request (e.g., cost per page, cost for transfer, etc.), and

5.10.1.iii. only charge fees that are reasonable.

5.10.2. When determining what is reasonable to charge, registrants must ensure that:

5.10.2.i. fees do not exceed the amount of reasonable cost recovery, and

5.10.2.ii. correlate with the nature of the service provided and professional costs (i.e., reflect the cost of the materials used, the time required to prepare the material and the direct cost of sending the material to the requesting individual).

5.10.3. Registrants must consider the financial burden that these fees might place on the patient and consider whether it would be appropriate to reduce, waive, or allow for flexibility with respect to fees based on compassionate grounds.

5.10.4. Registrants may request pre-payment for records or take action to collect any fees owed to them but must not put a patient's health and safety at risk by delaying the transfer of records until payment has been received.