Records Management

Standards of Practice of the Yukon Medical Council ("the Council") are the minimum standards of professional behavior and ethical conduct expected of all physicians registered in the Yukon. Standards of Practice will be referenced in the management of complaints and in discipline

(1) In the course of providing advice or treatment to a patient, where a member has authority and control of the patient record, the member must document and retain that advice and treatment in a patient record.

(2) In this standard, "patient record" includes paper-based and electronic formats.

(3) A physician must ensure that a patient record is accessible to ensure continuity of care for a patient.

(4) A physician must ensure that a patient record is accessible for a minimum of six (6) years following the date of last service or, in the case of minors – the record must be accessible for six (6) years or until two (2) years past the patient's age of majority – whichever is longer.

(5) A physician must keep an accounting record showing the date the service was rendered, the type of medical service, and the fee charged as required by the Canada Revenue Agency.

(6) A physician must keep a record of appointments showing for each day the names of patients who received professional services for a period of at least two (2) years.

(7) A physician must maintain safeguards to protect confidentiality and to protect against reasonably anticipated threats or hazards to the security, integrity, loss or unauthorized use, disclosure, modification or unauthorized access to health information.

(8) A physician who uses an electronic patient record must ensure that the system has safeguards to protect the confidentiality and security of information, including but not limited to, ensuring:

(a) an unauthorized person cannot access identifiable health information on electronic devices;

(b) each authorized user can be uniquely identified;

(c) each authorized user has a documented access level based on the individual's role;

(d) appropriate password controls or data encryption are used;

(e) audit logging is enabled where available;

(f) where electronic signatures are permitted, the authorized user can be authenticated;

(g) identifiable health information is transmitted securely;

(h) secure backup of data;

(i) data recovery protocols are in place and the regular testing of these protocols;

(j) data integrity is protected such that information is accessible as stipulated in subsection (9);

(k) practice continuity protocols are in place in the event that information cannot be accessed electronically; and

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Terms used in the Standards of Practice:

- *Physician* means any person who is registered or who is required to be registered under the Medical Profession Act.
- *Must* refers to a mandatory requirement.
- *May* means that the physician may exercise reasonable discretion.
- *Patient* includes, where applicable, the patient's legal guardian or substitute decision maker.

(l) when hardware is disposed of that contains identifiable health information, all data is removed and cannot be reconstructed.

(9) Where a physician places patient information into an electronic record which is not under his or her direct custody and control, there must be in place:

(a) a written information management agreement which addresses the requirements of subsection (8); and

(b) a written information sharing agreement which manages issues related to access, secondary use and disclosure of patient information.

(10) A physician who works in a medical practice described in subsection (9) is expected to fulfill all obligations respecting the completion of patient records, the maintenance of security of patient records, and confidentiality of the information contained in the patient records as established by agreement with the individual(s) having direct custody and control.

(11) Physicians in a group medical practice must determine custodianship arrangements of patient records within that medical practice so that:

(a) if a physician leaves the medical practice, custodianship of patient records will be clear to all parties and to the patients of the departing and remaining physicians; and

(b) the departing physician and his or her patients have reasonable access to the relevant patient records.

(12) While a physician may be the custodian of a patient's record, the patient whose information is contained in that record owns the information; on the request of a patient, the physician must, in a timely manner:

(a) provide the patient access to the patient record; and

(b) provide the patient with a copy of the patient record.

(13) A physician may charge a reasonable fee for a patient's request for access to or a copy of his or her record.

(14) A physician may not charge another healthcare provider for the exchange of limited patient information such as a copy of a discharge summary.

(15) The physician responsible for the care of a patient in a hospital or healthcare facility must complete a discharge summary in a timely manner consistent with the policies of the institution.

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