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STANDARDS AND GUIDELINES

TITLE:	RECORD KEEPING AND PRIVACY OF INFORMATION[1] -- GUIDELINE DOC #: 1
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Note to Readers: In the event of any inconsistency between this document and the legislation that affects homeopathic practice, the legislation governs.

College publications contain practice parameters and standards which should be considered by all Ontario homeopaths in the care of their patients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

This practice guideline has been developed to assist Registrants understand the requirement for Record Keeping, as laid out in the Draft Record Keeping Regulation for the College of Homeopaths of Ontario (the "CHO" or the "College"). The proposed regulation, at the end of this document, is before the Ministry of Health and Long-Term Care.

POLICY

Records – hard copy or electronic regardless of their format – are maintained and retained for a period of at least 10 years after the date of the last entry. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday. An important component of record keeping is ensuring that the patient's health information is kept confidential. This policy will assist Registrants in ensuring that staturory obligations are fulfilled.

INTENT

To assist Registrants in developing, achieving and maintaining best practices in record keeping and patient privacy of information.

PREAMBLE

Record keeping is an essential component of patient care. Good records help registrants to provide effective, progressive and organized care. They also assist in providing continuity of services if the care of the patient is transferred to another practitioner for any reason. Concise, accurate, legible records should provide a full account of the patient's past and current health status and concerns, the treatment provided and the patient's response to treatment.

[1] College of Dietitians of Ontario, Record Keeping Guidelines for Registered Dietitans

Patient records provide patients with evidence of the care that was provided to them and when it was provided. Patients have the right to access and control the information contained in their health records. Registrants, or the facilities they work for, act as the custodians of that information[2].

Good record keeping helps to facilitate the care of treatment of patients, ensures patients have access to up-to-date, accurate information about their health, provides Registrants with a framework for organizing clinical notes and other records, and maintains confidentiality and prevent unauthorized disclosure of patient records.

Record keeping is also a requirement for professional practice. The record can assist Registrantsin demonstrating their competence, and that they have met their professional and regulatory obligations by providing homeopathic care that is in the best interests of the patient. A record that is complete and documented in a timely fashion can assist Registrants to reliably recall events and decisions made during a course of treatment.

The patient record consists of the patient chart, appointment book and financial records. The patient chart is an essential chronicle of the history of medical care and a guide for the direction of future care. It is often the Registrant's most important evidence in a complaint or a lawsuit.

Legibility of records is vital. Even if all the requirements of the Guideline on Record Keeping and Privacy of Information are met, if a record is not legible it is impossible to comprehend the care that was provided. This renders the record useless to the patient or any individual with authorized access.

Respect for each patient's privacy is critically important. Privacy legislation exists at both the Federal and Provincial level to guide patients and health care professionals in the handling of a patients' personal and confidential information. At the Federal level, the Office of the Privacy Commissioner (OPC) of Canada oversees compliance with the *Personal Information Protection and Electronic Documents Act (PIPEDA).* At the Provincial level the Information and Privacy Commissioner of Ontario oversees the *Personal Health Information Protection Act, 2004* (*PHIPA*), which governs the collection, use and disclosure of personal health information within the health-care system. PHIPA establishes rules about how government organizations and health information custodians may collect, use, and disclose personal data. PHIPA also establishes a right of access that enables individuals to request their own personal information and have it corrected if necessary.

In addition to this guideline excellent resources on privacy of information and the applicable legislation is available on the OPC (www.priv.gc.ca), IPC (www.ipc.on.ca) and CHO (www.collegeofhomeopaths.on.ca) websites.

[2] *Personal Health Information Protection Act, 2004* (PHIPA)

A. DISCRETIONARY ISSUES

Registrants can use their discretion and make their own decisions regarding:

- The format, organization or style of the record (e.g. use of SOAP, DAR, FOCUS or other method); however the CHO does recommend that a consistent method be used to ensure that all relevant information is included.

- The colour of ink to be used when documenting. Keep in mind that the content of the record should be retrievable and reproducible for the entire retention period.

- The method of recording or storing information and the media used (e.g., paper vs. electronic), provided that the complete record can be retrieved and reproduced throughout the retention period; an audit trail of persons who have made entries or changes (and the changes made) can be identified and authenticated; and a method of protecting both confidentiality and data integrity exists.

- List of abbreviations The CHO requires that reasonable means be provided for those who access the record to understand the meaning of acronyms and abbreviations used in charting. The CHO does not specify which abbreviations are acceptable for use or how this information is maintained. For example, a term may be written out in full the first time it is used with the acronyms/abbreviations and their meanings could be referenced and maintained for the duration of the retention period. A legend of abbreviations/codes is in the appointment record and/or accessible elsewhere in the office.

B. DESCRIPTION OF GUIDELINE

1. Reports

   Patient records are commonly needed to prepare reports. Patients may request them for use by others, such as insurers, employers and lawyers. Patients may need the information for legal proceedings, such as a disability claim, motor vehicle accident, or a discrimination suit on the basis of disability. Failure to provide an adequate report because of poor records may lead not only to embarrassment for the homeopath who kept those records.

2. Accountability

   Records are critical in a Registrant's accountability for services. Patients, employers, payers and the CHO will rely heavily on a Registrant's record in assessing the adequacy of a Registrant's conduct or competency if the occasion arises. The axiom "if it wasn't recorded, it wasn't done" is not that far from the truth.

   Accountability is not restricted to disputes with patients. A Registrant's record is often the focus of risk management. In its Quality Assurance Program, the CHO may review charts.

3. Tips for Good Record Keeping

Records must be an accurate and honest account of what occurred and when it occurred with attention to clarity and legibility. The following tips will help ensure accuracy, clarity and legibility. Although the focus here is on the individual patient record, the inherent principles apply to all types of documenting and record keeping in any setting.

a. Clear, concise and complete - includes the essential information.
b. Accurate and honest - an objective report of findings.
c. Relevant - reflects important issues requiring communication.
d. Objective - based on observations and supported by facts.
e. Factual and professional - use factual terms e.g. patient shouting, shaking fists vs. difficult, non-cooperative, rude.
f. Retrievable - easy to locate within the patient health record.
g. Confidential - respects the privacy of the patient and others.
h. Patient-focused - incorporates patient goals. Always assume the patient will read their chart.
i. Consistent - a consistent format is used throughout the chart for recording the date e.g. DD/MM/YYYY OR MM/DD/YYYY.
j. Using forms, methods or systems that are consistent with the CHO's Professional Misconduct Regulation and #1 Guideline on Record Keeping and Privacy of Information.
k. Timely - information is recorded in charts and consult reports are sent out in time frames appropriate for use. All chart entries are recorded as soon as possible after the patient encounter while the details are fresh in the Registrant's mind.
l. Chronological - events are recorded in the order that they occurred, with documents consecutively numbered and dated.
m. Permanent and cannot be altered – written in ink or electronic medium that is permanent, no blank lines between written entries; or using electronic medium from which the original content can not be deleted or permanently altered.
n. Audio and video records must be authicated or the original source must be stated.
o. Signed (name and credential) by the individual who saw the patient. Never chart or sign an entry on behalf of another Registrant or support personnel.
p. Secure - All notes and papers must be secured in the file.
q. Accountable - Assume the patient will read the record. Avoid non-factual language.

4. Correcting Records

Necessary corrections to the patient chart are acceptable as long as the change is clearly indicated as such and is dated and initialed. Corrections are only to be in the form of additions and not erasure or overwriting. At all times the original entry is available and legible. A patient's chart is never to be re-written.

Registrants can only make corrections to their own documentation. Electronic records require special programming in order to make sure that the original entry can be retrieved for corrections if necessary.

a. Corrections must be made openly and honestly using a strikethrough or single line through the error ensuring that the correction and the original note are both legible.
b. Handwritten corrected notes should still be legible. Do not erase, white out or use correction tapes as they obscure the original documentation. Simply draw a neat line through the entry or use strike through for electronic entries.
c. Corrected by date, initial and an explanation of the corrections, if deemed appropriate – A signature and date are always necessary when a correction is made. In some cases, the time of the day may also be required.
d. Depending on the urgency of the correction, a homeopath may need to communicate the correction to others by means other than the correction noted in the chart. This action should be noted.
e. Attach the original notes if required. Date record and note date of subsequent changes to the record.
f. Changes to dictated records must be initialed.

5. Storage of Records

5.1 Retention Period

Records – written or electronic –are retained for at least ten (10) years following the date of the last entry in the chart. In the case of a minor, records are retained for at least 10 years following the patient's 18th birthday, regardless of the date of the last entry in the file. Records are transferred in a manner ensuring continuing access by patients and the CHO. Security and confidentiality are criteria to protecting patient's privacy and identity.

Even though records must be kept for ten years, there is no limitation on a patient complaint or civil litigation. For example, although the statuory limitation period is usually limited to 2 years from the date of discovery, that timeline can be found to never trigger in certain situations.

5.2 PHIPA and Record Keeping

The federal legislation, *Personal Information Protection and Electronic Documents Act* (PIPEDA), became law on January 1, 2004 and applies to personal information, including health information, collected and used for commercial activities in Canada. The Ontario Government passed its own *Personal Health Information Protection Act* (PHIPA) May 13, 2004, in effect November 2004. Both acts build on the same set of privacy and access principles and both require information policies and practices to be transparent.

PIPEDA and PHIPA are based on a number of principles that organizations individual, associations, partnerships and trade unions must follow when collecting, using and disclosing personal information in the course of a commercial activity. This involves the making and provision of a product or service that is commercial in nature.

a. Let patients know about the collection, use or disclosure of their personal information;
b. Obtain consent to disclose information to third parties when appropriate;

c. Provide an individual with access to his or her own personal records;
d. Provide secure storage of information and implement measures to limit access to patient records;
e. Ensure the proper destruction of records that are no longer necessary;
f. Inform patients of the organizations information-handling practices through various means (i.e. the posting of notices, brochures and pamphlets, and/or through normal discussions between a patient and a health care provider.

5.3 Practice Expectation – Storage of Records

All patient charts are stored in an area accessible only to authorized staff as per the *PHIPA*.

All patient charts are securely stored and organized in a way that the chart can be extracted for each individual patient when required.

When storing patient charts, the Registrant will:

- Ensure all patient charts are secured when the office is closed, e.g. in a locked filing cabinet.
- Ensure sensitive information is never left unattended in an unsecure location.
- Store all patient charts alphabetically or numerically, such that a specific file can be easily identified and retrieved.

Registrants maintain a separate chart for each patient. In multi-disciplinary clinics, patient charts may be filed with other charts in the clinic as long as they can be readily identified e.g. different colored file folders. Registrants maintain a chart for each patient so that the information can be extracted individually when required. If other practitioners also see the same patient, their notes are kept in a separate file.

Every patient health case record, including accompanying reports and every financial record, shall be retained for at least ten years following the patient's last visit, or, if the patient was less than 18 years old at the time of his/her last visit, the day the patient became or would have become 18 years old.

6. Confidentiality of and Access to Records

Registrants adhere to the *PHIPA*. The Registrant identifies a Health Information Custodian (HIC) who establishes written policies and procedures relating to the collection, use, and disclosure of all personal health information.

In a single-practitioner private practice, the owner of the practice is generally the HIC and often serves as its privacy information officer.

In a shared practice/partnership, the terms of the written agreement made between or among the Registrants specify that the patient charts are the responsibility of the HIC of the practice. Regardless of the agreement, all treating Registrants are given access to the chart where necessary to fulfill their

professional obligations, including their obligations to the CHO. All patients are made aware that other practitioners may have access to their charts and patients may choose to decline that access in accordance with PHIPA.

Generally, patient consent is required for the collection, use and disclosure of personal health information. Consent can be implied, particularly if the information is only used for the provision of health care. Unless a patient directs otherwise, information can be shared with others on the health care team (i.e., within the circle of care) where obtaining consent is not practical. There are some other exceptions where consent is not required. For example, consent is not needed to use the information to collect an unpaid account. Disclosure can be made without consent for a number of reasons including to protect another person from serious bodily harm or for certain legal proceedings. For example, disclosure of charts to assist the CHO in performing its regulatory functions does not need patient consent.

Where a patient is incapable of giving consent, it can be obtained from a substitute decision maker (generally a power of attorney or a relative). Patients, or their substitutes, can prohibit Registrants from disclosing certain information to others (unless *PHIPA* permits disclosure without consent). This is called a “lock box”. Where a record is transferred, but the patient refuses to permit another health provider in the circle of care from receiving part of the information that the practitioner will likely need for treatment, the Registrant must notify the other practitioner that some of the information has been withheld.

Under *PHIPA* the patient has a right to review or obtain a copy of his/her patient chart. That right of access includes any portions of the chart provided by others, such as consultation reports. Generally the Registrant may only decline access to information for legally permitted reasons like the following:

- the information is raw data from standardized psychological tests or assessments,
- there is a risk of serious harm to the treatment or recovery of the patient or of serious bodily harm to another person, or
- providing access to the patient would reveal the identity of a confidential source of information (assuming that the case was a suitable one for the Registrant to collect information in this way, e.g., for a medico-legal report).

An individual also has the right to request the correction of erroneous personal information held by the Registrant. If the Registrant agrees that an error has been made, s/he must correct the error. Where the individual and the Registrant cannot agree, then the Registrant must note the disagreement in the file. Some grounds for refusing to correct information include the following:

- where the request is frivolous, vexatious or made in bad faith,
- the custodian did not create the record and the custodian does not have sufficient knowledge, expertise or authority to make the correction, or
- the information consists of a professional opinion or observation made in good faith.

For more detailed information about the implications of *PHIPA* on record keeping, see the website of the Information and Privacy Commissioner of Ontario at www.ipc.on.ca.

RELEVANT COMPETENCIES & PERFORMANCE INDICATORS

Competencies are the specific knowledge, skills, attributes and abilities required of an entry-to-practice homeopath in order to practise safety and ethically. These competencies, from the Competency Profile for Entry-to-Practice Homeopaths Practising in Ontario, where adopted by the transitional Council of the College of Homeopaths of Ontario in 2012.

1.5 Maintain patient confidentiality and privacy. (K, S) (20)
PERFORMANCE INDICATORS
1. Apply the confidentiality and privacy requirements as per the *Personal Health Information Protection Act (*2004).
2. Apply the confidentiality and privacy requirements as per the *Personal Information Protection and Electronic Documents Act (*2000).
3. Describe how confidentiality can be inadvertently breached.
4. Provide an environment that fosters patient privacy.

2.26 Review patient intake form (e.g., family health history, patient health history, chief complaint, etiology, supplements and pharmaceuticals, lifestyle assessment). (20)
PERFORMANCE INDICATORS
1. Confirm intake form information during initial meeting with the patient.
2. Evaluate and clarify any information pertaining to the form.

2.39 Provide written instruction to patient on use of medicine including:
(20)a. Administration; (K, S)
PERFORMANCE INDICATORS
1. Provide, in writing, how medicine is to be taken.
b. Storage; (K, S)
PERFORMANCE INDICATORS
1. Provide, in writing, how medicine is to be stored.
c. Cautions and warnings; (S)
PERFORMANCE INDICATORS
1. Provide, in writing, the cautions and warnings associated with taking the medicine.
d. Interactions; (K,S) and
PERFORMANCE INDICATORS
1. Provide, in writing, the possible interactions with other treatments.

2.41 Document treatment plan in patient's file including name, potency and posology, and rationale of medicine. (K, S) (20)
PERFORMANCE INDICATORS
1. Record all applicable data related to patient treatment plan.

3.2 Maintain confidential patient records as per standards, regulations and guidelines. (K) (20)
PERFORMANCE INDICATORS
1. Demonstrate knowledge of relevant standards, regulations and guidelines.
2. Demonstrate how to protect confidentiality and security of information throughout collection, use, storage, disclosure and destruction processes.

DEFINITIONS

For the purpose of this guideline, the following defintions apply:

Clinical Record

Clinical Record is anything that contains information (in any media) that has been created or gathered as a result of any professional encounter, aspect of care, or treatment by a Registrant or a person working under the supervision of a homeopath. It may also include information created or gathered by other health care providers.

Health Information Custodian (HIC or Custodian)

A HIC is a person or organization who has custody or control of personal health information as a result of or in connection with performing the person's or organization's powers or duties. It includes individual health care practitioners or people who operate a group practice of health care practitioners, individuals providing services defined within the *Home Care and Community Services Act, 2004*, and other organizations including licensed public and private hospitals, independent health facilities, long-term care centres, retirement homes, nursing homes, pharmacies, laboratory and specimen collection centres, ambulance services, homes for special care and centres/programs or services offering community or mental health provisions. (See CHO Definitions document for further information or the *Personal Health Information Protection Act* for a complete definition.)

Homeopath

"Homeopath" means a registrant of the College of Homeopaths of Ontario.

Record

A record is an account that contains information intended to document actions, events or facts. Clinical records are a subcomponent of the broader category of records.

As defined by the *Personal Health Information Protection Act, 2004* "record" means a record of information in any form or in any medium, whether in written, printed, photographic or electronic form or otherwise, but does not include a computer program or other mechanism that can produce a record.

Registrant

A Registrant is a member of the College of Homeopaths of Ontario.

LEGISLATIVE CONTEXT

Health Care Consent Act (HCCA), 1996 www.ontario.ca/laws/statute/96h02
Personal Health Information Protection Act (PHIPA), *2004* www.ontario.ca/laws/statute/04p03#BK69
Personal Information Protection and Electronic Documents Act (PIPEDA), *2000*

https://laws-lois.justice.gc.ca/eng/acts/P-8.6/
Regulated Health Professions Act (RHPA), 1991 https://www.ontario.ca/laws/statute/91r18

In addition to the legislative provisions outlined above, Registrants are reminded that the following under *Homeopathy Act, Ontario Regulation 315/12 Professional Misconduct*:

23. Failing to keep records in accordance with the standards of the profession.

25. Falsifying a record relating to the member's practice.

35. If the member intends to close his or her practice, failing to take reasonable steps to give appropriate notice of the intended closure to each patient for whom the member has primary responsibility or failing to,

    i. ensure that each patient's records are transferred to the member's successor or to another member, if the patient so requests, or

    ii. ensure that each patient's records are retained or disposed of in a secure manner.

Personal Health Information Protection Act, 2004
The following highlights sections of the *Personal Health Information Protection Act, 2004*, to improve each Registrant's understanding of the importance of maintaining patient privacy and confidentiality and the consequences for not doing so. Registrants are encouraged to utilize all the available privacy resources to expand their understanding and compliance to appropriate record keeping and patient privacy and confidentiality.

Personal Health Information Protection Act, 2004
S.O. 2004, CHAPTER 3
SCHEDULE A

Consolidation Period: From May 7, 2018

Personal health information

4 (1) In this Act,

"personal health information", subject to subsections (3) and (4), means identifying information about an individual in oral or recorded form, if the information,

(a) relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,

(b) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual,

(c) is a plan of service within the meaning of the *Home Care and Community Services Act, 1994* for the individual,

(d) relates to payments or eligibility for health care, or eligibility for coverage for health care, in respect of the individual,

(e) relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance,
(f) is the individual's health number, or
(g) identifies an individual's substitute decision-maker.

Identifying information

4 (2) In this section,

"identifying information" means information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual.

Mixed records

4 (3) Personal health information includes identifying information that is not personal health information described in subsection (1) but that is contained in a record that contains personal health information described in that subsection.

Exception

4 (4) Personal health information does not include identifying information contained in a record that is in the custody or under the control of a health information custodian if,

(a) the identifying information contained in the record relates primarily to one or more employees or other agents of the custodian; and
(b) the record is maintained primarily for a purpose other than the provision of health care or assistance in providing health care to the employees or other agents.

PART II

PRACTICES TO PROTECT PERSONAL HEALTH INFORMATION

GENERAL

Information practices

10 (1) A health information custodian that has custody or control of personal health information shall have in place information practices that comply with the requirements of this Act and its regulations.

Duty to follow practices

(2) A health information custodian shall comply with its information practices. 2004, c. 3, Sched. A, s. 10 (2).

Use of electronic means

(3) A health information custodian that uses electronic means to collect, use, modify, disclose, retain or dispose of personal health information shall comply with the prescribed requirements, if any. 2004, c. 3, Sched. A, s. 10 (3).

Providers to custodians

(4) A person who provides goods or services for the purpose of enabling a health information custodian to use electronic means to collect, use, modify, disclose, retain or dispose of personal health information shall comply with the prescribed requirements, if any. 2004, c. 3, Sched. A, s. 10 (4).

Accuracy

11 (1) A health information custodian that uses personal health information about an individual shall take reasonable steps to ensure that the information is as accurate, complete and up-to-date as is necessary for the purposes for which it uses the information. 2004, c. 3, Sched. A, s. 11 (1).

Same, disclosure

(2) A health information custodian that discloses personal health information about an individual shall,

(a) take reasonable steps to ensure that the information is as accurate, complete and up-to-date as is necessary for the purposes of the disclosure that are known to the custodian at the time of the disclosure; or

(b) clearly set out for the recipient of the disclosure the limitations, if any, on the accuracy, completeness or up-to-date character of the information. 2004, c. 3, Sched. A, s. 11 (2).

Steps to ensure collection

11.1 A health information custodian shall take steps that are reasonable in the circumstances to ensure that personal health information is not collected without authority. 2016, c. 6, Sched. 1, s. 1 (3).

Security

12 (1) A health information custodian shall take steps that are reasonable in the circumstances to ensure that personal health information in the custodian's custody or control is protected against theft, loss and unauthorized use or disclosure and to ensure that the records containing the information are protected against unauthorized copying, modification or disposal. 2004, c. 3, Sched. A, s. 12 (1).

Notice of theft, loss, etc. to individual

(2) Subject to subsection (4) and to the exceptions and additional requirements, if any, that are prescribed, if personal health information about an individual that is in the custody or control of a health information custodian is stolen or lost or if it is used or disclosed without authority, the health information custodian shall,

(a) notify the individual at the first reasonable opportunity of the theft or loss or of the unauthorized use or disclosure; and

(b) include in the notice a statement that the individual is entitled to make a complaint to the Commissioner under Part VI. 2016, c. 6, Sched. 1, s. 1 (4).

Notice to Commissioner

(3) If the circumstances surrounding a theft, loss or unauthorized use or disclosure referred to in subsection (2) meet the prescribed requirements, the health information custodian shall notify the Commissioner of the theft or loss or of the unauthorized use or disclosure. 2016, c. 6, Sched. 1, s. 1 (4).

Exception

(4) If the health information custodian is a researcher who has received the personal health information from another health information custodian under subsection 44 (1), the researcher shall not notify the individual if the information is stolen or lost or if it is used or disclosed without authority, unless the health information custodian that disclosed the personal health information under subsection 44 (1),

(a) first obtains the individual's consent to having the researcher contact the individual; and

(b) informs the researcher that the individual has given the consent. 2016, c. 6, Sched. 1, s. 1 (4).

PART V
ACCESS TO RECORDS OF PERSONAL HEALTH INFORMATION AND CORRECTION

Individual's right of access

52 (1) Subject to this Part, an individual has a right of access to a record of personal health information about the individual that is in the custody or under the control of a health information custodian unless,

(a) the record or the information in the record is subject to a legal privilege that restricts disclosure of the record or the information, as the case may be, to the individual;

(b) another Act, an Act of Canada or a court order prohibits disclosure to the individual of the record or the information in the record in the circumstances;

(c) the information in the record was collected or created primarily in anticipation of or for use in a proceeding, and the proceeding, together with all appeals or processes resulting from it, have not been concluded;

(d) the following conditions are met:

(i) the information was collected or created in the course of an inspection, investigation or similar procedure authorized by law, or undertaken for the purpose of the detection, monitoring or prevention of a person's receiving or attempting to receive a service or benefit, to which the person is not entitled under an Act or a program operated by the Minister, or a payment for such a service or benefit, and

(ii) the inspection, investigation, or similar procedure, together with all proceedings, appeals or processes resulting from them, have not been concluded;

(e) granting the access could reasonably be expected to,

(i) result in a risk of serious harm to the treatment or recovery of the individual or a risk of serious bodily harm to the individual or another person,

(ii) lead to the identification of a person who was required by law to provide information in the record to the custodian, or

(iii) lead to the identification of a person who provided information in the record to the custodian explicitly or implicitly in confidence if the custodian considers it appropriate in the circumstances that the identity of the person be kept confidential; or

(f) the following conditions are met:

(i) the custodian is an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* or is acting as part of such an institution, and

(ii) the custodian would refuse to grant access to the part of the record,

(A) under clause 49 (a), (c) or (e) of the *Freedom of Information and Protection of Privacy Act*, if the request were made under that Act and that Act applied to the record, or

(B) under clause 38 (a) or (c) of the *Municipal Freedom of Information and Protection of Privacy Act*, if the request were made under that Act and that Act applied to the record. 2004, c. 3, Sched. A, s. 52 (1); 2007, c. 10, Sched. H, s. 19; 2009, c. 33, Sched. 18, s. 25 (5).

Severable record
(2) Despite subsection (1), an individual has a right of access to that part of a record of personal health information about the individual that can reasonably be severed from the part of the record to which the individual does not have a right of access as a result of clauses (1) (a) to (f). 2004, c. 3, Sched. A, s. 52 (2).

Same
(3) Despite subsection (1), if a record is not a record dedicated primarily to personal health information about the individual requesting access, the individual has a right of access only to the portion of personal health information about the individual in the record that can reasonably be severed from the record for the purpose of providing access. 2004, c. 3, Sched. A, s. 52 (3).

Individual's plan of service
(4) Despite subsection (1), a health information custodian shall not refuse to grant the individual access to his or her plan of service within the meaning of the *Home Care and Community Services Act, 1994*. 2004, c. 3, Sched. A, s. 52 (4); 2007, c. 8, s. 224 (7).

Consultation regarding harm
(5) Before deciding to refuse to grant an individual access to a record of personal health information under subclause (1) (e) (i), a health information custodian may consult with a member of the College of Physicians and Surgeons of Ontario or a member of the College of Psychologists of Ontario. 2004, c. 3, Sched. A, s. 52 (5).

Informal access
(6) Nothing in this Act prevents a health information custodian from,

(a) granting an individual access to a record of personal health information, to which the individual has a right of access, if the individual makes an oral request for access or does not make any request for access under section 53; or

(b) with respect to a record of personal health information to which an individual has a right of access, communicating with the individual or his or her substitute decision-maker who is authorized to consent on behalf of the individual to the collection, use or disclosure of personal health information about the individual. 2004, c. 3, Sched. A, s. 52 (6).

Duty of health information custodian
(7) Nothing in this Part relieves a health information custodian from a legal duty to provide, in a manner that is not inconsistent with this Act, personal health information as expeditiously as is necessary for the provision of health care to the individual. 2004, c. 3, Sched. A, s. 52 (7).

Request for access
53 (1) An individual may exercise a right of access to a record of personal health information by making a written request for access to the health information custodian that has custody or control of the information. 2004, c. 3, Sched. A, s. 53 (1).

Detail in request
(2) The request must contain sufficient detail to enable the health information custodian to identify and locate the record with reasonable efforts. 2004, c. 3, Sched. A, s. 53 (2).

Assistance
(3) If the request does not contain sufficient detail to enable the health information custodian to identify and locate the record with reasonable efforts, the custodian shall offer assistance to the person requesting access in reformulating the request to comply with subsection (2). 2004, c. 3, Sched. A, s. 53 (3).

Response of health information custodian
54 (1) A health information custodian that receives a request from an individual for access to a record of personal health information shall,

(a) make the record available to the individual for examination and, at the request of the individual, provide a copy of the record to the individual and if reasonably practical, an explanation of any term, code or abbreviation used in the record;
(b) give a written notice to the individual stating that, after a reasonable search, the custodian has concluded that the record does not exist, cannot be found, or is not a record to which this Part applies, if that is the case;
(c) if the custodian is entitled to refuse the request, in whole or in part, under any provision of this Part other than clause 52 (1) (c), (d) or (e), give a written notice to the individual stating that the custodian is refusing the request, in whole or in part, providing a reason for the refusal and stating that the individual is entitled to make a complaint about the refusal to the Commissioner under Part VI; or
(d) subject to subsection (1.1), if the custodian is entitled to refuse the request, in whole or in part, under clause 52 (1) (c), (d) or (e), give a written notice to the individual stating that the individual is entitled to make a complaint about the refusal to the Commissioner under Part VI, and that the custodian is refusing,
    (i) the request, in whole or in part, while citing which of clauses 52 (1) (c), (d) and (e) apply,
    (ii) the request, in whole or in part, under one or more of clauses 52 (1) (c), (d) and (e), while not citing which of those provisions apply, or
    (iii) to confirm or deny the existence of any record subject to clauses 52 (1) (c), (d) and (e). 2004, c. 3, Sched. A, s. 54 (1); 2007, c. 10, Sched. H, s. 20 (1, 2).

Providing reasons
(1.1) A custodian acting under clause (1) (d) shall not act under subclause (1) (d) (i) where doing so would reasonably be expected in the circumstances known to the person making the decision on behalf of the custodian to reveal to the individual, directly or indirectly, information to which the individual does not have a right of access. 2007, c. 10, Sched. H, s. 20 (3).

Time for response
(2) Subject to subsection (3), the health information custodian shall give the response required by clause (1) (a), (b), (c) or (d) as soon as possible in the circumstances but no later than 30 days after receiving the request. 2004, c. 3, Sched. A, s. 54 (2).

Extension of time for response
(3) Within 30 days after receiving the request for access, the health information custodian may extend the time limit set out in subsection (2) for a further period of time of not more than 30 days if,

(a) meeting the time limit would unreasonably interfere with the operations of the custodian because the information consists of numerous pieces of information or locating the information would necessitate a lengthy search; or

(b) the time required to undertake the consultations necessary to reply to the request within 30 days after receiving it would make it not reasonably practical to reply within that time. 2004, c. 3, Sched. A, s. 54 (3).

Notice of extension
(4) Upon extending the time limit under subsection (3), the health information custodian shall give the individual written notice of the extension setting out the length of the extension and the reason for the extension. 2004, c. 3, Sched. A, s. 54 (4).

Expedited access
(5) Despite subsection (2), the health information custodian shall give the response required by clause (1) (a), (b), (c) or (d) within the time period that the individual specifies if,

(a) the individual provides the custodian with evidence satisfactory to the custodian, acting on a reasonable basis, that the individual requires access to the requested record of personal health information on an urgent basis within that time period; and

(b) the custodian is reasonably able to give the required response within that time period. 2004, c. 3, Sched. A, s. 54 (5).

Frivolous or vexatious requests
(6) A health information custodian that believes on reasonable grounds that a request for access to a record of personal health information is frivolous or vexatious or is made in bad faith may refuse to grant the individual access to the requested record. 2004, c. 3, Sched. A, s. 54 (6).

Effect of non-compliance
(7) If the health information custodian does not respond to the request within the time limit or before the extension, if any, expires, the custodian shall be deemed to have refused the individual's request for access. 2004, c. 3, Sched. A, s. 54 (7).

Right to complain
(8) If the health information custodian refuses or is deemed to have refused the request, in whole or in part,

(a) the individual is entitled to make a complaint about the refusal to the Commissioner under Part VI; and

(b) in the complaint, the burden of proof in respect of the refusal lies on the health information custodian.

Identity of individual
(9) A health information custodian shall not make a record of personal health information or a part of it available to an individual under this Part or provide a copy of it to an individual under clause (1) (a) without first taking reasonable steps to be satisfied as to the individual's identity. 2004, c. 3, Sched. A, s. 54 (9).

Fee for access
(10) A health information custodian that makes a record of personal health information or a part of it available to an individual under this Part or provides a copy of it to an individual under clause (1) (a) may charge the individual a fee for that purpose if the custodian first gives the individual an estimate of the fee. 2004, c. 3, Sched. A, s. 54 (10).

Amount of fee
(11) The amount of the fee shall not exceed the prescribed amount or the amount of reasonable cost recovery, if no amount is prescribed. 2004, c. 3, Sched. A, s. 54 (11).

Waiver of fee
(12) A health information custodian mentioned in subsection (10) may waive the payment of all or any part of the fee that an individual is required to pay under that subsection if, in the custodian's opinion, it is fair and equitable to do so. 2004, c. 3, Sched. A, s. 54 (12).

CORRECTION

Correction
55 (1) If a health information custodian has granted an individual access to a record of his or her personal health information and if the individual believes that the record is inaccurate or incomplete for the purposes for which the custodian has collected, uses or has used the information, the individual may request in writing that the custodian correct the record. 2004, c. 3, Sched. A, s. 55 (1); 2007, c. 10, Sched. H, s. 21.

Informal request
(2) If the individual makes an oral request that the health information custodian correct the record, nothing in this Part prevents the custodian from making the requested correction. 2004, c. 3, Sched. A, s. 55 (2).

Reply
(3) As soon as possible in the circumstances but no later than 30 days after receiving a request for a correction under subsection (1), the health information custodian shall, by written notice to the individual, grant or refuse the individual's request or extend the deadline for replying for a period of not more than 30 days if,

(a) replying to the request within 30 days would unreasonably interfere with the activities of the custodian; or
(b) the time required to undertake the consultations necessary to reply to the request within 30 days would make it not reasonably practical to reply within that time. 2004, c. 3, Sched. A, s. 55 (3).

Extension of time for reply
(4) A health information custodian that extends the time limit under subsection (3) shall,

(a) give the individual written notice of the extension setting out the length of the extension and the reason for the extension; and
(b) grant or refuse the individual's request as soon as possible in the circumstances but no later than the expiry of the time limit as extended. 2004, c. 3, Sched. A, s. 55 (4).

Deemed refusal
(5) A health information custodian that does not grant a request for a correction under subsection (1) within the time required shall be deemed to have refused the request. 2004, c. 3, Sched. A, s. 55 (5).

Frivolous or vexatious requests
(6) A health information custodian that believes on reasonable grounds that a request for a correction under subsection (1) is frivolous or vexatious or is made in bad faith may refuse to grant the request and, in that case, shall provide the individual with a notice that sets out the reasons for the refusal and that states that the individual is entitled to make a complaint about the refusal to the Commissioner under Part VI. 2004, c. 3, Sched. A, s. 55 (6).

Right to complain
(7) The individual is entitled to make a complaint to the Commissioner under Part VI about a refusal made under subsection (6). 2004, c. 3, Sched. A, s. 55 (7).

Duty to correct
(8) The health information custodian shall grant a request for a correction under subsection (1) if the individual demonstrates, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information and gives the custodian the information necessary to enable the custodian to correct the record. 2004, c. 3, Sched. A, s. 55 (8).

Exceptions
(9) Despite subsection (8), a health information custodian is not required to correct a record of personal health information if,

(a) it consists of a record that was not originally created by the custodian and the custodian does not have sufficient knowledge, expertise and authority to correct the record; or
(b) it consists of a professional opinion or observation that a custodian has made in good faith about the individual. 2004, c. 3, Sched. A, s. 55 (9).

Duties upon correction
(10) Upon granting a request for a correction under subsection (1), the health information custodian shall,

(a) make the requested correction by,
    (i) recording the correct information in the record and,
        (A) striking out the incorrect information in a manner that does not obliterate the record, or
        (B) if that is not possible, labelling the information as incorrect, severing the incorrect information from the record, storing it separately from the record and maintaining a link in the record that enables a person to trace the incorrect information, or
    (ii) if it is not possible to record the correct information in the record, ensuring that there is a practical system in place to inform a person who accesses the record that the information in the record is incorrect and to direct the person to the correct information;
(b) give notice to the individual of what it has done under clause (a);

(c) at the request of the individual, give written notice of the requested correction, to the extent reasonably possible, to the persons to whom the custodian has disclosed the information with respect to which the individual requested the correction of the record, except if the correction cannot reasonably be expected to have an effect on the ongoing provision of health care or other benefits to the individual. 2004, c. 3, Sched. A, s. 55 (10).

Notice of refusal

(11) A notice of refusal under subsection (3) or (4) must give the reasons for the refusal and inform the individual that the individual is entitled to,

(a) prepare a concise statement of disagreement that sets out the correction that the health information custodian has refused to make;

(b) require that the health information custodian attach the statement of disagreement as part of the records that it holds of the individual's personal health information and disclose the statement of disagreement whenever the custodian discloses information to which the statement relates;

(c) require that the health information custodian make all reasonable efforts to disclose the statement of disagreement to any person who would have been notified under clause (10) (c) if the custodian had granted the requested correction; and

(d) make a complaint about the refusal to the Commissioner under Part VI. 2004, c. 3, Sched. A, s. 55 (11).

Rights of individual

(12) If a health information custodian, under subsection (3) or (4), refuses a request for a correction under subsection (1), in whole or in part, or is deemed to have refused the request, the individual is entitled to take the actions described in any of clauses (11) (a), (b), (c) and (d). 2004, c. 3, Sched. A, s. 55 (12).

Custodian's duty

(13) If the individual takes an action described in clause (11) (b) or (c), the health information custodian shall comply with the requirements described in the applicable clause. 2004, c. 3, Sched. A, s. 55 (13).

PART VII
GENERAL

Offences

72 (1) A person is guilty of an offence if the person,

(a) wilfully collects, uses or discloses personal health information in contravention of this Act or its regulations;

(b) makes a request under this Act, under false pretences, for access to or correction of a record of personal health information;

(c) in connection with the collection, use or disclosure of personal health information or access to a record of personal health information, makes an assertion, knowing that it is untrue, to the effect that the person,

(i) is a person who is entitled to consent to the collection, use or disclosure of personal health information about another individual,

(ii) meets the requirement of clauses 26 (2) (b) and (c),

(iii) holds the beliefs described in subsection 26 (5), or

(iv) is a person entitled to access to a record of personal health information under section 52;

(d) disposes of a record of personal health information in the custody or under the control of the custodian with an intent to evade a request for access to the record that the custodian has received under subsection 53 (1);

(e) wilfully disposes of a record of personal health information in contravention of section 13;

(f) contravenes subsection 34 (2), (3) or (4) or clause 47 (15) (a), (e) or (f);

(g) wilfully obstructs the Commissioner or a person known to be acting under the authority of the Commissioner in the performance of his or her functions under this Act;

(h) wilfully makes a false statement to mislead or attempt to mislead the Commissioner or a person known to be acting under the authority of the Commissioner in the performance of his or her functions under this Act;

(i) wilfully fails to comply with an order made by the Commissioner or a person known to be acting under the authority of the Commissioner under this Act; or

(j) contravenes section 70. 2004, c. 3, Sched. A, s. 72 (1).

Penalty

(2) A person who is guilty of an offence under subsection (1) is liable, on conviction,

(a) if the person is a natural person, to a fine of not more than $100,000; and

(b) if the person is not a natural person, to a fine of not more than $500,000. 2004, c. 3, Sched. A, s. 72 (2); 2016, c. 6, Sched. 1, s. 1 (26).

THIS SECTION IS FOR INFORMATION ONLY

The development of this draft regulation received 60-day consultation from August to October 2011.
The draft Record Keeping Regulation for the College of Homeopaths of Ontario is before the Ministry of Health and Long-Term Care for consideration and approval.

Part III – Record Keeping

3.(1) The standard of the profession for record keeping relating to the treatment of a patient includes the following:

(a) The record shall be in English or in French.

(b) The record shall contain the name and date of birth of the patient.

(c) The record shall include all relevant subjective information provided by the patient or his or her authorized representative.

(d) The record shall include all relevant objective findings.

(e) The record shall include the results of any testing and any testing from other health professionals obtained by the member to determine the condition of the patient.

(f) The record shall include the member's treatment plan.

(g) The record shall include a notation of all relevant communications with the patient.

(h) The record shall include the relevant information obtained from any re-assessment of the patient and any modification of the treatment plan

(i) The record shall indicate who made each entry and when each entry was made.

(j) Any amendment to the record shall indicate what change was made at what date by whom and shall ensure that the previous entries are legible.

(k) The original record shall be retained by the member or the health information custodian[3] for whom the member works and only copies shall be provided to others

(l) The record shall be retained for ten years from the last interaction with the patient or the patient's eighteenth birthday, whichever is later

(m) The records required by regulation shall be legibly written or typewritten.

[3] The term "health care custodian" is defined in the *Personal Health Information Protection Act, 2004*.

3.(2) The standard of the profession for record keeping includes creating and maintaining appropriate financial records for ten years from the last interaction with the patient or the patient's eighteenth birthday, whichever is later.

3.(3) The standard of the profession for record keeping includes creating and maintaining appropriate equipment records for ten years.

3.(4) The standard of the profession for record keeping includes creating and maintaining appropriate records of the receipt, storage and disposition of homeopathics or other substances for ten years.

3.(5) The standard of the profession for record keeping includes creating and maintaining an appointment and attendance record for ten years.