Clinic Privacy Statement

Our clinic wants to ensure the highest standard of medical care for our patients. We are consistent with the Medical Council guidelines and the privacy principles of the Data Protection Acts. We see our patients' consent as being the key factor in dealing with their health information. This leaflet is about making consent meaningful by advising you of our policies and practices on dealing with your medical information.

MANAGING YOUR INFORMATION

- In order to provide for your care here we need to collect and keep information about you and your health on our records.
- We retain your information securely.
- We will only ask for and keep information that is necessary. We will attempt to keep it as accurate and up to-date as possible. We will explain the need for any information we ask for if you are not sure why it is needed.
- We ask you to inform us about any relevant changes that we should know about. This would include such things as any new treatments or investigations being carried out that we are not aware of. Please also inform us of change of address and phone numbers.
- All persons in the clinic (not already covered by a professional confidentiality code) sign a confidentiality agreement that explicitly makes clear their duties in relation to personal health information and the consequences of breaching that duty.
- Access to patient records is regulated to ensure that they are used only to the extent necessary to enable the clinic staff to perform their tasks for the proper functioning of the practice. In this regard, patients should understand that practice staff may have access to their records for:
  - » Identifying and printing repeat prescriptions for patients. These are then reviewed and signed by the doctor.
  - » Typing referral letters to other consultants or allied health professionals such as physiotherapists, occupational therapists, psychologists and dieticians.
  - » Opening letters from hospitals and consultants. The letters could be appended to a patient's paper file or scanned into their electronic patient record.
  - » Scanning clinical letters, radiology reports and any other documents not available in electronic format.
  - » Downloading laboratory results and performing integration of these results into the electronic patient record.
  - » Photocopying or printing documents for referral to consultants.
  - » Checking for a patient if a hospital or consultant letter is back or if a laboratory or radiology result is back, in order to schedule a conversation with the Doctor.
  - » Handling, printing, photocopying and postage of medico legal and life assurance reports, and of associated documents.

DISCLOSURE OF INFORMATION TO OTHER HEALTH AND SOCIAL PROFESSIONALS

- We may need to pass some of this information to other health and social care professionals in order to provide you with the treatment and services you need. Only the relevant part of your record will be released. These other professionals are also legally bound to treat your information with the same duty of care and confidence that we do.

DISCLOSURES REQUIRED OR PERMITTED UNDER LAW

- The law provides that in certain instances personal information (including health information) can be disclosed, for example, in the case of infectious diseases.
- Disclosure of information to Employers, Insurance Companies and Solicitors
- In general, work related Medical Certificates from your GP will only provide a confirmation that you are unfit for work with an indication of when you will be fit to resume work. Where it is considered necessary to provide additional information we will discuss that with you. However, Social Welfare Certificates of Incapacity for work must include the medical reason you are unfit to work.
- In the case of disclosures to insurance companies or requests made by solicitors for your records we will only release the information with your signed consent.

USE OF INFORMATION FOR TRAINING, TEACHING AND QUALITY ASSURANCE

- It is usual for doctors to discuss patient case histories as part of their continuing medical education or for the purpose of training doctors and/or medical students. In these situations the identity of the patient concerned will not be revealed.
- In other situations, however, it may be beneficial for other doctors within the practice to be aware of patients with particular conditions and in such cases this practice would only communicate the information necessary to provide the highest level of care to the patient.

USE OF INFORMATION FOR RESEARCH, AUDIT AND QUALITY ASSURANCE

- It is usual for patient information to be used for these purposes in order to improve services and standards of practice. In general, information used for such purposes is done in an anonymous manner with all personal identifying information removed.
- If it were proposed to use your information in a way where it would not be anonymous or the Practice was involved in external research we would discuss this further with you before we proceeded and seek your written informed consent.
- Please remember that the quality of the patient service provided can only be maintained and improved by training, teaching, audit and research.

YOUR RIGHT OF ACCESS TO YOUR HEALTH INFORMATION

- You have the right of access to all the personal information held about you by this practice. If you wish to see your records in most cases it is the quickest to discuss this with your doctor who will outline the information in the record with you. You can make a formal written access request to the practice and the matter can be dealt with formally. There may be a charge of up to €6.35 where a formal request is made.

We hope this leafet has explained any issues that might arise. If you have any questions please speak to our admin team or your doctor.