



Main Street Clinic

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MEDICAL RECORDS – WHO HAS ACCESS?

A General Practice is a trusted community governed by an ethic of privacy and confidentiality.

In order to provide for your care we need to collect and keep information about you and your health in your personal medical record.

Our practices are consistent with the Medical Council guidelines and the privacy principles of the Data Protection Acts.

Please see Practice Privacy Statement.

Thank you.

Practice Privacy Statement

This Practice wants to ensure the highest standard of medical care for our patients. We understand that a General Practice is a trusted community governed by an ethic of privacy and confidentiality. Our practices 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 practice (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 secretary or manager 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 GP.

"Generating a social welfare certificate for the patient. This is then checked and signed by the GP.

"Typing referral letters to hospital 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 Out of Hours Coop reports and performing integration of these results into the electronic patient record.

"Photocopying or printing documents for referral to consultants, attending an antenatal clinic or when a patient is changing GP.

"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 GP.

"When a patient makes contact with a practice, checking if they are due for any preventative services, such as vaccination, ante natal visit, contraceptive pill check, cervical smear test, etc.

"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.