



Communicating a Request Not to Upload a Pathology or Diagnostic Imaging Report to the My Health Record System Implementation Guide

3 December 2019 v1.1
Approved for external information
Document ID: DH-3021:2019

Background

Pathology and diagnostic imaging providers are now uploading reports to the My Health Record system. This has necessitated discussion about the process of communicating to the diagnostic services providers (laboratory and diagnostic imaging practices) when reports should **not** be uploaded to a patients' My Health Record.

A consultation process with the pathology and diagnostic imaging sectors confirmed that the model for incorporating pathology and diagnostic imaging reports into the My Health Record system would be consistent where appropriate.

Purpose

This guide explains how a requesting clinician in a community care setting can communicate on the diagnostic request to a pathology or diagnostic imaging provider that they should not upload the diagnostic report to the patient's My Health Record.

Intended audience

The intended audience includes developers and vendors of digital health systems that generate pathology and/or diagnostic imaging requests.

Authorisation to upload a report

Under the *My Health Records Act 2012*, healthcare provider organisations are authorised to upload information to the My Health Record system. This means that there is no requirement for a healthcare provider to obtain consent on each occasion prior to uploading clinical information unless:

- the patient has requested them not to upload the report¹;

¹ *My Health Records Act 2012*

45 Condition of registration—uploading of records, etc.

It is a condition of registration of a healthcare provider organisation that the healthcare provider organisation does not, for the purposes of the My Health Record system:

d) upload to a repository a record that includes health information about a registered consumer if the consumer has advised that the record is not to be uploaded.

- state or territory law requires the healthcare provider to seek specific consent from the patient, and that consent has not been obtained; or
- uploading the report may cause a serious threat to the life, health or safety of the patient.

Software enhancement requirements

- a At the time of creating a pathology or diagnostic imaging request in the requesting software, the enhanced software must be capable of displaying in its user interface a 'check box' or some other interface element as may be agreed between the parties. The purpose for this check box is for the requesting clinician to indicate that the patient has withdrawn their consent to upload the report(s) to the My Health Record system;
- b This check box must be labelled "Do not send reports to My Health Record" and the default state of this check box must be unchecked;
- c The enhanced software must capture and store this request to not send the report to the patient's My Health Record locally, and for each request for a report, for auditing and tracking purposes;
- d When printing a paper request, the enhanced software must print the statement "Do not send reports to My Health Record" and provide a single check box. If the clinician or patient requests that the report not be uploaded, the enhanced software must print a tick in that check box;
- e The check box and the "Do not send reports to My Health Record" statement must be printed in any space allocated to clinical notes/history or reason for examination, and they must be in close proximity to where the requesting clinician affixes their signature to the paper request, or in some other location on the paper request as agreed in writing between the parties; and
- f There must be only one question per request and the consent may cover many orderable items within the requesting event. Irrespective of the requestor's communication not to upload, it is ultimately the responsibility of the pathology or diagnostic imaging provider to comply with the requirements for uploading in the *My Health Records Act*.

The table below displays the expected behaviours/functionality for the abovementioned requirements:

Requirement/s	Expected behaviour/functionality
a; b and f	<ul style="list-style-type: none"> • The phrase “Do not send reports to My Health Record” is present in both the pathology and diagnostic imaging ordering screens. • The phrase is present regardless of whether the provider is a participating provider. • The phrase is present regardless of whether the patient has a My Health Record. • The check box correctly defaults to unchecked on instantiation of the new order. • There is only one question per request and the request is able to cover many orderable items within the requesting event. • The requesting clinician is able to toggle the check box from checked to unchecked during the ordering process. • If the software already includes the patient’s wishes, this should override the default state of the check box. For example, if patient has explicitly stated not to upload to the My Health Record, then on any request for that patient, the check box may default to checked. The requesting clinician will have the option to change the state of the check box as required based on the preferences of the patient.
c	<ul style="list-style-type: none"> • View an existing order or an audit of that order and see the check box value stored from the time of the ordering event.
d and e	<ul style="list-style-type: none"> • The phrase “Do not send reports to My Health Record” is present on both the pathology and diagnostic imaging request forms. • The phrase is correctly positioned (near the bottom right boundary of the section for clinical notes or reason for investigation and in close proximity and if possible aligned to where the requesting clinician signs). • The font and font size must match the font and font size of other information printed by the software onto the form. • The checkbox is located to the right of the statement e.g.: Do not send reports to My Health Record <input type="checkbox"/> (and not <input type="checkbox"/> Do not send reports to My Health Record). • The value in the printed check box matches the value stored with the order. • The phrase only appears once on the request form when the request is for more than one test or examination. • The printed form should be demonstrated on branded request form(s).

Publication date: 3 December 2019

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Acknowledgements

Council of Australian Governments

The Australian Digital Health Agency is jointly funded by the Australian Government and all state and territory governments.