MODULE 15 | HOSPITAL INFORMATION SYSTEMS, RECORDS AND DATA

Medical Records, Confidentiality and Lawful Disclosure

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LECTURE

Practical hospital governance in Punjab, Pakistan

Keep a reliable record of care.
Control access, release and retention.

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SELF-STUDY PDF

A reliable record is part of safe care

The record should show what happened, who acted and what the next team needs to know.

- Check record quality and reliability.
- Manage access and requests for disclosure.
- Control correction, storage and disposal.
- Review gaps and verify that corrective actions work.

OFFICIAL SOURCE

A principle tied to a named law, standard or official guidance.

WORKING METHOD

A practical control or teaching format to adapt to the authorised system.

TEACHING CASE

An invented hospital example, used to practise applying the correct process.

Study output

A record-quality review and a documented response to a request for patient information.

Module 15 | Presentation 2 of 3. Allow 45-60 minutes with exercises. All explanations are on the pages; check the cited sources before live use.

Assign responsibility for the whole record

Clinical, records and information technology (IT) teams have different duties. The MS needs a working system across departments.

Role	Practical responsibility
Treating professionals	Make accurate, timely entries and act on important results.
Records team	Register, index, track, retrieve and store records securely.
IT team	Control accounts, system availability, logs and recovery arrangements.
Authorised decision-makers	Decide requests, legal holds and disposal within their powers.
Hospital leadership	Approve procedures, provide resources, review failures and follow up.

A computer system does not replace clinical authorship or the hospital’s responsibility for its records.

WORKING METHOD | Illustrative material is identified in the text.

Keep six linked procedures

Use the hospital’s approved system and identify who may make each decision.

01 Creation

Identity checks, authorised entries, required content and completion.

02 Corrections

Visible amendments, reasons and a traceable author.

03 Access

Care access, records movement and exceptional access.

04 Disclosure

Request checking, decision, secure release and receipt.

05 Retention

Record categories, approved periods and holds.

06 Review

Sampling, findings, corrective actions and recheck.

Keep each procedure’s approval, owner, version and review date. Train the people who use it.

WORKING METHOD | Illustrative material is identified in the text.

Link information to the correct patient

Punjab Healthcare Commission (PHC) indicator 144 requires a unique record identifier or a system to identify and consolidate duplicates.

At registration and care

- Check the patient’s details against the existing record before creating another file. A bed or room number can change and should not be the only identifier.
- Use the approved temporary identification process for an unidentified emergency patient. Confirm and reconcile identity when reliable information becomes available.

When a duplicate is found

- Ask authorised staff to verify that both records concern the same person. Similar names alone are insufficient.
- Link or merge through the approved process. Preserve the history of the change and check prescriptions, results and active care for wrong-patient information.

A duplicate record can hide earlier care; a wrong merge can place another person’s information into the care pathway.

Sources: **R1**: IMS indicator 144

Make every entry attributable

PHC distinguishes authority to enter information, date and time, and the identity of the author.

Check	What should be clear
Authority	The author is permitted to make that type of entry.
Date and time	When the entry was made and, where different, when the event happened.
Author	Name and professional role; approved signature or electronic authentication.
Content	Relevant findings, decisions, actions and follow-up in understandable language.
Sequence	An up-to-date account of care that can be followed in time order.

Do not share a login or sign an entry as if you personally provided care that another person delivered.

Sources: **R1**: IMS indicators 145–148

Record the reason, decision and next action

Use the record to communicate care, not simply to prove that a form was completed.

Stage	Useful content
Assessment	Reason for attendance or admission; relevant history, findings and diagnosis.
Plan	Care required, responsible team, observation needs and review arrangements.
Progress	Changes in condition, response to treatment and reasons for important decisions.
Procedure	Provider, procedure, findings, specimens and condition at completion.
Consent	The relevant consent process and the approved record of the decision.

Clinical information should be sufficient for the next authorised team to understand and continue care.

Sources: **R1**: IMS indicators 148–150; PRE indicators 72–73

Close the gap between an order and an action

An order, a completed test and a reviewed result are different events.

Orders

- Use the designated place for medication orders. PHC requires legibility, date, time and identification of the prescriber.
- Record cancellations and changes clearly so the team knows the current instruction. Follow the approved procedure for urgent verbal instructions.

Results and follow-up

- Check that reports belong to the correct patient and episode. Make significant findings available to the responsible clinician.
- Record review, important communication and the action taken. Assign responsibility for results still pending when the patient leaves.

A result being available in the system does not establish that the responsible clinician has reviewed it.

Sources: **R1**: MOM indicators 53–54; IMS indicators 144 and 148

Send information that supports the next episode

Keep the required copy in the hospital record and provide the appropriate information to the next recipient.

Transfer to another hospital

- Record the date, reason, receiving hospital, investigations and treatment already given.
- Include the patient’s condition and required arrangements for care during transfer. Use a clear referral or transfer document.

Discharge

- Include admission reason, important results, procedures or treatment and the patient’s response.
- Include discharge medicines and follow-up instructions. The appropriate authorised professional signs the note; preserve the hospital’s copy.

PHC also requires the relevant death certificate and final clinical autopsy report in the record when applicable.

Sources: **R1**: IMS indicators 151–154

Correct errors without concealing the earlier entry

Use an approved method that shows what changed, why it changed and who changed it.

Paper records

- Keep the original wording readable. Use the approved correction method, add the corrected information, date and time, and identify the author.
- Do not remove pages, use correction fluid or rewrite the entire record to make the sequence appear different.

Electronic records

- Use the amendment function and preserve the earlier version and audit history. Restrict deletion and record merging to authorised processes.
- Check whether the error affected a prescription, test, report or clinical decision. Correct the related workflow and notify the care team where needed.

An audit trail is a history of events or changes. It supports review; it does not by itself prove the clinical content is correct.

WORKING METHOD | Illustrative material is identified in the text.

TEACHING CASE

A late entry must identify itself

Invented example: a nurse notices at 15:20 that a discussion at 14:10 was not recorded.

Event time	14:10: the clinician reviewed the patient and gave the documented follow-up plan.
Entry time	15:20: record that this is a late entry about the event at 14:10.
Author and basis	Identify the author and what the author personally observed or reliably verified.
Limits	State uncertainty. Do not invent observations, copy an unverified account or backdate the entry.
Follow-up	If the omission affected care, address the risk and report it through the relevant hospital procedure.

A late entry should explain the actual sequence. It must not be used to manufacture consent after an event.

TEACHING CASE | Illustrative material is identified in the text.

Know where the original record is

Availability and confidentiality must be maintained together.

Paper control

- Use a tracking record when a file leaves storage: patient identifier, person receiving it, destination, time out and return.
- Keep files away from public areas and protect storage from water, fire and unauthorised access. Follow up missing and overdue files.

Electronic and mixed records

- Identify which system holds the official record and where paper documents, images and outside reports are indexed.
- When an original must leave under lawful authority, preserve a permitted copy and document custody, recipient, purpose and return arrangements.

PHC requires a policy for access to records and their availability to authorised care providers.

Sources: **R1**: IMS indicators 148 and 155

Give access for an authorised purpose

Staff status alone does not justify looking at every patient’s information.

Routine access

- Match access to the person’s role and assigned work. Review access when staff join, move or leave.
- Provide the necessary current and previous information to the treating team through the approved route. Avoid controls that obstruct urgent care.

Exceptional access

- Use a defined emergency-access process where the system supports it. Record the reason and review unusual access afterwards.
- Investigate suspected browsing, shared accounts or bulk exports fairly. Restrict the immediate risk and preserve the relevant evidence.

PM&DC’s 2026 announcement places confidentiality and informed consent among the core ethical principles.

Sources: **R1**: IMS indicator 155 | **R4**: announcement of 2 March 2026

Use a clear route for requests

Apply the actual legal and professional basis for the request. Consent is not the only possible lawful basis.

1	**Register and verify**	Identify the requester, patient, records sought, recipient and relevant authority.
2	**Classify the route**	Patient request, consented disclosure, care, legal requirement, court process or RTI.
3	**Decide the scope**	Obtain the competent decision. Identify the information necessary or legally required.
4	**Release and record**	Use a secure channel; log what was sent, to whom, when and under whose decision.

For routine requests, verify purpose. Under Punjab RTI, an applicant cannot be required to give reasons for the request.

Sources: **R2**: section 10(3)

Keep a record of the disclosure decision

This suggested register supports follow-up and later review.

Field	What to record
Request and identity	Reference, date, requester and identity checks appropriate to the route.
Authority and scope	Consent, relevant legal power, order or approved care purpose; records covered.
Decision	Approver, release or refusal, reasons and any information withheld.
Delivery	Actual documents or data, verified recipient, secure method and receipt.
Follow-up	Due date, unresolved queries, complaint or review route and closure.

Retain the request, authority and exact released version. Do not put unnecessary patient detail in a widely shared register.

WORKING METHOD | Illustrative material is identified in the text.

Verify who may receive the information

Use the hospital’s patient-access procedure and the applicable legal position.

The patient requests a copy

- Verify identity in a proportionate way, clarify the requested record and route it to the authorised records process.
- Check for information about other people and any restriction requiring review. Give clear reasons and the proper review route for any limitation.

Someone acts for the patient

- Check identity and the patient’s valid authority, or another applicable legal basis. Confirm the scope and intended recipient.
- A spouse, employer, insurer, politician or colleague does not automatically obtain the full record. Do not rely only on familiarity or a telephone claim.

A general consent to treatment should not be treated as unlimited permission for every later disclosure.

Sources: **R4**: confidentiality and informed consent

Check authority where representation is uncertain

The answer may depend on the person, the type of information and the applicable law.

Children or adults unable to decide

- Confirm the representative’s legal authority and the scope of the decision. Consider the patient’s circumstances, protection and confidentiality.
- Escalate conflicting parental requests, disputed guardianship or suspected harm. Record the competent decision and its basis.

After a patient’s death

- Do not treat death as general permission to release the record. Verify the requester’s identity, authority, purpose and applicable process.
- Separate requests for a certificate from requests for the full clinical file. Seek legal review when authority, entitlement or competing interests are unclear.

This lecture gives a checking process; it does not create a universal rule for guardianship, capacity or inheritance.

WORKING METHOD | Illustrative material is identified in the text.

Verify the legal demand and preserve the evidence

An informal request and a binding legal requirement need different handling.

Police or investigation request

- Confirm the officer, official channel, case reference, legal basis and precise information requested. Obtain the authorised legal or administrative decision.
- Do not assume that every police request requires patient consent or that every request permits the complete file. Follow the actual lawful power.

Court order or summons

- Verify the document, scope, recipient and deadline. Send it promptly to the officer responsible for compliance and legal advice.
- Preserve the record and comply through the proper route. Seek clarification of an uncertain order through counsel; do not silently ignore it.

A custody record should show each transfer of an original or evidential copy. Preserve electronic versions and relevant logs.

WORKING METHOD | Illustrative material is identified in the text.

Match disclosure to the specific requirement

A valid duty to provide information does not create permission for unrelated release.

Statutory and regulatory reporting

- Identify the current provision, authorised recipient, required information and reporting period for the actual event.
- Use the designated route for applicable disease, birth, death, medico-legal or regulatory reporting. Obtain help promptly if the basis is unclear.

Audit, insurance and administration

- Check the reviewer’s authority and the task. Give the information properly required, using protected access and copies where appropriate.
- For an insurer or other third party, verify the applicable permission or legal basis and the claim scope. A commercial agreement alone needs proper review.

Explain what was disclosed and why. Do not create a rule that all disclosure always requires consent.

WORKING METHOD | Illustrative material is identified in the text.

Transparency includes lawful privacy protection

The Punjab Transparency and Right to Information Act 2013 governs requests to covered public bodies.

Apply the correct process

- Send an RTI request to the designated Public Information Officer (PIO). Hospital staff should assist that officer in locating and checking the record.
- A request for hospital spending or service totals is different from a request for named patients’ clinical information.

Apply the actual exceptions

- Section 13 addresses likely harm to legitimate privacy, confidence and other protected interests. Give a reasoned decision under the Act.
- Release reasonably separable information that is not exempt. The Commission has the stated power to order disclosure where public interest outweighs harm.

Do not release a patient list merely because a letter is labelled RTI; do not refuse all hospital information merely because it is held in a hospital.

Sources: **R2**: sections 7, 11 and 13

Track the statutory response route

These are the Punjab Act’s requirements; they are not a timetable for every routine patient request.

Requirement	What the Act states
Reasons for asking	Section 10(3): an applicant is not required to provide reasons for the request.
Ordinary response	Section 10(7): as soon as possible, within 14 working days; necessary extension up to 14 further working days.
Life or liberty	Section 10(7): the relevant information is to be provided within two working days.
Refusal	Give the reasons and applicable provision, with the available internal review or complaint route.
Partial disclosure	Provide reasonably separable non-exempt information under section 13(3).

Check current rules and directions. Log receipt, transfers, due date, decision and delivery; never conceal or destroy requested information.

Sources: **R2**: sections 10–13 and 16

A research interest is not access permission

Refer to Module 14 for the wider research approval process.

Before access

- Check the approved project, responsible researcher, institutional permission and ethics decision, including the actual consent or approved waiver position.
- Approve the necessary dataset and authorised users. A retrospective study or a request by a senior colleague should not bypass review.

During use

- Prefer information with identifiers removed when it meets the approved purpose. A coded dataset may still identify people if the linking key exists.
- Control copies, transfer, storage, publication and the agreed return or disposal. Do not upload identifiable records to an unapproved AI or cloud service.

Removing a name alone may leave identification possible through dates, rare diagnoses, images or linked information.

WORKING METHOD | Illustrative material is identified in the text.

Treat patient images and messages as information

PM&DC has expressly raised confidentiality and consent concerns about recording patients.

Clinical images

- Use the authorised clinical process, relevant permission and secure storage. State the purpose and attach the image to the correct record.
- Permission for treatment or a clinical image does not automatically permit teaching, publication, publicity or social media use.

Messages and remote sharing

- Use the approved communication channel and verify the recipient. Keep clinical decisions that affect care in the official record.
- Do not send full files to a broad group for convenience. Avoid visible names, labels or screen details in teaching material unless properly authorised.

Patient information remains sensitive when shown in a screenshot, photograph, audio message or video.

Sources: **R5**: statement of 30 March 2026

Respond when information reaches the wrong person

Act promptly through the hospital’s incident procedure. Preserve facts while limiting further exposure.

1	**Contain**	Stop further sharing, restrict affected access and seek safe recovery where possible.
2	**Preserve**	Record what happened, when, the information involved and the recipients. Keep relevant logs.
3	**Assess and escalate**	Inform the designated lead. Review clinical risk, likely harm and any legal or contractual duties.
4	**Correct and review**	Make required notifications, support affected people and check that the cause has been addressed.

Do not invent a universal 72-hour reporting rule. The applicable duty and deadline must be identified for the actual incident.

WORKING METHOD | Illustrative material is identified in the text.

Use an authorised schedule for each record category

A retention schedule states what is kept, for how long, from which event and under whose authority.

Build the schedule

- Identify the applicable statutory instructions, PHC requirements and institutional orders. Cover paper records, images, results, electronic records and relevant logs.
- Define the start point for each period and any special categories. Obtain competent legal and administrative review before adopting or changing the schedule.

Check before any disposal

- Confirm that the correct period has ended and no complaint, claim, investigation, request or other preservation duty requires the record.
- Do not infer a universal destruction date from a limitation period or an isolated manual footnote. Retention and permission to destroy are separate questions.

PHC indicator 148 requires ordered storage and compliance with applicable retention provisions and instructions.

Sources: **R1**: IMS indicator 148

Suspend disposal when a record must be preserved

A hold is a documented instruction to preserve identified information for a matter requiring it.

1	**Define the scope**	Identify the matter, patient or file, period, systems and related paper or electronic evidence.
2	**Notify custodians**	Tell the records, clinical, IT and other relevant owners what must be preserved.
3	**Protect the information**	Stop routine disposal for the covered material and keep access and transfer traceable.
4	**Review and release**	Track the matter. End the hold only through the authorised decision and document that decision.

Include relevant messages, reports and logs. Keep the information needed for ongoing care available through controlled access.

WORKING METHOD | Illustrative material is identified in the text.

Electronic form is recognised, but reliability matters

The Electronic Transactions Ordinance 2002 provides conditions for electronic records, signatures and retention.

What the law addresses

- Electronic form alone does not remove legal recognition. Accessibility, integrity and accurate representation matter for writing, original form and retention.
- Electronic signatures and certified copies have their own provisions. Public authorities may prescribe the accepted format and procedure.

Practical hospital checks

- Test whether the record can be retrieved, read and linked to its author. Preserve the information needed to explain origin, time and changes.
- Check the receiving authority’s requirements. A typed name, a scan and an authenticated system entry are not automatically equivalent evidence.

Do not promise that every screenshot is sufficient proof or that scanning automatically permits destruction of the original.

Sources: **R3**: sections 3–9, 12 and 16

Validate the scanned record before relying on it

This working checklist supports an authorised digitisation process.

01 Identity

Correct patient and episode; no pages from another file.

02 Completeness

All pages, both sides where relevant, attachments and images.

03 Readability

Text, signatures, markings and clinically relevant detail are clear.

04 Indexing

Correct document type, date, sequence and retrieval route.

05 Integrity

Quality check, authorised access and a traceable correction process.

06 Recovery

Backup, restoration test and continued ability to read the format.

Retain originals until the applicable retention, evidential and authorised disposal conditions have been satisfied.

WORKING METHOD | Illustrative material is identified in the text.

Make disposal an authorised, recorded action

A crowded store or an IT storage limit is not a disposal authority.

1	**Check eligibility**	Use the approved schedule and confirm all relevant holds and special requirements.
2	**Approve the list**	Record the categories, date range, identifiers and competent approval securely.
3	**Destroy securely**	Use a controlled paper or electronic process that prevents unauthorised reconstruction.
4	**Verify completion**	Keep the disposal record, date, method and responsible people; check contractor evidence.

Do not put clinical records into ordinary waste or sell readable records as scrap. Apply the approved process to digital media too.

WORKING METHOD | Illustrative material is identified in the text.

Review the actual quality of documentation

PHC’s hospital manual specifies a periodic review process, not just a storage function.

Element	Requirement in the cited indicators
Frequency	Defined procedure, implemented at least quarterly.
Sample	Representative of the hospital’s services and staff, with a justified sampling approach.
Reviewers	Identified authorised care professionals; not only records-office staff.
Record types	Both active and discharged patient records.
Assessment and action	Timeliness, legibility and completeness; record deficiencies and take corrective action.

Keep the sample method, findings, responsible people, agreed action and evidence of the follow-up review.

Sources: **R1**: IMS indicators 156–162

Separate the measures in a record review

Invented sample: 40 discharged patient records. These figures are for learning, not a PHC score.

Measure	Calculation	Meaning
Summary present	36 ÷ 40 × 100 = 90%	Four sampled records lack a discharge summary.
Summary complete among those present	30 ÷ 36 × 100 = 83.3%	Six existing summaries miss at least one required element.
Complete summary in all sampled records	30 ÷ 40 × 100 = 75%	Only 30 of the 40 records meet this combined check.

State the denominator. A small sample does not prove the same percentage applies to every hospital record.

TEACHING CASE | Illustrative material is identified in the text.

Assign actions that address the cause

Use the review to improve care and the record, without manufacturing earlier evidence.

Finding	Useful action	Evidence to review
Missing discharge details	Review the form, workflow and responsible clinical team.	A later sample with the required content.
Untraceable authors	Correct account and signature controls; train staff.	Identifiable authors in sampled entries.
Missing paper files	Check movement logs, storage and overdue returns.	Retrieval performance and unresolved cases.
Unauthorised access	Restrict the risk and investigate the access route.	Corrected permissions and reviewed logs.

A corrected template is an action. Better completed records show whether that action worked.

WORKING METHOD | Illustrative material is identified in the text.

TEACHING CASE

Four requests arrive on the same morning

Invented hospital example: the records officer asks the MS for direction.

Request	What is known
Patient request	A patient seeks a copy of their recent discharge record through a verified channel.
Relative request	A caller claiming to be the patient’s brother asks for the complete file by personal email.
RTI request	A citizen asks for service totals and a list naming every patient treated last month.
Preservation concern	A complaint concerns a record included in a proposed routine disposal list.

What can be processed, what needs verification, and what information must be preserved?

TEACHING CASE | Illustrative material is identified in the text.

TEACHING CASE

Give a separate decision for each route

Record the basis and next action instead of issuing one blanket answer.

1	**Patient copy**	Process through the approved patient-access route after identity and record checks.
2	**Relative request**	Verify authority and scope before release. The claimed relationship and personal email are insufficient.
3	**RTI request**	Send to the PIO. Consider service totals separately from identifiable patient information and apply section 13.
4	**Disposal list**	Remove the relevant material from disposal and arrange a documented preservation hold.

The hospital can support access to information while protecting confidential records and preserving evidence.

Sources: **R2**: sections 7, 11 and 13

Practise the three decisions

Write your answer and the reason before turning to the next page.

1. The changed entry

A user asks IT to erase the earlier version of a note because the new version is more accurate.

What should happen to the correction and the earlier record?

2. The review result

A sample contains 50 records. Forty-five have a summary; 36 summaries have all required fields.

Calculate completeness among summaries and among all records.

3. The scanned archive

Paper records have been scanned. No approved disposal schedule or hold check is available.

Can the store be cleared because an electronic copy exists?

Explain the relevant control, the information still needed and the responsible decision-maker.

TEACHING CASE | Illustrative material is identified in the text.

Answers and reasons

Use the evidence, the calculation and the cited source.

1. Preserve the correction history

Use the authorised amendment process, retain the earlier version and identify author, time and reason. Check whether care was affected; do not silently erase the history.

2. Use the correct denominator

36 ÷ 45 × 100 = 80% of existing summaries are complete. 36 ÷ 50 × 100 = 72% of all sampled records have a complete summary. These are different measures.

3. Scanning is insufficient

No. Verify the scan quality, applicable retention duties, holds and competent disposal authority before destroying originals. Electronic form alone does not establish those conditions.

A good answer identifies both the required action and the evidence that supports it.

Prepare a practical records-control brief

Use a non-confidential real case or the invented examples in this lecture.

Review sample

Choose a justified sample and check identity, authorship, content and retrieval.

Release case

Use an invented request to document identity, authority, scope and delivery.

Retention check

Map one record category to its schedule, custodian and preservation holds.

Review with records, clinical, IT and legal leads: what is confirmed, what remains unresolved, who will act and by when?

Use anonymised findings. The brief should help the competent authority make a clear decision.

WORKING METHOD | Illustrative material is identified in the text.

Sources and continued use | 1

Select a source title or its official-source link to open the document.

R1

Minimum Service Delivery Standards for Hospitals 2024

PHC Category I manual: IMS standards 28–30, indicators 144–162; PRE indicator 72 and MOM indicators 53–54. Read the applicable edition and later directions.

Punjab Healthcare Commission | **Official source**

R2

Punjab Transparency and Right to Information Act 2013

Sections 7–13: information officers, records, requests, time limits and exceptions. Section 16 addresses deliberate obstruction through destruction of requested information.

Government of Punjab | official Health Department copy | **Official source** | **Punjab Laws**

R3

Electronic Transactions Ordinance, 2002

Sections 3–9, 12 and 16: recognition, integrity, retention, signatures, certified copies and public-authority procedures. This is not an automatic destruction permission.

Ministry of Law and Justice | Pakistan Code | **Official source**

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Sources and continued use | 2

Select a source title or its official-source link to open the document.

R4

Revised Code of Ethics: official announcement, 2 March 2026

PM&DC confirms the revised Code and its emphasis on safety, dignity, confidentiality and informed consent. This announcement is not a substitute for the operative Code.

Pakistan Medical and Dental Council (PM&DC) | **Official source**

R5

Patient filming: official statement, 30 March 2026

PM&DC statement on recording patients without consent and the implications for dignity and confidentiality. Used for this narrow principle, not as a full disclosure code.

Pakistan Medical and Dental Council (PM&DC) | **Official source**

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