College of Physiotherapists of Manitoba

PRACTICE DIRECTION

Current and updated as of: September 17, 2024

4.39 Privacy and Record Retention

Standard

The physiotherapist maintains client privacy and confidentiality in compliance with the requirements of the privacy legislation relevant to their practice.

Expected outcome

Clients can expect that:

A. The physiotherapist will limit their collection of personal information to that which is needed to provide physiotherapy services.

B. Their physiotherapy records are confidential, and their private information will be collected, used, and shared with the highest degree of anonymity possible.

C. They will know when their private information is collected, who will have access to it, how it is used, how it is protected, and conditions for its disclosure.

D. Their consent for information collection, access, use and disclosure will be sought when required by applicable privacy legislation.

Performance expectations

The physiotherapist must:

Confidentiality:

E. Protect the privacy of private client information in all environments, regardless of the format of information collection (written, verbal, photo, video).

F. Be attentive to the physical environment during client assessment, treatment, and education and proactively addresses privacy risks including the risk of being overheard when discussing private health information.

Collection:

G. Collect only the relevant and necessary individually identifying health information required to provide physiotherapy services.

Consent

H. Obtain client consent for collection, use and disclosure of health information unless authorized by relevant legislation to do so without consent.

I. Clearly discloses instances where audio or video recordings are generated in the practice setting and obtains client consent for audio or video recording of physiotherapy treatment sessions.

Access and Amendment

J. Access only relevant individually identifying health information when providing physiotherapy services for the client.

K. Grant client's access to their own individually identifying health information within the time period specified by relevant legislation.

L. Have clear processes for making corrections to health information.

M. Provide a copy of the complete clinical and financial record to the client or their authorized representative, and to third parties with client consent or when required by relevant legislation.

N. Establish fees for access to client health records that are consistent with the requirements of applicable legislation, reflect the costs of providing the record, and which are consistent.

Use and Disclosure:

O. Use individually identifying health information only for the purposes for which the information was collected.

P. Make a reasonable effort to confirm that all correspondence with or regarding clients is sent to the intended recipient.

Security Retention and Disposition

Q. Prevent unauthorized access or use of client information while in use, storage or during transfer, through the appropriate use of physical, technical, and electronic security mechanisms.

R. Report privacy breaches (e.g. unauthorized access or use or private information) to the appropriate individual(s), and contribute to privacy breach investigation, mitigation, and

remediation in accordance with organization policies, role-based responsibilities, and legislative requirements.

S. Retain client clinical and financial records for seven (7) years after the last date of service.

    - Clinical and financial records made while the client was a minor are retained until the minor reaches twenty-five (25) years of age

T. Retain records in a manner that enables a complete copy, or any component of the record to be retrieved and copied upon request, regardless of the media (paper or electronic) used to create the record.

U. Ensure contractual agreements are in place any time a third party is engaged to process, store, retrieve or dispose of health information or provide information technology services, and that the terms of the agreements address ongoing access, security, use and destruction of client information for the duration of the required retention period.

V. Dispose of records (e.g., electronic, paper) in a manner that maintains privacy and confidentiality of personal information.
    - Physiotherapists must have clear policies for completely deleting electronic health information and ensure the database system fully removes data.

W. Take action to prevent abandonment of client records.

X. Ensure the retention, accessibility, and security of client records in the event that the physiotherapist is unable to continue as custodian of client records (e.g., in the case of retirement, closing a practice)

Records Available to the College

Y. Allow all records and documents to be available for inspection or copying by a person appointed for the purpose under The Physiotherapy Act.

Z. Not charging a fee for any copies of any records requested by the college.

Definitions

Abandonment of records – the act of leaving behind records without providing for their ongoing security and protection for the duration of the mandatory retention period. This occurs in instances where the physiotherapist fails to actively provide for the secure retention, ongoing access and appropriate destruction of records when leaving a practice or retiring or fails to have contingency plans in place to address records management when leaving and practice or retiring or fails to have contingency plans in place to address records management when faced with unexpected illness.

Related Standards:

- Documentation
- Client Records When Closing/Moving/Selling a Clinic