



Retention of Patient Records & Confidentiality

Patient health information is highly confidential and must always be handled with care, even after a patient has left the medical centre or is deceased.

Storage & Security

- **Electronic Records:** Must be stored in a password-protected system with secure backups to prevent data loss.
- **Hard Copy Records:** Should be securely stored, away from public areas, and easily accessible when required.

Retention Period

- Patient records must be retained for a **minimum of 10 years and one day** from the date of the last patient encounter.
- Enrolment forms must be kept for **10 years** from the last date a payment was claimed. A legible electronic copy of the signed form meets this requirement.
- Enrolment and dis-enrolment records should be **readily retrievable for audits** and may be stored with medical records or in separate files.
- Retaining records **beyond the minimum period** is recommended for patients with complex or long-term conditions, including pediatrics, psychiatry, obstetrics, gynecology, and orthopedics.

Destruction of Records

- Patient records must be destroyed in a **secure and confidential** manner, such as **shredding or burning**.
- A professional document destruction service may also be used.

Access & Transfer of Records

- Patients (or their representatives) are entitled to copies of their records **at no charge**, unless a request has already been made within the past year. Exceptions apply to **video recordings, x-rays, and CAT scans**.
- Patient records **must not** be withheld due to outstanding payments or commercial disputes.

Links to further information

[Health \(Retention of Health Information\) Regulations 1996](#)

[Medical Council of New Zealand: Current Standards](#)

[Medical Council of New Zealand: Managing Patient Records](#)

[The Privacy Commissioner](#)

[Te Whatu Ora](#)