Information and Privacy Commissioner,
Ontario, Canada

Commissaire à l'information et à la protection de la vie privée,
Ontario, Canada

PHIPA DECISION 76

Complaint HA17-92-2

Dr. Theresa Chow

November 28, 2018

Summary: An individual sought access to her records of personal health information from a former physician. The physician issued a decision granting access to the responsive records in their entirety. The individual filed a complaint with this office regarding the physician's decision on the basis of her belief that additional records should exist. The sole issue in this complaint is whether the physician conducted a reasonable search for responsive records. In this decision, the adjudicator upholds the search as reasonable and dismisses the complaint.

Statutes Considered: *Personal Health Information Protection Act, 2004*, SO 2004, c 3, Sched A, as amended, section 54.

Decisions Considered: PHIPA Decision 18.

BACKGROUND:

[1] The complainant submitted a request to her former physician, the health information custodian (the physician), under the *Personal Health Information Protection Act* (*PHIPA* or the *Act*), seeking access to her records of personal health information. In response, the physician issued a decision granting access to "the consultation and follow up visits from Feb 10, 2010 to Aug 11, 2010."

[2] Upon receipt of the disclosed records, the complainant filed a complaint with this office concerning the physician's decision. The complainant maintains that some of the records she received are incomplete and/or missing.

[3] During the mediation stage of the complaint, the complainant clarified her concerns and provided details about the information that she believes is missing from the disclosed records. Subsequently, the mediator asked the physician to respond to the following questions resulting from discussion with the complainant:

1. Confirm that you, as the health information custodian, conducted a search for records responsive to the complainant's request and provided the complainant with access to all such records.

2. Regarding the laboratory report dated February 23, 2010, is there a page two of this report?

3. Do you have in your custody a copy of the requisition for the February 23, 2010 laboratory report?

4. Do you have in your custody any other documentation of the complainant's blood work results from February 23, 2010?

5. Do you have in your custody copies of pages one through three of a fax dated November 6, 2009, sent from [a university health clinic] to you? The information provided consists of a page labelled "p. 4", but there are no other pages included.

6. For the February 10, 2010 fax which consisted of one page, are there additional pages?

7. Do you have in your custody a copy of page one of a fax dated April 27, 2010, sent from [a university health clinic] to you? The information provided consists of a page labelled "p. 2", but there are no other pages included.

8. Do you have in your custody a copy of a fax dated April 28, 2010, sent by you to the [university health clinic]? The complainant explained that her records from [a university health clinic] state that they received a fax from you on April 28, 2010.

9. Were you ever instructed not to provide the complainant with access to some of her health records? If so, please explain.

[4] In addition, the physician was asked to respond to the complainant's concerns that there appears to be a separate file about her at the physician's office and that the file she reviewed with the physician's staff member did not contain her recent *PHIPA* request form and her letter requesting a fee waiver. The complainant also requested any other information regarding inquires about, and disclosure of, her personal health information to any parties.

[5] In response, the physician provided a list of the documents contained in the complainant's medical record. The physician stated that the list comprised of all of the

records in her possession, and that all of the documents had been provided to the complainant.

[6] The physician's response also addressed each of the items identified by the complainant, stating:

1. All records are stored in the patient charts, which are filed alphabetically by surname and stored in a cabinet in her office. The physician retrieved the complainant's file and copied all of its contents. Medical records are not stored anywhere else in her office and there is no separate file in relation to the complainant.

2. The laboratory report dated February 23, 2010 has only one page. The physician's practice is to only file pages containing substantive information in the patient's record. If there was a second page that did not contain substantive information, it would not have been included in the patient's record, but would have been shredded.

3. The requisition for the bloodwork dated February 23, 2010 was given to the complainant when she was sent to do the test and was not copied or maintained in the patient's record. This is the physician's standard practice.

4. The physician does not have any additional documentation of the complainant's blood work results from February 23, 2010. The physician's practice is to only file pages containing substantive information in the patient's record; pages consisting of non-substantive information would be shredded.

5. Regarding the fax that only included the page labelled "p. 4," the physician does not have copies of pages one through three. The physician's practice is to only file substantive medical records; fax cover pages and blank fax pages are not retained in the patient's file.

6. The physician has only one page dated February 10, 2010, which is the Patient History Form.

7. The physician does not have a copy of page one of a fax dated April 27, 2010, sent from [a university health clinic]. The physician's practice is to only file substantive medical records; fax cover pages and blank fax pages are not retained in the patient's file.

8. The physician does not have a copy of a fax dated April 28, 2010, sent from the physician to [a university health clinic].

9. The physician was not instructed to deny the complainant with access to some of her health records. The only request the physician received for the complainant's records was from the complainant.

[7] The physician's responses were shared with the complainant. The complainant was not satisfied and asked to move the matter to the adjudication stage of the complaint process.

[8] Since a mediated resolution was not possible, the file was transferred to the adjudication stage. Given the responses provided by the physician during mediation, I decided to begin my review by sending a Notice of Review to the complainant, inviting her submissions on the issue of reasonable search. I received written representations from the complainant, the non-confidential portions of which were shared with the physician.[1] I invited the physician to provide written representations in response to the issue of reasonable search set out in the Notice of Review as well as in response to the complainant's submissions. Reply and sur-reply representations were also sought and received from both parties.

[9] For the reasons that follow, I uphold the physician's search for records as reasonable and dismiss the complaint.

DISCUSSION:

Did the physician conduct a reasonable search for records responsive to the complainant's request?

[10] The sole issue I must decide is whether the physician conducted a reasonable search in this complaint. Since the complainant claims that additional records exist beyond those identified by the physician, I must decide whether the physician conducted a reasonable search for records as required by sections 53 and 54 of *PHIPA.* If I am satisfied that the search carried out was reasonable in the circumstances, I will uphold the physician's decision. If I am not satisfied, I may order further searches.

[11] Section 54 of *PHIPA* is relevant when reviewing the adequacy of a health information custodian's search for records responsive to a request. This section states, in part:

> (1) A health information custodian that receives a request from an individual for access to a record of personal health information shall,
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> > (a) make the record available to the individual for examination and, at the request of the individual, provide a copy of the record to the individual and if reasonably practical, an explanation of any term, code or abbreviation used in the record;

[1] Portions of the complainant's representations were withheld in accordance with in *Practice Direction Number 3* of the IPC's *Code of Procedure for Complaints under PHIPA.*

> (b) give a written notice to the individual stating that, after a reasonable search, the custodian has concluded that the record does not exist, cannot be found, or is not a record to which this Part applies, if that is the case.

[12] The issue of whether a health information custodian has conducted a reasonable search for records under the *Act* has been addressed in several orders issued by this office.[2] In PHIPA Decision 18, Adjudicator Catherine Corban concluded that the principles established in reasonable search orders issued under the *Freedom of Information and Protection of Privacy Act* and the *Municipal Freedom of Information and Protection of Privacy Act* are relevant in determining whether a custodian has conducted a reasonable search under *PHIPA*. As the access provisions in all three acts are substantially similar, Adjudicator Corban adopted the search principles discussed in *FIPPA* and *MFIPPA* orders for the purpose of determining the issue of reasonable search under *PHIPA*. Subsequently, this approach has been adopted and applied in more recent *PHIPA* decisions,[3] and I adopt it for the purposes of this complaint.

Representations

[13] The complainant takes the position that she was provided incomplete access to her records of personal health information. Due to the length and confidential nature of the complainant's submissions, I have not summarized the entirety of her position below; however, I have taken her representations as a whole into consideration in deciding the issue before me.

[14] The complainant expresses concern that the physician's practice does not support patients' right of access to their records of personal health information. For example, she submits that before allowing her to review her file in person, staff at the physician's office took the file into an empty office where she could not see what they were doing. The complainant submits that this "strongly suggests that [the staff member] removed items before [she] was permitted to view [her] chart."

[15] The complainant revisits the issue of missing fax pages. Again, she questions why only page 4 of a fax dated November 6, 2009, was provided. She also submits that the physician's handwritten notes for May 17, 2010 refer to information in the referral note, but notes that the information is not included on the page that was disclosed to her. Further, she submits that the same handwritten notes indicate that an ultrasound was ordered, but maintains that she was not provided access to any records about an ultrasound.

[16] The complainant notes that the physician's responses during mediation refer to documentation related to her access request. She submits that she did not receive copies of these documents. She also submits that she did not receive a copy of the

[2] See, for example, PHIPA Decisions 18, 43, 48, 52, 57, and 61.
[3] See, for example, PHIPA Decisions 43, 48, 52, 57, and 61.

Ministry of Health "Health Numbers Release" form that she knows to be included in her file.

[17] The complainant's representations also include a number of questions following up on the physician's responses provided during mediation. For example, the complainant asks where her records of personal health information were stored before her access request; why the physician refused to transfer the records to her treating physician, despite her consent; whether there were any instructions on her file regarding to whom records could be disclosed; whether the physician received "input" from any parties other than a named health clinic during the time that she was in her care; whether there were any inquiries made about her at any time; whether there were any prior disclosures of her personal health information; whether her file contains records after August 11, 2010; and whether any additional documents had been added to her file since her access request.

[18] In response, the physician submits that she has complied with her obligations under the *Act*, has performed a reasonable search for records, and has provided the complainant with the complete medical record maintained by her office. She submits that she has no objections to providing the complainant with a copy of her medical records.

[19] The physician submits that she did not contact the complainant to clarify the request, as she understood her to be requesting copies of her medical records on file, as is common in the medical field. However, the physician submits that upon receipt of the request, her secretary contacted the complainant to determine where the records would be stored based on the size of the file and the dates of her visits. The physician submits that each patient has only one file folder (subject to size) which is stored alphabetically by surname. The physician explains that older records are kept in storage in her office, while newer/current patient files are kept in the reception area. The physician maintains that following that conversation with the complainant, her secretary was able to locate the complainant's chart, which "is not large and is contained in one file folder."

[20] The physician maintains that since 2014, she has used a combination of paper and electronic medical records (EMR). The physician explains that out of an abundance of caution, she also searched her EMR for records relating to the complainant. The physician advises that the search produced no records, which she believes is appropriate given that she treated the complainant prior to 2014.

[21] The physician submits that it is not possible that responsive records existed but no longer exist. She also submits that it is not possible that responsive records exist which are not in her possession, as her patient files are not maintained anywhere else. The physician notes that the complainant will have medical records with other health information custodians, but those records are not in her possession.

[22] Regarding the complainant's concerns about the fax records in her chart, the physician explains again that she only files faxed information that contains personal health information. Any blank pages or "non-substantive" information, such as fax cover sheets, are securely shredded.

[23] In response to the complainant's concern about the physician's handwritten notes, the physician clarifies what the notation states and explains that it does not, in fact, refer to a referral source. The physician also explains that while she ordered an ultrasound on May 17, 2010, the requisition form would have been provided to the complainant, who is then responsible for attending a laboratory to undergo the procedure. The physician maintains that she did not receive an ultrasound report from a laboratory, which suggests that the complainant did not attend for an ultrasound.

[24] The physician submits that she has no record of previous access requests from the complainant or her physician in 2011. The physician notes that she did receive a request for the complainant's bloodwork from a university health clinic on April 22, 2010, which was stamped as being responded to on April 27, 2010. The physician submits that the evidence of this request and its response in the complainant's chart demonstrates the physician's practice of responding to record requests promptly and keeping copies of such requests in the patient file.

[25] The physician submits that she provided the complainant with all records related to her medical care, but did not necessarily disclose administrative records. For example, regarding the records related to the complainant's access request, the physician submits that, "intuitively, it was not understood that the access request at issue (the purpose for which these documents were prepared after the request was received), were also subject to the access request." The physician maintains that this information is either already in the complaint's possession or was collected to facilitate the handling of the access request. Accordingly, the physician did not disclose those records to the complainant. Similarly, with reference to the Health Number Release Form, the physician explains that it is a generic administrative document for billing the Ontario Health Insurance Plan. She submits that the document was not provided in response to the complainant's access request, as it is not related to her medical care. The physician explains that the document contains demographic information only, and nothing related to the provision of medical care. Regardless, the physician has offered to provide the complainant with copies of these records upon request.

[26] The physician also responds to questions raised in the complainant's submissions. For example, the physician submits that she would not have told the complainant or any physician with appropriate consent that they could not request the complainant's medical records. The physician submits that, with the exception of the bloodwork request mentioned above, no transfer of the complainant's records has occurred, nor has there ever been a request from anyone other than the complainant. The physician maintains that she has not had any discussions about the complainant with any other individuals, and has no reason to withhold information.

[27] In response to the physician's submissions, the complainant indicates that she will request the records considered to be administrative in nature from the physician's legal counsel; however, she maintains that she is still concerned about being provided incomplete access to her records. The complainant asks whether the physician has excluded records after August 11, 2010, and whether there are additional records in her chart that the custodian considers to be non-responsive to her request.

[28] With respect to the November 6, 2009 fax, she submits that it is reasonable to assume that a fax would have a one-page cover sheet, but maintains that the physician has not explained why her chart does not include pages 2 and 3.

[29] With respect to the handwritten notes, the complainant expresses appreciation for the physician's explanations, but maintains that they only address the examples provided in her representations. The complainant submits that she has additional reasons for believing additional information exists that has not yet been provided.

[30] Finally, regarding records that the physician claims are not in her possession, the complainant asks whether the physician is treating records received from other sources as being outside her authority to disclose in response to an access request.

[31] By way of sur-reply, the physician offered the a few points of clarification. First, the physician maintains that the complainant's file now contains the following documents:

- Patient History Form, dated February 10, 2010 (1 page);
- MDS Laboratories Lab Data, dated October 19, 2009 (1 page);
- [Named university health clinic] Letter dated November 5, 2009 (1 page);
- The physician's office visit notes (3 pages);
- [Named laboratory] data dated February 23, 2010 (1 page);
- [Named university health clinic] request for bloodwork (1 page);
- [Named laboratory] Histopathology Report reported July 28, 2010 (1 page);
- The physician's letter to [a named doctor] dated March 12, 2010 (1 page);
- Health Number Release Form dated February 10, 2010 (1 page);
- Complainant's request to access personal health information dated June 26, 2017 (1 page);
- The physician's secretary note, undated (1 page);

- Complainant's letter to the physician dated August 8, 2017 (1 page);
- The physician's fax correspondence to the complainant dated August 10, 2017 (1 page); and
- The complainant's handwritten note to the physician, undated (1 page).

[32] The physician maintains that there are no additional records – responsive to the request or otherwise.

[33] At the time the sur-reply representations were submitted, the physician noted that the complainant had not yet requested a copy of the last six pages of administrative records listed above. Again, the custodian offered to make those documents available if requested.

[34] In response to the complainant's questions about the remaining pages from the November 6, 2009 fax, the physician reiterates that her office only files faxed information that contains personal health information. Any other pages of the faxed correspondence containing only non-substantive information are securely shredded. The physician explains that she cannot offer any other information relating to any destroyed fax pages, as she no longer possesses them. However, the physician submits that the pages would not have been shredded if they contained substantive information.

[35] Finally, in response to the complainant's query about her authority to disclose records held by other health information custodians, the physician explains that her submissions were referring to other health information custodians located in their own facilities maintaining their own files and records related to the complainant. The physician explains that she has possession of records received from other health information custodians, and that such records would be included in her files and previously disclosed to the complainant.

Analysis and findings

[36] As the complainant claims that additional records exist beyond those identified by the physician, the issue to be decided is whether the physician conducted a reasonable search for records as required by sections 53 and 54 of *PHIPA*, as described above.

[37] *PHIPA* requires custodians to provide sufficient evidence to demonstrate that they have made a reasonable effort to identify and locate responsive records.[4] A reasonable search is one in which an experienced employee knowledgeable in the subject matter of the request expends a reasonable effort to locate records that are reasonably related to the request.[5] A further search will be ordered if the physician does

[4] Orders P-624 and PO-2559, PHIPA Decision 17 and PHIPA Decision18.
[5] Orders M-909, PO-2469 and PO-2592, PHIPA Decision 17 and PHIPA Decision18.

not provide sufficient evidence to demonstrate that it has made a reasonable effort to identify and locate all of the responsive records within its custody or control.[6]

[38] Based on the evidence before me, I am satisfied that the search conducted by the physician was reasonable and in accordance with her obligations under the *Act*. The physician's representations specify, and I accept, that the scope of the request was clear. I also accept the physician's evidence that she provided all requested records relating to medical care to the complainant. Although the complainant expresses some concern that the physician's administrative staff may have removed items from her file before she was permitted to view it, this does not alter my conclusion on this point. I am satisfied that administrative documents and records relating to the access request were not within the scope of the request, but I note from the physician's representations that the complainant is welcome to access them, upon request.

[39] The physician and her secretary conducted the search for responsive records. I am satisfied that both are experienced employees knowledgeable in the subject matter of the request, and that they understood their responsibility to provide the complainant with access to her medical records.

[40] I acknowledge that the physician's secretary contacted the complainant for information that would assist her in determining where in the office the complainant's hardcopy file would be stored. I also note that despite the fact that the physician did not treat the complainant after 2014, which is the year the physician started using electronic medical records, she searched her EMR system to determine whether it contained any responsive records just in case. Based on the physician's representations, I am satisfied that she made reasonable efforts to locate the records requested by the complainant.

[41] Although a requester will rarely be in a position to indicate precisely which records a custodian has not identified, the requester must still provide a reasonable basis for concluding that such records exist.[7] On multiple occasions during the complaint process, the complainant asked about certain pages of records that she believes have yet to be disclosed and the physician explained why those pages were not located. The physician produced a list of all of the documents in the complainant's file and indicated that there would be no other records that might have existed, but no longer exist. As I stated, above, the *Act* does not require the physician to prove with absolute certainty that further records do not exist.[8] I accept the physician's explanation that such pages appear to be missing because they did not contain personal health information and so would have been securely destroyed, rather than filed. I find that the complainant's submissions do not provide a reasonable basis upon which I could conclude that other responsive records might exist, but have not yet been located.

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[6] Order MO-2185.
[7] Order MO-2246, PHIPA Decision 17 and PHIPA Decision18.
[8] Orders P-624 and PO-2559, PHIPA Decision 17 and PHIPA Decision18.

[42] For the reasons outlined above, I am satisfied that the physician has demonstrated that she conducted a reasonable search for records responsive to the complainant's request in compliance with her obligations under the *Act*. On that basis, I uphold the physician's search, and I dismiss the complaint.

ORDER:

For the foregoing reasons, no order is issued.

Original Signed by: November 28, 2018

Jaime Cardy
Adjudicator