

# National Guideline for Filing, Archiving and Disposal of Patient Records in Primary Health Care Facilities



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## FOREWORD



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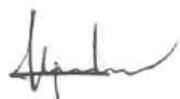
Health facilities must control and manage records according to the legislation promulgated by government to enable healthcare workers to have timely access to accurate and reliable patient information. The legislative provisions in Section 13 of the National Archives and Records Service of South Africa Act, 1996 (Act 43 of 1996) are aimed at promoting sound records management and thereby promoting accountability and better service delivery.

The purpose of this guideline is to explain to healthcare professionals and administrative employees what their records management obligations are in terms of the National Archives and Records Service of South Africa Act.

Patient records form an essential part of a patient's existing and future healthcare needs. As a written collection of information about a patient's health and treatment, they are used essentially for the immediate and continuing care of the patient. If a medical record cannot be located, the patient may come to harm because information, which may be vital for their continuing care, is not available. Proper filing and archiving will reduce the time that patients wait for the retrieval of their records while the correct disposal of records will ensure that only records that are eligible for destruction are destroyed.

Thank you to Ms. Ronel Steinhöbel and Dr. Shaidah Asmall who led the development and completion of this guideline. My sincere gratitude to the National Archives and Records Service of South Africa for providing crucial guidance and inputs during the development of this guideline.

I sincerely thank the national Department of Health programme managers and provincial department of health managers who provided insightful comments and direction to the final guideline.



**MS MP MATSOSO**

**DIRECTOR-GENERAL: HEALTH**

**DATE: 14/12/2017**

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## 1. INTRODUCTION

The purpose of this *Guideline for Filing, Archiving and Disposal of Patient Records in Primary Health Care Facilities* is firstly to give guidance to employees in primary health care facilities on the procedures to follow to ensure that patient records are stored safely and filed in a systematic and orderly manner so that it can be retrieved in the most efficient manner possible. Secondly, the guideline gives guidance to employees on archiving and disposal of patient records to ensure that there is sufficient space available for filing of patient records and that regulatory requirements regarding the disposal of records are adhered to.

The content of this guideline is based on Section 13 of the National Archives and Records Service of South Africa Act, 1996 (Act 43 of 1996). The first draft was developed and circulated to relevant provincial and district managers for input. Comments were incorporated into draft two. Draft two was further refined through written communication with provincial heads of health and presentations to the management committee of the national Department of Health as well as the National Health Information Systems for South Africa Committee.

Provincial and district offices should use this guideline to develop their own provincial or district specific guideline for filing, archiving and disposal of patient records. Where provincial legislation allows for provincial procedures for the filing, archiving and disposal of patient records, the requirements as set out in the provincial procedures must be followed.

## 2. DEFINITIONS

**Patient record:** Any relevant record made by a healthcare professional at the time of/or subsequent to a consultation and/or examination or the application of health management. A health record contains the information about the health of an identifiable individual recorded by a healthcare professional, either personally or at his/or her direction.

The following documents can be regarded as the essential components of a patient record:

- any written notes taken by a healthcare practitioner
  - patient discharge summary or summaries
  - referral letters to and from other healthcare practitioners
  - laboratory reports
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- laboratory evidence such as histology sections, cytology slides and printouts from automated analysers, X-ray films and reports, electrocardiography (ECG) traces, etc.
- audiovisual records such as photographs, videos and tape-recordings
- clinical research forms and clinical trial data
- other forms completed during the health interaction such as insurance, legal, consent, prescription chart and administrative forms
- death certificates and/or autopsy reports<sup>1</sup>

**Record storage room:** The room where patient records are stored.

**Archives:** A physical space where patient records that have been dormant/inactive for two or more years (24 months from the date of the last entry in the record) are stored.

**Archiving:** The act of determining and removing patient records from the records storage room that have been dormant/inactive for two or more years (24 months from the date of the last entry in the record) to the archives.

**Disposal:** The action of destroying a record.

**Disposal authority:** A written authority issued by the National Archivist specifying which records should be transferred into archival custody or specifying which records should be destroyed/deleted or otherwise disposed of.

**Disposal authority number:** A unique number identifying each disposal authority issued to a specific governmental body.

**Record classification system:** A plan for the systematic identification and arrangement of business activities and/or records into categories according to logically structured conventions, methods and procedural rules represented in the classification system.

**Retention period:** The length of time that records should be retained by governmental bodies before they are either transferred into archival custody or destroyed/deleted.<sup>2</sup>

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<sup>1</sup> Guidelines on the keeping of patient records, Health Professionals Council of South Africa, May 2008, p1.

<sup>2</sup>Records Management Policy Manual, National Archives and Records Service of South Africa, First Edition, Version 1.4, October 2007.

### 3. STATUTORY AND LEGISLATIVE FRAMEWORK

The statutory and regulatory framework that sound records management is founded in:

#### 3.1 Constitution of the Republic of South Africa, 1996 (Act 108 of 1996)

Section 195 of the Constitution provides, amongst others, for the:

- effective, economical and efficient use of resources
- provision of timely, accessible and accurate information; and requires that
- the public service must be accountable

#### 3.2 The National Archives and Records Service of South Africa Act, 1996 (Act 43 of 1996) as amended

Section 13 of the act contains specific provisions for efficient records management in bodies. It provides for the National Archivist to:

- determine which record keeping systems should be used by governmental bodies
- authorise the disposal of public records or their transfer into archival custody
- determine the conditions
  - according to which records may be microfilmed or electronically reproduced
  - according to which electronic records systems should be managed

The regulations for the act are set out in the National Archives and Records Service of South Africa Regulations (R1458 of 20 November 2002). Part V: Management of Records contains the specific parameters within which the governmental bodies should operate regarding the management of their records.

#### 3.3 Protection of Personal Information Act, 2013 (Act 4 of 2013)

The purpose of Section 2 of the act is to give effect to the constitutional right to privacy, by safeguarding personal information when processed by a responsible party, subject to justifiable limitations that are aimed at:

- (i) balancing the right to privacy against other rights, particularly the right of access to information
  - (ii) protecting important interests, including the free flow of information within the Republic and across international borders.
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### **3.4 Promotion of Access to Information Act, 2000 (Act 2 of 2000)**

The Promotion of Access to Information Act, (PAIA), which flows from Section 32 of the Constitution, gives effect to the constitutional right of access to any information held by the State and any information held by any other person, provided that such information is required for the exercise or protection of any rights.

### **3.5 Provincial archives and records acts**

Eight of the nine provincial departments have a Provincial Archives and Records Act. The following provincial departments have provincial acts in place:

#### **3.5.1 Eastern Cape**

Provincial Archives and Records Service Act of the Eastern Cape, 2003 (Act 7 of 2003)

#### **3.5.2 Free State**

Free State Provincial Archives Act, 1999 (Act 4 of 1999)

#### **3.5.3 Western Cape**

Provincial Archives and Records Service of the Western Cape Act, 2005 (Act 3 of 2005)

#### **3.5.4 Gauteng**

Gauteng Provincial Archives and Records Service Act, 2013 (Act 5 of 2013)

#### **3.5.5 Northern Cape**

Northern Cape Provincial Archives and Records Service Act, 2013 (Act 7 of 2013)

#### **3.5.6 KwaZulu-Natal**

KwaZulu-Natal Archives and Records Service Act, 2011 (Act 8 of 2011)

#### **3.5.7 Mpumalanga**

Mpumalanga Archives Act, 1998 (Act 14 of 1998)

#### **3.5.8 Limpopo**

The Limpopo Province Archives Act, 2001 (Act 5 of 2001)

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## 4. VALUE OF RETAINING PATIENT RECORDS

Patient record must be retained to:

- provide clinical data
- further effect the diagnosis and/or ongoing clinical management of the patient
- conduct clinical audits
- promote teaching and learning
- be kept as direct evidence in litigation or for occupational disease or injury compensation purposes
- be used to further research by providing research data
- promote good clinical and laboratory practices
- make case reviews possible<sup>3</sup>

## 5. RESPONSIBILITIES

Specific responsibilities must be assigned to employees to ensure the effective management of patient records that include the archiving and disposal of records.

These responsibilities are set out in sections 5.1 to 5.4.

### 5.1 Provincial head of health

The provincial heads of health must:

- develop and publish a provincial policy/guideline to ensure that all patient records receive appropriate physical care, are protected by appropriate security measures and are archived and disposed of according to the standing orders of the relevant department of health
- comply with all directives and instructions issued by the national archivist
- monitor that certificates of destruction are submitted to the provincial archivist as prescribed
- report to the provincial archivist without delay all cases of serious damage, loss or unauthorised destruction of that body's records
- appoint a departmental records manager to ensure that the province-wide policy/guideline for record management is implemented

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<sup>3</sup> Guidelines on the keeping of patient records, Health Professionals Council of South Africa, May 2008, p1.

## 5.2 District manager

The district manager must:

- establish a record management support unit to:
  - give guidance to facilities regarding the management of patient records
  - assist facilities with archiving and destroying patient records
  - ensure compliance with the act and all other legislation pertaining to record management
- assign an official as the designated records manager at every facility

## 5.3 Primary health care facility manager

The facility manager must:

- ensure that a health record is created and maintained at the facility for every user of the health service
- set up control measures to prevent unauthorised access to those records and to the storage facility in which, or system by which, records are kept
- take responsibility for the management of the records (filing, archiving and disposal) of the facility
- assign administrative employees to manage records at reception and filing
- arrange that an annual clean-up of the records storage room takes place by archiving and disposal of the eligible records
- ensure that all employees (administrative and clinical) respects the right to privacy and confidentiality when it comes to patient records
- ensure where possible that patients do not carry their own files

## 5.4 Administrative employees

The administrative employees assigned to reception and filing must manage records at reception and the records storage room in the following manner:

- ensure access control to medical records and the confidentiality of patient information is maintained at all times
  - where an electronic record system is in place, capture the data and follow processes according to the standard operating procedure of the specific electronic record system
  - retrieve records ahead of time according to patient appointments
  - issue records and record all folders issued per day
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- update patient demographic information regularly
- monitor returned records and track outstanding records
- record, track and merge temporary records
- record, track and recover loaned/removed records
- issue temporary records when the original is not available/missing
- ensure that all shelves and records are properly labelled as per filing system in use
- open a continuation record once the current record is full (where booklets are used) or the folder is thicker than three centimetres
- where folders are used, replace broken folder covers
- check the shelves regularly for duplicate or misfiled folders
- ensure that the records storage area is regularly tidied and cleaned
- undertake the annual clean-up of the records storage room under the supervisions of the primary health care facility manager

## 6. FILING OF PATIENT RECORDS

The filing of patient records must be done systematically, using a standard record registration system and it must be stored in a record storage room that adheres to requirements for records storage areas.

### 6.1 Storage space for patient records

Patient records should ideally be stored in a single location that is in close proximity to the patient registration desk. The location for storing of patient records will hereafter be referred to as the patient record storage room. Patient records must be stored in a safe, lockable place, protected from external and internal deterioration and if they are in electronic format, safeguarded by passwords.

The patient record storage rooms must:

- have a security gate
  - have a fire-proof door and roof
  - have a fire extinguisher
  - not be near water pipes as these may leak, burst or flood the area (this includes the registry or other record storage areas)
  - preferably have very small windows. In instances where there are big windows, dark blinds must be installed and kept closed as sunlight is harmful to records
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- have shelves or cabinets that are made of coated metal. Wooden shelving should be avoided, as it can release harmful vapours, contribute to the spread of fire and may harbour insects. The lowest shelf should start at least 100 mm off the floor to prevent flood damage, the top of the shelving should not be less than 320 mm from the ceiling to allow airflow
- have aisles and shelves labelled correctly according to the approved standardised filing system
- have a counter and or a sorting table
- have proper lighting
- have an air-conditioner to ensure that the temperature is maintained below 18 to 20 degrees Celsius
- be kept clean and dust free as this can be harmful to records
- be free of rodents and other pests<sup>4</sup>

## 6.2 Record registration system

Every facility must have a standardised record registration system. Any of the following methods can be used to generate a unique registration number for each patient record:

- surname of patient
- identity document number or date of birth of patient
- a set of numbers or alphabet letters or a combination of the two. The unique number can be generated manually or electronically in cases where an electronic patient registration system is in place

The unique registration number must be clearly indicated on every patient record.

## 6.3 Access to the records room

The records room must be locked at all times and only employees that are authorised to access the record storage room may enter the room. In facilities where electronic records are kept, access must be restricted by password protection. Where employees other than those appointed by the Department of Health requires access to patients records (electronic or paper), such access must be approved in writing by the district office and the facility manager.

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<sup>4</sup> Records Management Policy Manual, National Archives and Records Service of South Africa, First Edition, Version 1.4, October 2007.

## 6.4 Filing and tracking of patient records

It is the responsibility of administrative employees working at reception to file-back patient records into the filing system after the designated person has consolidated all patient records used for the day.

Each record must be checked against the day's patient registration list to ascertain the return of each record to reception, see **Annexure A** as an example.

All electronic records must be saved and backed-up as stipulated in the standard operating procedure of the specific health information software applications in use at the facility.

## 6.5 Handling of patient records that were not returned to registration/reception

In the event of a patient record that has not been returned to reception by the patient, the following must be done:

Report the incident to the facility manager. The facility manager must ensure that the following is done (can delegate an employee to do the task but facility manager must receive a report):

- contact the patient telephonically (if patient has a telephone/cell phone), to determine why the patient record has not been returned to reception
  - if the patient, for some reason, left the record in some other area in the facility, he/she must explain exactly the location in the facility where the record has been left
  - if the patient removed the record from the facility, he/she must be requested to return the record to the facility within one day
  - if the patient is unable to return the record within one day's time or does not return the record after agreeing to do so, arrangements must be made with the ward-based outreach team (WBOT) member responsible for the area where the patient resides, to retrieve the record from the patient's home and return it to the facility
  - in the event of a patient that cannot be reached by phone or who refuses to return the record to the facility, the police must be contacted to retrieve the record from the patient
  - if the patient refuses to hand over the record to the police, the facility manager must report the incident to the district manager via his/her supervisor, in the form of a written report. The district manager must lay a formal charge of theft against the patient at the police station.
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## 6.6 Handling of pre-retrieved records of patients who did not turn up for their appointment

The pre-retrieved records of patients who did not turn up for their appointments will enter a grace period of five days. The records must be kept in the box with pre-retrieved records should the patients turn up at the clinic during the grace period.

The records must be placed into the defaulter box should the patient not turn up at the clinic during the grace period to enable the ward-based primary health care outreach team to make a follow-up with the patients. Such records must then be filed back into the filing system.

## 7. ARCHIVING OF PATIENT RECORDS

The filing system must be cleaned up on an annual basis. All records that are dormant/inactive for two years (twenty-four months from the date of the last entry in the record) must be archived in a separate lockable storage space at the facility if there is storage space available. If there is no storage space available, the records must be taken to the provincial/district archives. Records for archiving can also be scanned and stored electronically to save space. A back up of such records must be made at all times. This will allow auditors access to the records when and if needed.

The process to be followed is:

- all records must be sorted, listed, batched and packed
- sort the records according to the type of record set out in section 8.2 of these guidelines for the register for disposal of patient records e.g. general, minor, obstetric records
- minimum information about the patient must be retained; therefore a register should be kept of all patient records that are archived for possible later disposal.<sup>5</sup> See **Annexure B** for an example of the register to be kept for records that will be archived
- the registers should be kept in one file in each primary health care facility and stored in the patient record storage room

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<sup>5</sup> National Archives and Records Service of South Africa act (ACT NO. 43 OF 1996) as amended.

## 8. DISPOSAL OF PATIENT RECORDS

Disposal of records refers to the action of destroying a record. Shredding is considered the best method of disposal of confidential documents.

Patient records that are dormant for six years (from the date of the last entry in the record) should be destroyed.

There are however the following exceptions:

### 8.1 Patient records that must be kept for longer than six years

- For minors under the age of 18 years, health records should be kept until the minor's 21<sup>st</sup> birthday because legally, minors have up to three years after they reach the age of 18 years to bring a claim.
- Obstetric records until the child reached 21 years of age.
- For mentally incompetent patients, including those who have been declared State patients by the courts, the records should be kept for the duration of the patient's lifetime.
- Records where patients were involved in an occupational health and safety incidents must be kept for 20 years according to the Occupational Health and Safety Act, 1993 (Act 85 of 1993).
- Records of patients that work under conditions that take a long period to manifest themselves and may have an impact on their health, e.g. mining and asbestosis, should be kept for a sufficient period of time. The Health Professions Council of South Africa (HPCSA) recommends that this should not be less than 25 years.
- Records where possible claims against the State may arise, must be kept until the matter has been finalised.
- Records of patients that have been enrolled in clinical trials at that facility must be kept for 15 years.
- Records of patients who accessed clinical forensic medicine services must be kept for not less than 25 years for any future request by the criminal justice system.

A balance must be reached between the costs of (indefinite) retention of records (in terms of space, equipment, etc.) and the occasional case where the practitioners' defense of a case of negligence is handicapped by the absence of records. The value of the record for

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academic or research purposes, and the risks resulting from the handling or complications of the case, are additional considerations.<sup>6</sup>

Destruction must take place regularly, but at least once a year. A complete register must be kept of records that are destroyed, see **Annexure C** as an example.

## 8.2 Categories of records

The files should be grouped together on the register according to the category of the file using the following categories:

- general record (that has been dormant for six years)
- records for minors (under the age of 18 year where the patient has reached the age of 21 years and the folder has been dormant for six years)
- obstetric records (where the child has reached 21 years and the record has been dormant for six years)
- occupational health and safety records (that have been inactive for 20 years)
- psychiatric records (where the patient has passed away)
- litigation records (where the case has been finalised and the record has been dormant for six years)
- clinic trial records and data (where the trial has been completed at least 15 years prior to disposal)
- clinical forensic medicine (to be retained for 25 years)

According to the National Archives and Records Service of South Africa Act, no public record under the control of a governmental body shall be transferred to an archives repository, destroyed, erased or otherwise disposed of without the written authorisation of the national archivist.<sup>7</sup> A general disposal authority number has been issued by the national archivist for the disposal of patient records (referred to as clinic patient files in the authorisation), therefore the archivist does not need to approve every application for the destruction of records. For health facilities governed by local government, the general disposal authority number PAK4 and for provincial health departments the general disposal authority number AK2 has been issued<sup>8</sup>.

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<sup>6</sup> Guidelines on the keeping of patient records, Health Professionals Council of South Africa, May 2008, p8.

<sup>7</sup> National Archives and Records Service of South Africa act (ACT NO. 43 OF 1996) as amended.

<sup>8</sup>Records Management Policy Manual, National Archives and Records Service of South Africa, First Edition, Version 1.4, October 2007.



See **Annexure D** for an example of a destruction certificate. The following information must be completed on the certificate:

- disposal authority number (for local government the number PAK4 and for provincial health departments the number AK2 must be used)
- name of the health facility
- name of applicant
- telephone number
- e-mail address
- date
- signature
- description of the folders e.g. general records
- period covered by these folders

The original destruction certificates must be submitted to the respective provincial archivist and a copy must be kept and filed by the facility. It is good practice that the provincial or district office keeps records of the destruction certificates and takes on the responsibility of submitting it to the provincial archivist, instead of letting individual facilities submit their own certificates to the archivist. Proof of receipt by the provincial archivist must also be kept. The register for disposal of patient records must be filed at the facility, together with the destruction certificate for each batch of records that is destroyed.

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**Annexure A: Tracking tool for patient records**

No.	Record number	Full name and surname of patient	Comment	Record retrieved		Appointment attended (only for scheduled appointments)		Record returned	
				Y	N	Y	N	Y	N
<b>07.30-10.00</b>									
1.	2468013579	Mary Saints	CCMDD	Y	N	Y	N	Y	N
2.					N	Y	N	Y	N
3.					N	Y	N	Y	N
4.					N	Y	N	Y	N
5.					N	Y	N	Y	N
6.					N	Y	N	Y	N
7.					N	Y	N	Y	N
8.					N	Y	N	Y	N
9.					N	Y	N	Y	N
10.	1234567890	James Doe	FU	Y	N	Y	N	Y	N
<b>10.15-12.45 (Tea time = 10.00-10.15)</b>									
11.					N	Y	N	Y	N
12.					N	Y	N	Y	N
13.					N	Y	N	Y	N
14.					N	Y	N	Y	N
15.					N	Y	N	Y	N
16.	2345678901	Polly Jacaranda	LR		N	Y	N	Y	N
17.					N	Y	N	Y	N
18.					N	Y	N	Y	N
19.					N	Y	N	Y	N
20.					N	Y	N	Y	N
<b>13.30-16.00 (2.45-1.30)</b>									
21.				Y	N	Y	N	Y	N
22.				Y	N	Y	N	Y	N
23.				Y	N	Y	N	Y	N
24.				Y	N	Y	N	Y	N
25.				Y	N	Y	N	Y	N
26.				Y	N	Y	N	Y	N
27.				Y	N	Y	N	Y	N
<b>Missed appointments (Record all patients who present with 5 working days of a missed appointment)</b>									
28.	5678901234	Zentembe Ndlovu		Y	N	Y	N	Y	N
29.				Y	N	Y	N	Y	N
30.				Y	N	Y	N	Y	N
31.				Y	N	Y	N	Y	N
32.				Y	N	Y	N	Y	N

Complete patient file number

Indicate if the patient's file was retrieved

Indicate if the patient's record was returned to reception for filing

Indicate reason for appointment, e.g. laboratory results (LR), referred for doctor consultation (DR), collection of meds only (CCMDD), regular follow-up (6mth FU). This is done at the time that the appointment is being made

Complete patient's full name and surname

Indicate if the patient attended the appointment (only for scheduled appointment)

At the end of the day indicate how many patients attended their appointments, missed their appointments, records retrieved and records returned

Total number of patients attended	<input type="text"/>	Total number of missed appointments	<input type="text"/>
Total number of records retrieved	<input type="text"/>	Total number of records returned	<input type="text"/>



### Annexure C: Register of records for disposal

Name of facility: \_\_\_\_\_

Official who may be contacted regarding proposed disposal instructions:

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Cellphone number: \_\_\_\_\_

E-mail: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Unique patient record/file number	Name and surname of patient	Period that record was active	
		Date from	Date to
<b>General records</b>			
<b>Records for minors</b>			
<b>Obstetric records</b>			
<b>Occupational health and safety records</b>			
<b>Psychiatric records</b>			
<b>Litigation records</b>			
<b>Clinic trial records and data</b>			
<b>Clinical forensic medicine</b>			

## Annexure D: Destruction certificate

I hereby certify that the records listed below were destroyed on \_\_\_\_\_ (enter date that records were destroyed)

Disposal authority number: \_\_\_\_\_

Name of health facility: \_\_\_\_\_

Name of applicant: \_\_\_\_\_

Telephone: \_\_\_\_\_

Cellphone number: \_\_\_\_\_

E-mail: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Description	Date active from	Date active to

Where a series of case files is destroyed only the first and last date of the group of records is indicated under the date from and to column.

The register for disposal of patient records as indicated on this destruction certificate must be filed together with the destruction certificate at the health facility.

\* Description:

- general record (that has been dormant for six years)
- records for minors (under the age of 18 year where the patient has reached the age of 21 years and the folder has been dormant for six years)
- obstetric records (where the child has reached 21 years and the record has been dormant for six years)
- occupational health and safety records (that have been inactive for 20 years)
- psychiatric records (where the patient has passed away)
- litigation records (where the case has been finalised and the record has been dormant for six years)
- clinic trial records and data (where the trial has been completed at least 15 years prior to disposal)
- clinical forensic medicine (to be retained for 25 years)