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SOP: Health Records Management

1. Purpose

- Ensure health records are managed in line with legal and professional standards.
- Maintain confidentiality, accuracy, security, and proper handling of all records.

2. Scope

- Applies to all staff involved in creating, storing, keeping, or disposing of health records.
- Covers both electronic and manual records.

3. Filing of Health Records

- File records promptly after each consultation or update.
- Use systematic, secure filing systems or electronic databases.
- Always ensure easy and correct retrieval.

4. Confidentiality & Security

- Protect all records from unauthorized access.
- Follow legal requirements for electronic health records (EHRs)
- Use secure passwords, restricted access, and encryption where needed.

5. Retention of Records

- Retain records according to:
- HPCSA Booklet 9
- National Health Act Section 13

- POPIA Section 14
- MPS Guide: Retention & Destruction of Records
- Follow prescribed timelines for each record type.

6. User Access

- Users may access their health records upon request.
- Provide access securely and in compliance with privacy laws.

7. Release to Third Parties

- Only release records with signed user consent or legal authority
- Never show information without proper authorization

8. Archiving

- Archive electronic records securely when not in active use.
- Ensure data is backed up, protected, and retrievable for the full retention period.

9. Disposal of Records

- Dispose of records securely once retention periods end.
- Use approved methods that protect confidentiality.
- Follow MPS retention and destruction guidelines.

10. Review & Approval

- Review the SOP at least every 5 years or when laws change.
- Document must be approved, signed, and dated by the practice owner or authorized person.