LICENCE CONDITIONS
ON THE RETENTION PERIODS OF PATIENT HEALTH RECORDS

IMPOSED UNDER SECTION 13(1) OF THE HEALTHCARE SERVICES ACT 2020

Application

1. These licence conditions ("LCs") on the retention periods of patient health records apply to all licensees licensed under the Healthcare Services Act ("HCSA") ("Licensees").

2. For avoidance of doubt, the defined terms as used in these LCs shall have the meaning ascribed to them in the HCSA and any Regulations made thereunder, unless otherwise stated.

3. A breach of these LCs may result in regulatory action being taken against Licensees under section 20 of the HCSA, including but not limited to:

   (a) suspension or revocation of the Licensee's licence;

   (b) shortening the term of the Licensee's licence;

   (c) directing the Licensee to rectify the contravention, or to prevent a recurrence of the contravention; and/or

   (d) directing the Licensee to pay a financial penalty.

Definitions

4. In these LCs, unless the context otherwise requires:

   (a) "**Assisted Reproduction (AR) Records**" means:
      (i) registers of children conceived through AR procedures and delivered in Singapore, identified by their birth certificate numbers; and
      (ii) patient health records of AR procedures (whether resulting in a live birth or otherwise), including the investigations carried out before the start of the AR treatment, indications for undergoing AR, treatment protocols, data captured from the start of the cycle till the end (e.g. in the case of a fresh cycle: from the date of ovarian stimulation till the confirmation of clinical pregnancy), as well as the outcome and any complications of the AR treatment.

   (b) "**Computerised / Electronic Patient Health Records**" means all Patient Health Records entered into an electronic system and paper Patient Health Records which have been digitised into an electronic format. This includes information and/or data that is generated electronically and entered into Patient Health Records.

   (c) "**Diagnostic Images**" means film/paper-based images.

(d) "**High Risk Patients and/or Cases**" includes (i) patients who suffered complications during treatment, (ii) pending complaint cases, and (iii) patients who lacked mental capacity, or are suspected to have lacked mental capacity, at the time of the consultation or treatment.

(e) "**ILTC**" means Intermediate & Long-Term Care.

(f) "**Inpatient Records**" means Patient Health Records for inpatient stays at healthcare institutions including acute hospitals, community hospitals and residential ILTC institutions. This includes dental records and hardcopy Diagnostic Images which are stored as part of the Inpatient Record.

(g) "**Lifetime**" means a patient's actual lifetime or 110 years where the actual time of death of the patient is unknown.

(h) "**Outpatient Records**" means Patient Health Records for outpatient visits at and/or services rendered by healthcare institutions including Accident & Emergency departments (A&E), polyclinics, General Practitioners clinics, private specialist clinics, dental clinics, ambulatory surgical centres, renal dialysis centres and emergency ambulance and medical transport services. This includes records of teleconsultations and Diagnostic Images which are stored as part of the Outpatient Record.

(i) "**Patient Health Records**" means a record containing the personal data and medical information of a patient that is maintained by a Licensee in relation to the provision of a healthcare service licensable under the HCSA to the patient, and includes all clinical encounters and original inpatient and outpatient records generated at the time of admission or outpatient attendance.

(j) "**Persons who lack mental capacity**" means a person who lacks mental capacity as defined in section 4 of the Mental Capacity Act 2008.

(k) "**Retention Period**" means the period of time that the Patient Health Records should be kept for, following:

(i) the last day of consultation or treatment, whichever is later;
(ii) the patient's death,
as applicable and stipulated in these LCs.

Minimum Retention Periods of Patient Health Records

5. Licensees shall ensure that all original Patient Health Records are retained for the corresponding minimum Retention Period as provided in Table 1 below.

Table 1: Retention Period of Patient Health Records

S/N	Category	Retention Period
1.	**COMPUTERISED / ELECTRONIC RECORDS**	
	Computerised / Electronic Patient Health Records	Lifetime +6 years
2.	**PAPER RECORDS (subject to paragraph 7)**	
2.1	**Inpatient Records (includes acute hospitals, community hospitals and all residential ILTC institution)**	
(a)	Adults	15 years from last day of: (i) stay in the facility, or (ii) consultation or treatment (if applicable), whichever is later
(b)	Minors	Until the patient is 24 years of age; or 15 years from last day of: (i) stay in the facility, or (ii) consultation or treatment (if applicable), whichever is later
(c)	Persons who lack mental capacity	Lifetime +6 years;
2.2	**Outpatient Records**	
	Outpatient Records	6 years from last day of consultation or treatment, whichever is later (unless High Risk Patients and/or Cases)
2.3	**Assisted Reproduction Records**	
(a)	Where a child was successfully born via AR treatment: (i) Register of children conceived through AR procedures; (ii) Patient Health Records of AR procedures	(i) Register of children conceived through AR procedures: Child's Lifetime +6 years; (ii) Patient Health Records of AR procedures: Child's Lifetime +6 years
(b)	Patient Health Records for AR treatments that did not result in a live birth	(i) Where treatment was caried out in *inpatient* settings: 15 years from last day of consultation or treatment, whichever is later; (ii) Where treatment was carried out in *outpatient* settings: 6 years from last day of consultation or treatment, whichever is later (unless High Risk Patients and/or Cases)

Retention of Computerised / Electronic Patient Health Records

6. Where it is impractical to store electronically generated information and/or data entered into Patient Health Records in its entirety, Licensees shall ensure that representative data

of sufficient granularity is entered into the Patient Health Records and retained for the minimum Retention Period for purposes of documentation, care provision and review.

Retention of Paper Patient Health Records

7. Licensees shall develop appropriate retention and archival strategies for the storage of paper Patient Health Records.

8. Licensees may cull paper Patient Health Records after four years of retention. In the event that Licensees elect to cull paper Patient Health Records, Licensees must retain at least the following records for the remainder of the relevant Retention Period set out in Table 1:
   (a) Inpatient/ outpatient discharge summary;
   (b) Operation reports;
   (c) All consent forms;
   (d) X-ray reports;
   (e) Histopathology investigation reports;
   (f) Maternity records;
   (g) Neonatal records which are enclosed in the mother's case notes;
   (h) Labour records;
   (i) Work Injury Compensation reports;
   (j) Insurance forms;
   (k) Medical and other medico-legal forms;
   (l) Treatment and progress notes (including doctors, nurses and allied health professionals);
   (m) Inpatient medication charts;
   (n) Prescription orders; and
   (o) Blood transfusion records.

9. Where Licensees convert original paper Patient Health Records into a digitised form through processes such as scanning or microfilming, such digitised records are to be regarded as Computerised / Electronic Patient Health Records. Licensees shall ensure that such digitised records are retained for the remainder of the relevant Retention Period for Computerised / Electronic Patient Health Records.

Maternity Records

10. Licensees shall retain maternity records relating to a minor, including pregnancy and delivery records, as part of the mother's Patient Health Records, for the relevant Retention Period applicable to the records of that minor.

Outpatient Records

11. Licensees shall classify A&E Patient Health Records as Outpatient Records where the patient is not admitted into the same healthcare institution for inpatient treatment.

12. Where an outpatient patient is admitted into the same healthcare institution for inpatient treatment, Licensees shall retain Patient Health Records relating to the patient's outpatient and inpatient treatment. Such Patient Health Records shall be regarded as Inpatient Records for the purposes of these LCs.

Retention of Patient Health Records In Legal Proceedings

13. Where legal or other dispute resolution (e.g. mediation) or disciplinary proceedings in relation to a patient's consultation or treatment have commenced or where it is reasonably foreseeable to a Licensee that such proceedings may be commenced (e.g. a complaint has been made, there are related criminal investigations or proceedings, etc.), Licensees shall ensure that that patient's complete Patient Health Records are retained until the conclusion of such proceedings or as per the relevant Retention Period, whichever is later.

14. For the avoidance of doubt, paragraph 13 shall apply to all types of Patient Health Records.

High Risk Patients and/or Cases

15. Licensees shall develop appropriate retention and proper documentation protocols for High Risk Patients and/or Cases.

16. Licensees shall retain Patient Health Records of High Risk Patients and/or Cases for a minimum duration of 15 years from the last day of consultation or treatment, whichever is later.

17. Where Licensees decide to retain Patient Health Records for High Risk Patients and/or Cases for a period longer than the relevant Retention Period, Licensees shall ensure that the decision is supported by clear reasons which are noted in the patient's Patient Health Records.

Diagnostic Images

18. Licensees shall ensure the proper retention of Diagnostic Images as part of the patient's Patient Health Records of the relevant care setting (whether inpatient or outpatient), save for Diagnostic Images which have been released to the patient.