



Information and Privacy
Commissioner/Ontario
Commissaire à l'information
et à la protection de la vie privée/Ontario

Personal Health Information Protection Act, 2004

REPORT

FILE NO. HI-050018-1

A Regional Health Sciences Centre



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INVESTIGATOR:

Nancy Ferguson

HEALTH INFORMATION CUSTODIAN:

A Regional Health Sciences Centre

SUMMARY OF INFORMATION GIVING RISE TO THIS REVIEW:

A staff member at a regional health sciences centre (the Centre) disclosed personal health information about a father to his son while the son was receiving services at the Centre. The matter was reported to the Office of the Information and Privacy Commissioner/Ontario (the IPC). The Centre undertook a consideration of its obligations under the *Personal Health Information Protection Act, 2004* (the Act) including the notification of the affected patient.

RESULTS OF REVIEW:

The Centre wrote to the IPC to describe the incident, its investigation of the incident and the steps that would be taken to help avoid this from occurring in the future.

The Centre reported that the incident arose when an EEG technician was preparing a patient for testing and the patient reported that his father had suffered from seizures in the past. The technician decided to check to see if an EEG had been performed on the father in the past. The technician wondered if the seizures were familial and if so, this would be recorded for the physician that would read the son's EEG. The technician accessed the father's record on the computer as the son sat beside the technician. The computer screen contained a listing of the father's visit dates and the diagnosis for each visit. The son became upset when he saw one of the diagnoses set out on the screen relating to his father. The technician reported the incident to her manager immediately as she realized that the son should not have been permitted to see his father's personal health information.

The Centre's privacy officer contacted the IPC to discuss how to carry out notification of the father. The process of contacting the father to advise him that his son had seen his personal health information on a computer screen at the hospital could reveal the son's personal health information. The information the son had seen on the screen could have been misleading and unnecessarily alarming, but to correct any misunderstanding would lead to a further disclosure of the father's personal health information.

The Centre decided in consultation with the IPC to contact the son and inform him of the Centre's obligation under the *Act* to notify his father about what had been viewed on the computer screen. The privacy officer explained this to the son and asked him whether his father was aware that he had been in the hospital for an EEG. The son confirmed that his father was aware of this fact. The son advised the privacy officer that he would like to tell his father that he had seen information on the computer screen before the hospital called.

The privacy officer later called the father and explained the incident. The father confirmed his son had already informed him of what had happened. The father advised that he was not concerned that his son had seen the record but was concerned about who else would be able to view it. The privacy officer explained the hospital's commitment to protecting privacy and advised that in response to this incident a privacy screen, which covers the computer screen, allowing data to be clearly visible when seated directly in front of the screen but blurring it when the screen is viewed from an angle, had been ordered to help avoid a similar incident from occurring in the future.

The Centre advised that disciplinary action was taken by the human resources department with respect to the particular technician involved in the disclosure.

The Centre also advised that future privacy education for staff will include a discussion about the importance of being aware of who is permitted to view a computer screen at the time that staff are accessing patients' personal information.

On the basis of all of the above, it was determined that further review of this matter was not warranted and the file was closed.

Original signed by: _____
Ann Cavoukian, Ph.D.
Commissioner

January 23, 2006