



RACGP

Royal Australian College of General Practitioners

My Health Record

A brief guide for general practice



My Health Record: A brief guide for general practice

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.



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The basics

What is My Health Record?

My Health Record is Australia's national eHealth record system. Launched in 2012 as the Personally Controlled Electronic Health Record (PCEHR), My Health Record is an online repository for documents and data that contains information about an individual's health and healthcare. It can be accessed online by healthcare consumers and their healthcare providers.

An individual's My Health Record may contain various types of content from the consumer, their healthcare providers, and Medicare. Consumers have the option to restrict access to some or all of the documents in their My Health Record by different healthcare organisations, such as particular general practices (but not individual healthcare providers, such as general practitioners [GPs]). Healthcare providers who are caring for a consumer in an emergency can access that person's My Health Record without obtaining consent.

In the 2017–18 Budget, the Australian Government announced that every person known to Medicare or the Department of Veterans' Affairs (DVA) who has not already registered for a My Health Record will automatically have a record created for them in 2018, unless they choose to opt out. Individuals can cancel their My Health Record at any time.

Potential benefits

The intention behind My Health Record is that it will eventually help healthcare providers spend more time with patients and less time searching for clinically relevant information. Proponents of My Health Record hope that as it grows, healthcare providers will find they are able to access helpful medical information they do not already have in their local records.

There might be particular benefit in using My Health Record to gather relevant information in the following situations:

- in the event of a medical emergency
- when the consumer is travelling and needs to seek care from a number of healthcare providers who are unknown in advance
- where the consumer has many healthcare providers because they have chronic or multiple conditions.

In all of the above situations, the healthcare providers who are providing care to the consumer should still communicate with each other directly, as they do currently. Where this fails for any reason, viewing information in the consumer's My Health Record may be useful.

Having access to their My Health Record might also help patients to better track and manage their own health.

Limitations and precautions

My Health Record does not replace local records

My Health Record is not designed to replace clinical information systems. GPs and other healthcare providers will continue to keep patient records at the local level.

My Health Record does not replace usual communication channels

My Health Record is not designed as a substitute for direct communication between healthcare providers about a patient's care, and should not be used in this manner. Healthcare providers must continue to communicate directly with other healthcare providers involved in the care of a patient through the usual channels, preferably through secure electronic communication.

Information in My Health Record can be inaccurate or incomplete

As with other sources of health data, a My Health Record does not provide a complete picture of a patient's health status and needs. It is important to note that the information might not be up to date, and that the consumer can choose to remove documents from view, or restrict access, so clinically relevant information might be missing. Wherever possible, GPs should verify the information in a My Health Record using other sources.

Use of My Health Record is not compulsory

There is no requirement for patients or healthcare providers to actively participate in My Health Record. However, GPs should be aware they are passively contributing to patients' My Health Records (where they exist), regardless of whether they are registered to use My Health Record themselves. GPs might be generating information for a patient's My Health Record when using Medicare services, generating electronic prescriptions, ordering pathology and diagnostic imaging through participating laboratories or providers, and providing information to government databases.

Types of content in My Health Record

Added by a consumer and/or their authorised representative

Consumers and/or their authorised representatives can add the following types of content to a My Health Record:

- personal details, including
 - Aboriginal and/or Torres Strait Islander status
 - veteran/Australian Defence Force (ADF) status
- emergency contact details
- advance care planning documents
- a Personal Health Summary, comprising information about medications, allergies and adverse reactions (accessible by healthcare providers)
- personal health notes, which are private diary entries (not accessible by healthcare providers).

Uploaded by an authorised healthcare provider/organisation

Authorised healthcare providers/organisations can add the following types of content:

- a Shared Health Summary, which is a document that can include information about the consumer's medical history, medicines, allergies, adverse reactions, and immunisations
- Event Summaries, which are clinical documents detailing one or more episodes of care
- hospital discharge summaries
- pathology reports
- diagnostic test results
- referrals to medical specialists and other health professionals that have been uploaded to provide information to others
- prescribing and dispensing information.

Supplied by Medicare

Government data might be displayed, including:

- Medicare Benefits Schedule (MBS) claims information
- Pharmaceutical Benefits Scheme (PBS) and Repatriation PBS (RPBS) claims information
- Australian Immunisation Register (AIR) records
- organ donor status from the Australian Organ Donor Register (AODR).

Added by an authorised parent/guardian of a newborn or young child

Authorised parents/guardians of newborns and young children can keep records on child development, including the following information:

- personal measurements for head circumference, height and weight
- information and reminders about immunisation
- information and reminders about child health checks
- observations about personal growth and developmental achievements
- growth and development questionnaires for completion prior to appointments with a healthcare provider.

Access controls for My Health Record

Powers of the consumer

My Health Record is predominantly a consumer-controlled tool.

Consumers can:

- opt out of the system altogether, so a My Health Record is not created for them automatically in 2018
- cancel an existing My Health Record, so that no-one can view it or upload information; however, this does not delete the information, it just removes the information from view
- ask healthcare providers not to add particular information to their My Health Record
- restrict access by particular healthcare organisations to their entire My Health Record (by setting a Record Access Code [RAC]) or to particular documents contained within it (by setting a Limited Document Access Code [LDAC]; however, this does not apply to particular documents such as Shared Health Summaries, Personal Health Summaries, or advance care planning information)
- remove particular documents from view so they are not visible to healthcare providers (but can be made visible again at any time)
- grant a healthcare provider one-time access to their whole My Health Record (by giving them an RAC) or to particular documents contained within it (by giving them an LDAC)
- track how others have accessed and edited their My Health Record through an audit log.

However, consumers cannot:

- alter the content of the clinical documents
- delete records entirely (they can only remove certain documents from view)

- restrict access by particular healthcare providers within a particular healthcare organisation (they can only restrict access to all providers within a particular healthcare organisation)
- restrict access to certain documents (Shared Health Summary, Personal Health Summary, and/or advance care planning information) by healthcare organisations using an LDAC. However, consumers can request that particular information be excluded from a Shared Health Summary when it is created and uploaded, and they can remove these documents from view entirely.

Powers of the healthcare provider/organisation

If a consumer has not set access controls for their My Health Record, all authorised healthcare providers linked to an authorised healthcare organisation involved in that person's care will be able to view all of the documents in that My Health Record. All relevant and authorised healthcare organisations have standing consent under the default setting to upload clinical information to a patient's My Health Record (refer to 'Consent to upload documents').

There are provisions in the system to override an individual's access controls for a time-limited period to view a My Health Record in certain emergency situations. A registered healthcare organisation can access a consumer's My Health Record in order to lessen or prevent a serious threat to a person's life, health, or safety (or public health or public safety) and where it is unreasonable or impractical to obtain the individual's consent. This triggers a notification in the audit log for the record. The consumer can opt to be notified by email or SMS in the event of emergency access.

Provider access to My Health Record

Access via a clinical information software system

Authorised healthcare providers can access My Health Record via a clinical information software system that conforms to the requirements of the Australian Digital Health Agency (ADHA).

A full list of conformant software products is available on the ADHA website (www.digitalhealth.gov.au).

Using a conformant clinical information software system to access a patient's My Health Record allows an authorised healthcare provider to both view the record and upload documents to it.

Access via the Provider Portal

Authorised healthcare providers can view a patient's My Health Record without a conformant clinical information software system by using the Provider Portal, available at <https://portal.ehealth.gov.au>. Healthcare providers cannot upload new documents to a My Health Record using the Provider Portal.

Consumer access to My Health Record

Access via an internet browser

Consumers can access their My Health Record through their myGov account (<https://my.gov.au>), which is associated with a username and password.

Access via a mobile app

There are several mobile apps consumers can use to access their My Health Record. A list of approved apps is available on the ADHA website.

Information about the Shared Health Summary

What is a Shared Health Summary?

A Shared Health Summary is a clinical document within a My Health Record that provides an overview of specific health information about a person at a particular point in time. It includes information on:

- current medicines
- medical history
- allergies and adverse reactions
- immunisations/vaccines.

Who can create a Shared Health Summary?

Under the *My Health Records Act 2012* (Cwth), a Shared Health Summary should be created and uploaded by a consumer's Nominated Healthcare Provider. This person is usually the consumer's usual GP or another health provider who usually provides care to the patient. A Nominated Healthcare Provider must be a medical practitioner (not necessarily a GP), a registered nurse, or an Aboriginal or Torres Strait Islander health practitioner who has a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice). The decision about whether this person is the consumer's Nominated Healthcare Provider is decided by mutual agreement between the consumer and the healthcare provider. Only one person can serve as the Nominated Healthcare Provider at any given time.

It is important to note, however, that there are no technical constraints built into My Health Record to restrict any authorised healthcare provider from creating and uploading a Shared Health Summary.

When can a Shared Health Summary be created?

A Shared Health Summary can be created in the context of any consultation. A Nominated Healthcare Provider might feel it is useful to create and upload a new Shared Health Summary in the following situations:

- where a Shared Health Summary does not already exist, perhaps at the request of the patient
- when completing a patient health assessment – for example, a GP management plan or child health check
- when there have been significant changes to a patient's medical conditions, medicines, allergies, adverse reactions or immunisations.

How is a Shared Health Summary created?

The information in a Shared Health Summary is similar to the information found in a GP health summary, so the time taken to create a Shared Health Summary will depend in part upon the quality and currency of the information already available in the patient's local record. It will also depend on the complexity of the patient's health conditions and management.

Sensitive information can be left out of the Shared Health Summary if this is requested by the patient, and the Nominated Healthcare Provider agrees to exclude it. However, if the Nominated Healthcare Provider believes that omitting the information might mislead other healthcare providers, they may decline to upload the Shared Health Summary that omits the information. While it is best practise to do so, there is no legal requirement for a healthcare provider to give a patient the opportunity to review the Shared Health Summary prior to upload.

Once the Shared Health Summary has been created, the Nominated Healthcare Provider uploads the document to My Health Record from their clinical information system.

How is the information in a Shared Health Summary updated?

Documents in a person's My Health Record cannot be edited. The only way to update the Shared Health Summary is by creating and uploading a new Shared Health Summary.

There is no legal requirement to regularly update a Shared Health Summary. In order to receive payments under the Practice Incentives Program eHealth Incentive (ePIP), practices must upload Shared Health Summaries for a specified minimum proportion of their patients.

Information about the Event Summary

What is an Event Summary?

An Event Summary is a standalone document within a My Health Record providing information about a healthcare event relevant to the patient's ongoing care, for example, a clinical intervention, treatment commencement or cessation, or a change in clinical status. There is a free text field to provide a clinical synopsis. An Event Summary might contain information about:

- allergies and adverse reactions
- medicines
- diagnoses
- interventions
- immunisations/vaccines
- diagnostic interventions.

The purpose of an Event Summary is to provide information that might be useful to as-yet-unknown healthcare providers at as-yet-unknown times in the future. Creating and uploading an Event Summary does not replace the need to communicate directly with the consumer's usual GP or general practice.

Who can create an Event Summary?

Any authorised healthcare provider who is working under the auspices of an authorised healthcare organisation can create and upload an Event Summary.

When can an Event Summary be created?

An Event Summary might be created for a patient who is receiving care from an after-hours GP service, a transient/holidaying patient, or a patient who is receiving an immunisation/vaccine from someone other than their regular GP. In all of these cases, the same information should be sent directly to the patient's usual GP or general practice as well.

An Event Summary can be used in a situation when a significant healthcare event has occurred or there has been a change in a person's health status, but it is not appropriate to create a Shared Health Summary, discharge summary or specialist letter.

How is an Event Summary created?

An Event Summary should contain enough information to appropriately communicate the change or action taken. The information should be presented in such a way that it can be easily understood by another healthcare provider.

How is an Event Summary updated?

An Event Summary cannot be edited. A new Event Summary can be created and uploaded to supplant the original.

The healthcare provider who created and uploaded the Event Summary can delete it if it contains a mistake or was uploaded in error.

Creating and uploading an Event Summary does not replace communicating directly with the patient's usual GP or general practice to inform them about the contact with the patient.

Financial matters

GP billing

GPs can account for the time taken to create and upload a Shared Health Summary or Event Summary if that activity occurs within the context of providing clinical services and the patient is present at the time. For the purposes of the MBS, those activities count towards the calculation of consultation time for billing purposes. There are no specific MBS item numbers for the creation/upload of documents to a My Health Record.

The Practice Incentives Program eHealth Incentive

The ePIP is an Australian Government initiative that aims to encourage general practices to use My Health Record. There are a number of requirements general practices must meet in order to receive ePIP payments. For more information about the ePIP and eligibility criteria, refer to the RACGP's resources at www.racgp.org.au/MyHealthRecord

Medico-legal information

Authorised access

A consumer can choose whether to grant or deny access to their My Health Record to a healthcare organisation. The default setting allows all authorised healthcare organisations involved in an individual's care to access that person's My Health Record.

There is no provision in My Health Record for consumers to grant or deny access to individual healthcare providers, only to healthcare organisations.

This allows all healthcare providers who are authorised to access My Health Record in a particular organisation to access a patient's My Health Record for the following authorised purposes:

- providing healthcare to the patient
- disclosing the health information to the patient or their authorised representative
- collecting, using or disclosing the health information for any purpose with the patient's consent
- collecting, using or disclosing the health information for purposes related to the provision of indemnity cover. Under the My Health Records Act, healthcare organisations can access information in an individual's My Health Record for the purpose of defending medical negligence claims. This provision does not apply to the consumer's personal health insurance company, and it does not allow the healthcare organisation to access any personal health notes the consumer has made within their My Health Record.

A patient does not have to be physically present in order for an authorised healthcare provider to access their My Health Record for one of the legitimate purposes described above.

There are emergency provisions to override the access controls of a person's My Health Record to collect, use and disclose information in specific circumstances. Refer to 'Powers of the healthcare provider/organisation'.

Unauthorised access

Under the My Health Records Act, it is an offence for a person to collect, use, or disclose health information contained in a My Health Record if that activity is not authorised under the Act and the person knows the activity is not authorised, or is reckless as to whether it is authorised. Penalties apply under the Act, including up to 600 penalty units (\$126,000 for an individual and \$630,000 for a body corporate), or up to two years' imprisonment.

Accessing a My Health Record by mistake is not associated with a penalty under the My Health Records Act, but might constitute a privacy breach under the *Privacy Act 1988* (Cwlth). Failure to notify the Office of the Australian Information Commissioner (OAIC) might incur a civil penalty of up to 100 penalty units (\$18,000 for an individual and \$90,000 for a body corporate).

The RACGP supports the OAIC's preferred regulatory approach to facilitate voluntary compliance with privacy obligations and to work with entities to ensure best privacy practice and prevent privacy breaches.

Consent to upload documents

When a My Health Record is established, the healthcare consumer provides standing consent for all healthcare organisations involved in their care to access that record and upload information. There is no legal requirement for a healthcare provider to obtain consent from a patient on each occasion prior to uploading clinical information, or to provide an opportunity for a patient to review clinical information prior to upload. However, where a patient explicitly requests that specific information is not uploaded to My Health Record, the healthcare provider must comply with that directive.

GPs should act in accordance with state and territory laws with regard to consent and the disclosure of sensitive information.

Discrimination

Healthcare providers must not discriminate against a patient who does, or does not, have a My Health Record or because of their access control settings.

Quality of the record

Healthcare providers must not upload a record that contains defamatory material. Providers may only upload a record if it does not infringe upon another person's intellectual property rights or moral rights. Providers must take reasonable steps to ensure the quality of the content of the record.

Indemnity coverage

Every medical defence organisation (MDO) will have their own policies related to My Health Record. Contact your MDO for more information.

Registration and set-up

An overview of the process

Healthcare organisations and healthcare providers must take a number of steps to use My Health Record with patients.

1. The healthcare organisation registers with the Healthcare Identifiers (HI) Service.
2. The healthcare provider registers with the HI Service, if they are not already registered.
3. An authorised person registers the organisation to use My Health Record.
4. All relevant and authorised people register for National Authentication Service for Health (NASH) Public Key Infrastructure (PKI) certificates.
5. The healthcare organisation develops internal policies and procedures for using My Health Record.
6. An authorised person sets up the HI.
7. An authorised person downloads the patient Individual Healthcare Identifier (IHIs).

All relevant registration forms can be lodged at the ADHA's Digital Health Online Forms website (<https://forms.digitalhealth.gov.au>). More information about each step is provided below.

Step 1: The healthcare organisation registers with the HI Service

All healthcare organisations that want to participate in My Health Record must first register with the HI Service, which is a national system for identifying healthcare providers, healthcare organisations, and individuals receiving healthcare.

Healthcare organisations apply to register as a Seed Organisation (a standalone organisation, such as an independent general practice) or a Network Organisation (a subordinate department/division within a large organisation, such as a hospital or a general practice with multiple sites). Most general practices would be registered as a Seed Organisation.

To register with the HI Service, the healthcare organisation needs to nominate:

- a Responsible Officer (RO), who is a person with the authority to act on behalf of the organisation in its dealings with the System Operator of My Health Record. In a general practice, the RO is usually the business owner or practice manager
- an Organisation Maintenance Officer (OMO), who is a person with the authority to act on behalf of the organisation in its day-to-day administrative dealings with the HI Service and My Health Record. There may be more than one OMO in an organisation. In a general practice, the OMO is likely to be the practice manager or another senior staff member who is familiar with the practice's clinical and administrative systems.

After registering with the HI Service, the healthcare organisation will receive a unique, 16-digit number called a Healthcare Provider Identifier for Organisations (HPI-O).

Step 2: The healthcare provider registers with the HI Service, if they are not already registered

Healthcare providers who wish to use My Health Record will need a Healthcare Provider Identifier for Individuals (HPI-I) from the HI Service.

All providers registered with the Australian Health Practitioner Regulation Agency (AHPRA) are automatically registered, so all GPs already have a HPI-I; however, people employed in a healthcare profession not regulated by AHPRA will need to lodge an application.

Healthcare providers who do not know their HPI-I can obtain the details by logging in to their account at the AHPRA website or calling the HI Service enquiry line on 1300 361 457.

The healthcare provider should provide their HPI-I to the organisation's OMO.

Step 3: The RO registers the organisation to use My Health Record

After they have been assigned an HPI-O, the RO can register the healthcare organisation to participate in My Health Record. Applicants will receive confirmation of registration via post.

Step 4: All relevant and authorised persons register for NASH PKI certificates

A NASH PKI certificate is a digital certificate in the form of a USB key or smart card that authenticates the user when they attempt to access My Health Record.

All healthcare organisations will need a NASH PKI certificate for their site in order to connect to My Health Record via a conformant clinical information software system.

Authorised people (eg healthcare providers, ROs, and OMOs) who will be using a conformant clinical information software system to access My Health Record do not need to apply separately for individual NASH PKI certificates. Authorised people who will only use the Provider Portal for access will need to apply.

Provider Digital Access (PRODA), an authentication system used to securely access government online services, will eventually replace individual NASH PKI certificate access.

Once registered, applicants will receive their NASH PKI certificates via post.

Step 5: The organisation creates relevant internal policies and procedures

The healthcare organisation must establish policies and procedures to guide staff in the use of My Health Record. The RACGP has designed a template to assist you to develop a policy, which is available at www.racgp.org.au/your-practice/ehealth/myhealthrecord/resources

Applicable staff must be trained in the policies and procedures.

Step 6: An authorised person links the clinical information software system to My Health Record

An authorised person (either a person within the healthcare organisation or its IT support service) will first need to check the practice is running an up-to-date version of the conformant software they will use to access My Health Record (if applicable).

Next, the HPI-O is added to the clinical information software system and all the healthcare providers' HPI-Is are linked to the HPI-O in the software.

An authorised person can then install the PKI certificate for the site and all relevant PKI certificates for individual providers using the personal identification codes (PICs) sent separately.

This person should then verify that the clinical information software system can connect to the HI Service by downloading a patient's IHI, a unique code that identifies a recipient of healthcare. More information can be found at the ADHA website.

Step 7: An authorised person downloads the patient IHIs

Next, an authorised person downloads the patient IHIs held by Medicare to connect these to the patient records at the local level. IHIs can be downloaded for individual patients or in bulk. The download process will be determined by the clinical information software system used at the local level. Contact the software vendor for more information.

Additional resources

RACGP

My Health Record resources, www.racgp.org.au/MyHealthRecord

Privacy resources, www.racgp.org.au/your-practice/ehealth/protecting-information/privacy

Information security in general practice, www.racgp.org.au/your-practice/ehealth/protecting-information/information-security

OAIC

Guide to mandatory data breach notification in the My Health Record system, www.oaic.gov.au/agencies-and-organisations/guides/guide-to-mandatory-data-breach-notification-in-the-my-health-record-system

My Health Records (Information Commissioner Enforcement Powers) Guidelines 2016, www.oaic.gov.au/agencies-and-organisations/legally-binding-guidelines-and-rules/my-health-records-information-commissioner-enforcement-powers-guidelines-2016

ADHA

'My Health Record', www.myhealthrecord.gov.au

Digital Health Online Forms, <https://forms.digitalhealth.gov.au>

Provider Portal, <https://portal.ehealth.gov.au>

'What is My Health Record?' for healthcare providers, <https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/healthcare-providers-faqs>

'What is My Health Record?' for consumers, <https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/find-out-more>

'How to use the My Health Record system', www.digitalhealth.gov.au/using-the-my-health-record-system/how-to-use-the-my-health-record-system

'Software products using digital health', www.digitalhealth.gov.au/get-started-with-digital-health/what-is-digital-health/who-is-using-digital-health/software-products-using-digital-health

'Penalties' fact sheet, <https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/penalties-fact-sheet>

'Clinical software simulators and demonstrations', www.myhealthrecord.gov.au/for-healthcare-professionals/clinical-software-simulators-and-demonstrations



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