# Disposal of Patient Records if the Practice Closes Policy

This policy describes the means by which patient records will be disposed of safely in the event of the practice closing.

NB: disposal means the safe storage/archiving of records until they require to be accessed again or confidentially destroyed when the minimum retention period expires\*.

**NHS patient records**

1. Prior to the closure of the practice, [Name of owners or partners] will liaise with the Records Manager at [Name of Health Board]to discuss the secure transfer of the records to a designated storage location for safe keeping for the minimum retention period\*.

2.[Name of owners or partners]will record the arrangements made, including the contact details of the Health Board Records Manager.

**Private patient records**

1. Prior to the closure of the practice,[Name of owners or partners] will arrange for the records to be stored securely [state method, e.g., archive facility] for the minimum retention period\*. At the end of the minimum retention period records will be confidentially destroyed unless a decision is taken to continue storage.

2.[Name of owners or partners] will record details of the arrangements made.

[Name of owners or partners] will consider lodging details of the arrangements made for disposal of both NHS and private patient records with the owners’ or partners’ solicitors.

\*Paper and computerised notes, including study models, radiographs etc are part of a patient’s record/file. There is a [requirement](https://www.digihealthcare.scot/app/uploads/2024/08/RM-CoP-for-HSC-2024-v04.0-MASTER-2024-08-09.pdf) for records to be kept for adults for 10 years from last contact. For children, the child record should evolve into the adult record.

On death, keep adult records for 3 years. Where the person dies before their 17th birthday, the record should be held until they would turn 25.