Medical Radiation Practice Board Ahpra

Implementing updated Professional capabilities

November 2025

Managing and recording information in patient health records

Executive Summary

The third iteration of the Professional capabilities for medical radiation practice (2026) builds on existing obligations for medical radiation practitioners to create, maintain, and manage accurate patient health records. Maintaining and recording information in patient health records is fundamental to safe, high-quality, person-centred care and forms part of every practitioner's professional and legal responsibilities.

This document provides information to assist registered medical radiation practitioners, other health practitioners, employers, health organisations, education providers and professional associations to support the implementation of these capabilities.

Introduction

The Professional Capabilities recognise that accurate record keeping is central to the role of the medical radiation practitioners and are essential for the continuity and quality of patient care.

Maintaining clear, accurate and secure health records is a fundamental part of safe and effective medical radiation practice.

Why health records matter

Health records form the foundation of patient care. They tell the story of the patient's health history, the procedures undertaken, the decisions made, and the outcomes achieved. Accurate and comprehensive records ensure that the care provided by one practitioner is clearly understood by others involved in the patient's treatment. They also support informed consent, protect patient rights, and provide evidence of professional decision-making in line with legal and ethical standards.

Medical radiation practitioners often work within multiprofessional teams where effective information sharing supports timely diagnosis and treatment and subsequent decisions about care. The accuracy and integrity of records directly affect the safety of patients and confidence in the healthcare system.

Creating good records

Medical radiation practitioners use a range of systems that create and establish patient health records, these Radiology Information System (RIS) a Picture Archiving and Communication System (PACS) Radiation Oncology Information Systems (ROIS), risk management systems, radiation dose tracking systems. They also use Electronic Medical Records (EMR) or My Health Record (MHR)

Medical radiation practitioners are expected to create records that are accurate, factual, respectful and complete. Each record should clearly identify the date, time and location of the service, the name of the practitioner, and the details of the examination or treatment performed. Records should include relevant clinical history, patient preparation, consent documentation, imaging or treatment details, and any follow-up advice or referrals.

All entries should be objective and free from language that could be interpreted as biased, demeaning or culturally unsafe. Documentation should demonstrate respect for the patient's privacy and dignity and reflect a commitment to culturally safe and person-centred care.

The Professional Capabilities reinforce that medical radiation practitioners must understand and comply with the legal and ethical responsibilities that govern the collection, use, storage and disclosure of health information. This includes the Privacy Act 1988 (Cth) and relevant state or territory health records legislation.

What should be recorded in a patient's health record

Patient health records should be used to convey essential information and details of care. The information a practitioner records in the patient record will be dependent on the circumstances of the care or interaction with the patient, but may include the following

- Any new or relevant information that assists, contributes or influences the continuity or subsequent decisions on care
- Patient or administrative details
- The examination, treatment or procedure performed where it is not already captured or integrated with the medical record
- New or updated clinical history or assessment
- Any relevant consent or communication
- Relevant details about an examination, treatment or procedures as necessary, particularly if medicines, contrast media or radiopharmaceuticals are used — including dose, route and time
- Complications or adverse events and how they were managed
- Urgent or unexpected findings or other observations or monitoring, and
- Any other relevant information that contributes to the care and safety of the patient

In some circumstances medical radiation practitioners may need to use multiple health record systems in order to communicate safely.

Using digital health and information systems

Most medical radiation practitioners work within digital environments that integrate multiple information systems — including PACS, RIS, ROIS, EMR and My Health Record.

Practitioners must ensure that data entered into these systems is complete, accurate and linked to the correct patient. This includes verifying patient identifiers, reviewing existing data before conducting procedures, and promptly correcting or reporting any discrepancies or system errors.

The Professional Capabilities emphasise that practitioners must be able to use digital health systems responsibly to enhance patient care, while understanding their limitations and potential risks.

Practitioners should also recognise how digital systems and artificial intelligence tools can influence patient outcomes and should take appropriate action to minimise any associated risks to safety, privacy or quality of care.

Maintaining privacy, confidentiality and security

Respect for patient privacy and confidentiality underpins professional and ethical practice.

Medical radiation practitioners must hold health records securely and prevent unauthorised access, disclosure or modification. Access should be limited to those directly involved in the patient's care or with explicit authorisation.

When using or sharing information for teaching, research or quality improvement, practitioners should ensure that all identifying details are appropriately removed or coded.

Maintaining confidentiality also means being aware of the environment in which discussions and electronic communications occur — ensuring that patient information is not inadvertently disclosed in open or public areas, or through unsecured digital channels.

Ensuring continuity of care

Continuity of care depends on clear, consistent and comprehensive record keeping.

Practitioners should record management plans, actions taken, follow-up requirements, and communications with other members of the healthcare team.

When transferring care or when a patient moves between services, medical radiation practitioners have a professional responsibility to ensure that relevant records are accessible to those continuing the patient's care, in accordance with privacy requirements.

Patients also have a right to access their own health information. Consistent with organisational procedures, practitioners must facilitate access in a timely and respectful way and support the appropriate transfer or secure disposal of records when a practice closes, relocates or ceases operation.

Cultural safety and respectful documentation

Cultural safety is a key aspect of person-centred care. Health records should reflect cultural and social factors that may influence care, including language preferences, family relationships, or relevant community considerations.

Documentation should use inclusive, respectful language and demonstrate awareness of the patient's cultural context. For Aboriginal and Torres Strait Islander patients, this includes recognising cultural protocols and the importance of community and family in decision-making.

Culturally safe record keeping supports trust, communication and equitable care outcomes and aligns with the expectations of Domains 1–3 of the Professional Capabilities.

Further information

Medical Radiation Practice Board of Australia –

- Code of Conduct and
- Professional Capabilities for Medical Radiation Practitioners (2026)

Australian Commission on Safety and Quality in Health Care (ACSQHC) – NSQHS Standards

Office of the Australian Information Commissioner (OAIC)

Privacy for Health Service Providers

Guide to Health Privacy

My Health Record – Legislation and Governance