



# Review of the My Health Records Legislative Instruments

## Public consultation outcomes summary



**March 2026**

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# Acknowledgement

The department extends its appreciation to all individuals and organisations who provided submissions to the public consultation on the Review of the My Health Records Legislative Instruments.

Your considered feedback has been instrumental in informing the review process. The department acknowledges and appreciates the time and effort contributed to this important work.

# Executive Summary

On 7 August 2025, the Department of Health, Disability and Ageing (the department) released a [public consultation paper](#) to inform the review of the My Health Records legislative instruments. The My Health Record (MHR) system is established under the *My Health Records Act 2012* (MHR Act). Four legislative instruments made under the MHR Act are due to sunset (cease) on 1 April 2026:

1. *My Health Records Regulation 2012* (MHR Regulations)
2. *My Health Records Rule 2016* (MHR Rules)
3. *My Health Records (Assisted Registration) Rule 2015*
4. *My Health Records (Opt-Out Trials) Rule 2016*

A fifth instrument, the *My Health Records (National Application) Rules 2017*, is also under review but is not due to sunset until April 2028. Under the *Legislation Act 2003*, legislative instruments must be reviewed and remade every 10 years to ensure they remain valid and aligned with current government policy.

The consultation aimed to determine whether the listed legislative instruments remain necessary and fit for purpose. While amendments to the MHR Act itself are outside the scope of this review, it was acknowledged that respondents may wish to provide broader feedback, which could be used to inform future policy directions in relation to the My Health Record system and digital health policy, with any such feedback to be noted for consideration in future projects.

The consultation paper included 17 questions, covering both specific topics and general issues (refer to Appendix A). The department received 26 formal submissions from stakeholders across the health and care sector, including health professional bodies, organisations representing consumers and those working in the insurance and digital health sector. As responding to all questions was not mandatory, and not all respondents consented to publication of their feedback, only this summary will be made publicly available.

The purpose of this document is to summarise the feedback received in response to the questions outlined in the consultation paper. To support clarity and facilitate analysis, responses have been grouped into thematic categories aligned with the consultation questions.

This document does not represent a final policy position on any of the matters discussed.

# Introduction

My Health Record (MHR) is a foundational component of Australia's digital health strategy, designed to create a connected and patient-centred digital health system. It provides a secure, national platform for storing and sharing health information, enabling clinicians and consumers to access data when and where it is needed. This improves continuity of care, reduces unnecessary duplication of tests and procedures, and enhances patient safety through better-informed clinical decision making. MHR also supports interoperability across the health system by enabling information exchange between healthcare providers and digital systems.

The MHR system plays a critical role in advancing Australia's digital health agenda by enhancing access to health information and empowering individuals to actively manage their health. While the MHR system is not directly integrated with initiatives such as electronic prescribing, secure messaging, and telehealth, it interfaces with clinical systems that connect to these services. As a result, MHR continues to complement and strengthen these broader digital health efforts, contributing to a more coordinated and effective health system.

## Related projects and initiatives

A number of related projects are underway to uplift Australia's digital health capabilities, a number of which are relevant to this review and were raised by stakeholders in their feedback. Accordingly, a brief summary of some key related initiatives is set out below for context.

- **Healthcare Identifiers (HI) Framework:** Underpins Australia's digital health ecosystem by assigning unique identifiers to individuals, individual healthcare providers, healthcare provider organisations and healthcare support service providers. These identifiers enable safe, secure, and accurate linking of health information across care settings. Legislative reforms to the *Healthcare Identifiers Act 2010* are underway to modernise authorisations, improve adoption, and embed identifiers into emerging standards such as AU Core FHIR. Enhanced use of healthcare identifiers will support interoperability, reduce duplication, and strengthen continuity of care, particularly for vulnerable populations and during transitions between primary, acute, aged, and disability care.
- **Sharing by Default:** The Australian Government has legislated requirements for healthcare providers to share key health information to My Health Record by default, which will initially apply to pathology and diagnostic imaging reports. This reform aims to improve access to key health information to support continuity of care, reduce duplicate testing, and empower consumers with near real-time access to their health information.
- **HealthConnect Australia:** HealthConnect is being developed as a national health information exchange capability to enable secure, near real-time sharing of health data across care settings and jurisdictions. It will provide foundational infrastructure such as a national provider directory and record locator service to support better connections across the health sector.
- **MyMedicare:** MyMedicare is a voluntary patient registration initiative designed to strengthen continuity of care and support multidisciplinary team-based models. Integration with the 1800MEDICARE app (formally my health app) in future will allow consumers to register, manage

care team preferences, and link to clinical information, positioning MyMedicare as a gateway for future incentives.

- **1800MEDICARE App:** The 1800MEDICARE app is a government-provided mobile application designed to give consumers convenient access to key health information stored in My Health Record (MHR). It is intended to serve as the primary entry point for consumers to access their MHR and other digital health systems and services. The app will also be able to support broader Strengthening Medicare initiatives over time.
- **Fast Healthcare Interoperability Resources (FHIR):** FHIR is the international standard adopted to enable consistent, real-time exchange of health information across diverse clinical systems. Australia's FHIR implementation is being accelerated through the Sparked program to support interoperability and future digital health reforms.
- **AU Core:** AU Core is Australia's localisation of the FHIR standard, incorporating national requirements such as healthcare identifiers. It provides the foundation for interoperable data exchange and will underpin use cases such as eRequesting and patient summaries to support safe, connected care.
- **Australian Core Dataset for Interoperability (AUCDI):** The AUCDI defines the essential data elements for standardised clinical documentation and safe information exchange. Release 1 includes foundational data groups such as medication summaries and vital signs, forming the basis for AU Core implementation.
- **Sparked:** Sparked is Australia's first FHIR Accelerator program, led by the CSIRO, in partnership with the Department of Health, Disability and Ageing, the Australian Digital Health Agency and HL7 Australia, to deliver national FHIR standards through community collaboration.
- **Electronic requesting (eRequesting):** eRequesting is Australia's first national interoperability use case, enabling end-to-end digital workflows for pathology and diagnostic imaging requests. Building on AU Core FHIR standards, eRequesting will allow clinicians to create, transmit, and track requests electronically, with results shared to My Health Record by default.
- **International Patient Summary (IPS):** Australia is seeking to align with the International Patient Summary standard to ensure patients and clinicians have access to critical health information—such as health problems/diagnosis, allergies, medications, and immunisations—anywhere care is delivered. This will support safer transitions and global interoperability.

## Key themes and findings

1. **Expanded Eligibility:** There was strong support for revising rule 19 of the MHR Rules, which applies to limit the types of documents that may be shared to MHR unless certain conditions are met. Stakeholders cited the importance of the MHR system in supporting multidisciplinary care and emerging data sources (e.g. wearables, care plans). Stakeholders recommended enabling uploads by additional professions while maintaining clinical integrity and privacy safeguards.
2. **Expanding Provider Roles:** Respondents supported broadening the definition of *nominated healthcare provider* and *Shared Health Summary (SHS)* authorship. Additional professions recommended to be considered eligible included midwives, pharmacists, allied health, and all Aboriginal and Torres Strait Islander health practitioners<sup>1</sup>. Concerns with the proposal to broaden the definition centred on governance and accountability to prevent fragmentation.
3. **Relevance and Evolution of Shared Health Summaries (SHSs):** Respondents acknowledged the continued value of SHSs in supporting patient safety and care coordination. However, there was strong consensus that SHSs should evolve into more dynamic and interoperable models aligned with the Australian Clinical Dataset for Interoperability (AUCDI)/International Patient Summary (IPS) standards, complementing real-time data flows.
4. **Participation and Cyber Security:** Participation requirements are considered generally fit for purpose, but feedback highlighted the importance of clear guidance, profession-specific templates and ongoing training. There is strong support for enforceable cyber security baselines aligned with national frameworks, balanced against scalability for small providers.
5. **Emergency Access Provisions:** Emergency access rules are generally considered as appropriate; however, it was noted that processes would benefit from clearer definitions and safeguards.
6. **Post-Death Provisions:** Views on access to the MHR of deceased individuals varied. Most stakeholders supported granting limited, time-bound access for representatives and providers, subject to legislative change and cultural considerations. In contrast, some respondents emphasised the need to uphold privacy and maintain the system's original design, which limits access and disclosure of sensitive information from a recordholder's MHR after their death.
7. **Assisted Registration:** Retaining assisted registration is widely supported as an equity measure, with calls for process simplification, multilingual resources, and expansion of assisting entities.
8. **Regulatory Alignment and Simplification:** Stakeholders recommend repealing obsolete instruments (e.g. Opt-Out Trials Rule) and consolidating rules for clarity and compliance. Broader revisions are recommended to address interoperability, usability and equity.

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<sup>1</sup> Currently, only Aboriginal and Torres Strait Islander health practitioners who hold an accredited Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice), approved by the Australian Health Practitioner Regulation Agency, are eligible to author Shared Health Summaries.

Overall, submissions emphasised usability, interoperability, broader professional participation, and sustained investment in engagement and training. Messaging suggested that the success of the MHR system depends on co-design with clinicians, vendor enablement, and pragmatic rulemaking aligned with national digital health strategies.

# Outcomes summary

## 1. Review of rule 19 of the MHR Rules

### Overview of feedback

Rule 19 of the *My Health Records Rule 2016* (MHR Rules) provides an exemption from the requirement that a record must have been authored by an individual with a current Healthcare Provider Identifier-Individual (HPI-I) for certain document types, such as shared health summaries and advance care planning information.

There was broad consensus amongst stakeholders supporting the revision of rule 19 to better reflect multidisciplinary models of care and modern data flows (i.e. digital movement, integration and use of health information). Respondents emphasised the importance of implementing clear safeguards to ensure:

- accurate identification of authorship
- reliable provenance of health information
- respect for data sovereignty
- ongoing privacy protections

Some stakeholders noted that the current wording of Rule 19 remains workable, provided it does not limit the upload of clinically relevant documents.

Several stakeholders cautioned against overloading the My Health Record (MHR) system with information which is non-clinical or provides little or no meaningful benefit for clinical decision making. They recommended prioritising information that healthcare professionals can rely on to provide safe, effective, and efficient care, such as diagnostic reports.

Considerations cited by different stakeholders for rule 19 review included:

- Ensure that clinical information software system-generated uploads recognise and link authorship to the correct individual healthcare provider and associated HPI-I.
- Enable uploads from additional professions, including, all Aboriginal and Torres Strait Islander health practitioners, all allied health professionals and other appropriately qualified professionals without a HPI-I.
- Expand accepted data sources and types of information to include health wearables, referrals, and care plans.

Stakeholders also noted addressing the impediments to Australian Defence Force (ADF) clinicians uploading information to the MHR system. These impediments do not relate to Rule 19 but to section 70A of the MHR Act, which prescribes prohibited purposes (i.e. purposes for which MHR information must not be used). Amendments to the Act fall outside the scope of this review.

## Response to feedback

There was strong support for reviewing Rule 19, particularly in relation to expanding the eligibility criteria for who can prepare information to upload to the MHR system, and the types of documents that can be shared. However, as there was no consensus among respondents as to the additional types of documents that might be relevant for sharing to MHR, further consultation would be needed before amendments could be made. Future consultation will help to clearly define the categories of documents that should be eligible to be uploaded, and why they are relevant to a person's individual health care record, despite not being authored or prepared by an individual provider with a current healthcare identifier.

This will ensure the quality and integrity of health information, uphold professional accountability and support team-based care.

Consideration as to whether this should be broadened, for example to eligible support service providers, such as those providing in-home supports to aged care recipients, who are now eligible for a new provider identifier under the amended *Healthcare Identifiers Act 2010*, will be the subject of future consultation.

The incorporation of data from wearables will be explored as part of future reform initiatives under the Healthcare Identifiers Framework and Health Connect projects.

## 2. Expansion of Shared Health Summary (SHS) authorship and “nominated healthcare provider” definition

### Overview of feedback

A *nominated healthcare provider* is defined in the MHR Act as a person who has ‘an agreement in force’ with a consumer for the purpose of the Act, including preparing a SHS.

There was strong support for expanding the definition of *nominated healthcare provider* authorship of SHSs. Suggested practitioners recommended for inclusion in the definition were midwives (those who are not registered nurses), pharmacists, allied health professionals, and all Aboriginal and Torres Strait Islander health practitioners. However, despite broad support for review, there was limited consensus across submissions regarding which additional practitioners should be prescribed.

Some responses indicated that expanding the authorisation for SHS authorship could potentially dilute the quality of information shared in the MHR system, and that event summaries and other clinical documents, such as prescriptions records and discharge summaries are a suitable avenue for other healthcare providers to share relevant health information with the system.

Expanding the definition of a *nominated healthcare provider* and SHS authorship is seen by most stakeholders as essential to:

- Improve timeliness and completeness of health records by enabling more healthcare professionals to contribute directly.
- Reflect realities of team-based care, particularly in rural and remote settings where access to general practitioners may be limited.

- Support continuity of care by allowing trusted healthcare professionals already involved in a patient's care to contribute to their record.

Despite strong support for expanding provider roles, stakeholders raised several key risks and concerns that need to be addressed:

- Risk of record fragmentation and reduced accountability if roles and responsibilities are not clearly defined.
- Need for robust governance structures and effective clinical oversight to maintain quality and safety standards.
- Need to clearly articulate role boundaries and scope of practice to prevent duplication, and errors at transitions of care (e.g. medication errors).
- Comprehensive audit trails to support transparency and accountability of contributions to the MHR system.
- Expanding SHS authorship to include other classes of health professionals will require enhancing digital capabilities across these groups for effective system participation.

### **Response to feedback**

Whilst there was strong support to broaden the definition to include other healthcare professions, stakeholder concerns persist, particularly those related to clinical governance, patient safety and regulatory oversight. Stakeholders conveyed a strong sentiment that these must be addressed before any substantive amendments are considered.

Further, while some stakeholders were supportive of change and suggested additional practitioners who would be suitable to author a SHS, as there was no consensus among respondents as to the additional practitioners or other criteria for inclusion, it is not proposed to amend the provisions at this time. As such, the authorship of SHS documents would continue to be tied to the existing definition of a nominated healthcare provider.

Given parallel reforms to modernise the infrastructure underpinning the MHR system, and the FHIR standards agenda, the ongoing relevance of the SHS, with preparation by a single responsible practitioner, is under review. Going forward, alternative ways to present a summary of a patient's health information, potentially with contributions from multiple providers in a consumer's care team, may be proposed, and may replace the utility of the existing SHS. The department will monitor this work which may inform future recommendations for amendment to the *My Health Records Act 2012*. This is further discussed in the next section of this document.

## **3. Relevance and Evolution of Shared Health Summaries**

### **Overview of feedback**

A shared health summary is a clinical record that provides a snapshot of an individual's health at a specific point in time. It can include information, such as current medications, allergies, medical history, and immunisations. Under the MHR Act, only the consumer's nominated healthcare provider is authorised to prepare this summary.

Most responses noted that SHSs remain valuable for capturing an individual's health status at a given point in time. They contribute to patient safety and care coordination, particularly when real-time

health information data is unavailable or incomplete, and during transitions of care or complex care involving multidisciplinary teams. On the other hand, other responses questioned its current relevance in the modern digital environment and the preference for 'living' summaries that could be automatically updated, with contributions from multiple providers involved in a consumer's care.

Overall, all stakeholders who responded to the public consultation agreed that SHSs need to evolve to remain clinically relevant and useful for healthcare providers and consumers.

There is consensus that SHSs should transition towards models that align with the Australian Core Dataset for Interoperability (AUCDI) and the International Patient Summary (IPS).

Stakeholders stated that the transition would make SHSs more:

- Dynamic: capable of adapting to real time data feeds and automatically generate content.
- Interoperable: easier to share and integrate across different healthcare systems.
- Comprehensive: including input from a wider range of accountable healthcare providers, each assigned a HPI-I, ensuring multidisciplinary perspectives in the summaries.

Additional feedback and considerations for changes to SHSs:

- Alignment to the MyMedicare program: some suggested consideration be given to aligning the concept of *nominated healthcare provider* (individual authorised to prepare a SHS) with the program.
- e-PIP Review: consideration of outcomes of the Review of e-PIP (e-Health incentive program) and whether current incentives and practices are achieving their objectives.
- Eligibility to prepare a SHS: consideration of whether permission should be based on the individual healthcare provider meeting specific criteria in addition to, or instead of, membership in a prescribed class of healthcare professional, along with the development of guidelines to support any adopted model.

### **Response to feedback**

The MHR Act establishes the concept of a SHS and requirement that it be prepared by a nominated healthcare provider. The MHR Regulations may specify additional types of providers that may author a SHS. As amendment to the Act is beyond the scope of this review, change to the provision for a SHS is not proposed at this time. However, in the context of considering whether other practitioners should be authorised to prepare a SHS, it was considered relevant to seek feedback from stakeholders as to the ongoing utility of the SHS, given emerging policy and systems in development.

Stakeholder feedback highlighted the need for SHSs to evolve to remain clinically relevant. The department acknowledges the value of transitioning SHSs toward models aligned with the AUCDI and IPS and recommendations regarding expanding eligibility to prepare SHSs. Accordingly, it is not proposed to amend the existing provisions at this time, and the future settings for the SHS or other health summary will be considered further in due course.

## 4. MHR system participation and Cyber Security

### Overview of feedback

There was broad consensus among stakeholders that the participation requirements outlined in the MHR Rule are mostly appropriate and fit for purpose. However, it was emphasised the need for clearer expectations and guidance, profession-specific guides and templates, and targeted education and training. These resources are considered essential for fostering a comprehensive understanding of the MHR legislation, including the MHR Rules, clarifying obligations, and supporting consistent compliance by all system participants. This support is particularly critical for small/solo healthcare organisations, which may face a disproportionate administrative burden.

Stakeholders also highlighted the critical role of software vendors in meeting conformance standards to enable integration with the MHR system. This is especially relevant for allied health providers, many of whom rely on diverse clinical software platforms that may not yet be fully compatible with the system. Without adequate support and vendor alignment, these providers may face barriers to participation and compliance.

Other recommendations related to MHR participation requirements included:

- Regular reviews of participation requirements should occur to ensure they remain practical, enforceable, and aligned with evolving digital health practices, risks, and technologies.
- Tailored security and access policies should be required for different participant types to better reflect how they access the MHR system.
- Physical and information security measure requirements within the security and access policy should be separated to clearly indicate that both domains must be addressed.
- Periodic staff training should be required to maintain awareness and compliance.
- Exemptions for small entities should be reviewed to ensure they remain appropriate.

Stakeholder views on cybersecurity provisions varied. Many expressed strong support for enforceable minimum cybersecurity standards, citing that healthcare is a prime target for cybercrime.

Recommended enforceable standards raised by stakeholders include alignment with national cybersecurity frameworks, such as Australian Cyber Security Centre (ACSC) Essential Eight Maturity Model, ISO/IEC 27001 Information Security Management System, Security Management System (SMS) frameworks and the National Cybersecurity Strategy (2023-2030). These frameworks provide structured approaches to risk mitigation, resilience, and compliance, particularly for healthcare organisations managing sensitive personal data.

Conversely, others felt that current obligations, especially under the *Privacy Act 1988*, already set adequate expectations. Those of this view expressed support for education initiatives over the introduction of prescriptive rules.

Overall, most stakeholders agreed that training is essential, with several recommending that periodic training be mandatory. Stakeholders also suggested strengthening security measures through the use of multifactor authentication (MFA), encryption, and the implementation of comprehensive breach-notification procedures.

## **Response to feedback**

It is proposed to review the existing participation requirements to ensure they reflect expectations regarding the settings needed to promote transparency related to MHR system access and provide clear requirements for participants to protect the privacy and security of the MHR system.

The department will continue collaborating with the Australian Digital Health Agency (the MHR System Operator) to provide support for MHR participants, including education and uplift in relation to security measures.

## 5. Emergency Access Framework under Rule 7 and 8 of the MHR Rule

### Overview of feedback

Stakeholder feedback reflected broad support for the MHR emergency access ('break glass') framework. However, some stakeholders identified areas of improvement to ensure it is used appropriately, so as to maintain public trust.

Key issues and concerns raised by stakeholders:

- Clarifying definitions: particularly of terms such as *serious threat*. Clear definitions are seen as essential to guide consistent and lawful use of emergency access.
- Stronger oversight and transparency: stronger oversight mechanisms are recommended to prevent misuse of the access controls and ensure transparency.
- Education on appropriate use: examples of inappropriate use of emergency access functionality, such as cases where emergency access is claimed in cases of forgotten access codes by healthcare recipients, highlights the need for targeted education for both healthcare providers and recipients.

Recommendations to improve the emergency access framework included:

- Shorter access windows: some stakeholders recommended reducing emergency access windows, for example to 24 hours, or developing simpler, consent-based pathways to reduce reliance on the emergency access mechanism.
- Consent based override pathways: There was support for permitting non-emergency override pathways, such as when a patient consents in forgotten code<sup>2</sup> scenarios.

Additional suggestions included to limit emergency access to relevant data points rather than full records, and to support healthcare providers and recipients by developing profession-specific guides and educational resources to reinforce proportionality and trust as system participation grows.

### Response to feedback

Invoking emergency access to a consumer's MHR, outside of section 64 of the MHR Act, even with consent, is currently unlawful. Any changes would require amendments to the Act to establish a distinct consent-based override function. Accordingly, such change is beyond the scope of this review. Stakeholder views on adjustments required to the existing emergency access framework will be used to guide future analysis and recommendations to government on proposals for amendment to the MHR Act.

There was strong evidence in the feedback on the need for education for healthcare providers as to permitted uses of the existing emergency access functionality. Further, increased consumer

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<sup>2</sup> Consumers can set access controls that require a record access code for their My Health Record or documents in it. If they forget this code and cannot provide it, healthcare providers are unable to access the record or the documents. In some cases, providers have used the emergency access function, claiming the consumer consented because they were unable to recall or supply their code.

awareness and knowledge of access codes, emergency access functions and the legal implications of misuse would also improve existing settings.

The department will collaborate with the Australian Digital Health Agency and the Office of the Information Commissioner<sup>3</sup> to review and refresh education and awareness and to consider system enhancements to ensure the 'break glass' function is only used for its intended purposes, and the collection of accurate data when the function is utilised.

## 6. Access to a deceased recordholder's MHR

### Overview of feedback

Consultation responses revealed a broad spectrum of views on post-death access to a consumer's MHR, reflecting diverse professional, ethical, legal and cultural considerations.

Some stakeholders supported limited, time-bound, purpose-specific access for authorised and/or nominated representatives and/or healthcare providers. While others pointed out the importance of maintaining privacy and the system's original design, which limits access and disclosure of sensitive information from a recordholder's MHR after their death.

Several recurring considerations emerged that reflect the complexity and sensitivity of accessing a recordholder's MHR following their death. These considerations included:

- The current legislative framework requires the cancellation of MHR registration upon death. The MHR Act and Rule would require amendment to support access for representatives or healthcare providers following confirmation that a MHR-holder is deceased.
- Practices surrounding death and sharing of personal and health information vary across cultures, particularly across First Nations communities. Automatic termination or continuation of access to a deceased recordholder's MHR may not align with these cultural norms. Any legislative changes must consider First Nations peoples' data sovereignty to ensure respectful and culturally appropriate policy outcomes.
- Exploring preserving pre-set access controls and preferences after death, allowing recordholders to determine which sensitive information may be available to representatives and healthcare providers for specific, defined purposes.
- Ensuring operational feasibility of any legislative change by establishing measures such as differentiating between types of representatives, restricting access to relevant data subsets and providing clear guidance and education for both healthcare recipients and providers.
- Ensuring accountability and transparency by implementing mechanisms to track and monitor access to support accountability and maintain public trust.

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<sup>3</sup> The Office of the Australian Information Commissioner (OAIC) plays a key role in regulating the privacy aspects of the My Health Record (MHR) system. OAIC oversees compliance with the *Privacy Act 1988* and the MHR Act, ensuring that healthcare providers use personal health information appropriately. This includes monitoring the use of the emergency access function, which allows providers to override a patient's access controls in limited circumstances—such as when it is necessary to prevent a serious threat to life, health, or public safety and obtaining consent is impracticable. OAIC conducts privacy assessments, provides guidance, and works with the Australian Digital Health Agency (System Operator) to address risks and prevent misuse of emergency access provisions.

Overall, stakeholders noted that any future policy development and legislative changes must be guided by the need for legislative clarity, cultural sensitivity, operational feasibility, and with strong safeguards in place to maintain public trust and uphold individual rights.

### **Response to feedback**

Currently, the My Health Records Rules requires the System Operator to suspend access to a MHR for authorised and nominated representatives when notified that the healthcare identifier status of the recordholder has changed to *deceased*. In contrast, healthcare professionals continue to retain access to the deceased individual's MHR after the IHI status is updated to *deceased*.

It is proposed that the rules be amended to allow representatives to retain *view-only* access, prior to receiving formal notification of death. This would enable representatives to see the record without making changes during this period. The proposed change supports continued access to important health information for legal, administrative, or care-related purposes, for a limited period, while preserving data integrity and protecting privacy.

After formal notification of death, the MHR Act provides for the individual's MHR registration to be cancelled. At that time, access for all representatives and healthcare providers ceases.

No changes are proposed to the current access arrangements for healthcare professionals. The amendments aim solely to align the level of post-death access between representatives and healthcare providers.

The considerations raised through this consultation process will inform future analysis and potential recommendations for legislative and system reforms, particularly in relation to access to MHR information after a person's death, where such access may be appropriate and supported by adequate safeguards. Further consultation will be used to test and refine future policy directions.

## **7. Assisted Registration**

### **Overview of feedback**

Stakeholders expressed strong support to retaining assisted registration provisions as an equity measure, particularly for older Australians, individuals with limited digital literacy or access, First Nations peoples, residents of rural and remote communities and people re-registering after opting out.

Assisted registration continues to be used regularly and remains the only face to face registration option. Some stakeholders noted that demand may increase with the implementation of the “share by default” initiative<sup>4</sup>.

While a few organisations argued that assisted registration is infrequently used and may be unnecessary under the opt-out model, most responses highlighted persistent barriers, such as digital exclusion and language and identity proofing challenges, which were considered to justify its continued availability.

Despite the overall support, stakeholders recommended a legislative and operational review to improve accessibility and simplify the registration process. Key recommendations included:

- Process improvements: simplify registration steps, provide multilingual resources and interpreter support, enable remote identity verification, and expand assisting entities to include trusted non-health organisations.
- Increased flexibility: reduce current requirement for consumers to present to a healthcare provider on at least three occasions (including one for assisted registration), as outlined in the My Health Record Identification Framework<sup>5</sup>, which incorporates the Known Customer Model (KCM)<sup>6</sup>; and clarify that assisted registration may be offered at every presentation.

Additional considerations included:

- Suggestions to introduce mechanisms to support cancellation of registration, particularly in complex cases (e.g. child protection).
- The need to ensure adolescent privacy and better support transitions to mature minor control, with clear parental responsibility checks.
- Recognition that expanding the scope of assisted registration will require technical solutions and clear guidance for both healthcare recipients and providers.

## Response to feedback

Having regard to the strong support for the ongoing need for assisted registration, it is proposed to review relevant provisions from the *My Health Records (Assisted Registration) Rule 2015*, and incorporate those, as necessary, into a new MHR Rule. Any change will be supported by process reviews, education and training, in line with feedback on this issue. This approach would streamline

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<sup>4</sup> Amendments were made to the MHR Act and related legislation to introduce a requirement to share certain health information to a consumer’s MHR by default, subject to certain exceptions. Eligibility for certain Medicare benefits will be subject to requirements to share information about the service provided, and constitutional corporations may face civil penalties for failure to upload required health information. As a result of these changes, it is expected that there will be increased volumes of records shared to MHR going forward, which may also drive increased levels of consumer access to MHR.

<sup>5</sup> Australian Digital Health Agency. My Health Record Identification Framework. Retrieved from <https://www.digitalhealth.gov.au/healthcare-providers/initiatives-and-programs/my-health-record/help-your-patients-to-register>

<sup>6</sup> The KCM model enables healthcare organisations to verify identity without full documentary evidence, relying instead on an established relationship with the consumer.

and simplify the MHR legislative framework, by consolidating registration processes under one legislative instrument. It is proposed that assisted registration will be governed under updated definitions and operational rules, in response to the feedback received on the complexity of the current process.

## 8. Regulatory Alignment and Simplification of Legal Obligations

### Overview of feedback

Most stakeholders agreed that the *My Health Records (Opt-Out Trials) Rule 2016* is obsolete and should be repealed. Harmonisation and merging relevant provisions of the *My Health Records (National Application) Rules 2017* into the MHR Rule, received widespread support.

Stakeholders recommended reviewing and/or clarifying the following provisions and requirements:

- Rule 32A - Uploading advance care planning information: provide clear guidance on acceptable forms of instruction for uploading advance care planning documents and specify who is authorised to give such instructions. Additionally, stakeholders suggested considering alignment with other document upload processes, including exploring the feasibility of removing the requirement for a healthcare provider to be instructed to upload information, subject to maintaining strong privacy and security safeguards.
- Rule 21 (Effective removal of records): decouple the conditions under Rule 21(1)(c), so that either a breach of section 45(ba) of the MHR Act (i.e. that the individual's professional registration or membership is not conditional, suspended, cancelled or lapsed) or the presence of clinical risk independently justifies the removal of a document.
- Rule 30 - Notification to the System Operator: clarify which non-clinical system related errors must be reported to the System Operator to ensure timely risk mitigation. Additionally, stakeholders suggested introducing a requirement for healthcare provider organisations to promptly update the contact details of the responsible officer/s (RO) and organisation maintenance officer/s (OMO) to prevent delays in critical notifications.
- Tailoring policy requirements by participant type: adjust obligations to reflect operational differences amongst participant types, ensuring policies are practical and proportionate to the role of each participant.
- Revising preserved privacy laws: review and address privacy law provisions that may create barriers to upload authority under a "share by default" model.

As outlined in the recommendations under other key themes, stakeholders also called for:

- Broadening SHS authorship and revisiting Rule 19 to allow uploads by more professions and additional data types, with appropriate and privacy safeguards.
- Explicit inclusion of allied health provider data and roles.
- Operational refinements (e.g. definition of "access"; security policy structure; training mandates; requiring all organisations, irrespective of size, to have a MHR security and access policy; and improved record transfer/contact mechanisms).

Overall, stakeholders believe the revision of provisions should aim to:

- Consolidate rules to improve legislative clarity and compliance.

- Enhance usability by making the MHR more intuitive and better integrated into clinical workflows.
- Strengthen interoperability across systems.
- Ensure alignment with national digital health strategies (e.g. the National Digital Health Strategy) and interoperability frameworks.

### **Response to feedback**

Adjustments to definitions and processes outlined in the rules are proposed in response to consultation feedback. The aim of the amendments will be to adopt clear and simple language into the new Rule, to assist with interpretation and implementation of the requirements.

The privacy laws preserved under the MHR Regulation operate so that express consent is required to share certain types of health information to MHR, which is contrary to the general MHR model which authorises health information to be shared to MHR unless a consumer advises they do not wish this to occur. Removal of the existing preserved privacy laws could only occur with the agreement of the relevant states and territories. The department will continue to collaborate with the states and territories in relation to opportunities to seek alignment of approaches to the sharing of health information.

## **9. General feedback and Considerations**

Some stakeholders did not have additional comments. However, others identified additional legislative and operational issues they felt were not addressed in the consultation questions, including the need to:

- Consider the structure of documents that support transitions of care, such as discharge summaries, medication information, and event-based notifications.
- Support for workforce enablement, specifically supporting pharmacy technicians with appropriate access controls to participate in national digital health systems.
- Continue aligning digital national systems with the CSIRO Sparked initiative, AUCDI, and HL7 standards, while ensuring continuous engagement with states and territories, software vendors, healthcare providers and consumers.
- Integrate the MHR system with other national systems, to achieve interoperability across systems, enhance visibility across entities and ensure continuity of care across the health and care sectors, for example in areas such as aged care.
- Continue investing on improvements to interoperability and real-time data access, consumer and healthcare provider engagement and education.

Overall, respondents envision that current and future changes to legislative frameworks and operational systems will enhance coordinated and patient centre-care, while maintaining and where possible strengthening individual protections and auditability.

These comments will be considered by the department, in collaboration with the Australian Digital Health Agency and other key stakeholders and delivery partners, to inform existing education and training opportunities and future proposals for system and legislative reform.

# Appendix A: consultation questions

## Specific questions

1. Should rule 19 of the *My Health Records Rule 2016*, which relates to restrictions on uploading certain health information, be reviewed? If so, what amendments would you propose and why? What considerations should guide the review of this rule?
2. Should the definition of a ‘nominated healthcare provider’ be expanded to include other health professionals involved in patient care (e.g. pharmacists, or enrolled nurses, or midwives who are not registered nurses)? Explain why or why not.
3. Should other health professionals also be able to author a shared health summary? If so, what types of health professionals and why?
4. Do you think that shared health summaries are still relevant as we modernise the MHR system? Explain why or why not and if possible, detail your experience with shared health summaries.
5. Are the participation requirements as set out in the *My Health Records Rule 2016* fit for purpose?
6. Do the provisions in the *My Health Records Rule 2016* need to be more specific in their application to cyber security?
7. Are rules 7 and 8 under the *My Health Records 2016*, which pertains to emergency access, still fit for purpose in their current form?
8. Should authorised and nominated representatives continue to have access to a deceased recordholder’s MHR? Explain why or why not.
  - a. If access was to be continued, should this apply equally to authorised and nominated representatives? If not, why?
  - b. What should that access involve? (e.g. view all or limited information?)
  - c. For what purposes should access be granted?
  - d. If applicable, for how long should such access be retained?
9. Should nominated healthcare providers and/or other healthcare providers continue to have access to a deceased recordholder’s MHR? Explain why or why not.
  - a. What should that access involve? (e.g. view all or limited information?)
  - b. For what purposes should access be granted?
  - c. If applicable, for how long should such access be retained?
10. Is there an ongoing need for assisted registration?
11. If assisted registration is to be retained, should any revisions to the process be considered?

## General questions

12. Are there any instruments that you believe are no longer fit for purpose, necessary or require revision? If yes, please explain reasoning.
13. Are there any specific provisions in the instruments that you believe are no longer fit for purpose, necessary or require revision to better support the operation of the MHR system? If yes, please explain reasoning.
14. Are there any issues that you would like to address that have not been covered by any other questions? If yes, please explain reasoning.
15. Do you have any concerns or comments about the *My Health Records (National Application) Rules 2017* being repealed and remade into a new instrument with alignment of the other instruments?
16. Do you have any other comments related to the scope of the review?
17. Do you have any overall feedback or comments about the operation of the MHR system?

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All information in this publication is correct as at March 2026

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