

Help understanding your health records.

- Please remember our clinicians only have on average 12mins to consult with you. This includes reading any documents, the actual consultation, writing their notes, and giving you any advice, treatments or referrals required.
- It is impossible for them to document everything that has been said to you, instead they will write the points they feel important to them or the next clinician, often using short-hand and abbreviations.
- Medical records are a record of events and information for clinical staff and not a word for word account of what may have taken place for your own reference.
- They may contain professional opinion or ideas that you may not necessarily agree with.
- Most medical records contain 'Clinical Codes' They may not match exactly your problem or may be in medical jargon. These are required and are common terms and problems that make linking and searching records easy.

For example, 'Earache' automatically gets saved by the computer system as 'otalgia'

- There is not enough capacity and time in General Practice to explain your notes to you. It is also not an NHS duty for this to be done.
- If you have any major or serious concerns regarding your notes, then please get in touch with the practice in writing.