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**A COMPREHENSIVE REVIEW OF MEDICAL REPORTING  
PRACTICES IN MALAYSIA: MEDICAL RECORDS AND  
MEDICAL REPORTS**

*by*

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**INTRODUCTION TO MEDICAL REPORTING PRACTICES IN  
MALAYSIA**

An essential component of a doctor's responsibilities when treating patients is maintaining medical records. A medical record is an extensive, thorough, and continuous record of a patient's medical history, treatments and other health-related information kept by healthcare professionals. Medical records will constitute a permanent record of the patient's health conditions. This systematic upkeep is carried out daily, indicating continuity of care and any progression resulting from treatments. Keeping thorough and accurate medical records guarantees that patients' demands are satisfied and facilitates easy communication between patients and medical staff.<sup>[1]</sup>

**CONTENTS OF MEDICAL RECORDS**

The medical record provides details to help identify a patient by containing information about the patient's case history. This comprises a wide range of "notes" that medical experts have entered throughout time, including recording observations and administration of drugs and therapies, orders for the administration of drugs and therapies, test results, x-ray reports, etc.

**THE IMPORTANCE OF MEDICAL RECORDS**

Medical records enable medical professionals to ascertain the patient’s medical background and deliver well-informed treatment. It serves as a “central repository” for planning patient care and documenting correspondence between the patient and healthcare provider, and any other professionals involved in the treatment. Moreover, health care providers agree that the medical record is a vital and essential supplement to medical education and treatment.

**MEDICAL REPORT**

Medical reports are written by a medical professional about a patient, using information from the patient’s medical records. A medical report is a specific document prepared by a healthcare professional that summarises the findings, diagnosis, treatment, or procedure related to a particular medical event or condition.

Usually, a medical report is written for a particular circumstance, such as following a consultation, test, operation, or other medical interaction. It serves as a record for administrative, legal, or insurance purposes, or it conveys a specific element of the patient’s treatment to other medical professionals.

**KEY DIFFERENCES BETWEEN MEDICAL RECORD AND MEDICAL REPORT**

	<b>Medical record</b>	<b>Medical report</b>
<b>Definition</b>	A comprehensive, ongoing account of a patient’s entire health history and care.	A focused document entailing a specific medical event or condition of a patient.
<b>Content</b>	Personal info, medical history, diagnoses, treatments, test results, progress notes, medical	Specified dates, diagnosis, test results, examination findings, facts, treatment details, etc.

	opinions, recordings, consultations, reports.	
<b>Time duration</b>	Continuous, updated regularly throughout the patient’s care.	Created at specific times (e.g., after surgery, consultation, or test).
<b>Use</b>	Used for ongoing healthcare management and continuity of care.	Provides a snapshot of specific health information for a particular event.

**E-MEDICAL RECORDS**

In the context of clinical trials, both e-medical records and e-medical reports play fundamental roles in ensuring the proper documentation, management, and monitoring of participants’ health data. Electronic medical records (EMR) are continuously collected data sources which entail standard medical and clinical data from the specific institution of a patient.

The importance of e-medical records is paramount, which in all improves patient care. Due to the convenience of accessibility, health care professionals are able to have up-to-date information about a patient, resulting in faster decision making, better coordination of care, and thus allowing them to make informed decisions and a more efficient and accurate treatment.<sup>[2]</sup>

Electronic medical records reduce risk of mistakes by increasing the precision of medical data, offering automated notifications for any problems, fostering better provider-to-provider contact, and guaranteeing that all data is current and safe. These elements aid in avoiding errors pertaining to patient history, test findings, medication, and therapy.

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## **IMPORTANT CONCEPTS AND PRINCIPLES OF MEDICAL RECORDS AND MEDICAL REPORTS IN MALAYSIA**

### **Confidentiality**

Medical records and reports may include patient identification data, doctors' clinical notes, imaging records, laboratory reports, drug prescriptions, diagnoses, and treatments. These are confidential in nature and can be accessed only by authorised persons, namely medical practitioners, as indicated in the International Code of Medical Ethics 1949, "A doctor shall preserve absolute secrecy on all he knows about his patients because of the confidence entrusted in him". Doctors and healthcare facilities are legally obligated to keep medical records and reports confidential.

The medical records and reports may contain the patient's personal data, for example, full name, identification number, and telephone number, which falls under the Malaysian Personal Data Protection Act 2010 ('PDPA'). Section 8 of the PDPA states that personal data cannot be disclosed to third parties without the data subject's consent. In this context, no disclosure of the personal information can be made without the patient's consent unless it falls within the exceptions stated under the PDPA, which are: (a) the disclosure is for a purpose that was disclosed to the data subject when the data was collected, or for a purpose that is directly related to that purpose, (b) the disclosure is to a third party that is listed in a written notice given to the data subject, and (c) the disclosure is required by law or in the public interest. Section 8 is further subject to section 39 of the PDPA 2010, which sets out exceptions to confidentiality where the disclosure of the information is required under any law or by court order, in the public interest, and for other reasons stated under this section.

The PDPA also covers "sensitive personal data", defined under the PDPA as "any personal data consisting of information as to the physical or mental health or condition of a data subject, his political opinions, his religious beliefs or other beliefs of a similar nature, the commission or alleged commission by him of any offence or any other personal data as the

Minister may determine by order published in the Gazette”. This certainly includes the patient’s medical records and reports, as they consist of the patient’s physical and mental health condition. Section 40 of the PDPA states that sensitive personal data can only be processed if the data subject (i.e., the patient) gives their explicit consent, unless it falls under the exceptions, which include when the data subject has intentionally made the information public, the processing is for the purposes of exercising or performing a right or obligation imposed by law on the data user in connection with employment, and other cases as stated in section 40 of the PDPA.

The obligation to preserve the confidentiality of medical records of the patients is stated under the Malaysian Medical Council’s guidelines on confidentiality (‘Confidentiality Guidelines’),<sup>[3]</sup> which highlights that “The justification for this information being kept confidential is that it enhances the patient-doctor relationship. Without assurances about confidentiality, patients may be reluctant to give doctors the information they need in order to provide good care”. It is also stated under the Confidentiality Guidelines that confidentiality is an important duty of the doctors, but it is not absolute as a practitioner can disclose the personal information if: (a) it is required by law, (b) the patient consents either implicitly for the sake of their own care or expressly for other purposes; or (c) it is justified in the public interest.<sup>[4]</sup>

Therefore, it is deducible that medical records and reports are confidential in nature and shall not be disclosed to any unauthorised person without consent, except where they are required to be disclosed under the law.

### **Ownership and Access**

The MMC Guideline 002/2006 (Medical Records and Medical Reports) (‘MMC Guideline 002/2006’) states that a patient’s medical record is the property of the medical practitioner and the healthcare facility and services, which hold all rights associated with ownership. Regulation 44(1) of the Private Healthcare Facilities and Services) Regulations 2006 also state that “a patient’s medical record is the property of a private healthcare

facility or service”. Therefore, it can be derived that patients have no right to keep their original medical record, as it is owned by the relevant healthcare institution and the medical practitioner. However, patients have the right and are entitled to access their own medical records and be given copies of such records as patients may require access for various reasons, such as for further medical treatment at different facilities, seeking a second opinion and litigation purposes.

In the case of *Nurul Husna Muhammad Hafiz & Anor v. Kerajaan Malaysia & Ors* [2015] 1 CLJ 825, the High Court held that:

“Based on the legal duties and rights that arise from the physician-patient fiducial relationship, and further having regard to the provisions in the guideline and the common law principles, the legal position in Malaysia *vis-à-vis* the patient’s right of access to medical records can be summarised as follows: (a) The ownership of a patient’s medical record vests with the physician or hospital as the case may be. However, the physician or hospital must deal with the medical records in the best interest of the patient; (b) The patient has an innominate and qualified right of access to his medical records and there is a corresponding general duty on the part of the physician or hospital to disclose the patient’s medical records to the patient, his agents, medical advisers or legal advisers; (c) The physician or hospital may refuse to disclose partly or wholly the medical records to the patient in certain limited circumstances, such as, but not limited to, situations when such disclosure would be detrimental or prejudicial to the patient’s health in that the information is likely to cause serious harm to the physical or mental health of the patient or of any other individual contained in the medical records; or when such disclosure would divulge information relating to or provided by an individual, other than the patient, who could be identified from that information; (d) When the circumstances giving rise to such qualification for refusal to disclose does not present itself, and when the request for disclosure is reasonable, having regard to all the circumstances, the physician or hospital shall give copies of the

medical records to the patient upon payment of reasonable copying charges.”

In this case, it is clear that medical records and reports are owned by the medical practitioners and healthcare facilities, but patients and their agents can have access to the patients’ medical records and reports. It is also expected that the medical practitioner and the person in charge in the healthcare institutions will release such information and record when requested by the patients and their authorised agent, as stated in MMC Guideline 002/2006. The MMC Guideline also indicates that if a patient’s or their agent’s request for access is refused, the patient may resort to civil action. This is further supported in the same case cited above, where the Court held:

“If access is withheld unreasonably and the patient is to put to cost and expense to procure a court order to compel production of the medical records, for instance under the provisions of O. 24 r. 7A of the Rules of Court 2012, then the patient would in such circumstance be entitled to cost on a solicitor-client basis.”

Thus, in cases where the patient’s access to their medical records is being denied, the patient can seek the court’s intervention to obtain those medical records. The MMC Guideline 002/2006 also stipulates that the disclosure of medical records may be denied where it may be detrimental or disparaging to the patient or any other individual, or where it may cause serious harm to the patient’s mental or physical health or endanger the patient’s life. In such instances, the practitioner should be able to justify their decision to deny the disclosure.<sup>[5]</sup>

### **Record Keeping and Retention**

Due to the confidential nature of the medical records and reports, it is vital for these documents to be documented accurately and promptly, and good record-keeping practices must be in place to foster effective patient care and legal compliance.<sup>[6]</sup> Some of the best practices are as follows:

(1) Accuracy and Completeness

The medical practitioner should ensure that the medical documents are accurately recorded, in which he shall record all relevant patient interactions, including medical history, examination findings, diagnostic results, treatments, and patient preferences. To keep the completeness of the medical documents, the medical practitioner shall include both positive and negative findings, differential diagnoses, and necessary steps taken to exclude them for future reference.<sup>[7]</sup>

(2) Timeliness

The medical documents shall be recorded in a timely manner, preferably as soon as possible after the patient's visit, to accurately reflect what took place during the patient's visit.<sup>[8]</sup> The medical practitioner shall maintain the medical records in chronological order to demonstrate the continuity of care and provide a full picture of the patient's health over time.<sup>[9]</sup>

(3) Legibility and Clarity

It is important to use clear writing when writing medical documents to ensure their legibility. The medical practitioner is advised to use clear and concise language,<sup>[10]</sup> plus a standardised format to ensure consistency across records.<sup>[11]</sup> While medical practitioners are known to be familiar with medical jargon, it is advisable to use standard medical terminology to avoid misunderstandings.<sup>[12]</sup>

(4) Legal compliance

The medical practitioner shall adhere to the local and international regulations regarding medical record-keeping.<sup>[13]</sup> This also includes obedience to the appropriate retention policies for different types of documents, as each document may have its own retention policy. Furthermore, the medical practitioner shall conduct regular audits to ensure the record-keeping practice at healthcare institutions is aligned with the highest record-keeping standards.<sup>[14]</sup>

(5) Retention period

According to Bali et. al. (2011), the medical records are generally retained for the following periods:<sup>[15]</sup>

Adult Patients	3 years
Newborn Patients	18 + 3 years
Children Patients	Up until they are 18 years + 3 years
Mentally Retarded Patients	As long as the healthcare institution is operating
From Income Tax POV	7 years

However, from a medical perspective, medical documents should be preserved for as long as they are necessary for the standard of care and the management of cases by medical practitioners. Furthermore, it is also significant to highlight that medical documents must be kept for as long as there are legal reasons for doing so. For example, if records are needed for a court case, they must be kept until the case is concluded.<sup>[16]</sup>

**Disclosure to Third Party**

Generally, the medical documents can be disclosed to a third party with the consent of the patient. This has been highlighted in MMC Guideline 002/2006, which states that “Medical practitioners and persons in charge of healthcare facilities and services are generally expected to cooperate and release all parts of the medical records, or certified true copies of the records, when so requested by the patient.” However, the medical practitioner may refuse a request to disclose the medical documents under certain reasonable conditions:<sup>[17]</sup>

- (1) If the medical practitioner believes that the information in the medical documents, if disclosed, could be harmful or disparaging to the patient or any other person, or could seriously impair the patient’s physical or mental health or jeopardise his life;

- (2) If the patient has passed away; or
- (3) If the patient, his legal next of kin, or guardian, has not given written consent for the release of the medical information to a third party.

The disclosure of medical documents to a third party usually happens in medical negligence lawsuits. Hence, medical practitioners should understand the patient's position when the patient requests the disclosure of medical documents. Purposefully making the process challenging for the patient by irrationally denying them access to their medical records could be against MMC policy and result in disciplinary action.<sup>[18]</sup>

## **LEGAL STATUS OF MEDICAL RECORDS AND MEDICAL REPORTS IN MALAYSIA**

In Malaysia, medical records and medical reports are not merely administrative or clinical documents. Once created, they acquire an independent legal status that carries enforceable consequences under civil, regulatory, and disciplinary frameworks. Their legal significance arises from their role as authoritative records of medical decision-making, professional judgment, and factual events occurring during patient care.

### **Medical Records and Reports as Legal Documents**

Medical records are treated in law as contemporaneous records generated in the ordinary course of professional practice. Because they are created at or near the time of clinical events, they are accorded a presumption of reliability.<sup>[19]</sup> Medical reports, although derived from medical records, are distinct in nature as they involve interpretation, summarisation, and professional opinion prepared for a defined external purpose.

Once issued, a medical report constitutes a formal representation by the medical practitioner. Any inaccuracy, omission, or mischaracterisation may give rise to legal consequences, including professional misconduct, civil liability, or evidentiary challenge.<sup>[20]</sup> Practitioners, therefore, bear

personal responsibility for the contents of medical reports, even where the underlying information originates from institutional records.

### **Professional Accountability and Standard of Care**

The legal status of medical documentation is closely tied to professional accountability. Medical records are frequently used to assess whether a practitioner has met the applicable standard of care. In situations where records are incomplete, inconsistent, or absent, adverse legal inferences may be drawn against the practitioner or healthcare facility.

Medical reports carry an even higher threshold of responsibility, as they often influence third-party decisions such as insurance approvals, employment determinations, regulatory assessments, or judicial findings. A practitioner issuing a medical report is expected to exercise independent professional judgment and ensure that conclusions are supported by documented clinical findings.

### **Liability Arising from Inaccurate or Improper Documentation**

Errors in medical records or reports may expose healthcare providers to multiple layers of liability. In civil proceedings, inaccurate documentation may weaken the defence of a medical practitioner or institution. In regulatory or disciplinary contexts, misleading or negligent reporting may constitute a breach of professional duties.

Importantly, liability may arise not only from what is recorded, but also from what is omitted. Failure to document key clinical observations, patient complaints, informed consent discussions, or treatment rationales may be interpreted as a failure in care, even where appropriate treatment was in fact provided.

### **Evidentiary Weight in Judicial and Quasi-Judicial Proceedings**

Medical records and reports are routinely relied upon as documentary evidence in Malaysian courts, tribunals, and regulatory proceedings. Courts generally distinguish between factual entries recorded during

treatment and retrospective opinions expressed in medical reports. While both are admissible, contemporaneous medical records often carry greater evidentiary weight because of their proximity in time to the events described.

Medical reports prepared for litigation or third-party use may be subjected to closer scrutiny, particularly where there is a perceived lack of neutrality or inconsistency with the underlying medical records. Any discrepancy between medical records and reports may affect the credibility of the practitioner and the probative value of the evidence.

### **Institutional Responsibility and Risk Management**

From an institutional perspective, medical records and reports form part of the organisation's legal risk profile. Healthcare facilities are expected to implement governance structures that ensure proper documentation practices, internal review mechanisms, and clear protocols for the issuance of medical reports.

Failure to maintain robust documentation standards may expose healthcare institutions to systemic liability, reputational harm, and regulatory sanction, even where individual practitioners are involved in the preparation of the documents.

### **Legal Implications in the Digital Environment**

With the increasing use of electronic medical records and digitally generated medical reports, the legal status of these documents extends equally to electronic formats. Electronic records are treated as legally valid provided their integrity, authenticity, and auditability can be demonstrated. Any unauthorised alteration, deletion, or improper access to electronic medical records may carry legal and evidentiary consequences.

## **CONCLUSION**

In essence, medical records and reports in Malaysia are more than just clinical paperwork. They serve as reliable evidence of how medical care

was delivered and how professional judgment was exercised. Beyond supporting patient treatment, these documents can have real legal consequences, whether in demonstrating compliance, highlighting potential liability, or influencing the outcome of disputes. For this reason, careful record-keeping and thoughtful preparation of medical reports are not merely good practice, but an essential legal responsibility within Malaysian healthcare.

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**Endnotes:**

[1] Abdelrahman, W and Abdelmageed, A, ‘Medical Record Keeping: Clarity, Accuracy, and Timeliness are Essential’ (2014) *British Medical Journal* 348.

[2] ‘Electronic Medical Records (EMR) for Malaysia’s Medical Industry’, *Aoikumo* (Web Page) <<https://www.aoikumo.com/emr-malaysia/>>.

[3] Malaysian Medical Council Guidelines on Confidentiality (revised as at 11 October 2011).

[4] *Ibid* Parts I–III.

[5] See 1.17 Denial of Disclosure of the Confidentiality Guidelines.

[6] ‘Effective record-keeping’, *MDU* (5 August 2025, Web Page) <<https://www.themdu.com/guidance-and-advice/guides/effective-record-keeping>>;

Bali, A, et al., ‘Management of Medical Records: Facts and Figures for Surgeons’ (2011) 10(3) *Journal of Maxillofacial and Oral Surgery* 199–202.

[7] *MDU* (n 6). See also 1.7 Patient’s Expectations and Rights to Medical Records of the MMC Guideline 002/2006.

[8] *MDU* (n 6).

[9] Abdelrahman and Abdelmageed (n 1).

[10] ‘How to Maintain Accurate Healthcare Records’, *Charter College* (Web Page) <<https://chartercollege.edu/news-hub/how-maintain-accurate-healthcare-records/>>.

[11] Nabwami, L, ‘Record Keeping and Documentation’, *Ausmed* (Web Page) <<https://www.ausmed.com/learn/articles/record-keeping-documentation>>.

[12] *Ibid.*

[13] *MDU* (n 6).

[14] Nabwami (n 11).

[15] Bali et al. (n 6).

[16] ‘Medical Records: Preservation and Matters of Evidence’, *PS Ranjan & Co* (Web Page, 2020) <<https://www.psrango.com/cdn/articles/Preservation-of-Medical-Records.pdf>>.

[17] See 1.15 Access to Medical Records of the MMC Guideline 002/2006.

[18] Shona Anne Thomas, ‘Can I Have My Medical Records?’, *Medico Dento Practice* (LHAG Advocates and Solicitors, 2021) <<https://lh-ag.com/wp-content/uploads/2022/11/Can-I-Have-My-Medical-Records-LHAG-Insights-20210107.pdf>>.

[19] Evidence Act 1950 s. 80.

[20] *Nurul Husna Muhammad Hafiz & Anor v. Kerajaan Malaysia & Ors* [2015] 1 CLJ 825.