

My Health Record FAQs: for clinical immunology/ allergy specialists

My Health Record is secure, it can save you time, and it may reduce unnecessary duplication of diagnostic services. Accessing My Health Record ensures safe prescribing, especially for patients with known food or drug allergies.



1. How is My Health Record useful in the allergy setting?

One of the most useful applications of My Health Record is being able to communicate information about a patient's drug or food allergy to other healthcare providers (particularly emergency and hospital physicians). Allergy information is included in a range of documents, such as patient history, medical records (paper and electronic), letters between specialists and GPs, and hospital discharge summaries. My Health Record provides a single location for all these documents that can be accessed at any time.

My Health Record can also provide specialists with information about patient:

- medications
- pathology test results
- diagnostic imaging reports.

This is particularly useful if a referral does not have this information and if the patient cannot recall current medications or recent pathology and/or diagnostic imaging results.

For more information see the fact sheet: [My Health Record for clinical immunology/allergy specialists](#).

2. How far back does the information in a patient's My Health Record go?

- Clinical information is uploaded when patients interact with the healthcare system, and uploaded documents such as discharge summaries, pathology and imaging reports and immunisation history can date back to 2012, when My Health Record first started.

3. Will many of my patients have a My Health Record that has information in it?

- There are over 24.4 million records and over 99% now have information in them. This will continue to increase. If a patient has not had many interaction with the health system since their record was created, neither the patient or their healthcare professionals may have had any reason to update the record, and there therefore may be limited information.
- In August 2025:
 - 99% of general practices and pharmacies were connected to My Health Record and uploading or viewing documents.
 - 97% of public hospitals were connected, and 95% were using My Health Record.

For the latest My Health Record statistics visit digitalhealth.gov.au.

4. I work in private practice and have conformant software. How do I get access to My Health Record?

The registration process for clinical immunology/allergy specialists is outlined step by step on the page: [Getting started: My Health Record for private allergy practices](#). For assistance, please contact the Australian Digital Health Agency's Help Centre on 1300 901 001 or email: help@digitalhealth.gov.au.

5. Can I download or save documents from a patient's My Health Record to my local system, such as pathology reports?

Yes, if you have access to My Health Record through [conformant clinical software](#) or the National Provider Portal, you can view, download and save information from your patient's My Health Record. Some healthcare providers find it useful to download documents and save them to their patient's record in their local information system. Any use, storage, or disclosure of downloaded information must comply with the Privacy Act 1988 and the *My Health Records Act 2012*, this includes:

- Ensuring the information is stored securely.
- Using it only for the intended healthcare purpose.
- Not disclosing it improperly.

6. How is My Health Record being used in public hospitals and health services? Are outpatient clinic letters uploaded to My Health Record?

As of June 2025, 97% of public hospitals are now registered with My Health Record and 95% are using My Health Record. How public hospitals are using My Health Record will depend on the hospital. You can check the list of [participating hospitals](#) and contact your hospital's chief information officer to find out more.

Most public hospitals are uploading discharge summaries, pathology results and diagnostic imaging reports. Outpatient letters are being uploaded from some public hospitals, but only uploaded in small numbers at this stage. The Agency continues to engage with more public hospitals to upload this information, which will allow results of skin prick testing and food and drug challenges to be shared with other members of the patient's healthcare team.

A list of pathology laboratories and diagnostic imaging services (both public and private) is published on the [My Health Record website](#).

7. What changes have been made recently in regards to required information on My Health Record?

In December 2024, the Health Legislation Amendment (Modernising My Health Record - Sharing by Default) Bill 2024 was passed that required certain health information to be shared by default on My Health Record, unless the patient has opted out. This includes most pathology and diagnostic imaging reports. There is a delay in pathology and diagnostic imaging results being made accessible for patients. Reports for diabetes monitoring (HbA1c), blood clotting time monitoring (or international normalised ratio [INR] test), respiratory infection tests (such as flu), and COVID-19 are not implicated by the delay and are available immediately for patients to view on their My Health Record.

For further information, please read [Frequently Asked Questions Health Legislation Amendment \(Modernising My Health Record – Sharing by Default\) Bill 2024](#).

8. What might a patient ask about the information in their My Health Record?

Patients or their carers might be concerned about the safety of their medical and identifying information. You can advise patients that My Health Record uses high level security and protection to safeguard their information. Their information can only be accessed by healthcare providers involved in their care and they can track who has accessed their record.

For further information on privacy and access, including how to set access controls, visit [Discover who can access your medical records | Privacy and access](#)

You can also refer your patients to the [People with allergies and their carers page](#) on the National Allergy Council's website.

9. How can I ensure my patient's My Health Record contains accurate information about their allergies?

If you have [conformant clinical software](#), you can upload an event summary with information about their confirmed allergies, or information that a patient has been confirmed to be not allergic, following a food or drug challenge. For information about how to do this, see: [Event summaries: A guide for clinical immunology/allergy specialists using conformant software](#).

If you do not have conformant clinical software, you can advise your patients to add this information into My Health Record themselves by providing them with the name of the substance(s)/agent(s) they are allergic to and the reaction type. You can refer your patients to the [Getting set up with My Health Record: a guide for people with an allergy and their carer](#) page on the National Allergy Council's website.

You can also include a note to the patient's GP in your specialist letter, encouraging the GP to upload a shared health summary with the current allergy information you've provided.

10. An event summary seems like extra administrative work when I already write a specialist letter back to the referrer. Can I upload my specialist letter to My Health Record? How would I do this with conformant software?

Specialist letters can be uploaded through conformant clinical software. You can contact your software provider to confirm if you can generate and upload specialist letters to your patient's My Health Record.

An up-to-date list of conformant software products is also available at [Registers](#). If your software does not allow you to upload a specialist letter, uploading an event summary is a way of ensuring that allergy information is available to other healthcare providers involved in the patient's care. While this may seem like extra administrative work, it is important for patient safety.

11. Is there a Practice Incentive Program for specialists to get them started? I believe there was an eHealth Incentive for GPs.

There are no practice incentives for specialists to get started with My Health Record. The Practice Incentive Programs is administered by the Australian Department of Health, and not by the Australian Digital Health Agency who is the System Operator of My Health Record.

12. Can practice administration staff upload a specialist letter or does the specialist have to do this?

A registered healthcare organisation can authorise their administrative staff to access My Health Record to upload documents on behalf of the organisation. Authorised users may be individual healthcare providers and other local users who need to access the My Health Record system as part of their role in healthcare delivery.

Organisations are required to have appropriate policies in place to ensure that staff accessing My Health Record as part of their role within the organisation are trained.

For more information about how non-clinical staff can access the My Health Record, refer to the [Digital Handbook for Practice Management](#) and [The My Health Record Practice Manager Registration Guide](#).

13. For what percentage of patients is accessing My Health Record information of benefit?

- Accessing My Health Record is particularly useful for patients with complex medical histories, or when a referral contains incomplete information. One clinical immunology/allergy specialist found that accessing My Health Record (via the National Provider Portal) was useful for around 25% of his patients. His experience was that he could save time by accessing pathology reports in one place rather than phoning the pathology provider or GP. Furthermore, if he used conformant software to access My Health Record, he would use it more seamlessly in his workflow and therefore more frequently than 25%.