

## Normative Juridical Study of Patient Storage Obligations and Access Rights to Medical Records

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### Abstract

**Introduction:** Medical records are not merely administrative documents, but legal instruments that guarantee continuity of care, patient autonomy, and protection of sensitive health data. The expansion of electronic medical records in Indonesia has intensified the need to reconcile record-retention obligations, patient access rights, medical confidentiality, and personal data protection. **Objective:** To analyze the legal construction governing the storage of medical records and patient access rights, and to assess whether the current regulatory framework is adequate from the perspectives of human rights, proportionality, and personal data protection. **Method:** This study uses normative juridical research with statutory and conceptual approaches. Legal materials were analyzed prescriptively using a human rights approach, the proportionality principle, and data-protection principles, particularly confidentiality, purpose limitation, security, and accountability. **Result and Discussion:** The study finds that Indonesian law already recognizes the obligation of healthcare facilities to retain medical records and the right of patients to access their health information; however, implementation remains fragmented. Normative tension arises because regulations affirm patient access, yet do not sufficiently detail the limits, procedures, classification of accessible information, and safeguards for sensitive clinical notes in electronic systems. This ambiguity creates inconsistent practice, bureaucratic barriers, and legal uncertainty. **Conclusion:** Regulatory harmonization is needed through derivative rules that define the scope of patient access, role-based access control, retention governance, complaint mechanisms, and digital security standards so that patient rights are fulfilled without undermining confidentiality and data protection.

## **Introduction**

Health is a human right guaranteed by the 1945 Constitution of the Republic of Indonesia, as stipulated in Article 28H, paragraph (1), and Article 34, paragraph (3). The state is obliged to guarantee the right to safe, high-quality, non-discriminatory health services and respect for human dignity as part of the fulfillment of human rights. This obligation is implemented through a responsible, equitable, and sustainable health care system (Tombokan et al., 2024). Hospitals are providers of health services, with individual health care functions, including specialist and/or subspecialist services. According to Law Number 17 of 2023 concerning Health, hospitals are required to provide comprehensive health services, including the obligation to maintain medical records, as stated in Law Number 17 of 2023 concerning Health, Article 189 Paragraph (1) point h. Medical records are the primary instrument for systematically documenting the entire process of health care provided to patients. Maintaining accurate, complete, and continuous medical records is not only a hospital's administrative obligation but also a form of legal protection for patients, allowing them to access their right to information and ensuring transparency in the provision of healthcare services in accordance with the principles of health law and medical ethics.

Maintaining medical records is closely related to fulfilling patients' rights to health information. Every patient has the right to receive complete, correct, clear, and honest information regarding their health condition, including their diagnosis, medical procedures, and potential risks (Daud et al., 2024). Medical records are the primary means of ensuring the fulfillment of this right and reflecting the hospital's adherence to legal standards and professional ethics. Therefore, medical records must be maintained in a complete, secure, and confidential manner to protect patient rights. Furthermore, health information contained in medical records constitutes sensitive personal data and is protected by Law Number 27 of 2022 concerning Personal Data Protection. As subjects of personal data, patients have the right to know, access, and obtain a copy of their medical data, as well as the right to request correction of inaccurate data. However, the exercise of these rights is inseparable from the hospital's legal obligation to maintain confidentiality and retain medical records for a specified period, as stipulated by laws and regulations.

The conflict between medical confidentiality and patient access rights is becoming increasingly apparent in the implementation of electronic medical records. In practice, patients often demand full access to the entire contents of their electronic medical records, including subjective clinical notes, sensitive diagnoses, and psychiatric examination results. However, healthcare facilities frequently restrict this access, citing concerns about protecting medical confidentiality, information system security, and preventing misuse and misinterpretation of medical data. This situation creates a legal and ethical dilemma, as on the one hand, restricting access could be considered a violation of patients' right to autonomy over their personal data, as guaranteed by Law Number 27 of 2022 concerning Personal Data Protection. On the other hand, granting unlimited access potentially increases the risk of data leaks and privacy violations, particularly in digitally connected electronic medical record systems (Komala et al., 2024). This normative and practical gap demonstrates the need for clear regulations regarding patients' right to access to medical records within the national health law system. Therefore, this article aims to formulate and analyze the legal obligations of healthcare facilities regarding the storage of medical records and patients' right to access medical records as part of fulfilling human rights, the right to personal data protection, and patients' rights in healthcare services. Providing

hospitals with access to medical records must be accompanied by guarantees of data security and confidentiality, in accordance with Law Number 17 of 2023 concerning Health and Law Number 27 of 2022 concerning Personal Data Protection. It is also hoped that this will provide normative input to improve medical record regulations, including the Law and Regulation of the Minister of Health concerning Medical Records.

### **Method**

This study is normative juridical legal research employing a statutory approach and a conceptual approach. The statutory approach examines the 1945 Constitution of the Republic of Indonesia, Law Number 17 of 2023 concerning Health, Law Number 27 of 2022 concerning Personal Data Protection, Law Number 39 of 1999 concerning Human Rights, Minister of Health Regulation Number 24 of 2022 concerning Medical Records, and Minister of Health Regulation Number 22 of 2024 concerning Medical Records. The conceptual approach uses a human rights framework, the principle of proportionality, and data-protection principles - particularly confidentiality, purpose limitation, security, and accountability - to assess whether restrictions on patient access are justified and whether the retention of medical records is governed with sufficient legal certainty. Legal materials were collected through literature study and classified into primary legal materials, secondary legal materials, and relevant supporting doctrine. All legal materials were analyzed qualitatively through prescriptive-argumentative reasoning to identify normative consistency, implementation gaps, conflicting norms, and appropriate legal recommendations.

### **Result and Discussion**

#### **1. Legal Norms**

Medical records have a dual juridical position. First, they are professional and administrative instruments that document examination, treatment, action, and other health services provided to a patient. Second, they function as legal evidence that can demonstrate whether healthcare services were delivered according to standards of care, informed consent obligations, and institutional accountability. Because of that dual function, the obligation to create and retain medical records cannot be reduced to internal hospital administration; it is part of the state's obligation to guarantee the right to health, the right to information, and legal protection for patients.

This normative construction is clearly reflected in the Indonesian legal framework. Article 28H paragraph (1) of the 1945 Constitution guarantees the right to health services, while Article 14 paragraph (1) of Law Number 39 of 1999 concerning Human Rights guarantees the right to obtain information necessary for personal development. Law Number 17 of 2023 concerning Health places medical records within the mandatory responsibilities of healthcare facilities, and Law Number 27 of 2022 concerning Personal Data Protection classifies health data as specific personal data that requires heightened protection. From a human rights perspective, medical records are closely linked to the right to privacy, particularly because they contain highly sensitive health data. As emphasized in Article 32 of Law Number 39 of 1999 concerning Human Rights, personal protection includes health information. Thus, storage and access rights must be interpreted as one integrated legal regime rather than as separate administrative questions.

From this perspective, patient access to medical records is not a derivative privilege granted solely at the discretion of healthcare providers, but a legal consequence of the patient's status as the subject of health data and as the holder of the right to information.

However, that access is not absolute. Because medical records also contain professional assessments, third-party information, and sensitive clinical data, access must be regulated in a manner that is proportionate, secure, and limited to legitimate purposes. Thus, the core legal issue is not whether patients have access rights, but how those rights should be structured so that autonomy, confidentiality, and patient safety remain balanced.

The regulatory framework already indicates that storage and access are inseparable. If a medical record is not stored properly, the patient's right to know and to prove the history of care becomes illusory. Conversely, if access is opened without security safeguards, the right to privacy is undermined. This interdependence shows that record retention and access rights must be interpreted as one integrated legal regime rather than as separate administrative questions.

Accordingly, the doctrinal position of this study is that medical record governance must be read through an integrated rights-based lens: healthcare facilities are custodians of records, but patients remain rights-holders over the health information related to themselves. Any restriction on access therefore requires a clear legal basis, a legitimate aim, and a proportionate mechanism. (Yustiarta et al., 2025) emphasize that unequal access to medical information places patients in a subordinate position in their legal relationship with healthcare institutions. Furthermore, confidentiality is emphasized in Article 32 of Law Number 39 of 1999 concerning Human Rights, which concerns the right to personal protection, including health information. (Suwani et al., 2024) emphasize that the balance between accessibility and data protection is a key principle of modern medical record governance.

## **2. Implementation Problems in Retention and Electronic Medical Record Governance**

Although the normative framework is relatively complete, implementation remains uneven. In many healthcare facilities, retention governance is still affected by incomplete digitization, inconsistent archiving practices, loss of physical files, limited infrastructure, and insufficient human-resource readiness. These problems weaken continuity of care and reduce the evidentiary value of medical records when disputes arise. In legal terms, weak retention practice transforms a formal obligation into a merely symbolic norm.

The shift toward electronic medical records intensifies this problem. Minister of Health Regulation Number 24 of 2022 requires electronic medical record implementation, but field studies show that many facilities still face budget constraints, limited interoperability, unclear standard operating procedures, and weak segregation of access rights between internal and external users. As a result, the legal command to digitalize has not always been followed by equivalent institutional readiness to guarantee confidentiality, integrity, and availability of data.

Empirical studies reinforce these findings. For example, (Hamama, 2023) identified obstacles to the security and protection of electronic medical record data at M. Djamil Padang General Hospital, including budget constraints, the lack of standard operating procedures for electronic medical records, human resource readiness for electronic medical records, and a suboptimal electronic system. (Mulyani et al., 2023) found that access rights to EMRs in several hospitals were not clearly separated between internal and external users, creating the potential for data leakage. Furthermore, other research highlighted the weakness of manual archiving procedures and the suboptimal training of human resources responsible for managing electronic systems (Damayanti et al., 2025).

### **3. Norm Conflicts and Ambiguities: Confidentiality, Access, and Proportionality**

The principal normative tension lies in the intersection between medical confidentiality and patient access rights. On one hand, patients are entitled to obtain information about their diagnosis, treatment, and medical history. On the other hand, healthcare facilities have a duty to prevent unauthorized disclosure, misuse, and misinterpretation of sensitive medical data. This tension becomes sharper in electronic systems, where data can be copied, transferred, or disseminated more easily than in manual records.

Current regulation recognizes both interests, but it does not yet regulate them with sufficient precision. The law affirms that patients may access their medical information, yet there is limited detail regarding at least four crucial issues: the scope of information that must be disclosed directly to patients; the categories of data that may require mediated disclosure; the procedure and timeframe for obtaining copies; and the limits applicable to highly sensitive notes, including psychiatric assessments, third-party data, or confidential professional observations. This incomplete regulation creates room for divergent interpretation by healthcare facilities.

Using the principle of proportionality, restrictions on patient access can only be justified when they pursue a legitimate aim, are necessary, and are limited to what is strictly required to protect confidentiality, patient safety, or the rights of others. Therefore, a blanket refusal to provide medical records on the ground of 'confidentiality' is difficult to justify, because confidentiality is designed to protect the patient from unauthorized third parties, not to negate the patient's own rights over personal health information. At the same time, unlimited disclosure without classification of sensitive content is also problematic because it may expose third-party data or increase the risk of misuse.

From a data-protection perspective, the unresolved issue is not only access, but governance. Health data must be processed according to the principles of purpose limitation, data minimization, security, and accountability. If healthcare facilities cannot explain who may access data, for what purpose, for how long, and under what security protocol, then the legal framework remains under-specified. This ambiguity weakens legal certainty for patients, healthcare workers, and institutions alike. Accordingly, the author's analysis is that the present Indonesian framework has recognized the correct normative values, but it has not yet translated those values into sufficiently operational rules. The legal problem is therefore one of normative incompleteness: the right exists, the duty exists, but the mechanism that reconciles them remains insufficiently regulated.

Research (Agustian, 2025) indicates that these obstacles include inconsistent access fees, lengthy bureaucracy, low patient awareness of their rights, and hospital refusals citing confidentiality or data security concerns. Similar findings were presented by (Damayanti et al., 2025), who stated that the unpreparedness of digital systems and weak information service procedures hinder the realization of patient rights. Lack of digital literacy and suboptimal electronic archives make it difficult for patients to obtain copies of their medical records quickly and securely.

### **4. Normative Recommendations**

First, derivative regulation is needed to define the scope and procedure of patient access to medical records in greater detail. The rules should distinguish between general clinical information, complete copies of records, and categories of highly sensitive data that may require special procedures or professional accompaniment. Clear service

standards, response timeframes, and reasonable administrative procedures are necessary to prevent arbitrary refusal.

Second, electronic medical record governance must adopt mandatory role-based access control, audit trails, authentication standards, and periodic data-security audits. These technical mechanisms should not be treated as optional institutional preferences, but as part of legal compliance with both health law and personal data protection law. Accreditation and certification mechanisms should also verify whether healthcare facilities are genuinely capable of protecting sensitive health data.

Third, complaint and supervision mechanisms must be strengthened. Patients should have access to an effective channel for contesting refusal, delay, excessive fees, or mishandling of their medical data. At the regulatory level, continuous monitoring by the Ministry of Health and coordination with data-protection oversight institutions are needed so that digital health governance does not stop at formal digitalization, but ensures substantive protection of rights. In this way, retention obligations and access rights can operate coherently within a rights-based health-law system.

### **Conclusion**

In conclusion, Indonesian law has established that healthcare facilities must retain medical records and those patients have the right to access health information related to themselves. However, the current framework still leaves significant ambiguity regarding the scope, procedure, and limits of patient access, especially in electronic medical record systems. Therefore, the legal challenge is no longer the absence of normative recognition, but the need to operationalize that recognition through clearer derivative regulation, proportional access rules, stronger digital security governance, and effective supervisory and complaint mechanisms. Only through such harmonization can legal certainty, confidentiality, and patient rights be protected simultaneously.

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Maria Verawati, Ni Luh Gde Ari Natalia Yudha/KESANS  
**Normative Juridical Study of Patient Storage Obligations and Access Rights to Medical Records**

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