Fact sheet

Primary Health Networks Share by Default Guide

Key messages, frequently asked questions, myth busters

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Approach to messaging on Better and Faster Access – for requesting providers

Key Messages

These reforms help to

- ensure consumers do not need to retell their health and wellbeing story to different healthcare providers
- save time for consumers by avoiding unnecessary duplicate testing, and minimising travel to and from healthcare appointments
- make it easier for consumers with a My Health Record to find and use their key health information enabling them to be more active in their health and wellbeing journey
- make it easier for members of a consumer's healthcare team to have the information they need to coordinate care
- support healthcare providers to make better and safer clinical decisions that can reduce avoidable adverse outcomes, hospital admissions and duplicate tests
- support selection of appropriate, evidence-based treatments and interventions.

Benefits for providers who request pathology or diagnostic imaging services

My Health Record is a secure online summary of key patient health information. Healthcare providers can access the system to view and add information. While it is not a complete health record, it can be used to supplement other sources of information about a patient. When a provider accesses a result in My Health Record, they will continue to have the option to save a copy in their local information system.

When information is included in a person's My Health Record, it is available to all providers involved in a person's care. This helps to overcome information gaps that can occur, when people receive health and care services in a variety of different settings, move from one geographical location to another, or undertake extended travels across Australia.

The requirement to share pathology and diagnostic imaging reports to My Health Record will help to bridge this gap by enabling providers to view results that have been ordered by another member of a person's treating team. Better access to this information will make it easier for healthcare providers to coordinate care and make well informed clinical decisions.

Before ordering a pathology or diagnostic imaging test, providers can check a patient's My Health Record to see whether any relevant results are available. This can help to inform whether additional diagnostic tests are required, reduce unnecessary repeat tests and minimise delays in treatment.

Overview of Changes

What is changing and why is it changing?

There are two separate but complementary changes that improve access to pathology and diagnostic imaging reports. One is a legislative change that places new requirements on specified healthcare providers, the other is a policy change that is managed by the Agency and doesn't require any adjustments to healthcare providers' software.

Legislative Requirements (Share by Default)

Amendments to the *My Health Records Act 2012* and the *Health Insurance Act 1973* occurred in February 2025. The changes are summarised in the *Health Legislation Amendment (Modernising My Health Record—Sharing by Default) Act 2025*. Collectively, these amendments provide a legislative framework for key health information to be shared to My Health Record by default.

The requirement to upload information to My Health Record by default applies to healthcare services and record types prescribed in the Health Insurance (Share by Default) Rules 2025 and the My Health Record (Share by Default) Rules 2025—collectively referred to as the Share by Default rules.

Initially, the requirement to share health information to My Health Record by default will apply to pathology and imaging reports prepared by (or on behalf of) a pathologist or radiologist. The requirement does not include images.

Policy Changes (Faster Access)

Most pathology reports (like blood and urine tests) are available for consumers to view in My Health Record as soon as they are uploaded. They can also be viewed via the 1800MEDICARE app (previously called *my health* app).

Some results won't be available for consumers to view until after a 5-day delay (reduced from the previous 7-day delay that was in place prior to October 2026). These include:

- anatomical pathology
- cytopathology
- genetic testing.

Consumers can now view X-ray reports for limbs (arms and legs) in My Health Record immediately after they are uploaded. Other diagnostic imaging reports are available after a 5-day delay (reduced from the previous 7-day delay that was in place prior to March 2026).

Healthcare providers continue to have access to all reports as soon as they are uploaded.

Who helped to inform the changes?

Consultation for faster access

A committee known as the Clinical Reference Group was established by the Agency and the Department of Health, Disability and Ageing to provide strategic advice and clinical oversight to support safe implementation of these reforms. It had 24 members from relevant peak bodies, professional associations, consumer groups (including people with lived experience) and other stakeholders involved in pathology and diagnostic imaging services. It was chaired by prominent clinicians from the Agency and the Australian Commission on Safety and Quality in Health Care.

The National Clinical Governance Committee for Digital Health replaces and builds on the work of the Clinical Reference Group. This committee was established in late 2025, to provide ongoing clinical governance and stewardship, including strategic clinical and consumer advice for the Share by Default program. Members are appointed for a term of 3 years.

Upload Requirements and Obligations

Most organisations that prepare written reports authored (or co-authored) by a **pathologist** or **radiologist** will be required to share these reports with My Health Record, from 1 July 2026.

The Share by Default scope interactive guide provides further information about which organisations are required to upload reports by default.

Requesting providers vs pathology and diagnostic imaging providers

Generally, the pathology or diagnostic imaging provider will be the entity responsible for uploading the report. Where multiple organisations are involved in authoring a report, they will need to agree on which provider uploads the report.

It is important to note that a report doesn't need to be uploaded by multiple organisations. Organisations that outsource reporting to external radiologists or pathologists (e.g. via teleradiology or secondary pathology analysis) must determine which party will upload the report to satisfy the legislative requirement to share with My Health Record.

Exceptions to Uploading

Under the Share by Default legislative provisions, it is only permissible to withhold a result if

- a valid exception applies
- the report relates to a non-mandatory test category
- the organisation has received a formal extension of time to comply.

Exceptions

a) the patient does not have a My Health Record (i.e. they have opted out or they are not eligible to have a record – such as an international visitor on a tourist visa).

b) the patient requests that the report is not uploaded, or this is requested by their nominated or authorised representative.

c) a healthcare provider has a reasonable belief that uploading a particular result would negatively impact the patient's health, safety or wellbeing.

d) circumstances beyond the reasonable control of the entity prevent the upload from occurring (such as an unforeseen technical issue that prevents upload).

Evidence of exceptions must be retained for 2 years.

Non-mandatory test categories

Under the share by default rules sharing is optional for the following categories **only**:

- Workplace drug or alcohol testing
- Court-ordered testing
- Testing conducted for law enforcement purposes
- Pathology testing solely for research and clinical trials (where the pathology reports are not otherwise provided to the patient or their healthcare providers).

Extensions

If an organisation has a genuine reason that it will not be able to start uploading to My Health Record by 1 July 2026, it can apply for an extension of time to comply. Extension requests will be individually considered. The duration of any extension will be based on the information and evidence provided by the applicant. When an extension ceases, the legislative obligations will apply immediately.

Request to not upload information to My Health Record

If a patient or their nominated or authorised representative asks for something to not be uploaded, the provider must comply with the request. If the request relates to information that the provider would usually upload, they should make a note in their clinical record and ensure that they don't upload the information.

If a patient advises the requesting provider that they don't want a pathology or diagnostic imaging report uploaded, the healthcare provider will need to convey this request to the pathology or diagnostic imaging provider. There is not a specified way in which this must occur, however, most commonly it would involve:

- Ticking a box on a paper form or electronic request advising that the report is not to be uploaded to My Health Record or
- Making a note within the notes section of the paper form or electronic request.

The healthcare provider may wish to advise the patient to also tell the pathology or diagnostic imaging provider that they don't want the report uploaded.

It may also be appropriate to advise the patient of the potential flow on effect to clinical care, as the result won't be available for clinicians to view in My Health Record if it is not uploaded. Other options that the patient could consider as an alternative include setting access controls to restrict access to a particular report or to their entire record.

Patient consent, privacy and authority to upload

In most cases, it is not necessary to obtain a patient's consent to upload pathology and diagnostic imaging. However, there are a number of things to be aware of, which are summarised below.

Authority to upload

Under the *My Health Records Act 2012*, staff members authorised by a healthcare organisation can access, view and upload information to a patient's record for the purpose of providing that patient with healthcare, provided any access occurs in accordance with access controls set by the patient. In addition to clinicians, a healthcare organisation may authorise other staff to access the system as part of their role in healthcare delivery.

Complying with a patient request to not upload

Healthcare providers **must** comply if a patient or their nominated representative requests that a report not be uploaded to My Health Record. Where information is not uploaded, the healthcare provider should inform the patient that Medicare information relating to the clinical encounter may still be visible in My Health Record, as this is uploaded by Medicare. The patient can choose to remove or manage access to the Medicare information themselves by logging into their record via myGov, or they can call the My Health Record helpline for assistance (1800 723 471).

Situations where consent is required – preserved privacy laws

Generally, there is no need to obtain a patient's consent to upload information to My Health Record, except where requirements under a state or territory law are recognised in the My Health Records Regulation 2012. These laws identify specific circumstances where consent needs to be obtained prior to sharing. This includes where the information relates to HIV (ACT, NSW, QLD), notifiable conditions (ACT, QLD), contagious conditions (QLD), environmental health events (QLD) and perinatal history (QLD).

Be familiar with local processes

Staff must ensure they are familiar with the organisation's process for preventing an upload to My Health Record, if the patient requests that it not be uploaded or if consent required under a state or territory law has not been obtained. The process for stopping an upload will vary depending on the software that each organisation uses.

Can a Healthcare Provider upload a document they didn't author?

Documents are uploaded to My Health Record by the organisation that provides the service or produces the report. This occurs via conformant clinical software such as a

- Radiology Information System (RIS)
- Clinical Information System (CIS)
- Hospital EMR.

This means, for example, if a GP is asked to upload a pathology or diagnostic imaging report, they are not able to do this. If a patient wants a certain report to be uploaded to My Health Record, the request should be made to the organisation that provided the service or produced the report.

Compliance

What happens if a pathology or imaging provider doesn't comply?

If an organisation fails to comply with the requirement to share to My Health Record by default, they could be instructed to repay money that was payable under the Medicare Benefits Scheme. In some cases, civil penalties may also apply.

Where an organisation is required to upload information to My Health Record by default and they are not doing so – for example, because they have been granted an extension of time to comply – they **must** display a notice informing consumers of this. The notice must be visible at the provider's premises and on their website. In addition, the notice must be displayed on any online platforms that consumers use to book appointments at the organisation. If the notice is not displayed, penalties may apply.

Notifications

Will doctors receive alerts when reports are added to My Health Record?

My Health Record is not a primary communication mechanism for results and as such no automatic alerts are sent via My Health Record to either doctors or patients in relation to abnormal results.

Results will continue to be sent to requesting providers by pathology and diagnostic imaging services, using existing processes. Where existing flags are provided for abnormal results, these current processes will continue. Responsibility for follow-up remains with the ordering clinician. Their existing practice systems and processes should continue to be followed.

Providers should not rely on My Health Record as the primary communication method for results. They should continue to follow up with patients in accordance with current organisational processes.

Support for providers in relation to upload requirements and obligations

The Agency is proactively contacting a range of pathology and diagnostic imaging providers to support them to register for My Health Record and begin uploading reports.

In addition, the Agency is working with a number of software providers to support them as they progress through the software conformance process. Over the coming months, additional software packages are expected to enable sharing to My Health Record by default. A quick reference guide is available outlining which pathology and diagnostic imaging software packages are currently conformant.

An extensions process has been established to enable organisations to seek an extension of time to comply if there is a genuine reason that it cannot upload to My Health Record by 1 July 2026. Extension requests will be individually considered. The duration of any extension will be based on the information and evidence provided by the applicant. When an extension ceases, the legislative obligations will apply immediately.

Providers can request support by emailing help@digitalhealth.gov.au or phoning 1800 723 471.

Patient Support

Communicating the Share by default changes with patients.

Explain the benefits for continuity of care

My Health Record is a secure online summary of key patient health information. Healthcare providers can access the system to view and add information. When information is included in a person's My Health Record, it is available to all providers involved in a person's care. This helps to overcome information gaps that can occur, when people receive health and care services in a variety of different settings, move from one geographical location to another, or undertake extended travels across Australia.

The requirement to share pathology and diagnostic imaging reports to My Health Record will help to bridge this gap by enabling providers to view results that have been ordered by another member of a person's treating team. Better access to this information will make it easier for healthcare providers to coordinate care and make well-informed clinical decisions.

Support for patients who may not return to get results or attend follow up appointments

It is important for providers to ensure that they are familiar with, and follow, critical results management processes for their organisation. These may be set by professional colleges, peak bodies or state and territory guidelines.

Providers should not rely on My Health Record as the primary communication method for results, they should continue to follow up with patients in accordance with current organisational processes.

Providers should follow their existing practices to ensure timely review. This includes ensuring robust workflows are in place for prompt review of all incoming pathology and diagnostic imaging results. This should include processes for critical results management and follow-up.

How to support patients who may misinterpret their results

There are opportunities for providers to partner with their patients as active participants in monitoring their health, particularly when they are living with chronic conditions.

In addition, providers should consider:

- Proactive discussion – before ordering a test, consider whether the results may be complex, unexpected or sensitive. Where appropriate, explain to the patient that their results will likely appear in their My Health Record shortly after their test or scan. Let them know what to expect, including that some results may be difficult to interpret without context, and advise that resources are available (such as Pathology Tests Explained which patients can access from within My Health Record).
- Managing expectations – Explain that a follow-up consultation with the requesting healthcare provider is the best way for them to understand their results, as they can provide context based on the patient's own medical history, social factors and clinical circumstances.

- Guidance on receiving results – offer clear advice about what patients should do once they see their results, particularly if any values fall outside of a normal range. Reassure them that not all abnormal results are cause for alarm, and that healthcare providers will continue to contact them directly if urgent action is required. Where applicable, discuss how the results can help them manage their ongoing conditions.

When results are not uploaded to a patient's My Health Record

The patient will need to check if the pathology or imaging provider has uploaded the report. If not, they should follow up with the pathology or diagnostic imaging organisation directly.

Currently, some pathology and diagnostic imaging reports are not uploaded to My Health Record. Changes will transition into effect throughout 2026, so results must be shared to My Health Record by default from 1 July 2026, unless the provider has an extension, or an exception applies.

Prior to this, some reports may not be uploaded.

Following 1 July 2026, there are some situations where information may not be uploaded. Including where an exception applies, such as:

- If a patient or their representative asked that it not be uploaded.
- If a healthcare provider has concerns that uploading the report would have a negative impact on the patient's health, safety or wellbeing.
- If technical issues (like a serious or prolonged system outage) prevent uploading.

There may be another reason that a report is not uploaded, for example, if a state or territory law requires consent before uploading particular information (refer to previous question), or the organisation has been granted an extension of time to comply.

It is also worth noting that patients can choose to set access controls to restrict access to specific documents, remove or hide documents, restrict access to their entire record or cancel their record.

Future plans for inclusion to better and faster access

It is expected that the share by default requirements will be extended to other types of information and other healthcare providers in the future. The Department of Health, Disability and Ageing will lead the work to identify what these future phases are.

Contact the Department via your usual contact channels or email MHR@health.gov.au.

Resources

Healthcare providers

Links & Resources for Providers

- Webpage for healthcare providers
- Register your organisation for My Health Record if not already connected – refer to implementing My Health Record in your healthcare organisation for details
- Ensure your clinical software can upload information to My Health Record. For more details, download the quick reference guide - pathology and diagnostic imaging conformant software
- Access education and training resources and communication materials to prepare your team for the new requirements
- Download the guide for healthcare providers that request pathology and diagnostic imaging (requesting providers)
- Download the guide for pathology and diagnostic imaging service providers.
- Refer to the fact sheet for pathology laboratories
- Visit the Department of Health, Disability and Ageing website: Modernising My Health Record – Improved access to health information

Over time, additional resources will be added to the Australian Digital Health Agency website.

Patients

Links & Resources to support understanding pathology & diagnostic imaging reports

- Pathology Tests Explained – up-to-date, evidence-based information about pathology tests and is a leading trusted source for consumers.
- Healthdirect –consumer friendly information about different types of diagnostic tests
- Better and Faster Access webpage for everyone (consumer-focus)
- Consumer guidance – Your reports in My Health Record – A4 fact sheet and tri-fold brochure
- Pathology reports in My Health Record
- Additional guidance about My Health Record other digital health solutions – communication materials and eLearning modules.

Contact Information

- The Australian Digital Health Agency: www.digitalhealth.gov.au/support/contact-us
- The Department of Health, Disability and Ageing via your usual contact channels, or email MHR@health.gov.au.

Note: Any queries regarding future phases of the Share by Default reforms and the future of ePIP and other practice incentives programs should be directed to the Department of Health, Disability and Ageing.

Myth busting

"Share by default means I now need to upload pathology or imaging reports."

Fact: Most Healthcare providers that request tests do not upload pathology or diagnostic imaging reports themselves. Uploading is usually done by the reporting pathology and radiology providers. Further information regarding the scope of Share by Default requirements is available from the Better and Faster Access to health information webpage.

"This changes how I order tests."

Fact: The process for ordering tests stays the same. The difference is that more reports will be visible in My Health Record once authorised, including tests ordered by other providers.

"If a hospital orders a test, I won't have visibility"

Fact: More hospital-ordered tests will be visible in My Health Record as a result of the Share by Default reforms. This supports continuity across GP, specialist and hospital care.

"This will increase my workload."

Fact: A fuller picture of results can help reduce repeat tests and unnecessary follow-up work. It can enable you to make treatment decisions sooner, because you will have access to recent test results ordered by other providers. The aim is to make information easier to find, not add tasks.

"I need to learn a new system."

Fact: You can view results using your existing clinical information system that is connected to My Health Record. If your practice prefers, you can also use the National Provider Portal (refer to implementing My Health Record in your healthcare organisation).

"I need to explain to every patient how to use My Health Record"

Fact: There is no new requirement for this. Patients can choose to view their results and access information through My Health Record. Brochures about My Health Record can be printed and provided to patients as required.

"Patients will see results before I do."

Fact: Clinicians continue to have immediate access to results as soon as they are uploaded to My Health Record. Patients can choose to view their results in My Health Record once available. Clinicians can still discuss results with patients in the usual way.

"Patients will be confused or distressed by seeing results."

Fact: Some patients already access their results through My Health Record. In addition a number of health services provide their own patient portals enabling them to access their results. With My Health Record, patients can choose whether or not they want to view their reports and they are encouraged to discuss results with their clinician as usual. Providers can discuss expectations with patients at the time of ordering a test. International studies support patient access to results[1].

[1] *Perspectives of Patients About Immediate Access to Test Results Through an Online Patient Portal*

“Patients will be able to edit diagnostic results.”

Fact: Patients cannot change or edit pathology or imaging reports. They can only view them. A patient can choose to remove or hide a report if they do not want it to be visible in My Health Record.

“Patients are required to view their results.”

Fact: Patients can choose whether to view their results. Many will not. Those who do choose to look at their results are often already active in managing their health conditions.

“If a patient deletes a report in My Health Record, the requesting provider loses access to it.”

Fact: Deleting a report from My Health Record does not affect the provider's clinical record. Their local system remains unchanged. This means they will retain access to any reports sent directly to, or stored within, their local clinical information system.

“If a patient ticks ‘do not upload’ to My Health Record on the requesting form, I have no visibility”

Fact: Providers still have access to results within their own clinical system if they requested or performed the test. The ‘do not upload’ option only prevents the report from appearing in My Health Record.

“Patients who see their results will misunderstand them”

Fact: Patients can choose whether they want to view results and they are encouraged to discuss them with their clinician as they normally would. Patients can also access Pathology Tests Explained via the link in My Health Record.

“*My practice needs to train staff before using My Health Record”*

Fact: Healthcare provider organisations must provide staff with My Health Record training before they are authorised to use the system. The Share by Default requirement does not change this. Training resources for healthcare providers can be found here: eLearning for healthcare providers.

“*If a report is visible in My Health Record, the patient must have already been contacted”*

Fact: My Health Record does not replace communication with patients. Clinical follow-up processes still apply. If a report is visible in My Health Record, it’s possible the patient may choose to view it but, in many cases, they won’t have logged into their record.

“I have no ability to stop a report being uploaded to My Health Record when I believe it may not be appropriate for the patient”

Fact: Healthcare providers can use the “do not upload to My Health Record” tick box on the diagnostic form where they have a reasonable belief that uploading a report could negatively impact the patient's health, safety or wellbeing. Wherever possible, this decision should be made in conjunction with the patient. The pathology or radiology provider will then apply the ‘do not upload’ request when processing the report