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Medical Records Under Nigerian Law: A Critical Appraisal of Patient Autonomy, Privacy, Confidentiality, Data Protection and Access to Justice

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Abstract. Medical records are simultaneously instruments of clinical care, repositories of sensitive personal information, evidence of treatment, and potential evidence in medical-negligence proceedings. Their accessibility therefore implicates patient autonomy, informed decision-making, continuity of care, privacy, confidentiality, data protection and access to justice. Nigerian law does not, however, provide a single and comprehensive statutory regime governing patients' access to medical records. Relevant norms are dispersed across the Constitution of the Federal Republic of Nigeria 1999 (as amended), the National Health Act 2014, the Patients' Bill of Rights, the Nigeria Data Protection Act 2023 (NDPA), the Freedom of Information Act 2011, the Evidence Act 2011, professional ethical rules and the common law. This article critically examines the interaction of these regimes and argues that Nigerian law now recognises a substantive, though procedurally incomplete, right of patients to access personal health information. The article distinguishes custody of the physical record from legal interests in the information it contains; analyses confidentiality, therapeutic privilege, third-party information, minors, persons lacking capacity, deceased patients and electronic records; and considers the evidentiary significance of access in negligence litigation. Comparative lessons are drawn principally from the United Kingdom's subject-access framework. The article concludes that the principal Nigerian deficit is not the absence of a right but its fragmentation and weak procedural enforcement. It proposes a unified statutory regime providing for inspection, copies, explanation, correction, secure electronic portability, prescribed response periods, proportionate fees, reasons for refusal, redaction and independent review.

Keywords: Medical records; patient autonomy; privacy; confidentiality; data protection; patient rights; medical negligence; access to justice.

1. Introduction

The modern law of healthcare has moved progressively from paternalism towards autonomy, participation and respect for the dignity of the patient (Pellegrino and Thomasma, 1988). A patient is no longer properly understood as a passive recipient of professional decisions. Meaningful autonomy requires access to sufficient information to understand a diagnosis, evaluate treatment options, obtain a second opinion and participate in decisions affecting bodily integrity. Access to medical records is a practical expression of that transformation.

Medical records may contain medical history, examination notes, diagnoses, laboratory and radiological results, prescriptions, operative and anesthetic notes, nursing observations, consent forms, referral letters, discharge summaries and electronic communications generated during treatment. They therefore have a dual character. On one hand, they are operational documents required for safe and continuous healthcare. On the other, they are repositories of information about an identifiable individual and may become critical evidence in disputes concerning treatment.

The practical importance of access is considerable. A patient may require records to transfer care, obtain a second opinion, understand treatment, correct inaccurate information, make an insurance claim, establish entitlement to benefits, investigate suspected malpractice or institute proceedings. The evidentiary dimension is particularly significant in Nigeria because much of the documentary material necessary to reconstruct treatment is ordinarily held by the healthcare institution. In *Ojo v Gharoro* (2006), the Supreme Court demonstrated the evidentiary difficulty confronting a claimant in a medical-negligence action, including the importance of appropriate medical evidence. The case involved a surgical operation following which a broken needle was discovered in the patient's abdomen. Although the Court ultimately rejected the negligence claim, the case illustrates the informational imbalance between a patient and an institution possessing the records of treatment.
At the same time, health information is among the most private categories of personal information. Disclosure to unauthorised persons may expose patients to stigma, discrimination, embarrassment or other harm (Stauch et al, 2012).

The legal question is consequently not whether access or confidentiality should prevail absolutely. Rather, the law must determine how a patient's right to know information concerning the patient can coexist with the duty to protect that information from inappropriate disclosure.

Nigerian law now contains several important building blocks. Section 34 of the Constitution protects human dignity, while section 37 protects privacy. Sections 23 and 25–29 of the National Health Act 2014 address information, health records, confidentiality and record security. The Patients' Bill of Rights expressly recognises timely access to detailed and accurate medical records and separately recognises privacy and confidentiality. The NDPA (Nigerian Data Protection Act) establishes data-subject rights of access, rectification and portability and expressly treats health status as sensitive personal data. The Evidence Act 2011 regulates the evidentiary use of documents, including electronically generated evidence, while professional regulation reinforces confidentiality.

The central problem one may observe is fragmentation. A patient should not have to construct a right of access by combining provisions from several statutes and a policy document, while the healthcare institution remains uncertain about the precise procedure, deadline, permissible fee, grounds for refusal and mechanism of review. This article therefore asks whether Nigerian law presently provides an enforceable right of access to medical records; what limits may legitimately qualify that right; and what reforms are required to produce a coherent patient-centred regime.

The article adopts a doctrinal and comparative methodology, analysing Nigerian legislation, constitutional provisions, cases, professional and institutional materials and scholarship, with comparative reference to the United Kingdom. It argues that Nigerian law has crossed the threshold from institutional discretion to legal entitlement but lacks the procedural architecture required to make that entitlement reliably effective.

2. Medical Records: Concept, Scope and Legal Character

There is no single exhaustive statutory definition of "medical record" in Nigerian law. Medical record is the legal documentation of all relevant clinical data and his historically paper based (Kristopher et al, 2011). In functional terms, a medical record should encompass information created or maintained in connection with the diagnosis, treatment, management or care of an identifiable patient, irrespective of whether it is held on paper or electronically. This includes registration information, medical history, examination findings, diagnoses, laboratory results, radiological images and reports, prescriptions, medication histories, operative and anaesthetic records, nursing notes, consent documentation, referrals, discharge summaries and relevant electronic communications.

The broader statutory expression "health record" is important because it prevents the law from becoming tied to the traditional physical hospital file. The growth of electronic health records introduces questions of interoperability, authentication, cybersecurity, auditability, retention and evidentiary integrity. Nigerian scholarship has identified accessibility, confidentiality, security and control as central legal concerns arising from electronic medical records (Ihekoronye et al., 2024). The legal framework should therefore be medium-neutral: a patient's right should attach to the information and not depend upon whether the information is stored in a cabinet, server, cloud environment or interoperable health-information system.

The question of ownership also requires conceptual care. It is tempting to ask whether the record belongs to the patient, physician or hospital. That framing obscures the more useful distinction between custody of the record and rights in the information contained in

it. A health establishment may have legitimate reasons to retain the original record for continuity of care, professional regulation, audit, statutory retention and litigation. That custodial responsibility does not logically confer an unrestricted power to withhold the patient's personal health information.

The NDPA reinforces this distinction. Its data-subject framework focuses on personal data and the obligations of controllers and processors rather than proprietary ownership of the physical medium. A hospital may therefore remain custodian of an original record while the patient exercises a right to obtain personal data contained in the record. This approach is also consistent with the work of Abimbola and Olugasa (2021), who emphasise that the legal significance of patient records extends beyond physical custody to questions of confidentiality, access and use.

3. Constitutional and Human-Rights Foundations

Section 37 of the Constitution guarantees privacy as well as other regional and global regimes (African Charter on Human and Poeples', 1981). Although medical records are not expressly named, the constitutional value of privacy encompasses intensely personal health information. Privacy here protects the patient against unjustified intrusion by third parties; it should not be converted into a basis for withholding personal information from the person to whom it relates.

Section 34, guaranteeing human dignity, provides an additional foundation. In *Okekearu v Tanko* (2002), the Supreme Court's treatment of consent demonstrated that professional authority over a patient's body is not unlimited. Although the case did not concern records, its autonomy-based reasoning supports the view that patients are rights-bearing participants in healthcare and require access to information necessary for meaningful participation.

4. The National Health Act 2014

The National Health Act (NHA) is central to the Nigerian framework, but its provisions must be read carefully because not every provision concerning health records creates a direct procedure for obtaining the complete file.

Section 23 requires healthcare providers to give users relevant information concerning health status and treatment, including diagnostic procedures, treatment options, benefits, risks, costs and consequences, and the right to refuse services. Information should, where possible, be communicated in a language and manner appropriate to the patient's literacy. Section 23 therefore supplies a strong autonomy-based foundation for access to health information.

Section 25 requires the person in charge of a health establishment to ensure that an appropriate health record is created and available at the establishment for every user. Section 26 establishes confidentiality, subject to specified exceptions such as written consent, court order or legal requirement, requests concerning minors and persons unable to consent, and serious threats to public health. Its proper function is to regulate disclosure to others; it should not be read as a blanket prohibition on disclosure to the patient.

Section 27, despite its heading "Access to health records", principally regulates disclosure by health workers and providers to other persons, providers or establishments where necessary for a legitimate purpose within their duties and in the user's interest. It does not itself prescribe a comprehensive patient subject-access procedure. Section 28 regulates professional access for treatment and authorised study, teaching or research. Section 29 requires measures against unauthorised access, copying, alteration and interference with health records.

The combined effect is important: Nigerian law requires health information to be generated and preserved, protects it from unauthorised disclosure and interference, and recognises lawful sharing. The major deficiency is procedural. The NHA does not comprehensively prescribe how a patient requests a copy, the deadline, permissible fees, reasons for refusal, redaction or independent review.

5. Patients' Bill of Rights

The Patients' Bill of Rights (PBoR), launched in 2018, provides one of the clearest policy formulations of the patient's entitlement. Among its twelve rights are the right to relevant information in a language and 8manner the patient understands; the right to timely access to detailed and accurate medical records and available services; and the right to privacy and confidentiality of medical records. These rights are not unique to Nigeria, they are in similar terms also provided for under global health regimes, such as the World Medical Association's Declaration of Lisbon on the Rights of the Patient (2015) and the rights of Patients: The Basic ACLU Guide to Patient Rights (published by the American Civil Liberties Union). Of these rights are:

- Obtain from his physician complete and current information regarding his diagnosis, treatment, and prognosis in terms the patient can understand.
- Receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment, where medically significant alternatives exist, the patient has the right to such information.
- Every consideration of privacy concerning his own medical-care program.
- Expect that all communications and records pertaining to his care will be treated as confidential.
- Expect that, within its capacity, a hospital must make reasonable response to the request of a patient for services or for transfer to another facility when medically permissible.
- Obtain information as to any relationship of the hospital to other health-care and educational institutions as far as his care is concerned.
- Be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment.

The significance of the PBoR lies in its combination of access and confidentiality. It rejects the false assumption that these values are contradictory. A patient must be able to obtain personal information in order to exercise autonomy, while the same information must be protected from unauthorised disclosure. The PBoR therefore provides an interpretive bridge between the autonomy and privacy dimensions of medical law.

Its principal weakness is procedural. The PBoR does not prescribe a complete application mechanism, response period, fee structure, redaction rules, electronic delivery, correction procedure or independent review. It is therefore an important interpretive guide, but not a substitute for legislation.

6. Nigeria Data Protection Act 2023: The Strongest Modern Access Right

The NDPA substantially changes the analysis. A patient is not merely a user of health services but a data subject whose health information is personal data processed by healthcare institutions. Section 34 recognises data-subject access and related rights, section 38 addresses portability, and section 65 expressly includes health status within sensitive personal data.

The importance of section 34 is that access is framed as a right rather than an administrative courtesy. The Nigeria Data Protection Commission (NDPC) describes sections 34–38 as providing rights including access, rectification, restriction and portability and operates a Data Subject Access Request mechanism. Its published procedure states that it endeavours to respond promptly and, in any event, within 30 days of a written request and necessary information (Nigeria Data Protection Commission [NDPC], 2026).
Access does not mean that every physical page must automatically be supplied without review. Records may contain protected third-party information. The better view is that the patient should receive meaningful access to personal health information concerning the patient, with proportionate redaction where necessary.

The NDPA also strengthens rectification. A patient should be able to challenge an incorrect allergy, medication, blood group or factual history. Rectification should not, however, become a power to rewrite professional clinical judgment. Where disagreement concerns clinical opinion, the patient's contrary statement may be appended while the original entry and audit trail are preserved.
Section 38 makes portability particularly relevant to healthcare. Secure transfer of personal data can facilitate referrals, second opinions, emergency treatment and continuity of care. Its practical success will depend on interoperability, authentication and cybersecurity.

The NDPA does not resolve every healthcare-specific issue, but it provides the strongest contemporary statutory basis for treating patient access as a legal entitlement.

7. Confidentiality, Privacy and Professional Ethics

Confidentiality is indispensable to effective healthcare because patients must be able to disclose sensitive information without fear of inappropriate exposure (Gillion, 1986). Nigerian scholarship identifies confidentiality as foundational to the doctor-patient relationship and recognises that lawful disclosure may arise through consent, legislation, court order or public interest (Ibitoye, 2018).

The Code of Medical Ethics in Nigeria reinforces professional duties concerning confidentiality and medical information. Confidentiality should be understood primarily as a duty owed for the patient's protection, not as an institutional privilege against the patient. In electronic systems, confidentiality also

requires access controls, authentication, audit logs, secure backups and staff training.

8. Medical Records and Access to Justice

Access to records has a direct relationship with the ability to obtain legal redress. A patient considering medical-negligence proceedings may need the record to reconstruct treatment, obtain independent medical advice, identify relevant practitioners, formulate pleadings and instruct counsel.

Ojo v Gharoro (2006) is instructive. The Supreme Court rejected the appellant's negligence claim and emphasised the need for appropriate expert evidence in a complex medical case. The decision illustrates why a patient requires access to the documentary foundation needed to investigate a claim. Where the healthcare institution controls much of that material and can prevent access, informational asymmetry may become a practical barrier to justice.

The Evidence Act 2011 adds another layer and dimension. Medical records may become evidence in civil, criminal or regulatory proceedings, while electronic records raise questions of authenticity, reliability, certification and statutory requirements applicable to electronically generated evidence. Access and admissibility must nevertheless remain distinct. Potential evidentiary objections do not justify blanket denial of access.

The principle of equality of arms is therefore relevant. A healthcare institution should not simultaneously control the principal documentary evidence of treatment and possess an unrestricted power to prevent the patient from obtainin8g it. This does not require surrender of originals or protected third-party material; it requires meaningful access to information reasonably necessary to understand and, where appropriate, challenge treatment.

9. Special Categories of Access

We interrogate some peculiar cases of access to medical record as it relates to minors, persons lacking capacity, deceased persons, third party access, and therapeutic privileges. In the case of a minor, section 26 (2)(b)(i) of the NHA (National Health Act) contemplates disclosure to a parent or guardian in specified circumstances. This becomes a corollary to access to medical records. We share the view, that a legal regime should avoid assuming that parental authority always means unrestricted access to every aspect of an adolescent's health information (Family Law Reform Act, 1969). Reproductive and sexual health, mental-health treatment and abuse-related records may require a more nuanced approach based on age, capacity, best interests and applicable confidentiality rules.

On the other hand, subject to section 27 and as an exception to section 26(1), section 26 (2)(b)(ii) of the NHA (National Health Act) provide for the case of a person who is otherwise unable to grant consent upon the request of a guardian or representative. We submit that, where an adult cannot or do not have the capacity of exercise of the right of access or consent personally, access through a verified guardian or lawful representative may be necessary. The representative's authority should however be proportionate to the purpose for which access is sought and exercised consistently with the patient's interests (Mental Capacity Act, 2005).

On the issue of access to medical records after death, the Hippocratic Oath binds a doctor to keep medical confidences after death, but it is not clear even in jurisdiction such as the UK, whether there is any legal obligation to so do, after the death of the person to whom the duty is owed. The common law is not clear on the issue either. Some statute confirm that confidentiality does not apply to deceased persons (Data Protection Act, 1998, 2018) and some do (the Access to Health Record Act, 1990). As a corollary to the unsettled issue of confidentiality of medical record after death in the UK, the Nigerian law, takes same part on the issue of access to medical record upon the death of a patient, albeit through a more unclear path. There is need for Nigerian law to provide a clearer path to the issue. Surely, legitimate interests may arise in estate administration, medical-negligence or wrongful-death claims, insurance, cause-of-death inquiries and hereditary medical history. A statute should therefore, identify eligible applicants and relevant purposes, while giving substantial weight to the known wishes of the deceased.

Third party access become also apposite, records may contain information supplied by relatives, donor information or information about another patient. Where the patient's information can be separated from protected third-party material, redaction should ordinarily be preferred to wholesale refusal, evince in the case *of Re C* (*A Minor*) (*Evidence: Confidential Information*) and its likes.

On therapeutic privileges, we submit that, a limited therapeutic restriction may be justified where immediate disclosure presents a specific and demonstrable serious risk as evince from *Re B (Minor) Wardship: Sterilisation* (1988). However, it should not

become a broad paternalistic doctrine (Pellegrino and Thomasma, 1988). Restrictions should be documented, consideration should be placed on partial or mediated disclosure and should remain subject to review.

10. Timeliness, Fees, Explanation and Form of Access

A right exercised only after prolonged delay may become practically meaningless where records are needed for continuing treatment, a second opinion, insurance or impending litigation. The PBoR's requirement of timely access and the NDPC's (Nigerian Data Protection Commission) 30-day administrative benchmark provide useful starting points. A healthcare regime should establish an ordinary maximum period and expedited procedures for urgent clinical and litigation-related requests.

Fees should not deter access. Electronic access should ordinarily be free where practicable, while reasonable reproduction costs may be charged for paper copies. Meaningful access also requires explanation where necessary because records contain technical abbreviations and specialised terminology (Stauch et al, 2012). This follows the information-based autonomy reflected in section 23 of the NHA and the PBoR.

Patients should be able to receive records securely in electronic form where available. Identity verification, secure transmission and safeguards against unintended disclosure must accompany electronic delivery.

11. Grounds for Refusal and Proportionality

A comprehensive access regime should enumerate limited grounds for refusal, including an unauthorised request, disclosure prohibited by law, protected third-party information, a narrowly defined therapeutic risk, or another lawful and proportionate restriction. Even where a ground applies, complete refusal should not be automatic (Stauch et al, 2012).

Redaction, partial disclosure, delayed or mediated disclosure should be preferred where they can protect the relevant interest while preserving access. Any refusal should be written, specific and reviewable, identifying the information withheld, legal basis, possibility of partial access and route of challenge.

12. Comparative Perspective: Lessons from the United Kingdom

The United Kingdom illustrates the value of a structured subject-access framework (Stauch et al, 2012). Its contemporary data-protection regime generally gives individuals a right to obtain a copy of personal information subject to defined exemptions (Data Protection Act, 2018); and (the Access to Health Record Act, 1990). Under article 15 of the UK GDPA, a data subject generally has the right to obtain confirmation as to whether personal data concerning him or her are being process and, where applicable, access to that data. The DPA (Data Protection Act) supplements this framework and provide certain exceptions, in which disclosure of health information would be likely to cause serious harm to the physical and mental health of the patient or another person (DPA, 2018).

The Information Commissioner’s Office states that subject access requests ordinarily attract a response within one month and that information should be supplied in an accessible form (ICO, 2025).

The General Medical Council (GMC) expressly recognizes that patients have rights to access their own health records and requires doctors to assist patients in exercising that right.

An important analytical of the UK system is that access is treated principally as a legal entitlement rather than as a matter dependent upon the Doctor’s or Institutional discretion, this approach promotes patient autonomy and informational self-determination. The UK framework is equally more operationally developed. NHS (National Health Service) guidance identifies the organisation responsible for the records and provide established procedures for making request.

Equally, privacy in the UK has a particular stronger human rights foundation than Nigeria through Article 8 of the European Convention on Human Right, incorporated into domestic law by the Human Rights Act 1998. Article 8 protects respect for private and family life, and health information falls within the sphere of protected personal information. Article 5 of the GDPR (General Data Protection Regulation) identify the seven principles at the heart of data protection in the UK, some of these include the positive obligation to deal with personal information fairly and lawfully, as well as that it should be relevant and limited to the purpose for which it was collected, which is integrated into the UK health care system. The UK system apparently connects information

rights with access to justice than that of the Nigerian system.

The lesson for Nigeria is procedural: legislation should identify applicants, verification, deadlines, lawful restrictions, fees, delivery methods and review mechanisms.

13. Critical Evaluation of the Nigerian Framework

The Nigerian framework has substantial strengths. The NHA requires creation and preservation of records, protects confidentiality, regulates lawful disclosure and requires security. Section 23 supports informational autonomy. The PBoR recognises timely access to detailed and accurate records. The NDPA supplies access, rectification and portability, while the Constitution and professional regulation reinforce privacy, dignity and confidentiality.

The weaknesses are fragmentation, uncertainty about custody and information rights, absence of a comprehensive access procedure, inadequate rules for therapeutic privilege and deceased patients, and insufficient healthcare-specific regulation of electronic portability. There is also an enforcement problem: patients may lack knowledge, hospitals may lack standard procedures, and litigation may be costly or slow.

14. Proposed Framework for Reform

Nigeria should enact a dedicated Medical Records Access and Health Information Act, or comprehensively amend the NHA while coordinating it with the NDPA. The legislation should:
(a) state that every competent patient has a right to access personal health information held by public or private providers, without ownership of the physical file;
(b) provide a simple written or electronic request procedure with proportionate identity verification;
(c) establish ordinary and expedited response periods;
(d) regulate fees, favouring free electronic access and reasonable reproduction charges;
(e) codify proportionate restrictions, preferring redaction or partial disclosure to blanket refusal;
(f) provide correction of factual inaccuracies and a mechanism for recording disagreement with clinical opinions without destroying the audit trail;
(g) recognise secure electronic access and portability and promote interoperable standards;
(h) provide rules for minors, persons lacking capacity and deceased patients; and
(i) require written reasons for refusal, internal review and rapid external review through an appropriate regulatory or tribunal mechanism.

15. Conclusion

The legal position in Nigeria has developed beyond the proposition that medical records are simply hospital property or that access is a matter of administrative grace. The NHA establishes duties to provide health information, create and preserve health records, protect confidentiality and secure records. The PBoR expressly recognises timely access to detailed and accurate medical records. The NDPA adds a contemporary and enforceable data-subject framework that strengthens access, rectification and portability, while the Constitution supplies important privacy and dignity values.

The principal weakness is therefore not the total absence of a right but the absence of a coherent procedure for exercising it. Nigerian law should distinguish clearly between institutional custody of original records and the patient's legal interest in personal health information. Confidentiality should protect patients from unauthorised third-party disclosure, not prevent patients from accessing their own information. Restrictions should be narrow, proportionate and reviewable.

Access to medical records is ultimately about more than obtaining a file. It enables patients to understand, participate, verify, correct, transfer and, where necessary, challenge healthcare decisions, as buttress in *Mclnerney v MacDonald* (1992). It also reduces informational inequality in medical-negligence litigation and strengthens access to justice. A unified statutory regime, integrated with the NDPA and supported by clear professional and administrative standards, would transform these dispersed rights into a predictable and enforceable component of Nigerian healthcare law.

References

Abimbola, O., & Olugasa, O. (2021). Patients' rights to their medical records in Nigeria. *Carnelian Journal of Law & Politics*, 2(1).

Abioye, A. (2021). An exposition of the legal issues in the management of health records in Nigeria. *African Journal of Educational Management,* 12(2), 25–34.

Access to Health Records Act 1990 (UK).

African Charter on Human and Peoples Right, 1981

Anas, G.J. (2004). *The rights of Patients: The Authoritative ACLU guide to the rights of patient*. South Illinois University Press.

Chief M. A. Inegbedion v. Dr Selo-Ojemen & Ors. (2013) JELR 46227 (SC).

Constitution of the Federal Republic of Nigeria 1999 (as amended).

Data Protection Act, 2018 (UK)

Department of Health and Social Care. (2025) Guidance handbook to the NHS Contitution for England.

Dr Rom Okekearu v. Danjuma Tanko. (2002) JELR 44538 (SC).

Evidence Act 2011.

Family Law Reform Act, 1969 (UK)

Federal Ministry of Health. (2018). Patients' Bill of Rights.

Freedom of Information Act 2011.

Gillion, R, (1986). *Philosophical Medical Ethics*. Chichester: John Wiley.

Human Right Act, 1998

Ibitoye, T. R. (2018). *The medico-legal principle of confidentiality in doctor-patient relationships in Nigeria*. University of Ibadan Repository.

Ihekoronye, et al. (2024). Legal considerations for electronic medical records in Nigeria. *Law and Social Justice Review*, 5(3).

Information Commissioner's Office. (2025). A guide to subject access. https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/subject-access-requests/a-guide-to-subject-access/

Kristopher et al., (2011). Telepsychiatry in Juvenile Justice Settings. *Child and Adolescent Psychiatric Clinics of North America*, 20(1) 113-123

Mclnerney v MacDonald (1992) 2 SCR 138

Medical and Dental Council of Nigeria. (2008). Code of Medical Ethics in Nigeria.

Mental Capacity Act, 2005 (UK)

National Health Act 2014.

Nigeria Data Protection Act 2023.

Nigeria Data Protection Commission. (2026). Data Subject Access Request Form. https://forms.ndpc.gov.ng/dsar-request/

Nwakamma, I (2022). Whose rights are being violated when receiving HIV and sexual and reproductive health services in Nigeria? *BMC Health Services Research.* https://doi.org/10.1186/S12913-022-08624-9

Ojo v. Gharoro & Ors. (2006) JELR 56140 (SC).

Pellegrino, E.D & Thomasma, D.C. (1988). *For the Patients Good: The Restoration of Beneficience in Health Care*. Oxford: OUP

Re B (Minor) Wardship Sterilisation (1988) AC 199.

Re C (A Minor) Evidence Conference (1991) 7 BMLR 138

Stauch et al., (2012) *Test, Cases and Materials on Medical Law and Ethics*. 4th Edn. Routledge

UK General Data Protection Regulation, 2021

World Medical Association. (2015). WMA Declaration of Lisbon on the Rights of the Patient.