

**Mum's the Word:
Mental Health and
Substance Abuse Treatment
Information and Other
Specialized Medical Records
Issues**

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In today's legal and regulatory climate, it is crucial for healthcare providers to understand what information and records they may release, to whom and under what conditions. Likewise, it is important for those seeking information, such as lawyers and patients, to know their rights in accessing information. However, doing so is not a simple task. A myriad of laws apply that are related to confidentiality of healthcare information and the special categories of information – particularly mental health and substance abuse treatment information. Further complicating the matter are numerous exceptions to confidentiality and various laws affirmatively requiring disclosure of certain information in some circumstances.

I. MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT INFORMATION RECEIVES SPECIAL PROTECTION UNDER THE LAW.

Numerous statutes and regulations exist governing the confidentiality of healthcare information and its protection from use and disclosure. However, information regarding mental health and substance abuse treatment, whether oral or written, receives special treatment under the law. Such records and information historically have enjoyed a higher level of protection than ordinary medical information.

Access to mental health and substance abuse treatment information is greatly limited. Not only is the information restricted, the identity of a person seeking or receiving mental health and substance abuse treatment is protected.

A. Purpose of special protections

Several reasons have been advanced for the special protection given to mental health and substance treatment information. Unfortunately, persons seeking treatment for a mental illness or addiction are stigmatized by society. Thus, people are more likely to

seek and accept needed treatment if they are secure in the confidentiality of their information and protection of their anonymity. As stated by the Surgeon General: “In an effort to reduce the risk of stigma and the discrimination that often results, confidentiality laws seek to protect both the fact that an individual has sought mental health treatment as well as the disclosures that are made during treatment.” *Mental Health: A Report of the Surgeon General*, Ch. 7 (1999).

Additionally, these patients are more likely to make the full disclosure necessary for effective treatment if they are secure in the confidentiality of their information. The U.S. Supreme Court has noted the importance of confidentiality related to mental health treatment, stating:

Treatment by a physician for physical ailments can often proceed successfully on the basis of a physical examination, objective information supplied by the patient, and the results of diagnostic tests. Effective psychotherapy, by contrast, depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.

Jaffee v. Redmond, 518 U.S. 1, 10 (1996). Obviously, people may be less willing to make disclosures during therapy or treatment if they believe the information may be disseminated outside the treatment relationship. Thus, the Surgeon General has recommended strong confidentiality laws as critical in increasing the willingness of people to fully participate in treatment. Report, Ch. 7, *supra*. Nonetheless, confidentiality is not absolute, and the treatment provider generally is obligated to disclose the limits of confidentiality.

B. Sources of confidentiality laws– state, federal, statutory, administrative, etc.

Currently, confidentiality of healthcare information is governed by a collage of federal and state statutes, regulations, rules and case law. Examples of such laws include the following:

- 43A O.S. § 1-109 (all mental health & substance abuse information in Oklahoma)
- 12 O.S. § 2503 (physician-patient & psychotherapist-patient privileges under Oklahoma Evidence Code)
- 63 O.S. § 1-502.2 (communicable diseases)
- 59 O.S. § 1376 (communications between psychologist and patient)
- 59 O.S. § 1910 (information acquired by LPCs)
- OAC 38:10-3-3(d)(2) (responsibility of LADCs to maintain confidentiality of information)
- 59 O.S. § 328.32 (dental record confidentiality)
- 59 O.S. § 1272.1 (confidentiality of social worker records)
- 45 C.F.R., Parts 160 & 164 (federal HIPAA Privacy Regulations)
- 42 C.F.R., Part 2 (patient information possessed by federally-funded substance abuse treatment programs)
- *Jaffee v. Redmond*, 518 U.S. 1, 10 (1996) (recognizing psychotherapist/patient privilege under federal law).

Of course, this list is not exhaustive. Nearly all laws governing the licensure and regulation of healthcare professionals address the confidentiality of their information.

Many of these laws describe information related to mental health treatment or drug or alcohol treatment as both confidential and privileged. Confidentiality and privilege are related but distinct issues. The two terms are commonly confused and used interchangeably, but it is important to understand the difference between them.

The requirement to keep information and records confidential – confidentiality – is a prohibition against dissemination of information to third parties to the treatment relationship. A privilege is an evidentiary matter; it is a right belonging to the patient, in the case of healthcare information, to prevent treatment information from being used as

evidence in a judicial or quasi-judicial proceeding. It is possible to have one of these concepts apply but not the other, in a given situation. For example, a patient may authorize the release of certain information to specifically identified persons, i.e. give a limited waiver of confidentiality, but that does not mean the information is automatically admissible as evidence in court. Likewise, if the evidentiary privilege is waived, permitting treatment information to be admitted into evidence, that does not necessarily mean the information is no longer confidential and may be disclosed to the public at large.

C. **Preemption**

In the early 1970s, Congress, recognizing the stigma associated with substance abuse and fear of prosecution from people needing treatment, enacted legislation guaranteeing strict confidentiality to such people; that law is now found at 42 U.S.C. § 290dd-2. As directed and authorized by this legislation, the U.S. Department of Health and Human Services issued regulations – 42 C.F.R., Part 2 – specifically implementing and setting forth the confidentiality requirements for drug and alcohol treatment “programs,” as defined by the regulations.

Over twenty years later, Congress passed the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), now codified at 42 U.S.C. § 201, *et seq.* Pursuant to HIPAA, the U.S. Department of Health and Human Services issued the Standards for Privacy of Individual Identifiable Health Information (commonly referred to as the HIPAA “Privacy Rule”). These rules became effective on April 14, 2003.

Thus, while the HIPAA Privacy Rule is not the first privacy rule of its kind, it is the first federal law addressing all types of healthcare information. Both sets of

regulations establish standards for the maintenance, use and disclosure of information, including what one must do before disclosing confidential information and to whom it may be disclosed.

HIPAA and 42 C.F.R., Part 2 both preempt or override certain state laws, which generally means they take precedence over any state law which gives fewer rights than the federal law. More specifically, 42 C.F.R., Part 2 preempts any state law that permits or requires a disclosure prohibited by the regulations. However, if a statute requires greater confidentiality, it is not preempted and the more restrictive state law controls. 42 C.F.R. § 2.20. The HIPAA Privacy Rule preempts “contrary” state law. 45 C.F.R. § 160.203. That is, HIPAA preempts a state law provision if it is “impossible to comply with both” or if the state law “stands as an obstacle” to achieving the purposes of HIPAA. 45 C.F.R. § 160.202. A state law related to the privacy of health information is not preempted if it is “more stringent” than the HIPAA Privacy Rule. 45 C.F.R. § 160.203(b).

Who must comply? The HIPAA Privacy Rule and 42 C.F.R., Part 2 each specify the types of persons or entities covered

The HIPAA Privacy Rule applies to “covered entities,” which are health plans, health care clearinghouses and health care providers who transmit health information in electronic form. 45 C.F.R. §§ 160.102, 160.103, 164.103, 164.104. Thus, if a health care provider does not transmit health information electronically, the provider is not subject to the HIPAA Privacy Rule.

While HIPAA applies to much of the healthcare industry, 42 C.F.R., Part 2 applies only to “federally assisted” drug or alcohol treatment “programs.” 42 U.S.C. §§ 290dd-2; 42 C.F.R. § 2.11, 2.12(b). A “program” is any individual or organization that, in

whole or in part, provides alcohol or drug abuse diagnosis, treatment or referral for treatment or prevention. 42 C.F.R. § 2.11. Identified drug or alcohol abuse units within general medical facilities or medical staff in a hospital whose primary function is to provide services for substance abuse are covered by 42 C.F.R., Part 2, although the hospitals and emergency rooms as a whole are not covered.

If a federally-assisted substance abuse treatment program transmits health information electronically, it must comply both with 42 C.F.R., Part 2 and the Privacy Rule. HIPAA does not preempt 42 C.F.R., Part 2.

Oklahoma has one statute, 43A O.S. § 1-109, that applies to all mental health and substance abuse treatment information, and all communications between a psychotherapist and a “consumer.” Thus, mental health professionals and substance abuse counselors must comply with this statute although their own licensing laws also likely address confidentiality. Such professionals therefore must follow 42 C.F.R., Part 2 and/or the HIPAA Privacy Rule, if subject to those laws, as well as Section 1-109 and other state laws to the extent those laws are not contrary to 42 C.F.R., Part 2 or HIPAA. Fortunately, much effort has been made for Section 1-109 to be consistent with these federal laws.

Whose information is covered? For purposes of 42 C.F.R, Part 2, it is important to understand who qualifies as a “patient.” These regulations protect individuals who have applied for, participated in, or received an interview, counseling or any other service from a federally-assisted program. That means a patient includes someone who has applied for services, whether or not admitted to the program. 42 C.F.R. § 2.11; 2.15(b). HIPAA, however, does not make the same distinction between those who receive services and applicants or no-shows; the focus is on protecting all health-related

information that identifies an individual. 45 C.F.R. §§ 164.501, 165.502(f).

D. General Rule regarding use and disclosure of confidential information

An individual or entity covered by HIPAA and/or 42 C.F.R., Part 2 may not use or disclose patient-related information except as permitted or required by the regulations. 42 C.F.R. §§ 2.12, 2.13(a); 45 C.F.R. § 164.502(a). The type of information protected is health information, whether oral or recorded, that identifies an individual, i.e. patient-identifying information. Under 42 C.F.R., Part 2, this protection covers any information that would directly or indirectly reveal a person's status as a current or former patient as a drug or alcohol abuser and all information related to that person's treatment. 42 C.F.R. §§ 2.11, 2.12(a)(1)(i). HIPAA protects all health information which identifies an individual, including any information, whether oral or recorded, created or received by a covered entity and which is related to the past, present or future physical or mental health of an individual. 45 C.F.R. § 164.501, 164.502, 164.514.

Beyond this basic protection, 42 C.F.R., Part 2 and 43A O.S. § 1-109 are very different from the HIPAA Privacy Rule regarding the permitted uses and disclosures of patient information. Under 42 C.F.R., Part 2 and Section 1-109, mental health professionals and substance abuse treatment programs must not disclose any information identifying a person as a mental health or substance abuse patient or treatment information unless the patient has consented in writing or unless another very limited exception applies. Any disclosure must be limited to the minimum information necessary to carry out the purpose of the disclosure.

HIPAA, on the other hand, permits uses and disclosures for "treatment, payment and health care operation" as well as certain other disclosures without the patient's prior

written authorization. Otherwise, a disclosure must be preceded by an authorization that meets certain requirements. With certain exceptions, the Privacy Rule requires uses and disclosures of protected health information (“PHI”) to be the minimum necessary for the intended purpose of the use or disclosure.

Although HIPAA permits uses and disclosures without patient consent for the purposes of treatment, payment and healthcare operations, such disclosures would violate Section 1-109 (and 42 C.F.R., Part 2 if applicable). Accordingly, mental health and substance abuse treatment professionals in Oklahoma must follow 1-109 (because it is more stringent) and are not permitted to make these disclosures without written consent unless an exception applies.

E. Permitted disclosures

While the general rule under state and federal law prohibits disclosure of mental health and substance abuse treatment information, circumstances exist permitting limited disclosure. Permitted disclosures fall into three basic categories: 1) those pursuant to proper written permission from the patient; 2) those pursuant to a valid court order; and 3) those pursuant to other exceptions to the general rule. As noted, under Oklahoma law, disclosures of mental health and substance abuse information are not permitted for purposes of treatment, payment or healthcare operations, despite HIPAA’s permitting such disclosures.

1. Patient’s written consent. Most disclosures are permissible if a patient has given written permission, which has not expired or been revoked. The Privacy Rule, 42 C.F.R, Part 2 and Section 1-109 each use different terms when referring to the written permission provided by a patient for the use or disclosure of health information. The

Privacy Rule uses the term “authorization,” the term “consent” is used under 42 C.F.R., Part 2, and Section 1-109 uses the terms “release” and “authorization,” presumably interchangeably. This paper uses the term “release.” Regardless of the title placed on the document permitting disclosure of information, the elements of state and federal law must be included in the document.

The core required elements for a release to be valid under HIPAA as well as Section 1-109, are as follows:

- 1) name or general designation of the program or person permitted to make the disclosure;
- 2) name or title of individual or name of organization to which disclosure is to be made;
- 3) the name of the patient who is subject to the disclosure;¹
- 4) the purpose of the disclosure;
- 5) a description of type and amount of information to be disclosed;
- 6) the dated signature of the patient or authorized representative or both when required with a description of the authority of the representative to act for the patient;
- 7) an expiration date, event or condition that will ensure the release will last no longer than reasonably necessary to serve the purpose for which it is given;
- 8) a statement of the right of the patient to revoke the release in writing and a description of how the patient may do so.

43A O.S. § 1-109(C)(1); 45 C.F.R. § 164.508(c)(1). Because the core required elements for a release under the Privacy Rule and Section 1-109 are similar to those of 42 C.F.R., Part 2, a release containing the above items also will comply with 42 C.F.R., Part 2.

To comply with the Privacy Rule, the release also must contain statements sufficient to place the individual signing the release on notice of the following:

- the ability of the provider or covered entity to condition treatment, payment or enrollment or eligibility of benefits on whether the individual signs the consent by stating either the covered entity may not condition these services on patient’s signing the release or the consequences for refusing to sign the release; and

¹ Most healthcare providers track patients by either date of birth or social security number; thus, if seeking to obtain records, it is helpful to have that information on the release as well.

- the potential for information disclosed pursuant to the release to be subject to redisclosure by the recipient and no longer be protected by HIPAA.

However, regarding the potential for redisclosure, a “program” covered by Part 2 is required when it discloses information pursuant to written consent of the patient to include a written statement (specifically set forth in the regulation) that the information cannot be redisclosed. 42 C.F.R. § 2.32. While Part 2 requires this statement to be delivered to the recipient at the time of disclosure (even if the disclosure is made orally) and does not require it to be on the release form, if the provider is both a “program” under 42 C.F.R., Part 2 and a “covered entity” under HIPAA, the release form should contain a statement notifying the patient the information is not permitted to be redisclosed or expressly authorizing redisclosure.²

If records or information to be released may identify a person as having any reportable communicable or non-communicable disease or as having participated in a public health investigation, the release must contain a specific notice to be valid under Oklahoma law. 63 O.S. § 1-502.2(A) & (C). The release must contain the following notice: **“The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease.”** 63 O.S. § 1-502.2(B). The language must be in bold typeface. Additionally, for the release to be valid, the person whose information is required to be kept confidential must be informed of all persons or organizations to which such information may be disclosed by the release.

² Special rules exist under 42 C.F.R., Part 2 for consents related to criminal justice referrals. The rules regarding duration and revocability of the consent are different. Covered “programs” receiving criminal justice referrals must familiarize themselves with these rules.

If the release form does not contain all of the items required by Section 1-109 or HIPAA or there are blanks where information is required, the release is invalid and may not be relied upon to disclose information. 43A O.S. § 1-109(C)(2); 45 C.F.R. § 164.508(b)(2). In addition to the above requirements, HIPAA now requires covered entities to provide patients with a copy of all releases the patient signs. 45 C.F.R. § 164.508(c)(4). It also requires the release to be written in “plain language.” 45 C.F.R. § 164.508(c)(3). A release that conforms to the Privacy Law, 42 C.F.R., Part 2 and state law is included as Appendix 1 to this paper.

A proper release form authorizes, but does not require, the disclosure of information. Therefore, a provider may exercise its discretion and not make the proposed disclosure. Accordingly, if an attorney is seeking records for purposes of discovery in litigation, it is recommended the attorney send a subpoena *duces tecum* along with the consent. It must be noted, however, a subpoena alone is not sufficient to obtain mental health or substance abuse records. 43A O.S. § 1-109(D). Likewise arrest and search warrants, without more, are insufficient to disclose information identifying persons as having a substance abuse disorder. If a provider receives a subpoena or law enforcement shows up with an arrest warrant, the provider must refuse to make the disclosure in such a way that does not reveal the individual as someone who has a substance abuse disorder.

2. Other exceptions allowing disclosure. The HIPAA Privacy Rule, 42 C.F.R., Part 2 and Section 1-109 all set out a number of circumstances under which limited disclosure may be made regardless of patient consent, i.e. exceptions to the general rule. Each circumstance has its own specific requirements and limitations. Generally, the exceptions are very narrow and fall into the following categories:

- internal communications of those engaged in treatment or related administrative work
- court order
- medical emergency
- crime or threatened crime at provider's premises or against staff
- research
- audit and evaluation
- child abuse reporting
- qualified service organization agreement/business associate agreement

A few of these exceptions are discussed in more detail below.

Court orders. If a patient is unwilling to sign a written release permitting the disclosure of mental health or substance abuse treatment information, the person seeking the information may wish to seek a court order for the release of the information. State law simply provides “[e]xcept as otherwise permitted, mental health and alcohol or substance abuse treatment information may not be disclosed without valid patient authorization or a valid court order issued by a court of competent jurisdiction.” 43A O.S. § 1-109(D). No direction is given regarding how to go about getting such an order, but similar to disclosures authorized by written release, disclosures made pursuant to court order are permitted but not required. *See Holmes v. Nightingale*, 2007 OK 15, 158 P.3d 1039 (holding a court order permitting, rather than mandating, oral communication with healthcare providers is consistent with HIPAA and state law). Again, it is wise to require/provide both a court order and subpoena.

If 42 C.F.R., Part 2 applies, the court and the party seeking the information must follow a specific procedure before an order may be entered permitting disclosure of protected information. 42 C.F.R. §§ 2.63-2.67. The proceeding must be filed using a fictitious name for the patient, the patient and the provider must be given notice and an

opportunity to be heard before an order is issued, and the court must make certain findings, including “good cause” for disclosure.

Medical emergency exception. Patient-identifying information may be disclosed for the purpose of treating a condition that poses an immediate threat to the health of an individual and requires immediate medical intervention. Only the minimum information necessary may be disclosed and it must be disclosed only to medical personnel. 43A O.S. § 1-109(E)(6). If 42 C.F.R., Part 2 applies, the details of the disclosure must be documented in the patient’s record.

Crime exception. Limited information may be disclosed to law enforcement officers regarding the commission of a crime on the premises of a provider or against the provider’s staff, or the threat to commit such a crime. With respect to substance abuse patients, the disclosure must be limited to the circumstances of the incident, and the patient’s name, address and last-known whereabouts. 43A O.S. § 1-109(E)(2); 42 C.F.R. §§ 2.12(c)(5)(ii).

Audit and evaluation exception. The Privacy Rule, 42 C.F.R., Part 2, and Section 1-109 all permit disclosure, without patient consent, of patient-identifying information to qualified persons conducting an audit or evaluation. If the audit or evaluation is conducted by a “health oversight agency” or outside entity, Part 2 has certain additional measures that are necessary, such as requiring the agency to make a written commitment to comply with limitations on redisclosure. 42 C.F.R § 2.53.

Child abuse reporting exception. Oklahoma, like most states, has a law mandating individuals to report suspected child abuse. An exception exists, under state law as well as the Privacy Rule and 42 C.F.R., Part 2, allowing persons who provide

mental health or substance abuse services to comply with this mandatory reporting law. 43A O.S. § 1-109(E)(5); 45 C.F.R. § 164.512(b)(1)(ii); 42 C.F.R. § 2.12(c)(6). However, under state law and Part 2, disclosures related to individuals with a substance abuse disorder are limited to the initial report; no follow-up information is allowed (*e.g.*, review of records, interviews of providers) unless the patient has signed a written release.

Use of agreements to disclose information to persons/agencies supplying services. Under state and federal law, a mechanism exists that allows mental health and substance abuse treatment providers to disclose information without a patient's consent to outside persons or organizations that provide services to the provider, such as legal or accounting services. HIPAA refers to these outside service providers as business associates, Part 2 refers to them as "qualified service organizations," and state law uses both terms. 45 C.F.R. §§ 160.103, 164.504(e); 42 C.F.R. § 2.12(c)(4); 43A O.S. § 1-109(E)(4). Part 2 essentially requires service providers to acknowledge they are fully bound by Part 2 and promise to safeguard information and resist efforts to obtain information. Fortunately, a business associate agreement and qualified service organization agreement may be combined into one document. A sample Business Associate/Qualified Service Organization Agreement is included as an Appendix 2 to this paper.

3. What if no exception exists but there is a duty to disclose? It is important to say a few words about situations involving a duty to disclose without a corresponding exception. Examples of such situations include a duty to warn, reports of elder abuse and reports of communicable diseases. Although disclosure of such information is required by statutes, regulations, case law and/or ethical rules, state and federal law do not permit

such disclosure to identify the person directly or indirectly as a person with a substance abuse disorder.³ Because no direct exception exists, therefore, the best way to resolve the dilemma is to make the report anonymously without patient-identifying information.

For example, the exception for reporting crimes on the premises does not permit disclosure of a substance abuse patient's confessions about past or planned crimes away from the facility. If there is a duty to warn or a desire to disclose other criminal activity, the provider should obtain a court order or make the disclosure anonymously without providing patient-identifying information.

F. Psychotherapy notes

The HIPAA Privacy Rule does not single out mental health and substance abuse treatment information as a whole for special treatment; for the most part, that is left to state law and 42 C.F.R., Part 2. HIPAA, however, does single out a sub-category of such information – “psychotherapy notes.” If health information falls into this category, it generally cannot be used or disclosed without written authorization from the patient, unlike other protected health information, which HIPAA allows to be used and disclosed for treatment, payment or healthcare operations. 45 C.F.R. § 164.508(a)(2).

The Privacy Rule defines the term “psychotherapy notes” as “notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.” 45 C.F.R. § 164.501. The regulation provides psychotherapy notes do not include medication prescription and monitoring, start and stop times of counseling

³ Because state law protects the identity of mental health consumers, similar to the federal law protection for those having a substance abuse disorder, it is wise to proceed the same with respect to mental health information as one does with substance abuse treatment information.

sessions, modalities and frequencies of treatment, results of clinical tests, and any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and any progress to date. *Id.*

Some ambiguity exists regarding the scope of this definition, especially since the preamble to the Privacy Rule equates psychotherapy notes to “process notes.” Nonetheless, it is clear psychotherapy notes are narrowly defined under the regulation and do not include what mental health professionals often refer to as “progress notes” (because typically those are not separate and are a summary of diagnosis, symptoms and prognosis).

If information meets the narrow definition and is kept separate from the rest of the patient’s record, a covered entity must obtain the patient’s written authorization for its use or disclosure, except the covered entity who originated the notes may use them for treatment or training and may disclose them to defend itself in a legal action brought by the patient and for regulatory oversight purposes. Additionally, HIPAA permits the disclosure of such information to coroners and medical examiners for the purpose of identifying a deceased person or to avert a serious and imminent threat to a person, but state law and 42 C.F.R., Part 2 prohibit such disclosure from identifying a person as having a substance abuse disorder. An authorization for the release of psychotherapy notes must be separate and may not be combined with any other type of release. 45 C.F.R. § 164.508(b)(3)(ii).

G. Right to name a Treatment Advocate

A relatively recent (2003) change in state law affecting the release of mental health information is the right of a person under the care of a licensed mental health

professional or mental health treatment facility to name a “treatment advocate.” 43A O.S. § 1-109.1. Under this statute, mental health professionals must inform patients under their care of the patients’ right to designate a treatment advocate, who may participate in the treatment planning and discharge planning of the patient to the extent consented to by the consumer and as permitted by law. 43A O.S. § 1-109.1(A). Facilities certified by the Department of Mental Health and Substance Abuse Services must use a treatment advocate consent form, which they must keep in the patient’s record, containing certain items, including a signature and statement by the treatment advocate indicating he or she will comply with all standards of confidentiality. OAC 450:15-3-28. Of course, the patient still must sign a proper written release for information to be shared with the treatment advocate.

II. PATIENT ACCESS TO HEALTHCARE INFORMATION

Under the HIPAA Privacy Rule, two disclosures are required– 1) to the individual who is the subject of the health information, 2) to the U.S. Department of Health and Human Services to investigate or determine compliance with the Privacy Rule. All other disclosures are permissive.

An individual’s right to inspect and copy his or her protected health information is a critical aspect of the Privacy Rule. It lays out specific procedures for handling a patient’s request for his protected health information. For instance, covered entities must respond to a patient’s request for access within 30 days of receipt of the request (or 60 days under certain circumstances). The entity may require the patient to make the request in writing. The Privacy Rules also gives patients the right to have the covered entity amend the patient’s health information and the right to obtain and accounting of certain disclosures of health information

made by the covered entity during the six years prior to the request. 45 C.F.R §§ 164.526, 164.528(a).

Oklahoma law also affords individuals the right to access their medical information. 76 O.S. § 19(A)(1) (regarding all types of medical information); 43A O.S. § 1-109(B) (regarding mental health and substance abuse treatment information). Moreover, a patient has a private right of action against a healthcare provider who refuses to provide records including psychological records, to the patient. *Gens v. Casady School*, 2008 OK 5, 177 P.3d 565; *Bettis v. Brown*, 1991 OK CIV APP 93, 819 P.2d 1381.

Of course, certain exceptions do exist under the Privacy Rule as well as state law to the right of access. A patient does not have the right to inspect or copy psychotherapy notes, information compiled in reasonable anticipation of litigation, information that may be subject to or exempt from certain provisions of Clinical Laboratory Improvement Amendment. The Privacy Rule also gives covered entities the discretion to deny access on several other grounds, some of which are subject to the patient's right to request a "review" of the decision by a designated licensed healthcare professional. Circumstances under which a covered entity may deny a request for access without providing a review include:

- Records exempt from the right of access, e.g. psychotherapy notes;
- Information requested by inmate if a correctional institution has determined access may jeopardize the health, safety, security, custody or rehabilitation of the inmate or other person;
- The requested information was created or obtained as part of research that includes treatment, provided the patient has agreed to this denial of access when consenting to participate in the research; or
- The requested information was obtained under a promise of confidentiality and the access would likely reveal the source of the information.

Grounds for denial, provided the patient is given a right to a review, include the following:

- A licensed mental health professional (“LMHP”) has determined, in the exercise of professional judgment, the access is reasonably likely to endanger the life or physical safety of the patient or another person;
- The information makes reference to another person and an LMHP has determined the access is reasonably likely to cause substantial harm to the other person; or
- The request for access is made by the patient’s personal representative and an LMHP has determined the provision of access to the representative is reasonably likely to cause substantial harm to the patient or another person.

The Oklahoma statute relating to mental health and substance abuse treatment information also provides patients are entitled to personal access to their information and provides exceptions to that right. 43A O.S. § 1-109(B). It combines the last three grounds into one exception, but otherwise generally provides the same exceptions. It is important to note under the Privacy Rule as well as state law a provider cannot deny a patient access simply because the provider believes doing so would not be in the best interest of the patient or another person. There must be a reasonably likely danger to the life or physical safety of a person.

III. RECORDS MAINTAINED BY EMPLOYERS

Employers maintain medical information about employees for a variety of reasons. They may have records related to drug-testing, workers’ compensation or requests for leave.

Unless an employer is a covered entity, it is not subject to the HIPAA Privacy Rule simply because the employer may possess medical records. Moreover, the Privacy Rule does not preempt other laws related to the privacy of medical records possessed by employers, such as ERISA, the Family Medical Leave Act, the Americans with Disabilities Act , or the Oklahoma Standards for Workplace Drug and Alcohol Testing

Act. Employers should continue to maintain records related to those laws are required under each law.

IV. MINORS RECORDS

The HIPAA Privacy Rule defers to requirements in other applicable laws regarding the use or disclosure of health information regarding minors. 45 C.F.R. § 164.502(g). Generally speaking, if a minor may consent to treatment without parental consent, then only the minor may consent to the release of information.

Regarding the ability of a minor to consent to treatment, Oklahoma law provides:

Notwithstanding any other provision of law, the following minors may consent to have services provided by health professionals in the following cases:

1. Any minor who is married, has a dependent child or is emancipated;
2. Any minor who is separated from his parents or legal guardian for whatever reason and is not supported by his parents or guardian;
3. Any minor who is or has been pregnant, afflicted with any reportable communicable disease, drug and substance abuse or abusive use of alcohol; provided, however, that such self-consent only applies to the prevention, diagnosis and treatment of those conditions specified in this section. Any health professional who accepts the responsibility of providing such health services also assumes the obligation to provide counseling for the minor by a health professional. If the minor is found not to be pregnant nor suffering from a communicable disease nor drug or substance abuse nor abusive use of alcohol, the health professional shall not reveal any information whatsoever to the spouse, parent or legal guardian, without the consent of the minor;
4. Any minor parent as to his child;
5. Any spouse of a minor when the minor is unable to give consent by reason of physical or mental incapacity;
6. Any minor who by reason of physical or mental capacity cannot give consent and has no known relatives or legal guardian, if two physicians agree on the health service to be given; or

7. Any minor in need of emergency services for conditions which will endanger his health or life if delay would result by obtaining consent from his spouse, parent or legal guardian; provided, however, that the prescribing of any medicine or device for the prevention of pregnancy shall not be considered such an emergency service.

63 O.S. § 2502. This statute provides a health professional is protected if he relies in good faith on a minor's representation that he or she may give consent even if the minor misrepresents such fact. 63 O.S. § 2502(A). Information obtained about a minor under any of the foregoing circumstances may not be released without the minor's consent.

If a provider is governed by 42 C.F.R., Part 2, it must always obtain the minor's consent (not the parent's) for disclosures, even if the disclosure is to be made to the parents.. Because parental consent is not necessary for a minor to receive substance abuse treatment, parental consent for disclosure to a third-party is not required. 42 C.F.R § 2.14.

A minor 16 years of age or older may be admitted for inpatient mental health treatment upon consent of the minor and the minor's parent(s). 43A O.S. § 5-505(A)(1). Accordingly, for disclosure of information related to such treatment, the minor and the parent each must sign a written release.

In situations where a minor is not specifically authorized to consent to treatment and parental consent is obtained, information and records related to that treatment must be made available both custodial and non-custodial parents unless restricted by a court as being in the best interests of the minor. 10 O.S. § 5.2. Parents continue to be parents even when they do not have physical custody of their children.

V. DECEASED CLIENTS

Former patients and deceased patients continue to be protected under 42 C.F.R., Part 2, as well as the HIPAA Privacy Rule. 42 C.F.R. §§ 2.11, 2.15; 45 C.F.R. §§

164.501, 164.502(f). These laws permit executors, administrators or other persons authorized to act on behalf of a deceased person or his estate to sign a release for the disclosure of protected health information. Both laws also permit limited disclosure about deceased patients without consent when required by federal or state laws providing for the collection of vital statistics or an inquiry into the cause of death.