Release of Medical Records

HOUSTON PUTNAM LOWRY

Introduction

A great deal of confusion currently exists about the confidentiality of medical records. Even though this area has a number of statutes governing it, the confusion persists. Part of it may be due to an honest paranoia, which may even be healthy in this age of automated data bases. The other part of it is due to political maneuverings, where the issue is used as a political club. Whatever the reason, there is a strong surge of interest in a right to privacy. Whether the trend is growing awareness or simply a cyclical fad, it is currently a problem to be reckoned with.

Some statutes are definitely inapplicable. The Administrative Procedures Act,[1] Freedom of Information Act,[2] and Privacy Act of 1974[3] need not be followed because they apply only to governmental agencies.[4] A private hospital, such as Saint Francis Hospital and Medical Center, need not follow them. The records are not government property nor are they subject to significant government control. Merely because the hospital receives government monies is immaterial. All monies are received because the patient assigns his benefits to the hospital in order to pay his bill. The hospital is acting for its own benefit, not for the government's benefit. The hospital has no independent authority at law to perform any specific government functions. Mere government access or reliance on the records in question is insufficient to demonstrate an agency's existence. Receipt of Hill-Burton Funds in and of itself is insufficient.[5] The only time this issue has come before the courts of this jurisdiction, it was held that a private hospital is not a government agency.[6]

Eliminating these three statutes removes the bulk of restrictions on releasing information. This relative freedom should not be expected to last forever. Two bills are currently pending before the United States Congress[7] which will impose restrictions on all hospitals through commerce clause jurisdiction.[8] For the most part, a private hospital may currently do pretty much as it sees fit.

Access by Patient

A patient may access his medical record. Although a small number of court cases do exist,[9] Connecticut does have statutory law directly on point.[10] The most common and general statute is Conn. Gen. Stat. § 4-104. That governs all records, regardless of content. Once a patient makes demand on the hospital after receiving treatment and being discharged, the patient may review his record. A patient who has not been treated has no right to see his record. A patient who has not been discharged has no right to see his record. Access can either be by the patient himself, his physician, or his attorney. Ultimately, the right of access belongs to the patient.

One interesting point does appear here. A patient may inspect his history, bedside notes, charts, pictures, and plates. Yet, a patient need only be allowed to copy his history, bedside notes, and charts. Apparently a patient has no right to copy his pictures and plates, although he may view them. Yet, Conn. Gen. Stat. § 4-105 allows a judge to compel production of everything. There is no provision for penalizing a hospital that forces a patient to secure his records by court order. It is very important to note that a doctor does not have any veto power over whether or not the patient can see his record.

The same section governs production of medical records by subpoena.[11] At the hospital's option, either the original or a copy of the medical record can be delivered to the clerk of the court. Nothing can force the hospital into sending the original instead of a copy, since this choice has been vested by law into the hospital's discretion. For J.C.A.H. purposes, it would be best if only a copy is sent out and not the original.

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The record itself need only be delivered to the clerk of the court; there is no indication it need be hand carried. Use of the mails should constitute a constructive delivery, within the meaning of the statute.

Psychiatric records are also governed by Conn. Gen. Stat. § 17-206i(b). Under this section, a patient[12] has a right to inspect all of a patient's records once a written request has been made if the request is in connection with any litigation related to the hospitalization. Follwing discharge, a patient may request in writing to see his own records even though there is no litigation connected or related to the hospitalization. Under that condition, access can be denied for certain reasons.[13] Of course, a patient may still petition the superior court for relief. What effect this new revision will have, if any, is debatable. Supposedly, this new section is not intended to limit access under Conn. Gen. Stat. § 4-104.[14] Yet, a patient has unlimited access under that section once they are discharged. The restrictions only apply under the new law when the patient has been discharged and the information is not for the purposes of litigation. In short, there is an apparent contradiction.[15] It should be resolved in favour of disclosure, considering the underlying philosophies of the two sections.

In short, a patient has a right to see his medical record. This right has been found in the common law and been codified into Connecticut's statutory law. There is no requirement that either the inspection or the making of copies shall be free.[16] If the cost is placed too high, courts may hold that constructively denies a patient access to his record. In this light, the price should be reasonable.[17]

Information That Can Be Disclosed to Persons Other Than the Patient Without Consent

Very little information can be disclosed to persons other than the patient without patient consent. No information may be disclosed at all if the patient has forbidden disclosure. It is up to the patient to express his disapproval of even the most general information to the hospital. Until the patient does so, the hospital is under no obligation to withhold all information.

The hospital may disclose a patient's name and the fact the patient was hospitalized. Admitting date, discharge date, and the patient's general condition may also be disclosed. A patient may prevent the disclosure of even this general information by informing the hospital that he objects to it. It is the patient's responsibility to communicate this desire to the hospital. The patient's room number should only be disclosed while the patient is in house and the requesting party is here to visit. Otherwise, an enterprising sleuth could figure out the general nature of the patient's illness, such as the psych ward or the delivery room. Likewise, the address, phone number, attending physician, marital status, age, and religion of the patient should not be disclosed. A doctor's specialty is generally known as a matter of public record. That will give a substantial clue as to the patient's ailment. Suppose the attending physician is in only obstetrics and the patient is single. To release such information lets the public know that the woman is having an illegitimate child. Similar career damage can be done by disclosing the fact the attending physician is a psychiatrist. Therefore, as little information as possible should be given out.

Consent is not required for disclosure of psychiatric communications under certain conditions.[18] The first two exceptions involve determinations by the patient's psychiatrist, so the hospital need not be concerned with them directly. A notice of disclosure must be given to the patient when his records are disclosed in furtherance of his treatment. That is about the maximum extent of the hospital's possible involvement under these two exceptions.

The third and most relevant exception involves disclosing the name, address, and fees for psychiatric services to those involved in the collection of fees for such services. If a dispute arises only limited information can be disclosed.[19] However, the entire problem can be circumvented if the patient's consent is obtained, which it usually is.

Finally, the fourth and fifth exceptions deal with court cases such as appointing conservator by the probate court or when the patient introduces his mental condition as an element of his defense. Under these two exceptions, the psychiatric record may be introduced into evidence. Otherwise, the psychiatrist-patient or psychologist-patient could preclude the record and its contents. This privilege belongs to the patient, not the doctor.[20] If the patient desires the communications to be introduced, they will be regardless of the psychiatrist's view on the advisability of disclosure. It should be noted the patient's consent must be in writing to be effective.

Information may be disclosed "in house" without a patient release. All information should be released on a "need to know" basis. That is the most effective way to control the flow of information. People who have no "need to know" the information should not have the information disclosed to them. But the information can be disclosed for the purposes of treatment, completing records, a financial audit, or a management audit. Any information that is released for general circulation from these general studies should not contain any patient identifiable data. That will prevent unauthorized and unintentional redisclosure of potentially confidential information.

Drug and Alcohol Abuse

In recognition of the sensitive nature of these problems, the law has provided a special status for

this information.[21] These regulations apply to any institution which is even indirectly assisted by the federal government in performing a drug abuse or alcohol abuse prevention program. Drug abuse or alcohol abuse prevention program means any program or activity relating to drug abuse or alcohol abuse education, training, treatment, rehabilitation or research.[34] Whenever a statute is that broad in its jurisdiction, the hospital will probably have to follow it. If any Hill-Burton funds were used to build the building in which the program is housed, the statute is mandatory. If any Medicare or Medicaid patient is admitted to any drug or alcohol program, that also appears to be sufficient to make the statute mandatory.

Specific elements are required for this release form.[22] Most importantly, it must be in writing. A simple oral request or telephone call is insufficient. When the information requested in the release is disclosed, it must be accompanied by a notice forbidding re-disclosure.[23] The notice must either accompany or follow an oral disclosure. Without such proper written authorization, even the patient's status as a patient in the rehabilitation program cannot be disclosed.

The record can be disclosed in certain circumstances even without proper written authorization.[24] It can be disclosed to medical personnel to the extent necessary to meet a bona fide medical emergency, to qualified personnel conducting scientific research, management audits, financial audits, or program evaluation,[25] or on a proper court order. However, not just any court order will do. It should be granted only after showing good cause. Good cause shall be determined by weighing the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.[26] A simple subpoena is insufficient, as it is a mere request; a court order is necessary.[27] A court order alone will not require production, although it will allow it. To compel the production of the documents, both a court order and a subpoena are necessary. This special protection is available only to the original records, not to any reports (such as financial audits, management audits, program evaluations, or scientific research, which cannot legally identify a specific patient) produced from the original patient record, which is primarily used as a document to aid in the treatment of the patient.

When a patient on medication is traveling, incarcerated, hospitalized, or otherwise cannot deliver a written release to the hospital at the time the disclosure is needed, a special alternative procedure can be used to release some information.[28] Basically, medical personnel need only orally represent that the patient is currently under their care, has requested his medication, and has consented to such disclosure. Then the patient's status may be confirmed and any information necessary to continue or modify the patient's medication can be released. Upon release, a written memorandum[29] must be put into the patient's chart.

Psychiatric Communications

Psychiatric communications are specially protected at law, as previously discussed.[30] Generally, they cannot be disclosed without the patient's consent. Once they are properly authorized for disclosure by a written release, they must be labelled as confidential.[31] The precise label is required; a substantially similar label is not sufficient.

Disclosure to Parents

A minor may consent to treatment for drug abuse or venereal disease.[32] Any such treatment cannot be disclosed to his parent or guardian without the minor's express consent. Obviously, the parent cannot even be informed of the grounds for refusing to disclose that part of the record. It is suggested the relevant part of the record not be refused, it should simply be not supplied without any unasked for explanation.

Who Can Consent to Release of Information

Any patient with capacity may consent to the release of medical records. This means anyone who has obtained the age of majority can issue a release (18 in Connecticut). Only the minor involved can release his records in drug abuse or venereal disease cases, even to his parents or guardians. Normally, a parent or guardian can release a minor's records until that minor obtains his majority. It is apparently immaterial that the parent may also be a minor.[33] If one parent has been awarded custody of the minor, then it is preferable although not mandatory to get that parent to release the medical information.

The mature minor doctrine may be useful in allowing minors to release their records in certain circumstances. Usually, medical records personnel lack the necessary knowledge to make this determination. But in a rare case where the minor knows the nature, quality, and consequences of his act, his medical record can be released on his authorization. As a practical matter, this will not happen . . . the parent's authorization should also be secured. Since P.A. 79-397 has been signed by the governor on June 14, 1979, minors may be emancipated by court order. Once emancipated, a minor may unilaterally release his medical record as he sees fit.

If a former patient is dead, the executor, administrator, or personal representative may release the medical record. If an adult patient is temporarily unable to consent, then a court appointed guardian will have to release the record. Of course, a record may be released to the extent necessary in an emergency. No consent is necessary, as the emergency creates the power to act.

REFERENCES

1 .5 U.S.C. § 551 (1)

2. 5 U.S.C. § 552 (e)
may also be an exception to the act, even if it did apply . . . *see* 5 U.S.C. § 552 (b) (6)

3. 5 U.S.C. § 552a (a) (1)

4. *CIBA-Geigy Corp v. Mathews* 428 F. Supp. 523 (S.D.N.Y. 1977)

5. *Window Systems Inc. v. Manchester Memorial Hospital* 424 F. Supp. 331 (D.C. Conn. 1976)

6. *supra* at 336

7. S. 96-865
H.R. 96-2979

8. Raising an interesting possibility of conflict between the commerce clause and the police power in health services. If either bill is upheld, the police power over health, public safety, and morals will be greatly eroded.

9. *Application of Weiss to Take the Testimony of Mount Sinai Hospital* 208 Misc. 1010, 147 N.Y.S.2d 455, 456 (1955)
Emmett v. Eastern Dispensary and Casualty Hospital 396 F. 2d 931 (D.C. Cir. 1967)
Cannell v. The Medical and Surgical Clinic 21 Ill. App. 3d 383, 315 N.E. 2d 278 (Ill. 1974)
Pyramid Life Insurance Co. v. Masonic Hospital Association of Payne County, Oklahoma 191 F. Supp. 51 (W.D. Okl. 1961)
Rabens v. Jackson Park Hospital Foundation 40 Ill. App. 3d 133, 351 N.E. 2d 276 (Ill. 1976)

10. Conn. Gen. Stat. §§ 4-104, 4-105, and 17-206i(b), as amended by P.A. 79-389 signed into law June 5. All 33 hospitals in the state received $1.00 a year from the state to qualify them for regulation under Conn. Gen. Stat. § 4-104. Effective 10/1/79

11. Psychiatric medical records are specifically exempted from this part of the section.

12. Or his attorney.

13. Reasons for denying access: Conn. Gen. Stat. § 17-206i(b)
1. Would be medically harmful to the patient.
2. Would constitute an invasion of privacy of another person.
3. Would violate an assurance of confidentiality furnished to another person.
Note the reasons for refusing access belong to the facility, not to the doctor, psychiatrist, or psychologist involved. Effective 10/1/79

14. P.A. 79-389 § 2

15. The only possible case where different results might be reached under the two statutes is when a patient has not been treated but has been discharged. Inspection could be denied under Conn. Gen. Stat. § 4-104, leaving Conn. Gen. Stat. § 17-206i (b). Of course, this applies only to psychiatric records.
Another possible difference could occur if Saint Francis Hospital and Medical Center refused to accept the one dollar a year in state aid. Then Conn. Gen. Stat. § 4-104 would be inapplicable although Conn. Gen. Stat. § 17-206i(b) would still be applicable.
Finally, Conn. Gen. Stat. § 17-206i could apply only to psychiatric portions of the record. Perhaps this is what the legislature intended, but this is not clear.

16. *Rabens, supra* at 279

17. In relation to personnel time, office space, and xerox machine usage at cost to the hospital.

18. Conn. Gen. Stat. § 52-146f

19. 1. The person was in fact a patient.
2. Diagnosis
3. Dates and duration of treatment.
4. General description of the treatment which shall include evidence a plan of treatment exists and has been carried out and evidence to substantiate the necessity for admission and length of stay in the facility.

20. Conn. Gen. Stat. § 52-146e

21. 21 U.S.C. § 1175
42 U.S.C. § 4582
42 C.F.R. part 2

22. 42 C.F.R. § 2.31(a)
1. Name of program to make disclosure.
2. To whom the disclosure should be made.
3. Patient's name.
4. Purpose of disclosure.
5. Nature of information to be disclosed.
6. A statement that the consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon and a specification of the date, event, or condition upon which it will expire without express revocation.
7. Date the release is signed.
8. Signature authorizing disclosure.

23. 42 C.F.R. § 2.32(a)
It must substantially read: "This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose."

24. 21 U.S.C. § 1175(b) (2)
42 U.S.C. § 4582(b) (2)
42 C.F.R. part 2, subpart D

25. Except no individual patient may be identified in any report. *see* 42 C.F.R. § 2.52

26. 21 U.S.C. § 1175(b) (2) (c)
42 U.S.C. § 4582(b) (2) (c)
42 C.F.R. part 2, subpart E

27. 42 C.F.R. § 2.61

28. 42 C.F.R. § 2.33(b)

29. 42 C.F.R § 2.51(e) Consisting of:
1. patient name or number
2. date and time of disclosure
3. nature of emergency
4. information disclosed
5. name of person disclosing information
6. name of person receiving information

30. Conn. Gen. Stat. § 52-146c et seq.
see supra Information that can be disclosed without consent.

31. Conn. Gen. Stat. § 52-146i
"The confidentiality of this record is required under Chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes."

32. Conn. Gen. Stat. §§ 19-89a, 19-496c

33. Conn. Gen. Stat. § 19-142a

34. 42 C.F.R. § 2.11(k)