

CHAPTER 1: GENERAL RULES FOR RELEASE OF INFORMATION

Disclaimer: The information contained in this manual is not intended to be used as legal advice. Please refer to the most current specific state statutes and your own legal counsel when warranted. Some statutes will be referred to throughout this manual.

INTRODUCTION

The State of Maine became one of the first states to codify the release of information practices which have been the standard of health information professionals for decades. See the Maine confidentiality law (22 MRSA § 1711-C). This statute specifically defines the rules and regulations for disclosing patient information including instances when exceptions, policies, financial penalties, etc. apply. In addition, the (Federal) Health Insurance Portability and Accountability Act's (**HIPAA**) Privacy Standards (CFR 45 Parts 160 and 164) provide further guidance on managing Protected Health Information (**PHI**). For a fuller discussion of the HIPAA standards, see Chapter Two of this manual.

Release of information is a complex process involving a variety of confusing and sometimes conflicting standards and principles. The following information is meant to provide general guidance, but is no substitute for legal advice or the advice of your colleagues in similar roles in Maine. Health Information Management (HIM) professionals have long been advocates for patient privacy, and it now falls to us to implement and maintain compliance with the various rules and regulations while maintaining a commitment to our ethical belief that the expectation of privacy is essential to quality patient care. Managing the needs of providers, concerned others, insurers and the many regulatory agencies while keeping patient privacy as the primary consideration is a challenge for all HIM Professionals.

DESIGNATED RECORD SET

In general, rules for disclosure of protected health information pertain to information contained within the designated record set. The designated record set is composed of the patient's medical record as well as billing records and any other records used in whole, or in part, to make decisions about the patient. Facilities are required under HIPAA to define the designated record set and document this in a policy and/or procedure.

NEED FOR AUTHORIZATION

As a fundamental principle, confidential health information may not be released without authorization from the patient or the patient's legally authorized representative (**LAR**). Under certain circumstances however, as when required by statute or in the case of a medical emergency, authorization may not be required. These exceptions will be discussed below and are summarized in the "Requestor's Guide to Authorization Requirements".

PARTIES ENTITLED TO AUTHORIZE DISCLOSURE

Disclosure of information concerning an adult patient must be authorized by the patient, or his/her legally authorized representative. Parties legally authorized to approve release of information for an adult include a legal guardian, guardian ad litem or a durable medical power of attorney. Documentation of this relationship is required prior to the disclosure, if at all possible (in an emergency situation it may not be) and this documentation should be retained in the medical record. HIM Professionals are encouraged to read these documents prior to disclosure, as not all guardianships are the same and some do not address health care decision-making authority. Legal opinion is divided as to whether a general power of attorney (as opposed to a durable medical power of attorney) carries the right to authorize disclosure of health information unless this right is specifically stated. HIM professionals should consult legal counsel before developing policies on this point.

MINOR PATIENTS

In the case of a minor patient (under age 18), health information is, as a general rule, released only upon the authorization of the patient's parent, legal guardian or legally authorized representative. Any authorization signed by a legal guardian or authorized representative should be accompanied by a photocopy of that appointment documentation. Maine law outlines certain circumstances under which a minor may consent to medical treatment. Although the law does not specifically address the right to authorize the release of health information, many attorneys suggest that it may be assumed that if the minor is able to consent to treatment, he or she should also consent to disclosure of that information. Minors who may consent to treatment include:

- Minors who have been living separately from parents or legal guardians for at least 60 days and are independent of parental support.
- Minors who are or have been legally married.
- Minors who are or have been members of the Armed Forces of the United States.
- Minors who have been declared emancipated by the courts.

In addition, any minor may consent to treatment for substance abuse, emotional or psychological problems (on an outpatient basis), or sexually transmitted disease. A minor may consent to family planning services if the minor is a parent, is married, *or* "may suffer probable health hazards (in the professional judgment of a physician) if such services are not provided." A minor may consent to termination of pregnancy under some circumstances outlined in Chapter 9 of this manual (22MRS 1597A).

NOTE: Be aware that minor patients consenting to their own treatment for the above diseases and/or issues should be informed that listing their parent(s)' insurance could result in disclosure of information regarding the diagnosis to the parent(s). Separate arrangements for payment may be made, but care should be taken not to deny or recommend against treatment on the basis of inability to pay.

In the case of a minor whose parents are divorced, Maine law (19 MRSA § 752) specifies that both parents have access to the child's health records, regardless of custody status, unless the court rules

otherwise. If the court has denied one parent access to the child's records, this will be stated in the divorce decree or by court order and the onus is on the parent who is attempting to deny access to provide legal documentation of this restriction. HIM professionals should request copies of divorce decrees in cases involving sensitive information (HIV testing, sexually transmitted diseases, mental health, abuse, etc.). If in doubt, legal counsel should be consulted.

A step-parent may not access or authorize disclosure of information from a minor child's records unless there is an order from the court or proof of legal adoption. Copies of these documents should be retained in the record. When custody is in question, insist on a current legal document showing current custody of the child. This must be produced prior to disclosure of information.

INCARCERATED MINORS

In the case of a minor who is incarcerated, the correctional authority acting in the role of guardian is responsible for the minor and can authorize release of information. Release of "specially protected information" (substance abuse, mental health, HIV, STD's) should also be authorized by the minor.

AN INDIVIDUAL WHO HAS REACHED THE AGE OF MAJORITY

At the age of 18, the individual gains the right to control access to his or her own health information. Therefore, an authorization from the patient's parent is not sufficient to authorize disclosure of health information on a patient who is age 18 or over, regardless of whether that information was recorded prior to the patient's 18th birthday.

FOSTER PARENTS

The Department of Health and Human Services (DHHS) is the legal custodian/guardian of minors in foster care. However, foster parents are permitted to consent to routine, non-invasive treatment (including immunization). Foster parents should provide documentation of their relationship to the patient and this documentation should be maintained in the patient's record. DHHS must be informed of, and consent in writing to, any proposed non-routine care. Foster parents do not have the authority to permit disclosure. An authorization from DHHS is required.

DECEASED PATIENTS

Upon a patient's death any authorizations signed by the patient are no longer valid. Health information concerning a deceased patient can be disclosed only upon the authorization of the patient's personal representative or other legally authorized representative. (The personal representative was formerly referred to as the executor or the administrator of the estate.) Legal opinion is divided as to who has the right to authorize release of information when there is no personal representative. The content of the information, purpose of request, or other circumstances shall be considered to determine whether information should properly be disclosed. It is recommended that each facility establish procedures which outline under what circumstances such releases may occur. HIM professionals should consult legal counsel on this point. In the absence of a personal representative, some providers choose to accept an authorization from the patient's next of kin as defined in the Maine advance directive statute (18-A

MRSA §5; see Chapter 10). This is, *in order of priority*: the patient's spouse; adult child or majority of adult children, if more than one; parent; adult sibling or majority of adult siblings if more than one; or nearest other adult relative.

REQUIREMENTS FOR VALID AUTHORIZATION

Maine State Law 1711-C, HIPAA (45 CFR Parts 160 & 164), CFR 42 Part 2(Federal drug and alcohol treatment law) and The Rights of Recipients for Individuals Receiving Mental Health Services (Title 34-B Section 1207) all have specific requirements for a proper authorization to disclose PHI form.

WRITTEN AUTHORIZATIONS MUST INCLUDE:

- Specific and meaningful description of the information to be used or disclosed (include specific identification of substance abuse, mental health and/or HIV testing and or treatment information, if applicable)
- Name or specific identification of the health care facility or other person or entity or class of persons authorized to make the use or disclosure
- A description of each purpose of the requested use or disclosure
- An expiration date or event of the authorization that relates to the purpose of the disclosure (i.e. end of treatment) not to exceed 36 months from the date of signature
- Statement concerning the patient's right to revoke an authorization and a description of how to revoke the authorization, or a reference to the Notice of Privacy Practices which includes this information
- Description of the consequences to the patient if they refuse to sign an authorization such as improper diagnosis or treatment, denial of coverage or a claim for health benefits or other adverse consequences.
- Statement that the information might be redisclosed by the recipient and no longer subject to the privacy rule
- Statement that, if the information pertains to mental health treatment, the patient is entitled to review it prior to its disclosure
- Signature of the patient (or legally authorized representative) and date
- If signed by someone other than the individual, that person's authority to sign on behalf of the patient must be documented
- A statement that the individual is entitled to a copy of the authorization form.

VERBAL AUTHORIZATIONS

Verbal authorizations are valid only if being used to disclose information for treatment, payment or healthcare operations (**TPO**) as outlined under HIPAA. Note that verbal authorization is never sufficient to disclose substance abuse, HIV or mental health treatment information unless to not do so would jeopardize the care of the individual. Generally speaking, it is recommended that written authorization be obtained from the individual whenever possible.

Since HIPAA Privacy Regulations require that we be able to furnish patients with an "accounting of

disclosures”, it is very important that all disclosures, whether pursuant to a written or verbal authorization or not, are documented in the patient record and that there is a method for assembling this information should it be requested. Many facilities have created a form to document unauthorized disclosures.

ACCESS TO HEALTH INFORMATION BY THE INDIVIDUAL

Both HIPAA and Maine law ([22 MRSA §1711-C](#)) allow patients and/or legally authorized representatives the right to gain access to their own health information. Copies of health records maintained in the designated record set must be disclosed to the individual “within a reasonable time” if requested after discharge. (Designated record set is defined as the individual’s healthcare and billing records. Each facility may exclude certain records from its’ designated record set.) The law does not require that records be made available to the individual prior to discharge or termination of services although most facilities will permit the supervised review of inpatient records by the patient or his/her legally authorized representative. If the facility feels that disclosure of information to the individual could be detrimental to the individual’s health, records must be disclosed to the patient’s “authorized representative.” Hospitals may charge a fee for the records not to exceed \$10 for the first page and \$.35 for each additional page, per LD 363, “An Act to Ensure Patient Access to Medical Records”. Prepayment may be required.

Health care providers other than hospitals are required to release to the patient “within a reasonable time” following the individuals request either copies of treatment records, or “an abstract containing all relevant information in the treatment records.” The provider may exclude any “personal notes” which are not relevant to the individual’s treatment. If the provider feels that access to the records might be detrimental to the patient’s health, the provider may release either the records or the narrative to the individual’s authorized representative.

HIPAA specifically excludes *psychotherapy notes* from that information which must be released to the patient or to any other requestor. Psychotherapy notes are defined as notes kept separate from the medical record and which are NOT used to obtain reimbursement or serve as the official documentation of the care provided. Psychotherapy notes are not routinely included in the designated record set.

Whenever the patient is denied access to the hospital or health care provider’s record, the physician or other provider should document the reason for the denial, and this information should be filed in the patient’s record.

ADOPTIONS

Birth records of individuals who have been adopted may not be released, and the identity of the birth parents must be kept confidential. Adopted persons wishing to contact their birth parents should contact the Adoption Reunion Registry of the Department of Health and Human Services (207-287-1919). If both birth parent and adopted child request it, the Registry will put them in touch with one another. Adopted persons desiring access to medical and genetic information may file a petition with probate court. If the court orders release of the information, the HIM professional may release records named in the court order.

CONTINUING CARE

When a patient is transferred to another healthcare facility or provider, information needed to ensure continuity of care may be released to the receiving facility or provider. As a professional courtesy, reproduction fees for this service are waived.

THE OMNIBUS BUDGET RECONCILIATION ACT (OBRA)

The Omnibus Budget Reconciliation Act (OBRA) contains “anti-dumping” provisions designed to prevent hospitals from refusing emergency care to or inappropriately transferring patients who are uninsured or indigent. OBRA requires that the facility transferring a patient send the receiving facility all available medical records related to the condition requiring emergency treatment, including observation of signs or symptoms; preliminary diagnoses; treatment provided; results of any tests; informed written consent to transfer; and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.

Hospitals are also required to:

- Adopt and enforce a policy to ensure compliance with the law.
- Maintain medical and other records related to individuals transferred to or from the hospital for a period of five years from the date of transfer.
- Maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition.
- Post signs in conspicuous locations specifying the rights of individuals under the Act and whether the hospital participates in the Medicaid program.
- In addition, the transferring hospital must have the physician sign a certification for transfer and the patient sign a request to transfer (if possible).

WORKERS’ COMPENSATION

Release of information in workers’ compensation cases is governed by Maine state law (39-A MRSA §208), (Rule 10.14 of the Maine Workers’ Compensation Statute).

Under the workers’ compensation law, providers do not need an authorization from the patient to release information to the employer, *provided that the information pertains to a condition for which the patient has claimed workers’ compensation benefits and has not been afforded special protection due to its sensitive nature (mental health, HIV and/or substance abuse)*. The employer may at any time request medical information pertaining to the injury about an employee undergoing treatment for a work-related injury. The health care provider must respond to such requests within 10 business days. If the employee notifies the provider that the employee is going to be treated elsewhere, the provider is required by law to forward all of the employee’s workers’ compensation-related records, including x-rays, to the new provider.

The state workers’ compensation regulations are superseded by the federal regulations on chemical

dependency records (see Chapter 3 of this manual) and on state laws governing disclosure of information pertaining to HIV and mental health. Chemical dependency records should not be disclosed to an employer unless the patient has appropriately authorized their disclosure. The workers' compensation regulations specify that if a health care provider refuses to disclose information to an employer, the provider must notify the employer of the statutory grounds for doing so. Unfortunately, in the case of records pertaining to substance abuse, HIV or mental health, such a notification would be in violation of state and federal regulations. HIM professionals who are faced with such a situation should consult legal counsel.

PUBLIC PROSECUTOR

Maine State law 5 MRSA §200 E, permits the release of crime victims' medical records to the Attorney General's (AG) office without authorization, provided that there is a certification from the AG that the patient is in fact a victim. However, the HIPAA Privacy Rule requires authorization, and since HIPAA affords a higher protection for privacy, it is recommended that authorization be obtained. HIPAA does permit an exception for imminent harm or immediate law enforcement activities. Consult legal counsel.

DHS DISEASE SURVEILLANCE: See Chapter 5 on Reporting from Health Records

DISCLOSURE OF PHI VIA TELEPHONE

Confidential health information should only be disclosed by telephone when no other option is available, and again, the facts of the disclosure must be documented. If one is going to disclose information by telephone, it is recommended that the facility call the requestor back in order to have verification of the requestor's identity/association with a healthcare facility.

MEDICAL EMERGENCY:

- In situations of a bona fide medical emergency
- Request a written authorization from the requesting party as soon after if possible, or request documentation on the requesting facility's letter head of the emergent need for the information.

FAXING

Transmission of health information by facsimile (fax) machine is recommended only when the original paper record or mail-delivered copies will not meet the needs of immediate patient care. Sensitive information contained in health records should be transmitted via fax only when: (1) urgently needed for patient care or (2) required by a third-party payor for ongoing certification of payment of a hospitalized patient. As with any disclosure of information, the information transmitted should be limited to the minimum necessary to meet the requestor's needs, and the disclosure should be documented in the medical record.

The same guidelines for obtaining authorization apply to faxing as to disclosing information in other ways. Authorizations transmitted by fax are acceptable. As mentioned above, information may be

released for explained medical emergencies without an authorization. Facilities and health care providers are required to develop policies on the use of faxing to avoid any possible threat to patient confidentiality and/or increased legal risk.

Special areas of concern regarding faxing are:

- Sensitive nature of information relating to HIV infection status, substance abuse treatment, and mental health records.
- Misdirected transmissions. Policies should make provisions for misdirected documents. Use pre-programmed numbers whenever possible.
- Integrity of the paper record. Thermal fax paper fades rapidly. Thermal paper faxes should be photocopied before being included in the patient's record.

EMAIL

The explosion of internet access has led to many patients and providers wishing to communicate via email. While a complete discussion of the pros and cons of this form of patient/provider communication is outside the scope of this chapter, it is recommended that all facilities have policies regarding the use of email, particularly the exchange of patient information via email. If providers elect to permit communication via email, it is suggested that the communication be printed or stored electronically as a permanent part of the patient record. The **HIPAA Security Regulations**, released in 2003, have very specific technical safeguards, which must be in place to protect PHI stored or communicated electronically. In addition, HIM professionals should consider the potential issues of forwarding, misdirecting, tampering and human error, all of which could lead to confidentiality breaches. For this reason, many facilities prohibit the use of email containing protected health information or to communicate with patients.

REDISCLASURE OF PROTECTED HEALTH INFORMATION

Records from other health care providers should not normally be disclosed without authorization from the patient. Most facilities and providers have developed policies detailing specific circumstances for redisclosure of medical information. Note that there are special prohibitions against the redisclosure of substance abuse treatment information and these, being more stringent, should be followed barring a medical emergency. However, records protected by CFR 42 Part 2 (drug and alcohol treatment records) are specifically prohibited from redisclosure.

NON-HEALTHCARE INFORMATION STORED IN PATIENT RECORDS

Some health care providers choose to store non-healthcare related documents (for example, requests for disclosure of information, correspondence, billing information) in the same folder as the paper copy of the patient's record. When this occurs, it is essential that the provider have a written policy stating that these documents are not part of the designated record set and will not be released when the record is requested. With more and more hybrid medical records (paper and electronic) facilities should clearly state what is considered the 'designated record set' and what is not, and develop policies for the handling of other records, including those received from other providers. Records from other facilities used, even

in part, to make decisions about treatment should become a part of the patient's designated record set.

REVIEW OF ORIGINAL PATIENT HEALTHCARE RECORD

When a patient or a party authorized by the patient is to review the original healthcare record, the record should be prepared ahead of time as specified by policy. A proper authorization for disclosure of PHI should be secured, the identity of the person reviewing the record should always be verified, and the HIM professional should have the person sign an authorization form. Access should be limited to the designated record set. The review of the record should be supervised to ensure that no documents are removed, added, or defaced. A detailed list should be kept of any documents photocopied. Copying, if requested, must be done by facility staff in order to minimize the chance of loss, damage or tampering.

HIM professionals or staff supervising a record review should be careful not to attempt to answer questions concerning the patient's medical condition and/or treatment, since this is outside the scope of their practice. It is appropriate to assist the reviewer in locating information in the record or with interpretation of abbreviations or symbols

The HIM professional should involve risk management and/or legal counsel whenever a request is received for review of the original record in cases involving litigation against the facility or its medical staff.

REFUSAL TO HONOR AUTHORIZATION

There may be rare situations when honoring an authorization to release information would not be in the best interests of the patient or the facility.

The facility has the right to refuse the release of information when:

- The identity of the person presenting the authorization is in doubt. (The HIM professional should request proof of identity via a driver's license or photo ID.)
- There is doubt that the requestor is the person named in the authorization. (Again, further identifying information may be requested by the HIM professional—e.g., requestor's address, telephone number, or further patient identification can be requested.)
- There is doubt as to the competency of the person who has signed the authorization.
- There is a question as to the legal status of a person claiming to be the patient's guardian or other legal representative.
- The signature on the authorization does not match other signatures of the patient appearing in the medical record.
- The patient has clearly restricted the release of information via prior communication with the health information department. (When the patient has placed such a restriction on the information, the HIM professional should flag either the master patient index or the record itself in some way to alert personnel to this restriction.)
- If the information requested is deemed to possibly be detrimental to the patient.

- If the expiration date on the authorization has passed.
- If the authorization is a compound authorization. An authorization for use or disclosure of PHI may not be combined with any other document to create a compound authorization, with exceptions. See 45 CFR 164.508.

If after the usual checks there are still concerns regarding the validity of an authorization, the HIM professional should consult legal counsel/risk management. Depending upon the situation, it may be feasible to ask for a court order from the party requesting the information.

NEWS MEDIA

Requests for information from the media should be handled in accordance with facility policy as mandated in Maine law 22 MRSA § 1711-C and by HIPAA. (This most often involves referring the request to the facility's public relations department or administrator.) Generally (but NOT when the facility is a specialty substance abuse or psychiatric treatment center) a statement of condition, as long as the patient has chosen not to opt out of the directory or given other restrictions on release of information, may be given by the designated spokesperson, and facilities would do well to insist that all requests from media be handled centrally.

DISCLOSURES PURSUANT TO RESEARCH AND MARKETING

HIPAA has very strict rules regarding research and marketing. Refer to Chapter 2 of this manual.

REMOVAL OF PATIENT HEALTHCARE RECORDS

To preserve record security, health records should not be removed from a facility or provider's office for *any* reason unless authorized by administration or required by court order. Policies and procedures should clearly define protocols for handling the transfer of health records to any storage method.

NON-PATIENT CARE USE

Use of the healthcare record by an authorized employee for healthcare operations should occur in the health information department whenever possible. If employees must remove the record to another area of the facility, they should:

- Sign the record out
- Return the record the same day
- Safeguard the record while out of the department (i.e., the record should not be left unattended).

REPRODUCTION FEES

In 2003, Maine passed a law Title 22 1711-A to limit the fees charged for copies of medical records. Facilities may only charge actual costs for reproduction which may not exceed \$10 for the first page and .35 cents per page thereafter. Facilities may charge mailing fees if mailing of records is requested. Refer to the Requestor's Guide to Authorization Requirements for more information.