# Firehouse Lawyer

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# Seminar On Confidentiality Of Medical Records

Occasionally, the pages of the newsletter include a report on what I just learned in a continuing legal education seminar. In January, I attended a seminar on the confidentiality of medical records, wherein the speakers covered HIPAA and the Washington State Health Care Information Act.

Since the privacy of medical records is a subject that I am asked about by clients frequently, it seemed like a good topic to feature in the newsletter for February.

The Health Care Information Act was amended in a few particulars in 2005, primarily to align it better with the federal Privacy Rule of HIPAA. One significant change was in RCW 70.02.030 (3), which now requires an authorization to release health care information, to contain an expiration date or event. Apparently, the prior requirement of expiration upon 90 days after signing, as to release for future health care provided, created some problems. Since it was more stringent than HIPAA, the state law 90-day rule prevailed, and was not pre-empted by HIPAA.

It is not certain that this attempted "fix" will work, since under HIPAA you may write "none" under expiration date and it will remain valid until revoked. So there is still an apparent conflict between the state law and the federal rule.

In any event, some of the 90-day rule still survives, because authorizations for disclosures to financial institutions or employers (other than for payment) expire after 90 days! See RCW 70.02.030 (6).

## FEES AND CHARGES

Under State law, a health care provider does not have to produce the records until the requester pays their reasonable fee. What is "reasonable" is adjusted every other year by the State Secretary of Health and promulgated in the WAC regulations. Currently, WAC 246-08-400 allows a health care provider to charge 91 cents per page for the

first 30 pages and 69 cents per page thereafter. The WAC also allows a clerical or labor charge (a so-called "chart-pulling fee") of up to $21.00, but please note that HIPAA pre-empts in this area and does *not* allow any chart-pulling fee if the patient is the requester. Only those providers subject to HIPAA need to be concerned about that. Of course, the patient's attorney is not the patient, so they can be charged.

Under State law and HIPAA, a patient may revoke an authorization at any time. However, please note that if a provider has already taken substantial action in reliance on an authorization, the revocation does not affect that.

## PERMISSIVE RELEASES

Absent an authorization from the patient, the state statute recognizes both permissive (discretionary) and in particular instances, mandatory disclosures. There are numerous permissive instances. Disclosure from one provider to another is allowed when the provider reasonably believes the other provider is also treating the patient. HIPAA also allows disclosure for treatment purposes. Second, it is allowed for quality assurance, peer review and other educational purposes, as well as legal or administrative reasons. Third, disclosure is allowed to past providers of treatment, to the extent necessary to provide future health care to that patient, unless the patient has instructed otherwise in writing. Fourth, you may disclose in order to avoid or minimize an "imminent danger" to the patient or any individual.

The foregoing fourth exception is probably the result of cases like *Tarasoff v. Regents of the University of California*, a 1976 California case in which the State Supreme Court held that a psychologist/therapist did have a duty to warn the intended targets of any threats of bodily harm made by patients. In the case, the psychologist did notify the police, both verbally and in writing, but the Court ultimately held that the professional needs to take reasonable steps to warn or notify the third party (the intended victim). Thus, this permissive disclosure (you may disclose) can be misleading, because under other authority you must disclose in a certain way!

The fifth permissive exception is a bit vague, but is supported by common sense. RCW 70.02.050(1) (e) provides that, unless the patient has instructed you in writing not to disclose, you may make disclosures to immediate family members or to anyone with whom the patient is known to have a "close personal relationship", as long as the disclosure is made in accord with good medical or other professional practice.

No doubt this exception would support a paramedic, for example, who tells family or others at an emergency call at the patient's residence about the general nature of their assessment and other information to mitigate their concerns about the survival of their loved one.

The sixth permissive exception allows disclosure to a provider who is the successor in interest. This would apply when a doctor retires and someone else takes over their practice and their patients. It would not often apply to EMS providers, although perhaps it could be cited in a post-merger situation. The seventh one applies to research projects and is of little interest to us. The eighth one applies to audits, and requires that you get assurances from auditors to de-identify patient information.

The ninth permissive exception, which we have used at least once in the past upon proper request, is disclosure to prison officials or institutions in which the patient is detained. In my opinion, this applies to county jails and holding cells and not just state prisons.

The tenth exception allows disclosing "directory information" unless instructed not to, by the patient (even verbally). Of interest primarily to hospitals and their emergency rooms, this one pertains to directory information, which means information disclosing the presence, and for the purposes of identification, the name, residence, sex, and general health condition of a particular patient. That latter phrase means only, for example, "critical", "poor", "good" or the like.

The eleventh exception allows disclosure to fire, law enforcement, or other public authorities that brought the patient to the provider, provided that the information is limited to name, residence, sex, age, occupation, condition, diagnosis, estimated or actual discharge date, or extent and location of injuries, and whether the patient was conscious when admitted. Some EMTs and paramedics complained when the Privacy Rule was adopted that the Emergency Rooms were not giving out any information on patients they brought in, but this state law exception seems to allow at least limited information to be provided.

The twelfth exception allows disclosure to law enforcement authorities if you believe in good faith that the health care information disclosed constitutes evidence of criminal conduct that occurred on the premises of the health care provider. Obviously, only a very few factual patterns would fit these circumstances and so this exception would rarely be used.

The last permissive exception allows disclosure to another provider for "operations", if that provider also treated the patient. This is similar to HIPAA, which allows disclosure for "TPO" without patient authorization. TPO means for treatment, payment and operations. They are not identical laws, however, as the state law allows disclosure for treatment, payment, and certain operations only if two added conditions are met: (1) both entities have a relationship with the person whose PHI is being shared and (2) the disclosure is for certain specified operations, such as QA, peer review, case management, or credentialing. See RCW 70.02.010 (7) for the full list.

## MANDATORY RELEASES OF RECORDS

The remainder of this article pertains to the mandatory disclosures. On these, even without patient authorization, you must disclose. There are four of these exceptions under RCW 70.02.050(2). First, you must disclose to public health authorities under various listed circumstances, including "when needed to protect the public health". We have personal experience with disclosure requests to the fire dispatch agency and others from the State Board of Health investigators, when they are investigating complaints against EMTs or paramedics.

Second, to law enforcement to the extent required by law. This refers to specific statutes mandating such disclosure, such as the child abuse reporting law, the dog bite statute, and the like. It is not a generalized requirement to release to police whenever they say you must. Third, to county coroners and medical examiners to investigate deaths.

## ATTORNEY REQUESTS / NOTICES / SUBPOENAS

Fourth, you must disclose pursuant to compulsory process (subpoenas) in accord with RCW 70.02.060. So, let us talk briefly about that important procedural statute. That section applies to attorney requests. It requires an attorney to provide advance written notice to the provider and the patient by service or first class mail advising both parties that the attorneys are requesting health care information. This written notice must also inform the provider and the patient that they have no less than 14 days within which to seek a protective order.

After the time is up, on the date set forth in the notice, the attorney may serve a subpoena on the provider and the patient to obtain the necessary information.

So, what if the attorney sends the letter with the subpoena, stating on the face of the subpoena that it is not effective until after the 14-day period ends? In our opinion, this would meet the intent of the law and probably some attorneys do it that way. The speaker at the seminar agreed with that analysis.

If health care information is sought (not just written records) by subpoena for a records deposition, a subpoena for oral examination (deposition) of a witness, a subpoena to appear at trial and testify about health care provided, or even a Rule 34 Request for Production to a party defendant (this could apply if the fire district itself is being sued), all of the foregoing discussion, and the statute, is applicable. That is because all of the above are "compulsory process" and all scenarios involve delving into private health care information without authorization of the patient.

Obviously, if the attorney also sends you a patient authorization, you are not really under the .060 procedures and do not need to worry much about it, as long as the authorization appears normal or regular.

The foregoing presents the highlights of a very good seminar. Although not much of the information was entirely new to me, I did learn that the legislature tried to fix the 90-day expiration of authorizations issue. The question remains as to whether that "fix" was entirely successful.

## DISCLAIMER