RESPONDING TO RECORD REQUESTS

by: Regina A. Casey, JD, RN

There are severe penalties for not protecting personal health information. Fines and penalties for violations of the HIPAA Privacy Rule have been significantly increased and now include mandatory fines for willful negligence. The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its Business Associate in any form, whether electronic, paper, or oral. Any organization or person that meets the definition of a covered entity, regardless of size or complexity, is subject to the Privacy Rule. Covered entities are defined in the rules as 1) health plans; 2) health care clearinghouses; and 3) health care providers who electronically transmit any health information including electronic submissions for billing. However, it's important to keep in mind that while the primary purpose of an organization may not be providing healthcare, the organization may still be subject to the HIPAA Privacy Rules if even a small portion of the organization's business involves providing or billing for health care related services.

What is Protected Health Information (PHI)?

"Health Information", as used in the Privacy Rule, includes all information created or received by a health care provider, health plan, and/or health care clearinghouse and others[1] that relates to the physical or mental health or the condition of an individual, or the payment made for care. The Privacy Rule outlines 18 separate categories that encompass protected personal identifiers including name, birth date, demographic information (more localized than the state of residence), and of course, actual health care.

Protected Health Information may *not* be disclosed *except* as *permitted* by the Privacy Rule or as *authorized in writing* by the individual who is the subject of the information or their personal representative. Under the Privacy Rule, *mandated* record disclosure is required in only two situations, (1) requests made by the Secretary to support government enforcement oversight, and (2) when a resident requests access to personal health information. There are other circumstances in which *permissive* disclosure is allowed. Permissive disclosure occurs only when the elements of an *exception* to the primary *nondisclosure* mandates are met.

Records Use: No Authorization from the Resident is Required to Maintain the Flow of Care

A covered entity is entitled to use and disclose PHI when necessary to provide care and treatment, to obtain payment, and to support health care operations including administrative requirements, quality assurance, and legal services. If vendors are not members of the covered entity work force, a Business Associate Agreement to support privacy and security is required whenever PHI is disclosed.

Records Requests

Under federal law, a current resident or their legal representative has the *right to access* his or her records within 24 hours of making a request, excluding weekends and holidays. Additionally, after receipt of their records, a resident may demand the facility provide copies of records so long as they give advance notice of two working days. The provider is entitled to charge a reasonable cost-based fee to cover the cost of copying and postage. This represents the most expeditious production requirement that can be demanded by a resident and generally applies to records requests made on behalf of current residents. An oral request by a resident or their representative is sufficient to require the production of current records for their review. (Note that this regulation is often interpreted by aggressive plaintiff counsel as applying to all resident records requests. The stronger argument however is that such an interpretation would negate recently enacted federal law pursuant to the federal Privacy Rule which would be inconsistent with fundamentally accepted legal principles.)

Time given to providers to produce records under federal Privacy Rules is more generous, allowing 30 days for production of records. Providers can obtain an additional 30 days to recover and copy records that are not immediately available under certain circumstances if they provide a written statement of the reasons for the delay and an anticipated date of completion. This more reasonable production timeline is presumably related to the lack of exigency associated with treatment decisions as well as the likelihood that records involved in prior treatment will not be as readily available.

California Evidence Code section 1158 applies whenever an attorney at law or his or her representative presents a written authorization for records prior to the filing of litigation. The service of an appropriately signed authorization requires a facility to make records available for a photocopier service to copy within 5 days. Once litigation has been filed, all such demands should be addressed only through your defense attorney.

In order to respond to each body of law appropriately, analysis of the status of the patient (living or deceased; current or former resident) and the authority of the requestor is critical: penalties for the unauthorized release of records under California Civil Code section 56.36 include monetary penalties up to $25,000 and misdemeanor conviction.

Unfortunately, as demonstrated by the above legal references, there are times when state and federal laws give rise to arguments which create challenges for providers, particularly when demands are made by plaintiff attorneys. It is therefore important for each provider to evaluate how you will respond, to establish appropriate policies and procedures to guide your medical records department, and seek legal guidance to navigate demands when necessary.

Required Elements for a HIPAA Compliant Authorization

The general rule is that a valid authorization is required when disclosing PHI. To be HIPAA compliant, an authorization must be written in plain language and contain the following elements:

- A description of the information to be used or disclosed that identifies the requested information in a specific and meaningful fashion;
- The name or specific identification of the person(s) or class of persons authorized to make the requested use or disclosure;
- The name or other specific identification of the person(s) or class of persons to whom the covered entity may make disclosures to;

- A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not provide a statement of the purpose;

- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure; and

- The signature of the requesting individual and date. If the authorization is signed by a personal representative of the individual, a description of the representative's authority must be provided.

In addition, the authorization must contain language that evidences that the requesting individual is on notice of:

- Their right to revoke the authorization in writing;

- Their ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization; and

- The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the recipient and no longer be protected.

Has the Appropriate Person Signed the Authorization?

It is always appropriate to release health information to the individual resident. In long term care and home care situations, however, it is often not the resident who is signing the authorization. The most common scenario involves a family member signing the authorization on behalf of a deceased or incapacitated resident. This raises the issue of who has the authority to request records containing the PHI of another person. The HIPAA Privacy Rule requires a covered entity to treat a "personal representative" the same as the individual, with respect to uses and disclosures. A personal representative is a person legally authorized to make health care decisions on an individual's behalf or to act for a deceased individual or the estate.

The threshold question becomes: What is the status of the resident/patient: Are they living or deceased? This question is followed by: If living, are they still a resident and do they have capacity to sign on their own behalf, or has another individual been designated through a legal instrument to act on their behalf, or neither? If deceased, is the party seeking records of a beneficiary or representative?

If the person requesting disclosure of the records is not the patient/resident with capacity, they must have a legal right to request the documents. There are two documents commonly used to confer authority to a personal representative for health care decisions. Sometimes these two documents may be combined into a single form:

Advanced Directive for Health Care - An advanced directive allows a person to name someone else to make health care decisions on their behalf and/or to give instructions about their own health care.

Durable Power of Attorney - A power of attorney authorizes a person to act on behalf of another.

The Advanced Directive or Durable Power of Attorney must s*pecifically grant the representative the*

power to obtain copies of the patient's health information.

Additional considerations are found in California Civil Code section 56.10 et seq. regarding who has the authority to request records on behalf of another, what penalties can be levied for unauthorized release of records, and what elements constitute a valid authorization.

Unfortunately, not all patients have appointed health care agents, which in turn leads to one of the most challenging decisions a facility must make when receiving a request for the release of Protected Health Information: Is the person requesting the Personal Health Information entitled to disclosure of the records they have requested? The answer oftentimes involves a grey area of the law where the interpretation and application of state and federal laws can vary amongst attorneys and oftentimes, government agencies. The California legislature has expressed their intent to permit access to medical information to those individuals who are responsible for the health care of others however, this intent does not relieve the facility of their obligation to obtain "satisfactory assurance" that the authorization to release such protected information is itself proper and supports disclosure. Furthermore, there is an obligation to obtain this assurance without unnecessary delay in release of the records or frustrating the efforts to obtain the records.

The stakes are high for a misstep in records release. Compliance is often difficult to define and is unique to each situation presented. A comprehensive policy, outlining the critical elements to consider and steps to take in response will provide structure and guidance at all levels of the organization, minimizing risk concerns and compliance challenges.

Footnote [1]:
(1) The term "health information" means any information, whether oral or recorded in any form or medium, that—
(A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (B) Relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual. 42 U.S.C. section 1320d(5).

About the Author:
A shareholder at Wroten & Associates, Regina A. Casey has been defending physicians, hospitals and various other healthcare providers for over 26 years. Previously serving as a litigation partner at an East Coast firm with offices in Maryland and Washington D.C., she then worked with a West Coast medical malpractice defense firm. She has been with Wroten & Associates since it was founded.

Ms. Casey has successfully defended medical malpractice cases in federal and circuit courts in Maryland. She has also tried cases in the U.S. District Court and Superior Court for the District of Columbia, and in California's Superior Court. She has participated in a number of arbitrations and is a mediation specialist. She has represented physicians in administrative hearings before the Medical Board in Maryland and at hearings to defend physicians' hospital privileges.

She graduated magna cum laude from Duke University earning a Bachelor of Science in Nursing in 1975. After working as a nurse at the University of Virginia and Georgetown University Hospitals, she earned her Master of Science in Nursing at Catholic University America, where she was a member of the Nursing Honor Society, Sigma Theta Tau. She graduated with honors from the University of Maryland Law School and was admitted to the Maryland Bar in 1986; the District of Columbia Bar in 1987, and the California Bar and U.S. District Court for the Central District of California in 2001.

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