REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

REVIEW OF THE CONFIDENTIALITY OF PATIENT MEDICAL RECORDS STUDY

(SB 702)

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Preface

Following the 2000 General Assembly Session, the Senate Committee on Education and Health requested the Joint Commission on Health Care (JCHC) to study issues relating to patient consent for release of medical records, ownership of medical records, and patient confidentiality. A copy of the letter from the chairman of the Senate Education and Health Committee to the JCHC is attached as Appendix A. The JCHC subsequently approved this study request. According to the letter from the chairman of the Senate Education and Health Committee, the study was originally requested by the patron of Senate Bill (SB) 702, which sought to amend portions of Virginia law concerning the privacy and ownership of patient medical records. SB 702 was stricken from the docket at the request of the patron, following objections to the bill that were raised by several interested parties. In so doing, the patron of SB 702 requested that the issues presented by the bill be referred to the JCHC for study. A copy of SB 702 is attached as Appendix B.

Based on our research and analysis during this review, we concluded the following:

- The health care delivery system depends upon the collection, analysis, and distribution of detailed information concerning patients.

- The widespread use of and need for personal health information has, however, inspired debate across the country concerning the appropriate degree of external access to an individual's medical and health-related information.

- States have typically sought to protect a patient's privacy and ensure he has an adequate level of access to his own information while, at the same time, allowing appropriate access to personal information by third parties for essential health care operations and to promote important public policy objectives.

- There are several medical record and health information privacy statutes in Virginia. These include, but are not limited to, §32.1-127.1:03, which governs records held by health care providers; and §38.2-600 et seq., which governs records held by insurance entities. Health maintenance organizations are governed by the provisions of both these statutes.

- Virginia's health information privacy and access statutes are comparable to those of most other states. For example, the number and types of circumstances under which personal medical information may be disclosed without an individual's written authorization are generally consistent with most other states.

- There are some types of provisions that, while not found in Virginia's patient health records privacy statute (§32.1-127.1:03), are contained within recommendations developed by several national organizations. These types of provisions include: (1) a patient's right to not only request copies of their medical records but also to request an opportunity to inspect and examine the original records; (2) a patient's right to request that information in the medical record be corrected, amended, or supplemented; (3) a requirement that a health care provider notify patients of the providers' policies and practices concerning the collection and disclosure of personal health information; and (4) specific authorization for all types of providers to charge a reasonable fee for providing requested medical information.

- The following organizations have recommended that the types of statutory provisions described above be adopted: (1) The Health Privacy Working Group (Joint Commission on Accreditation of Health Care Organizations, National Committee for Quality Assurance, Partners Healthcare System, Intermountain Healthcare, IBM Corporation, National Association of People with AIDS, Consortium for People with Disabilities, and others) have issued "Best Principles for Health Privacy"; (2) the National Conference of Commissioners on Uniform State Laws has adopted a Uniform Health Care Information Act and recently proposed several amendments to that model act; and (3) the United States Department of Health and Human Services has promulgated proposed regulations (which could potentially pre-empt state law) governing privacy of and access to personal health information.

- The Virginia Department of Health Professions received 114 complaints concerning either "records release" or "confidentiality breach" from April 1999 – August 2000. Seventy-five of the complaints have a final disposition (66 – no violation, nine – undetermined).

- It is difficult to identify any strong evidence indicative of health information privacy or access problems within Virginia.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 41-42.

Public comments were solicited on the draft report. A summary of the public comments is attached at Appendix C.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Virginia Hospital and Healthcare Association, the Medical Society of Virginia, the Office of the Attorney General, the Virginia Department of Health Professions, and the Virginia Bureau of Insurance for their cooperation and assistance during this study.

Patrick W. Finnerty
Executive Director

December, 2000

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I.
Authority and Background for the Study

Following the 2000 General Assembly Session, the Senate Committee on Education and Health requested the Joint Commission on Health Care (JCHC) to study issues relating to patient consent for release of medical records, ownership of medical records, and patient confidentiality. A copy of the letter from the chairman of the Senate Education and Health Committee to the JCHC is attached as Appendix A. The JCHC subsequently approved this study request. According to the letter from the chairman of the Senate Education and Health Committee, the study was originally requested by the patron of Senate Bill (SB) 702, which sought to amend portions of Virginia law concerning the privacy and ownership of patient medical records. SB 702 was stricken from the docket at the request of the patron, following objections to the bill that were raised by several interested parties. In so doing, the patron of SB 702 requested that the issues presented by the bill be referred to the JCHC for study. A copy of SB 702 is attached as Appendix B.

The Confidentiality of Personal Medical Records Is Becoming a Significant Public Policy Issue Across the United States

The modern health care delivery system depends upon the reliable collection and distribution of accurate, detailed and current information concerning recipients of health care services. The National Conference of State Legislatures (NCSL) reports that within today's health care delivery system "confidential health and medical data are collected, analyzed, distributed, and accessed in unprecedented quantities." For example:

- Health care providers access records to diagnose illness, coordinate treatment and obtain payment for services rendered, and monitor other health care providers in an attempt to hold costs down to a minimum.

- Clinical researchers use medical records to gather valuable data on the course of a disease and how it responds to treatment.

- Insurers refer to medical records to determine coverage, make payments on claims, conduct utilization reviews, and for underwriting purposes.

- An employer may use employee health care data to track worker compensation claims and overall health care costs.

The widespread use of and need for personal health information has, however, inspired debate across the country concerning the appropriate degree of external access to an individual's medical and health-related information. According to the Healthcare Leadership Council, "Privacy is becoming a central political issue, with concerns over e-mail, the Internet, financial records and medical records." NCSL reports that "Medical records confidentiality has blossomed into one of the bigger state and federal topics of the 2000 legislative session." During their respective 2000 legislative sessions, 16 states enacted legislation addressing, in a variety of ways, the privacy of medical records.

In terms of personal medical and health information, one of the most important broad themes in legislative bodies appears to be how best to protect an individual's privacy while, at the same time, allowing appropriate access for essential health care operations and to promote important public policy objectives. Although ease of access to such information is beneficial and often necessary for research and for basic operation of the health care delivery system, a lack of adequate protections and safeguards may make it potentially intrusive to individual patients whose medical records may be accessible without their consent, authorization or knowledge.

Report Outline

This report presents the results of JCHC's staff research and analysis and is divided into four sections. This section discussed the authority for the study and provided some general background to the issue of medical records privacy. The second section provides a general overview of the various Virginia statutes, regulations and other laws and standards that govern the confidentiality and privacy of patient medical records. The third section reviews statutory approaches that other states have taken, as well as other approaches that have been proposed by national organizations, towards safeguarding the privacy of patient medical records. This section also includes a review of health information privacy regulations that have been proposed by the federal government. The fourth and final section presents policy options.

II.
Virginia Statutory and Regulatory Environment

The General Assembly Has Enacted a Series of Medical Records Privacy Provisions That Are Found in Various Sections of the *Code of Virginia*

As is the case with most states, Virginia has enacted multiple laws to protect the confidentiality of individual medical records. For example, §32.1-127.1:03 of the *Code of Virginia* governs the privacy of patient medical records maintained by health care providers. Section 38.2-600 et seq. prescribes standards for the collection, use, and disclosure of information gathered in connection with insurance transactions. Both of these statutes govern the degree of access to, and disclosure of, personal medical information.

There are other sections of the *Code of Virginia* that also pertain, at least in part, to the privacy of individual medical records in the possession of public sector entities. These include the Privacy Protection Act (§2.1-377 et seq.) and the Freedom of Information Act (FOIA) (§2.1-340 et seq). The Privacy Protection Act requires government agencies that maintain information systems containing personally-identifiable information, including medical information, to ensure safeguards for personal privacy. This statute provides a procedural framework for an individual to correct, erase, or amend inaccurate, obsolete, or irrelevant information. FOIA requires that, except as otherwise specifically provided by law, all public records shall be open to inspection and copying by any citizen of the Commonwealth. Medical and mental health records are generally exempt from the provisions of FOIA, except that such records may be personally reviewed by the subject person or physician of the subject person's choice.

The *Code of Virginia* also addresses privacy protections for the Patient Level Database maintained by Virginia Health Information (VHI). According to §32.1-276.9, patient, physician, and employer identifier data elements are generally not releasable. However, such data may be released at the discretion of VHI, solely for research purposes if otherwise permitted by law, but only if "such identifier is encrypted and can not be reasonably expected to reveal patient identities." Any violation of this provision is subject to a maximum civil penalty of $5,000.

Finally, the *Code of Virginia* contains numerous provisions that impose condition-specific privacy requirements designed to shield individuals with certain types of illnesses from broad disclosure of personal health information. These conditions include cancer, congenital anomalies, genetic and metabolic diseases, and HIV/AIDS. The *Code of Virginia* also provides each person who is admitted to a hospital or other facility operated, funded, or licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services with the right to be assured of the confidentiality of his or her medical and mental health records.

Virginia's Patient Health Records Privacy Statute Establishes a Statutory Right to Privacy, and Attempts to Balance Individual Privacy Protections With Appropriate, Reasonable Access to Health Information by Third-Parties

Section 32.1-127.1:03 of the *Code of Virginia* recognizes a patient's right to privacy in the content of his or her medical record and generally prohibits health care providers, as well as health maintenance organizations, from disclosing such records without a patient's informed consent. The statute, which was enacted in 1997, represented a consensus reached by a coalition of health care organizations, the Virginia Bar Association, and patient advocacy groups. Under the terms of the statute, "health care provider" is defined broadly and includes but is not limited to hospitals, nursing homes, and all providers licensed, certified or registered by Virginia's health regulatory boards. The statute defines "record" as "any written, printed, or electronically recorded material maintained by a provider in the course of providing health services to a patient concerning the patient and the services provided." The definition of record also includes "the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of health services to a patient or information otherwise acquired by the provider about a patient in confidence and in connection with the provision of health care services to the patient."

Section 32.1-127.1:03 states that patient records are "the property of the provider maintaining them." (This provision is cross-referenced at §54.1-2403.3 concerning all health care providers licensed, certified, or registered by Virginia's health regulatory boards.) However, except as otherwise permitted by state or federal law, "no provider or other person working in a health care setting may disclose the records of a patient."

Furthermore, no person to whom records are disclosed "shall redisclose or otherwise reveal the records of a patient, beyond the purpose for which such disclosure was made, without first obtaining the patient's specific consent to such redisclosure." This redisclosure provision is subject to two categories of exemptions:

- Any provider who receives records from another provider may make subsequent disclosures as permitted by law.

- Any provider may furnish records and "aggregate or other data", from which patient-identifying prescription information has been removed, encoded or encrypted, to qualified researchers including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

The general statutory rule against disclosure of a patient's medical record without the patient's informed consent is subject to 24 exceptions. These include:

- pursuant to a court or attorney-issued subpoena, (however, no subpoena for medical records shall be requested from a court or issued by an attorney unless a copy of the request for subpoena or the subpoena itself is simultaneously provided to opposing counsel or to the opposing party if they are pro se);

- where necessary in connection with the care of the patient, including in the implementation of a hospital routine contact process;

- in emergency cases or situations where it is impractical to obtain the patient's written consent, pursuant to a patient's oral consent for a provider to discuss the patient's records with a third-party specified by the patient;

- to third-party payers or their agents for purposes of reimbursement;

- as is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized

governmental agency reviewing such application or reviewing benefits already provided;

- upon the sale of a medical practice or upon a change of ownership or closing of a pharmacy;

- in connection with the work of any entity established to evaluate the adequacy or quality of professional services or the competency or qualifications for professional staff purposes;

- in situations where disclosure is reasonably necessary to defend a provider or the provider's employees or staff against any accusation of wrongful conduct, or as required in the course of an investigation, audit, review, or proceedings regarding a provider's conduct by a duly-authorized law enforcement, licensure, accreditation or professional review entity;

- to the Office of the Inspector General for Mental Health, Mental Retardation, and Substance Abuse Services;

- to the agent appointed under a patient's power of attorney or to an agent or decisionmaker designated in a patient's advance directive for health care or for decisions on anatomical gifts and organ, tissue or eye donation;

- for the purpose of conducting record reviews of inpatient hospital deaths to promote identification of all potential organ, eye, and tissue donors;

- when examination and evaluation of a patient are undertaken pursuant to judicial or administrative law order;

- a minor's records to the Court Appointed Special Advocate program;

- to the personal representative or executor of a deceased patient or to the legal guardian or committee of an incapacitated or incompetent patient;

- in the normal course of business in accordance with accepted standards of practice within the health services setting;

- to communicate a patient's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

- as required or authorized by any other provision of law including contagious disease, public safety, and suspected child or adult abuse reporting requirements;

- to the guardian ad litum in the course of a guardianship proceeding of an adult patient; or

- to the attorney appointed by the court to represent the patient in a civil commitment proceeding.

The statute, which does not apply to workers' compensation claims or to the medical records of minors, contains a suggested form for use in providing written consent to the release of an individual's medical records. This suggested form contains the name of the affected patient and the provider who maintains the records, the person who will receive the records, and a specific description of what records are to be disclosed. The suggested form also informs patients of the rule against redisclosure, their right to revoke consent, and asks patients to list the expiration date of their consent to disclose.

Section 32.1-127.1:03 requires health care providers to respond to a request for copies of medical records within 15 days of receipt. The provider has a range of possible responses to such a request:

- provide the copies as requested,

- inform the requestor that the information does not exist or cannot be found;

- if the provider does not maintain a record of the information, so inform the requester and, if known, provide the name and address of the provider who maintains the record; or

- deny the request on a basis permitted by statute.

A provider may deny a request for copies under two prescribed circumstances. First, if the requester has not established his authority to receive such records or proof of his identity. Second, if the patient's attending physician or clinical psychologist has made a part of the patient's record a written statement that, in his opinion, the furnishing to or review by the patient of such records would be "injurious to the patient's health or well-being." However, in the case of a subpoena, such records must nevertheless be furnished to a patient's attorney.

Section 32.1-127.1:03 is silent concerning the authority of a health care provider to charge a reasonable fee to recover his or her expenses associated with providing copies of patient medical records. However §8.01-413 of the *Code of Virginia*, which governs the issuance of subpoenas for health care records in civil litigation, and which is extensively cross-referenced by §32.1-127.03, states that the party requesting the records shall be liable for "reasonable charges" associated with the service of maintaining, retrieving, reviewing, preparing, copying, and mailing the items produced. According to §8.01-413,

> charges shall not exceed fifty cents per page for up to fifty pages and twenty-five cents a page thereafter for copies from paper, and one dollar per page for copies from microfilm or other micrographic process, plus all postage and shipping costs and a search and handling fee not to exceed ten dollars. (This statutory fee schedule does not apply to X-ray photographs).

However, this statute is limited specifically to records obtained pursuant to a subpoena. Section 54.1-111 of the *Code of Virginia* authorizes providers to charge a reasonable fee, not in excess of the amounts authorized in §8.01-413, for copies of patient records. However, this statute governs only those providers regulated by the Department of Health Professions and Virginia's health regulatory boards. Consequently, it does not specifically apply to hospitals. It may be beneficial to clarify in the *Code of Virginia* the authority of all types of health care providers to impose a reasonable fee to cover the costs of providing copies of patient medical records that are not requested pursuant to subpoena.

Senate Bill 702 of the 2000 Session Sought to Amend §§32.1-127.1:03, 8.01-413, and 54.1-2403.3 of the *Code of Virginia* Regarding Ownership of Medical Records and Other Related Issues; Several Objections Were Raised

SB 702 sought to make the following statutory amendments concerning the confidentiality of, and access to, patient medical records:

- make patient medical records the property of both the provider and the patient, rather than the sole property of the provider;

- specify that patient records may not be disclosed without a patient's consent, including in instances when records are disclosed in compliance with a subpoena or when disclosed to third party payers for purposes of reimbursement;

- change the definition of "record" to no longer include "the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of health services..."; and

- provide that a patient could not be charged for obtaining a copy of his own medical records.

SB 702 was stricken from the docket at the request of the patron following objections that were raised by several parties, including the Medical Society of Virginia.

One of the primary objections to SB702 involved the issue of ownership of patient medical records. Representatives of the Medical Society of Virginia stated that patient ownership of medical records would harm continuity of care if the patient were able to take his or her original medical records from provider to provider. For example, the inability of a provider to reliably replicate a patient's medical record would harm a physician's ability to appropriately manage referrals and other aspects of a patient's treatment. Furthermore, a physician's lack of reliable access to all of a patient's medical records could affect the quality of care provided to that patient.

A health care attorney interviewed by JCHC staff identified another type of objection to SB 702. This attorney stated that, if patients were the statutory owners of their medical records, this would create significant operational and logistical difficulties for health care providers. For example, in the event of a merger of two physician practices, assuming the merger agreement would cover the ownership of medical records, each individual patient would need to be contacted in order to gain his or her approval to the transfer of medical records. Currently, §54.1-2405 of the Code of Virginia requires health care practitioners to simply notify patients of a pending transfer of their records (by mail and through a newspaper of general circulation), in conjunction with the sale of a practice. This provision is intended to give the patient the opportunity to have the records or copies sent to another provider or destroyed.

According to legal research recently conducted by the Division of Legislative Services, since 1939 it has been accepted in Virginia that the owner of medical/health records is the health care provider. This conclusion is based upon three Attorney General opinions, issued in 1939, 1977, and 1978, concerning the legal status of patient records. The 1977 opinion construed state statute as conferring upon patients the right to receive, upon request, copies of their medical records in the possession of both hospitals and physicians.

It could be argued that patient ownership of his or her medical records would, at least theoretically, give a patient a significantly increased degree of control over his or her medical records. In practice, this degree of individual control has typically, in Virginia and across the country, been viewed from a public policy perspective in relation to other important policy objectives. Furthermore, specific personal benefits and privacy protections that might be achieved through patient ownership of medical records should be considered in the context of the scope and extent of individual privacy protections that are already contained in law. For example, the Virginia Supreme Court, in its 1997 Fairfax Hospital v. Curtis decision ruled that "...a health care provider owes a duty to the patient not to disclose information gained from the patient during the course of treatment without the patient's authorization, and that violation of this duty gives rise to an action in tort."

Most other state statutes are silent concerning the ownership of a patient's medical records. To the extent any state statute has provisions specifying the owner of a patient's medical records, which is rare, the

statutes tend to identify the provider as the owner of the records. JCHC staff definitively identified only two other states, Hawaii and South Carolina, with specific statutory provisions identifying the health care provider as the owner of patient medical records. Likewise, JCHC staff was able to definitively confirm only one state, New Hampshire, with a statutory provision identifying the patient as the owner of his or her medical records. It is fair to say that, for the most part, state statutes do not utilize "ownership of medical records" as a key variable, one way or the other, in structuring individual health information and medical record privacy protections.

Another key objection to SB 702 was the provision requiring a patient's consent prior to the disclosure of personal medical information to third-party payers for reimbursement purposes. Health care organization representatives interviewed by JCHC staff stated that such a statutory provision would be completely unworkable and impractical in today's health care delivery system. Given the sheer volume of services provided to patients and the volume of information-sharing in today's managed care environment, requiring patients' consent before providing information to payers would create substantial administrative burdens and costs.

Section 38.2-600 et seq. of the *Code of Virginia* Establishes Health Record Privacy Requirements for Insurance Institutions

This statute is somewhat similar in structure and purpose to §32.1-127.1:03 in that it seeks to maintain a balance between the need for information by those conducting the business of insurance and the public's need for fairness in insurance information practices, including the need to minimize intrusiveness. The provisions of this statute, which were enacted in 1981, are based almost entirely on the Insurance Information and Privacy Protection Model Act which was adopted by the National Association of Insurance Commissioners in 1980. One purpose of the statute is to establish a regulatory mechanism to enable individuals to "ascertain what information is being or has been collected about them in connection with insurance transactions and to have access to such information for the purpose of verifying or disputing its accuracy." The statute requires that insurers respond to written requests for access to recorded personal information within 30 business days. The insurer must permit the individual to "see and copy, in person", the recorded personal information pertaining to him or to obtain a copy of the recorded personal information by mail, whichever the individual prefers.

"Personal information" is defined as "any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics." Personal information does not include "privileged information," which is any individually-identifiable information relating to, or collected in connection with, a claim for insurance benefits or a civil or criminal proceeding involving the individual. The statute defines "medical-record information" as personal information that:

- relates to an individual's physical or mental condition, medical history, or medical treatment, and

- is obtained from a medical-professional or medical-care institution, from the individual, or from the individual's spouse, parent, or legal guardian.

While the statute permits an individual to see and copy, in person, recorded personal information, access to the "medical record information" subset of "personal information" is governed somewhat differently. Medical record information requested by an individual, which has been supplied to the insurance entity by either a medical-care institution or a medical professional, "shall be supplied either directly to the individual or to a medical professional designated by the individual", whichever the insurance entity prefers. Pursuant to the statute, if the insurance entity elects to provide the requested information to a medical professional, it shall so notify the individual who requested the information.

This statute also aims to limit the disclosure of information collected in connection with insurance transactions. Generally, an insurance institution may not disclose personal information, including medical information, about an individual without the person's written authorization. However, the statute specifies numerous circumstances under which such information can be disclosed without an individual's authorization. These include:

- verifying insurance coverage to a medical professional,

- conducting actuarial or research studies,

- providing information to insurance agents for the purpose of conducting the insurance entity's business when such disclosure is reasonably necessary,

- providing information to law enforcement agencies in order to prevent or prosecute fraud, and

- providing information in response to a valid administrative or judicial order, including a search warrant or subpoena.

Section 38.2-609 provides an individual with the right to request the correction, amendment, or deletion of any recorded personal information, including medical-record information, about the individual that is in the possession of an insurance institution. The insurance institution may refuse the request, but must notify the individual of the reason. If the individual disagrees with the refusal, he or she has the right to file with the insurance institution a concise statement setting forth what the individual thinks is "correct, relevant or fair information," as well as a concise statement of why the individual disagrees with the refusal to correct, amend or delete information. Thereafter, anyone reviewing the disputed personal information must be made aware by the insurance institution of the individual's statement and have access to it.

Other pertinent provisions of the statute include:

- authorizing insurers to charge a reasonable fee to cover the costs incurred in providing copies of requested information;

- requiring an insurance institution or agent to provide a notice of insurance information practices to all applicants or policyholders in connection with insurance transactions, and specifying that such notice shall describe (1) the circumstances under which information disclosures may be made without prior authorization, and (2) the individual's statutory right to gain access to recorded personal information and the individual's statutory right to request the correction, amendment or deletion of recorded personal information;

- specifying the content requirements for written authorizations for release of personal information, which must be written in plain language and must include a description of the purpose for which the information is being requested; and

- establishing the statutory right of an individual to bring a civil lawsuit for violations of the provisions of the statute.

Nursing Homes Are Required by Have Policies and Procedures Pertaining to Various Patient Rights, Including Confidentiality

Section 38.2-138 of the *Code of Virginia* requires nursing homes to promulgate policies and procedures to ensure that each patient admitted to the facility "is assured confidential treatment of his personal and medical records and may approve or refuse their release to any individual outside the facility, except in the case of his transfer to another health care institution or as required by law or third-party payment contract." These policies and procedures are required to be printed "in at least twelve-point type" and posted conspicuously in a public place within the facility. Furthermore, copies of the policies and procedures shall be given to each patient upon admittance. Each facility is required to provide appropriate staff training to implement these rights.

Various State Administrative Regulations Address the Privacy of Medical Records

State regulations for licensure of hospitals require that medical records be kept confidential, and that only authorized personnel shall have access to the records. The regulations also state that a hospital shall release medical records only with the written consent of the patient, or the legal representative, parent, guardian or as otherwise authorized by law. Hospitals are required to provide for safe storage of medical records, which must be retained for at least five years following discharge of the patient.

State regulations for licensure of both home health agencies and hospices require written procedures to implement patient rights policies to ensure that each patient is "assured confidential treatment of his medical and financial records as provided by law," and "assured of the right to privacy." Copies of these policies must be available to the public for review, and given to each patient or designee upon admission to service.

Virginia's Medicaid regulations define a Medicaid recipient's right of access to his or her personal information. According to the regulations, "Upon written or verbal request, the client shall be permitted to review or obtain a copy of the information in his record." This right of access is subject to certain exceptions. The Medicaid regulations also specify the types of information that must be contained in a written authorization for release of information, including a statement that consent is limited to the purpose designated, and the length of time for which the consent is valid.

State regulations promulgated by the Board of Psychology, the Board of Social Work, and the Board of Counseling contain standards of conduct regarding confidentiality of patient records, violation of which may serve as the basis for disciplinary action. For example, the psychology and social work regulations require that practitioners maintain confidentiality of their professional relationships with patients or clients, and that they disclose client records to others only with written consent, when the client is a danger to himself or others, or as otherwise permitted by law. The counseling regulations are similar, but they also require licensees to "inform all employees of the requirements of confidentiality...." The regulations require a client's informed consent before videotaping, audiorecording, permitting third party observation, or using client records in teaching, writing, or public presentations.

Federal Regulations Governing Provider Participation in Medicare and Medicaid Address Medical Records Privacy Protection

As a condition of participation in the Medicare and Medicaid programs, home health agencies (HHAs) are required to advise patients of their policies and procedures regarding disclosure of clinical records, and of their right to the confidentiality of the clinical records maintained by the HHA. In addition, HHAs are required to have procedures that govern the use and removal of records and the conditions for release of information. An HHA must obtain the patient's written consent before releasing information not required to be released by law.

The conditions of participation for hospitals state that the patient has the right to "personal privacy" and to the "confidentiality of his or her clinical records," and must be notified of those rights. The federal regulations also provide that:

> The patient has the right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its recordkeeping system permits.

Hospitals are also required to "have a procedure for ensuring the confidentiality of patient records." The hospital must ensure that unauthorized individuals cannot gain access to or alter patient records.

Hospital Accreditation Standards Issued by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) Address the Privacy and Confidentiality of Medical Records

JCAHO standards require hospitals to demonstrate respect for patient privacy and confidentiality of information. According to JCAHO, an example of how to implement this standard would be to have policies and procedures that address confidentiality of information, and to inform the patient of the hospital's policy on confidentiality at the time of admission. The JCAHO standards also require hospitals to ensure that each patient receives a written statement of his or her rights.

According to JCAHO, "admission to a hospital can be a frightening and confusing experience for patients, making it difficult for them to understand and exercise their rights." JCAHO states that its intent is for the written statement of rights to be "appropriate to the patient's age, understanding, and language." JCAHO notes that "the hospital may also post its patients' rights document in public areas accessible to patients and their visitors." Furthermore, when written communication is not effective with the patient (i.e. if the patient can not read or speak the language), the patient is to be informed again of his or her rights after admission, "in a manner that he or she can understand."

Section 32.1-127(B)(8) of the *Code of Virginia*, enacted in 1993, requires the State Board of Health to promulgate regulations requiring each licensed hospital to "establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities". Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be based on JCAHO standards. According to

the Virginia Department of Health (VDH), such regulations have not yet been promulgated. VDH management states that it enforces the statutory provision concerning patient rights through provisions of its hospital regulations which allow it to accept aspects of a hospital's compliance with JCAHO requirements.

III.
Other Statutory Approaches to Protecting the Confidentiality and Privacy of Health Information and Medical Records

There Are Some Common Themes, But Also Considerable Variation, in Other States' Statutory Approaches to Protecting the Privacy of Medical Records

In 1999, Georgetown University's Institute for Health Care Research and Policy completed a 50-state analysis of medical records privacy statutes. Some of the primary conclusions of the analysis, conducted as part of its Health Privacy Project, are as follows:

- While virtually every state has some law aimed at the confidentiality of patient health information, very few states have "anything approaching a comprehensive health privacy law."

- States vary widely in the rights they grant to patients to examine, receive and/or copy their own medical information. Virginia is one of 33 states that provide some right of access to hospital records, one of 13 states that provide a right of access to HMO records, and one of 16 that provide a right of access to insurance records.

- The most common restriction found in state statutes concerning disclosure of patient medical information is that patient authorization must first be secured. Some states specify the format and content of the authorization form in statute. Many states allow patients to revoke authorizations. (*In Virginia, §32.1-127.1:03 contains suggested content for an authorization form, while §38.2-606 specifies required content for disclosure authorization forms. Authorizations can be revoked in Virginia.*)

- All state statutes specify numerous exceptions to the general rule in which a person or entity may not disclose personal medical information without a patient's written authorization. The most common exceptions include: for purposes of treatment, to secure payment for health care, for auditing purposes, for quality

assurance activities, and for research purposes. (*Virginia's statutes contain these types of exceptions*).

- Many states have granted patients the right to amend or correct their medical information, particularly when the records are held by insurance companies. (*In Virginia, §38.2-609 contains this type of provision relevant to insurers, but §32.1-127.1:03 does not provide a similar type of provision relevant to health care providers*).

- Most states allow a person or entity to charge patients for copies of their medical record. The most common approach is to stipulate that a provider may charge a "reasonable" fee. However, some states specify a cost in the statute. (*In Virginia, a reasonable fee can be charged but the statutes are unclear in some respects concerning the authority of all types of providers to charge a fee in all types of situations.*)

- State statutes vary in terms of limits placed on the redisclosure of patient data. In many states, the receiving entity may not be under any legal obligation to adhere to the privacy rules imposed on the disclosing entity. A few states have statutes that prohibit medical information from being disclosed, regardless of the entity holding the record. (*Virginia's statutes prohibit redisclosure, subject to certain exceptions.*)

Overall, Virginia's Statutory Protections for Medical Records Privacy Appear To Compare Favorably With Most Other States

JCHC staff interviewed the attorney on the Georgetown University Health Privacy Project staff who conducted the 50-state analysis. This attorney told JCHC staff that Virginia's various health records privacy statutes are consistent with the mainstream of state statutory provisions across the country, in terms of the degree of access that a patient has to his or her own medical records as well as the number and types of circumstances under which a third-party may gain access to an individual's medical records without the individual's authorization. Furthermore, the Health Privacy Project staff attorney indicated that Virginia has a very good health record privacy statute in comparison to most other states.

However, the Health Privacy Project staff attorney did not believe that Virginia should be included in a small select group of states that the Health Privacy Project considers to have "cutting-edge" statutes. These states were identified as California, Hawaii, Minnesota, Rhode Island, and Wisconsin. One of the primary reasons for not considering Virginia's statutes to be of the highest caliber, according to the Health Privacy Project staff attorney, is that Virginia's statute (§32.1-127.1:03 of the *Code of Virginia*) does not specifically provide an individual with the right to, in some way, amend, correct, or supplement the information contained in their medical record. In addition, the Health Privacy Project analysis appears to place considerable value on a state having, to the greatest extent possible, a single statute that encompasses all situations and circumstances concerning the privacy of individual medical records. The Health Privacy Project report stated that Hawaii, Rhode Island, and Wisconsin were three "notable exceptions" to the vast majority of states in that they have "comprehensive" health information privacy statutes.

JCHC staff compared the specific provisions of Virginia's various medical record privacy statutes with those of the five "cutting-edge" states identified by the Health Privacy Project staff attorney, and with the statutes of Virginia's five neighboring states. Overall, Virginia's statutory provisions appear to be quite comparable, and often compare very favorably, in terms of the types of protections that are provided to confidentiality and privacy of individual medical records and health information. For example, Virginia's statute specifically states that the patient has a right to privacy in the content of his or her medical record.

On the other hand, there are several types of medical record privacy provisions that some other states have enacted but which are not included in Virginia's patient health records privacy statute (§32.1-127.1:03 of the *Code of Virginia*.) These include:

- requirements that health care providers notify patients of the provider's policies and practices concerning the collection and disclosure of a patient's medical and health information;

- clear, specific authorization for all types of health care providers to charge a reasonable fee for providing requested medical records to an individual;

- clear, specific definition of a patient's right not only to receive copies of their medical records, but also to inspect and examine their medical records; and

- granting patients the right to request that information in their medical records by corrected, amended, or supplemented.

A summary of statutory provisions from the aforementioned states is provided in the following paragraphs.

California. Health care providers must allow patients to inspect and/or copy their medical records within five days of a written request and may charge a "reasonable fee" for locating records and making them available, and for making copies. Providers may not withhold records because of unpaid bills for health services. Providers who willfully violate the access provisions may be guilty of unprofessional conduct and may be fined up to $100. Providers must maintain records for at least seven years following patient discharge. There are many exceptions to the general requirement that personal medical information be disclosed only upon written authorization of the patient.

Hawaii. The Hawaii constitution provides an individual right to privacy with respect to personal health information and records. Under the Hawaii statute, which implements the constitutional right, an individual has the right to inspect and copy protected health information pertaining to him that is maintained by health care providers, health plans, health care data organizations, employers, health data organizations, insurers or educational institutions. According to the statute, a health care provider is the owner of the medical records in its possession that were created in treating a patient. However, a patient has the right to request, in writing, that a health care provider append additional information to the record in order to improve the accuracy or completeness of the information. The covered entities are required to post or provide current notice of the their confidentiality practices, including an individual's right to inspect and copy his information and his right to request that a health care provider append information to this medical record. An individual may avoid having his health information disclosed without his authorization or consent by paying directly for health care services, as opposed to have the service paid for by a third-party.

Personal health information may be disclosed without the patient's authorization for the purpose of treatment, payment, or "qualified health care operations." There are also a number of additional circumstances under which protected health information may be used or disclosed without the specific authorization of the individual. For example, a health care provider may disclose protected health care information to an individual's relative if the individual who is the subject of the information has been notified of his right to object to the disclosure and has not objected, or is not physically or mentally capable of objecting, and there are no prior indications that the person would object. Other circumstances include: emergencies, to protect the health and safety of the individual, health oversight functions, public health purposes, and to qualified health researchers. The state is required to adopt rules to establish standards for disclosing, authorizing, and authenticating protected health information in electronic form. A court may impose civil penalties of up to $100,000 in the event of multiple violations of the statute.

Minnesota. A reasonable charge may be imposed by health care providers for the cost of copying requested medical records. No charge may be imposed, however, when a patient requests a copy of his record for purposes of reviewing current medical care. A health care provider or facility must give patients, in a clear and conspicuous manner, written notice concerning the right of patients to have access to and obtain copies of their health records. The notice must also explain disclosures of health records that may be made without the written consent of the patient.

Rhode Island. The state statute applies to all persons "having information relating to a patient's health care history, diagnosis, condition, treatment or evaluation obtained from a health care provider who has treated the patient." The statute specifies the type of information that must be included in an individual's written authorization for disclosure of medical information. Upon receipt of a written request, a physician must permit a patient to examine and copy his or her confidential health care information or provide him a summary of the information, at the physician's option. A reasonable fee can be charged for copying expenses. There are 22 general circumstances under which confidential health care information can be released without consent of the patient including, but not limited to, peer review boards, to other providers for coordination of health care services, to other providers for purposes of education and training within the same facility, to school authorities for health screening

purposes, and to qualified researchers provided they do not subsequently reveal personal identifying information.

Wisconsin. Upon written request of an individual, a health care provider must allow the person to inspect his health care records during regular business hours upon reasonable notice. A provider may charge a reasonable fee for the copying of medical records. Any person who is injured as a result of a knowing and willful violation of the statute is entitled to actual damages plus a maximum of $25,000 in exemplary damages. Exemplary damages for negligent violations of the statute are capped at $1,000.

Among Virginia's neighboring states, the following is a brief summary of a few of their statutory provisions:

- *Maryland*: A health care provider must establish reasonable procedures to allow a person to request an addition to, or correction of, a medical record. However, a person can not have information deleted from a medical record. A health care provider may not refuse to disclose a medical record because of failure of the person to have paid for prior health care services rendered. Knowing and willful violations of the health record privacy statutes are subject to a maximum fine of $1,000 for the first offense and not more than $5,000 for each subsequent conviction.

- *North Carolina*: State law grants a patient the right of access to his medical records which are in the possession of an insurance entity, HMO, or a mental health facility. The statute also restricts the disclosure of confidential medical information by those entities. However, unlike Virginia and most other states, the statute does not address medical record privacy and access issues involving information maintained by health care providers.

- *Kentucky*: There is no general statute granting a patient the right of access to his medical records. However, upon written request, a health care provider or hospital must provide, without charge to the patient, a copy of the patient's medical record. Statutory restrictions on disclosure of individual medical information are quite limited. A private utilization review agent may not disclose

individual medical records without appropriate procedures for protecting the patient's confidentiality.

- *Tennessee*: A health care provider must provide an individual with a copy (or summary) of his medical records within ten working days of a written request. The patient is responsible for paying reasonable copying and mailing costs, and may be required to pay those costs in advance. Hospitals are required to furnish copies of records "without unreasonable delay." In terms of disclosure of patient medical information, the statute specifies that personal patient identifying information "shall not be sold for any purpose." Hospitals must retain records for ten years following the discharge or death of a patient.

- *West Virginia*: A health care provider must furnish a copy of a patient's medical records to the patient within a reasonable time after receiving a written request. In the case of records of psychiatric or psychological treatment, a summary of the record is to be made available to the patient or his authorized representative following termination of the treatment program. A reasonable charge may be imposed for copies, which shall not exceed 75 cents per page for copying and the search fee may not exceed $10. A charge may not be imposed on indigent persons if the records are necessary for supporting a claim or appeal under the Social Security Act.

Best Principles for Health Privacy Have Been Developed

The Health Privacy Working Group, an initiative of Georgetown University's Health Privacy Project, recently published "best principles" for health privacy. The working group contained a fairly diverse membership and included representatives from JCAHO, the National Committee for Quality Assurance, Partners Healthcare System, IBM Corporation, Intermountain Healthcare, National Association of People with AIDS, Consortium for People with Disabilities, Bazelon Center for Mental Health Law, Brooklyn Law School, and the University of California San Francisco. The health privacy principles (Figure 1), published in July 1999, represent "significant compromises" between working group members and "should be seen as a framework that aims to accommodate the various information needs of diverse interest groups." The principles are further designed to "establish a baseline of protections that should be

Figure 1

Best Principles for Health Privacy – Health Privacy Working Group

Principle	Rationale/Description
For all uses and disclosures of health care information, health care organizations should remove personal identifiers to the fullest extent possible, consistent with maintaining the usefulness of the information	Generally, the use and disclosure of non-identifiable information does not compromise patient confidentiality. Health care organizations will need to consider the practicality and cost of using and disclosing non-identifiable information.
Privacy protections should follow the data	Recipients of health information can use or disclose personally identifiable health information only within the limits of existing authorizations. Any further uses or disclosures require specific, voluntary patient authorization.
An individual should have the right to access his or her own health information and should have the right to supplement that information	Supplementation should not be implied to mean deletion or alteration of the medical record. Data holders may charge a reasonable fee for copying the records, but they can not refuse inspection of the records simply because they are owed money by the individual requesting inspection.
Individuals should be given notice about the use and disclosure of their health care information and their rights with regard to that information	The notice should tell the patient how the collecting organization will use or disclose the information, what information the patient can inspect and copy, steps the patient can take to limit access, and any consequences the patient may face by refusing to authorize disclosure of information.
Health care organizations should implement security safeguards for the storage, use, and disclosure of health information	Safeguards should be appropriate for use with electronic and paper records. Safeguards should recognize the trade-off between availability and confidentiality and should be tailored to meet needs as organizations adopt more sophisticated technologies.

Figure 1 (continued)

Best Principles for Health Privacy – Health Privacy Working Group

Principle	Rationale/Description
Health care organizations should establish policies and review procedures regarding the collection, use, and disclosure of health information	Such policies should be coherent, tying together authorization requirements, patient notice, safeguards, and procedures for assessing personally-identifiable health information
Health care organizations should use an objective and balanced process to review the use and disclosure of personally identifiable health information for research	For some areas of research, it is not always practical to obtain informed consent and, in some cases, a consent requirement could bias results. Patient authorization should not always be required for research. However, waivers of informed consent should only be granted through an objective and balanced process.
Personally identifiable health information should not be disclosed without patient authorization, except in limited circumstances. Health care organizations should provide patients with certain choices about the use and disclosure of their health information	A two-tiered approach to patient authorization is recommended. A single, one-time authorization for disclosure for core activities that are directly tied to treatment, payment, and necessary business functions in keeping with medical ethics. Delivery of or payment for care may be conditioned upon receiving this authorization. Disclosure for any other types of activities must be separately authorized, and refusal to authorize should not result in any adverse consequences. Such activities include but are not limited to marketing, disclosure of psychotherapy notes, and disclosure to an employer except when necessary to provide or pay for care. Circumstances under which information may be disclosed without patient authorization include public health reporting, oversight purposes, court order or warrant, and research

Figure 1 (continued)

Best Principles for Health Privacy – Health Privacy Working Group

Principle	Rationale/Description
Health care organizations should not disclose personally identifiable health information to law enforcement officials, absent a compulsory legal process, such as a warrant or court order	As a general rule, federal privacy laws require that some form of compulsory legal process, based on a standard of proof, be presented in order to disclose to law enforcement officers. However, government officials may have legally authorized access to health information for purposes of health care oversight and enforcement of law. In such instances, where compulsory legal process may not be required, the information should not be used against the individual in an action unrelated to the oversight or enforcement of law, nor should the information be redisclosed, except in conformance with privacy protections that have attached to the data
Health privacy protections should be implemented in such a way as to enhance existing laws prohibiting discrimination	Privacy can serve as the first line of defense against discrimination on the basis of a person's health status, thereby creating a more comprehensive framework of protection
Strong and effective remedies for violation of privacy protections should be established	Remedies should be available for internal and external violations of confidentiality. Health care organizations should also implement appropriate employee training, sanctions, and disciplinary measures.

Source: JCHC staff analysis of Best Principles for Health Privacy – A Report of the Health Privacy Working Group (Georgetown University, Institute for Health Care Research and Policy, July 1999).

considered when implementing comprehensive patient privacy policies and practices."

The National Conference of Commissioners on Uniform State Laws Has Proposed Revisions to the Uniform Health Care Information Act

The National Conference of Commissioners on Uniform State Laws (NCCUSL) adopted its Uniform Health Care Information Act in 1985. According to NCCUSL, because health care is now carried out or supported by "many multi-state operations and because medical information is widely disseminated nationally, and even internationally, uniformity of state law is highly desirable." However, the 1985 model act was adopted by only two states: Montana and Washington. According to the NCCUSL, one of the main criticisms of the 1985 model act was that it did not provide detailed policy on redisclosure of information. In addition, in the mid-1980's and still today there has been a tendency on the part of most states to tailor privacy rules by sector or specific entity, as opposed to taking a more comprehensive approach. The NCCUSL represents a more comprehensive statutory approach to protecting the privacy of individual health information and medical records. Other objections to the uniform act, according to a NCCUSL official, included concerns by groups within the health care industry that they would be negatively affected by the proposed legislation. Other groups, such as mental health and AIDS organizations, preferred that health information in their subject areas be treated individually and not included with other privacy issues.

Over the course of the past year, the NCCUSL has been discussing proposed revisions to the model act. A revised draft has been prepared which is under discussion, subject to further review, and not yet approved by NCCUSL. Following the NCCUSL protocol, adoption of the proposed revisions will take at least two more years. The following is a summary of some of the provisions contained in the NCCUSL model act. Provisions which represent proposed revisions to the model act are indicated by *italics*:

- The act applies to health care providers, defined as a person who is licensed, certified, or otherwise authorized by state law to provide health care in the ordinary course of business or practice of a profession.

- "Health care" is broadly defined as including (1) "preventive, diagnostic, therapeutic, rehabilitative, or palliative care", (2) with respect to the "physical or mental condition of an individual," (3) affecting the structure or function of the human body or any part of the human body, *including the banking of blood, blood products, sperm, ova, genetic material, or organs or other tissue,*" or (4)

pursuant to a prescription or medical order, the sale or dispensing of a drug, device, equipment or other item related to health care;

- The types of information that must be contained in an individual's written authorization for disclosure of information are specified. *An authorization to permit the sale or marketing of health care information must be executed separately from an authorization for other purposes and contain a conspicuous statement of that purpose.*

- A person to whom health care information is disclosed in the regular course of business or pursuant to an authorization may not disclose the information to any other person unless a health care provider would be authorized to make the disclosure under other provisions of law.

- An individual's personal medical information may be disclosed by a health care provider without the patient's authorization for purposes of facilitating the medical practice or an audit, *but only if the purpose could not be satisfied by the same information in non-identifiable form, and provided the recipient has established safeguards or given express assurance that the information will be protected.*

- An individual's personal medical information may be disclosed by a health care provider without the patient's authorization to members of the patient's immediate family, or any other individual with whom the patient is known to have had a close personal relationship, if the recipient needs to know the information and the disclosure is made in accordance with good medical or other professional practice, unless the patient has instructed the provider not to make the disclosure.

- An individual's personal medical information may be disclosed by a health care provider without the patient's authorization if the disclosure is directory information (disclosing the presence and general health condition of a particular patient) and the patient is an inpatient or currently receiving emergency health care, unless the patient has instructed the provider not to make the disclosure.

- Health care providers shall respond to a written request for examination or copying of the patient's recorded health care information within 10 days of receipt. Upon request, a health care provider shall provide an explanation of any code or abbreviation used in health care information the provider maintains. The provider may charge a reasonable fee for providing the health care information and need not permit examination or provide a copy until the fee is paid.

- A patient may request in writing that a health care provider correct or amend its record of the patient's health care information to which the patient has access. In making a requested amendment or correction, the provider shall add the amending information as part of the health care record and mark the challenged entries as corrected or amended entries. If the health care provider refuses to make the requested correction or amendment, the patient shall be permitted to file a concise statement of the correction or amendment requested and the reasons therefore. *A provider shall not be required to delete, obliterate or erase health care information.*

- Providers must give each patient a notice of information practices *at the beginning of the patient-provider relationship*, or upon request. The required notice is designed to alert patients to ordinary medical practices concerning use and disclosure of health care information, and to the patient's rights with respect to those practices.

- A health care provider shall establish and maintain safeguards for the security of all health care information it maintains, including policies, standards and procedures for the management of health care information which are reasonably designed to prevent the prohibited collection, use or disclosure of that information. A health care provider shall require any person to which it discloses health care information, without the patient's authorization, to have similar safeguards. (*The revision is more specific than the 1985 Act as to the nature of safeguards that must be implemented.*)

- Civil remedies are authorized, and criminal penalties specified, for violations of the statute. An individual is entitled to receive actual damages for willful and intentional violations or reckless disregard of the statute. The maximum criminal penalty is defined as a $10,000 fine or imprisonment of one year, or both.

The National Association of Insurance Commissioners Adopted a Health Information Privacy Model Act in 1998

The purpose of this model act is to set standards to protect health information from unauthorized collection, use, and disclosure by requiring insurance carriers to establish procedures for the treatment of all health information. Unlike the 1980 NAIC Insurance Information and Privacy Protection Model Act, the 1998 model act is specifically-tailored to health information. Based on a review and comparison by JCHC staff, it appears that many of the 1998 model act provisions which protect the confidentiality of an individual's medical and health information appear, at least to some extent, in the current Virginia statute (§38.2-600 et seq). However, there are also some differences (Figure 2).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Required New Federal Health Information Privacy Regulations In the Event Congress Was Unable to Enact a Health Information Privacy Statute

The provisions of HIPAA spoke to the need for minimum national health care privacy standards to protect against inappropriate use of individually-identifiable health information. In particular, HIPAA called for enactment of a health information privacy statute within three years. According to HIPAA, if legislation establishing privacy rights was not enacted by August 21, 1999, the Secretary of Health and Human Services was to promulgate regulations. The United States Congress missed the enactment deadline. However, several pieces of health information privacy legislation are currently pending in Congress. These include:

- H.R. 1941 –The "Health Information Privacy Act" defines the rights of protected individuals (including the right to copy and inspect protected health information, the right to request the amendment of protected health information and the right to be notified of a covered entities' confidentiality practices) and

Figure 2
Comparison of Selected Provisions of Section 38.2-600 of the *Code of Virginia* With Provisions of the 1998 NAIC Health Information Privacy Model Act

Type of Provision	Section 38.2-600 et seq.	1998 NAIC Model Act
Amount of Time For Insurers to Respond to Written Request for Access to Information	30 business days	20 working days
Right of An Insured to Request That an Insurer Correct, Amend, or Delete Protected Health Information	Establishes a process to follow upon receipt of such a request	Establishes a process to follow upon receipt of such a request, but also specifies that a carrier shall not be required to alter, delete, erase or obliterate medical records provided to them by a health care provider
Policies, Standards and Procedures For Management of Health Information	No specific provision	A carrier shall develop and implement written policies, standards, and procedures for the management of health information, including those to guard against the unauthorized collection, use or disclosure of protected health information by the carrier
Authority of Insurers to Charge a Reasonable Fee To Cover Costs of Providing Copies of Requested Information	A reasonable fee may be charged except in cases where information is requested in connection with an adverse underwriting decision	A reasonable fee may be charged. However, no fee shall be charged for information requested for the purpose of supporting a claim, supporting an appeal, or accessing any federal or state-sponsored or operated health benefits program

Source: JCHC staff analysis of Section 38.2-600 et. seq. of the *Code of Virginia* and the Health Information Privacy Model Act (National Association of Insurance Commissioners, 1998).

establishes permissible disclosures of protected health information;

- S. 578 –The "Health Care Personal Information Nondisclosure Act of 1999" and H.R. 2470 – The "Medical Information Protection and Research Enhancement Act of 1999" are identical, with both defining individual rights, requiring the establishment of health information confidentiality safeguards, establishing restrictions on the use and disclosure of protected health information, and defining criminal provisions and civil sanctions for violations of the statute; and

- H.R. 4585 – The "Medical Financial Privacy Protection Act" provides individuals the right to inspect, copy, and correct individually-identifiable health information maintained by a financial institution, restricts the ability of financial institutions to disclose individually-identifiable health information to an affiliate or non-affiliate third-parties, and prohibits the use of medical information in providing credit without an individual's consent.

The United States Secretary of Health and Human Services Has Proposed New Health Information Privacy Regulations

HHS expressed the opinion that there is a significant need for regulations which establish safeguards and protections for individual health care information. According to HHS:

- The exchange of individually-identifiable health information is an integral component of the delivery of quality health care.

- However, the risk of improper uses and disclosures has increased as the health care industry has begun to move from primarily paper-based information systems to systems that operate in various electronic forms. Improper uses include using health information for direct marketing, employment decisions, and fundraising.

- The current system of patient consent in which patients must sign "broad authorizations" before receiving treatment provides little or no information about how their information is used. Since the authorization usually precedes creation of the record, the individual can not predict all the information the record may

contain and therefore can not make an informed decision as to what would be released.

The regulations proposed by HHS seek to protect electronically maintained health data from misuse by regulating disclosures of patient health data. The proposed rule is intended to make the exchange of protected health information relatively easy for health care purposes and more difficult for purposes other than health care. As proposed, the regulations are limited to electronic records and records printed from electronic transactions. The proposed regulations focus on the information sharing practices of "covered entities" which include health providers who transmit health information in electronic form, health plans, and health information clearinghouses. The proposed regulations also pertain to the "business partners" of covered entities.

The provisions of the proposed health information privacy regulations include, in part, the following:

- once information has been maintained or transmitted electronically by a covered entity, the protections would follow the information in whatever form, including paper records, in which it exists (while it is held by a covered entity);

- health plans and providers must provide individuals with a written notice of their information privacy practices;

- individuals are given the right to inspect, copy, and amend their health record, and

- disclosure of health information without written patient authorization could occur in support of specific functions of "treatment,", "payment," and "health care operations".

"Health care operations" is defined by the proposed rule to include the following activities:

- quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines;

- reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs, accreditation, certification, licensing or credentialing activities;

- insurance rating and other insurance activities relating to the renewal of a contract for insurance;

- conducting or arranging for medical review and auditing services, including fraud and abuse detection and compliance programs; and

- compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding.

The proposed health information privacy regulations also state that:

- Covered entities would be permitted to use or disclose a patient's protected health information without authorization for specified public and public policy-related purposes, including public health, research, health oversight, public health data systems, law enforcement, to provide information to next-of-kin, for facility patient directories and use by coroners.

- Covered entities would be permitted to use and disclose protected health information when required to do so by other law, such as mandatory reporting under state law or pursuant to a search warrant.

- For any other purpose not specifically recognized by the rule (i.e. if an authorization is sought so that a covered entity may sell, barter or otherwise exchange the information for purposes other than treatment, payment, or health care operations, or for disclosure to an employer for use in employment determination), the covered entity would have to disclose this fact on the authorization form. Treatment or payment may not be conditioned on an individual authorizing the disclosure of information for such purposes.

- With certain exceptions, permitted uses and disclosures of protected health information would be restricted to the minimum amount of information necessary to accomplish the purpose for which the information is used or disclosed.

- An individual is given the right to request that a covered entity restrict the protected health information that results from an encounter (with the exception of encounters for emergency treatment) from further use or disclosure for treatment, payment, or health care operations; covered entities are not required to agree to such a request but would be bound by any agreements reached with an individual.

- Covered entities are required to make available upon request a list of everyone to whom protected health information was disclosed.

- Covered entities are required to ensure that the business partners with which they share protected health information understand – through contract requirements – that they are subject to standards regarding use and disclosure of protected health information and agree to abide by such rules.

- Contracts between covered entities and their business partners with which they share protected health information must impose certain security, inspection, and reporting requirements on the business partner.

- Covered entities must designate a privacy official to be responsible for enforcing privacy standards within the organization, and must train their employees in handling protected health information.

- Appropriate administrative, technical and physical safeguards must be in place to protect the privacy of individual health information.

- A complaint system will be established to permit individuals to make complaints to the Secretary of HHS about violations of the rule, with a maximum civil fine of $25,000 established for each

violation of the rule. The proposed regulations do not provide individuals with a private right of action to sue when they believe the confidentiality of their health information has been breached.

As a general rule, the proposed federal regulations preempt provisions of state law that are contrary to standards or requirements of the federal regulations. There are essentially four exceptions to preemption:

- provisions of state law that are necessary to prevent fraud and abuse, ensure appropriate state regulation of insurance and health plans, report on health care delivery or costs for purposes relating to improving Medicare, Medicaid or the efficiency and effectiveness of the health care system, or which address controlled substances;

- state law which relates to the privacy of health information and is more stringent than a federal regulatory provision;

- state law which is established to provide for reporting of disease or injury, child abuse, birth, death, or for the conduct of public health surveillance, investigation, or intervention; and

- state law which requires a health plan to report or provide access to information for the purpose of management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification.

One of the major issues for states arising from the proposed regulations is the extent to which their existing laws will be found to be "contrary" or "more stringent" than the federal provisions. The proposed regulations establish a process for states to request preemption exception determinations or advisory opinions from HHS.

HHS has received more than 50,000 public comments on the proposed regulations, with many of them being quite critical of numerous aspects of the proposal. Many health care industry representatives have criticized the proposal as being overly burdensome. On the other hand, numerous consumer representative and personal privacy advocates have

complained that the proposal does not go far enough to protect individuals. According to HHS, the target date for publication of the final rule is unknown, although recent media reports state that the final rule will be published by November 2000. The rule would be effective 26 months after the final rule is published.

Conclusion

The scope and extent of privacy and confidentiality protections provided to individual health and medical information by Virginia statutes are quite comparable, overall, with those of other states. However, there are certain types of provisions not found in some of Virginia's statutes which, if present, could strengthen the degree of existing personal protections while also clarifying rules and requirements which have previously been imposed on health care providers. For example, §38.2-600 et seq. of the *Code of Virginia* contains several types of provisions designed to enhance the degree of access that an individual has to his medical information, and to protect the confidentiality of that information, that are not found in §32.1-127.1:03. Since both of these statutory sections are applicable to health maintenance organizations, and for the more general reason that both are intended to help protect the confidentiality of individual medical information, statutory clarification and amendment may be appropriate.

Types of provisions that could potentially be added to §32.1-127.1:03 include those concerning (1) the degree of access to information that must be provided, (2) provision of notice to individuals concerning health information confidentiality policies and procedures, (3) the authorization to charge a reasonable fee to provide requested information, and (4) the right of individuals to request that their personal health information be amended or corrected. On the other hand, additional statutory provisions could add to regulatory and administrative burdens placed on health care providers.

While there are potential issues concerning consistency between provisions of Virginia's health and insurance statutes that could be addressed, it is difficult to identify any strong evidence indicative of problems with health information privacy in Virginia. Nationally, the U.S. Department of Health and Human Services and the Georgetown University Health Privacy Project have both cited recent public opinion surveys which indicate some apprehension concerning the extent to which

the confidentiality of personal medical information is protected. However, in Virginia, the Department of Health Professions reports that the majority of 114 complaints that it has received since April 1999 concerning medical records involve allegations that a provider has not produced the records in a timely manner or has failed to produce the records. VDH reports that it receives few, if any, complaints concerning medical record-related issues. In addition, the Bureau of Insurance reports no problems with enforcement of statutory requirements. Most significantly for Virginia, and all states, is the prospect of federal regulations which may preempt existing provisions of state law. This is a major issue that needs to be thoroughly examined and evaluated at the state level.

IV.
Policy Options

The following policy options are offered for consideration by the Joint Commission on Health Care regarding the confidentiality and privacy of patient medical records in Virginia. However, these policy options do not represent the full range of options that the Joint Commission on Health Care may wish to pursue with regard to medical records privacy issues. Furthermore, these policy options are not mutually exclusive. The Joint Commission on Health Care may choose to pursue two or more of these options.

Option I: **Take no action**

Option II: **Introduce legislation to amend §32.1-127.1:03 of the *Code of Virginia* clearly specifying a patient's right to examine and inspect his or her original medical records maintained by a health care provider**

Option III: **Introduce legislation to amend §32.1-127.1:03 of the *Code of Virginia* to authorize a patient to submit a written request to a health care provider to correct, amend, or supplement information contained in the individual's medical record, and establishing a process by which a health care provider shall respond to such a request**

Option IV: **Introduce legislation to amend §32.1-127.1:03 of the *Code of Virginia* to require a health care provider to provide a patient with notice of the provider's policies and practices concerning the use and disclosure of personal health care information, and concerning the patient's rights with regard to that information**

Option V: **Introduce legislation to amend §38.2-608 of the *Code of Virginia* to reduce the number of days, from 30 to 15, within which insurance institutions must respond to an individual's request for medical information, to be consistent with statutory requirements for health maintenance organizations and other health care providers**

Option VI: Introduce legislation to amend §32.1-127.1:03 of the *Code of Virginia* clarifying the authority of hospitals to charge a reasonable fee for copies of patient medical records in instances other than those involving a subpoena

Option VII: Introduce legislation to amend §32.1-127.1:03 of the *Code of Virginia* specifying the types of information required to be included in a written authorization for release of medical records

Option VIII: Request the Virginia Department of Health, via a letter from the Chairman of the Joint Commission on Health Care to the State Health Commissioner, to fulfill its statutory responsibility, pursuant to §32.1-127(B)(8) of the *Code of Virginia*, to promulgate regulations requiring each licensed hospital to establish a protocol relating to the rights and responsibilities of patients, consistent with Joint Commission on Accreditation of Health Care Organization standards

Option IX: Introduce a joint resolution requesting the Office of the Attorney General, with assistance from the Virginia Department of Health and the Virginia Bureau of Insurance, to monitor the continued development and promulgation of health information privacy regulations by the U.S. Department of Health and Human Services, guide development of the Commonwealth's response to the federal regulations, and evaluate the necessity of amendments to the *Code of Virginia*

APPENDIX A

SENATE OF VIRGINIA

WARREN E. BARRY
37TH SENATORIAL DISTRICT
PART OF FAIRFAX AND
PRINCE WILLIAM COUNTIES, AND
PART OF THE CITY OF FAIRFAX
POST OFFICE BOX 1146
FAIRFAX, VIRGINIA 22030-1146

COMMITTEE ASSIGNMENTS:
EDUCATION AND HEALTH, CHAIR
COMMERCE AND LABOR
FINANCE
TRANSPORTATION
RULES

May 11, 2000

The Honorable Kenneth R. Melvin, Chairman
Joint Commission on Health Care
1001 East Broad Street
Richmond, Virginia 23219

Dear Delegate Melvin:

The Senate Committee on Education and Health considered several complex issues relating to patient records, consent for release of patient records, and patient confidentiality during the 2000 Session, including the provisions of Senate Bill 702, which was introduced by Senator Patricia S. Ticer. When appearing before the Committee to present this bill, Senator Ticer requested that the bill be struck from the docket and that the issues presented by the bill be referred to the Joint Commission on Health Care for inclusion in its study plan for the coming interim.

Therefore, I respectfully request, on behalf of the members of the Senate Committee on Education and Health, that the Joint Commission on Health Care include the issues relating to patient consent to release of medical records, ownership of medical records, and patient confidentiality in its study plan for the 2000 interim and provide the Committee with any findings or recommendations on these matters.

Thank you in advance for your consideration of this request.

Sincerely,

Warren E. Barry

Senator Warren E. Barry
Chairman
Senate Committee on Education and Health

cc: Members, Senate Committee on Education and Health
The Honorable Patricia S. Ticer
Mr. Patrick W. Finnerty, Executive Director, Joint Commission on Health Care

APPENDIX B

000207544

SENATE BILL NO. 702

Offered January 24, 2000

A BILL to amend and reenact §§ 8.01-413, 32.1-127.1:03, and 54.1-2403.3 of the Code of Virginia, relating to medical records.

Patrons—Ticer, Byrne, Lambert, Marye and Miller, Y.B.; Delegates: Darner and Van Landingham

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 8.01-413, 32.1-127.1:03, and 54.1-2403.3 of the Code of Virginia are amended and reenacted as follows:

§ 8.01-413. Certain copies of health care provider's records or papers of patient admissible; right of patient or his attorney to copies of such records or papers; subpoena; damages, costs and attorney's fees.

A. In any case where the hospital, nursing facility, physician's, or other health care provider's original records or papers of any patient in a hospital or institution for the treatment of physical or mental illness are admissible or would be admissible as evidence, any typewritten copy, photograph, photostatted copy, or microphotograph or printout or other hard copy generated from computerized or other electronic storage, microfilm, or other photographic, mechanical, electronic or chemical storage process thereof shall be admissible as evidence in any court of this Commonwealth in like manner as the original, if the printout or hard copy or microphotograph or photograph is properly authenticated by the employees having authority to release or produce the original records.

Any hospital, nursing facility, physician, or other health care provider whose records or papers relating to any such patient are subpoenaed for production under this section or the Rules of the Supreme Court of Virginia may comply with the subpoena by a timely mailing to the clerk issuing the subpoena properly authenticated copies, photographs or microphotographs in lieu of the originals. The court whose clerk issued the subpoena may, after notice to such hospital, nursing facility, physician, or other health care provider, enter an order requiring production of the originals, if available, of any stored records or papers whose copies, photographs or microphotographs are not sufficiently legible. The party requesting the subpoena shall be liable for the reasonable charges of the hospital, nursing facility, physician, or other health care provider for the service of maintaining, retrieving, reviewing, preparing, copying and mailing the items produced. Except for copies of X-ray photographs, however, such charges shall not exceed fifty cents for each page up to fifty pages and twenty-five cents a page thereafter for copies from paper and one dollar per page for copies from microfilm or other micrographic process, plus all postage and shipping costs and a search and handling fee not to exceed ten dollars.

B. Copies of hospital, nursing facility, physician's, or other health care provider's records or papers shall be furnished within fifteen days of such request to the patient or his attorney upon such patient's or attorney's written request, which request shall comply with the requirements of § 32.1-127.1:03. However, copies of a patient's records shall not be furnished to such patient where the patient's treating physician has made a part of the patient's records a written statement that in his opinion the furnishing to or review by the patient of such records would be injurious to the patient's health or well-being, but in any such case such records shall be furnished to the patient's attorney within fifteen days of the date of such request. A reasonable charge may be made *to the attorney or other party* for the service of maintaining, retrieving, reviewing and preparing such copies*; however, no charge shall be made to the patient for obtaining a copy of his record.* Except for copies of X-ray photographs, however, such charges shall not exceed fifty cents per page for up to fifty pages and twenty-five cents a page thereafter for copies from paper and one dollar per page for copies from microfilm or other micrographic process, plus all postage and shipping costs and a search and handling fee not to exceed ten dollars. Any hospital, nursing facility, physician, or other health care provider receiving such a request from a patient's attorney shall require a writing signed by the patient confirming the attorney's authority to make the request.

C. Upon the failure of any hospital, nursing facility, physician, or other health care provider to

comply with any written request made in accordance with subsection B within the period of time specified in that subsection and within the manner specified in § 32.1-127.1:03, the patient or his attorney may by affidavit filed with the clerk of the circuit court wherein any eventual suit, if any, would be required to be filed, upon payment of the fees required by subdivision A 18 of § 17.1-275, and fees for service, request that the clerk subpoena such records or papers. The clerk shall thereupon issue a subpoena, returnable within twenty days of proper service, directing the hospital, nursing facility, physician, or other health care provider to produce and furnish copies of the reports and papers to him, whereupon, the clerk shall make the same available to the patient or his attorney. If the court finds that a hospital, nursing facility, physician, or other health care provider willfully refused to comply with a written request made in accordance with subsection B, either by willfully or arbitrarily refusing or by imposing a charge in excess of the reasonable expense of making the copies and processing the request for records, the court may award damages for all expenses incurred by the patient to obtain such copies, including court costs and reasonable attorney's fees.

D. The provisions of subsections A, B, and C hereof shall apply to any health care provider whose office is located within or without the Commonwealth if the records pertain to any patient who is a party to a cause of action in any court in the Commonwealth of Virginia, and shall apply only to requests made by an attorney, or his client, in anticipation of litigation or in the course of litigation.

E. Health care provider, as used in this section, shall have the same meaning as provided in § 32.1-127.1:03 and shall also include an independent medical copy retrieval service contracted to provide the service of retrieving, reviewing, and preparing such copies for distribution.

F. Notwithstanding the authorization to admit as evidence patient records in the form of microphotographs, prescription dispensing records maintained in or on behalf of any pharmacy registered or permitted in Virginia shall only be stored in compliance with §§ 54.1-3410, 54.1-3411 and 54.1-3412.

§ 32.1-127.1:03. Patient health records privacy.

A. There is hereby recognized a patient's right of privacy in the content of a patient's medical record. Patient records are the property of the provider maintaining them *and the patient*, and, except when permitted by this section or by another provision of state or federal law, no provider, or other person working in a health care setting, may disclose the records of a patient *without the patient's consent.*

Patient records shall not be removed from the premises where they are maintained without the approval of the provider, except in accordance with a court order or subpoena consistent with § 8.01-413 C or with this section or in accordance with the regulations relating to change of ownership of patient records promulgated by a health regulatory board established in Title 54.1.

No person to whom disclosure of patient records was made by a patient or a provider shall redisclose or otherwise reveal the records of a patient, beyond the purpose for which such disclosure was made, without first obtaining the patient's specific consent to such redisclosure. This redisclosure prohibition shall not, however, prevent (i) any provider who receives records from another provider from making subsequent disclosures as permitted under this section or (ii) any provider from furnishing records and aggregate or other data, from which patient-identifying prescription information has been removed, encoded or encrypted, to qualified researchers, including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

B. As used in this section:

"Agent" means a person who has been appointed as a patient's agent under a power of attorney for health care or an advance directive under the Health Care Decisions Act (§ 54.1-2981 et seq.).

"Guardian" means a court-appointed guardian of the person.

"Health services" includes, but is not limited to, examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind.

"Parent" means a biological, adoptive or foster parent.

"Patient" means a person who is receiving or has received health services from a provider.

"Patient-identifying prescription information" means all prescriptions, drug orders or any other prescription information that specifically identifies an individual patient.

"Provider" shall have the same meaning as set forth in the definition of "health care provider" in

§ 8.01-581.1, except that state-operated facilities shall also be considered providers for the purposes of this section. **Provider** shall also include all persons who are licensed, certified, registered or permitted by any of the **health regulatory boards within the Department** of Health Professions, except persons regulated by the Board of **Funeral Directors and Embalmers** or the Board of Veterinary Medicine.

"Record" means any written, printed or electronically recorded material maintained by a provider in the course of providing health services to a patient concerning the patient and the services provided. ~~"Record" also includes the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of health services to a patient or information otherwise acquired by the provider about a patient in confidence and in connection with the provision of health services to the patient.~~

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§ 65.2-604 and 65.2-607 of the Virginia Workers' Compensation Act; or

2. Except where specifically provided herein, the records of minor patients.

D. Providers may disclose the records of a patient:

1. *To the patient, except as provided in subsections E and F of this section and subsection B of § 8.01-413;*

2. As set forth in subsection E of this section, pursuant to the written consent of the patient or in the case of a minor patient, his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § 54.1-2969; also, in emergency cases or situations where it is impractical to obtain the patient's written consent, pursuant to the patient's oral consent for a provider to discuss the patient's records with a third party specified by the patient;

~~2~~*3.* In compliance with a subpoena issued in accord with subsection H of this section, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § 8.01-413;

~~3~~*4.* In accord with subsection F of § 8.01-399 including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a provider or the provider's employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a provider's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

~~4~~*5.* In testimony in accordance with §§ 8.01-399 and 8.01-400.2;

~~5~~*6.* In compliance with the provisions of § 8.01-413*; however, the patient's consent shall be required*;

~~6~~*7.* As required or authorized by any other provision of law including contagious disease, public safety, and suspected child or adult abuse reporting requirements, including, but not limited to, those contained in §§ 32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-276.5, 32.1-283, 32.1-283.1, 37.1-98.2, 53.1-40.10, 54.1-2403.3, 54.1-2906, 54.1-2907, 54.1-2966, 54.1-2966.1, 54.1-2967, 54.1-2968, 63.1-55.3 and 63.1-248.11;

~~7~~*8.* Where necessary in connection with the care of the patient;

~~8~~*9.* In the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§ 54.1-3410, 54.1-3411 and 54.1-3412;

~~9~~*10.* When the patient has waived his right to the privacy of the medical records;

~~10~~*11.* When examination and evaluation of a patient are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such;

~~11~~*12.* To the guardian ad litem in the course of a guardianship proceeding of an adult patient authorized under §§ 37.1-128.1, 37.1-128.2 and 37.1-132;

~~12~~*13.* To the attorney appointed by the court to represent a patient in a civil commitment proceeding under § 37.1-67.3;

~~13~~*14.* To the attorney and/or guardian ad litem of a minor patient who represents such minor in any judicial or administrative proceeding, provided that the court or administrative hearing officer has entered an order granting the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the provider of such order;

denying the request shall inform the patient of the patient's right to select another reviewing physician or clinical psychologist under this subsection who shall make a judgment as to whether to make the record available to the patient. Any record copied for review by the physician or clinical psychologist selected by the patient shall be accompanied by a statement from the custodian of the record that the patient's attending physician or clinical psychologist determined that the patient's review of his record would be injurious to the patient's health or well-being.

G. A written consent to allow release of patient records may, but need not, be in the following form:

CONSENT TO RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

Patient Name .....

Provider Name .....

Person, agency or provider to whom disclosure is to be made .....

Information or Records to be disclosed .....

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

This consent expires on (date) .....

Signature of Patient ..... Date .....

H. 1. No party to an action shall request the issuance of a subpoena duces tecum for an opposing party's medical records unless a copy of the request for the subpoena is provided to opposing counsel or the opposing party if they are pro se, simultaneously with filing the request. No party to an action shall request the issuance of a subpoena duces tecum for the medical records of a nonparty witness unless a copy of the request for the subpoena is provided to the nonparty witness simultaneously with filing the request.

In instances where medical records being subpoenaed are those of a pro se party or nonparty witness, the party requesting the issuance of the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters:

NOTICE TO PATIENT

The attached Request for Subpoena means that (insert name of party requesting subpoena) has asked the court to issue a subpoena to your doctor or other health care providers (names of health care providers inserted here) requiring them to produce your medical records. Your doctor or other health care provider is required to respond by providing a copy of your medical records. If you believe your records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court to quash the subpoena. You may contact the clerk's office to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, it must be filed as soon as possible before the provider sends out the records in response to the subpoena. If you elect to file a motion to quash, you must notify your doctor or other health care provider(s) that you are filing the motion so that the provider knows to send the records to the clerk of court in a sealed envelope or package for safekeeping while your motion is decided.

2. Any party filing a request for a subpoena duces tecum for a patient's medical records shall include a Notice to Providers in the same part of the request where the provider is directed where and when to return the records. Such notice shall be in boldface capital letters and shall include the following language:

NOTICE TO PROVIDERS

IF YOU RECEIVE NOTICE THAT YOUR PATIENT HAS FILED A MOTION TO QUASH

(OBJECTING TO) THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, SEND THE RECORDS ONLY TO THE CLERK OF THE COURT WHICH ISSUED THE SUBPOENA USING THE FOLLOWING PROCEDURE: PLACE THE RECORDS IN A SEALED ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT WHICH STATES THAT CONFIDENTIAL HEALTH CARE RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING THE COURT'S RULING ON THE MOTION TO QUASH THE SUBPOENA. THE SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT.

3. Health care providers shall provide a copy of all records as required by a subpoena duces tecum or court order for such medical records. If the health care provider has, however, actual receipt of notice that a motion to quash the subpoena has been filed or if the health care provider files a motion to quash the subpoena for medical records, then the health care provider shall produce the records to the clerk of the court issuing the subpoena, where the court shall place the records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge. In the event the court grants the motion to quash, the records shall be returned to the health care provider in the same sealed envelope in which they were delivered to the court. In the event that a judge orders the sealed envelope to be opened to review the records in camera, a copy of the judge's order shall accompany any records returned to the provider. The records returned to the provider shall be in a securely sealed envelope.

4. It is the duty of any party requesting a subpoena duces tecum for medical records to determine whether the patient whose records are sought is pro se or a nonparty. Any request for a subpoena duces tecum for the medical records of a nonparty or of a pro se party shall direct the provider (in boldface type) not to produce the records until ten days after the date on which the provider is served with the subpoena duces tecum and shall be produced no later than twenty days after the date of such service.

In the event that the individual whose records are being sought files a motion to quash the subpoena, the court shall decide whether good cause has been shown by the discovering party to compel disclosure of the patient's private records over the patient's objections. In determining whether good cause has been shown, the court shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

The provisions of this subsection have no application to subpoenas for medical records requested under § 8.01-413, or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a provider's conduct. The provisions of this subsection apply to the medical records of both minors and adults.

A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

Providers may testify about the medical records of a patient in compliance with §§ 8.01-399 and 8.01-400.2.

§ 54.1-2403.3. Medical records; ownership; provision of copies.

Medical records maintained by any health care provider as defined in § 32.1-127.1:03 shall be the property of such health care provider *and the patient* or, in the case of a health care provider employed by another health care provider, the property of the employer *and the patient.* Such health care provider shall release copies of any such medical records *with the consent of the patient and* in compliance with § 32.1-127.1:03 or § 8.01-413, if the request is made for purposes of litigation, or as otherwise provided by state or federal law.

Official Use By Clerks

Passed By The Senate		**Passed By The House of Delegates**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the Senate Clerk of the House of Delegates

APPENDIX C

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:
Review of Confidentiality of Patient Medical Records
(SB702 of 2000 Session)

Organizations and Individuals Submitting Comments

A total of seven individuals and organizations submitted comments in response to the report on the Confidentiality of Patient Medical Records:

- The Medical Society of Virginia,
- Virginia Association of Health Plans,
- Trigon Blue Cross Blue Shield,
- Virginia Hospital and Healthcare Association,
- Crews & Hancock, P.L.C. (on behalf of The Reciprocal Group),
- Mays & Valentine, L.L.P. (on behalf of Golden Rule Insurance Company), and
- Ellen Penar.

Policy Options Included in the HJR 9 Issue Brief

Option I: **Take no action.**

Option II: **Introduce legislation to amend §32.1-127.1:03 of the *Code of Virginia* clearly specifying a patient's right to examine and inspect his or her original medical records maintained by a health care provider.**

Option III: **Introduce legislation to amend §32.1-127.1:03 of the *Code of Virginia* to authorize a patient to submit a written request to a health care provider to correct, amend, or supplement information contained in the individual's medical record, and establishing a process by which a health care provider shall respond to such a request.**

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the use and disclosure of personal health care information, and concerning the patient's rights with regard to that information.

Option V: **Introduce legislation to amend §38.2-608 of the *Code of Virginia* to reduce the number of days, from 30 to 15, within which insurance institutions must respond to an individual's request for medical information, to be consistent with statutory requirements for health maintenance organizations and other health care providers.**

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Option VII: **Introduce legislation to amend §32.1-127.1:03 of the *Code of Virginia* specifying the types of information required to be included in a written authorization for release of medical records.**

Option VIII: **Request the Virginia Department of Health, via a letter from the Chairman of the Joint Commission on Health Care to the State Health Commissioner, to fulfill its statutory responsibility, pursuant to §32.1-127(B)(8) of the *Code of Virginia*, to promulgate regulations requiring each licensed hospital to establish a protocol relating to the rights and responsibilities of patients, consistent with Joint Commission on Accreditation of Health Care Organization standards.**

Option IX: **Introduce a joint resolution requesting the Office of the Attorney General, with assistance from the Virginia Department of Health and the Virginia Bureau of Insurance, to monitor the continued development and promulgation of health information privacy regulations by the U.S. Department of Health and Human Services, guide development of the Commonwealth's response to the federal regulations, and evaluate the necessity of amendments to the *Code of Virginia*.**

Overall Summary of Comments

Five of the commenters, The Medical Society of Virginia, Virginia Association of Health Plans, Trigon Blue Cross Blue Shield, Virginia Hospital and Health Care Association, and Crews & Hancock, all expressed clear support for Policy Option I. In general, these five commenters cited pending federal health information privacy regulations, as well as the JCHC staff finding that "it is difficult to identify any strong

evidence indicative of problems with health information privacy in Virginia" in support of their position to take no action at this time. Mays & Valentine expressed some concerns with Policy Options V and VII.

Summary of Individual Comments

The Medical Society of Virginia (MSV)

Marni Langbert Eisner, Director of Legislative Affairs, expressed support for Policy Option I. Ms. Eisner noted that a lack of complaints from MSV members "lead us to believe that Virginia's privacy laws are working well for both patients and providers in the Commonwealth." Ms. Eisner also noted that "the issue of medical record confidentiality is being debated and investigated on the federal level, therefore making any state action premature." Finally, Ms. Eisner stated that "any changes to our state law should be delayed until the full impact of the new federal regulations can be fully evaluated."

Virginia Association of Health Plans (VAHP)

Lynn M. Warren, Director of Policy, expressed support for Policy Option I. VAHP does not believe that it is necessary or prudent to seek amendments to Virginia's existing patient medical records statutes for two primary reasons. First, "there appears to be little evidence to suggest that the current statutory provisions are insufficient." Second, "the federal privacy regulations, which are scheduled to be released this fall, are likely to address the issues raised." Ms. Warren did state that VAHP is not opposed to efforts by state agencies to monitor the development and promulgation of the federal privacy regulations.

Trigon Blue Cross Blue Shield

Leonard L. Hopkins, Jr., Vice President, Public Policy Officer, expressed support for Policy Option I. Mr. Hopkins stated that Trigon agrees with and supports the written comments supported by VAHP. Mr. Hopkins stated that "Privacy of patients' medical records is a very important issue but is an issue which is being addressed by the federal government in a very comprehensive manner." Mr. Hopkins cited information from the JCHC staff issue brief concerning the Bureau of Insurance reporting no problems with enforcing statutory requirements, and the Department of Health reporting no complaints regarding medical records.

Virginia Hospital and Healthcare Association

Susan C. Ward, Vice President and General Counsel, expressed support for Policy Option I. Ms. Ward indicated that the current Virginia statute achieves "what we believe is an appropriate balance between patient privacy and appropriate access to health information." Ms. Ward stated that "We are not aware of specific problems with

Virginia's privacy laws that require action at this time." In addition, according to Ms. Ward, "because of the dynamic and uncertain state of federal privacy regulation, we believe that any additional state action would be premature at this time." Noting that "the timetable for implementation of the federal regulations is still unclear", Ms. Ward stated that "any changes to state law should await final federal regulations to avoid further confusion and to facilitate consistency of state and federal laws."

Crews & Hancock, P.L.C. (on behalf of The Reciprocal Group)

W. Scott Johnson of Crews & Hancock expressed support for Policy Option I. Mr. Johnson stated that, subsequent to enactment of the current Virginia patient health records privacy statute, "I am not aware of problems that health care providers or patients have faced regarding access to or release of medical records." According to Mr. Johnson, "...health care providers are appropriately protecting the privacy of their patients' medical records and with the enactment of Virginia Code §32.1-127.1:03 the privacy laws became even stronger." With regard to the pending federal regulations, Mr. Johnson believes "it would be prudent to wait for the final federal regulations to determine if any changes are needed in Virginia law to bring the two into compliance."

Mays & Valentine, L.L.P. (on behalf of Golden Rule Insurance Company)

Theodore F. Adams, III of Mays & Valentine stated that Golden Rule Insurance Company has "no particular comment on nor any objection to" Policy Options I, II, III, IV, VI, VIII or IX. Mr. Adams did express concerns about Policy Option V. According to Mr. Adams, "in the absence of specific complaints about the thirty day time period, Golden Rule recommends that it not be changed." Mr. Adams stated that the proposal contained in Policy Option VII could unnecessarily complicate the process for preparing appropriate releases for medical records. According to Mr. Adams, absent specific concerns which need to be addressed, Golden Rule believes Policy Option VII is not necessary.

Ellen Penar

Ms. Penar stated that "the report is appalling and does not represent the interests of the public."

JOINT COMMISSION ON HEALTH CARE

Executive Director

Patrick W. Finnerty

Senior Health Policy Analysts

Joseph J. Hilbert
E. Kim Snead

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Mamie V. White

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