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Altered States: State Health Privacy Laws and the Impact of the Federal Health Privacy Rule

Joy L. Pritts, J.D.*

Medical records contain some of the most intimate details about an individual that can be found in a single place. Health information privacy is based on the principle that individuals should be able to exercise control over this intimate information, both by having full knowledge about what information is contained in the records and by being able to control who has access to the information. Because professional ethical requirements do not adequately protect health information in today's complex health care system, we have increasingly turned to the law as a source of protection.

Until the recent promulgation of the Federal Health Privacy Rule,1 states have been the primary regulators of health information through their constitutions, common law, and statutory provisions. Although all three of these legal sources remain important, recent focus has been on the enactment of detailed health privacy statutes that apply the fair information practice principles to health information. However, for the most part states have adopted these principles in a fairly haphazard fashion resulting in a patchwork of legal protections both within and between states.

The recently issued Federal Health Privacy Rule has effectively evened out some of this discrepancy by establishing a federal floor of privacy protections based on fair information practices. The Federal Rule, however, does not afford adequate protection of health information

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because it has limited applicability and areas of lax protection. Because the Federal Rule only preempts conflicting, less protective state laws, there is still room for states to protect their own citizens by retaining or enacting health privacy protections that mirror and improve upon those in the Federal Health Privacy Rule.

INTRODUCTION

Health information privacy is based on the principle that individuals should have some control over their own medical records. This general principle can be broken down into two different rights: the ability to protect against unwarranted disclosures of health information (i.e., the right to protect the confidentiality of health information), and the right of access to one's own health information. Although these rights have evolved along different paths, they are equally important in today's health care system.

A. Confidentiality of Health Information

Quality medical care requires patients to share some of the most personal details of their lives with their doctors. As a result, a complete medical record may contain more intimate details about an individual than could be found in any single document. Since the time of Hippocrates, doctors have sworn to maintain the confidentiality of this sensitive information, in order to establish a trusting relationship with their patients.

Until the twentieth century, this ethical obligation has been the primary protection of health information. But the Hippocratic Oath, which is premised on a simple one-on-one doctor-patient relationship where information can remain under the control of the doctor, does not address the complexities of the modern practice of health care. Obtaining health care today can involve an entire network of health care professionals and insurers. In an attempt to contain escalating health care costs, large amounts of health care data are collected and used by those who pay for health care, including insurers, the government, and employers. The recent revolution in information technology has encouraged a movement towards computerization of the storage and transmission of medical information. Furthermore, there is an increased demand for health care information from secondary users for purposes that are not really related to health care.

Many of these holders of health information are not subject to ethical obligations to maintain its confidentiality. Even where an ethical duty
exists, in some jurisdictions it is not enforceable by law.⁸

Given the numerous uses of health information and the number of people who have access to health information in today's complex health care system, many patients have concerns about the confidentiality of their own, identifiable health information.⁹ According to a recent poll,¹⁰ only one third of U.S. adults say they trust health plans and government programs like Medicare to maintain confidentiality all or most of the time. One in five American adults believe that a health care provider, insurance plan, government agency, or employer has improperly disclosed personal medical information. Half of these people say it resulted in personal embarrassment or harm. Patients fear that their employers, family members, or friends may discover that they have a sensitive health condition that could negatively impact their job security, relationships, or personal safety. As a result, one in six American adults say they have done something out of the ordinary to keep personal medical information confidential. Among the actions reported: going to another doctor; paying out-of-pocket for services; not seeking care; giving inaccurate or incomplete information on a medical history; and asking a doctor not to write down the health problem or record a less serious or embarrassing condition. Clearly, ethical obligations cannot sufficiently protect the confidentiality of health information in today's health care system, and additional measures are warranted.

**B. Patients' Right of Access to Their Health Information**

Protecting the confidentiality of health information is only a portion of the principle of health privacy. Assuring patients access to their health information is the other part of the equation. To a lay person, it may seem self-evident that individuals should be able to see the information in their health records. However, it was not until 1984 that the American Medical Association officially expressed the belief that doctors should, on request of the patient, provide a copy or a summary of patient's medical record.¹¹ Although many health care professionals have similar ethical obligations, many holders of health information, such as insurers, are not subject to these same ethical guidelines. With the increasingly wide use of health information for secondary purposes, such as employment, it has become even more important that individuals be able verify the accuracy of their health information.¹²

Because ethical guidelines are insufficient to protect either the confidentiality of health information or to ensure an individual's access to information, individuals have increasingly turned to the law as a source of protection.
I. STATE HEALTH INFORMATION PRIVACY LAWS

Until recently, states have been the primary regulators of health information. State laws may protect the privacy of health information through three major venues: state constitutions, common law, and statute. The type and extent of protection afforded varies greatly from state to state and from entity to entity. Although there are many people and organizations that maintain health information, this Article focuses on the regulation of health care providers.

A. State Constitutional Protections

Most state constitutions afford only limited protection from the unwarranted disclosure of health information. All states have constitutional provisions similar to those in the United States Constitution, which give rise to an implied right of privacy. In addition, several states expressly grant the right to privacy in their constitutions. Whether express or implied, however, the vast majority of state constitutions protect only against state action. Even when state action is at issue, the individual's privacy interest is often outweighed by the state's interest in disclosure. Thus individuals generally cannot rely on state constitutions to protect them against the unwarranted use and disclosure of health information either by private parties or by the state.

Two states, California and Hawaii, however, stand out for their constitutional protections. The constitutions of both states explicitly guarantee the right of privacy to their citizens. These constitutional rights are broad and protect individuals from invasions of privacy by private citizens as well as by the state. Additionally these constitutional rights to privacy extend to medical information. Thus, citizens of California and Hawaii may rely on their state constitutions as a source of protection against unwarranted disclosures of health information.

B. State Common Law Protections

State common law provides broader protections against the disclosure of health information and affords patients a right of access to their own health information.

1. Confidentiality of Health Information. Recognizing that certain health care providers owe a common law duty of confidentiality to their patients, courts have found that actions may be maintained against these providers for unauthorized disclosures of health information under a number of legal theories including invasion of privacy, implied breach of contract,
and breach of fiduciary relationship. Obtaining a remedy for disclosure of health information under any of these theories, however, is difficult.

An increasing number of states recognize the tort of invasion of privacy based on unreasonable public disclosure of private facts. Two states, Colorado and Minnesota, have only recognized this tort within the last few years. In contrast, New York and Nebraska have affirmatively declined to recognize an invasion of privacy tort based on this particular theory and demonstrate no indication of changing their position. Although in the past Indiana seemed to endorse this cause of action, recently the state appears to be wavering on its position. Some states, such as North Dakota and Wyoming, appear to have not squarely addressed the issue.

Even where the cause of action has been recognized, the success rate of plaintiffs has been extremely low, perhaps because of its strict requirements. Prevailing on a “wrongful disclosure” claim requires proof that there was a public disclosure of a private matter that was not of legitimate concern to the public and that the disclosure would be highly offensive to a reasonable person. Although matters concerning a person’s medical treatment or condition are generally considered private, proving that the publication of a particular medical condition or treatment is “highly offensive” may be more problematic. Additionally, some courts have found that the tort requires disclosure to the general public or a wide audience, a standard that may not be met when health information is disclosed to only a few.

Having struggled in their efforts to devise a civil remedy for wrongful disclosures of health information, courts have moved towards adopting a tort for breach of confidentiality in its own right, “based on the nature of the patient-physician relationship itself, either because of its fiduciary character or because it is customarily understood to carry an obligation of secrecy and confidence.” Courts in at least twelve jurisdictions have adopted this approach, Ohio as recently as 1999. The underlying duty of confidentiality is not absolute, and the courts have indicated that there is no breach of confidentiality when a disclosure is made as required by statute (such as mandatory reporting to state officials of infectious or contagious diseases) or common law (such as a duty to disclose information concerning the safety of third persons).

In sum, there are a number of common law actions upon which a patient can bring an action for the unauthorized disclosure of her health information. And most courts seem to be willing to find some theory under which they can address the wrongful disclosure of health information.

2. Patient Access to Health Information. Another aspect of health

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informational privacy is the ability to know the contents of one’s medical records. Although there is not a surfeit of common law in this area, states that have confronted the issue generally have recognized a qualified common law right to inspect one’s own medical records. Some courts based this right of access on property principles, holding that although the health care provider may own the actual medical record, the patient has a property right in the information contained in the record sufficient to afford reasonable access rights to that information. Other courts have based the common law right of access to medical information on a health care provider’s fiduciary duty to reveal to a patient information that is in her best interest to know.

Although the common law establishes a general right of access to one’s own health information, it gives little guidance as to what constitutes “reasonable access.” These cases also fail to define parameters as to the degree of discretion the health care provider has in determining what information is in the best interest of the patient.

C. State Statutory Protections

Beginning in the 1970s, the trend has been to augment existing state constitutional and common law rights with statutory protections specifically designed to protect the confidentiality of health information and to ensure that individuals have access to their own information. Although common law developments continue to be important, states have increasingly focused on enacting distinct statutory requirements.

This shift to statutory protections can be seen as an outgrowth of the development of fair information practice principles. Although these standards have been grouped and characterized in various fashions, with respect to health information, they may generally be seen as encompassing the following principles:

- A patient should have the right to see and copy her own health information.
- A patient should have the right to amend or correct such information.
- There should be defined limits on how identifiable health information can be used and shared. A patient’s authorization should be obtained before using or disclosing health information for purposes not related to health care.
- An entity that maintains and shares identifiable health information should provide individuals with a notice of its information practices.
Entities that maintain health information should be required to have procedures and practices in place to safeguard the information from unwarranted intrusion.

Entities should be held accountable if they violate these principles.

Although states have applied many of these principles to health information, most have done so in a fairly ad hoc fashion, addressing particular entities or medical conditions, and applying certain principles but not others. Furthermore, in spite of some concerted efforts, these principles have not been adopted uniformly among states. The net result is a patchwork of state health privacy laws that provide little consistency from entity to entity or from state to state.

1. Patients’ Access to Their Own Health Information. Patients should be able to see and copy their own health information. There are a variety of policy factors supporting this principle, not the least of which is a matter of basic fairness. If others outside the medical system are using health information to make important employment and insurance related decisions about individuals, those individuals should at least have the right to see and verify the information upon which those decisions are based. Moreover, patients who have access to their medical information can better understand their medical conditions and participate more actively in treatment.

In 1977, only nine states clearly granted a patient the right to inspect, and in some instances obtain a copy of, her own medical record, while ten other states had “vaguely worded statutes or regulations that allow a patient, relative, physician or attorney to access the patient’s medical record.” Although these numbers have significantly improved, there is still a wide disparity in statutory access rights both between states and within many given states.

Currently, more than thirty states statutorily grant patients an unencumbered right to inspect and/or copy their medical records that are held by hospitals and health care professionals, including doctors. Some states, such as Ohio and Wyoming, provide a statutory right of access only to records held by hospitals. Other states afford access rights only to records held by hospitals and doctors, while yet others define the term health care provider broadly to encompass a variety of health care professionals. Nebraska, for instance, recently passed an act that for the first time statutorily provided patients access to their medical records maintained by a wide range of health care providers. A few state statutes grant patients access to their medical records only through an attorney. Some states, such as Iowa, Kansas, and Vermont, however, have no general
statutory right of access to medical records.\footnote{54}

Many states have begun to recognize the need to extend the right of access beyond doctor and hospital records. For example, almost one third of the states have statutes that expressly grant patients access to health records maintained by pharmacists.\footnote{55} Some states, such as Montana and Washington, have purposefully chosen to exclude pharmacists from their access provisions on the grounds that, traditionally, the relationship between a pharmacist and a patient more closely resembled a seller-customer relationship than a provider-patient relationship.\footnote{56} This perspective, however, fails to take into account the increasingly complex role that pharmacists play in today’s health care systems.\footnote{57}

With the growing popularity of alternative health care,\footnote{58} states are beginning to subject some of these non-traditional providers to patient access requirements.\footnote{59} For example, at least sixteen states clearly grant patients the right to see and copy their health information that is maintained by acupuncturists.\footnote{60} Similarly, as states begin to recognize naturopaths and homeopaths as legitimate health care providers, they have also begun to statutorily grant patients access to the records maintained by these alternative care providers.\footnote{61}

The result of this piecemeal approach is that in any given state patients may have a statutory right of access to health records maintained by only a fraction of the health care professionals who are engaged in their care. For instance, in Ohio, patients have a statutory right of access to their hospital records, but not the records of their doctors.\footnote{62} Oklahoma statutorily grants patients access rights with respect to health information maintained by hospitals and doctors, but not with respect to similar information maintained by pharmacists.\footnote{63} And Rhode Island citizens have the statutory right of access to health information maintained by physicians, but not to information held by hospitals, pharmacists, or other health care providers.\footnote{64} Thus, even within a particular state, there may be, at best, a sporadic application of the fair information principle of individual access.

The same holds true when comparing access rights between different states, with the result that citizens in neighboring states can have vastly different rights with respect to their health information.\footnote{65} For instance, Maryland provides its citizens with a broad right to see, copy, and amend their health information maintained by a wide range of health care providers and health care facilities.\footnote{66} In contrast, its neighboring state, Delaware, does not statutorily grant its citizens the right of access even to health information held by hospitals and doctors.\footnote{67}

2. Patients' Right to Amend Health Records. A patient should be able to not only review her medical records but also should be able to correct any
errors or amend any inadequacies in them. The accuracy of health care information is obviously important for the delivery of quality health care. However, accuracy is equally important for many of the non-medical uses of health information. Medical information may be used to evaluate applications for life and health insurance, to make employment decisions, or used in civil litigation, totally unrelated to the quality of health care received (such as child custody cases). Given the potentially serious repercussions of having incomplete or inaccurate medical records, patients should be able to at least supplement or amend their health information.

Yet, only a handful of states, including California, Maine, Maryland, Montana, New York, Texas, and Washington afford patients the right to amend or supplement medical records maintained by health care providers and facilities. Generally, these states have taken a consistent approach: If there is a right of access to health information held by a particular health care provider, there is also a right to amend that information.

3. Restrictions on Use and Disclosure of Health Information. There should be clear rules delineating the appropriate uses and disclosures of health information. Widespread demands for health information from parties both within and beyond the health care system and increasing reliance on computer-based information systems threaten to undermine the confidentiality of the physician-patient relationship. Statutorily imposing restrictions on the use and disclosure of health information is beneficial for both patients and health care providers. From the patient’s perspective, there will be no surprises. The statutory restrictions spell out to whom their health information can be shared and under what circumstances. From the provider’s perspective, a concrete set of rules often can function essentially as a shield: If the provider discloses health information in accordance with the rules, he will not be liable for an improper disclosure. Equally important, enforceable limits on disclosure can serve as the basis for refusing outside demands for health information.

While every state has some statutes restricting the use and disclosure of medical information, few states have taken a comprehensive approach. Rather, state statutes protecting the confidentiality of health information tend to be either condition specific or entity specific, leaving much information in the health care system uncovered.

One type of health privacy statute is common to virtually every state. States provide some protection to health data collected for public health purposes. All states require health care providers to report to state agencies certain types of patient health conditions, such as contagious or infectious diseases, HIV/AIDS, cancer, and congenital defects, and
typically place restrictions on the agency's use and disclosure of the reported information. The level of protection afforded by these statutes often varies with the type of health condition.76

Most states also have some type of statutory provider-patient privilege, which affords some limited protection of health information. The provider-patient privilege allows a patient to restrict her physician (and sometimes other health care providers) from disclosing in judicial and administrative proceedings health information received in confidence during treatment. Some experts believe that even this limited restriction has been seriously eroded in recent years.77 Moreover, there are a number of states that do not provide for the physician-patient privilege in statute and, because the privilege did not exist at common law, therefore do not recognize the privilege at all.78

Many states also have more general provisions that restrict the use and disclosure of health care information by specific health care providers. These statutes are often contained in licensing provisions, enacted at different times. As a result, coverage is piecemeal. For instance, Vermont imposes statutory restrictions on hospitals but not on physicians or other health care providers.79 Oklahoma statutorily limits the disclosures by dentists and chiropractors but not by physicians or hospitals.80 And West Virginia has statutory restrictions on pharmacists, but not on most of the other major categories of health care providers.81 Oregon has taken a singular approach and statutorily restricts the use and disclosure of health information by public health care providers in a fairly detailed fashion, while merely encouraging private health care providers to adopt similar guidelines.82 The result of this ad hoc approach is that in many states, there is no statutory guidance as to the proper use and disclosure of health information with respect to many of the major providers of health care.

It naturally follows that this discrepancy is also evident in doing comparisons between states. For instance, North Dakota statutorily restricts when and how hospitals may disclose health information, and South Dakota does not.83 Indiana statutorily regulates the use and disclosure of health information by a broad range of health care providers, but Ohio, its neighbor state, has no similar statutory protections.84

States also vary widely in terms of the restrictions or prohibitions they impose on disclosures of medical records and medical information. Some states have fairly perfunctory provisions that deem records confidential and provide little additional guidance.85 However, an increasing number of states have detailed provisions governing how health care providers may use and share identifiable health information.86 Many of these statutes have the same general framework. They allow health care providers to use and
disclose patient-identifying information without the patient's authorization for certain purposes such as treatment, payment, peer review, and research. The statutes then often impose conditions that must be met prior to disclosing health information under these circumstances. For uses and disclosures not specified in the statute, the patient's written authorization is required. Many statutes specify the particular elements that a valid authorization form must include, such as the patient's dated signature and the identification of the intended recipient of the information.

Although the general framework of these statutes may be the same, the details of the statutes can vary widely from state to state. Arizona, for example, statutorily provides that the recipient of health information from a health care provider may not further disclose the information unless it obtains the patient's authorization. In contrast, Montana and Washington have no such requirement. Virginia permits the release of health information pursuant to a subpoena only if the person seeking the records has adhered to detailed procedures intended to give the subject of the record notice that her records are being sought have been followed. But Connecticut permits the release of health information pursuant to a subpoena without any specific requirements. Florida permits the release of identifiable health information to researchers only with the permission of the patient. Rhode Island, in contrast, allows the disclosure of health information to qualified researchers without patient authorization so long as any resulting report does not identify the patient.

4. Notice of Information Practices. Under the principles of fair information practices, patients should be given notice, in plain language, of the information practices of those who generate and maintain their health information. The notice should inform patients how information will be used and to whom it will be disclosed. It should also advise patients of their right to see and amend (if applicable) their health information.

A notice of information practices can serve several important functions. In one sense, such notices serve a market function, enabling people to "make informed, meaningful choices about uses and disclosures of their health information." Furthermore, absent such notices, patients may be ignorant of the rights that they have with respect to their health information (such as their right to see and copy the information). Notices can also serve to bolster trust between health care providers and patients to the extent they remove the element of surprise about the use and disclosure of health information.

Although there seems to be little dispute that the principle of providing a notice of information practice is a sound one, only a few states require health care providers to furnish such notices to their
patients. Even Maryland's Confidentiality of Medical Records Act, which provides broad access and amendment rights, does not include such a requirement.

5. Security Safeguards. Health care providers should have in place appropriate safeguards to protect health information from unauthorized use or disclosure. These safeguards identify the means by which a provider protects the confidentiality of health information, and may include such procedures as requiring individuals to provide identification prior to furnishing access to health information. A few states such as California, Florida, and Washington have statutorily required providers to undertake security measures to ensure that health information is used and disclosed properly. Florida, for example, requires those who maintain medical records to develop and implement policies, standards, and procedures to protect the confidentiality and security of the medical record, and to train their employees in these policies, standards, and procedures.

6. Accountability. To be truly effective, health privacy statutes must be supported by strong remedies and penalties for violations. States have instituted a wide range of mechanisms for holding health care providers accountable for violations of state health privacy statutes. With respect to wrongful refusals to give patients access to their health information, some state statutes expressly grant patients the right to bring suits for equitable relief, often making the provider liable for any attorney fees resulting from the need to file suit. Other states, such as Louisiana, presume such a right to sue exists, and statutorily limit the recovery of the aggrieved patient to attorney fees and expenses incurred. Several states have no statutory remedies for violations of their statutory access provisions.

There is an even wider range in the remedies and penalties available for disclosures of health information in violation of state health privacy laws. South Carolina, for example, has no statutory remedy for disclosures in violation of its Physicians' Patient Records Act. At the other end of the continuum, Rhode Island statutorily provides that a person who violates its Confidentiality of Health Care Communications and Information Act may be liable for actual and punitive damages. If the violation is knowing or intentional, the person may be subject to criminal penalties including fine and imprisonment. Many states have statutory remedies that are somewhere in the mid-range, allowing actions for damages, but not providing for punitive awards.

7. Towards a More Uniform Approach. By incorporating only isolated elements of the fair information principles into their statutes, most states have failed to accomplish any uniformity. There are a few exceptions. For
example, through the enactment of various statutes over a period of time, California has crafted some of the most consumer-protective health privacy laws in the nation. Through the Information Practices Act, the Patient Access to Medical Records Act, the Confidentiality of Medical Information Act, and the Insurance Information and Privacy Protection Act, California affords patients access rights to most of the major holders of health care information. The state not only restricts disclosures by health care providers and HMOs to employers, but also directly regulates the use and disclosure of health information by employers. Moreover, individuals have the right to sue to enforce their rights under these statutes. As recently as 1999, California amended its law to broaden the category of record holders covered by its Confidentiality of Medical Records Act and to increase the penalties for violating that Act. Yet, even California law is lacking in two major areas. There is no requirement that health care providers furnish a notice of information practices and policies to patients. The result of this lack of notice is that many individuals may be unaware of their rights with respect to their health information. Additionally, the statutory right of access to health information is not sufficiently broad. It does not cover pharmacists, a group that maintains a vast amount of health information. Neither does it cover acupuncturists and other alternative health care providers, to whom patients are increasing turning for health care.

Although most recent state legislation continues to be undertaken in a piecemeal fashion, a few states, such as Maine and Hawaii, enacted more comprehensive statutes regulating the privacy of health information. In the late 1990s, Maine substantially revised its health privacy laws by providing patients the right to amend their medical records and enacting comprehensive provisions governing the use and disclosure of health information by a wide range of health care practitioners (including doctors, pharmacists, and others) and health care facilities. The statute incorporates the main fair information practice principles. Maine statutorily provides patients the right to see, copy, and amend health information. The statute generally prohibits disclosure of health information without the patient’s authorization and then lists the circumstances under which no such authorization is required. Using health information for marketing purposes is prohibited unless the patient’s authorization has been obtained. At certain times, patients are entitled to a notice of information practices. Additionally, Maine’s statute requires health care providers to implement policies to ensure information is not negligently, inappropriately, or unlawfully disclosed. In order to hold health care providers accountable, the statute provides that the state
YALE JOURNAL OF HEALTH POLICY, LAW, AND ETHICS

attorney general may enforce it. The statute also expressly grants patients a private right of action for intentional disclosures and explicitly leaves in place any common law remedies that may be applicable, including actions based on negligence.

Hawaii enacted a truly comprehensive health privacy law in 1999, with the intention of addressing the threats to health care information in the modern health care environment. The Privacy of Health Care Information Act applied to all major holders of health information including health care providers, health plans, employers, health data organizations, and educational institutions. Broadly defining health information, it protected identifying information that relates to a person's physical or mental condition, including tissue and genetic information. Individuals had the right to see, copy, and amend their health information. The Act imposed restrictions on the use and disclosure of health information, allowing it to be used freely for certain core purposes such as treatment and payment, so long as the patient had been given notice of its potential use. For other uses and disclosures, the Act required the individual's written authorization. There were, of course, major exceptions in which health information could be disclosed without the individual's authorization, such as for public health purposes and to health oversight agencies. In order to enforce the Act, individuals had the right to sue violators and could collect actual and punitive damages. The Act also provided for civil and, in certain circumstances, criminal penalties. In short, Hawaii had the most comprehensive health information privacy statute in the nation. It applied all of the fair information practice principles to all of the major holders and users of health information in the state.

II. THE FEDERAL HEALTH PRIVACY RULE UNDER HIPAA

The role of states as the predominant regulators of the privacy of health information may have changed dramatically with the recent issuance of federal regulations governing the use and disclosure of health information by the U.S. Department of Health and Human Services (HHS). The rule constitutes the first broad-ranging federal health privacy law, and effectively injects the federal government into an arena that had previously been primarily occupied by the states. Since the rule does not preempt stronger state law, however, state laws should still play an important role in protecting health information.
HEALTH PRIVACY LAWS

A. Background

HHS promulgated the Federal Privacy Rule under authority granted it in the “Administrative Simplification” provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In enacting these provisions, Congress primarily sought to encourage the use of electronic technology in the health care industry as a means of improving efficiency and reducing costs. Recognizing the privacy concerns arising from an electronic health information system, Congress also required new safeguards to protect the security and confidentiality of that information. HIPAA specified that if Congress failed to pass comprehensive health privacy legislation by August 1999, HHS must promulgate such privacy protections by regulation. Congress missed the deadline for enacting legislation.

As required under HIPAA, the Secretary of HHS issued final health privacy regulations in December 2000. After a short delay, the final regulation, known as the “Privacy Rule,” became effective April 14, 2001, and compliance is generally required by April 2003.

B. General Requirements of the Federal Health Privacy Rule

The Federal Health Privacy Rule covers a core group of entities that use and share information in the health care system including: health plans, health care clearinghouses, and health care providers who transmit health information in electronic form in connection with certain financial and administrative transactions. The rule incorporates many of the basic fair information practices into the health care setting.

1. Patients’ Access. The Federal Rule gives individuals the right to see and copy their own health information that is maintained by most health care providers. The procedures for initiating and responding to requests for access to health information are specified in detail, giving clear guidance as to what is expected. The Rule sets out specific limitations on when a provider may deny a patient access to her medical records (such as when the requested access is reasonably likely to endanger the life or physical safety of the individual or another). These standards for denial are more concrete than the common law approach of granting access to information that is “in the best interest of the patient.”

2. Patients’ Right to Amend Health Information. The Federal Rule also grants patients the right to request that their health information be amended. Patients do not have the right to delete information from their records, but can request that information be added to an incomplete or erroneous record. There are detailed requirements for requesting an
amendment and responding either affirmatively or negatively to such a request, including provisions designed to ensure that those who need accurate health information are informed of any changes. Even if the provider determines to deny the request to amend, the patient still has the opportunity to submit a brief statement of disagreement into his or her record, which must be provided along with future disclosures of the underlying disputed information.

3. Restrictions on Use and Disclosure. The Federal Health Privacy Rule imposes restrictions on how providers may use and disclose health information. Perhaps most notable from a provider's perspective is the requirement that providers obtain a patient's written permission (i.e., "consent") prior to using or sharing that patient's health information for treatment, payment, or health care operations. To disclose health information for other purposes, a provider must have an "authorization," a more detailed written permission, specifying, among other things, to whom the information may be released, the type of information to be disclosed, and a date or event upon which the authorization expires. Like most state disclosure laws, the Federal Rule lists a number of exceptions under which health information can be disclosed without the individual's written permission, such as for law enforcement and research purposes. Under many of these exceptions, specific conditions must be met prior to disclosing health information.

4. Notice of Privacy Practices. In order to ensure that patients are informed of their rights with respect to their health information and are aware of how their health information may be used and disclosed, the Federal Health Privacy Rule requires health care providers to furnish to patients a notice of their privacy practices. Such a notice must describe the rights that patients have with respect to their health information, including their rights to see, copy, and amend their own records. Additionally, the notice must inform patients of the anticipated uses and disclosures of their health information that may be made without the patient's consent or authorization.

5. Security. The Federal Privacy Rule requires providers to have appropriate administrative, technical, and physical safeguards in place to protect the privacy of health information, and to reasonably safeguard such information from intentional or unintentional use or disclosure. HHS has also issued a separate set of proposed security regulations specifically designed to address security issues surrounding the electronic transmission of health information, which should become final in the near future.

6. Accountability. HIPAA establishes civil and criminal penalties for
violations of the Privacy Rule.\textsuperscript{151} There is a $100 civil penalty up to a maximum of $25,000 per year for each standard violated. Criminal penalties may be imposed for knowing wrongful disclosures of health information. Criminal penalties are graduated, escalating to a maximum of $250,000 for particularly egregious offenses. HHS, which has authority to enforce the Privacy Rule,\textsuperscript{152} has expressed an intention to stress cooperation over enforcement.\textsuperscript{155}

HIPAA does not create a federal private right of action based on violations of the Privacy Rule, giving enforcement responsibility solely to HHS.\textsuperscript{154} However, there is at least the potential that individuals may be able to enforce the Privacy Rule though state causes of action. To the extent the new federal rule may be seen as creating a new duty of care with respect to health information, violations of the rule possibly may serve as the grounds for state tort actions.

C. The Interaction Between the Federal Health Privacy Rule and State Law

HIPAA employs an issue preemption scheme with respect to state health privacy laws.\textsuperscript{155} State laws that are contrary to the federal regulation and that are less protective are preempted.\textsuperscript{156} Existing or future state laws related to the privacy of health information that are “more stringent” than the federal rule will remain in effect, even if they are contrary to the federal regulation.\textsuperscript{157}

Generally, a state law is “more stringent” when it provides greater privacy protection for the individual who is the subject of the information.\textsuperscript{158} With respect to uses and disclosures, a state law is more stringent if it prohibits or restricts a use or disclosure that would be permitted under the federal regulation.\textsuperscript{159} As for laws that govern patient access, a state law is “more stringent” when it provides patients with greater access to their own health information.\textsuperscript{160} Thus, the federal privacy regulations establish a “floor” for protecting the privacy of health information, leaving the states free to impose privacy protections on health information that are similar to or more stringent than the federal privacy regulations.

D. Gaps and Weaknesses of the Federal Health Privacy Rule

As lengthy and detailed as it is, the Federal Health Privacy Rule is not truly comprehensive. The regulation is limited in scope, leaving gaps in the protections of health information as it flows through the health care system. Furthermore, some of its provisions are weak and do not provide adequate protection of health information. This section addresses some of
Due to HIPAA’s limited delegation of authority, the Federal Health Privacy Rule only covers a limited group of persons and organizations that hold health information: health plans, health care clearinghouses, and health care providers who transmit health information in electronic form in connection with HIPAA standard transactions. This limited applicability leaves a broad range of entities that maintain health information unregulated by the federal rule. First, health care providers who do not engage in electronic standard transactions (e.g., those who rely solely on paper claims) are not covered by the regulations. Second, the Privacy Rule does not directly regulate some major entities that are responsible for generating and maintaining health information, such as employers and life insurers. Furthermore, the Privacy Rule is not directly applicable to many of those who receive health information from covered health care providers. Thus, the Federal Health Privacy Rule is sporadic in coverage, leaving unprotected many areas where health information routinely flows.

Additionally, the Federal Health Privacy Rule is not fully enforceable. There is no federal private right of action. Any individual whose rights under the law have been violated should be permitted to bring an action for actual damages and equitable relief. As HHS, itself has stated: “Only if we put the force of law behind our rhetoric can we expect people to have confidence that their health information is protected, and ensure that those holding health information will take their responsibilities seriously.”

Furthermore, the office charged with enforcing the Privacy Rule traditionally has limited resources, and has indicated that it intends to use a “triage” approach to complaints, focusing on violations that have a wide impact. Although this makes perfect sense from an administrative point of view, it offers little solace to an individual who suffers from an isolated violation (e.g., a patient whose doctor will not furnish a copy of her medical record).

One of the most criticized aspects of the Federal Health Privacy Rule, is its lax restrictions on the use and disclosure of health information for marketing activities. The regulation allows a provider to use a patient’s health information for marketing activities without obtaining the patient’s informed consent. A patient only has the opportunity to opt out of such uses after he has received the initial marketing materials.

Additionally, the Federal Rule has only minimal protections with respect to disclosing health information to law enforcement personnel. The rule permits health information to be disclosed to law enforcement
officials under three types of legal process, two of which do not require any independent judicial review.\textsuperscript{170}

III. STATE ACTIVITY IN THE POST-HIPAA ERA

The promulgation of the Federal Health Privacy Rule will certainly affect some state health privacy laws. As a practical matter, states will need to review their statutes relating to health privacy to determine what impact the Federal Rule has on state law.

The Federal Rule preempts weaker, conflicting state law. In states that have weak or few state laws, the Federal Rule will provide the predominant protection of health privacy information. But states that already have, or are willing to enact, strong health privacy laws will maintain a large role in protecting the health information of their citizens.

The issuance of the federal privacy regulations already has caused some states to reevaluate their efforts to protect health privacy at the state level. It is too early to discern any definitive trends in state law post-HIPAA. One state has used the promulgation of the Federal Health Privacy Rule as justification for reducing protections at the state level. However, other states have demonstrated their intent to maintain and increase strong state laws.

At one extreme is Hawaii, which prior to the promulgation of the federal health privacy regulations had one of the most comprehensive, consumer-protective health privacy laws in the nation.\textsuperscript{171} In July 2001, Hawaii repealed its state health privacy statute, finding that there was "little support for a Hawaii Medical Privacy Law in light of the adoption of federal rules and regulations on medical privacy by the United States Department of Health and Human Services."\textsuperscript{172}

The state has essentially reverted to a statutory scheme that has no generally applicable restrictions on the use and disclosure of health information. State statutory access rights are now limited to a few specified health care providers, and there is no statutory right to amend health information.\textsuperscript{173}

Although the Federal Health Privacy Rule does establish a minimum floor of protection, Hawaii's reliance on the federal rule in lieu of a comprehensive state law is misplaced. Taken together, the federal and state laws provide at best intermittent coverage. Many of the major entities that use and maintain health information, such as employers and other secondary recipients (who would have been regulated under Hawaii's comprehensive law) are now unregulated at both the federal and state level. Furthermore, patients have no remedy for violations of the Federal
Health Rule, other than filing a complaint with HHS. Thus, Hawaii’s repealing its state law in reliance on the Federal Privacy Rule has the net effect of weakening health privacy protections in the state.

In contrast to Hawaii, other states have demonstrated a more privacy protective policy following the issuance of the Federal Privacy Rule. Some have reaffirmed their existing health privacy laws, while others have acted to fill gaps and strengthen the weaknesses evident in the federal privacy rule.

For example, at the time the federal privacy rule was issued, Maine had a fairly comprehensive health privacy statute. Some of the protections afforded by Maine’s privacy statute exceed those contained in the Federal Privacy Rule. However, the state statute contained a sunset provision under which the privacy statute was scheduled to expire in March 2002. After the issuance of the Federal Privacy Rule, Maine repealed the sunset provision of its privacy statute, thereby allowing the state statute to co-exist with the Federal Rule indefinitely. As a result, the citizens of Maine will enjoy the floor protections afforded by the Federal Privacy Rule and enhanced protections under state law.

Florida achieved a similar result by amending its health privacy statute to strengthen some of the perceived weaknesses of the federal health privacy regulation. In particular, Florida enacted legislation that prohibits disclosing health information for marketing purposes without the patient’s written consent or authorization that would specifically permit this activity. Thus, the state law affords higher protections than the Federal Rule. Moreover, the state attorney general can enforce the state law by obtaining injunctive relief or fines up to $5,000 per violation. As a result, Florida citizens will be afforded more stringent protections against marketing that can be enforced locally.

Texas’ response to the Federal Health Privacy rule is diametrically opposed to that of Hawaii. While maintaining its existing health privacy protections, Texas recently adopted a broad health privacy statute that both mirrors and expands upon the Federal Health Privacy Rule. The Texas statute applies to a broader range of persons and entities that obtain or maintain health information than the Federal Rule. For instance, it directly regulates the recipients of health care information as well as all health care providers (not just those engaged in electronic transactions). The state statute requires these entities to comply with the Federal Health Privacy Rule, essentially enabling the state to enforce the federal standards. Disapproving of the Federal Rule’s approach towards marketing, Texas requires a provider to obtain a patient’s consent or authorization specifically for marketing purposes. Additionally, the Texas statute
provides for civil penalties, disciplinary action by the respective licensing boards, and potential exclusion from state programs for violations of the state standards.\(^2\) Notably, the statute preserves any right of a person under other law to bring a cause of action or otherwise seek relief with respect to violations.\(^3\) Thus, Texas has both mirrored and improved upon the protections afforded in the Federal Health Privacy Rule.

IV. RECOMMENDATIONS FOR STATE ACTION

States have traditionally been the primary regulators of health care information. While the promulgation of the Federal Health Privacy Rule changes the regulatory landscape, it need not supplant the importance of state health privacy laws. In fact, states have often become more active after the enactment of federal privacy laws, enacting statutes that either mirror or build upon the federal protections. This approach, endorsed by the Privacy Protection Study Commission in the 1970s, ensures that the states will be able to enforce the law and protect their citizens.\(^4\) Because the Federal Health Privacy Rule does not preempt current or future stronger state health privacy laws, the states have ample opportunity to fill the gaps and strengthen the weaknesses of the federal regulation.

States therefore should not rely solely on the Federal Health Privacy Rule to protect the privacy rights of their citizens. Rather, states should take advantage of the need to evaluate their health privacy laws in light of the Federal Health Privacy Rule and take appropriate action.

States with little statutory protection of health information in place may want to use Federal Health Privacy Rule as a roadmap for enacting comprehensive state health privacy laws. At a bare minimum, states can mirror the federal protections, thereby allowing enforcement to occur at the state level. However, to afford truly comprehensive protection, states should directly regulate not only the entities governed by the Federal Health Privacy Rule, but also the other major generators and holders of health information (such as employers and life insurers). Additionally, states should directly regulate the recipients of health information from these core record keepers. Furthermore, states should strengthen some of the weak provisions of the Federal Health Privacy Rule, such as the use of health information for marketing purposes.

States with fairly well developed health privacy rules should also re-evaluate their laws in light of the Federal Health Privacy Rule. Some state and federal rules may accomplish the same goals through slightly different requirements (e.g., different content requirements for a notice advising the patient of information practices). In this situation, a state may want to harmonize its provisions with the Federal Rule in order to avoid confusion.
and to afford some degree of uniformity between states. States should also use this as an opportunity to fill in gaps in state law that may exist (such as having statutory access rights to hospital records but not doctor's records).

**SUMMARY**

Although the Federal Health Privacy Rule has evened out some of the inconsistencies between states' health privacy laws, gaps in protection still remain. Furthermore, the Federal Rule contains some lax standards for the disclosure of health information. State laws can play a vital role in filling these gaps and strengthening the protections afforded health information.

By enacting legislation that has higher privacy-protective standards than the Federal Health Privacy Rule, states can play three important roles. First, because they can directly regulate entities that are beyond HHS's mandate, states can afford their citizens a broader degree of privacy protection than the Federal Health Privacy Rule. Second, by having state health privacy laws, states can enforce privacy protections at the local level. Finally, action by the states can positively influence health privacy policies at the federal level by raising the standard as to what constitutes sufficient privacy protection. High privacy protections imposed by states may serve as the standard for comprehensive federal legislation, if and when Congress reconsiders the issue.

So far, states' reactions to the Federal Privacy Rule have been mixed. Only time will tell whether states will assume the mantle of leadership on health privacy or relinquish their role as the primary protectors of health information.
## APPENDIX

### State Statutes Providing Patients the Right of Access to, and Right to Amend, Their Health Records (as of November 2001)

<table>
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<th>State</th>
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1. This chart does not address access to mental health records. State statutes that grant access to medical records only through an attorney are treated as not granting a patient access since obtaining an attorney may impose a formidable barrier for some patients.

2. Release to patient only in contemplation of a legal proceeding.

3. The West Virginia access statute appears to apply to hospitals. The statute covers "health care providers," a term that is not defined in the statute. See W. VA CODE §§ 16-29-1 and 16-29-2 (2001). However, other parts of the West Virginia Code define the term "health care provider" as including hospitals. See W. VA CODE §§ 16-2D-2(k) and 16-29B-3 (2001).
References

1. See discussion infra Part III regarding the recent issuance of federal health privacy standards by the United States Department of Health and Human Services.


3. Id.

4. See American Medical Association, Current Opinions of the Council on Ethical and Judicial Affairs, Ethical Opinion E10.02: Patient Responsibilities (June 2001), http://www.amaassn.org/ama/pub/article/4801-4412.html (stating that successful medical care requires an ongoing collaborative effort between patients and physicians, and that for their part “[p]atients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to present health”).

5. PRIVACY COMMISSION REPORT, supra note 2, at 282 (quoting testimony of the Executive Director of the American Medical Record Association).


7. Smith v. Driscoll, 162 P. 572 (Wash. 1917) appears to be one of the premier cases addressing the issue of whether there is a cause of action against a physician for wrongfully divulging confidential communications. See also Biddle v. Warren Gen. Hosp., 715 N.E.2d 518, 523 (Oh. 1999) (holding that an independent tort exists for the unauthorized disclosure to a third party of medical information that a physician or hospital has learned within the physician-patient relationship).

8. See Quarles v. Sutherland, 389 S.W.2d 249, 251 (Tenn. 1965) (holding that a physician obtained by the opposing party has no duty of medical confidentiality to the individual he examined).

9. See Fox News and Opinion Dynamics Poll, Online Privacy, (June 2000), at http://pollingreport.com/computer.htm (reporting that 69% of American adults were very concerned about their ability to keep personal information, such as medical or financial records, confidential. Another 17% of adults were somewhat concerned with confidentiality of these records.).


12. PRIVACY COMMISSION REPORT, supra note 2, at 288-89.

13. See discussion infra Part III regarding the recent issuance of federal health privacy standards by the United Department of Health and Human Services.

14. Francoise Gilbert, Privacy of Medical

15. People have not relied upon state constitutions as the basis for a patient’s right of access to his or her own medical records.


20. See, e.g., Stone v. City of Stow, 593 N.E.2d 294 (Ohio 1992) (finding that individuals’ interests in pharmaceutical records under Ohio and federal constitutions were outweighed by the state’s interest in reviewing records). See generally Gostin, supra note 19, at 498 (discussing difficulties in prevailing on claims based on violation of a constitutional right to privacy).


22. See Hill v. National Collegiate Athletic Ass’n, 865 P.2d 683, 644 (Cal. 1994) (holding that the California constitution protects against invasions of privacy by private citizens as well as by the state); Hawaii Op. Atty. Gen. 94-01 (1994) (“The constitutional history of this section indicates that the provision was added . . . to protect against possible abuses in the use of highly personal and intimate information in the hands of the government or private parties.”); see also Nakano v. Matayoshi, 706 P.2d 814, 818 (Haw. 1985) (citing the opinion of the attorney general in dictum).

23. Jeffrey H. v. Imai, 101 Cal. Rptr. 2d 916, 921 (Cal. Ct. App. 2000) (stating that disclosure of a medical condition concerned ‘the core value’ protected by California Constitution, article I, section 1, informational privacy); Hill, 865 P.2d at 658 (stating that “[a] person’s medical profile is an area of privacy infinitely more intimate, more personal in quality and nature than many areas already judicially recognized and protected.”) (quoting Board of Med. Quality Assurance v. Gherardini, 156 Cal. Rptr. 55 (Cal. Ct. App. 1979)); Painting Indus. of Hawaii Market Recovery Fund v. Alm, 746 P.2d 79, 82 (Haw. 1987) (holding that the state constitutional right to privacy extends only to highly personal and intimate information such as medical, financial, educational, or employment records).

24. Compare Jeffrey H., 101 Cal. Rptr. 2d 916 (right of privacy in California constitution protects against inappropriate disclosures of private information by private parties), with Chizmar, 896 P.2d at 206 (rejecting constitutional invasion of privacy claim against private physician who disclosed HIV test results without authorization of patient on ground that

https://digitalcommons.law.yale.edu/yjhple/vol2/iss2/6
Alaska constitution protects only against governmental action).


26. Ozer v. Borquez, 940 P.2d 371, 377 (Colo. 1997). There are four causes of action encompassed by the invasion of privacy tort: (1) intrusion upon seclusion, (2) appropriation of likeness, (3) public disclosure of private facts, and (4) false-light publicity. Hill, 865 P.2d at 647 (citing William Prosser, Privacy, 48 CAL. L. REV. 381, 389 (1960)). Causes of action based on the alleged wrongful disclosure of health information are usually brought under the category that addresses the public disclosure of private facts.

27. See Ozer, 940 P.2d 371 (deciding on a case of first impression to recognize tort); Lake v. Wal-Mart Stores Inc., 582 N.W.2d 231, 234 (Minn. 1998) (same).


29. See Doe v. Methodist Hosp., 690 N.E.2d 681 (Ind. 1997) (concluding with two justices declining to recognize that the public disclosure of private facts may form the basis of a civil action, and three justices concurring in result but disagreeing with legal conclusion that Indiana does not recognize such a tort).

30. See Hougum v. Valley Mem'l Homes, 574 N.W.2d 812 (N.D. 1998) (stating that the court has not yet decided whether a tort action exists in North Dakota for invasion of privacy). Wyoming does not appear to have any reported cases addressing the issue.


33. Id. (stating that a woman's election to have an abortion was a private fact). See also Y.G. v. Jewish Hosp., 795 S.W.2d 488 (Mo. Ct. App. 1990) (finding that the decision to undergo in vitro fertilization was private).

34. In Mills, 536 N.W.2d 824, for example, a television station defended itself in an invasion of privacy action by asserting that a reasonable person would not be embarrassed by the publication of the fact that they were undergoing in vitro fertilization treatment.

35. Compare Brown v. Mullarkey, 632 S.W.2d 507, 509-10 (Mo. Ct. App. 1982) (holding that no public disclosure occurred when information in a personnel file was disclosed to one or two others on the basis that it was not communication to the public in general or to a large number of persons), with McSurely v. McClellan, 755 F.2d 88, 112-13 (D.C. Cir. 1985), cert. denied, 474 U.S. 1005 (1985) (finding that disclosure of information to a limited number of people when a special relationship exists is sufficient to state an invasion of privacy claim under Kentucky law).


37. See id. at 524 (recognizing the independent tort for the unauthorized,
unprivileged disclosure to a third party of nonpublic medical information that a physician or hospital has learned within a physician-patient relationship). In addition to Ohio, jurisdictions cited as adopting a similar cause of action are: Pennsylvania, West Virginia, Texas, New Jersey, Massachusetts, New York, the District of Columbia, Oregon, Alabama, Utah, and Nebraska. Id. at 523-24.

38. Id. at 524; Morris v. Consolidated Coal Co., 446 S.E.2d 648 (W. Va. 1994) (stating that a physician's ex parte disclosure to employer of health information of employee was actionable, but would not have been had it taken place in accordance with workers' compensation requirements).

39. See, e.g., Emmett v. Eastern Dispensary and Casualty Hosp., 396 F.2d 931, 935 (D.C. Cir. 1967) (holding that a patient or her personal representative has a right of access to her hospital records); Ruffin v. Strange, 434 So. 2d 1200, 1202 (La. Ct. App. 1983) (holding that a physician's failure to furnish a medical record to a patient or her personal doctor was actionable at common law); Striegel v. Tofano, 399 N.Y.S.2d 584 (N.Y. App. Div. 1977) (finding that a patient has a right of access to dental records); Wallace v. University Hosp. of Cleveland, 164 N.E.2d 917, 918 (Oh. Ct. Common Pleas 1959), modified and aff'd, 170 N.E.2d 261 (Oh. Ct. App. 1960) (stating that a patient or her authorized representative has a right to inspect her hospital records); Hutchins v. Texas Rehab. Comm'n, 544 S.W.2d 802 (Tex. Civ. App. 1976) (noting that the patient has a common law right to inspect her medical records).

40. Striegel, 399 N.Y.S.2d 584 (finding that although a doctor or dentist has primary custodial rights to the treatment record, a patient has a property right sufficient to afford reasonable access rights to those records); accord In re Gerkin, 434 N.Y.S.2d 607, 608 (N.Y. Sup. Ct. 1980) (holding that a patient has property rights in her medical records that can be exercised by her surviving spouse). See also Wallace, 164 N.E.2d 917 (finding that a patient has a property right in his hospital records and that he, or an authorized representative, has a right to inspect these records).

41. Emmett, 396 F.2d at 935 (stating that the hospital has a fiduciary duty to reveal to the patient or her personal representative information that is in her best interest to know, including what is in the medical record); Cannell v. Medical & Surgical Clinic, 315 N.E.2d 278, 280 (Ill. App. Ct. 1974) (finding that the fiduciary qualities of the physician-patient relationship require disclosure of medical data to the patient or her agent at the patient's request).

42. The concept of Fair Information Practice principles was first formulated in U.S. DEP’T OF HEALTH EDUC. & WELFARE, RECORDS, COMPUTERS AND THE RIGHTS OF CITIZENS: REPORT OF THE SECRETARY'S ADVISORY COMMITTEE ON AUTOMATED PERSONAL DATA SYSTEMS, at xx-xxiii (1973). These standards have formed the basis for subsequent codes and laws related to information collection, such as the Privacy Act of 1974 and the Video Privacy Protection Act.

43. See HEALTH PRIVACY WORKING GROUP, BEST PRINCIPLES FOR HEALTH PRIVACY (1999), http://www.healthprivacy.org/usr_doc/33807%2Epdf. The Health Privacy Working Group, an initiative of the Health Privacy Project of Georgetown University's Institute for Health Care Research and Policy, was comprised of a
group of diverse stakeholders in the health care system who were able to reach some consensus about the general principles that should be applied to protecting the privacy of health information. See also PRIVACY COMMISSION REPORT, supra note 2, at 277-318 (setting forth some of these same principles). Although both of these reports include additional, more detailed principles, this paper focuses only on these six general concepts.

44. The Uniform Health Care Information Act of 1985 [hereinafter Uniform Health Care Act], drafted by the National Conference of Commissioners on Uniform State Law, incorporated the fair information principles contained in the Privacy Commission Report. See Prefatory Note to the Uniform Health Care Information Act of 1985, http://www.nccusl.org/nccusl/pubndrafts.asp. The Uniform Act was only adopted by two states, Montana and Washington. Wyoming also appears to have adopted the Uniform Act, but has restricted its applicability to hospitals. Compare Wyo. STAT. ANN §§ 35-2-605 to 35-2-617 (Michie 2001), with the Uniform Health Care Act.


46. JOHNSON & WOLFE, supra note 11, at 22; PRIVACY COMMISSION REPORT, supra note 2, at 289.

47. JOHNSON & WOLFE, supra note 11, at 1-2. See also Hayley Rosenman, Note, Patients' Rights to Access Their Medical Records: An Argument for Uniform Recognition of a Right of Access in the United States and Australia, 21 FORDHAM INT'L L.J. 1500, 1540-41 (discussing broad policy considerations in favor of a right of access).

48. PRIVACY COMMISSION REPORT, supra note 2, at 295.

49. See Chart in Appendix of this Article. (Nearly every state permits patients some limited access to their mental health records. This chart does not encompass this type of record.) All states with access statutes permit providers to deny a patient access to her medical records if the provider believes harm will result. Seven states impose additional restrictions on the right of access to physician or hospital records. See ARK. CODE ANN. § 16-46-106 (Michie 2001) (statute provides for release only in contemplation of legal proceeding); ME. REV. STAT. ANN. tit. 22, § 1711 (West 2000) (providing right of access to hospital records only after discharge); MISS. CODE ANN. § 41-9-65 (2001) (patient must demonstrate good cause to obtain hospital records); N.M. STAT. ANN. § 14-6-3 (Michie 2001) (statutory access provided to applicants for disability benefits); OR. REV. STAT. § 192.525 (1999) (state health care providers are required to give access to records, but private health care providers are only urged to adopt voluntary guidelines); S.D. CODIFIED LAWS § 34-12-15 (Michie 2001) (health care providers and hospitals have option of providing only a summary instead of full record). Although Maine gives health care providers the option of providing a narrative, the statute requires that the narrative contain all relevant information. ME. REV. STAT. ANN. tit. 22, § 1711-B (West 2000).


51. Compare 735 ILL COMP. STAT. 5/8-2003 (providing access to physician records), 5/8-2001 (2001) (providing access to hospital records), with MINN.
STAT. § 144.335 (2000) and chapters cited therein (providing access to records held by a broad range of health care practitioners and health care facilities).

52. See NEB. REV. STAT. §§ 71-8401 to 8407 (2001). The legislature recognized that “[p]atients need access to their own medical records as a matter of fairness to enable them to make informed decisions about their health care and correct inaccurate or incomplete information about themselves.” Ironically, it did not include any such right to amend in the statute, leaving a substantial gap in patients’ rights under state law.


54. These states do, however, provide a limited right of access to certain mental health records. See IOWA CODE § 229.25 (2001) (requiring the release of mental health records upon request to the attorney or advocate of a hospitalized mental health patient who has a waiver signed by patient); KAN. STAT. ANN. §§ 65-5602, 65-5603 (2000) (mental health treatment facilities generally may not claim “privilege” and refuse to furnish treatment information to patient unless the head of the facility has made a written determination that disclosing records would be injurious to patient); VT. STAT. ANN. tit. 18, § 7103 (2001) (clinical information related to commitment proceedings may be released pursuant to written consent of the patient, presumably including to patient, herself, or patient’s attorney).

55. See Appendix of this Article.


57. See Jannet M. Carmichael & Janice A. Cichowlas, The Changing Role of Pharmacy Practice—A Clinical Perspective, 10 ANN. HEALTH L. 179 (2001) (explaining the changing role of pharmacists). It should be noted that the National Conference of Commissioner’s on Uniform State Laws has proposed to revise the Uniform Health Care Information Act to include pharmacists as health care providers.


59. See, e.g., 1990 Alaska Sess. Laws 6 § 10 adding acupuncturists to the “health care providers” from whom patients have the right to obtain a copy of their health care records, codified at ALASKA STAT. § 18.23.070 (Michie 2001) (defining “health care provider” for purposes of access provisions in § 18.23.005.)

60. The states that clearly grant patients access to medical records maintained by acupuncturists include: Alaska, Arizona, Colorado, Florida, Georgia, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, Washington, and Wisconsin. See ALASKA STAT. §§ 18.23.005 (Michie 2001) (access provision), 18.23.070 (defining health care provider as including licensed acupuncturists); ARIZ. REV. STAT. §§ 12-2293 (2000) (access provision), 12-2291 (health care provider defined as person licensed under title 32), 32-3921 (acupuncturists license requirement); COLO. REV. STAT. § 25-1-802 (2001) (acupuncturists included as health care providers who must furnish access); FLA. STAT. ANN. §§ 456.057 (West 2000) (licensed practitioners must furnish
HEALTH PRIVACY LAWS

access), 457.105 (requiring acupuncturists to be licensed); GA. CODE ANN. §§ 31-32-1 (2000) (defining provider as including any person licensed under title 43, chap. 34), 31-32-2 (health care providers must furnish access), 43-34-64 (license requirement for acupuncturists); ME. REV. STAT. ANN., tit. 22, §§ 1711-B (West 2000) (requiring health care practitioners to give access), 1711-C (defining health care practitioners as those licensed to practice health care), tit. 32 §§ 12511-12513 (requiring acupuncturists to be licensed); MASS. GEN. LAWS ch. 112, §§ 12CC (2001) (requiring persons providing medical care to provide access), 148 (defining acupuncture as the practice of medicine based on Oriental theories), 151 (license requirement for acupuncturists); MINN. STAT. §§ 144.335 (2000) (requiring health care providers to furnish access and defining providers as including persons who are licensed under chap. 147B), 147B.02 (requiring license for practice of acupuncture); MO. REV. STAT. §§ 191.227 (2000) (duly licensed practitioner must furnish patient access to medical records), 324.487 (license requirement for acupuncturists); MONT. CODE ANN. §§ 37-13-103 (2001) (defining acupuncture), 37-13-301 (requiring license for practice of acupuncture), 50-16-541 (health care providers required to provide access to records), 50-16-504 (defining health care provider as those licensed to provide health care); NEB. REV. STAT. §§ 71-1,346 (2001) (acupuncturists must be licensed to practice), 71-8402 (provider means any licensed practitioner), 71-8403 (health care provider must furnish access); NEV. REV. STAT. §§ 629.031 (2001) (“health care provider” includes doctor of any Oriental medicine), 629.061 (health care provider must furnish records upon request); N.H. REV. STAT. ANN. §§ 328-G:1 (2000) (recognizing acupuncture as a distinct health care profession), 328-G:9 (license requirement for acupuncturists), 322-I:1 (requiring health care providers to give access and defining provider as any person licensed to provide health care); WASH. REV. CODE §§ 18.06.010 (2001) (defining acupuncture as a health care service based on Oriental medicine), 18.06.020 (license requirement for acupuncturists), 70.02.010 (defining health care provider as including any person licensed to provide health care), 70.02.080 (requiring health care providers to furnish access); WIS. STAT. ANN. §§ 146.81 (West 2000) (defining health care provider as including licensed acupuncturists), 146.83 (requiring health care providers to provide access to records).

61. See, e.g., NEV. REV. STAT. §§ 629.031 (2001) (defining “provider of health care” as including those licensed under Chapter 630A), 629.061 (requiring “providers of health care” to give patients access to their health records), and tit. 54, chap. 630A (providing for the licensing of practitioners of homeopathic medicine); N.H. REV. STAT. ANN. §§ 322-I:1 (2000) (requiring all licensed health care providers to furnish patients with a copy of their medical records upon request), 328-E:3 (requiring naturopathic health care practitioners to be licensed).


65. Compare MD. CODE ANN., HEALTH-GEN. §§ 4-301 to 4-304 (2001) (requiring a broad range of health care providers and health care facilities to allow patients to see, copy, and amend their health information), with DEL. CODE ANN. tit. 16, §§ 5161, 1121 (2000) (failing to contain
any provisions granting such access rights).

66. See Md. Code Ann., Health-Gen. §§ 4-301 (defining "health care provider" as including those licensed under the Health Occupations article), 4-304 (2001).

67. Delaware does grant minimal access rights to information held by a few isolated categories of health care providers such as mental health hospitals and nursing homes. See Del. Code Ann. tit. 16, §§ 5161, 1121 (2000).


72. Privacy Commission Report, supra note 2, at 278-82, 305-07. See Bartley L. Barefoot, Comment, Enacting a Health Information Confidentiality Law: Can Congress Beat the Deadline?, 77 N.C. L. Rev. 283, 286-93 (1998) (discussing the increased demand for health information due to internal pressures such as integrated health care, and the desire to control health care spending, as well as secondary users such as employers, law enforcement, and the media.)

73. Privacy Commission Report, supra note 2, at 305.

74. Id., at 305-06.


76. Id.

77. See Robert M. Gellman, Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy, 62 N.C. L. Rev. 255, 272 (1984) (noting that "In recommending against including a physician-patient privilege in the Federal Rules [sic] of Evidence, the Judicial Conference Committee found that exceptions to the privilege in many states are 'so numerous as to leave little if any basis for the privilege.'").

Quarles, 389 S.W.2d at 251 (Tennessee follows the common law rule that no evidentiary privilege exists between a physician and her patient and state has no statute creating such a privilege); State v. Bedell, 454 S.E.2d 77, 80 (W. Va. 1994) (West Virginia has “no statutory scheme establishing a physician/patient privilege, nor has this Court judicially recognized such a privilege”).


80. See OKLA. STAT. tit. 59, §§ 328.32 and 161.18 (2000).


82. See OR. REV. STAT. § 192.525 (1999).


86. See, e.g., ARIZ. REV. STAT. §§ 12-2291 to 12-2297 (2000); CAL. CIVIL CODE § 56.10 (West 2001); FLA. STAT. ANN. §§ 456.057 (West 2000); ME. REV. STAT. ANN., tit. 22, §§ 1711-C (West 2000); MD. CODE ANN., HEALTH-GEN. § 4-303 (2000); MINN. STAT. § 144.335 (2000); MONT. CODE ANN. §§ 50-16-525 (2001); R.I. GEN. LAWS § 5-37.3-4 (2001); TEX. OCC. CODE ANN. §§ 159.002 to 159.009 (West 2000); VA. CODE ANN. § 32-127.1:03 (Michie 2001); WASH. REV. CODE §§ 70.02.010 to 70.02.904 (2001); WIS. STAT. ANN. §§ 146.81, 146.82(West 2000); WYO. STAT. ANN. §§ 35-2-606 to 35-2-616 (Michie 2001) (statutory restrictions cover only hospitals).


88. See MONT. CODE ANN. § 50-16-501 to § 50-16-553 (2001); WASH. REV. CODE §§ 70.02.010 through 70.02.904 (2001).

89. See VA. CODE ANN. § 32.1-127.1:03 (Michie 2001).


91. See FLA. STAT. ANN. §456.057 (West 2000).

92. See R.I. GEN. LAWS § 5-37.3-4(d) (2001).

93. HEALTH PRIVACY WORKING GROUP supra note 43, at 19; Nat’l Conf. of Comm’rs on Unif. State Law, Comment on §5-101 of the Uniform Health Care Act, supra note 44. See also PRIVACY COMMISSION REPORT, supra note 2, at 313.


95. Id. at 19.

96. Id.

97. Although the eight comprehensive health privacy bills introduced at the federal level in the 106th Congress varied in many aspects, they uniformly included a requirement that covered health care providers and health plans furnish a notice of information practices to patients. See Health Information Act, H.R. 1941, 106th Cong. § 204 (1999); Personal Medical Information Protection Act of 1999, H.R. 2404, 106th Cong. § 103 (1999); Consumer Health and Research Technology Protection Act, H.R. 2455, 106th Cong. § 203 (1999); Medical Information Protection and Research Enhancement Act of 1999, H.R. 2470, 106th Cong. § 103 (1999); Medical Information Privacy and Security Act, H.R. 1057, 106th Cong. § 103 (1999); Medical Information Privacy and

98. See, e.g., ME. REV. STAT. ANN., tit. 22, §§ 1711-C (West 2000); MINN. STAT. § 144.335(5)(a) (2000); N.J. STAT. 26:2H-12.9 (West 2001) (requiring the Bill of Rights for Hospital Patients to be posted); WASH. REV. CODE § 70.02.120 (2001).


100. HEALTH PRIVACY WORKING GROUP, supra note 43, at 20; PRIVACY COMMISSION REPORT, supra note 2, at 304-05.

101. Id.


103. PRIVACY COMMISSION REPORT, supra note 2, at 293, 427-28.

104. See, e.g., CONN. GEN. STAT. §§ 20-7c(c) (right to file petition with superior court if provider refuses to grant access); MONT. CODE ANN. § 50-16-553 (2001) (providing for equitable relief as well as damages); N.H. REV. STAT. ANN. § 151.30 (2000) (granting a right to maintain action for equitable relief and for damages).


109. Id.


113. See CAL. CIV. CODE § 56.35 (West 2001).


117. ME. REV. STAT. ANN. tit. 22, § 1711-C (West 2000).


120. Id.

121. See ME. REV. STAT. ANN. tit. 22, § 1711-C(13) (West 2000).

122. Id.

123. Privacy of Health Care Information Act, 1999 Haw. Sess. Laws 87, repealed by Act of June 14, 2001. This act was repealed prior to its scheduled effective date of July 2001. In enacting the Privacy of Medical Information Act, the legislature found: "[I]ndividuals have a constitutional right to privacy with respect to their personal health information and records, and with...
HEALTH PRIVACY LAWS

respect to information about their medical care and health status. Traditionally, the primary health care relationship existed only between the patient and the doctor, and was founded upon the principle that all information transmitted between the patient and the doctor was confidential. With advancements in modern technology and systematic changes in health care practices, the patient-doctor relationship has expanded into a multi-party relationship that includes employers, health plans, consulting physicians and other health care providers, laboratories and hospitals, researchers and data organizations, and various governmental and private oversight agencies. These multiple relationships have fundamentally changed the handling and use of medical information. The legislature acknowledges that individuals are often unaware of how their medical information is being used and disclosed in the modern health care delivery system. Currently, there is no statute that comprehensively governs the disclosure of medical records. Most individuals sign a one-time blanket consent to release their medical records when they sign up for medical insurance, and doctors, hospitals, and insurance companies share these records as they see fit. Thus, the legislature believes that an individual's right to privacy of their medical records is currently unclear and at risk."

124. Id. at § 1.
125. Id. at § 2.
129. Id.
130. HIPAA, supra note 127, § 264.
131. See 65 Fed. Reg. 82463-82829 (Dec. 28, 2000) (for preamble to rule, HHS' response to comments to proposed rule, as well as text of final rule itself).
134. See Recommendations of the Secretary of Health and Human Services, Confidentiality of Individually-Identifiable Health Information, § I(G) (Sept. 11, 1997) (stating that recommendations to Congress were based on fair information practices in a health care setting ); 64 Fed. Reg. 59923 (1999) (preamble to proposed Health Privacy Rule) (stating that recommendations served as a template for privacy rule).
137. 45 C.F.R. § 164.524(a) (2001).
139. See 45 C.F.R. § 164.526(a) (2001); see also 65 Fed. Reg. 82736 (HHS, in response to comments to the proposed Health Privacy Rule, clarified "that covered entities are not required by this rule to delete any information... ").
140. 45 C.F.R. § 164.526(c)-(d) (2001).
141. 45 C.F.R. § 164.526(d) (2001).
142. 45 C.F.R. §§ 164.502 - 164.514.
This requirement differs from provisions in most state laws which permit health care providers to use and disclose health information for these purposes without any written permission from the patient. See e.g., ARIZ. REV. STAT. § 12-2292 (2000) (disclosure without patient authorization permitted to attending and consulting health care providers for purpose of diagnosis and treatment); WIS. STAT. ANN. § 146.82 (West 2000) (permitting disclosure to health care providers, volunteers, and others rendering assistance to the patient).


There are no provisions governing penalties in the Privacy Rule. Rather, HHS intends to promulgate separate regulations addressing penalties in the future. 65 Fed. Reg. 82487 (Dec. 28, 2000).

Within HHS, the responsibility for enforcing the Privacy Rule has been delegated to the Office of Civil Rights. Statement of Delegation of Authority, 65 Fed. Reg. 82381 (Dec. 28, 2000).


167. When a patient signs a consent permitting the use and disclosure of health information for “treatment, payment and health care information purposes, they are unwittingly consenting to the use of their health information for marketing purposes.” As long as certain conditions are met, the term “health care operations” includes marketing. See 45 C.F.R. §§ 164.501 (2001) (defining health care operations and marketing), 164.514(e) (setting out the conditions that must be met in order for marketing to be considered to be a health care operation). However, there is nothing in the consent form to indicate that it includes marketing, and it is not at all self-evident that the term “health care operations” would include this activity. See 45 C.F.R. §§ 164.506, 164.520 (2001) (establishing the required contents for a notice of privacy practices). This clearly does not constitute “informed” consent.

168. In order for marketing to come within the definition of health care operations, the provider must meet a number of conditions. See 45 C.F.R. § 164.514(e) (2001). In addition to informing the patient of her right to opt out, the communication must also identify the provider as the party making the communication, and disclose whether the provider is being paid for marketing the product. Id. If a provider targets the marketing based on a patient’s health status or condition, the communication must explain why the individual has been targeted. Id.


170. Id.

171. See supra text accompany notes 123-125.


174. See supra text accompany notes 117-122.

175. For instance, Maine’s law covers blood and organ banks, unlike the Federal Health Privacy Rule. MAINE REV. STAT. ANN. tit. 22, § 1171-C(1)(c) (West 2000). The state law also prohibits disclosure of health care information for the purpose of marketing or sales without the individual’s authorization. MAINE REV. STAT. ANN. tit. 22, § 1171-C(8) (West 2000).


177. 2001 Me. Laws 346.

178. 2001 Fla. Sess. Law Serv. 277 §§ 139-142 (West).


180. See Todd Ackerman, Medical Leaders Ask for Closure of Privacy Loophole; State Bills Could End Exemption to Rules, HOUS. CHRON., Jan. 22, 2001, at A1 (stating that state legislators had said that the loopholes in the federal regulations show why there needs to be a Texas law).

181. The state statute accomplishes this by first removing “marketing” from the definition of “health care operations.” 2001 Tex. Gen. Laws 1511 § 1. This eliminates the possibility that consent for treatment, payment and health care operations includes permission to use the information for marketing. See supra note 167 (explaining treatment of marketing under Federal Privacy Rule). Then the statute prohibits a covered entity (including a provider) from using or disclosing health information for marketing purposes without the consent of the individual who is the subject of the information. 2001 Tex.
Gen. Laws 1511 § 1.

182. Id.
183. Id.

184. See PRIVACY COMMISSION REPORT, supra note 2, at 307 (recommending that the Department of Health, Education and Welfare promulgate regulations protecting the confidentiality of health information, and stating that to be "fully effective" the regulations "should be adopted by statutory enactment in each of the 50 states. If this is not done the individual patient will...have to rely on the Department of Health, Education and Welfare to act on her behalf when a provider violates its duty of confidentiality to him.").