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Synopsis of State Case and Statutory Law

Editorial Board

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Synopsis of State Case and Statutory Law

The Journal's Editorial Staff

ALABAMA

Case Law

Ex parte Smitherman Bros. Trucking, 751 So. 2d 1232 (Ala. 1999): The Supreme Court of Alabama stated that Alabama law does not recognize a general physician-patient privilege.

Ex parte United Serv. Stations, 628 So. 2d 501 (Ala. 1993): In a negligence action for injuries, the Supreme Court of Alabama denied defendant landlord's petition for a writ of mandamus that directed the lower court to compel discovery of plaintiff tenant's psychological records. The court held that the plaintiff's psychological records were protected by the psychotherapist-patient privilege even though the plaintiff sought damages for injuries of a mental nature.

Crippen v. Charter Southland Hosp., 534 So. 2d 286 (Ala. 1988): The Supreme Court of Alabama ruled that a medical center's release of a patient's medical records to his employer without consent was unlawful, though the employer could have required the patient to produce the medical records by the terms of his employment contract. In this case the employer did not order the plaintiff to produce the records, and even if the employer had, the plaintiff could have refused to do so and resigned from the company. The unauthorized release amounted to breach of an implied contract of confidentiality on the part of the doctor.

Ex parte Rudder, 507 So. 2d 411 (Ala. 1987): A physician claimed libel and invasion of privacy against a television station and its reporter for broadcasting information relating to abusive prescription drug practices by the physician. The defendants sought to have the plaintiff physician produce all of his medical and psychiatric records relating to treatment of the particular patient mentioned in the broadcasts, and the Supreme Court of Alabama issued a protective order to prevent the discovery of these records. The court ruled a patient did not waive his privilege to his medical records because he was not party to the suit.

Horne v. Patton, 287 So. 2d 824 (Ala. 1973): The Supreme Court of Alabama ruled that the defendant physician's release of confidential medical information to the plaintiff's employer against the plaintiff's express instructions constituted a
breach of the continuing obligation to keep information obtained in the doctor-patient relationship confidential. The court stated that public knowledge of the Hippocratic Oath's secrecy provision or of the ethical standards of the medical profession may well have been justification for a reasonable expectation of privacy.

Harbin v. Harbin, 495 So. 2d 72 (Ala. Civ. App. 1986): The court held that privileged medical information can be subpoenaed in custody cases in which the issue of mental state of a party to a custody suit is clearly in controversy, and proper resolution of the issue requires disclosure of these records.

Statutes

Access

ALA. CODE § 12-21-6.1 (2001): Any person required to release copies of medical records may ask for a reasonable payment for reproducing the medical records. Reasonable payment shall not be more than $1.00 for each page of the first twenty-five pages, and not more than $0.50 for each page in excess of twenty-five pages, and a search fee of $5.00.

ALA. CODE § 22-9A-21 (2001): The State Registrar may review medical records to provide for a system for death reviews.

ALA. CODE § 22-56-4b (2001): Consumers of mental health services shall have the same general rights as other citizens, including the right to access upon request all information in the consumer's mental health, medical, and financial records, unless a clinical determination has been made by professional staff that access would be detrimental to the consumer's health.

Disclosure

ALA. CODE § 34-26-2 (2001): The confidential relations and communications between licensed psychiatrists and their patients shall be placed upon the same basis as those provided by law between attorney and client and shall be considered privileged. Generally, privilege can only be waived by the patient. Waiver should be granted in custody trials in which the mental state of a party to the suit is clearly in controversy and for presentation of evidence of insanity by a defendant in addition to a plea of insanity.

Case Law

No court cases dealing strictly with access or disclosure of medical records were found.
Statutes

Access

ALASKA STAT. § 18.23.005 (Michie 2001): Notwithstanding other provisions, a patient is entitled to inspect and copy any records developed or maintained by a health care provider or other person pertaining to the health care rendered to the patient.

Disclosure

ALASKA STAT. § 18.08.087 (Michie 2001): When requested for the purpose of evaluating the performance of an emergency medical technician, mobile intensive care paramedic, or physician who provided emergency medical care or other assistance to a sick or injured person, a licensed physician, advanced nurse practitioner, or physician assistant may disclose to an emergency medical technician, a mobile intensive care paramedic, or physician, the medical or hospital records of a sick or injured person to whom the paramedic, technician, or physician is providing or has rendered emergency medical care or assistance. However, disclosure shall be limited to the records that are considered necessary by the discloser for evaluation of the paramedic’s, technician’s, or physician’s performance in providing the emergency medical care or assistance. A mobile intensive care paramedic, emergency medical care technician, or physician to whom confidential records are disclosed under this section may not further disclose the information to a person not entitled to receive that information.

ARIZONA

Case Law

No court cases dealing strictly with access or disclosure of medical records were found.

Statutes

Access

ARIZ. REV. STAT. § 12-2293(A) (2001): On written request of a patient for access to, or copies of, his or her medical records, the health care provider in possession of the record shall provide medical records to the patient, or person designated in writing by the patient, unless the attending physician or psychologist determines and notifies the health care provider in possession of the record that access is contraindicated due to treatment of the patient for a mental disorder. Psychologists are exempt from making available raw test data and psychometric testing materials. If the attending physician or psychologist determines that the patient should not have access to his or her records, the physician or psychologist shall note this determination in the patient’s medical record.
ARIZ. REV. STAT. §§ 12-2293(B)-(D) (2001): On written request of a patient’s health care decision-maker for access to, or copies of, the patient’s medical records, the records shall be provided to the health care decision-maker or person designated in writing by the health care decision-maker unless access is limited by the patient. Records that are not in written form shall be released only if the patient or patient’s health care decision-maker specifically requests and identifies in writing the type of record desired. If the patient receives treatment for a mental disorder, the health care provider may refuse to provide records that indicate confidential information between the patient and the health care professional. If the attending physician determines that the health care decision-maker should not have access to that part of the patient’s medical record, the attending physician shall note this determination in the patient’s medical record and shall provide the health care decision-maker with a written explanation of the reason for denial. The health care provider shall release medical record information to the health care decision-maker that includes the patient’s therapy treatment plan and medication information.

Disclosure

ARIZ. REV. STAT. § 12-2292(A) (2001): Unless otherwise provided by law, all medical records and the information contained in medical records are privileged and confidential. A health care provider may only disclose information that is authorized pursuant to law or the patient’s written authorization.

ARIZ. REV. STAT. §§ 12-2292(B)-(C) (2001): If necessary for its own business operations, or in response to a request for a copy of the patient’s medical record, a health care provider may release a patient’s medical record to a contractor for the purpose of duplicating or disclosing the record on behalf of a health care provider. A contractor shall not disclose any part, or all of, a patient’s medical record in its custody except as provided in this article. After duplicating or disclosing a patient’s medical record, a contractor shall return the record to the health care provider who released the medical record to the contractor.

ARIZ. REV. STAT. §§ 12-2294(B), (E)-(F) (2001): A health care provider may disclose medical records or the information contained in medical records without the patient’s written authorization to (1) attending and consulting health care providers who are currently providing health care to the patient for the purpose of diagnosis or treatment; (2) health care providers who have previously provided treatment, to the extent that the records pertain to the provided treatment; (3) ambulance attendants for the purpose of providing care to the patient; and (4) the patient’s health care decision-maker at the time of the patient’s death. Medical records that are not in written form shall only be released if the written request specifically identifies the type of record desired. A person who receives medical records pursuant to this section shall not disclose those records without the written authorization of the patient or the patient’s health care decision-maker,
unless otherwise provided by law.

ARKANSAS

Case Law

No court cases dealing strictly with access or disclosure of medical records were found.

Statutes

Disclosure

ARK. CODE ANN. §14-14-110(b) (Michie 2001): Personal records, medical records, and other records that relate to matters in which the right to individual privacy exceeds the merits of public disclosure shall not be available to the public unless the person they concern requests that the records be made public.

CALIFORNIA

Case Law

Pettus v. Cole, 57 Cal. Rptr. 2d 46 (Cal. Ct. App. 1996): An employee requesting disability leave sued his employer and two employer-selected psychiatrists for unauthorized release of medical information in violation of the Confidentiality of Medical Information Act (CMIA), invasion of the constitutional right of privacy, and unauthorized use of medical information. The court held that (1) the psychiatrists violated the CMIA by providing the employer with a detailed report without specific written authorization for disclosure; (2) the employee made a prima facie showing of invasion of privacy by the psychiatrists; and (3) the employer violated the CMIA and the employee’s state constitutional rights to autonomy and informational privacy when it terminated the employee’s employment on the basis of the disclosed information.

Division of Med. Quality v. Gherardini, 156 Cal. Rptr. 55 (Cal. Ct. App. 1979): In response to a petition by the State Board of Medical Quality Assurance, the court held that (1) the defendant hospital, as a third-party recipient of privileged matter, had standing to claim physician-patient privilege on behalf of absent, non-consenting patients; and (2) the patients’ rights of privacy that were sought to be invaded fell squarely within constitutional protection.

Statutes

Access

CAL. BUS. & PROF. CODE § 2290.5(4) (West 2001): All existing laws regarding patient access to medical information and copies of medical records apply.
**CAL. HEALTH & SAFETY CODE § 123110(a) (West 2001):** Except as provided in section 123115, any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient representative shall be entitled to inspect patient records upon presenting to the health care provider a written request for those records and upon payment of reasonable clerical costs incurred in locating and making the records available. A health care provider shall permit this inspection during business hours within five working days after receipt of the written request. The inspection shall be conducted by the patient or patient’s representative requesting the inspection, who may be accompanied by one other person of his or her choosing.

**CAL. HEALTH & SAFETY CODE § 123110(b) (West 2001):** Any patient or patient representative shall be entitled to copies of all or any portion of the patient records that he or she has a right to inspect, upon presenting a written request to the health care provider specifying the records to be copied, together with a fee to defray the cost of copying that shall not exceed $0.25 per page or $0.50 per page for records that are copied from microfilm, and any additional reasonable clerical costs incurred in making the records available. The health care provider shall ensure that the copies are transmitted within fifteen days after receiving the written request.

**CAL. HEALTH & SAFETY CODE § 123110(c) (West 2001):** Copies of x-rays or tracings derived from electrocardiography, electroencephalography, or electromyography need not be provided to a patient or patient representative under this section if the original x-rays or tracings are transmitted to another health care provider upon written request by the patient or patient representative within fifteen days after receipt of the request. All reasonable costs, not exceeding actual costs, incurred by a health care provider in providing copies pursuant to this subdivision may be charged to the patient or representative requesting the copies.

**CAL. HEALTH & SAFETY CODE § 123115(a) (West 2001):** The representative of a minor shall not be entitled to inspect or obtain copies of the minor patient’s records if the minor has a right of inspection under section 123110, or if the health care provider determines that access to the patient records requested by the representative would have a detrimental effect on the provider’s professional relationship with the minor or the minor’s well being. The decision of the health care provider as to whether a minor’s records are available for inspection under this section shall not attach any liability to the provider unless the decision is found to be in bad faith.

**CAL. HEALTH & SAFETY CODE § 123115(b) (West 2001):** When a health care provider determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient, the provider may decline to permit inspection or provide
copies of the records subject to the following conditions: (1) The health care provider shall make a written record, to be included with the mental health records requested, noting the date of the request and explaining his or her reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse or detrimental consequences to the patient that the provider anticipates would occur if inspection or copying were permitted; (2) the health care provider shall permit inspection by, or provide copies of the mental health records to a licensed physician, surgeon, psychologist, marriage and family therapist, or clinical social worker designated by request of the patient, and these parties shall not permit inspection or copying by the patient; and (3) the health care provider shall inform the patient of the provider’s refusal to permit the patient to inspect or obtain copies of the requested records and inform the patient of the right to require the provider to permit inspection by, or provide copies to, a licensed physician, surgeon, psychologist, marriage and family therapist, or clinical social worker, designated by written authorization of the patient.

CAL. HEALTH & SAFETY CODE § 123130(a) (West 2001): A health care provider may prepare a summary of a medical record for inspection and copying by a patient.

CAL. HEALTH & SAFETY CODE § 123130(b) (West 2001): A health care provider may confer with a patient in an attempt to clarify the patient’s purpose and goal in obtaining his or her record. If the patient only requests information about certain injuries, illnesses, or episodes, this subdivision shall not require the provider to summarize other information.

CAL. HEALTH & SAFETY CODE § 123149(a) (West 2001): Providers of health services that utilize only electronic record-keeping systems shall comply with the additional requirements of this section. These additional requirements do not apply to patient records if hard copy versions of the patient records are retained.

CAL. HEALTH & SAFETY CODE § 123149(b) (West 2001): Any use of electronic record-keeping to store patient records shall ensure the safety and integrity of those records at least to the extent of hard copy records. Providers set forth in subdivision (a) shall ensure the safety and integrity of all electronic media used to store patient records by employing an offsite backup storage system, an image mechanism that is able to copy signature documents, and a mechanism to ensure that once a record is input, it is unalterable.

CAL. HEALTH & SAFETY CODE § 123149(d) (West 2001): A printout of the computerized record shall be considered the original.

Disclosure

CAL. CIV. CODE § 56.10(a) (West 2001): No provider of health care, health care service plan, or contractor shall disclose medical information regarding a patient without first obtaining authorization, except as provided in subdivision (b)
or (c).

**CAL. CIV. CODE** § 56.10(b) (West 2001): A provider of health care, a health care service plan, or a contractor shall disclose medical information if the disclosure is compelled by judicial or administrative proceedings, or by a patient or patient representative.

**CAL. CIV. CODE** § 56.10(c)(1) (West 2001): A provider of health care or a health care service plan may disclose medical information to providers of health care, health care service plans, contractors, or other health care professionals or facilities for diagnosis or treatment of the patient.

**CAL. CIV. CODE** § 56.10(c)(2) (West 2001): A provider of health care or a health care service plan may disclose medical information to an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, contractor, or any other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payment to be made.

**CAL. CIV. CODE** § 56.10(c)(7) (West 2001): A provider of health care or a health care service plan may disclose medical information to public agencies, clinical investigators (including investigators conducting epidemiologic studies), health care research organizations, and accredited public or private nonprofit educational or health care institutions for bona fide research purposes, but no information so disclosed shall be further disclosed by the recipient in any way that would disclose the identity of any patient.

**CAL. CIV. CODE** § 56.10(c)(8) (West 2001): A provider of health care or health care service plan that has created medical information as a result of employment-related health care services to an employee conducted at the specific prior written request and expense of the employer may disclose to the employer that part of the information that (1) is relevant in a lawsuit, arbitration, grievance, or other claim or challenge to which the employer and the employee are parties and in which the patient has placed in issue his or her medical history, mental or physical condition, or treatment, provided that information may only be used or disclosed in connection with that proceeding, or (2) describes functional limitations of the patient that may entitle the patient to leave work for medical reasons or limit the patient's fitness to perform his or her present employment, provided that no statement of medical cause is included in the information disclosed.

**CAL. CIV. CODE** § 56.10(c)(9) (West 2001): Unless the provider of health care or health care service plan is notified in writing of an agreement by the sponsor, insurer, or administrator to the contrary, medical information may be disclosed to a sponsor, insurer, or administrator of a group or individual insured or uninsured plan or policy that the patient seeks coverage by or benefits from, if the information was created by the provider of health care or health care service plan
as the result of services conducted at the specific prior written request and expense of the sponsor, insurer, or administrator for the purpose of evaluating the application for coverage or benefits.

**CAL. CIV. CODE § 56.10(c)(10) (West 2001):** A provider of health care or a health care service plan may disclose medical information to a health care service plan by providers of health care that contract with the health care service plan and may be transferred among providers of health care that contract with the health care service plan, for the purpose of administering the health care service plan.

**CAL. CIV. CODE § 56.10(c)(13) (West 2001):** A provider of health care or a health care service plan may disclose medical information to an organ procurement organization or a tissue bank processing the tissue of a decedent for transplantation, but only with respect to the donating decedent, for the purpose of aiding the transplant.

**CAL. CIV. CODE § 56.10(d) (West 2001):** Except to the extent expressly authorized by the patient, enrollee, subscriber, or as provided by subdivisions (b) and (c), no provider of health care, health care service plan, contractor, or corporation and its subsidiaries and affiliates shall intentionally share, sell, or otherwise use any medical information for any purpose not necessary to provide health care services to the patient.

**CAL. CIV. CODE § 56.10(e) (West 2001):** Except to the extent expressly authorized by the patient, enrollee, subscriber, or as provided by subdivisions (b) and (c), no contractor or corporation and its subsidiaries and affiliates shall further disclose medical information regarding a patient to any person or entity that is not engaged in providing direct health care services to the patient or his or her provider of health care, health care service plan, insurer, or self-insured employer.

**CAL. CIV. CODE § 56.13 (West 2001):** A recipient of medical information pursuant to an authorization as provided by this chapter or pursuant to the provisions of subdivision (c) of section 56.10 may not further disclose that medical information except in accordance with a new authorization, or as specifically required or permitted by other provisions of this chapter or by law.

**CAL. CIV. CODE § 56.14 (West 2001):** A provider of health care, health care service plan, or contractor that discloses medical information pursuant to the authorizations required by this chapter shall communicate to the person or entity to which it discloses the medical information any limitations in the authorization regarding the use of the medical information. No provider of health care, health care service plan, or contractor that has attempted in good faith to comply with this provision shall be liable for any unauthorized use of the medical information by the person or entity to which the provider, plan, or contractor disclosed the medical information.

**CAL. CIV. CODE § 56.16 (West 2001):** Unless there is a specific written request
by the patient to the contrary, nothing in this part shall be construed to prevent a provider, upon an inquiry concerning a specific patient, from discretionally releasing any of the following information: the patient’s name, address, age, and sex; a general description of the reason for treatment; the general nature of the treated condition; the general condition of the patient; and any information that is not medical information.

CAL. CIV. CODE § 56.25(c) (West 2001): A provider of health care that is an employer shall not be deemed to have violated section 56.10 by disclosing, in accordance with chapter 3 (commencing with section 56.20), medical information possessed in connection with employing the provider’s employees. Information maintained by a provider of health care in connection with employing the provider’s employees shall not be deemed to be medical information, unless it would be deemed medical information if received or maintained by an employer that is not a provider of health care.

CAL. CIV. CODE § 56.245 (West 2001): A recipient of medical information pursuant to an authorization as provided by this chapter may not further disclose such medical information unless in accordance with a new authorization, or as specifically required or permitted by other provisions of this chapter or by law.

**COLORADO**

**Case Law**

**Bodelson v. City of Littleton**, 36 P.3d 214 ( Colo. 2001): The Colorado Open Records Act prohibits disclosure of medical records to anyone other than the person in interest, unless otherwise provided by law. However, COLO. REV. STAT. § 30-10-606(6)(a)(I) expressly grants the coroner’s office access to ambulance reports relevant to investigations in which emergency medical technicians and ambulance medical crews are health care providers.

**People v. Paloma**, 31 P.3d 879 ( Colo. 2001): Drug screening and physical ability tests administered to employees fall under physician-patient privilege only if performed in order to enable physicians to treat employees. Employees submitting to tests for the benefit of their employers are not considered patients (and such tests, then, are not conducted on the patient’s behalf) for purposes of the physician-patient privilege and their corresponding medical information may be subject to disclosure.

**Beth Israel Hosp. v. District Court**, 683 P.2d 343 ( Colo. 1984): The mere use of patient medical records as part of a review committee’s proceedings does not make them “records of a review committee,” that cannot be viewed by the patient’s primary care physician. Patient records are not privileged simply because they are part of the peer-review process.

**Clark v. Dist. Ct.**, 668 P.2d 3 ( Colo. 1983): If a patient initiates a civil action
alleging his or her physical/mental condition as the basis of a claim for damages, he or she implicitly waives the physician-patient privilege with respect to that medical condition (including all relevant medical information). However, such an implied waiver is specific only to that medical condition (not all personal medical matters).

**Statutes**

**Access**

**COLO. REV. STAT. § 8-43-404 (2001):** In the case of injury, an employee maintains a right to compensation so long as he or she submits to a physical examination/vocational evaluation upon the written request of his or her employer. The employee is entitled to receive a copy of any report made by the examining physician/chiropractor at the same time information is made available to his or her employer or insurer.

**COLO. REV. STAT. § 25-1-801 (2001):** Health care facilities, upon reasonable notice, must allow patients access to their medical records at reasonable times.

**COLO. REV. STAT. § 25-1-802 (1) (2001):** All patient medical records in the custody of health care providers, except those pertaining to mental health problems, shall be available to the patient upon submission of a written authorization-request, at reasonable times, upon reasonable notice, and at a reasonable cost.

**COLO. REV. STAT. § 26-11.5-108 (2001):** An ombudsman, upon presenting a long-term care ombudsman identification card, shall have access to a long-term care facility and the medical records of patients eligible for ombudsman services, provided they have consented to such review.

**COLO. REV. STAT. § 30-10-606(6) (a) (I):** A coroner has the authority to request and receive a copy of any autopsy report or medical information from any health care provider if such report/information is relevant to his or her investigation.

**Disclosure**

**COLO. REV. STAT. § 6-18-103 (1) (2001):** Disclosure of individually identifiable health information, collected by a health care cooperative, is prohibited except when it is (1) given to an individual associated with the information; (2) authorized by informed consent; (3) sought by federal, state, or local law enforcement agencies for lawful purposes; or (4) used for bona fide research projects.

**COLO. REV. STAT. § 8-73-108 (4) (b) (III) (2001):** Any physician who performs or is present at an examination required by the provisions of the workers' compensation statutes may be called on to testify as to the results of his or her examination. However, he or she shall only disclose confidential communications related specifically to the treatment given and necessary for a proper understanding of the case.
COLO. REV. STAT. § 12-43-218 (1) (2001): Without the client's consent, a mental health professional, his or her employee/associate, or any person involved in group therapy with the client shall not disclose any confidential communications made by the client, or advice given thereon, in the course of his or her professional employment.

COLO. REV. STAT. § 15-21-110 (1) (2001): Medical records made available by law to a health care facility's utilization review committee are confidential and can only be used in the exercise of proper committee functions. A physician may provide any such review committee with records concerning any patient he or she examined/treated, or who was confined in such hospital/health care facility, relating to the committee's proper function.

COLO. REV. STAT. § 13-90-107(1)(d) (2001): A physician or nurse shall not be examined as a witness on any information, acquired through attending to a patient, necessary to enable him or her to prescribe or act for the patient, unless he or she is being either sued (or is in contact with another being sued) by the patient for care given or reviewed by a relevant committee.

COLO. REV. STAT. § 18-4-412 (1) (2001): Without a court order or the written authorization of the patient, anyone who obtains a patient's medical record/information for his or her own use or the use of another, who steals or discloses to an unauthorized person a patient's medical record/information, or who makes or causes to be made an unauthorized copy of a patient's medical record/information, commits theft.

COLO. REV. STAT. § 24-72-204 (3)(a) (2001): A custodian of medical/mental health records shall deny the right of their inspection to anyone other than the person in interest, unless otherwise provided by law.

COLO. REV. STAT. § 27-10-120 (2001): With respect to the care and treatment of the mentally ill, all information obtained and records prepared in the course of providing care shall be confidential and privileged. Such information may only be disclosed in communications between referring physicians; to an individual designated by the patient; and to adult family members actively involved in the care of the mentally ill patient.

**Connecticut**

*Case Law*

*Falco v. Institute of Living*, 757 A.2d 571 (Conn. 2000): The plaintiff was a patient at defendant psychiatric hospital and was attacked by another patient in the hospital. The plaintiff wanted to obtain the name, last known address, and social security number of his attacker, but the defendant turned down the request, contending that there is a psychiatrist-patient privilege statute (CONN. GEN. STAT. § 52-146e), which prohibits the disclosure of communications and record
identifying a patient. Although the superior court and appellate court granted the request of disclosure, on appeal, the supreme court reversed, contending that the psychiatrist-patient privilege can only be overridden by the exceptions listed in the statute.

_Cornelio v. Stamford Hosp._, 717 A.2d 140 (Conn. 1998): Plaintiff patient was seeking possession of medical specimen slides that pertained to her. The patient alleged that she used the slides to ascertain whether she had a good basis for bringing a malpractice claim against the hospital. The superior court held that the patient lacked a right to obtain the slides as they are specimens that cannot be duplicated, thus falling within the hospital’s right to retain original health records under _CONN. GEN. STAT._ § 19a-490b. The supreme court affirmed the superior court’s ruling.

**Statutes**

**Access**

CONN. GEN. STAT. § 4-104 (2001): Each private hospital, public hospital, society, or corporation receiving state aid shall, upon the demand of any patient who has been treated in such hospital and after his discharge, permit such patient or his physician or authorized attorney to examine the hospital record, including the history, bedside notes, charts, pictures, and plates kept in connection with the treatment of such patient, and permit copies of such history, bedside notes, and charts to be made by such patient, his physician, or authorized attorney.

CONN. GEN. STAT. § 10-15b (2001): Upon request to the board of education, a parent is entitled to knowledge of, and access to, all medical records maintained in the student’s record under this statute.

CONN. GEN. STAT. § 17a-548 (2001): Following discharge from a mental health facility, a patient has the right, upon written request, to inspect and make copies of his records. This provision applies to any hospital, clinic, ward, psychiatrist’s office, or other facility that provides services relating to the diagnosis or treatment of a patient’s mental condition. Access is not granted if the facility determines that disclosure would create a substantial risk that the patient would hurt self or others; cause severe deterioration in mental status of the patient; or violate an assurance of confidentiality furnished to another person.

CONN. GEN. STAT. § 19a-490b (2001): Upon the written request of a patient, all licensed health care institutions, including hospitals, nursing homes, and others, must supply a copy of his or her health record to the patient. The record includes, but is not limited to, copies of bills, laboratory reports, prescriptions, and other technical information used in assessing the patient’s health.

CONN. GEN. STAT. § 20-7c (2001): Upon request, a patient is entitled to access his or her current and complete information concerning any diagnosis, treatment and prognosis of the patient possessed by the health care providers including
physicians, dentists, pharmacists, and chiropractors. Within thirty days of receiving a patient's written request, the provider must also furnish a copy of his health record, including, but not limited to, bills, x-rays, copies of lab reports, contact lens specifications, and other technical information used in assessing the patient's health condition. However, access can be denied if the provider reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause harm to the patient or others.

Disclosure

CONN. GEN. STAT. § 1-210 (2001): All medical information, record of interviews, written reports, and statements, including data concerning a person's medical or emotional condition or history maintained by any public agency are exempt from disclosure under the state's Freedom of Information Act.

CONN. GEN. STAT. § 52-146d (2001): Communications and records of communications between a patient and a psychiatrist relating to the diagnosis or treatment of a patient's mental condition are confidential.

CONN. GEN. STAT. § 52-146e (2001): No person may disclose or transmit any communications and records that identify a patient to any person, corporation, or governmental agency without the consent of the patient or his authorized representative.

Case Law

Green v. Bloodsworth, 501 A.2d 1257 (Del. Super. Ct. 1985): The superior court held that a plaintiff waives the patient-physician privilege under Delaware law when a personal injury suit is filed. As medical authorizations in injury cases are routine, the plaintiff's refusal in the future could be subject to sanctions.

Statutes

Access

DEL. CODE ANN. tit. 16, § 1121 (2001): Each patient has the right to inspect all of his or her records upon written or oral request within twenty-four hours notice. The patient upon written request can also make photocopies of these records with a two-day advance notice. If a patient is adjudicated or medically considered to be incompetent or cannot communicate, all of the above rights shall be relayed to the next of kin, guardian, or representative.

DEL. CODE ANN. tit. 16, § 2509 (2001): An individual authorized to make decisions regarding the health care of a patient has the same rights as that patient to have access to that patient's medical records and the consent to disclose any health-related information.
Disclosure

DEL. CODE ANN. tit. 16, § 1121 (2001): Patients in nursing facilities and other such facilities shall receive respect and privacy in their medical care programs. Case discussion, consultation, treatment, and examination must be confidential, and all medical and personal records are considered confidential. These records shall not be made public without the consent of the patient, unless they are needed for the patient's transfer, required by law, or through a third party payment contract.

DEL. CODE ANN. tit. 16, § 5161 (2001): The medical information of individuals in mental health facilities are not considered public and are not to be disclosed without the permission of the patient. These records shall not be released to any person or agency outside the department in which the patient resides, unless to a parent or another health care professional if the patient is a minor, pursuant to an order of a court, to the patient's attorneys, to rights-protection agencies entitled to access by law, to departmental contractors to the extent necessary for professional consultation, to the state bureau of investigation, or as otherwise required by law.

DEL. CODE ANN. tit. 16, § 9926 (2001): In regards to the Delaware Health Information Network, the Delaware Health Care Commission must ensure that a patient's health information only be released with the consent of the patient. This information is neither subject to the Freedom of Information Act nor to court subpoena, and any violation of the above will result in a report to the office of the Attorney General and subject to prosecution and penalties.

DEL. CODE ANN. tit. 24, § 3913 (2001): The Delaware Code recognizes various provider-client privileges, in which the patient can refuse to disclose and disallow others from disclosing communications he or she has had with the provider.

DEL. CODE ANN. tit. 29, § 10002 (2001): Personal or medical files belonging to a "public body," the disclosure of which would bring about an invasion of privacy, are not considered "public." These are thus not subject to the Freedom of Information Act and not available to the public.

District of Columbia

Case Law

No court cases dealing strictly with access or disclosure of medical records were found.

Statutes

Access

D.C. CODE ANN. § 7-1201.03 (2001): If a mental health professional makes personal notes regarding a client, such personal notes shall not be maintained as part of the client's record. Notwithstanding any other provision of this chapter,
access to such personal notes shall be strictly and absolutely limited to the mental health professional and shall not be disclosed except to the degree that the personal notes or information contained therein are needed in litigation brought by the client against the mental health professional.

D.C. CODE ANN. § 7-1205.02 (2001): A mental health professional or mental health facility may limit the disclosure of portions of a client's record to the client or client representative only if the mental health professional primarily responsible for the diagnosis or treatment of such client reasonably believes that such limitation is necessary to protect the client from a substantial risk of imminent psychological impairment or to protect the client or another individual from a substantial risk of imminent and serious physical injury. The mental health professional shall notify the client or client representative if the mental health professional does not grant complete access.

Disclosure

D.C. CODE ANN. § 7-1201.02(a) (2001): Except as specifically authorized by law, no mental health professional, mental health facility, data collector, or employee or agent thereof shall disclose or permit the disclosure of mental health information to any person, including an employer.

**Florida**

**Case Law**

*Acosta v. Richter*, 671 So. 2d 149 (Fla. 1996): At issue in this case was whether Fla. STAT. ch. 455.241(2) barred the defense counsel in a medical negligence action from having ex parte conferences with a claimant's current treating physician. The Supreme Court of Florida held that Fla. STAT. ch. 455.241(2) barred such conferences, and "provided for a broad physician-patient privilege of confidentiality for a patient's medical information and a limited exception to the privilege for disclosure by a defendant physician in a medical negligence action in order for the physician to defend herself." The court's decision in this case has been codified as Fla. STAT. ch. 456.057(6).

*Butterworth v. X Hosp.*, 763 So. 2d 467 (Fla. Dist. Ct. App. 2000): The court concluded that despite the broad power to issue investigative subpoenas regarding Medicaid fraud, the Attorney General was still required to comply with Fla. STAT. ch. 394.4615(2)(c), and show good cause for their release. In order to respect privacy rights of patients, the legislature intended that sensitive records regarding mental health treatment require at least a court to find good cause to release them.

them. Humana contacted Fischman to retrieve patients’ medical records pursuant to the agreement. Fischman provided only those records for which he had received prior written consent from his patients. Humana filed a complaint seeking the return of the records. Fischman answered, seeking attorney’s fees pursuant to the agreement. He also counterclaimed. The trial court entered summary judgment on the complaint in favor of Fischman, and awarded him attorney’s fees and costs. On appeal, the court noted that Humana failed to remit to Fischman written authorizations from all his patients before demanding the release of their records. Thus, under statute, Fischman was not required to release the documents until he received those authorizations. The court also affirmed prevailing party fees on the counterclaim, because Humana’s voluntary payment amounted to a confession of judgment entitling Fischman to such fees pursuant to the agreement.


_Hospital Correspondence Corp. v. McRae_, 682 So. 2d 1177 (Fla. Dist. Ct. App. 1996): Under Florida law, the maximum charge that the defendant, a hospital copying service, was permitted to charge the plaintiff patients for paper copies of their medical records was $1.00 per page copied, regardless of the source used to store the records.

**Statutes**

**Access**

_FLA. STAT. ch. 455.667 (2000):_ Health care practitioners must, upon request of a patient or their authorized representative, furnish in a timely manner, the patient’s records or reports. If the information is a mental health record, a report of the examination may be provided instead of copies of the records, though copies must be provided in certain limited circumstances. Not more than the actual cost may be charged for such copying.

_FLA. STAT. ch. 199.07 (2000):_ Although records held by state agencies are generally publicly available, there are several exceptions, including an exemption for medical information pertaining to officers or employees of an agency if the information would identify the individual.

**Disclosure**

_FLA. STAT. ch. 381.026 (2000):_ Every patient who is provided health care services retains certain rights to privacy, which must be respected to the extent consistent with providing adequate medical care to the patient and with the efficient administration of the health care facility or provider’s office.

_FLA. STAT. ch. 394.4615 (2000):_ Providing for the confidentiality of mental
health records, this statute outlines the limited exceptions to when such records may be disclosed without the express and informed consent of the patient. FLA. STAT. ch. 490.0147 (2000) extends the above right of confidentiality to communications between a patient and her mental health provider, and FLA. STAT. ch. 456.059 (2000) extends this right to communications between psychiatrists and patients.

FLA. STAT. ch. 395.3025 (2000): Patient records held by a hospital are confidential and must not be disclosed without the consent of the person to whom they pertain, with only limited exception.

FLA. STAT. ch. 455.667 (2000): Generally, a patient’s records may not be disclosed without the written authorization of the patient or their representative, nor may their medical condition be discussed with anyone other than the patient, their legal representative, or other practitioners and providers involved in the patient’s care and treatment. Disclosure may be made without consent under certain limited circumstances.

FLA. STAT. ch. 456.057 (2000): Patient records may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient or the patient’s legal representative or other health care practitioners and providers involved in the care or treatment of the patient, without the written authorization of the patient.

**GEORGIA**

**Case Law**

*Payne v. Sherrer*, 458 S.E.2d 916 (Ga. 1995): Payne sued Sherrer, an employer-appointed physician, for providing copies of his medical records to Payne’s employer without his consent. In ruling against the plaintiff, the court cited GA. CODE ANN. § 24-9-40 (establishing the confidentiality of medical records under evidence law) but relied on the medical malpractice principle that patient-physician privity must exist before physicians are required to conform to a standard of conduct. When an employer retains a physician to examine an employee, no physician-patient relationship exists.

*Southeastern Legal Found. v. Ledbetter*, 400 S.E.2d 630 (Ga. 1991): Newspapers filed an action under the state Open Records Act against the Commissioner of the Department of Human Resources and the superintendent of hospitals seeking access to mental health records that directly or indirectly affected the release from custody of a person who allegedly shot people in a shopping mall. The court held that pursuant to GA. CODE ANN. § 37-3-166, mental health records were clinical records exempt from the Open Records Act.

*Griffin-Spalding County Hosp. Auth. v. Radio Station WKEU*, 241 S.E.2d 196 (Ga. 1978): WKEU filed a petition for mandamus against the Griffin-Spalding County
Hospital Authority alleging that its denial of access to records relating to its ambulance service constituted a violation of Georgia’s “open records” law. The hospital authority argued that the records were medical records and that Georgia’s open records law specifically excludes these materials from inspection by the public. The court ruled that the authority need not maintain two separate records, one with information the public may inspect, and one not accessible to the public. However, the court held that the open records law requires a custodian of public records to expunge any information that the public does not have a right to see. The hospital authority had a right to exact reasonable payment for these additional duties from the radio station before it released the information.

Mrozinski v. Pogue, 423 S.E.2d 405 (Ga. Ct. App. 1992): Pogue, a psychiatrist, treated Mrozinski’s daughter for drug addiction and other mental health problems. Mrozinski and his daughter also participated in family therapy with Pogue, who gave health information to the attorney of Mrozinski’s former wife for a custody suit at the request of the child. The information described Mrozinski’s conduct during family therapy, including Pogue’s criticisms of Mrozinski’s interaction with his daughter. Citing GA. CODE ANN. § 37-3-166, limiting disclosure of clinical records of persons receiving hospital treatment for mental illness to a patient’s attorney, the court noted that Pogue disclosed information to the wife’s attorney, not the child’s attorney. Similarly, GA. CODE ANN. § 37-7-166 permits disclosure of a substance abuser’s record to a third-party attorney whom the patient designates in writing, but Mrozinski’s daughter did not submit her request in writing. The court concluded that as the parent of the minor child, Mrozinski had standing to file suit for the unauthorized disclosure of his daughter’s clinical records.

Statutes

Access

GA. CODE ANN. § 31-8-108(b)(6) (2001): Each resident of a long-term care facility shall be permitted to inspect and receive a copy of his or her medical records unless medically contraindicated. The facility may charge a reasonable fee for duplication that shall not exceed actual cost.

GA. CODE ANN. §§ 31-33-2(a)-(c) (2001): Upon written request from a patient, the provider having custody and control of the patient’s record shall furnish a complete and current copy within a reasonable period of time to the patient, any provider designated by the patient, or any other person designated by the patient. If the provider reasonably determines that disclosure to the patient will be detrimental to the patient, the provider may refuse to furnish the record. However, upon such refusal, the patient’s record shall, upon written request by the patient, be furnished to any other provider designated by the patient.

GA. CODE ANN. § 37-3-162(b) (2001): Each patient in a mental health facility
and each patient receiving services for mental illness has the right to participate in his or her care and treatment. Unless disclosure to the patient is determined by the chief medical officer or the patient's treating physician or psychologist to be detrimental to the patient, and unless a notation to that effect is made a part of the patient's record, the patient shall have reasonable access to review his or her medical file.

**GA. CODE ANN. §§ 37-3-167(a)-(c) (2001):** Except as provided in GA. CODE ANN. § 37-3-162, every mental health patient has the right to examine all medical records kept in the patient's name by the state or the facility where the patient was hospitalized or treated. Every patient has the right to request that any inaccurate information found in his or her record be corrected. Nothing in this section shall be construed to require the state to delete information or constrain the state from destroying patient records after a reasonable passage of time.

**GA. CODE ANN. § 37-4-122(c) (2001):** Each client in a facility and each person receiving services for mental retardation has the right to participate in his or her habilitation. Unless disclosure to the client is determined by the superintendent or person having charge of the client's habilitation to be detrimental to the client, and unless a notation to that effect is made a part of the client's record, the client shall have reasonable access to review his or her medical file.

**GA. CODE ANN. § 37-7-162(b) (2001):** Each patient in a facility and each person receiving services for substance drug abuse has the right to participate in his or her care and treatment. Unless disclosure to the patient is determined by the chief medical officer or the patient's treating physician or psychologist to be detrimental to the patient and unless a notation to that effect is made a part of the patient's record, the patient shall have reasonable access to review his or her medical file.

**Disclosure**

**GA. CODE ANN. §§ 31-7-6(a), (c) (2001):** Any hospital, health care facility, medical or skilled nursing home, or other organization rendering patient care may provide information, interviews, reports, statements, memoranda, or other data relating to the condition and treatment of any person to research groups approved by the medical staff of the institution involved, to governmental health agencies, medical associations and societies, or to any in-hospital medical staff committee, to be used in the course of any study for the purpose of reducing rates of morbidity or mortality. No liability shall arise against any person or organization for providing such information or material, or for releasing or publishing study findings and conclusions, or summaries thereof, to advance medical research or medical education, or to achieve the most effective use of health manpower and facilities. In all events the identity of any person whose condition or treatment has been studied pursuant to this section shall be confidential and shall not be revealed under any circumstances.
GA. CODE ANN. §§ 37-3-166(a), (c) (2001): A clinical record for each mental health patient shall be maintained. Authorized release of the record shall include, but not be limited to, examination of the original record, copies of all or any portion of the record, or disclosure of information from the record, except for matters privileged under state law. Any disclosure authorized by this section or any unauthorized disclosure of confidential or privileged patient information or communications shall not in any way abridge or destroy the confidential or privileged character thereof, except for the purpose for which such authorized disclosure is made. Any person making an authorized disclosure shall not be liable to the patient or any other person notwithstanding any contrary provision of state evidence laws.

GA. CODE ANN. §§ 37-4-125(a), (c) (2001): A clinical record for each mentally handicapped client shall be maintained. Authorized release of the record shall include, but not be limited to, examination of the original record, copies of all or any portion of the record, or disclosure of information from the record, except for matters privileged under state law. Any disclosure authorized by this section or any unauthorized disclosure of confidential or privileged client information or communications shall not in any way abridge or destroy the confidential or privileged character thereof, except for the purpose for which such authorized disclosure is made. Any person making an authorized disclosure shall not be liable to the client or any other person, notwithstanding any contrary provision of state evidence laws.

GA. CODE ANN. §§ 37-7-166(a), (c) (2001): A clinical record for each substance abuse patient shall be maintained. Authorized release of the record shall include but not be limited to examination of the original record, copies of all or any portion of the record, or disclosure of information from the record, except for matters privileged under state law. Any disclosure authorized by this section or any unauthorized disclosure of confidential or privileged patient information or communications shall not in any way abridge or destroy the confidential or privileged character thereof, except for the purpose for which such authorized disclosure is made. Any person making an authorized disclosure shall not be liable to the patient or any other person, notwithstanding any contrary provision of state evidence laws.

Case Law

Painting Indus. of Hawaii Mkt. Recovery Fund v. Ablm, 746 P.2d 79 (Haw. 1987): The state constitutional right to privacy extends only to highly personal and intimate information such as medical, financial, educational, or employment records.
Statutes

No statutes dealing strictly with access or disclosure of medical records were found.

Case Law and Statutes

No court cases or statutes dealing strictly with access or disclosure of medical records were found.

ILLOIS

Case Law

Burger v. Lutheran, 759 N.E.2d 533 (Ill. 2001): The plaintiff patient's medical malpractice suit against defendants, hospital, corporations, and physicians in the circuit court of Cook County, declared parts of 210 ILL. COMP. STAT. 85/6.17 unconstitutional. Upon appeal, the Illinois Supreme Court reversed the circuit court's decision that found parts of 210 ILL. COMP. STAT. 85/6.17(d),(e) violated patient privacy rights under the state constitution; and remanded the matter to the circuit court for further proceedings.

Kunkel v. Walton, 689 N.E.2d 1047 (Ill. 1997): The court found that requiring consent forms from injured parties authorizing the release of medical information is unconstitutional and an invasion of privacy.

Best v. Taylor, 689 N.E.2d 1057 (Ill. 1997): The court held that the state's discovery statutes mandating unlimited disclosure of a plaintiff's medical records, violated the Illinois Constitution. The Act was found to interfere with privacy rights in its mandatory disclosure of all medical information and records.

Statutes

Access

735 ILL. COMP. STAT. 5/8-2001 (West 2001): Every private and public hospital shall, upon the request of any patient who has been treated in such hospital, and after his or her discharge, permit the patient or his or her physician or authorized attorney to examine the hospital records kept in connection with the treatment of such patient, and permit copies of such records. A request for examination of the records shall be in writing and shall be delivered to the administrator of such hospital. The hospital has a maximum of sixty days to comply with the request.

735 ILL. COMP. STAT. 5/8-2003 (West 2001): Every physician and other health care practitioner shall, upon the request of any patient who has been treated by such physician or practitioner, permit such patient's physician or authorized
attorney to examine and copy the patient's records. Such a request for examining and copying the records shall be in writing and shall be delivered to such physician or practitioner. The physician or practitioner has a maximum of sixty days to comply with the request and shall be reimbursed by the person requesting such records.

740 ILL. COMP. STAT. 110/4 (West 2001): Upon request, the parent or guardian of a recipient under twelve years of age, the recipient, the guardian of the recipient, or the attorney of the recipient of mental health services is entitled to inspect and copy his or her records.

Disclosure

410 ILL. COMP. STAT. 50/3 (2001): Each patient has a right to privacy and confidentiality in health care. Each physician, health care provider, health services corporation, and insurance company shall refrain from disclosing the nature or details of services provided to patients, except that such information may be disclosed to the patient; the party making treatment decisions if the patient is incapable of making decisions regarding the health services provided; those parties directly involved with providing treatment to the patient or processing the payment for that treatment; those parties responsible for peer review, utilization review, and quality assurance; and those parties required to be notified due to abuse or a notifiable condition.

INDIANA

Case Law

Terre Haute Reg'l Hosp. v. Trueblood, 600 N.E.2d 1358 (Ind. 1992): The patient filed an action against a hospital and the hospital's parent corporation alleging that the hospital's staff physician performed two unnecessary surgeries on the patient's neck and back. During discovery, the patient sought the records of non-party patients. The trial court entered an order, which permitted the patient's attorney and expert to inspect the medical records. On appeal, the intermediate appellate court held that the trial court's order constituted an abuse of discretion and vacated the discovery order. On review, the supreme court vacated the decision of the intermediate appellate court. The supreme court held that when all the information regarding the identities of the non-party patients had been redacted from the records, production of the medical records did not violate the physician-patient privilege. The court held that where adequate safeguards exist to protect the identity and confidentiality of the non-party patient, the trial court may allow the discovery of the non-party patient medical records even where the patient has not waived the physician-patient privilege.

Canfield v. Sandock, 563 N.E.2d 526 (Ind. 1990): The court affirmed the decision of the trial court and found that medical information, which is unrelated
to the medical condition and irrelevant to the issue in litigation, remains privileged, and therefore protected from discovery.

Andreatto v. Hunley, 714 N.E.2d 1154 (Ind. Ct. App. 1999): When a patient who is a party to a lawsuit places his or her physical condition at issue, the patient has implicitly waived the physician-patient privilege as to that condition. However, once the physician-patient privilege has been invoked, the burden is upon the party claiming it to prove his entitlement to protection. The bare assertion of a claim of privilege will not suffice to block discovery of the information sought by the discovery request.

**Statutes**

**Access**

IND. CODE § 16-39-1-1 (2001): On written request and with reasonable notice, a provider shall supply to the patient the health records possessed by the provider.

IND. CODE § 16-39-2-4 (2001): A patient is entitled to inspect and copy the patient’s own mental health record. However, if the provider that is responsible for the patient’s mental health records determines for good medical cause, upon the advice of a physician, that the information requested under this section is detrimental to the physical or mental health of the patient, or is likely to cause the patient to harm the patient or another person, the provider may withhold the information from the patient.

IND. CODE § 27-13-31-4 (2001): A health maintenance organization is entitled to access treatment records and other information pertaining to the diagnosis, treatment, and health status of any enrollee during the period of time the enrollee is covered by the health maintenance organization.

**Disclosure**

IND. CODE § 16-14-1.6-8 (2001): This statute provides that information obtained and maintained in the course of providing services to a patient is confidential and can be disclosed only with the consent of the patient. However, records reflecting the cost of care and maintenance are not confidential and may be disclosed without the consent of the patient, to the extent necessary to obtain payment for services rendered or other benefits to which the patient or client may be entitled.

IND. CODE § 16-39-1-5 (2001): A provider may withhold information from a patient that is judged to be detrimental to the health of the patient or likely to cause the patient to harm self or other.

IND. CODE § 16-39-5-3 (2001): This statute allows the owners of the original health records (health care providers) to use these without specific written authorization of the patient and for legitimate business purposes that include submission of claims for payment from third parties; collection of accounts; litigation defense; quality assurance; peer review; and scientific, statistical, and
educational purposes. The provider is obligated to protect the confidentiality of the health record at all times and disclose the identity of the patient only when disclosure is essential to the provider’s business use or to quality assurance and peer review.

**Case Law**

No court cases dealing strictly with access or disclosure of medical records were found.

**Statutes**

**Disclosure**

**IOWA CODE § 22.7 (2) (2001):** Medical records, hospital records, and professional counselor records of the condition, diagnosis, care, or treatment of a patient or former patient that are maintained by a public entity maintain their status as confidential records and are not open to public inspection unless otherwise ordered by a court.

**IOWA CODE § 228.2 (2001):** Mental health professionals, mental health facilities, data collectors, and their respective employees and agents are prohibited from disclosing (or permitting the disclosure of) mental health information without the written authorization of the client.

**IOWA CODE § 228.8 (2001):** Mental health professionals and mental health facilities may disclose mental health information to family members without the client’s authorization when specific conditions are met. Disclosure of mental health information without the client’s consent is also permitted to initiate or complete civil commitment proceedings; to file requisite reports for the funding of local community health services; and to meet other statutory requirements.

**Case Law**

**Burroughs v. Thomas, 937 P.2d 12 (Kan. Ct. App. 1997):** The county coroner argued that his underlying investigative materials should not be disclosed under the Kansas Open Records Act on the proposition that these materials constituted medical records that could not be revealed by Kansas statute. The court agreed that they were medical records not subject to public disclosure.
Statutes

Disclosure

KAN. STAT. ANN. § 21-3853 (2000): Entities holding medical records must turn them over to the attorney general within the context of the attorney general’s Medicaid fraud investigations. Anyone turning such information over shall not be liable for a breach of confidentiality.

KAN. STAT. ANN. § 38-1513 (2000): When the health or condition of a child who is a ward of the state requires it, a court may consent to the performing and furnishing of hospital, medical, surgical, or dental treatment or procedures, including the release and inspection of medical or dental records.

KAN. STAT. ANN. § 38-1609 (2000): The medical records of juvenile offenders shall be privileged and shall only be disclosed in limited situations, including whether such disclosure is ordered by a court and when the juvenile has given written consent.

KAN. STAT. ANN. § 40-22a09 (2000): Utilization review organizations must have written procedures for assuring that patient specific information obtained during a utilization review is kept confidential in accordance with state and federal law, and that the information is used only for the purposes of the utilization review, quality assurance, discharge planning, and catastrophic case management.

KAN. STAT. ANN. § 40-22a10 (2000): Medical records exchanged between health care provider or patient and utilization review organization shall not be subject to release, subpoena, or admissible into evidence in judicial or administrative proceedings other than in limited situations.

KAN. STAT. ANN. § 45-221 (2000): Unless specifically required by statute, no public agency shall be required to disclose the medical, psychiatric, psychological, or alcoholism or drug dependency treatment records that pertain to identifiable patients.

KAN. STAT. ANN. § 59-2979 (2000): Treatment or medical records that are in possession of a court or treatment facility (of mentally ill patients) shall not be disclosed unless, among other exceptions, (1) there is consent of the patient or his guardian; (2) the head of a facility determines that disclosure is necessary for the treatment of the patient; or (3) there is a court order.

KAN. STAT. ANN. §§ 65-5601, 65-5602, 65-5603 (2000): A patient of a community health center, community facility for the mentally retarded, psychiatric hospital, or state institution for the mentally retarded may prevent personnel at those facilities from disclosing that he has been, or is currently, receiving treatment, or from disclosing any confidential communications made for the purposes of diagnosis or treatment. Disclosure without the patient’s consent is permitted only in limited situations such as to protect a person who has been threatened with substantial physical harm by the patient and for the purposes of
involuntary commitment proceedings.

**KENTUCKY**

**Case Law**

*Geary v. Schroering*, 979 S.W.2d 134 (Ky. Ct. App. 1998): A woman filed suit seeking damages resulting from an accident in which she was involved. The trial court ordered her to sign a blank medical authorization. The court held that this was inappropriate and that pertinent medical information should have been discovered by taking subpoenas and depositions.

*Hardin County v. Hardin Mem'l Hosp.*, 894 S.W.2d 151 (Ky. Ct. App. 1995): An attorney in a personal injury action subpoenaed medical treatment records during discovery. The records were furnished at a cost of $1.00 per page. The party seeking the documents contested the cost as unreasonable. The lower court found that the rate was reasonable. The court of appeals reversed and remanded for further consideration.

**Statutes**

**Access**

KY. REV. STAT. ANN. § 422.317 (Michie 2001): Upon a patient's written request, a health care provider or hospital must provide, without charge to the patient, a copy of the patient’s medical record. The provider or hospital may charge up to $1.00 per page for the second copy.

**Disclosure**

KY. REV. STAT. ANN. § 17.574 (Michie 2001): With certain exceptions, state and local detention or correctional facilities, hospitals, and other institutions shall forward (among other things) medical records, including psychological records and the treatment record, of sex offenders to be discharged or paroled to an approved provider for review prior to the release or discharge for consideration in making recommendations to the sentencing court.

KY. REV. STAT. ANN. § 200.490 (Michie 2001): Medical records of children in the care of the Commission for Children with Special Health Care Needs shall be confidential and shall not be disclosed without the consent of a parent or guardian or other select individuals except where such disclosure may be necessary to provide additional services to the children through other medical, welfare, or service agencies and institutions.

KY. REV. STAT. ANN. § 304.17 A-555 (Michie 2001): This statute recognizes a patient’s right of privacy in the content of his or her record and communications with a health care provider with respect to mental health or chemical dependency. Insurers are limited in the information they can get from the provider, and no
third party to whom disclosure is made may redisclose the information.

KY. REV. STAT. ANN. § 422.315 (Michie 2001): A patient may ask to prohibit or limit the use of his medical records.

**Louisiana**

**Case Law**

*Speer v. Whitecloud*, 744 So. 2d 1283 (La. 1999): Speer sought records of a 1994 study published by Dr. Whitecloud that concerned spinal pedicle screw devices for a medical malpractice suit. Whitecloud countered that, under LA. REV. STAT. ANN. § 13:3715.1, a subpoena, court order, or patient consent was required for medical record release. Because the plaintiff desired only the model numbers and manufacturers of the pedicle screws, the supreme court affirmed the trial court ruling that discovery did not invade physician-patient privilege once personal identifying information was removed.

*Davis v. American Home Products Corp.*, 727 So. 2d 647 (La. Ct. App. 1999): The plaintiffs claimed that Norplant contraception caused injuries. In communications with the defendant, they presented a report from a Texas medical expert alleging that his institution evaluated patients with complications due to Norplant. The defendant wished to examine the medical records, with identifiable information removed, of these patients. The court of appeals reversed the decision of the trial court and pronounced the records not discoverable due to the absence of a statutory exception, of permission from the non-party patients, and of a contradictory hearing with the non-party patients.

*Lugar v. Baton Rouge Gen. Med. Ctr.*, 696 So. 2d 652 (La. Ct. App. 1997): The plaintiff signed multiple authorization forms allowing his insurance company, who was also his employer, access to his medical records. After being fired, the plaintiff filed suit against the hospital, contending its negligence, and that of its employees, in regards to releasing his confidential medical information. Ruling that the hospital rightfully released information allowed by the authorization form and that no reasonable evidence existed for the plaintiff's claim of tampering, the court of appeals affirmed the trial court's ruling in favor of the defendant.

*Farr v. Riscorp*, 714 So. 2d 20 (La. Ct. App. 1996): The plaintiff was injured in an industrial workplace accident and filed for workers' compensation. The medical case manager discussed the employee's medical situation with the treating physician, although the employee had previously signed a standard medical authorization with the provisions for medical discussions and opinions scratched from the form. Because the employee filed a workers' compensation claim, the court of appeals affirmed the trial court's decision that the case manager did not violate physician-patient privilege and was immune from tort.

The decedent was attacked by a fellow patient at a residential nursing facility and subsequently died from exacerbations, brought about by injuries sustained in the attack, of pre-existing conditions. Her executor requested documents concerning her attacker from the nursing home insured by the named insurance company. The insurer claimed that such records fell under the purview of physician-patient privilege, as the nursing facility acted as health care provider. The court of appeals affirmed the trial court ruling that the privilege existed only to patient and not provider, and thus the non-party patient's records were discoverable.

*Jo Ellen Smith Psychiatric Hosp. v. Harrell*, 546 So. 2d 886 (La. Ct. App. 1989): An employee of Smith Psychiatric Hospital had erroneously sent a Blue Cross Provider Register that listed confidential information of thirty-nine patients when the family of one patient requested information about its bill. Fearing disclosure of its record to others, the family proposed to contact the other thirty-eight patients to check upon the situation. The hospital then filed for an injunction, which was denied. Claiming the family's proposal to contact the others to investigate the possibility of a claim against the hospital would infringe on the privacy of the patients and that they would suffer irreparable harm, the hospital appealed. Believing that the patient's right to investigate for possible litigation did not outweigh the privacy of the other patients and that the irreparable harm would occur, the court of appeals reversed the trial court's decision.

**Statutes**

**Access**

*La. Rev. Stat. Ann.* § 40:1299.96 (West 2001): A health care provider will furnish each patient, upon request of the patient, a copy of any information related to the patient that has been provided to any company, agency, or person. But the provider may deny access if he or she concludes that knowledge from the records would be harmful to the patient or any other person. The provisions of this statute do not apply to providers who examine a patient at the request of any state or federal agency in charge of assistance or entitlement programs under the Social Security Act. No prohibition exists on records retained by the Social Security Administration, unless contrary to state or federal law or regulation.

*La. Rev. Stat. Ann.* § 40:2144 (West 2001): Upon receipt of a request in writing signed and dated by the person initiating the request, a hospital is required to, except for good cause shown, such as medical contraindication, furnish medical records as soon as practicable and upon payment of the reasonable cost of so providing.

**Disclosure**

*La. Rev. Stat. Ann.* § 13:3715.1 (West 2001): A health care provider shall disclose medical or hospital records of a patient who is party to litigation pursuant to a subpoena. Additionally, a court shall issue or order of a patient's record,
regardless of whether the patient is party to litigation only after contradictory hearing with the patient and a court finding that release is proper. But no health care provider is required to grant access to photographs of alleged victims of child sexual abuse unless court-ordered for counsel or expert evaluation of medical diagnosis of child sexual abuse.

LA. REV. STAT. ANN. § 44:7 (West 2001): The charts, records, documents, and other memoranda by the physicians, surgeons, psychiatrists, nurses, and employees in the public hospitals, mental health centers, or schools of Louisiana are exempt from the laws granting access to public records and are confidential.

**Case Law**

**Bailan v. Board of Licensure in Med.,** 722 A.2d 364 (Me. 1999): Dr. Bailan was fined by a medical board for failure to release psychiatric records to his patient’s doctors. Bailan testified that he did not release the records because he required that the patient’s signature be witnessed and attested to by someone from the requesting physician’s office, the witness sign the medical release form, and the physician make a specific request to Bailan. The court agreed with Bailan that the board erred in fining him because they failed to reveal or introduce into evidence the standards of professional ethics Bailan was alleged to have violated.

**Guy Gannett Publ’g Co. v. University of Maine,** 555 A.2d 470 (Me. 1989): The court found that a portion of the settlement agreement between the University and a former coach relating to medical information was properly kept from disclosure because the information fell within the definition of “medical information,” and thus was exempt from disclosure under the state Freedom of Access Act.

**Statutes**

**Access**

ME. REV. STAT. ANN. tit. 22, § 1711 (West 2000): Within a reasonable time of receiving a written authorization, a health care practitioner must release copies of all treatment records of a patient or a summary containing all the relevant information in the treatment records, to the patient. The practitioner may impose a reasonable charge for the copies or the report supplied, not exceeding the costs incurred by the practitioner. If the practitioner believes that the release of the records to the patient would be detrimental to the health of the patient, he must advise the patient that the records or summary will be made available to an authorized representative of the patient upon presentation of a written authorization by the patient. The copies must be provided to the representative.
within a reasonable time. Similar rules apply to hospitals.

Me. Rev. Stat. Ann. tit. 24-A, § 2211 (West 2000): A person has the right to have any factual error in his medical records corrected and to have any misrepresented or misleading entry amended or deleted in accordance with certain procedures.

Disclosure

Me. Rev. Stat. Ann. tit. 22, § 1711 (West 2000): Disclosure without an individual’s authorization is permitted in a number of circumstances such as to other health care practitioners and facilities within and outside the original office, to practice or organizational affiliates, to quality or peer reviewers, to certain family or household members unless specifically prohibited by the individual, to third parties who face a direct threat, when directed by a court, and to persons conducting scientific research. Health care practitioners and facilities are expressly prohibited from disclosing health care information for the purpose of marketing or sales without written or oral authorization for the disclosure.


MARYLAND

Case Law

Warner v. Lerner, 705 A.2d 1169 (Md. 1998): Warner was a patient of Dr. Schirmer, a urologist. Dr. Lerner was also a urologist at the same hospital, and he was sued by Kelly. Kelly retained Dr. Schirmer as an expert. In an attempt to discredit Dr. Schirmer, Dr. Lerner obtained plaintiff Warner’s urological record from the hospital and made it public by discussing it in a binding mediation. The lower courts found that Dr. Lerner’s conduct did not violate Warner’s rights. The court of appeals reversed, finding no authority in the statute for allowing such disclosure of confidential information.

Davis v. Johns Hopkins Hosp., 622 A.2d 128 (Md. 1993): Plaintiffs asked for compensatory and punitive damages against a hospital for not producing their medical records in a timely manner as required by state law. The court found that the mere failure to produce records is not enough to constitute a violation of the law unless there was evidence of intent on the part of the hospital not to produce the records in a timely fashion. The court found that in this case there was no such evidence and thus dismissal was warranted.

comply with a subpoena. Even though the information requested in the subpoena did not relate to the health care of a patient, the wording of the subpoena was such that the information could not be disclosed without acknowledging that a medical record of the patient existed. The court held that was enough to invoke the rule that a health care provider cannot disclose a medical record without proof that the agency to which it is released has procedures for ensuring the confidentiality of the record. Since there was no proof of such procedures here, the subpoena should not have been enforced.

Dr. K. v. State Bd. of Physician Quality Assurance, 632 A.2d 453 (Md. Ct. Spec. App. 1993): The State Board of Quality Assurance had an interest in reviewing the medical records of a patient in a hearing on an allegation that a doctor was having a romantic relationship with the patient. The patient argued that the Board did not have a right to inspect her medical records. The court held that the patient's privacy interest was outweighed by the Board’s need to investigate doctors, and thus the release of the records was appropriate.

Statutes

Access

MD. CODE ANN., HEALTH-GEN. I § 4-304 (2001): A health care provider shall allow a person to receive a copy of his mental health record or to see a copy of his medical records unless there is some physiological or psychiatric information that might be injurious to the patient, in which case the provider shall follow certain specified procedures. A person may request a change to be made in their medical records. The person may be charged for the costs of retrieving and copying the records. Such charges shall not exceed certain statutorily determined amounts.

MD. CODE ANN., HEALTH-GEN. I § 5-711 (2001): A local department that is investigating allegations of child abuse or neglect can get access to the child’s medical records from the physician.

Disclosure

MD. CODE ANN., HEALTH-GEN. I § 4-209 (2001): Medical records of inmates shall remain confidential and shall only be disclosed to certain law enforcement, correctional facilities personnel, or other listed authorities with the further restriction that such records shall only be used for certain circumscribed purposes.

MD. CODE ANN., HEALTH-GEN. I § 4-303 (2001): A health care provider can disclose medical records when the person has consented to such disclosure.

MD. CODE ANN., HEALTH-GEN. I § 4-305 (2001): A health care provider may disclose certain information without the consent of the person in certain limited situations, including (1) to certain limited persons for the purpose of offering, providing, evaluating, or seeking payment for health care to patients or recipients by the provider, to provider’s legal counsel, or to provider’s insurer; (2) to persons for educational and research purposes, for evaluation and management of health
care systems, and for accreditation purposes where such recipients agree not to redisclose the information; (3) to another provider for the purposes of treating the patient; (4) when disclosure is necessary in the case of an emergency; and (5) to family members of the patient in certain limited situations.

**MD. CODE ANN., HEALTH-GEN. I § 4-306 (2001):** A health care provider shall disclose medical records without authorization of the patient under limited circumstances, including (1) to certain authorities where there is suspicion of child abuse or neglect; (2) to health professional and disciplinary licensing boards; and (3) to an insurer or legal counsel when there is a civil claim related to the records.

**MD. CODE ANN., HEALTH-GEN. I § 4-308 (2001):** A health care provider who in good faith discloses or does not disclose medical records is not liable in any cause of action arising from the disclosure or nondisclosure of such records.

**MD. CODE ANN., HEALTH-GEN. I § 4-309 (2001):** If a health care provider refuses to disclose records within a reasonable time when the disclosure has been requested by a person in interest, the provider is liable for actual damages. Refusal cannot be based on refusal to pay for health care services rendered.

**MD. CODE ANN., CTS. & JUD. PROC. § 9-109 (2001):** There is a patient-psychologist privilege that allows the patient and/or provider to refuse disclosure of medical information except in certain situations, such as where disclosure is necessary to place the patient in a mental illness facility, a patient puts his mental illness at issue in a court proceeding, or when there is a malpractice claim made by the patient.

**MD. CODE ANN., STATE GOV'T § 10-617 (2001):** This statute excludes from state open disclosure laws certain public records that contain medical or psychological information about an individual, other than an autopsy report of a medical examiner.

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**Massachusetts**

**Case Law**

*Mitchell v. Subramanya,* 588 N.E.2d 319 (Mass. 1989): A plaintiff alleged that the defendant physician wrongfully refused to provide the plaintiff with her medical record. The court partially affirmed an earlier judgment for a suit brought against the physician, which held that evidence fell short of demonstrating that the doctor had furnished an incomplete or inaccurate summary of the medical record. In compliance with a regulation from the Board of Registration of Medicine, discretion was given to the doctor as to whether to provide the patient with her entire medical record in his possession, or a summary.
Statutes

Access

MASS. GEN. LAWS ch. 111, § 70 (2001): A patient or an authorized representative has the right to review the patient’s hospital records. Upon request, a copy must be provided after payment of a reasonable fee.

MASS. GEN. LAWS ch. 112, § 12CC (2001): Health care providers must grant a patient access to his or her medical records. Upon request, a copy of the medical records must be provided after payment of a reasonable fee.

Disclosure

MASS. GEN. LAWS ch. 111, § 70E (2001): Records of hospitals licensed to the department of public health are confidential to the extent provided by law. Hospitals are allowed to give third-party reimbursers the permission to inspect and copy records relating to diagnosis, treatment, or other services provided to any person for which coverage, benefit, or reimbursement is claimed if the policy or certificate under which the claim is made provides that such access to records is permitted. Hospital records can be disclosed without patient authorization in any peer-review or utilization procedures.

MASS. GEN. LAWS ch. 112, § 12G (2001): Medical records and information are included in a person’s statutory right of privacy. Statutory exceptions exist where physicians and hospitals may disclose medical information of a patient without his or her consent when establishing eligibility for, or entitlement to, government benefits in connection with mandatory health department reports, or as required by any law.

Case Law

In re Petition of Attorney Gen., 369 N.W.2d 826 (Mich. 1985): The contents of a hospital’s peer-review committee proceedings (likely to include patient medical records) are confidential.

Gaertner v. State, 187 N.W.2d 429 (Mich. 1971): A state hospital may not lawfully deny the guardian of an incompetent minor access to his or her records, for confidentiality purposes, because the physician-patient privilege belongs to the patient. The guardian can legally act for his or her mentally incompetent ward who cannot act for himself or herself.

Scott v. Ford Hosp., 501 N.W.2d 259 (Mich. Ct. App. 1993): Under MICH. COMP. LAWS § 600.2157, a defendant health care provider can only release a deceased patient’s medical records to his or her estate’s personal representative. Such a rule is necessary to protect the physician-patient privilege.

patient privilege precludes a hospital from releasing medical records of a nonparty. The privilege prohibits the disclosure of even the names of patients not involved in the litigation.


_Dierickx v. Cottage Hosp.,_ 393 N.W.2d 564 (Mich. Ct. App. 1986): A parent holds the right to assert the physician-patient privilege on behalf of his or her minor child. Though requested medical records may be relevant to a hospital’s theory of a child’s genetically transmitted defect, such records are privileged and not subject to discovery.

**Statutes**

**Access**

_MICH. COMP. LAWS § 333.20201(2)(b) (2001):_ A patient is entitled to inspect or receive, for a reasonable fee, a copy of his or her medical records. A third party shall not be given a copy of the patient’s medical records without the patient’s prior authorization.

_MICH. COMP. LAWS § 333.22210(3)(k)(vi) (2001):_ A patient in a short-term nursing care program, or a person who the patient has authorized in writing, may, after submitting a written request to the hospital, inspect and copy his or her medical records. The hospital shall make the records available for inspection and copying within seven days of receiving the patient’s (or other authorized individual’s) written request.

**Disclosure**

_MICH. COMP. LAWS § 15.243(1)(b) (2001):_ A public body may exempt from disclosure as public records information subject to the physician-patient privilege and medical records concerning an individual if the individual’s identity would be revealed by their disclosure.

_MICH. COMP. LAWS § 330.1750(3) (2001):_ Hospitals cannot disclose the fact that a patient was examined, treated, or underwent any diagnosis unless such medical information is relevant to the health care provider’s insurer’s rights and liabilities.

_MICH. COMP. LAWS § 331.531(1) (2001):_ A person, organization, or entity may provide to a review entity information relating to the physical and/or psychological condition of a person, the necessity, appropriateness, or quality of health care rendered to a person, or the qualifications, competence, or performance of a health care provider.

_MICH. COMP. LAWS § 333.20175(1) (2001):_ Health facilities shall keep and maintain full and complete records for each patient. Departmental officers and
employees shall respect the confidentiality of a patient’s clinical records and shall not disclose the contents of records in a manner identifying an individual except pursuant to court order.

**MINNESOTA**

**Case Law**

*Koudsi v. Hennepin County Med. Ctr.*, 317 N.W.2d 705 (Minn. 1982): The plaintiff brought an action against the hospital for an alleged violation of her statutory right to privacy. The court held that communication over telephone by the hospital’s patient information operator of information concerning the plaintiff’s discharge and the fact that she had given birth did not involve “medical records” within the meaning of the state Patients’ Bill of Rights. Furthermore, the hospital, despite having notice of the plaintiff’s desire that the birth not be disclosed to anyone, was not limited in its “use and dissemination” of such information to that necessary for administration and management of programs specifically authorized or mandated by the legislature, local governing body, or federal government.

*Swarthout v. Mutual Serv. Life Ins.*, 632 N.W.2d 741 (Minn. Ct. App. 2001): In a suit arising over the purchase of life insurance, the court held that **MINN. STAT. § 144.355** (prohibiting the unauthorized release of medical information) does not require the existence of a patient-physician relationship.

*Day v. Miner*, No. C3-97-1944, 1998 Minn. App. LEXIS 634 (Minn. Ct. App. June 2, 1998): Dr. Day was convicted of fourth-degree criminal sexual conduct. As a result, he was referred to the University of Minnesota’s Program in Human Sexuality, where he began treatment with Dr. Miner. During treatment, Day made written requests to review his medical records. Miner denied the requests, stating by letter that such review would be “counter-therapeutic.” Day subsequently sued Miner under **MINN. STAT. § 144.355** for denying him access to his medical records and for releasing private medical data to the Minnesota Board of Medical Practice (the Board). The court held that the denial complied with the statute and that when Day entered a stipulation with the Board to regain his license upon completion of treatment, he provided informed consent for release of information to the Board.
**Statutes**

**Access**

Minn. Stat. § 144.335(2)(b) (2001): Except as provided in paragraph (e), upon a patient's written request, a provider, at a reasonable cost to the patient, shall promptly furnish to the patient (1) copies of the patient's health record, including but not limited to laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's health condition, or (2) the pertinent portion of the record relating to a condition specified by the patient.

Minn. Stat. § 144.335(2)(c) (2001): If a provider reasonably determines that requested information is detrimental to the patient, or is likely to cause the patient to inflict self harm, or to harm another, the provider may withhold the information from the patient and may supply the information to an appropriate third party or to another provider. The other provider or third party may release the information to the patient.

Minn. Stat. § 144.335(2)(d) (2001): A provider shall release information upon written request unless, prior to the request, the provider has designated and described a specific basis for withholding the information.

**Disclosure**

Minn. Stat. § 144.335(3) (2001): A patient's health record, including but not limited to laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's condition, or the pertinent portion of the record relating to a specific condition, or a summary of the record, shall promptly be furnished to another provider upon the written request of the patient.

Minn. Stat. § 144.335(3)(a) (2001): A provider, or a person who receives health records from a provider, may not release a patient's health records without a signed and dated consent from the patient or the patient's legally authorized representative unless the release is specifically authorized by law.

Minn. Stat. § 144.335(3)(b) (2001): This subdivision does not prohibit the release of health records (1) for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency, or (2) to other providers within related health care entities when necessary for the current treatment of the patient.

Minn. Stat. § 144.335(3)(e) (2001): A person who negligently or intentionally releases a health record in violation of this subdivision, forges a signature on a consent form, obtains under false pretenses the consent form or health records of another person, or without the person's consent alters a consent form, is liable to the patient for compensatory damages caused by an unauthorized release, plus costs and reasonable attorney's fees.

Minn. Stat. § 144.335(3)(f) (2001): Upon the written request of a spouse,
parent, child, or sibling of a patient being evaluated for or diagnosed with mental illness, a provider shall inquire of a patient whether the patient wishes to authorize a specific individual to receive information regarding the patient’s current and proposed course of treatment. If the patient so authorizes, the provider shall communicate to the designated individual the patient’s current and proposed course of treatment.

Minn. Stat. § 144.651(16) (2001): Patients and residents of health care facilities shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview.

**Mississippi**

**Case Law**

No court cases dealing strictly with access or disclosure of medical records were found.

**Statutes**

**Access**

Miss. Code Ann. § 41-9-65 (2001): Hospital records constitute hospital property subject to reasonable access. With payment of a reasonable charge for such a service and with good cause, a patient, heirs, representatives, or attending medical personnel may have reasonable access.

Miss. Code Ann. § 41-21-102 (7) (2001): Unless disclosure is determined to be detrimental to the physical or mental health of the patient, and unless notation to that effect is made in the patient’s record, a patient has the right of access to his medical records.

**Disclosure**

Miss. Code Ann. § 13-1-21 (2001): All communications made to a physician, osteopath, dentist, hospital, nurse, pharmacist, podiatrist, optometrist, or chiropractor by a patient or a person seeking professional advice are privileged and generally may not be disclosed.


Miss. Code Ann. § 41-41-11 (2001): A patient’s medical records may be disclosed to others when the patient has waived the medical privilege or has consented to such disclosure.
Case Law

State ex rel. Wilfong v. Schaepkerketter, 933 S.W.2d 407 (Mo. 1996): A mother and natural guardian previously sued the treating physician and medical center for alleged injuries from their refusal to provide timely medical care to her child with a genetic disorder. During discovery, the mother was ordered by the court to sign authorizations for defendant’s attorneys as to all of her other children but applied for a writ of prohibition that was denied by the court of appeals. The Supreme Court of Missouri issued the writ of prohibition, ruling that the non-party siblings did not personally place their medical conditions at issue and that the mother could not waive the other children’s privilege.

State ex rel. Lester E. Cox Med. Ctr. v. Keet, 678 S.W.2d 813 (Mo. 1984): A woman filed a malpractice suit against treating physicians and the medical center for the death of her husband who died from a post-surgical bacterial infection. Writs in prohibition were previously granted to the treating physicians and medical center regarding the release of medical records of any patient at the medical center who had developed a bacteriological infection subsequent to surgery and disclosure of the reason for hospitalization of any patient who was in the same ward with the decedent. The Supreme Court of Missouri ruled to quash the preliminary writs of prohibition, enabling the respondent to conduct in camera examinations of the records sought with identifying information removed.

Fierstein v. DePaul Health Ctr., 949 S.W.2d 90 (Mo. Ct. App. 1997): In a child custody case, the court of appeals found that a physician had a duty of confidentiality not to disclose medical information, including medical records obtained during the patient’s treatment under MO. REV. STAT. § 630.140.

Wear v. Walker, 800 S.W.2d 99 (Mo. Ct. App. 1990): Previously, a woman filed an action against a group of physicians who refused to furnish her with a copy of her medical records upon request, and the circuit court moved to dismiss the case citing MO. REV. STAT. § 191.227. The court of appeals reversed the original ruling and remanded the case for a new trial stating that MO. REV. STAT. § 191.227 does not seek to eliminate the right of access completely, but merely to limit it.

Statutes

Access

MO. REV. STAT. § 191.227 (2000): All physicians and hospitals, upon written request of a patient, guardian, or legal representative of a patient, must furnish a copy of the patient’s medical record. Nevertheless, the provider has the right to limit access consistent with the patient’s condition and sound therapeutic treatment.

MO. REV. STAT. § 630.110 (2000): Persons admitted to mental health facilities
and mental health programs are entitled to access to their mental and medical records.

Disclosure

MO. REV. STAT. § 630.140 (2000): Medical records held by a health care facility will be kept confidential and disclosed only with the authorization of the patient, pursuant to an order of a court or administrative agency, to a representing attorney, or to a county board or other qualified personnel excluding patient identifiers.

Case Law

Huether v. District Court, 4 P.3d 1193 (Mont. 2000): The petitioner filed a wrongful death action against the defendant hospital and requested that the defendant produce any incident reports regarding the care and treatment of the decedent while a patient at the hospital. The defendant objected to the request on the grounds that these documents were not subject to discovery under statutes providing for the confidentiality of in-hospital medical staff committees. The supreme court held that documents were discoverable to the extent that they were relevant to the decedent’s hospital care and treatment. However, documents related solely to the training, supervision, or discipline of the medical staff were not discoverable.

Bowen v. Super Valu Stores, 745 P.2d 330 (Mont. 1987): On appeal from the worker’s compensation court, the supreme court found that the insurer was entitled to confidential health care information as it related to the injured employee’s claim for compensation. The employee had a duty to file all reasonable information with the insurer and the worker’s compensation court.

Statutes

Access

MONT. CODE ANN. § 50-16-502 (2001): Health care information is personal and sensitive information that if improperly used or released may do significant harm to a patient’s interests in privacy and health care or other interests. Patients need access to their own health care information as a matter of fairness, to enable them to make informed decisions about their health care and to correct inaccurate or incomplete information about themselves.

MONT. CODE ANN. § 50-16-541 (2001): Upon receipt of a written request from a patient to examine or copy all or part of the patient’s recorded health care information, a health care provider, as promptly as required under the circumstances, but no later than ten days after receiving the request, shall (1) make the information available to the patient for examination, without charge,
during regular business hours, or (2) provide a copy, if requested, to the patient or inform the patient if the information does not exist or cannot be found.

**MONT. CODE ANN. § 50-16-542 (2001):** A health care provider may deny access to health care information by a patient if the provider concludes that the knowledge of the health care information could be injurious to the health of the patient, lead to the patient's identification of an individual who provided the information in confidence, or could reasonably be expected to cause danger to the life or safety of any individual.

**Disclosure**

**MONT. CODE ANN. § 50-16-202 (2001):** A health care facility and its agents and employees may provide medical records or other health care information relating to the condition and treatment of any patient in the health care facility to any utilization review, peer review, medical ethics review, quality assurance, or quality improvement committee of the health care facility.

**MONT. CODE ANN. § 50-16-525 (2001):** Health care providers may not release health care information about a patient to any other person without the patient's written authorization.

**MONT. CODE ANN. § 50-16-526 (2001):** A patient may authorize a health care provider to disclose the patient's health care information. A health care provider shall honor an authorization and, if requested, provide a copy of the recorded health care information unless the health care provider denies the patient access to health care information.

**MONT. CODE ANN. § 50-16-529 (2001):** A health care provider may disclose health care information about a patient without the patient's authorization, to the extent a recipient needs to know the information. The disclosure can be made to a person who is providing health care to the patient; to any other person who requires health care information for health care education; to provide planning, quality assurance, peer review, or administrative, legal, financial, or actuarial services to the health care provider; for assisting the health care provider (or successors of the health care provider) in the delivery of health care; or to a third-party health care payer who requires health care information.

**NEBRASKA**

**Case Law**

No court cases dealing strictly with access or disclosure of medical records were found.
Statutes

Access

**NEB. REV. STAT. §§ 20-164(1)-(2) (2001):** To protect the legal rights of a mentally ill individual or with respect to matters that occur within ninety days after the discharge date of such an individual from a mental health facility, the protection and advocacy system shall be granted access to the records of (a) any mentally ill individual who is a client of the protection and advocacy system if such individual or the legal guardian, conservator, or other legal representative of such individual has authorized the protection and advocacy system to have such access; and (b) any mentally ill individual (1) who by reason of the mental or physical condition is unable to authorize the protection and advocacy system to have such access; (2) who does not have a legal guardian, conservator, or other legal representative, or for whom the legal guardian is this state; and (3) with respect to whom a complaint has been received by the protection and advocacy system or with respect to whom there is probable cause to believe that such individual has been subject to injury or deprivation with regard to his or her health, safety, welfare, rights, or level of care. The protection and advocacy system may not disclose information from such records to the mentally ill individual who is the subject of the information if disclosure would be detrimental to such individual's health.

**NEB. REV. STAT. §§ 71-8403(1)-(4) (2001):** A patient may request a copy of his or her medical records or may request to examine them. Access to medical records shall be provided upon written request, except that mental health records may be withheld if any treating physician, psychologist, or mental health practitioner determines in his or her professional opinion that release of the records would not be in the best interest of the patient. Upon receiving a written request for a copy, the health care provider shall comply within thirty days. Upon receiving a written request to examine medical records, the provider shall as promptly as required under the circumstances, but no later than ten days after receiving the request (a) make the medical records available for examination during regular business hours; (b) inform the patient if the records do not exist or cannot be found; (c) if the provider does not maintain the records, inform the patient of the name and address of the provider who maintains such records, if known; or (d) if unusual circumstances have delayed handling the request, inform the patient in writing of the reasons for the delay and the earliest date, not later than twenty-one days after receiving the request, when the records will be available for examination. A provider shall not be required to disclose confidential information in any medical record concerning another patient or family member who has not consented to the release of the record.

**NEB. REV. STAT. § 71-8404 (2001):** For medical records provided under NEB. REV. STAT. § 71-8403 (2001) to a patient or his or her authorized representative, a
provider may charge no more than $20.00 as a handling fee and no more than $0.50 per page as a copying fee. A provider may charge for the reasonable cost of all duplications of medical records that cannot routinely be copied or duplicated on a standard photocopy machine. A provider may charge an amount necessary to cover the cost of labor and materials for furnishing a copy of an x-ray or similar special medical record. If the provider does not have the ability to reproduce x-rays or other records requested, the person making the request may arrange, at his or her expense, for the reproduction of such records.

**NEB. REV. STAT. §§ 71-8505(1)-(4) (2001):** Prior to an initial telehealth consultation, a telehealth care practitioner shall ensure that the patient receive (1) a written statement that all existing confidentiality protections apply to the telehealth consultation; (2) a written statement that the patient shall have access to all medical information resulting from the telehealth consultation as provided by law for patient access to his or her medical records; and (3) a written statement that dissemination of any patient-identifiable images or information from the telehealth consultation to researchers or other entities shall not occur without the written consent of the patient.

**Disclosure**

**NEB. REV. STAT. § 71-1335(1) (2001):** No mental health practitioner shall disclose any information he or she may have acquired from any person consulting him or her in his or her professional capacity except with the written consent of the person or, in the case of death or disability, of the person’s personal representative, any other person authorized to sue on behalf of the person, or the beneficiary of an insurance policy on the person’s life, health, or physical condition. When more than one person in a family receives therapy conjointly, each such family member who is legally competent to execute a waiver shall agree to the waiver. Without such a waiver from each family member, a practitioner shall not disclose information received from any family member who received therapy conjointly.

**NEB. REV. STAT. § 71-5185 (2001):** No patient data received or recorded by an emergency medical service or an out-of-hospital emergency care provider shall be divulged, made public, or released except to the receiving health care facility, to the state for statistical purposes, or upon the written authorization of the patient. For purposes of this section, patient data means any data received or recorded as part of the records maintenance requirements of the Emergency Medical Services Act.

**NEB. REV. STAT. § 71-8406 (2001):** A provider who transfers or submits information in good faith to a patient’s medical record shall not be liable in damages to the patient or any other person for the disclosure of such medical records.

**NEB. REV. STAT. § 81-674 (2001):** Any private or public entity, individual, or
approved researcher who wrongfully discloses confidential data obtained from state medical records and health information registries, or uses such information with the intent to deceive, shall be guilty of a misdemeanor for each offense.

**Case Law**

No court cases dealing strictly with access or disclosure of medical records were found.

**Statutes**

**Access**

**NEV. REV. STAT. §§ 163A.B.363(1)-(3), (7) (2001):** Health care providers and all persons who own or operate an ambulance in Nevada shall make a patient’s health care records available for inspection by the patient or a representative with written authorization from the patient. The records must be made available at a place convenient for inspection, and inspection must be permitted at all reasonable office hours and for a reasonable length of time. If the records are located outside the state, the provider shall make them available within ten working days after the request. The provider shall also furnish a copy of the records to each patient or authorized representative who requests them and pays the actual cost of postage, if any, the costs of making the copy, not to exceed $0.60 per page for photocopies, and a reasonable cost for copies of x-ray photographs and other health care records produced by similar processes. No administrative fee or additional service fee of any kind may be charged for furnishing such a copy. Health care providers or owners or operators of ambulances, their agents, and their employees are immune from any civil action or consequential damages for any disclosures made in accordance with the provisions of this section.

**NEV. REV. STAT. §§ 443.504(1)-(2) (2001):** A mental health patient must be permitted to inspect his or her records and kept informed of his or her clinical status and progress at reasonable intervals, not longer than three months, in a manner appropriate to the clinical condition. Unless a psychiatrist has made an entry to the patient’s record to the contrary, the patient must be given a copy of his or her records at any time upon notice to the administrative officer of the facility and payment of costs to reproduce records.

**Disclosure**

**NEV. REV. STAT. § 433A.360(1) (2001):** Clinical mental health records cannot be released except (a) to physicians, attorneys, and social agencies authorized in writing by the patient, his or her guardian, or his or her attorney; (b) to persons authorized by a court of competent jurisdiction; (c) to qualified facility staff, an employee of the facility, or a staff member of a Nevada agency when the
administrator deems it necessary for proper care; (d) for statistical and evaluative purposes if the identity of the patient is protected; (e) to make a claim for insurance benefits with the written consent of the patient or his or her guardian; (f) to any staff member of a Nevada agency; or (g) for transfer to another facility.

**NEV. REV. STAT.** § 443.482(8) (2001): Each mental health or mentally handicapped patient admitted for evaluation, treatment, or training has the right to designate a person who must be kept informed by the facility of the patient's medical and mental condition, if the client signs a release allowing the facility to provide such information. Patients have a right to deny access to their medical records to any person other than a member of the facility staff or related medical personnel, a person who obtains a waiver by the patient, or a person who obtains a court order.

**NEV. REV. STAT.** § 449.720(4) (2001): Every patient of a medical facility, dependent care facility, or individual residential care facility has the right to privacy concerning his or her program of medical care. Discussions of a patient's care, consultation with other persons concerning the patient, examinations or treatments, and all communications and records concerning the patient are confidential except for personal injury suits, state efforts to collect and analyze data, forwarding medical records upon transfer of a patient, and activities related to "healing arts" occupations.

### NEW HAMPSHIRE

**Case Law**

No court cases dealing strictly with access or disclosure of medical records were found.

**Statutes**

**Access**

**N.H. REV. STAT. ANN.** § 151:21(X) (2001): Medical information contained in medical records at any licensed facility shall be deemed the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for copying medical records shall not exceed $15.00 for the first thirty pages or $0.50 per page, whichever is greater, provided that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

**Disclosure**

**N.H. REV. STAT. ANN.** §§ 135-C:19-a(I)-(II) (2001): Notwithstanding other provisions, a community mental health center or state facility providing services to seriously or chronically mentally ill clients may disclose information regarding diagnosis, admission to or discharge from a treatment facility, functional
assessment, the name of the medicine prescribed, the side effects of any medication prescribed, behavioral or physical manifestations that would result from failure of the patient to take such prescribed medication, treatment plans and goals, and behavioral management strategies to a family member or other person, if such family member or person lives with the client or provides direct care to the client. The mental health center or facility shall provide a written notice to the patient that shall include the name of the person requesting the information, the specific information requested, and the reason for the request. Prior to disclosure, the mental health center or facility shall request the patient's consent in writing. If consent cannot be obtained, the patient shall be informed of the reason for the intended disclosure, the specific information to be released, and the person or persons to whom the disclosure is to be made.

N.H. REV. STAT. ANN. § 151:21(X) (2001): Patients shall be ensured confidential treatment of all information contained in their personal and clinical records, including that stored in an automatic data bank. A patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it.

N.H. REV. STAT. ANN. §§ 151:30(I)-(II) (2001): Any person aggrieved by a hospital or sanitarium's failure to abide by the provisions of N.H. REV. STAT. ANN. § 151 may seek equitable relief from the superior court, which shall have original jurisdiction. A facility violating N.H. REV. STAT. ANN. § 151 will be liable in the sum of $50.00 for each violation per day or part of a day, or for all damages proximately caused by the violations, whichever is greater.

N.H. REV. STAT. ANN. § 329:26 (2001): The confidential relations and communications between a physician or surgeon and a patient are placed on the same basis as those provided by law between attorney and client. Except as otherwise provided by law, no such physician or surgeon shall be required to disclose such privileged communications. Confidential relations and communications between a patient and any person working under the supervision of a physician or surgeon that are customary and necessary for diagnosis and treatment are privileged to the same extent.

N.H. REV. STAT. ANN. §§ 332-1:1(I)-(III) (2001): Medical information contained in medical records in the possession of any health care provider shall be deemed the property of the patient. Release or use of patient-identifiable medical information for sales or marketing of services or products is prohibited without written authorization.

**New Jersey**

**Case Law**

Plaintiff patients sued the defendants, doctors and the medical record copying service, for overcharging plaintiffs for copies of medical records under N.J. ADMIN. CODE tit. 8 § 43G-15.3(d) and tit. 13 § 35-6.5(c)(4). Defendants moved for summary judgment, claiming that the complaint should have been addressed to the state board of medical doctors. The trial court granted summary judgment, but the appellate court reversed and remanded the decision because there was an issue of fact as to the meaning of “actual costs” used in the regulation governing copying of medical records.

*Estate of Behringer v. Med. Ctr. at Princeton,* 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991): The estate of a surgeon who died of AIDS brought an action against the hospital seeking damages for the breach of the hospital’s duty to maintain confidentiality of the plaintiff’s diagnosis. The defendant hospital denied any breach of confidentiality, but the trial court granted a judgment in favor of the plaintiff because the potential harm from non-consensual disclosure was substantial.

*In re J.C.G.*, 366 A.2d 733 (N.J. Hudson County Ct. Law Div. 1976): A parent who applied for the involuntary civil commitment of her thirteen year-old daughter requested, through counsel, that the Trenton Psychiatric Hospital release her daughter’s hospital records. The court denied the request, concluding that the parent failed to advance any evidence that the disclosure would be used directly or indirectly for the benefit of the patient.

**Statutes**

*Access*

N.J. STAT. ANN. § 26:2H-12.8(g) (West 2001): A patient has the right to access his or her medical records pertaining to his or her treatment from the hospital upon request within a reasonable cost unless the patient’s physician has stated in writing that access by the patient is not advisable.

*Disclosure*

N.J. STAT. ANN. § 26:2H-12.8(g) (West 2001): Every person admitted to a general hospital has a right to privacy and confidentiality of all records kept pertaining to the person’s treatment, except as otherwise provided by law or third-party payment contracts.

N.J. STAT. ANN. § 30:4-24.3 (West 2001): To protect the institutionalized mentally ill, all certificates, applications, records, and reports made in conjunction with any person presently or formerly receiving services in a non-correctional institution must be kept confidential and may not be disclosed by any person without the consent of the patient, except in limited circumstances.
Case Law

*Pina v. Espinoza*, 29 P.3d 1062 (N.M. Ct. App. 2001): The plaintiff, an injured woman, appealed a court decision that was made when she filed a personal injury action against a driver she claimed was responsible for hitting her car and causing her subsequent injury. The lower court requested a blanket release of her medical records for the trial, but the appellate court found that this was an abuse of discretion, and the case was remanded.

*Lara v. City of Albuquerque*, 971 P.2d 846 (N.M. Ct. App. 1998): The city filed a motion to compel the plaintiff, a city employee, to provide a signed medical release allowing the city to access his drug test results and other treatment records. The plaintiff refused to offer his medical records, asserting the psychotherapist-patient privilege and rules of confidentiality, and the appellate court found for the plaintiff on those grounds.

*Eckhardt v. Charter Hosp. of Albuquerque*, 953 P.2d 722 (N.M. Ct. App. 1997): The lower courts dismissed the claim that a hospital employee wrongfully disclosed confidential records to the patient’s husband. The appellate court reversed, finding that the patient’s wrongful disclosure claim was viable because the employee improperly disclosed information about the plaintiff.

*New Mexico v. Roper*, 921 P.2d 322 (N.M. Ct. App. 1996): The district court suppressed the results of the defendant’s blood tests after the defendant was charged with operating a vehicle under the influence of alcohol and causing great bodily injury while driving under the influence of alcohol. The state appealed, but the appellate court affirmed the decision of the lower court, stating that the results of the defendant’s blood tests constituted a confidential communication.

*New Mexico v. Gonzales*, 912 P.2d 297 (N.M. Ct. App. 1996): The victim claimed that the defendant had sexually assaulted her, and the defendant claimed that they had consensual sex. The defendant wanted dismissal of the charges since the prosecution would not produce the victim’s medical records for camera view. The lower court found that because the victim’s medical releases were signed in favor of the prosecution, this terminated the confidentiality of the records and waived the physician-psychotherapist privilege of New Mexico. The appellate court affirmed the trial court’s dismissal of the charges against the defendant.

Statutes

Access

N.M. STAT. ANN. § 14-6-3 (Michie 2001): Health care providers must provide a patient, a former patient, or an authorized representative of such a patient, who is applying for or appealing denial for benefits based on social security disability, with a copy of that patient’s medical records. The health care provider may charge
a fee to the requestor for such a copy.

N.M. STAT. ANN. § 32A-6-15 (Michie 2001): A child has a right to access confidential information about himself, and to make copies of information about himself, unless the physician or health professional believes and notes in the child’s medical record that disclosure is not in the best interest of the child. Except as otherwise provided in the Children’s Mental Health and Developmental Disabilities Act, no person shall, without the authorization of the child, disclose confidential information that would enable an acquainted person to recognize the child. When a child fourteen years or older is incapable of consenting to disclosure, the person seeking authorization shall petition the court for appointment of a treatment guardian to decide for the child. Authorization for disclosure is not necessary when the request is from a mental health or disability professional; when it is necessary to protect or treat the child; or when the disclosure is to a paying insurer. No disclosure authorization is effective unless it is in writing, signed, and contains a copy of the child’s right to copy the information.

N.M. STAT. ANN. § 43-1-19 (Michie 2001): A client has a right of access to confidential information about himself and has the right to make copies of any information, except if the physician, mental health, or disabilities professional believes and notes in the record that disclosure is not in the best interest of the client. In that case, a client may petition the court for access.

Disclosure

N.M. STAT. ANN. § 14-6-1 (Michie 2001): All health information that relates to and identifies specific individuals as patients is strictly confidential and shall not be a matter of public record or accessible to the public even though the information is in the custody of, or contained in the records of, a governmental agency or its agent, a state educational institution, a duly organized state or county association of licensed physicians or dentists, a licensed health facility, or staff committees of such facilities.

N.M. STAT. ANN. § 43-1-19 (Michie 2001): Without the authorization of the client, no person shall disclose any confidential information from which the client may be recognized, except when this information is requested by a mental health or developmental disability professional or a primary caregiver of the client; disclosure is necessary to protect against a clear and substantial risk of “imminent serious physical injury or death” of the client or another; or disclosure is to a contracted insurer obligated to pay any part of the expenses. No authorization shall be effective unless it is in writing, signed, and contains a statement of the client’s right to examine and copy the information to be disclosed.

N.M. STAT. ANN. § 59A-46-27 (Michie 2001): Records pertaining to physical or mental examinations and medical treatment of persons confined to any institution cannot undergo public inspection.
Case Law

McCrossan v. Buffalo Heart Group, 695 N.Y.S.2d 852 (N.Y. App. Div. 1999): The court held that, where a patient authorized a third party to receive a copy of her medical records, the provider could charge the authorized party no more than $0.75 per page as proscribed by N.Y. PUB. HEALTH LAW § 18(2)(c), even though the designated party is not a "qualified person" as defined in the statute.


Doe v. Roe, 599 N.Y.S.2d 350 (N.Y. App. Div. 1993): The court considered whether the defendant-physician’s disclosure of the patient plaintiff’s HIV status to a Pennsylvania court, in violation of N.Y. PUB. HEALTH LAW § 2782, was grounds for a private civil suit, and with what types of remedy. The defendant doctor had mailed the patient’s records, which included HIV status, to comply with a subpoena for the patient’s worker’s compensation suit. The court found the suit viable and the defendant liable for both compensatory and punitive damages. In addition, the court found the defendant’s oral agreement to keep the information confidential to be grounds for a breach of contract claim.

Calabrese v. PHF Life Ins. Co., 594 N.Y.S.2d 1016 (N.Y. App. Div. 1993): In reviewing a motion filed by the plaintiff doctor to quash, based on N.Y. PUB. HEALTH LAW § 4504, a subpoena issued by defendant insurance company for the plaintiff’s patients’ records, the court upheld the subpoena but ordered the patient records produced in redacted form, “deleting the patients’ names and addresses and any other identifying information to comport with...doctor-patient privilege.”

Rosen v. Arden Hill Hosp., 622 N.Y.S.2d 663 (N.Y. Sup. Ct. 1993): The court considered whether the defendant-hospital’s disclosure that the plaintiff had undergone a procedure violated his right to confidentiality under N.Y. PUB. HEALTH LAW § 2803-c. The defendant performed a test on the plaintiff and his two infant sons to confirm paternity. The sons’ mother, from whom the plaintiff was divorced, called the defendant and inquired whether plaintiff had made payment for a paternity test. Defendant informed her that payment had been made for such a test, thereby revealing that it had occurred. The court held that since she, as guardian of the children, had a legal right under N.Y. PUB. HEALTH LAW § 18 to any records concerning tests and procedures involving her children; and since it would be impossible to reveal that a paternity test had been administered on the children without revealing its administration on the plaintiff-father; the defendant-hospital’s disclosure was appropriate under law.
**Statutes**

**Access**

N.Y. PUB. HEALTH LAW § 18(2)(a)-(2)(c) (McKinney 2001): Upon written request, a health care provider must grant, within ten days, the opportunity to inspect a patient's non-excluded medical records to the patient; to a minor patient's parent or legal guardian (except where such access would be detrimental to the minor); to a "qualified person," which includes any properly identified subject or guardian appointed pursuant to article eighty-one of the mental hygiene law; to a guardian of an infant; or to a representing attorney; and, where the patient has been found incompetent, to the committee appointed for the patient's protection.

N.Y. PUB. HEALTH LAW § 18(2)(d)-(2)(i) (McKinney 2001): Upon request, a provider must furnish a copy of non-excluded records to a qualified person within a reasonable time. A provider may impose a reasonable charge for access not to exceed the costs incurred by the provider. For copies of medical records, the charge may not exceed $0.75 per page. Access to medical records may not be denied solely because of inability to pay. For inspections, a provider may place reasonable limitations on the time, place, and frequency of inspection; and may provide a copy instead if inspection is limited by space.

N.Y. PUB. HEALTH LAW § 18(3)(a)-(f) (McKinney 2001): A provider may refuse access to medical records only when (1) the provider has determined that identifiable harm would befall a patient as a result of disclosure or (2) when those medical records contain privileged and confidential physician notation. Where a provider has denied access to a patient's records, it may provide a summary of denied records. In the event of a denial of access, the qualified person shall be informed by the provider of the decision, and of the qualified person's right to obtain, without cost, a review of the denial by the appropriate medical record access review committee.

N.Y. PUB. HEALTH LAW § 18(9) (McKinney 2001): Any agreement to waive the right to access one's patient records as described in this statute is unenforceable and void as against public policy.

N.Y. MENTAL HYG. § 33.16 (McKinney 2001): Mental health records are subject to rules similar to those set forth in PUB. HEALTH LAW § 18, with the following differences. Qualified person status is extended to include the parent, spouse, or child of certain adult patients. There is no disclosure exemption for confidential physician notation.

**Disclosure**

N.Y. PUB. HEALTH LAW § 18(6) (McKinney 2001): Whenever a health care provider discloses patient information to a person or entity other than the subject of such information or to other qualified persons, a copy of the subject's

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authorization, or the name and address of such third party shall be placed or noted in the chart. The disclosure should be limited to information necessary in light of the reason for disclosure. If a provider must disclose patient information to a person or entity other than the relevant patient as authorized by law, the provider shall notify the patient.

N.Y. PUB. HEALTH LAW § 2808-c (McKinney 2001): Hospital patients have the right to confidentiality in the treatment of personal and medical records. A statement of this right (and other patient rights and responsibilities) must be both given to patients and conspicuously posted in each hospital.

### NORTH CAROLINA

**Case Law**

*Lavelle v. Guilford Area Mental Illness*, 456 S.E.2d 827 (N.C. 1995): The court held that mental health facilities are required to disclose confidential information to a patient’s attorney upon the patient’s request without restrictions.

*Baugh v. Woodward*, 287 S.E.2d 412 (N.C. Ct. App. 1982): In a class action on behalf of all prisoners, the plaintiff demanded that the Department of Correction provide each prisoner who had undergone psychiatric or psychological treatment while in prison with direct access to their mental health records pursuant to principles now codified in N.C. GEN. STAT. § 122C-53 (2001). The court ruled that prison-operated mental health facilities did not qualify as facilities subsumed by statute; that no prisoner would be allowed access to their mental health records even if treatment was received after transfer to a facility operated by the Department of Human Resources, so as to avoid equal protection problems; and that prisoners had no property rights in mental health records generated while in prison, and thus, no legitimate claim of entitlement protected by procedural due process.

**Statutes**

**Access**

N.C. GEN. STAT. § 90-85.35 (2001): Pharmacists employed in health care facilities shall have access to patient records maintained by those facilities when necessary for them to provide pharmaceutical services.

N.C. GEN. STAT. §§ 122C-53(c), (d) (2001): Upon request, a client of a mental health, developmental disability, or substance abuse facility shall have access to confidential information in his or her record except information that would be injurious to the client’s well being as determined by the attending physician or, if there is none, by the facility director or his or her designee. The legally responsible person of a client has the same right. If the attending physician or facility director or his or her designee has refused to provide information, the
client or legally responsible person may request that the information be sent to a physician or psychologist of his or her choice.

**Disclosure**

N.C. GEN. STAT. § 90-412(a) (2001): Notwithstanding any other provision of law, any health care provider or facility licensed, certified, or registered under state law, or any unit of state or local government, may create and maintain medical records in an electronic format. The health care provider, facility, or governmental unit shall not be required to maintain a separate paper copy of the electronic medical record; however, when a consent to treatment or authorization to disclose medical record information is contained in a paper writing, the writing shall be preserved in a durable medium, and its existence and location shall be noted in the electronic record.

N.C. GEN. STAT. § 90-412(c) (2001): The usual legal rights and responsibilities, including those regarding access to and disclosure of medical records, apply to records created or maintained in electronic form to the same extent as they apply to medical records embodied in paper or other media.

N.C. GEN. STAT. § 122C-53(a) (2001): A mental health, developmental disability, or substance abuse facility may disclose confidential information if the client or his or her legally responsible person consents in writing to the release of the information to a specified person. This release is valid for a specified length of time and is subject to revocation by the consenting individual.

N.C. GEN. STAT. § 122C-53(b) (2001): A mental health, developmental disability, or substance abuse facility may disclose the fact of admission or discharge of a client to the client's next of kin whenever the responsible professional determines that the disclosure is in the best interest of the client.

N.C. GEN. STAT. § 122C-55(a) (2001): Any area or state facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may share confidential information regarding any mental health, developmental disability, or substance abuse patient of that facility with one another when necessary to coordinate appropriate and effective care, treatment, or habilitation and when failure to share this information would be detrimental to the patient. Consent is not required, and the information may be furnished despite objection by the patient.

N.C. GEN. STAT. § 122C-55(b) (2001): A facility, physician, or other individual responsible for evaluation, management, supervision, or treatment of respondents examined or committed for outpatient mental health, developmental disability, or substance abuse treatment may request, receive, and disclose confidential information to the extent necessary to enable them to fulfill their responsibilities.

N.C. GEN. STAT. § 122C-55(c) (2001): When requested, a facility may furnish confidential information to the Department of Correction regarding any client of that facility when the inmate has been determined by the department to be in
need of treatment for mental illness, developmental disabilities, or substance abuse. The department may furnish a facility with confidential information in its possession about treatment that the department has provided to any present or former inmate if the inmate is presently seeking treatment from the requesting facility or if the inmate has been involuntarily committed to the requesting facility. The consent of the client or inmate shall not be required for this information to be furnished and the information shall be furnished despite objection by the client or inmate. Confidential information disclosed pursuant to this subsection is restricted from further disclosure.

N.C. GEN. STAT. § 122C-55(e) (2001): A responsible professional may exchange confidential information with a physician or other health care provider who is providing emergency medical services to a mental health, developmental disability, or substance abuse client. Disclosure of the information is limited to that necessary to meet the emergency as determined by the responsible professional.

N.C. GEN. STAT. § 122C-55(f) (2001): A mental health, developmental disability, or substance abuse facility may disclose confidential information to a provider of support services whenever the facility has entered into a written agreement with a person to provide support services and the agreement includes a provision in which the provider of support services acknowledges that in receiving, storing, processing, or otherwise dealing with any confidential information, he or she will safeguard and not further disclose the information.

N.C. GEN. STAT. § 122C-55(h) (2001): Within a mental health, developmental disability, or substance abuse facility, employees, students, consultants, or volunteers involved in the care, treatment, or habilitation of a client may exchange confidential information as needed for the purpose of carrying out their responsibility in serving the client.

N.C. GEN. STAT. § 122C-55(i) (2001): Upon specific request, a responsible professional of a mental health, developmental disability, or substance abuse facility may release confidential information to the physician or psychologist who referred the client.

N.C. GEN. STAT. § 122C-55(j) (2001): Upon request of the next of kin or other family member who has a legitimate role in the therapeutic services offered, or other person designated by a mental health, developmental disability, or substance abuse client or his or her legally responsible person, the responsible professional shall provide the next of kin or other family member or the designee with notification of the client's diagnosis, prognosis, prescribed medications, medication dosage, medication side effects, and progress, provided that the client or legally responsible person has consented in writing, or the client has consented orally in the presence of a witness selected by the client.

N.C. GEN. STAT. § 122C-55(k) (2001): Notwithstanding N.C. GEN. STAT. § 122C-53(b) (2001) or provisions governing transfer of clients between twenty-four-
hour facilities, upon request of the next of kin or other family member who has a legitimate role in the therapeutic services offered to a client of a mental health, developmental disability, or substance abuse facility, or other person designated by the client or his or her legally responsible person, the responsible professional shall provide the next of kin, family member, or designee notification of the client’s admission, transfer, decision to leave against medical advice, discharge, and referrals and appointment information for treatment after discharge, after notification to the client that this information has been requested.

N.C. GEN. STAT. § 122C-55(l) (2001): In response to a written request of the next of kin or other family member who has a legitimate role in the treatment of a mental health, developmental disability, or substance abuse client, or other person designated by the client, for additional information not provided for in N.C. GEN. STAT. §§ 122C-55(j), (k) (2001), and when such written request identifies the intended use for this information, the responsible professional shall, in a timely manner (1) provide the information based upon the responsible professional’s determination that it will be to the client’s therapeutic benefit, and provided that the client or his legally responsible person has consented in writing to the release; (2) refuse to provide the information based upon the responsible professional’s determination that it would be detrimental to the therapeutic relationship between client and professional; or (3) refuse to provide the information based upon the responsible professional’s determination that the next of kin or family member or designee does not have a legitimate need for the information.

N.C. GEN. STAT. § 131E-97(a) (2001): Medical records compiled and maintained by health care facilities in connection with the admission, treatment, and discharge of individual patients are not public records.

N.C. GEN. STAT. § 131E-98 (2001): Notwithstanding any other provision of law, a hospital does not breach patient confidentiality by providing the Department of Correction with medical records of inmates who receive medical treatment at the hospital while in the custody of the department.

**Case Law**

*Theven v. Job Serv. N.D.*, 488 N.W.2d 48 (N.D. 1992): A clerk in the medical records department of a hospital discovered her husband’s misfiled lab report while cleaning out records. The clerk removed the report and placed it in her desk, where a co-worker discovered it and reported the clerk to a supervisor. The clerk was subsequently fired for a breach of confidentiality, which the court upheld.

*Jane H. v. Rothe*, 488 N.W.2d 879 (N.D. 1992): Jane H. sued her doctors for medical malpractice, alleging that they negligently performed gynecological
surgery. Jane H. petitioned the court for a supervisory writ directing the trial court to vacate a discovery order that compelled her to disclose her chemical dependency treatment records. The trial court found that the three facilities where Jane received treatment are covered by acts that restrict the disclosure of a patient's records about drug and alcohol abuse treatment at federally assisted facilities. The court concluded that an in camera inspection should be conducted before ordering even limited disclosure of treatment records that are privileged under federal law. The petition was granted, and the court ordered to vacate the discovery order and remand for further proceedings.

**Statutes**

**Disclosure**

N.D. **CENT. CODE § 23-16-09** (2001): In the case of hospitals and related institutions providing maternity care, no agent of the state department of health or of any board of health, nor the licensee under the provisions of this chapter, may disclose the contents of case records of such institution except in a judicial proceeding, to certain health or social agencies, or to persons who have a direct impact on the well being of the patient or her infant.

**Case Law**

*McCleary v. Roberts*, 725 **N.E.2d** 1144 (Ohio 2000): The court held that names, addresses, phone numbers, family information, and medical records of children in a city's database are exempt from public disclosure under the state Public Records Act because they do not meet the definition of "records."

*Biddle v. Warren Gen. Hosp.*, 715 **N.E.2d** 518 (Ohio 1999): The court found that in Ohio, an independent tort exists for the unauthorized, unprivileged disclosure to a third party of non-public medical information that a hospital or physician learns within the physician-patient relationship. The court also noted a common law duty of disclosure of information concerning public health or safety to third persons and other situations where certain countervailing interests outweigh the patient's interest in confidentiality. Finally, the court held that a consent to the release of medical information must be fairly specific in terms of to whom the disclosure is made.

*Levias v. United Airlines*, 500 **N.E.2d** 370 (Ohio Ct. App. 1985): A flight attendant brought an action against her employer airline claiming an invasion of privacy for the disclosure of confidential medical data. The evidence showed that she had directed her physician to supply the airline's medical examiner with certain confidential medical information. The examiner used this information to authorize a waiver of weight limits imposed on certain employees. The examiner
released the information to the flight supervisor who then repeatedly contacted the plaintiff to discuss her medical condition with her. The court held that the employer and its examiner could be liable for unauthorized disclosure of medical records because the persons to whom it was disclosed had no "need to know" it.


Peeples v. Department of Corrections, No. 95API03-337, 1995 Ohio App. LEXIS 4491 (Ohio Ct. App. Oct. 12, 1995): Where an inmate fails to file a request for his medical records jointly with his attorney or physician, Ohio law states that such a request may be denied.

Ebsch v. Tanpnaichitr, 611 N.E.2d 430 (Ohio Ct. App. 1992): Where a doctor refused to release medical records of a patient without first receiving payment for his medical services, there was no violation of law because there was no legal duty under Ohio statute or common law to transfer, upon request, the medical records of a patient, and that there was no evidence of damages resulting from the delay in the release of the information.

Statutes

Access

Ohio Rev. Code Ann. § 1347.08 (Anderson 2001): A state or local agency that maintains health information about an individual must let the individual know about the existence of that information, allow the person to inspect those records, and inform the person about the uses of the information. The information shall not be disclosed to the person if a physician, psychiatrist, or psychologist determines that disclosure will have an adverse effect on the individual.

Ohio Rev. Code Ann. § 3701.74 (Anderson 2001): Within a reasonable amount of time after receiving a written request from a former patient, a hospital must provide patient access to, or a copy of, her hospital records. If the physician determines that such disclosure would have an adverse effect on the patient, the hospital must provide the record to a physician designated by the patient. If the hospital fails to furnish the requested records, the patient may bring a civil action to enforce her right of access.

Ohio Rev. Code Ann. § 4113.23 (Anderson 2001): No employer or physician, other than a provider that contracts with the employer to provide medical information pertaining to employees, shall refuse upon written request of an employee to furnish to the employee or their designated representative a copy of any medical report pertaining to the employee.

Ohio Rev. Code Ann. § 5119.61 (Anderson 2001): The recipient of services provided through local boards of alcohol, drug addiction, and mental health services has the right to access his own medical and mental health records unless
access is restricted for clear treatment reasons.

**Ohio Rev. Code Ann. § 5120.21** (Anderson 2001): An inmate may obtain a copy of his or her medical record if he or she signs a written request together with a written request of an attorney or licensed physician. Such a record will be made available to the physician or attorney. A reasonable fee may be charged for copying. If the physician concludes that revealing the medical record to the inmate will result in medical harm to the inmate, such disclosure shall be withheld. The records shall be made available to an attorney or physician not more than once in every twelve months.

**Ohio Rev. Code Ann. § 5122.81** (Anderson 2001): A mental health patient who has been institutionalized pursuant to a court order has a right to access his own psychiatric and medical records unless access is specifically restricted in a patient’s treatment plan for treatment-related reasons.

**Disclosure**

**Ohio Rev. Code Ann. § 149.43** (Anderson 2001): Medical records maintained by any public office are specifically excluded from the definition of “public records” that must be made available to the public under the state’s open records law.

**Ohio Rev. Code Ann. § 2305.24** (Anderson 2001): Records and information made available to a hospital’s quality assurance or utilization review committee retain their confidentiality and may be used by members of the committee only in the exercise of their functions as members of the committee.

**Oklahoma**

**Case Law**

**Bettis v. Brown,** 819 P.2d 1381 (Okla. Ct. App. 1991): A private right of action was available for a dentist’s breach of the statutory duty to provide the requested medical records to a patient pursuant to Okla. Stat. tit. 76, §§ 19-20, which governs health care providers in general.

**McFeely v. Tredway,** 816 P.2d 575 (Okla. Ct. App. 1990): Okla. Stat. tit. 76, § 19, providing that any patient of a doctor, hospital, or other medical institution has a right to access information contained in his or her medical records upon request, does not provide any implied private right of action against attorneys of doctors, hospitals, or other medical institutions when records are not so provided.

**Statutes**

**Access**

**Okla. Stat. tit. 36, §§ 6804(A), (D), (E)** (2001): Prior to the delivery of health care via telemedicine, the health care practitioner who is in physical
contact with the patient shall have the ultimate authority over the care of the patient and shall obtain informed consent from the patient. The informed consent shall include a statement that (1) all existing confidentiality protections apply; (2) patient access to all medical information transmitted during a telemedicine interaction is guaranteed, and that copies of this information are available at stated costs, which shall not exceed the direct cost of providing the copies; and (3) a statement that dissemination to researchers or other entities or persons external to the patient-practitioner relationship of any patient-identifiable images or other patient-identifiable information from the telemedicine interaction shall not occur without the written consent of the patient.

**OKLA. STAT. tit. 76, § 19(A) (2001):** Any person who is or has been a patient of a doctor, hospital, or other medical institution has a right upon request to access information contained in his or her medical records, including any x-ray or other photograph or image. A patient shall receive copies of all records upon request and upon tender of the expense of the copies. The cost of each copy, not including any x-ray or other photograph or image, shall not exceed $0.25 per page. The cost of each x-ray or other photograph or image shall not exceed $5.00 or the actual cost of reproduction, whichever is less. Physician, hospitals, or other medical professionals and institutions may charge for the actual cost of mailing the requested medical records, but may not charge a fee for searching, retrieving, reviewing, and preparing medical records. In the case of psychological or psychiatric records, a patient shall not be entitled to copies unless access to the records is consented to by the treating physician or practitioner or is ordered by a court of competent jurisdiction upon a finding that it is in the best interests of the patient. However, the patient may be provided access to information contained in the records, as provided in **OKLA. STAT. tit. 43A, § 1-109 (2001),** which specifically addresses mental health records and communications. A patient or his or her guardian may authorize the release of the psychiatric or psychological records to the patient's attorney, a third-party payer, or a governmental entity. The execution of an authorization shall not be construed to authorize the patient personal access to the records or information.

**OKLA. STAT. tit. 76, § 20 (2001):** Any person refusing to furnish records required is guilty of a misdemeanor.

### Oregon

**Case Law**

*In re Compensation of Coman,* 960 P.2d 383 (Or. 1998): The court acknowledged that the medical records of inmates are confidential under Oregon law, but that they should have been disclosed here where a worker at the prison needed those records to show that he had contracted tuberculosis while working
at the prison facility.

_Calley v. Olsen_, 532 P.2d 230 (Or. 1975): The beneficiary under a life insurance policy sought disclosure of the medical records of the deceased in an attempt to determine what caused his death. The court, interpreting Oregon statutory law, found that the beneficiary had the right to waive any doctor-patient privilege in order to take, by deposition, the testimony of the treating doctor, but that this terminated the privilege. The court also held that once a patient has waived his privilege as to one doctor, he cannot then exclude the testimony of other doctors.

_Nielson v. Bryson_, 477 P.2d 714 (Or. 1970): The plaintiff in a personal injury case argued that his medical records should not be disclosed and that such disclosure would violate Oregon law. The court agreed that there was no express or implied consent to release that information and that since such release was not specifically provided for in the statute, the release was not permissible. The court held that such statutes were not unconstitutional under Oregon law.

_In re Mershon_, 772 P.2d 440 (Or. Ct. App. 1989): The Workers Compensation Board may force a claimant to disclose medical information related to his own claim in its evaluation process.

**Statutes**

**Access**

_ORE. REV. STAT. § 179.505 (1999):_ Copies of medical records can be released to the patient within five days of a request. Disclosure may be denied when it is determined that such disclosure would result in the grave detriment to the treatment of the patient. Also, psychiatric information may be withheld by the Department of Corrections in certain situations with any such denials being documented and placed in the patient's records. The provider may be reimbursed by the patient for reasonable costs associated with producing the documents upon the patient's request.

_ORE. REV. STAT. § 192.525 (1999):_ A health care provider must disclose a patient's medical records upon the receipt of a medical release. Any records withheld must be identified as being withheld. Records that are injurious to the patient may be held back as long as the patient is notified that certain records are not being disclosed for this reason. The provider may charge a reasonable fee for producing the records.

**Disclosure**

_ORE. REV. STAT. § 109.650 (1999):_ A hospital or physician may advise a parent or legal guardian of a patient of the care, diagnosis, treatment, or need for treatment, without the consent of the patient and the doctor. The hospital or physician will not be liable for advising the parents or legal guardians of the minor without his or her consent.
ORE. REV. STAT. § 109.680 (1999): A physician, psychologist, or nurse practitioner may advise the parents or legal guardians of a minor of diagnosis or treatment whenever the disclosure is clinically appropriate and will serve the best interests of the minor's treatment because the minor's condition has deteriorated or the risk of suicide has become such that inpatient treatment is necessary, or the minor requires detoxification treatment. No liability shall attach to such disclosures.

ORE. REV. STAT. § 179.505 (1999): Medical records, such as case histories, clinical records, x-rays, treatment charts, and other forms of patient medical information maintained by a health care provider shall not be subject to inspection. The records may be released if there is informed consent on the part of the patient or a legal guardian in writing directing that such records may be released. Such records may be released without consent to any person (1) to the extent that there is a medical emergency; (2) at the discretion of the responsible officer of the provider, or to persons engaged in scientific research, program evaluation, peer review, and fiscal results; and (3) to governmental agencies when necessary to secure compensation for services rendered to the patient. When the identity of the individual is disclosed, the provider shall prepare a record of such and put it into the patient's permanent records. Records may also be disclosed to certain agencies when there has been a claim of constitutionally inadequate medical care. If any information obtained by the provider is deemed to reveal a clear and immediate danger to others, such information may be reported to appropriate authorities. The prohibitions against disclosure of medical records apply irrespective of whether the patient is still being treated by a given provider. Anyone who is given access to the medical records may not disclose the information to anyone else.

ORE. REV. STAT. § 192.502 (1999): Information of a personal nature such as that kept in a medical file that is maintained by a government agency is generally exempt from public inspection if the disclosure of the information would constitute an unreasonable invasion of privacy, unless the public interest, by clear and convincing evidence, requires disclosure.

ORE. REV. STAT. § 392.061 (1999): Any school board hearing at which the medical records of a student are discussed shall be conducted in a private session.

Pensylvania

Case Law

Commonwealth v. Moore, 584 A.2d 936 (Pa. 1991): The district attorney petitioned for access to the health department's medical records of a man charged with rape, statutory rape, indecent assault, and corruption of minors. The medical records contained information on treatment of gonorrhea, which occurred prior
to being charged with sexual misconduct offenses. The superior court granted the
district attorney’s petition for access to confidential information regarding
whether the accused received treatment for gonorrhea, but the supreme court
reversed.

Department of Military & Veteran Affairs v. Civil Serv. Comm’n, 719 A.2d 1134 (Pa.
Commw. Ct. 1998): The court found that a civil service physician was removed
without just cause from employment for his disclosure of confidential medical
records to his attorneys for the purposes of an agency investigation because the
disclosure did not negatively touch upon his competency or job performance.

Medical and mental health records of a deceased prisoner were not public records
subject to disclosure under Pennsylvania’s Right-to-Know Act because protection
from disclosure under statute does not end with the deceased’s death.

Ct. 1997): The claimant was properly denied unemployment benefits because her
willful violation of her employer’s policy against unauthorized access to
computerized medical records constituted willful misconduct.

1995): Petitioner filed a claim for workmen’s compensation benefits against his
employer for alleged clinical and situational depression. The court affirmed the
Workmen’s Compensation Appeal Board’s decision that dismissed petitioner’s
complaint on the ground that he refused to disclose medical information
regarding his status as HIV positive to his employer in its defense of his claim. The
court held that medical information could be disclosed in civil matters brought by
a patient for damages on account of personal injuries. Where a party places his
physical or mental condition in issue, the privacy right against disclosing private
medical information was waived.

Board of Psychology’s order that reprimanded a psychologist for releasing client
records pursuant to a subpoena was proper, as her ethical duty of confidentiality
required that she first seek the client’s consent or professional legal advice.

could not be held liable for the former police chief’s actions violating a police
officer’s privacy in obtaining the officer’s confidential hospital records simply on
the basis of vicarious liability or respondeat superior.

Statutes

Access

42 Pa. Cons. Stat. § 6155 (2001): A patient or his designee, including his
attorney, has the right to access and copy his medical records maintained by a
health care provider or a health care facility without the use of a subpoena.
Disclosure

35 PA. CONS. STAT. § 449.10 (2001): The Health Care Containment Council, charged with the collection of health data for the purposes of developing competitive health care services at low cost, shall not release any data, and no entity or person shall be allowed to gain access to any of the council’s raw data that could reasonably be expected to reveal the identity of the individual patient. A person who knowingly releases council data to an unauthorized person violates the patient’s confidentiality and is guilty of a misdemeanor punishable by fine, imprisonment, or both. An unauthorized person who knowingly receives or possesses such data is guilty of a misdemeanor.

50 PA. CONS. STAT. §§ 7103, 7111 (2001): Documents concerning patients receiving inpatient mental health treatment and those receiving involuntary outpatient treatment are confidential and may not be released without the patient’s consent except in very limited circumstances.

63 PA. CONS. STAT. § 12(b) (2001): Under the Medical Practice Act of 1985 concerning subpoena power, medical records may not be subpoenaed without the consent of the patient or without order of a court of competent jurisdiction. The court must indicate that the records are reasonably necessary for the investigation. The court may also place limitations on the subpoenas to prevent unnecessary intrusion into a patient’s confidential information.

RHODE ISLAND

Case Law

Fiore v. Lynch, 637 A.2d 1052 (R.I. 1994): It was not an error to order that medical records be delivered to an employee retirement investigation committee in redacted form because the plaintiffs introduced their physical conditions in proceedings before the retirement board.

Trembley v. City of Cent. Falls, 480 A.2d 1359 (R.I. 1984): Confidential medical information does not include a medical report that a patient directly procures from his own physician and personally delivers to a third-party employer.

In re Bd. of Med. Review Investigation, 463 A.2d 1373 (R.I. 1983): Physician’s records of patient treatment may be subpoenaed during the investigative stages of a board of medical review inquiry into alleged unprofessional conduct.

State v. Anthony, 440 A.2d 736 (R.I. 1982): Disclosure of the records of the department for children and their families is not prohibited in cases of known or suspected child abuse.

Statutes

Access

R.I. GEN. LAWS § 5-37.5-5 (2001): A patient has the right to request review and
revision of his confidential health care information in the possession of a third party when the third party has taken an adverse action based on that information. The patient does not have the right to review the records himself and must, instead, designate a physician to review them. The third party may require the patient to pay the third party for the actual costs incurred by the third party. The physician may disclose to the patient as much of the information as he deems appropriate. There are certain procedures whereby the patient may request that the third party amend or expunge any part of the record that he believes to be in error. If there is an unreasonable refusal to change the records, the patient has the right to apply to the district court to amend or expunge any part of his confidential health care information that he believes to be erroneous.

R.I. GEN. LAWS § 5-37-22 (2001): Upon written request, a physician must permit a patient to examine and copy the patient’s confidential health care information or provide him a summary of the information, at the physician’s option. The patient may be required to pay reasonable expenses incurred in connection with copying at the time the information is provided. If the patient is not satisfied with the summary, he may request the full record and such full record must be provided. Access may be denied if the physician believes that it would be injurious to the mental or physical health of the patient to disclose or provide information. In such a circumstance, the physician must provide the information to another physician designated by the patient.

R.I. GEN. LAWS § 5-37-25 (2001): A physician who does not comply with the rules for access to patient medical records is subject to fine, imprisonment, or both.

Disclosure

R.I. GEN. LAWS § 5-37.3-4 (2001): A patient’s confidential health care information shall not be released or transferred without written consent of the patient. Information can be provided to the department of health in certain circumstances so that it may carry out its function. Violations of the confidentiality mandate subject the violators to actual and punitive damages, with an award of attorney’s fees and capping the punishment at $5,000 and six months in jail for each violation. No consent is necessary where the information is, for example, necessary for the treatment of the individual in a medical emergency; for the release to peer review and other professional boards; or for the release to personnel conducting research, management audits, financial audits, program evaluations, and the like.

R.I. GEN. LAWS § 23-17-19.1 (2001): Government agencies that license health care facilities may not disclose patient identifying information received through filed reports and inspections except in a proceeding involving the question of licensure.

R.I. GEN. LAWS § 40.1-5-26 (2001): Mental health records are confidential and
such records shall only be disclosed in limited circumstances without the consent of the patient.

**SOUTH CAROLINA**

**Case Law**

*Brown v. Bi-Lo, Inc.* 535 S.E.2d 445 (S.C. Ct. App. 2000): The court held that a physician does not breach the duty of confidentiality by providing an employer or the employer's representatives with medical information relevant to workers' compensation cases.

*McCormick v. England*, 494 S.E.2d 431 (S.C. Ct. App. 1997): The plaintiff claimed that her physician, who was treating both her and her husband, violated patient-physician confidentiality by revealing her mental health problems to her husband during divorce proceedings absent a court order. The court held that South Carolina would henceforth recognize a common law tort for breach of a physician's duty of confidentiality.

*Doe v. North Greenville Hosp.*, 458 S.E.2d 439 (S.C. Ct. App. 1995): The plaintiff sued the defendant hospital for releasing the plaintiff's records to his insurer, which in turn disclosed information to the plaintiff's wife. The court held that the hospital, which initially released the plaintiff's records for reimbursement purposes, could not be held liable for the insurer's subsequent disclosure.

**Statutes**

**Access**

*S.C. CODE ANN.* § 42-15-95 (Law. Co-op. 2001): All existing information compiled by a health care facility or a health care provider pertaining directly to a workers' compensation claim must be provided to the insurance carrier, the employer, the employee, their attorneys, or the Workers' Compensation Commission within fourteen days after receipt of a written request.

*S.C. CODE ANN.* § 44-22-110 (Law. Co-op. 2001): A mental health patient or his or her guardian has access to the patient's medical records. Patients or guardians may be refused access to information provided by a third party under assurance that the information remains confidential and information determined by the attending physician to be detrimental to the patient's treatment regimen. The determination must be placed in the patient's records and must be considered part of the restricted information. Patients and guardians denied of access may appeal to the Director of the Department of Mental Health. The director of the residential program shall notify a patient or guardian of the right to appeal.

*S.C. CODE ANN.* § 44-115-30 (Law. Co-op. 2001): A patient or his or her legal representative has a right to receive a copy of the patient's medical record or have
the record transferred to another physician upon written request by the patient or representative.

S.C. CODE ANN. § 44-115-60 (Law. Co-op. 2001): Except as otherwise provided by law, a physician may refuse to release a copy of a patient's entire medical record and may furnish instead a summary or portion of the record when the physician has a reasonable belief that release of the information contained in the entire record would harm the patient or another person who has given information about the patient, or where the release is otherwise prohibited by law. However, a physician may not refuse to release the entire record or a portion thereof if the information is requested by a licensed attorney representing the patient, when the request is accompanied by a written authorization signed by the patient, the patient's legal guardian, or the patient's personal representative, for any reason, or by an insurance company with reference to an application for life or health insurance, or the payment and adjudication of claims relating to life and health insurance, or if the information is requested with reference to the payment or adjudication of personal injury claims.


25 S.C. CODE ANN. REGS. 67-1301(A) (2001): A medical practitioner or treatment facility shall furnish upon request all medical information relevant to an employee's complaint of injury to the claimant, the employer, the employer's representative, or the Workers' Compensation Commission.

Disclosure

S.C. CODE ANN. § 44-115-20 (Law. Co-op. 2001): A physician is the owner of medical records in his or her possession that were made in treating a patient and of records transferred to him or her concerning prior treatment of a patient.

S.C. CODE ANN. § 44-115-40 (Law. Co-op. 2001): Except as otherwise provided by law, a physician shall not honor a request for the release of copies of medical records without receiving express written consent from a patient or person authorized by law to act on behalf of the patient.

S.C. CODE ANN. § 44-115-50 (Law. Co-op. 2001): A physician may rely on the representations of a health and life insurance carrier or administrator of health and life insurance claims that the authorization of a patient for release of medical records, or that of a person upon whose status the patient's claim depends, is on file with the carrier. A physician who in good faith releases medical information for claims processing relying on such representations is immune from any civil or criminal liability allegedly caused by the physician's compliance with a request to release information. A physician is not subject to disciplinary action for an alleged violation of law or regulation due to compliance with the request to release information.

medical records to someone other than a physician or osteopath licensed by the South Carolina State Board of Medical Examiners or a hospital licensed by the South Carolina Department of Health and Environmental Control. Exceptions to this prohibition may be granted and approved by the South Carolina State Board of Medical Examiners. Before a physician may sell medical records, he or she must cause to be published a public notice of his or her intention to sell the records in a newspaper of general circulation in his or her practice locale at least three times in the ninety days preceding sale. The notice shall advise patients that they may retrieve their records if they prefer that their records not be included in the sale.

S.C. CODE ANN. § 44-115-140 (Law. Co-op. 2001): A physician who in good faith releases medical records to a party pursuant to a written authorization from the patient or patient’s representative is immune from civil or criminal liability allegedly caused by the physician’s compliance with the request. A physician is not subject to disciplinary action for an alleged violation of law due to compliance with the request to release information.

Case Law

No court cases dealing strictly with access or disclosure of medical records were found.

Statutes

Access

S.D. CODIFIED LAWS § 27A-12-26.1 (Michie 2001): Upon request, patients have the right to access their mental health records. However, patients may be refused access to (1) information provided by a third party under assurance that such information remain confidential; and (2) specific material if the qualified mental health professional responsible for the mental health services concerned made a determination in writing that such access would be detrimental to the patient’s health. However, such material may be disclosed to a similarly licensed, qualified mental health professional selected by the patient, and such professional may, in the exercise of professional judgment, provide the patient with access to any or all parts of such material or otherwise disclose the information.

S.D. CODIFIED LAWS § 34-12-15 (Michie 2001): A health care facility shall provide copies of all medical records, reports, and x-rays pertinent to the health of the patient, if available, to a discharged patient or the patient’s designee upon receipt by the health care facility of a written request or a legible copy of a written request signed by the patient. The health care facility may require before delivery that the patient pay the actual reproduction and mailing expense. A health care facility, complying in good faith with the provisions of this section, may not be
held liable for any injury or damage proximately resulting from compliance with this section. This section does not apply to chemical dependency treatment facilities.

Disclosure

S.D. CODIFIED LAWS § 27A-12-25 (Michie 2001): A complete statistical and medical record shall be kept current for each patient receiving mental health services. The material in the record shall be confidential.

S.D. CODIFIED LAWS § 27A-12-29 (Michie 2001): Mental health information may be disclosed in the discretion of the holder of the record (1) as necessary or beneficial for a patient, or persons acting on behalf of the patient, to apply for patient benefits; (2) as necessary or beneficial for evaluation and accreditation; (3) as necessary or beneficial to train persons enrolled in an accredited course leading to a degree and qualification, certification, or registration as a qualified mental health professional, licensed practical nurse, registered nurse, psychologist, social worker, physical therapist, occupational therapist, laboratory technician, medical records professional, dietician, or other health care professional; or (4) upon request of the human services center, with disclosure of records limited to relevant medical and psychiatric records.

S.D. CODIFIED LAWS § 27A-12-30 (Michie 2001): Any release of information by the holder of a psychiatric patient’s record shall be approved by the administrator or facility director holding the records. The record holder shall keep a record of any information released, to whom it was released, the date it was released, and the purpose for such release.

S.D. CODIFIED LAWS § 27A-12-31 (Michie 2001): If mental health information is disclosed, the patient’s identity shall be protected and may not be disclosed unless it is germane to the authorized purpose for disclosure.

S.D. CODIFIED LAWS § 34-14-3 (Michie 2001): It is a Class 1 misdemeanor to disclose any information, records, reports, statements, notes, memoranda, or other data obtained for or contained in any medical study for the purpose of reducing morbidity or mortality, except that necessary for the purpose of the specific study.

TENNESSEE

Case Law

Pratt v. Smart Corp., 968 S.W.2d 868 (Tenn. Ct. App. 1997): A patient filed a class action case to recover a portion of the payment she had made to receive copies of her medical records claiming that under TENN. CODE ANN. § 68-11-301, the amount charged was unreasonable. The court held that the statute was intended to insure patient’s access to their medical records and to protect them
from excessive charges. The case was remanded for further proceedings.

**Statutes**

**Access**

**TENN. CODE ANN. § 68-2-101 (2001):** A health care provider shall furnish to a patient or a patient's authorized representative a copy or summary of that patient's medical records within ten working days upon request in writing by the patient or such representative.

**TENN. CODE ANN. § 68-11-304 (2001):** Unless restricted by state or federal law or regulation, a hospital shall furnish to a patient or a patient's authorized representative such part or parts of such patient's hospital records without unreasonable delay upon request in writing by the patient or such representative. The party requesting the patient's records shall be responsible for the reasonable costs of copying and mailing the patient's records.

**Disclosure**

**TENN. CODE ANN. § 10-7-504 (2001):** The medical records of patients in state, county, and municipal hospitals and medical facilities, and of persons receiving medical treatment at the expense of the state, shall be treated as confidential and shall not be open to inspection by members of the public.

**TENN. CODE ANN. § 33-3-104 (2001):** Information about individuals receiving treatment or services for mental health problems or developmental disabilities are confidential. Such information may be disclosed only with the consent of a service recipient who is sixteen years of age or older; the conservator of a service recipient; the attorney in fact under a power of attorney of a service recipient; the parent or legal guardian of a service recipient who is a child; the service recipient's guardian ad litem, the treatment review committee for a service recipient who has been involuntarily committed; or the executor, administrator, or personal representative on behalf of a deceased service recipient. Disclosure without consent is permitted to carry out treatment or commitment of the individual upon court order, and for law enforcement purposes in very limited circumstances.

**TENN. CODE ANN. § 63-1-117 (2001):** Records of hospitals, laboratories, nursing homes, homes for the aged, ambulatory surgical treatment centers, home health agencies, home health services, and recuperation centers shall be made available for inspection and copying when requested by a duly authorized representative of the Division of Health Related Boards.

**TENN. CODE ANN. § 63-2-101 (2001):** Medical records are not public records and are confidential. Except for any statutorily required reporting to health or government authorities, and except for access by an interested third-party payer, the name, address, and other identifying information of a patient shall not be divulged, nor shall these be sold for any purpose.

**TENN. CODE ANN. § 68-11-304 (2001):** Hospital records are and shall remain
the property of the various hospitals, subject, however, to court order to produce them. Hospital records shall be made available when requested for inspection by a duly authorized representative of the Board or Department of Health. Except as otherwise provided by law, hospital records shall not constitute public records. Nothing in this section is intended to impair any privilege of confidentiality conferred by law on patients, their representatives, or their heirs.

TENN. CODE ANN. § 68-11-1502 (2001): Every patient entering and receiving care at a health care facility licensed by the board for licensing health care facilities shall have the expectation of and right to privacy for care received at such facility.

TENN. CODE ANN. § 68-11-1503 (2001): The name and address and other identifying information of a patient shall not be divulged except for any statutorily required reporting to health or government; access by an interested third-party payer or designee for the purpose of utilization review, case management, peer reviews, or other administrative functions; access by health care providers from whom the patient receives care; and, if the patient does not object, any directory information including only the name of the patient, the patient’s general health status, and the patient’s location and telephone number.

Case Law

Abrams v. Jones, 35 S.W.3d 620 (Tex. 2000): Because the minor daughter’s psychologist testified that it would be harmful to her to release his detailed treatment notes, the trial court’s order requiring him to release his notes to her father was reversed.

Vaughn v. Moulton, No. 14-95-01467-CV, 1997 Tex. App. LEXIS 1348 (Tex. App. Mar. 20, 1997): Because the disclosure of confidential medical records of a police officer by a police chief was not a discretionary act, but one prohibited by statute, the police chief was not entitled to summary judgment on the basis of official immunity.

Tobias v. Green Oaks Hosp., No. 05-95-01022-CV, 1996 Tex. App. LEXIS 3557 (Tex. App. Apr. 7, 1996): A hospital’s release of medical records in response to a subpoena was valid, and the hospital was not required to investigate the validity of the subpoena or notify the appellant of the subpoena.

Moore v. Henry, 960 S.W.2d 82 (Tex. App. 1996): A prison medical records custodian had no mandatory duty under statutory law to comply with an inmate’s medical record request, and therefore, the dismissal of the inmate’s mandamus petition as frivolous was proper.

appellee patient suffered severe brain damage. The hospital was then sold to another health corporation. After the sale, the appellee brought an action requesting medical records from the purchasing corporation, which informed the appellee that the records were under review by the appellant and unavailable. After requesting records, the appellee received a set of records from both the purchasing corporation and the appellant. A comparison of the two sets revealed that pages were missing from the purchasing corporation’s set, and a document dated the day of the injury had been altered to postdate the injury. The appellee requested and was granted a temporary injunction against the appellant. The court affirmed, holding that the evidence demonstrated the existence of a wrongful act, and that if further documents were lost or altered, the appellee would suffer irreparable harm. It was not error to enjoin the appellant rather than the purchasing corporation, because the appellant retained some control over the records, and was not responsible under the injunction if the purchasing corporation altered or destroyed records.

_Cassingham v. Lutheran Sunburst Health Service_, 748 S.W.2d 589 (Tex. App. 1988): Cassingham sued the hospital in question for allowing improper access to her medical records. Cassingham was involved in an assault, and had recently had her son abducted by her ex-husband. Her treating physician and psychiatrist recommended that she speak with someone from the non-profit group Missing and Exploited Children of Texas. The advocate from that group made notation in, and viewed, her medical records. The court ruled that the hospital acted in error.

**Statutes**

_Access_

TEX. HEALTH & SAFETY CODE ANN. § 241.152 (Vernon 2000): A hospital may only disclose health information to a patient or his or her authorized legal representative unless the hospital has written permission from the patient to do otherwise. The permission is valid for up to 180 days after it is given, and may be revoked by the patient or their authorized legal representative.

TEX. HEALTH & SAFETY CODE ANN. § 241.154 (Vernon 2000): A patient must be given access to and a copy of his hospital records within fifteen days after he has submitted a written authorization for disclosure and payment of a reasonable fee for retrieval of processing, copying, and mailing. The fees for retrieving, processing, copying, and mailing are specified by statute. However, a hospital may not charge a fee for a patient to examine his own health care information.

TEX. HEALTH & SAFETY CODE ANN. §§ 611.001, 611.008, 611.0045 (Vernon 2000): A person who consults a professional for diagnosis, evaluation, or treatment of any mental or emotional condition or disorder, including alcoholism or drug addiction, is entitled to have access to the content of the records made about him. Access to these records must be provided within a reasonable time and may charge
a reasonable fee. Access to a portion of the records may be denied if the professional determines that the release of that portion would be harmful to the patient. If so, the patient must be notified of such decision and a professional designated by the patient may then examine and copy the record.

TEX. HEALTH & SAFETY CODE ANN. § 611.005 (Vernon 2000): A patient who has been improperly denied access to his mental health records has the right to bring a civil action seeking injunctive relief and damages.

Disclosure

TEX. HEALTH & SAFETY CODE ANN. § 241.153 (Vernon 2000): Hospitals may disclose information without the patient’s consent under a few select circumstances and/or to the following individuals: general directory information (unless the patient requests otherwise); a health care provider who is rendering care or being asked to render care or is being consulted (as in the case of a specialist); the transporting emergency medical services provider solely for the purpose of determining the patient’s disposition; a member of the clergy specified by the patient; an organ or tissue procurement organization for the purpose of inquiring about donation; an employee or agent of the hospital who is going to use the information for education or peer review; the American Red Cross and poison control centers as identified by law; for participation in an approved research project; to facilitate reimbursement; or to a HMO as required by federal law.

TEX. REV CIV. STAT. ANN. art. 4495, §5.08 (Vernon 2000): Patient medical records may not be disclosed without the written consent of a patient. A physician must furnish to a patient copies of medical records requested, or if he prefers, a summary of the record upon receipt of the patient’s written consent for the release. The statute specifies what should be contained in the written authorization and how the physician should reply.

UTAH

Case Law

No court cases strictly dealing with access or disclosure of medical records were found.

Statutes

Access

UTAH CODE ANN. § 63-2-202 (2001): A governmental entity upon request can disclose a private record to the subject of the record, the parent or guardian of a minor who is the subject of the record, or the legal guardian of a legally incapacitated individual who is the subject of the record. In addition, an individual who has the power of attorney from the subject of the record, or an individual who
has a notarized release from the subject or legal representative that is not more than ninety days old, may also access the medical record.

**UTAH CODE ANN. § 78-25-25 (2001):** When an attorney of law is representing the interest of a patient, records in the custody of the hospital or health care provider shall be made available to him for examination and copying. The attorney must be authorized to do so by the patient, the guardian of the patient, or the personal representative of a deceased patient.

**Disclosure**

**UTAH CODE ANN. § 26-25-1 (2001):** A person, health facility, or organization may provide information from vital records, interviews, reports, statements, memoranda, or other data relating to the condition or treatment of a person if the information is being provided to the department and local health departments, the Division of Mental Health within the Department of Human Services, the scientific and health care research organizations affiliated with institutions of higher education, the Utah Medical Association, peer and professional review committees, professional societies and organizations, or a health facility's in-house staff. This information can be provided only for studies that are researching the reduction of mortality and morbidity and for the evaluation and improvement of health care.

**UTAH CODE ANN. § 63-2-302 (2001):** Records that contain data on an individual’s medical history, diagnosis, condition, treatment, evaluation, or other similar medical history is considered to be a private record and not a public record.

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**VERMONT**

**Case Law**

No court cases dealing strictly with access or disclosure of medical records were found.

**Statutes**

**Access**

**Vt. Stat. Ann. tit. 18, § 1852(7) (2001):** All communications and records pertaining to a patient’s care are confidential. Only medical personnel, or individuals under the supervision of medical personnel, directly treating the patient, or those persons monitoring the quality of that treatment, or researching the effectiveness of that treatment, shall have access to the patient’s medical records. Others may have access to those records only with the patient’s written authorization.

**Vt. Stat. Ann. tit. 18, § 9419 (2001):** A records custodian may impose a
charge that is no more than a flat $5.00 fee or no more than $0.50 per page, whichever is greater, for providing copies of a patient’s health care record. Health care records include all written and recorded health care information about a patient maintained by a custodian. A custodian may charge a fee, reasonably related to the associated costs, for providing copies of x-rays, films, models, disks, tapes, or other health care record information maintained in other formats.

**Virginia**

**Case Law**

*Fairfax Hosp. Sys., Inc. v. Curtis*, 492 S.E.2d 642 (Va. 1997): The patient received prenatal care and gave birth to a son, who later died, at the hospital. The patient, as administrator of the estate, filed a notice of claim against the hospital and a nurse in the neonatal intensive care unit. The hospital provided her personal medical records to a nurse without her permission. The court held that the hospital owed a duty of reasonable care to the patient to preserve the confidentiality of information.

*Pierce v. Caday*, 422 S.E.2d 371 (Va. 1992): The physician was consulted regarding stress as a result of sexual harassment by another doctor at the hospital where the patient worked. One of the physician’s employees disclosed the patient’s confidential information to other workers at the hospital. The patient filed a motion for judgment against the physician for breach of contract. The physician filed a motion to dismiss on the basis that he was not given notice of the claim prior to the suit, and the motion failed to state a cause of action. The trial court dismissed the patient’s action. The court affirmed because the patient’s claim was one in tort not contract and the patient failed to give notice prior to filing suit as required by the Virginia Medical Malpractice Act.

*Mansoor v. Favret*, No. 00A84, 2001 Va. Cir. LEXIS 286 (Va. Cir. June 13, 2001): Defendant physician acted willfully or arbitrarily in failing to provide the medical records in question to the plaintiff in a timely manner. The doctor’s failure to respond for nearly thirty-eight days to the initial request and twenty-three days to the second request violated the Virginia statute.

*Green v. Richmond Dep’t of Soc. Serus.*, 547 S.E.2d 548 (Va. App. 2001): The father, who was incarcerated and coming up for parole, petitioned the court for access to his daughter’s medical, hospital, and other health records. This request was denied by the district court. The appeals court affirmed the denial because the daughter’s therapist presented persuasive testimony that the father’s access to the records would impair treatment his daughter was receiving.

*S.R. v. INOVA Health Care Servu.*, No. 174290, 1999 Va. Cir. LEXIS 287 (Va. Cir. June 1, 1999): The plaintiff filed an amended motion for judgment claiming injury arising from various acts alleged to constitute invasions of plaintiff’s privacy...
when she sought treatment away from hospital co-workers. The plaintiff’s claim was found cognizable for unauthorized disclosure of private patient information because plaintiff’s medical condition was discussed without her consent.

**Statutes**

**Access**

**VA. CODE ANN. § 2.2-3705 (Michie 2001):** Medical and mental records may be personally reviewed by the subject of the record or a physician of that individual’s choice. However, an individual may not personally review his or her mental health records if the treating physician has made a written statement that review of such records by the individual would be injurious to the person’s physical or mental health or well being. The medical records of a person confined in a state or local correctional facility shall only be reviewed and shall not be copied by such administrator or chief medical officer. The information in the medical records of a person so confined shall continue to be confidential and shall not be disclosed by the administrator or chief medical officer of the facility to any person except the subject or except as provided by law.

**VA. CODE ANN. § 20-124.6 (Michie 2001):** Notwithstanding any other provision of law, neither parent, regardless of whether such parent has custody, shall be denied access to the academic, medical, hospital, or other health records of that parent’s minor child unless otherwise ordered by the court for good cause.

**VA. CODE ANN. § 32.1-40 (Michie 2001):** Every practitioner of the healing arts and every person in charge of any medical care facility shall permit the Commissioner or his designee to examine and review any medical records that he has in his possession or to which he has access upon request of the Commissioner or his designee in the course of investigation, research or studies of diseases or deaths of public health importance. No such practitioner or person shall be liable in any action at law for permitting such examination and review.

**VA. CODE ANN. § 32.1-138.13 (Michie 2001):** Private review agents who have been granted a certificate of registration by the department shall have reasonable access to patient-specific medical records and information to the extent and in the manner authorized by regulation.

**Disclosure**

**VA. CODE ANN. § 32.1-127.1:03 (Michie 2001):** Patients have a right to privacy in the content of their medical records. No provider, or other person working in a health care setting, may disclose the records of a patient. 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, subpoena, or in accordance with the regulations relating to change of ownership of patient records promulgated by a health regulatory board. 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.

VA. CODE ANN. § 54.1-2403.3 (Michie 2001): 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 or, in the case of a health care provider employed by another health care provider, the property of the employer. Such health care provider shall release copies of any such medical records 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.

**Washington**

**Case Law**

*Berger v. Sonneland*, 26 P.3d 257 (Wash. 2001): The court found that there was a cause of action against a physician for unauthorized disclosure of a patient’s confidential information to the patient’s former husband.

*Oliver v. Harborview Med. Ctr.*, 618 P.2d 76 (Wash. 1980): The court held that the medical records at a public hospital are public records, and that a patient’s public hospital medical records are “public records” under the Public Disclosure Act.

**Statutes**

**Access**

WASH. REV. CODE § 70.02.005 (2001): To enable patients to make informed decisions about their health care and correct inaccurate or incomplete information about themselves, patients need access to their own health care information.

WASH. REV. CODE § 70.02.080 (2001): When a written request from a patient is received, a health care provider has to make recorded health information available during business hours and provide a copy if requested. The health care provider may charge a reasonable fee for providing the requested information.

**Disclosure**

WASH. REV. CODE § 42.17.310 (2001): Personal information in any files maintained for patients or clients of public institutions or public health agencies, or welfare recipients are exempt from public inspection and copying.

WASH. REV. CODE § 70.02.020 (2001): A health care provider may not disclose health care information about a patient to any other person without the patient’s written authorization.

WASH. REV. CODE § 70.02.040 (2001): At any time, a patient may revoke in writing a disclosure authorization to a health care provider.
WASH. REV. CODE § 70.02.050 (2001): A health care provider may disclose health care information about a patient without the patient's authorization to the extent a recipient needs to know the information.

WASH. REV. CODE § 71.05.390 (2001): All information and records obtained, compiled, or maintained in the course of providing services to either voluntary or involuntary recipients of services at public or private agencies shall be confidential.

WASH. REV. CODE § 71.05.630 (2001): All treatment records will remain confidential. Disclosure will be limited to the portions of the records necessary to meet the medical emergency. Outside of health care professionals, treatment records may be released only to those designated in an informed written consent of the patient.

**WEST VIRGINIA**

**Case Law**

*West Virginia Dep't of Health & Human Res. v. Clark*, 543 S.E.2d (W. Va. 2000): Absent probable cause of abuse and neglect, a public agency did not have the right to review children's medical and school records, though they did have the right to interview the children.

*West Virginia Advocates, Inc. v. Appalachian Cnty. Health Ctr.*, 447 S.E.2d 606 (W. Va. 1994): The court held that where a mentally disabled person's lawyer sought access to his medical records and such access was denied by such person's legal guardian, the granting of the mentally disabled person of a right to someone other than the guardian to access his records needed to be tested by the lower court to determine whether he was mentally capable of giving such authority.

*Morris v. Consolidation Coal Co.*, 446 S.E.2d 648 (W. Va. 1994): When there is a worker's compensation claim, a physician may discuss the relevant medical information with the employer, but such a discussion must be limited to the injury itself and should not be an opening to discuss the worker's entire medical record. A patient has a cause of action for the breach of the duty of confidentiality against a physician who wrongfully divulges confidential information, and in certain circumstances, a patient has a cause of action against a third party that induces a physician to disclose confidential information.

*Child Prot. Group v. Cline*, 350 S.E.2d 541 (W. Va. 1986): After a school bus driver stopped a bus and lectured the school children on religion, the Child Protection Group sought the medical records of the bus driver. The court held that in deciding whether the public disclosure of medical information would constitute an unreasonable invasion of privacy, the court should adopt a five factor test: (1) whether disclosure would result in a substantial invasion of privacy and if so, how serious; (2) the extent or value of the public interest, and the purpose or object of the individuals seeking disclosure; (3) whether the information is
available from other sources; (4) whether the information was given with an expectation of confidentiality; and (5) whether it is possible to mould relief so as to limit the invasion of individual privacy.

**Statutes**

**Access**

W. VA. CODE § 16-29-1 (2001): Health care providers shall furnish patients copies of their medical records when asked to do so by the patient in writing subject to certain restrictions. These restrictions include denying parent’s access to the medical records of their children when records might include evidence of services such as the provision of birth control pills; allowing for records to be subpoenaed; and exclusions relating to patients with HIV/AIDS.

W. VA. CODE § 16-29-1(a) (2001): In the case of records for 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 fee may be charged unless the person is indigent and needs the records to support a claim or appeal under the Social Security Act. A patient may maintain a civil action to enforce these provisions, and if the health care provider is found to be in violation of the law, the patient may be awarded attorney’s fees and costs incurred in the course of enforcement.

W. VA. CODE §§ 29B-1-3, 29B-1-4(2) (2001): A person has the right to inspect and copy his or her medical files maintained by a public body. Information is exempt from general disclosure if the public disclosure of the information would constitute an unreasonable invasion of privacy. If a person demonstrates that the public interest requires disclosure, such information may be disclosed.

W. VA. CODE §§ 29B-1-5, 29B-1-7 (2001): A person who is denied access to his medical records may maintain an action in equity for injunctive or declaratory relief and, if he prevails, is entitled to recover attorney’s fees and court costs.

**Disclosure**

W. VA. CODE § 23-4-7 (2001): When an employee makes a filing for workers compensation, he or she is deemed to waive confidentiality as to the medical records generated in relation to the claim and therefore, the employer or its representative can contact the physician directly to discuss the worker’s medical situation.

W. VA. CODE § 27-3-1 (2001): Communications and information obtained in the course of treatment and evaluation of a mental health patient will be confidential and may not be disclosed unless it is necessary to comply with a court order, to prevent the patient from injuring himself or another, or for treatment and internal review purposes.

information must be in writing, signed by the patient, and the patient must know
that failure to provide authorization will not impact his right to obtain treatment.

W. VA. CODE § 27-5-9 (2001): Records of mentally ill patients shall be kept
confidential and shall not be released unless they are ordered to be released by a
court, the attorney of the patient requests them, or the patient or someone
authorized to act on his behalf provides written authorization.

W. VA. CODE § 33-25A-26 (2001): Medical records obtained from a physician
or a health maintenance organization shall be held confidential and shall not be
disclosed except in limited situations, such as where it is necessary to facilitate the
assessment of quality of care, when the enrollee consents to such disclosure, or
pursuant to court order.

**Wisconsin**

**Case Law**

No court cases dealing strictly with access or disclosure of medical records
were found.

**Statutes**

**Access**

WISC. STAT. § 146.83 (2000): Upon receipt of informed consent, any patient
may inspect his or her health care records held by a health care provider with
reasonable notice and receive copies of those records at reasonable cost.

**Disclosure**

WISC. STAT. § 51.30 (2000): All records of an individual's treatment shall
remain confidential and are privileged to the individual. Such records may only be
released to the individual or other persons as designated by the informed written
consent of the individual. Notwithstanding, treatment records may be released
without informed written consent of the individual to the parents, children, or
spouse of an individual who is or was a patient at an inpatient facility; to a law
enforcement officer who is seeking to determine whether an individual is on
unauthorized absence from the facility; and to mental health professionals who
are providing treatment to the individual at the time that the information is
released to others.

WISC. STAT. § 146.82 (2000): All patient health care records shall remain
confidential and may only be released to the individual or other persons as
designated by informed consent of the patient or of a person authorized by the
patient. Notwithstanding this, patient health care records shall be released upon
request without informed consent to a health care provider or any person acting
under the supervision of a health care provider, including medical staff members,
employees, persons serving in training programs, or persons participating in volunteer programs.

**WISC. STAT. § 905.04 (2000):** A communication or information is "confidential" if it is not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, interview, diagnosis, or treatment of the patient, such as a physician, registered nurse, chiropractor, psychologist, social worker, marriage and family therapist, or professional counselor.

**Wyoming**

**Case Law**

No court cases dealing strictly with access or disclosure of medical records were found.

**Statutes**

**Access**

**WYO. STAT. ANN. §§ 35-2-609(c),(d) (Michie 2001):** The medical staff committees of any hospital shall have access to the records, data, and other information relating to the condition and treatment of patients. All reports, findings, proceedings, and data of medical staff committees shall be confidential and privileged.

**WYO. STAT. ANN. §§ 35-2-611(a),(b) (Michie 2001):** Upon receipt of a written request from a patient to examine or copy all or part of his or her health record, a hospital, as promptly as required under the circumstances, but no later than ten days after receiving the request shall (1) make the information available for examination during regular business hours and provide a copy, if requested, to the patient; (2) inform the patient if the information does not exist or cannot be found; (3) if the hospital does not maintain a record of the information, inform the patient and provide the name and address, if known, of the health care provider or facility that maintains the record; (4) if the information is in use, or unusual circumstances of delay occur in handling the request, inform the patient and specify in writing the reasons for delay and the earliest date, which shall not be later than twenty-one days after receiving the request, when the information will be available for examination or copying or when the request will be otherwise answered; or (5) deny the request, in whole or in part, under WYO. STAT. ANN. § 35-2-612 and so inform the patient. If a record of the particular health care information requested is not maintained by the hospital in the requested form, the hospital is not required to make the information available in the requested form. The hospital may charge a reasonable fee, not to exceed the hospital's actual cost, for providing the health care information and is not required to
permit examination or copying until the fee is paid.

**Wyo. Stat. Ann. §§ 35-2-612(a)-(c) (Michie 2001):** A hospital may deny access to health care information by a patient if the hospital reasonably concludes that (1) knowledge of the health care information would pose an imminent threat to the life or safety of the patient; (2) knowledge could reasonably be expected to lead to the patient’s identification of an individual who provided the information in confidence and under circumstances in which confidentiality was justified; (3) knowledge could reasonably be expected to pose an imminent threat to the life or safety of any individual; (4) the information is compiled and used solely for litigation, quality assurance, peer review, or administrative purposes; or (5) access to is otherwise prohibited by law. If a hospital denies a request, in whole or in part, because of danger to the patient or others, the hospital shall permit examination and copying of the record by a health care provider selected by the patient who is licensed, certified, or otherwise authorized by law to treat the patient.

### Disclosure

**Wyo. Stat. Ann. §§ 25-10-122(a),(b) (Michie 2001):** Records and reports that directly or indirectly identify a mental health patient, a former patient, or an individual for whom an application for hospitalization has been filed, shall be confidential and shall not be disclosed by any person unless the patient or, if he or she is a minor or incompetent, a parent or guardian consents. Patient records may be provided without consent by and between a mental health center, a state hospital, and other hospitals only for the purpose of facilitating referral treatment, admission, readmission, or transfer.

**Wyo. Stat. Ann. §§ 35-2-606(a),(b) (Michie 2001):** Except as authorized in Wyo. Stat. Ann. § 35-2-609, a hospital or an agent or employee of a hospital shall not disclose any health care information about a patient to any other person without the patient’s written authorization. A hospital shall maintain, in conjunction with a patient’s recorded health care information, a record of each person who has received or examined, in whole or in part, the recorded health care information during the preceding three years. The record of disclosure shall include the name, address, and institutional affiliation, if any, of each person receiving or examining the health care information, the date of receipt or examination, and, to the extent practicable, a description of the information disclosed.

**Wyo. Stat. Ann. §§ 35-2-607(a)-(c), (e)-(g) (Michie 2001):** A patient may authorize a hospital to disclose his or her health care information. If requested, a hospital shall provide a copy of a patient’s health record unless the hospital denies the patient access to health care information under Wyo. Stat. Ann. § 35-2-612. A hospital may charge a reasonable fee not to exceed the hospital’s actual cost for providing the health care information and is not required to honor an authorization until the fee is paid. To be valid, the authorization must be in
writing and dated and signed by the patient, identify the nature of the information to be disclosed, and identify the person to whom the information is to be disclosed. A hospital shall retain each authorization or revocation in conjunction with any health care information from which disclosures are made. Except for authorizations to provide information to third-party health care payors, an authorization shall not permit the release of information relating to future health care that the patient receives more than twelve months after the authorization is signed. An authorization is invalid after the expiration date contained in the authorization, which shall not exceed forty-eight months. If the authorization does not contain an expiration date, it expires twelve months after it is signed.

Wyo. Stat. Ann. § 35-2-608 (Michie 2001): A patient may revoke an authorization to disclose health care information at any time unless disclosure is required to effectuate payments for health care that has been provided. A patient shall not maintain an action against the hospital for disclosures made in good faith reliance on an authorization if the hospital had no notice of the revocation of the authorization.

Wyo. Stat. Ann. § 35-2-609(a) (Michie 2001): A hospital may disclose health care information about a patient without the patient's authorization to the extent that a recipient needs to know the information, if, among other things, the disclosure is (1) to a person providing health care to the patient; (2) to any other person who requires health care information for health care education, planning, quality assurance, peer review, or administrative, legal, financial, or actuarial services to the hospital, or to assist the hospital in the delivery of health care, and the hospital reasonably believes that the person will not use or disclose the information for any other purpose and will use reasonable care to protect the confidentiality of the information; or (3) to any health care provider who has previously provided health care to the patient to the extent necessary to provide health care to the patient, unless the patient has instructed the hospital not to make the disclosure.