231129

Comments of the American Psychoanalytic Association

On

Standards of Privacy of Individually Identifiable Health Information

James C. Pyles, Counsel
Powers Pyles Sutter & Verville, PC
Twelfth Floor, 1875 Eye Street, NW
Washington, DC 20006-5409
(202) 466-6550
jpyles@ppsv.com

TABLE OF CONTENTS

Summary of Comments on Medical Information Privacy Regulation

The Health Information Privacy Regulations proposed by the Administration on November 3, 1999 represent one of the most thoughtful efforts to date to address the growing threat to the privacy of identifiable health information. The preamble to the regulations sets forth the most thorough analysis of the importance of medical information privacy to quality health care and the public's confidence in the health delivery system. With the exception of the protection for "psychotherapy notes," however, the privacy protections in the proposed regulations do not fulfill the promise of the preamble.

As the preamble notes, the preservation of health information privacy is a "major concern" of citizens. Health information privacy is also essential for quality health care because without an assurance of privacy, individuals will not make the disclosures to physicians and other caregivers necessary for treatment and diagnosis, caregivers will not accurately record information in the medical record and individuals will refrain from seeking the care they need.

The preamble correctly notes that an assurance of "strict confidentiality" is essential for patients to receive effective psychotherapy. That conclusion is supported by the "reason and experience" reflected in the therapist-patient privilege which is recognized by the statutory laws in all 50 states and the District of Columbia, both federal and state common law, the ethical standards of every mental health professional association, and the recently released Surgeon General's Report on *Mental Health.* The common thread of all of these laws and standards is that therapist-patient communications cannot be disclosed beyond the therapist without the patient's consent.

The underlying statute directs the Secretary to issue regulations that address at least the rights that individuals "should have" with respect to their identifiable health information. The preamble notes that privacy is a fundamental right which is an element of the constitutional right to liberty, but the regulations make no mention of an individual's right to privacy for identifiable health information.

The regulations also eliminate the traditional requirement of obtaining patient consent before disclosing identifiable health information except for marketing and certain other "non-health" related uses. Accordingly, these regulations would permit disclosure of most identifiable health information for most uses without patient notice or consent.

In an exception to the general rule, the regulations require consent for the disclosure of "psychotherapy notes" for the purposes of treatment, payment and health care operations. The regulations, however, permit the disclosure of psychotherapy communications that do not come within the narrow definition of

"psychotherapy notes" and do not recognize even that narrow exception for 13 other uses characterized as "national priorities." Accordingly, the regulations do not afford the protection for psychotherapy communications that is generally accepted as being essential for effective psychotherapy services.

The preamble to the regulations recognizes that statutory authority has not been granted to permit effective enforcement of the privacy protections contained in the regulations. Further, the protections in the regulations are unenforceable because, in the absence of notice of specific disclosures or consent, individuals will have no way of knowing when, where and to whom their information was disclosed. Two of the principal privacy protections in the regulations -- the limitation on disclosures to the minimum information necessary for the intended use and the "right to restrict" disclosures that are otherwise allowable -- are particularly unenforceable. The information necessary for an intended use varies with the size and technical capability of the disclosing entity, and providers have a right to refuse any request to restrict disclosures.

The regulations appropriately do not preempt state privacy laws, including state common laws, which furnish "more stringent" privacy protections. The recognition of state common laws is particularly appropriate because most privacy protections are found in state common laws, and those court rulings reflect the history of "reason and experience" in those states.

The American Psychoanalytic Association believes that the following changes must be made in the regulations if the public's confidence in the health delivery system is to be preserved:

1. Individuals' right to privacy for identifiable health information should be expressly recognized.

2. The right of patients to give or withhold consent for most disclosures should be preserved.

3. The regulations should establish "strict confidentiality" protections for mental health information and specify the information that may be disclosed with patient consent to third party payors. This approach is consistent with federal and state common law and has been in effect for 15-20 years in New Jersey and the District of Columbia.

4. The privilege recognized for psychotherapist-patient communications in the 1996 Supreme Court decision in *Jaffee v. Redmond* should be recognized in the regulations. They also should provide that any disclosure for a purpose under the regulations will not constitute a waiver of the federal or state privilege.

5. Patients should be permitted to preserve the privacy of their health information by paying for services with their own funds.

Privacy is essential for quality health care, but it is also an indispensable element of the right to liberty -- one of the core principles of our Constitution. These principles have been forged and preserved through the sacrifices of prior generations. With the consideration of the right to medical privacy, we reach one of those critical points in our nation's history when we must decide whether we remain committed to those principles.

February 15, 2000

U.S. Department of Health and Human Services
Margaret Ann Hamburg, MD
Assistant Secretary for Planning and Evaluation
Attention: Privacy-P, Room G-322A
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on Standards of Privacy of Individuallv Identifiable Health Information
RIN 0991-AB08

Dear Assistant Secretary Hamburg:

The following sets forth the comments of the American Psychoanalytic Association (the "American") with respect to proposed regulations entitled "Standards for Privacy of Individually Identifiable Health Information". 64 Fed. *Reg.* 59918 (November 3, 1999). Established in 1911, the "American" is one of the oldest mental health associations in the country and has approximately 3500 members who are engaged in both private clinical practice and research. Members of the "American" have affiliations with many of the most prominent academic medical institutions in the country.

I. Introduction *("Introduction to general rules", secs. 164.506, 164.508) (64 Fed. Reg.* at 59939)'

A. Strengths and Weaknesses in the Approach

At the outset we want to convey the "American's" appreciation and strong support for the thoughtful effort embodied in these proposed regulations to protect the rights of all citizens to medical information privacy. The preamble's extensive analysis of the importance of medical information privacy to the fundamental privacy rights of all citizens and to quality health care is an invaluable contribution to the medical privacy debate. We are particularly supportive of the recognition of special privacy protection necessary for psychotherapy communications. **The nearly 100-year experience of the "American" confirms that a confidential relationship between the patient and the psychotherapist is the "therapeutic tool" by which effective psychotherapy is practiced.**

We also concur with much of the analysis in the preamble regarding the importance of medical information privacy to quality health care generally and to

[1] As requested at 64 *Fed. Reg.* 59918, we are specifying the sections of the proposed rule to which our comments apply.

psychotherapy specifically. We are concerned, however, that the **regulations** as proposed do not provide the protection for identifiable medical information that the **preamble** indicates is necessary to preserve the public's confidence in the health delivery system. More specifically, we are concerned that the regulations do not provide the level of privacy protection for **psychotherapy communications** that currently exists under federal common law as well as the common law and statutory laws of all 50 states and the District of Columbia. **While the proposed regulations are a good first step, unless the privacy protections in them are strengthened substantially, access to quality health care will be eroded or lost.**

The most serious systemic weakness in the regulations is that they strip consumers of the ability to protect their own right to medical privacy, and then concede that the protections substituted by the federal government cannot be adequately enforced. For example, the preamble notes that under the regulations as proposed, **"most uses and disclosures of an individual's protected health information would not require explicit authorization by the individual...we propose to substitute regulatory protections for the pro forma authorizations that are used today". 64** *Fed. Reg.* at 59939/2.

The preamble also acknowledges, however, that the authorizing legislation limits the entities to which the security measures in the regulations can apply and does not provide the Secretary with adequate enforcement authority. 64 *Fed. Reg.* at 59923/2. Thus, the consumer is stripped of his or her ability to give or withhold consent for most disclosures of identifiable medical information, and the security measures which the government proposes to substitute are admittedly inadequate to protect the consumers right to privacy. The net effect **is that the consumer will be rendered virtually defenseless with respect to violations of his or her right to health information privacy.**

The preamble implies that the traditional requirement for patient consent for disclosure is being eliminated because it is ineffective in protecting the privacy of identifiable medical information. Yet, it is that very consent requirement which the regulations offer as the principal privacy protection for psychotherapy notes and health information used in marketing. 64 *Fed. Reg.* at 59925/2, 59942/1. We **believe that consent and accountability are essential to the protection of the patient's right to privacy, particularly with respect to mental health privacy.**

The "American's" concerns about the effect of these regulations is, perhaps, best illustrated by the following **example:**

Under the general rule set forth in these regulations, a family that enrolled in a health plan and never filed a claim, but paid for all health services with their own funds, could have any of their health information, past, present or future, disclosed in fully identifiable form, an unlimited number of times, without their

knowledge or consent, as long as the disclosure was "compatible with" the plan's "health care operations". Accordingly, the regulations, as proposed, do not seem to match the President's description as "an unprecedented step toward putting Americans back in control of their own medical records". Remarks by the President on Medical Privacy (October 29, 1999).

B. Structure of the Reoulations and the "American's" Comments

The effect of these regulations on quality health care and access to effective psychotherapy becomes clearer with an understanding of their basic structure:

1. **Privacy protection of identifiable health information** is segregated into three categories based upon the degree of patient consent and user accountability required.

    a. **Category one -- no consent, no accountability** -- Identifiable health information falls into this category if its disclosure is "compatible with or directly related to treatment, payment, or health care operations". Reg. sec. 164.508(a)(2)(i).

        1. **Exception for "psychotherapy notes"** -- Consent (or authorization) is required for disclosure of identifiable health information under this category that comes within this term as defined by the regulations. Reg. sec. 164.508(a)(3)(i)(A).

    b. **Category two -- no consent, accountability** -- Identifiable health information falls into this category if its disclosure is for any of 13 uses which the preamble states "are designed to permit and promote key national health care priorities". 64 *Fed. Reg.* at 59955; Reg. sec. 164.510.

    c. **Category three -- notice, accountability** -- Identifiable health information falls into this category if it is used for any of 6 purposes prescribed in the regulations relating generally to marketing and other "non-health" related purposes. Reg. sec. 164.508(a)(2)(ii).

2. **The rights of individuals** with respect to identifiable health information are specified. 64 **Fed.** *Reg.* **at** 59926, 59976, 60008.

3. **Compliance and enforcement** of privacy measures are set forth. 64 *Fed. Reg.* **at 59926, 60002; Reg. sec. 164.522.**

4. The **relationship** of these regulations **to other federal and state laws** is described. 64 *Fed. Reg.* at 59926, 59994; Regs. Subpart B.

"Consent" to disclosure is referred to under the regulations as "authorization" in order to connote the type of information required for a valid consent to disclose. Reg. sec. 164.508(c). "Accountability" is the process of accounting for disclosures so that individuals will be able to determine whether the protections offered by the regulations have been violated. Reg. sec. *164.515.*

Our comments first address the findings in the preamble and then follow the above structure of the proposed regulations.

II. Findinu: Privacy of Identifiable Health Information is Essential for Quality Health Care *("Need forprivacy standards", 64 Fed. Reg.* at 59919)

We concur with the findings in the preamble that protection of the privacy of identifiable medical information is of major importance to patients and to the public generally. 64 *Fed. Reg.* at 59920/2. A recent report on mental health by the Surgeon General noted that 85% of Americans responding to a recent poll characterized "protecting the privacy of medical records as essential or very important". U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General,* 437,440 (December 1999). The preamble notes that "loss of personal privacy" is a greater concern to consumers than such issues as terrorism, world war or global warming. 64 *Fed. Reg.* at 60010/2. Studies have shown that "[c]onfidentiality is considered to be a cornerstone of a doctor-patient relationship". *Surgeon General's Report* at 439.

We also concur that medical information privacy is essential for quality health care generally. Unless members of the public have confidence that their medical privacy will be protected, they will not seek the health care they need, they will not make the disclosures to their care givers necessary for accurate diagnosis and treatment, and the quality of the data used for research will be corrupted. 64 *Fed. Reg.* at 59920/2.

A recent study shows that the public is well aware that no privacy policies or procedures can ensure that identifiable health information will be protected from third parties and hackers once it is disclosed. See "Ethics Survey of Consumer Attitudes about Health Web Sites", California HealthCare Foundation (January 2000); "Medical Web Sites Faulted on Privacy", *The Washington Post,* El (February 1, 2000). Developments over the past year illustrate that the public's perception is accurate. See e.g., "Hackers' Attacks Force FBI, Senate, to Shut Down Their Web Sites", *The Washington Post,* A6 (May 29, 1999); "Hackers Hit More Federal Web Sites", *The Washington Post,* A5 (June 1, 1999). Reports of the vulnerability of computerized information systems surface almost

every week. See e.g., "New Hacker Weapons Pose Threat to Web", *The New* York *Times* (February 9, 2000).

We appreciate that an argument can be made that identifiable health information is needed for many "national priorities" including reducing health care fraud, outcomes research, protecting the public health and responding to emergency situations. See 64 *Fed. Reg.* at 59925, 59955. **We believe, however, that there are "priorities within priorities" and that the first and most important national priority of the nation's health delivery system is providing quality health care.** As the studies show, nothing is more essential to quality health care than an assurance of privacy.

For example, the creation of "government health data systems" may be important, but not if it means that patients will no longer make the disclosures to their physicians that are needed for accurate diagnosis and treatment for fear that they are thereby disclosing their personal information to an unknown number of government officials and employees. Research is clearly important, but not if it is conducted in a manner that destroys the public's confidence in the health delivery system. See, e.g., "Dying for a Cure", U.S. News *and World Report,* Investigative Report, 34-43 (October 11, 1999). Preventing impaired individuals from driving an automobile is a laudable goal, but a patients private medical record should not be used for this purpose because patients will become fearful that they will lose their drivers' licenses if they make an honest disclosure of information to their physicians, Permitting insurance companies to operate more efficiently is also an important goal, but the health delivery system is designed principally to serve the needs of patients rather than payors.

In short, providing the privacy protections that are essential for quality health care should be accorded the highest priority. The regulations, therefore, should address how other priorities can be accomplished while protecting medical privacy. Under that approach, incentives should be provided to use **non-identifiable** health information where possible.

The regulations as proposed, however, "balance privacy" against "other social values" and allow disclosures without patient consent whenever other national priorities arise. 64 *Fed. Reg.* at 59925/3. In effect, the consumer's right to medical privacy seems to have been ranked below all other national priorities. **The regulations permit the disclosure of health information in identifiable form for health care operations and 13 other uses even if the those purposes could be accomplished with non-identifiable information. Since there is little, if any, incentive to use non-identifiable information, the patients' rights to medical privacy will simply cease to exist in those circumstances.**

III. Finding: "Strict Confidentiality" is Essential for Effective Psychotherapy ("Treatment, payment and healthcare operations", 64 Fed. Reg. at 59940)

The experience of the "American" is consistent with the following recent finding by the Surgeon General:

> "Although confidentiality issues are common to health care in general, there are special concerns for the mental health care and mental health care records because of the extremely personal nature of the material shared."

Surgeon General's Report, 449. As numerous studies have shown, individuals in need of psychotherapy will not seek that treatment, and once in treatment will not make the disclosures necessary for effective diagnosis and treatment if they believe the disclosures will be disseminated outside of the treatment relationship. *Surgeon General's Report,* 440. Accordingly, we agree with the Surgeon General's finding that

> "People's willingness to seek help [for mental illness] is contingent on their confidence that personal revelations of mental distress will not be disclosed without their consent."

Surgeon General's Report, 449.

We also applaud the preamble's incorporation of the findings by the United States Supreme Court that "reason and experience" with respect to psychotherapy support the conclusion that **"the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment".** *Jaffee v. Redmond, 116* S.Ct. 1923, 1928(1996). 64 *Fed. Reg. at 59941/3*. We agree with the findings of the Judicial Conference Advisory Committee cited in that decision to the effect that

> "a psychiatrists ability to help her patient 'is **completely dependent** upon [the patients] willingness to talk freely. This makes it difficult if not impossible for [a psychiatrist] to function without being able to assure... the patients of confidentiality and, indeed, privileged communication. Where there may be exceptions to this general rule..., there is wide agreement that confidentiality is a *sine qua non* for successful psychiatric treatment."

Quoted at 64 *Fed. Reg.* at 59941/3. We also concur with the Supreme Courts finding that access to effective psychotherapy is in both the individual's and the public's interest. 64 *Fed. Reg.* at 59942/1.

Based on these findings, **the Supreme Court recognized a federal common law right to privacy for psychotherapy communications by**

establishing a privilege under the Federal Rules of Evidence for therapist-patient communications. The Surgeon General's recent report acknowledged that

> The U.S. Supreme Court recently has upheld the right to the privacy of these [mental health] records and the therapist-patient relationship.

Surgeon General's Report at 449.

A recent opinion provided to the "American" by the Department of Health and Human Services similarly concludes that the privacy protection for psychotherapy communications is "[f]irmly rooted in state case law, and established in federal law by the U.S. Supreme *Court* in *Jaffee v. Redmond".* Copy attached. **As the Surgeon General recently concluded, the right of patients to keep identifiable mental health information from being disseminated beyond their therapist without their consent is supported by ethical, legal and health policy considerations.** *See Surgeon General's Report, Chapter 7: Confidentiality of Mental Health Information: Ethical, Legal, and Policy Issues.*

While we applaud the recognition that the privacy of psychotherapy communications is particularly important to effective psychotherapy, we are concerned by the fact that the regulations

1. do not expressly recognize the therapist-patient privilege;

2. do not provide the regulation's "special" protection for "psychotherapy notes" to psychotherapy communications that would come under the therapist-patient privilege; and

3. do not state that disclosures under these regulations without the patient's consent (such as for treatment, payment and healthcare operations) will not constitute a waiver of the therapist-patient privilege.

These points will be addressed in greater detail in section VII.

IV. HIPAA Reauires the Adoption of Privacy Standards that Improve the "Effectiveness" of the Health Care Svstem *("Statutory background", 64 Fed. Reg.* at 59920)

The preamble notes that the Administration Simplification provisions of HIPAA require the establishment of standards that are "consistent with the objective of reducing the administrative costs of providing and paying for health care". 42 U.S.C. 1172(b). We agree with the conclusion in the preamble that Congress has also recognized that "adequate protection of the security and

privacy of health information is a *sine qua non* of the increased efficiency of information exchange brought on by the electronic revolution". 64 *Fed. Reg.* at 59922/2. We further agree that preserving and improving access to effective mental health services will result in savings. 64 *Fed. Reg.* at 60021.

We would add, however, that in the *Purpose* section of the Administrative Simplification provisions, Congress also stated that the intent of the Act was to "improve...the efficiency and effectiveness of the health care system" (emphasis supplied). See section 261 of the Administrative Simplification provisions of HIPAA. As reflected in the vast "reason and experience" noted by the Supreme Court, the Surgeon General and the preamble to these regulations, "effective psychotherapy" is "completely dependent" on the assurance of confidentiality of psychotherapy communications. **Accordingly, the intent of Congress under HIPAA cannot be furthered without providing adequate privacy protection for psychotherapy communications.**

Indeed, HIPAA expressly states that no standard can be adopted under the Act that would "require disclosure of trade secrets or confidential commercial information by a person required to comply with this part". Section 1172(e) of the Act. Clearly, Congress would not have intended to confer greater protection for commercial information than for identifiable health information in a statute intended to improve the effectiveness of the health care system.

Recommendation

The medical information privacy regulations should include privacy protections that have been shown to preserve or enhance the effectiveness of health care.

V. The Regulations Should Recognize a Riaht to Privacy for Identifiable Health Information *("Introduction to rights of individuals", 64 Fed. Reg.* at 59926, 59976)

The authorizing statute for these regulations requires the Secretary of HHS to make recommendations with respect to privacy standards that address

"at least the following:

> (1) The rights that an individual who is the subject of individually identifiable health information should have."

HIPAA sec. 264(b)(l). The statute requires the Secretary to then issue regulations which "shall address at least the subjects described in subsection (b) [the rights that an individual should have]". HIPAA sec. 264(c)(l).

The preamble to the regulations states that "[p]rivacy is a fundamental right." 64 *Fed. Reg.* at 60008/1. It notes further that the right to personal privacy is recognized in the common law or statutory law of all 50 states. *Id.* That right is recognized by the constitutions of at least two states (Tennessee and California), and the U.S. Supreme Court has specifically upheld the privacy of "personal health information" under the protection for liberty under the U.S. Constitution. *64 Fed. Reg.* at *6000812 citing, Whalen v. Roe, 429* US. 869, 876 (1977). The preamble further notes that the U.S. Supreme Court has preserved the right of individuals to protect the privacy of their psychotherapy communications by recognizing a therapist-patient privilege that is also recognized in all 50 states and the District of Columbia. *Id.* Citing Jaffee v. *Redmond, 116* S.Ct. 1923 (1996).

Despite the statutory mandate and the evidence that the right to medical information privacy is recognized under federal and state law, the regulations fail to identify a basic right to privacy for identifiable health information as a right that an individual "should have".

Instead the regulations are quite clear that individuals will have only three "basic rights" with respect to identifiable health information:

(1) the right to obtain access to protected health information including an accounting for disclosures for uses other than treatment, payment, or health care operations (Reg. sec. 164.514);

(2) the right to obtain written notice of information practices (Reg. sec. 164.512); and

(3) the right to request amendment or correction of protected health information that is inaccurate or incomplete (Reg. sec. 164.516).

See 64 *Fed. Reg.* at 59926, 59976. See also "Individual Rights" in the model notice to consumers. 64 *Fed. Reg.* at 60049/1.

Rather than recognize the traditional right to privacy in the individual, the regulations appear to supplant that right with a new "right to use and disclose protected health information" exercisable by covered entities for treatment, payment, health care operations and at least 13 other uses. 64 *Fed. Reg.* at 59940/3. That new "right to disclose", while not stated expressly, is implicit throughout the regulatory language. See Reg. sec. 164.508(a)(2); 164.510.

The preamble makes much of the fact that the regulations "would permit -- but not require --the covered entity to use or disclose protected health information without the individual's authorization". 64 *Fed. Reg.* at 59955/1. **Permitting disclosure of personal information without the individuals'**

knowledge or consent extinguishes their right to privacy just as thoroughly as requiring that disclosure.

The failure to recognize and protect the individual's right to medical privacy threatens one of the core principles of our system of government as well as the stability of the health delivery system. As the preamble to these regulations points out,

> "few experiences are as fundamental to liberty and autonomy as maintaining control over when, how, to whom, and where you disclose personal material."

64 Fed. Reg. at *6000813, citing Private Matters: In Defense of the Personal Life,* J. Smith (1997). Our Declaration of Independence sets forth the beliefs of the founders of our country with respect to the importance of liberty,

> "We hold these truths to be self evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, **Liberty** and the Pursuit of Happiness--That to secure these Rights, Governments are instituted among Men..."

The preamble to our Constitution states that one of its principal purposes was to "secure the Blessings of **Liberty** to ourselves and our Posterity". The Fifth and Fourteenth Amendments prevent citizens from being "deprived of life, **liberty,** or property without due process of law" by the federal government or the states.

Yet, these regulations fail to mention whether individuals have, or even "should have", a right to privacy for identifiable health information. Instead, they provide for identifiable health information to be disclosed whenever, however, and to whomever the covered entity desires without patient notice or consent and without any accounting so long as the disclosure is "compatible with or directly related to treatment, payment or health care operations". **The effect of these regulations, therefore, is to eliminate the right to privacy, and even the right to liberty, in these circumstances.**

In addition, conferring a right on state and federal governments to obtain identifiable health information without patient consent would appear to violate the right to privacy guaranteed by the U.S. Constitution. The Supreme Court has stated that the constitutionally protected right to informational privacy would be violated where the privacy of sensitive medical information in the governments possession is not adequately protected. *Whalen v. Roe, 429* U.S. at 879.

There is evidence that the federal government has not protected, and perhaps cannot protect, the privacy of identifiable health information that is

transmitted or stored electronically. A recent report from the General Accounting Office found that

(1) the management of electronic information by HCFA and its contractors leaves this information vulnerable to "unauthorized individuals reading, disclosing, or tampering with confidential information";

(2) HCFA does not have the ability to prevent unauthorized disclosures or uses and to provide timely corrective action because it "does not routinely monitor contractors and others, such as researchers, who use personally identifiable Medicare information"; and

(3) HCFA is contemplating requiring states to disclose sensitive health-related information to the federal government such as human immunodeficiency virus (HIV) status and the presence of sexually transmitted diseases (STD).

Medicare: Improvements Needed to Enhance Protection of Confidential Health Information, General Accounting Office, at 3-4 (July 1999). In fact, numerous accounts over the past year indicate that computer systems operated by Congress and by the Administration are not secure from hackers. See "Hackers' Attacks Force FBI, Senate to Shut Down Their Web Sites" and "Hackers Hit More Federal Web Sites", *supra* at *The Washington Post.*

The failure to recognize a right to medical information privacy is particularly disturbing in the context of communications between a psychotherapist and a patient. **There could be no greater threat to liberty than the compelled disclosure of one's innermost thoughts.**

Recommendation

The medical information privacy regulations should expressly recognize that individuals have a right to privacy for their identifiable health information.

VI. Patient Consent is Crucial to Patient Confidence in the Health Deliverv System *("Treatment, payment, and health* care *operations", 64 Fed. Reg.* at 59940)

The clearest indication of whether individuals have a right to privacy for identifiable health information is whether their consent is required for disclosure of that information. The preamble to the regulations acknowledges that consent (or "authorization") is the established practice in this country. 64 *Fed. Reg.* 59939/2. In fact, a survey which the preamble considers to be "the best and most comprehensive examination of state privacy laws currently published" (64 *Fed. Reg.* at 60011) includes the following finding:

> "Overall, the most common restriction [protection] found in state statute is that patient authorization must be secured prior to health information being disclosed..."

"The State of Health Privacy: An Uneven Terrain", Executive Summary, at p. 4, Health Privacy Project, Georgetown University (1999).

As the *Surgeon General's Report on Mental Health* noted, **the right to privacy of medical information is "a core ethical principle" recognized by all medical professions, and the right belongs to the client and generally is the client's to waive or not waive.** Surgeon General's Report on Mental Health, at 438-39.

The regulations, however, propose to eliminate this traditional method of protecting the individual's right to privacy for "most uses". 64 *Fed. Reg.* at 59939/2. The reason given is that such authorizations have not always been effective, and that they are often obtained long before the individual is aware of what information may be related to treatment or payment. 64 *Fed. Reg.* at **59940. It must be remembered that standards that permit disclosure without consent also would permit disclosure against the patient's will.**

In the experience of the "American", the practice of requiring consent before disclosing a patient's medical information has not been as ineffective as the preamble suggests. Psychiatrists routinely obtain the patients consent before disclosing mental health information to a third party payor or even to another psychiatrist.

In any event, the remedy where a crucial privacy protection has been eroded is not its elimination. Rather, the solution is to restore the protection's effectiveness. **How ironic it would be to reward those who have routinely violated the public's traditional right to medical privacy with the wholesale elimination of that protection.** Violations of fundamental rights should not become acceptable through repetition.

The failure to recognize the patients right to give or withhold consent also leads to an extremely complex and burdensome system for caregivers and other providers. When a caregiver is presented with a demand for identifiable health information under current law, he or she can refuse to provide the information if the patient has not authorized the disclosure of the information. *(See Humana Medical Plan, Inc. v. Charles M. Fischman, M.D.,* Fla. Dist. Ct. of App. (December 22, 1999) where the court upheld a physician's refusal to disclose to an HMO identifiable medical records of its enrollees when the patients refused to provide authorization for that disclosure.)

Under a system such as proposed in these regulations, care givers are deprived of a legal basis on which to deny a request for the disclosure of any

identifiable health information which is requested for a use asserted to be "compatible with" treatment, payment or health care operations. Reg. sec. 164.508(a)(2). This type of system imposes a duty on care givers to determine each time they receive a request for identifiable health information (a) whether the information really is going to be used for treatment, payment and health care operations or some other purpose (64 *Fed. Reg.* at 59940), (b) the "minimum necessary" information for that purpose (for which there is no "brightline" test) (64 *Fed. Reg* at 59943, 59945), (c) how to apply and enforce the security measures established by themselves as well as their "business partners" (64 *Fed. Reg.* at 59947), (d) whether to honor a patient's "request to restrict" access to certain information (64 *Fed. Reg.* at 59945) and (e) whether the request is affected by a "contrary" or "more stringent" state law (64 *Fed. Reg.* at 59996-97).

Finally, the model notice to the public of information practices does not adequately inform consumers of the extent to which their identifiable health information will be disclosed without their consent. The notice informs the consumer

> "We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive."

64 Fed. Reg. at 6004911.

This gives the erroneous impression that an individual's identifiable health information will be disclosed only for his or her specific benefit. The notice should inform the patient that identifiable health information also will be disclosed for more general "management functions" including "insurance rating", "experience rating", "outcomes evaluations", and "development of clinical guidelines". Reg. sec. 164.504. Further, the notice should inform the patient that the information is not just being used by the provider, but is also being disclosed, without notice and consent to other entities. In order to be accurate, the notice should contain the statement that appears in the preamble to the regulations that patients' identifiable health information will be disclosed for "most uses" without notice or consent. See 64 *Fed. Reg.* at 59939/2.

Recommendation

The "American" believes that the regulations should build on, rather than depart from, the human experience generally reflected in common law, state statutory laws, and "core ethical principles". The proposed regulations should improve on the privacy protections contained in current laws, rather than abolish them.

We believe that patients should retain the right to be notified of the reason their identifiable health information is being requested and have the right to give

or withhold consent for disclosure. We agree that the right to consent is seriously weakened when a health plan can condition enrollment on a "blanket consent" covering all information in the future. Accordingly, we believe that this practice should be outlawed.

The regulations should follow the traditional two-step practice in gaining access to identifiable health information. Under **step one,** insurers can ask whatever specific questions they desire when considering whether to enroll a patient. Of course, the more burdensome the questions, the less competitive that insurance plan will be in the marketplace. The patient has the choice of whether he or she wishes to answer any question, and the insurer can make a business judgement about whether to enroll the patient.

Under **step** two, the patient is asked by the caregiver when he or she seeks treatment for a condition whether he or she consents to the disclosure of identifiable health information beyond the caregiver. (For example, a patient should not have to disclose the fact that she was treated for depression five years ago in order to have an emergency room physician set her broken finger.) We believe it can be safely assumed that the patient is consenting to disclose information to the caregiver by the very act of making that disclosure. The term "care giver" should be defined to mean all those engaged directly in providing medical services to the patient and who have direct professional responsibility for that care. (This would mean that separate consents would not be required for a staff physician in a hospital to disclose information about a patients condition to members of the hospital staff and other staff physicians involved the patients care However, specific consent would be required to disclose the information to someone not connected professionally with the physician or the hospital. Those consents could, however, be obtained in a single interview.)

We believe that there are fundamental distinctions between "treatment, payment, and health care operations" which should be recognized and that patients who simply seek treatment should not be compelled to permit the use of their identifiable information for payment and health care operations. The preamble appropriately notes that the term "treatment" is intended to relate "only to services provided to an individual and not to an entire enrolled population". 64 *Fed. Reg.* at 5993911.

Consent for "payment" similarly should only relate to the payment of services reflected on an individual claim and not to services generally or the entire enrolled population. The preamble states that this information is to be used to determine a health plan's responsibilities for coverage or reimbursement, but it is unclear whether the use of the information is to be limited to the individual's claim. Uses other than to determine coverage or payment of the claim to which the information relates should be moved to "health care operations". See e.g., "improving payment methodologies or coverage policies".

The definition of "health care operations" in the preamble is fundamentally different from the definitions of "treatment" and "payment". "Health care operations" means services or activities provided by or on behalf of a health plan or provider "for the purposes of carrying out the management functions of such plan or provider necessary for the support of treatment or payment". 64 *Fed. Reg.* at 59933/3. **Stated succinctly, identifiable health information disclosed for "treatment and payment" is used principally for the direct benefit of the patient while identifiable health information disclosed for "health care operations" is used principally for the benefit of the health plan or provider (or perhaps the "entire enrolled population").**

Many of the uses included under the definition of "health care operations" are intended, either partially or entirely, to reduce the health plan's financial risk. See e.g., "insurance rating and other insurance activities relating to the renewal of a contract for insurance including underwriting, experience rating, and reinsurance"; "outcomes evaluations"; and "development of clinical guidelines". Reg. sec. 164.504. This is also the very type of "financially driven" use of identifiable health information that is making the public increasingly uncomfortable. 64 *Fed. Reg.* at 59920/1. See also "Medicare HMO's Hit for Lavish Spending", *USA Today,* Al (February 4, 2000).

Some patients are simply not willing to disclose their highly personal and sensitive medical information for any purpose other than their own treatment. Many others are willing to disclose such information only to the extent that it is essential for payment for that service. Some may not mind having their identifiable health information used for their own treatment, payment of their own claim or improving the management of the health plan or provider. **Patients should have the right, however, to know how specific information will be used and the right to refuse to disclose information for that purpose.**

We would suggest use of a simple consent form similar to the following:

"I understand that medical information about my condition and treatment cannot be disclosed beyond my caregiver without my consent (other than in limited circumstances required by statute). My identifiable health information may be used for the purposes I have indicated below:

___ treatment of my medical condition

payment of an insurance claim for treatment of my medical condition

___ health care operations to assist my provider or health plan to improve its management or the treatment or payment for individuals generally."

If the patient does not consent to the disclosure of certain information that the health plan believes is necessary to determine payment, the patient simply would assume the financial responsibility for that service as he or she does today. Of course, the health plan could always decide that the information that was disclosed was adequate to determine coverage and payment. The patient would not, however, lose health insurance coverage for all services in the future simply because he or she elected to not obtain coverage for a specific service or condition.

VII. Privacy Protections Must Cover all Psychotherapy Communications

A. Use of Mental Health Information for Treatment, Payment and Health Care Operations ("Treatment, *payment and health care operations",* Reg. sec. 164506(a), 64 *Fed. Reg.* at 59940).

As noted in section Ill, effective psychotherapy is completely dependent upon the patient's **"confidence and trust"** that he or she may make **"a frank and complete disclosure of facts, emotions, memories, and fears"** without even the possibility that this information will be disclosed beyond the therapist without the patient's consent. *64 Fed. Reg.* at 5994113 citing *Jaffee v. Redmond; Surgeon General's Report on Mental Health,* at 441.

The proposed regulations start down the right path by conferring special privacy protection for "psychotherapy notes" including (a) the requirement for patient consent for disclosure of information falling within that definition and (b) the prohibition on conditioning treatment, enrollment or payment on the patient granting that consent or authorization. Reg. sec. 164.508(a)(3). **The "American" strongly endorses those protections.**

The regulations, however, fail to follow through with protections that are sufficient to preserve the public's confidence in the privacy of therapist-patient communications, For example, the preamble states that psychotherapy notes "could not be involved in the documentation necessary for health care treatment, payment or operations". 64 *Fed. Reg.* at 59941/2-3. The determination of what information is necessary for treatment, payment or operations, and therefore the protection for psychotherapy notes, appears to be left to the discretion of the health plan.

The preamble further states that such notes could be used only by the therapist who wrote them. 64 *Fed. Reg.* 59941/2. Thus, it would appear that the protection of the regulations would be lost if a patient switched to a different psychotherapist or sought an evaluation from another therapist and asked that the notes regarding his or her treatment be shared with the second therapist.

The preamble also states that protected psychotherapy notes are only those "maintained separately from the medical record". *Id.* There would appear to be nothing to prohibit a health plan from requiring that some or all of the information contained in the therapist-patient communications be included in the medical record, thereby abolishing the protection for psychotherapy notes.

The regulations themselves expressly exclude from the definition of psychotherapy notes:

-- medication prescription and monitoring;

-- counseling session start and stop times;

-- the modalities and frequencies of treatment furnished;

-- results of clinical tests:

-- and any summary of

--- diagnosis;

--- functional status:

--- the treatment plan;

--- symptoms;

--- prognosis; and

--- progress to date.

Reg. sec. 164.508(a)(3)(iv)(A). It would appear that this information does not receive the "special" protection acknowledged as essential for effective psychotherapy even if it contains or reveals information including "facts, emotions, memories, and fears" that are part of the therapist-patient communications.

Accordingly, any communications between a therapist and his or her patient which do not fall within the narrow exception for "psychotherapy notes" can be disclosed without the patients knowledge or consent as long as they are arguably compatible with treatment, payment or health care operations.

In addition, the special protection for psychotherapy notes does not extend to the 13 additional uses for which identifiable health information can be disclosed without the patients consent. 64 *Fed. Reg.* at 59942/2. Accordingly, **the special privacy protections in the regulations would not encompass the**

very therapist-patient communications that are covered by the Supreme Court's ruling in *Jaffee v. Redmond* **on which those protections are based.**

This treatment of psychotherapy communications is not likely to preserve the patients' "confidence and trust" sufficiently to permit effective psychotherapy.

The flaw in the approach taken by the regulations is that they fail to recognize that it is the status of the communications that determines the necessity of privacy protection rather than the tile in which they are stored. It should make no difference if therapist-patient communications are relayed at the patients request from one therapist to another or whether notes reflecting those communications are maintained as part of the medical record. The disclosure of those communications cannot be made necessary for treatment, payment or health care operations, if psychotherapy is to retain its viability. Similarly, the privacy protection afforded these communications should not be adversely affected if those communications are reflected, as they undoubtedly will be, in summaries of the diagnosis, treatment plan or prognosis, for example. **The disclosure of these communications without the patient's consent destroys the relationship of confidence and trust that is the therapeutic instrument of psychotherapy.**

In fact, it is the basic approach taken by the regulations that is likely to undermine the public's confidence in the privacy of therapy communications. The regulations establish a general rule permitting the disclosure of all identifiable health information for treatment, payment or health care operations without patient consent unless it falls within an "exception" for psychotherapy notes which is narrowly circumscribed. 64 Fed. *Reg.* at 59941/2. There are an additional 13 uses to which the privacy "exception" does not apply.

A different approach has been adopted by the State of New Jersey that would appear to be much more likely to preserve the confidence in privacy essential for psychotherapy. This approach was suggested as a "useful model" in the Surgeon General's Report on Mental Health. See Report at 443. The District of Columbia has also adopted this approach. See the "Practicing Psychology Licensing Act", New Jersey Stat. 45:14B-2 through 45:14B-46 (1985); the " District of Columbia Mental Health Information Act", D.C. Code sec. 6-2001 through 6-2022 (1979).

The approach adopted in these statutes has three basic elements:

(1) A general rule that prohibits the disclosure of therapist-patient communications without patient consent;

(2) A list of the types of information which may be requested by third party payors to make payment and treatment determinations and which can be disclosed with patient consent; and

(3) A procedure for review of this or additional information by an independent review panel of comparably trained professionals to determine whether the services are reasonable and appropriate.

New Jersey Statutes 45:14B-28; 45:14B-32, 45:14B-34; D.C. Code sec. 6-2002; 6-2017. This approach is clearly more consistent with the holding in *Jaffee v. Redmond,* and would seem to be workable since the New Jersey law has been in effect for 15 years and the District of Columbia law for 21 years without reported hardship on patients, practitioners or insurers.

This approach would also facilitate implementation of one of the basic principles of the regulations that covered entities must not "use or disclose more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure". Reg. sec. 164.506(b)(l); 64 *Fed. Reg.* at 59943. These statutes list the types of mental health information that can be requested by third party payors to make payment determinations and define the meaning of each term.

The following types of information are listed in both statutes:

a. Administrative information;

b. Diagnostic information;

c. The status of the patient (voluntary or involuntary; inpatient or outpatient);

d. The reason for continuing services, limited to an assessment of the patients current level of functioning and level of distress (both described by the terms mild, moderate, severe, or extreme); and

e. A prognosis, limited to the estimated minimal time during which treatment might continue.

New Jersey Stat. 45:14B-32; D.C. Code sec. 6-2017(a). The statutes then define each term to prevent the privacy protection from being eroded away through creative interpretation of the law. For example, "Administrative information" is limited to "a patients name, age, sex, address, educational status, identifying number, date of onset of difficulty, date of initial consultation, dates and character of sessions (individual or group), and fees." "Diagnostic information" is limited to "therapeutic characterizations which are of the types that are found in the Diagnostic and Statistical Manual of Mental Disorders (DSM Ill), of the American Psychiatric Association, or other professionally recognized diagnostic manual." New Jersey Stat. 45:14B-31.a. and b.; D.C. Code sec. 6-2001(1) and (5).

Thus, third party payors know what information they can request, and patients and therapists know what information they may be expected to produce if they desire to have services reimbursed by insurance. This should enhance the patients' confidence that their communications will be protected because, as the Court noted in Jaffee, a promise of privacy that is contingent upon some later determination "would eviscerate" the effectiveness of the protection. 116 S.Ct. at 1932.

The "American" also urges adoption of the following additional features of these state laws. The District of Columbia Mental Health Information Act "strictly and absolutely" prohibits the disclosure of "personal notes" made by a mental health professional "except to the degree that the personal notes or the information contained therein are needed in litigation brought by the client against the mental health professional on the grounds of professional malpractice or disclosure in violation of this section". D.C. Code sec. 6-2003. The District of Columbia statute also prohibits mental health information that has been disclosed from being re-disclosed without patient authorization. D.C. Code sec. 6-2013.

The New Jersey statue contains a provision that any authorization or disclosure under that statute shall not constitute a waiver of the therapist-patient privilege. New Jersey Stat. 45:14B-35. Such a provision is crucial under the proposed regulations. Otherwise, any patient who consents to the disclosure of protected mental health information for payment purposes, for example, would run the risk of waiving the privilege established by the Court in Jaffee for other purposes. Of perhaps greater concern, the patient's psychotherapy privilege could be waived by the disclosures of psychotherapy communications that these regulations permit without the patient's consent.

B. Psychotherapy Communications Should Not Be Disclosed for the 13 "National Priorities" Without Patient Consent

("Introduction to uses and disclosures without individual authorization", 64 Fed. Reg. at 59955, Reg. sec. 164.510)

As with the disclosure of psychotherapy communications for use in treatment, payment, and health care operations, the degree of privacy protection to be afforded those communications in the context of the 13 national priorities listed in the regulations should be dictated by the level of protection that "reason and experience" indicates is necessary to preserve the "confidence and trust" essential for effective therapy.

The Supreme Court found in *Jaffee v. Redmond* that the patient-therapist privilege should have at least the same status as "the spousal and attorney-client privilege" since all three relationships are "rooted in the imperative need for confidence and trust". 116 S.Ct. at 1928. The Court in Jaffee also expressly rejected conditioning application of the patient-therapist privilege on a "balancing" test to determine whether disclosure was necessary when it is "in the interests of

justice". 116 S.Ct. at 1926,1932. The Court reasoned that balancing the need for privacy of psychotherapy communications against the "national priority" of promoting the interests of justice would eliminate the effectiveness of the privilege by rendering its application unpredictable. The Court again rejected this type of "balancing" test in the application of the attorney-client privilege to communications sought in a criminal grand jury investigation. *Swidler and Berlin v. United* States, 118 S. Ct. 2081(1998)

Applying the rationale of the *Jaffee* decision, which the preamble adopts, leads to the conclusion that the privacy protection for psychotherapy communications should also apply to the 13 other uses which are listed by the preamble as national priorities. None of those priorities exceeds in importance promotion of the interests of justice which the Jaffee decision rejected as an overriding competing interest.* Clearly, the therapist-patient privilege which is now recognized under federal and state common law would apply to the 13 uses listed, just as would the attorney-client and spousal privileges.

Because preserving the privacy of psychotherapy communications is essential to the effectiveness of the therapy, and access to effective therapy is in both the public's and the individual's interest *(Jaffee* at 1929), the "special" privacy protections for treatment, payment and health care operations should be extended to the other 13 uses mentioned in the regulations. The only exception that we believe would be appropriate is where disclosure is necessary to prevent or lessen a serious and imminent threat to an individual's health and safety (Reg. sec. 164.510(k)).

We are particularly concerned that the confidence and trust necessary for effective psychotherapy would be shattered by the weak protections contained in the regulations for **research.** Reg. sec. 164.510(j). We do not believe that patient confidence would be preserved by the practice of allowing patient consent or authorization to be waived by either an Institutional Review Board or a "privacy board" established by a private corporation. Reg. sec. 164.510(j)(1).

This loss of confidence and trust is especially likely in view of the numerous recent accounts of research being authorized by review boards without adequate patient notice and consent as a result of the pressure to approve research projects that bring millions of dollars in funding to the institutions. One recent report noted that

(a) "the rules developed to protect research subjects are largely ignored";

(b) "[t]he extent of the rule-breaking in clinical trials is vast but hard to measure";

*The importance of this "national priority" is illustrated by the fact that one of the purposes for which the Constitution was adopted was to "establish Justice". See Preamble, U.S. Constitution.

(c) "[f]ailure to obtain proper consent from participants in trials is a recurring problem"; and

(d) increasingly, major medical institutions are failing to obtain informed consent for such things as experimental surgery (the University of Arizona) and experimental drugs (the University of California at San Francisco).

"Investigative Report: Dying for a Cure", U.S. News *and World Report,* at 34, 36-37. One researcher summed up the increasing conflict of interest in conducting research as follows:

> "You are trying to serve two masters. The patient and the family think you're Dr. Welby, and your department chair and your colleagues think you're some giant hero who is going to bring in grant money and publish and bring glory to the field."

"Dying for a Cure", at 36.

More than 1000 research projects at Virginia Commonwealth University reportedly were recently shut down by the Food and Drug Administration after a patients father discovered that information was being obtained about him (whether he suffered from depression or had abnormal genitalia) without his consent. See "Father's Complaints Shut Down Research", *The Washington* Post, B7 (January 12, 2000). Medical research projects have also been shut down for similar reasons at Duke University, the Los Angeles Veterans Administration Hospital, the University of Illinois at Chicago, and the University of Colorado Health Sciences Center. *Id.*

If prestigious academic institutions are finding it increasingly difficult to conduct research without violating the basic rights of research subjects, then those violations are likely to become more pervasive if "privacy boards" established by for-profit corporations are permitted to act without the patients' consent. In fact, the Nuremberg Code established shortly after World War II and the Declaration of Helsinki, which established basic standards for health research, both elevate the concern for the rights of research subjects above scientific and societal goals. "Challenges to Human Subject Protections in U.S. Medicare Research", B. Woodward, JAMA, 1947 (November 24, 1999).

Thus, it would seem that greater, rather than weaker, patient privacy protections are warranted for research.

With respect to **law enforcement,** we believe that the privacy protections under the regulations for psychotherapy communications should be at least as broad as the therapist-patient privilege. As the Supreme Court noted in *Swidler*

and Berlin, privileges do not apply differently in criminal and civil cases. 118 S. Ct. at 2087. In that case, the attorney-client privilege was found to be a valid basis for quashing a federal criminal grand jury subpoena that was issued to determine whether a crime had been committed. The Court noted that while upholding the attorney-client and the therapist-patient privilege in criminal and civil litigation might mean that some information would be lost to the judicial system, that concern was probably minimal since those communications would not take place if the privileges were not upheld. 118 S.Ct. at 2087.

We also agree with the proposition in the preamble that **the information generally contained in psychotherapy communications is not likely to be useful or appropriate for the 13 uses prescribed in the regulations. 64** *Fed. Reg.* at 59942/2. For example, we believe that it would be highly unusual and inappropriate to permit the disclosure of psychotherapy communications without patient notice or consent for public health, government data banks, health oversight, directory information, research, for banking and payment processes, and health care fraud. Reg. sec. 164.510. Further, it is inconsistent to require consent for the disclosure of psychotherapy notes for health care operations but then permit disclosure without consent for health oversight activities. Reg. sec. 164.510(c).

The privacy protections for psychotherapy communications of **deceased individuals** should not be limited to two years. 64 *Fed. Reg.* at 5997013; Reg. sec. 164.506(f). The Supreme Court recently held that the attorney-client privilege survives the death of the client. *Swidler and Berlin v. United States 118* S.Ct. 2081 (1998). The only exception recognized by the Court is where the privilege is waived posthumously based on the assumption that this would further the clients intent. 118 S. Ct. at 2086. That could not be presumed in the criminal proceedings at issue in *Swidler and Berlin,* and it cannot be presumed under the broad exception to privacy set forth in these regulations.

Recommendation

The special privacy protections for psychotherapy communications should be applied to the 13 prescribed uses in the regulations.

VIII. The Privacy Protections Contained in the Reaulations are Ineffective

('Compliance", 64 Fed. Reg. at 60002, Reg. sec. 164.522)

As briefly mentioned in the Introduction, the preamble acknowledges that the compliance and enforcement authority in HIPAA is too weak to ensure compliance with the protections contained in the regulations, The preamble notes that HIPAA leaves many entities that receive, use and disclose protected health information "outside of the system of protection we propose to create." 64 *Fed. Reg.* at 59923/2.

Those who would not be subject to the protections in the regulations include anyone who obtains information from a researcher, worker's compensation carriers, life insurance issuers, employers and marketing firms. Further, the preamble notes that the protections in the regulations would not apply to "many of the persons that covered entities hire to perform administrative, legal, accounting, and similar services on their behalf...". Also, the protections in the regulations do not apply to identifiable health information maintained in a "paper information system". *Id.*

The preamble also notes that enforcement of the regulatory protections is further hampered by the Secretary's lack of authority to provide for a "private right of action" so that individuals can enforce the protections in the regulations. 64 *Fed. Reg.* at 60003/2. In addition, the penalty structure is inadequate given the importance of the rights at stake. 64 *Fed. Reg.* at 59924.

We agree that legislation should be enacted to provide for criminal and civil penalties for those who violate the privacy rights of individuals under these regulations. 64 *Fed. Reg.* at 59923/3. We also agree that the public cannot be expected to have confidence that their health information will be protected until such time as "we put the force of law behind our rhetoric". *Id.* **Accordingly, these regulations should ensure that patients retain as much control as possible over the disclosure of identifiable health information, at least until such time as adequate alternative protections are authorized by statute. That control should include the right to give or withhold consent for disclosure.**

In addition, we believe that several of the principal protections contained in the regulations would be ineffective even if adequate enforcement authority did exist. For example, we support the regulations' incorporation of the principle that only the "minimum amount" of identifiable information be disclosed to accomplish the intended purpose and that this limitation should include a determination of whether the purpose could be accomplished with non-identifiable information. 64 *Fed. Reg.* at 5994344.

The determination of what information is the minimum amount necessary, however, would have to be made by the entity making the disclosure. 64 *Fed. Reg.* at 59944/1. That entity would only be required to "make all reasonable efforts" to ensure that only the minimum amount of information was disclosed. The efforts required by the regulations would vary depending on the technological capability and size of the covered entity. 64 *Fed. Reg.* at 5993913, 59944/3. Under such a sliding scale, it is difficult to see how a patient could show that covered entities of various sizes failed to make "reasonable efforts" to avoid disclosing more than the minimum amount of identifiable health information for a purpose such as "conducting quality assessment and improvement activities" or "insurance rating and other insurance activities". Reg. sec. 164.504.

Further, the "right of an individual to restrict uses and disclosures" of identifiable health information is really only the right "to request" that uses by "a health care provider" be restricted, and a provider is not required to agree to any requested restriction. Reg. sec. 164.506(c). It is difficult to see how this measure confers any significant power on the individual to protect his or her right to medical information privacy.

The weakness of these measures is compounded by the fact that individuals will have no way of knowing when their information was disclosed, what information was disclosed or to whom it was disclosed because there is no requirement in the regulations for notice, consent or a record of the disclosures for most uses. Thus, individuals will have little opportunity of asserting even the weak protections set forth in the regulations.

The lack of a realistic ability to enforce the privacy measures in these regulations will inevitably destroy the public's confidence in the health delivery system.

Recommendations

We believe that, at the very least, patient consent should be required and a record should be kept of all disclosures of psychotherapy communications. We also recommend that the "minimum necessary" information restriction be strengthened by removing the "all reasonable efforts" language which renders the provision unenforceable. We also recommend that individuals be permitted to negotiate agreements with all covered entities, as they can currently, to not disclose certain types of identifiable health information.

We also recommend that any covered entity, other than a provider, which handles protected health information be required to have an agreement with the Secretary comparable to a provider agreement under Medicare. See sec. 1866 of the Medicare Act. Pursuant to that agreement, covered entities would have to certify that they are, and will remain, in compliance with the privacy regulations. One of the penalties for a serious violation of the privacy protections could be suspension or termination of the privacy agreement or certification. Providers would be required to comply with the regulations under the current conditions of participation which require compliance with all federal and state laws. See, e.g., **42** C.F.R. sec. 482.11.

IX. Relationship of the Reaulations to Federal and State Laws

A. More Protective State Privacv Laws Should Not Be Preempted

("Relationship to state laws", 64 *Fed. Reg.* at 59994, Reg. sec. 160.202)

The "American" strongly supports the provision in the regulations to not preempt state laws, including administrative and common laws, that relate to privacy and are "more stringent". As the preamble notes, much state privacy law "is not found in statutes, but rather in State common law". 64 *Fed. Reg.* at 59996/1. The Court in *Jaffee* observed that "all 50 states and the District of Columbia have enacted into law some form of psychotherapy privilege" (footnote citing those laws omitted). 116 S.Ct. at 1929.

Accordingly, we believe that the "reason and experience" reflected in the psychotherapy privacy laws in the states should be allowed to provide additional protections in addition to the "floor" of protection provided by federal law.

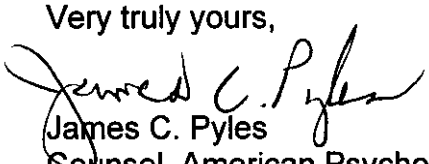
B. More Protective Federal Privacv Laws Should Be Given Effect

("Relationship to other federal laws", 64 *Fed. Reg.* at 59999)

The "American" believes that the privacy protection provided to psychotherapy communications by the federal common law principle in the Jaffee decision should be expressly incorporated into federal privacy regulations. The therapist-patient privilege recognized in Jaffee is based on the "reason and experience" at both the federal and state levels. A privilege established under the Federal Rules of Evidence cannot be eliminated by a regulation issued by a federal agency. See section 501 of the Federal Rules of Evidence.

It is time that protections for psychotherapy communications, which are included in all state statutory laws and in state and federal common laws, are included in federal regulatory law. In fact, the failure to include comparable protections would put federal privacy regulations out of step with virtually all other laws on the subject.

Very truly yours,



James C. Pyles
Counsel, American Psychoanalytic Association

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Health Care Financing Adminir

7500 SECURITY BOULE\
BALTIMORE MD 21244-1

Robert Pyles, M.D.
367 Worcester Street
Wellesley MA 02481

Dear Dr. Pyles,

Thank you for your inquiry on behalf of the American Psychoanalytic Association about the extent, if any, to which HCFA might access the records of non-Medicare patients receiving psychotherapy from a provider also serving Medicare beneficiaries. Our response to your inquiry follows. Please note that we address here only investigations by HCFA, and do not discuss the investigatory powers of other government agencies. Please accept our apologies for the delay in conveying this information to you.

At the core of your inquiry is concern about the Privacy of communications between a non-Medicare patient and his psychotherapist. Firmly rooted in state case law, and established in federal law by the U.S. Supreme Court in Jaffee v. Redmond, 5 18 U.S. 1 (1996), the psychotherapist-patient privilege protects "confidential communications between a licensed psychotherapist [or licensed social worker in the course of psychotherapy] and her Patients in the course of diagnosis or treatment." Id. at 15. The Court did riot create an absolute privilege, explaining, "we do not doubt that there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist." Id. at 18, n.19.

The Court in Jaffee did not define "confidential communications" beyond the phrase quoted above, but earlier federal case law indicates that certain medical records incidental to diagnosis or treatment, such as patient names, appointment times and length of treatment, might not fall under the umbrella of Jaffee's psychotherapist-patient privilege. Moreover, it is likely that even if a court were inclined to find this second tier of information otherwise privileged, such privilege would be deemed waived by a patient who authorized its disclosure to any third party, such as a health insurer.

There thus appear to be two universes of information. A request for the disclosure of confidential communications between a psychotherapist and a non-Medicare patient might not withstand scrutiny. However, to the extent that portions of the records of a non-Medicare patient of a Medicare-participating psychotherapist are not covered by the psychotherapist-patient privilege, those records may be obtained by the government.

We hope. you find this information responsive to your request, Should you have further questions or requite additional information, please contact Howard Cohen at 410-786-9537.

Sincerely,

Penny Thompson

Penny Thompson,
Director
Program Integrity Group

New Jersey Statute

45:14B-1. Short title

This act shall be known and may be cited as the "Practicing Psychology Licensing Act."

L.1966, c. 282, s. 1.

45:14B-2. Definitions

As used in this act, unless the context clearly requires otherwise and except as in this act expressly otherwise provided

(a) "Licensed practicing psychologist" means an individual to whom a license has been issued pursuant to the provisions of this act, which license is in force and not suspended or revoked as of the particular time in question.

(b) The "practice of psychology" means the rendering of professional psychological services to individuals, singly or in groups, whether in the general public or in organizations, either public or private, for a fee, monetary or otherwise. "professional psychological services" means the application of psychological principles and procedures in the assessment, counseling or psychotherapy of individuals fur the purposes of promoting the optimal development of their potential or ameliorating their personality disturbances and maladjustments as manifested in personal and interpersonal situations. Within the meaning of this act, professional psychological services does not include the application. for a fee, monetary or otherwise, of psychological principles and procedures for purposes other than those described in this section.

(c) "Board" means the State Board of Psychological Examiners acting 'as such under the provisions of this act.

(d) "Recognized educational institution" means any educational institution which is a 2-year junior college or one which grants the Bachelor's, Master's, and Doctor's degrees, or any one or more thereof, and which is recognized by the New Jersey State Board of Education or by any accrediting body acceptable to the State Board of Psychological Examiners.

L. 1966, c. 282, s. 2.

45:14B-3. Recognition of educational institutions

No educational institution shall he denied recognition as a recognized educational institution solely because its program is not accredited by any professional organization of psychologists and nothing in this act or in the administration of this act shall require the registration with the board by educational institutions of Departments of Psychology or doctoral programs in psychology.

L. 1966, c. 282, s. 3.

45:14B-4. Unauthorized practice of medicine and surgery

Nothing in this act shall authorize the practice of medicine and surgery by any person not licensed so to do pursuant to chapter 9 of Title 45 of the Revised Statutes.

L.1966, c. 282, s. 4.

45:14B-5. Use of title or description by unlicensed person

Commencing January 1, 1968, no person who is not licensed under this act shall represent himself to be a licensed practicing psychologist, use a title or description, including the term "psychology," any of its derivatives, such as "psychologist" or "psychological" or modifiers such as "practicing" or "certified," in a manner which would imply that he is licensed under tbis act, or offer to practice or practice psychology as defined in this act, except as otherwise permitted in sections 6 and 8. The use by a person who is not licensed under this act of such terms, whether in titles or descriptions or otherwise, is not prohibited by this act except when in connection with the offer to practice or the practice of psychology as defined in section 2(b) of this act. Use of such terms in connection with professional activities other than the rendering of professional psychological services to individuals for a fee, monetary or otherwise, shall not be construed as implying that a person is licensed under this act or as an offer to practice or as the practice of psychology.

L.1966, c. 282, s. 5.

45:14B-6. Activities of unlicensed practicing psychologist

6. Any individual who is not a licensed practicing psychologist shall not be limited in his activities:

(a) As part of his duties as an employee of:

(1) an accredited academic institution, a federal, State, county or local governmental institution or agency, or a research facility while performing those duties for which he was employed by such an institution, agency or facility;

(2) a business organization, while performing those duties for which he was employed by such an organization, and providing the purposes of such an organization do not include the offer to practice, or the practice of, psychology as defined in section 2(b) of this act;

(3) an organization which is nonprofit and which is, in the opinion of the board, a bona fide community agency, while performing those duties for which he was employed by such an agency under the direct supervision of a licensed practicing psychologist. For the purposes of this subsection a "community agency" means a nonprofit organization supported wholly or in a major part by public fimds.

(b) As required by his employer to the pupils, students or other normal clientele within the scope of his employment but not to the general public, provided he is employed by a private elementary or secondary school that requires its psychologists to be certified as school psychologists by the New Jersey State Department of Education.

(c) As a student of psychology, psychological intern or person preparing for the practice of psychology under qualified supervision **in a training** institution **or facility** recognized by the board provided he is designated by such titles as "psychological intern," **"psychological** trainee" **or** others, clearly indicating such training status.

(d) As a practicing psychologist for a period not to exceed 10 consecutive business days or 15 business days in any 90-day period, if he resides outside, and his major practice is outside, of the State of New Jersey and gives the board a summary of his qualifications and a minimum of 10 days' written notice of his intention to practice in the State of New Jersey under this section 6(d), provided he (1) is certified or licensed in another State under requirements the board considers to be the equivalent of requirements for licensing under this act or (2) resides in a State which does not certify or license psychologists and the board considers his professional qualifications to be the equivalent of requirements for licensing under this act; and is not adjudged and notified by the board that he is ineligible for licensing under this act.

(e) As a practicing psychologist for a period not exceeding one year, if he has a temporary permit therefor which the board may issue upon his filing of an application for licensing under this act.

(f) As a practicing psychologist for a period not exceeding three years under the supervision of a licensed practicing psychologist or a person designated by the board as an eligible supervisor, if he has a temporary permit therefor which the board may issue upon his completion of all the requirements for licensing under this act except the supervised experience requirement.

(g) As a practicing psychologist certified as a school psychologist by the State Department of Education and performing services on behalf of a local school district to students for whom the school district is responsible to provide services.

L.1966,c.282,s.6; amended **1997, c.140, s.1.**

45:14B-7. Exceptions not available to certain persons

The exceptions specified in section 6(d), (e) and (f) shall not be available to any person who has been found by a court of this or any State of the United States to have been guilty of and who fails to present satisfactory evidence of recovery from or correction of gross immorality, habitual intoxication, drug addiction, criminality involving felonious action or moral turpitude, or dishonorable or unprofessional conduct. An action to determine whether any person asserting an exemption under section 6(d), (e) or (f) has committed one or more of the acts listed in this section may be brought by the Attorney General on behalf of the board.

L.1966, c. 282, s. 7.

45:14B-8. Members of other professional groups doing work of psychological nature

Nothing in this act shall be construed to prevent qualified members of other profession-d, groups such as physicians, osteopaths, optometrists, chiropractors, members of the clergy, authorized practitioners, attorneys at law, social workers or guidance counselors from doing work of a psychological nature consistent with the accepted standards of their respective professions, provided, however, that they do not hold themselves out to the public by any title or description stating or implying that they are psychologists or are licensed to practice psychology.

L.1966, c. 282, s. 8.

45:14B-9. State board of psychological examiners; number of members

There is hereby created, in the Division of Professional Boards of the Department of Law and Public Safety, the State Board of Psychological Examiners, which shall consist of 7 members to be appointed by the Governor. The board shall at all times, except for vacancies, be composed of members who represent equitably the diverse fields ofpsychology, a majority of whom shall be licensed practicing psychologists. All members shall have the qualifications hereinafter set forth in section IO of this act.

L.1966, c. 282, s. 9.

45:14B-10. Members of board; qualifications

Each member of the board shall have the following qualifications:

(a) He shall be a resident of this State and a citizen of the United States.

(b) He shall either be a member of or have professional standing equivalent to that required for classification as a member of the New Jersey Psychological Association and the American Psychological Association.

(c) He shall be at the time of his appointment, and shall have been for at least 5 years prior thereto, actively engaged as a psychologist in one or more phases or branches of psychology or in the education and training of doctoral or postdoctoral students of psychology or in psychological research, and shall have spent the major portion of the time devoted by him to such activity, during the 2 year.9 preceding his appointment, in this State.

(d) He shall hold the doctoral degree in psychology or in a closely allied field from a recognized educational institution.

L.1966, c. 282, s. LO.

45:14B-11. Terms

The terms of the first 7 members of the board shall expire as follows: one member, June 30, 1968; 2 members, June 30, 1969; 2 members, June 30, 1970; 2 members, June 30, 1972. Thereafter, each member of the board shall be appointed for a term of 3 years. If before the expiration of his term any member shall die, resign, become disqualified or otherwise cease to be a board member, the vacancy shall be filled by the Governor by appointment for the unexpired term. Each appointee shall, upon accepting appointment to the board, take and subscribe to the oath or affirmation prescribed by law and file same in the office of the Secretary of State.

The first 7 appointees shall be deemed to be and shall become licensed practicing psychologists immediately upon their appointment and qualification as members of the board.

L.1966, c. 282, s. 11.

45:14B-12. Removal; **hearing; written notice**

The Governor shall have power to remove from office any member of the board for incompetence, neglect of duty, unprofessional conduct or moral turpitude; but no board member may be thus removed until after a public hearing of the charges against him, and at least 3 0 days prior written notice to such accused member of the charges against him and of the date fixed for such hearing.

L.1966, c. 282, s. 12.

45:14B-13. Meetings; chairman, **vice-chairman** and secretary; seal; quorum; rules and **regulations; issuance of permit or license; expenses; subpoenas**

The board shall, at its first meeting, to be called by the Governor as soon as may be following the appointment of its members, and at all annual meetings, to be held in June of each year thereafter, organize by electing from among its members **a chairman, vice-chairman and secretary whose** election shall be subject to the approval of the Attorney General. Such officers shall serve until the following June 30 and until their successors are appointed and qualified, The board shall adopt a seal which shall be affixed to all licenses issued by the board. The board shall administer and enforce the provisions of this act. The board shall hold at least one regular meeting each year, but additional meetings may be held upon call of the chairman or at the written request of any 2 members of the board. Four members of the **board shall constitute** a quorum and no action at any meeting shall be taken without at least 3 votes in accord. The board shall from time to time adapt such rules and regulations and such amendments thereof and supplements thereto as it may deem necessary to enable it to perform its duties under and to carry into effect the provisions of this act. The board shall examine and pass on the qualifications of all applicants for permits or licenses under the act, and shall issue **a permit** or license to each qualified successful applicant therefor, attesting to his professional qualifications to engage in the practice of psychology.

Each member of the board shall be reimbursed for actual expenses reasonably incurred in the performance of his duties as a member of or on behalf of the board.

Subject to the approval of the Attorney General, the board shall be empowered to hire such assistants as it may deem necessary to carry on its activities. All expenditures deemed necessary to carry out the provisions of this act shall be paid by the State Treasurer from the license fees **and** other sources of income of the board, within the limits of available appropriations according to law, but in no event shall expenditures exceed the revenues of the board during any fiscal year. The board, through its chairman or secretary, may issue subpoenas to compel the attendance of witnesses to testify before the board and produce relevant books, records and papers before the board and may administer oaths in taking testimony, in any matter pertaining to its duties under the act (including, without limitation, any hearing authorized or required to be held by the board under any provisions of this act), which subpoenas shall issue under the seal of the board and shall be served in the same manner as subpoenas issued out of the Superior Court, Every person who refuses or neglects to obey the command of any such subpoena, or who, after hearing, refuses to be'swom and testify, shall, in either event, be liable to a penalty of $50.00 to be sued for in the name of the board in any court of competent jurisdiction, which penalty when collected shall be paid to the secretary of the board

L.1966, c. 282, s. 13.

45:14B-14. Application for license; contents

Each person desiring to obtain a license as a practicing psychologist shall make application therefor to the board upon such form and in such manner as the board shall prescribe and shall furnish evidence satisfactory to the board that he:

(a) Is at least 21 years of age;

(b) Is of good moral character;

(c) Is not engaged in any practice or conduct which would be a ground for refusing to issue, suspending or revoking a license issued pursuant to this act;

(d) Qualifies for licensing by an examination of credentials or for admission to an assembled examination to be conducted by the board.

L.1966, c. 282, s. 14.

45:14B-17. Persons applying after January 1, 1968; qualifications for admission to assembled examination

Any person applying to the board, after January 1, 1968, may be admitted to an assembled examination if he meets the qualifications set forth in section 14(a), (b) and (c) and provides evidence satisfactory to the board that he:

(a) Has received the degree of Doctor of Philosophy in psychology from a recognized educational institution, or in lieu of such degree, a doctoral degree in a closely allied field if it is the opinion of the board that the training required therefor is substantially similar, or has otherwise had training in psychology deemed equivalent by the board;

(b) Has engaged for the equivalent of at least 2 years full time, at least 1 year of which was subsequent to his receiving the doctoral degree, in professional employment in the practice of psychology under the supervision of a licensed psychologist or of one clearly eligible for licensure in the opinion of the board, which employment the board deems sufficient to warrant its option that the applicant is competent to engage in the practice of psychology as a licensed psychologist, subject to his satisfying the other requirements for such license specified in this act.

L.1966, c. 282, s. 17.

45:14B-18. Conduct of examinations

The board shall conduct assembled examinations ‘at least once a year at a time and place to be designated by it. Assembled examinations shall be written and, if the board deems advisable, oral. In any written examination each applicant shall be designated by a number so that his name shall not be disclosed to the board until examinations have been graded. Examinations shall include questions in such theoretical and applied fields as the board deems most suitable to test an applicant’s knowledge and competence to engage in the practice of psychology. An applicant shall be held to have passed an examination upon the affirmative vote of at least 4 members of the board.

L.1966, c. 282, s. 18.

45:14B-19. Failure to pass examination; reexamination

Any person who shall have failed an examination conducted by the board may not be admitted to a subsequent examination for a period of at least 6 months.

L.1966, c. 282, s. 19.

45: 14B-20. License without examination

The board may issue a license by an examination of credentials to any applicant who presents evidence that **he** (a) is licensed or certified as a psychologist in another State with requirements for said license or **certificate** such that the board is of the opinion that said applicant is competent to engage in the practice of psychology in this State or (b) holds a diploma from a nationally recognized psychological board or agency.

L. 1966, c. 282, s. 20.

45:14B-23. Renewal; application **forms**

On or before April 15 in each year the secretary of the board shall forward to the holder a form of application for renewal thereof Upon the receipt of the completed form and the renewal fee on or before June 30 the secretary shall issue a new license for the year commencing July 1. Any application for renewal of a **license** which has expired shall in addition require the payment of a reregistration fee, or in such cases as the board may by rule prescribe, by a new application fee.

L.1966, c. 282, s. 23.

45:14B-24. Refusal to **grant or renew; revocation or suspension; review**

The board may **refuse** to grant or renew or may revoke or suspend a license on any of the following grounds:

(a) Use of fraud or deception in applying for a certificate or in passing the examination therefor required by this act.

(b) Practice of psychology under a false or assumed name or impersonation of a licensed practicing psychologist of like or different name, or permitting an unlicensed person to practice psychology in the name of a **licensee** and to use his license for that purpose.

(c) Conviction of a crime involving moral turpitude.

(d) Habitual intemperance in de use of intoxicants, narcotics or stimulants to such an extent as to incapacitate him for the performance of his professional duties as a licensed practicing psychologist or conviction of or has pleaded **nolo** contendere, non vult contendere or non vult to an indictment, information or complaint alleging a violation of any Federal or State law relating to narcotic drugs.

(e) Violation of any provision of this act or rule, regulation or code of ethics promulgated by the

board.

(f) Negligence or misconduct in the performance of his professional duties as a licensed practicing psychologist.

(g) Advertising in any manner, whether as an individual, through a professional service corporation or through a third party on behalf of a licensee, the practice of psychology; provided, however, that the following shall not be deemed to be advertising prohibited under this act:

(1) Public information for educational purposes on the practice **or profession of psychology** which does not contain the name of any psychologist licensed to practice in this State or the address of any location where psychological examination or treatment may be had or is recommended or suggested;

(2) Publication of a brief announcement of the opening of an office or the removal to a new location, containing the name, professional degree, address, telephone number, and office hours of the licensee;

(3) A listing in an alphabetical telephone directory of the name of a licensee together with his professional degree or the abbreviation therefor;

(4) A listing in a classified telephone directory with standard type limited to the name, professional degree, office and home addresses and telephone numbers, and office hours of a licensee;

(5) The use of small signs on the doors, windows and walls of a licensee's office or on the building in which he maintains an office setting aut his name, professional degree, address and office hours in **lettering no larger than 4 inches in height** for street-level offices, and no larger than 6 inches in height for offices above street-level;

(6) Communications with or without the name of the licensee distributed or mailed to his patients of record at his discretion.

The board shall not refuse to grant and shah **nat** revoke or suspend the license of any person for any of the foregoing reasons, until after a hearing of the charges against the accused (which shall be public, unless the accused requests a private hearing thereon), and at least 20 days prior written notice to the accused of the charges against him **and** of the date fixed for such hearing. Such written notice shall be mailed by the United States certified or **registered mail** to the accused's last known address, but the accused's failure to appear shall not prevent or invalidate such **hearing or any** action taken by the **board** thereat.

Every action of the board in refusing to issue a license **or in suspending or revoking a license pursuant** to this section shall he subject to review **by** appeal to the Superior Court by **a proceeding in** lieu **of** prerogative writ.

L.1966, c. 282, s. 24. Amended by L.1971, c. 453, s. 3, eff. Feb. 16, 1972.

4 5:14B-25. Reinstatement

Application may be made to the board for reinstatement, **at any time after the** expiration of 1 year from the date of revocation of a license. Such application shall be **in** writing **and shall** be accompanied by the reinstatement fee. The board shall not reinstate any applicant, unless satisfied that he is competent to engage in the practice of psychology, and, if it deems same necessary for such determination, may require the applicant to pass an examination.

L.1966, c. 282, s. 25.

45:14B-28 Confidential relations and communications.

28. The confidential relations and communications between and among a licensed practicing psychologist and individuals, couples, families or groups in the course of the practice of psychology are placed on the same basis as those provided between attorney and client, and nothing in this act shall be construed to require any such privileged communications to be disclosed by any such person.

There is no privilege under this section for any communication: (a) upon an issue of the client's condition in au action to commit the client or otherwise place the client under the control of another or others because of alleged incapacity, or in an action in which the client seeks to establish his competence or in an action to recover damages on account of conduct of the client which constitutes a crime; or (b) upon an issue as to the validity of a document as a will of the client; or (c) upon an issue between parties claiming by testate or intestate succession from a deceased client.

L.1966,c.282,s.28; amended 1981, c.303, s.1; 1994, c.134, s.11; 1997, c.379, s.11.

45:14B-29. Disposition of fees, fmes, penalties and other moneys

All fees, fines, penalties and other moneys derived from the operation of this act shall be paid to the board and by it remitted to the State Treasurer.

L.1966, c. 282, s. 29.

45:14B-30. Partial invalidity

If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect any other provisions or applications of the act which can be given effect without such invalid provision or application, and to this end the provisions of this act are declared to be severable.

L.1966, c. 282, s. 30.

45:14B-31. Definitions

As used in this act:

a. "Administrative information" means a patients name, age, sex, address, educational status, identifying number, date of onset of difficulty, date of initial consultation, dates and character of sessions (individual or group), and fees;

b. "Diagnostic information" means therapeutic characterizations which are of the types that are found in the Diagnostic and Statistical Manual of Mental Disorders (DSM III), of the American Psychiatric Association, or other professionally recognized diagnostic manual;

c. “Disclose” means to communicate any information in any form;

d. "Independent professional review committee” means that group of licensed psychologists established pursuant to section 14 of this act by the State Board of Psychological Examiners;

e. "Third-party payor" means any provider of benefits for psychological services, including but not limited to insurance carriers and employers, whether on au indemnity, reimbursement, service or prepaid basis, **but excluding** governmental agencies;

f. “Usual, customary or reasonable.” In applying this standard the following definitions are applicable:

(1) “Usual” means a practice in keeping with the particular psych&gist’s general mode of operation;

(2) "Customary" means that range of usual practices provided by psychologists of similar education, experience, and orientation within a similar geographic or socioeconomic area;

(3) “Reasonable” means that there is an acceptable probability that the patient will realize a significant benefit from the continuation **of** the psychological treatment.

In applying the standards of “usual, customary, and reasonable,” the following **guidelines are** applicable: If a psychological treatment is "usual" or "customary," an inference that the treatment is also “reasonable” is warranted. If the treatment **is neither “usual”** nor “customary,” then it shall satisfy the criterion of **“reasonable.”**

L. 1985, c. 256, s. I.

45:14B-32. Disclosure to third-party payor

A patient who is receiving or has received treatment from a licensed, practicing psychologist may be requested to authorize the psychologist to disclose certain confidential information to a third-party payor for the purpose of obtaining benefits from the third-party payor for psychological services, if the disclosure is pursuant to a valid authorization as described in section 6 of this act and the information is limited to:

a Administrative information;

b. Diagnostic information;

c. The status of the patient (voluntary or involuntary; inpatient or outpatient);

d. The reason for continuing psychological services, limited to an assessment of the patient’s current level of functioning and level of distress (both described by the terms mild, moderate, severe or extreme);

e. A prognosis, limited to the estimated minimal time during which treatment might continue.

L. 1985, c. 256, s. 2.

45:14B-33. Independent review

If the third-party payor has reasonable cause to believe that the psychological treatment in question may be neither usual, customary nor reasonable, the third-party payor may request, and compensate reasonably for, an independent review of the psychological treatment by an **independent** professional review committee. The request shall be made in writing to the treating psychologist. No third-party payor having such reasonable cause shall terminate benefits without following the procedures set forth in section 4 of this act.

L. 1985, c. 2.56, s. 3.

45:14B-34. Review **procedure**

Within 10 days of the receipt of the request for review by a third-party payor, the treating psychologist shall notify the State Board of Psychological Examiners of the request. Pursuant to the provisions of section 14 of this act, the State Board of Psychological Examiners shall, within 10 days of the notification, inform the treating psychologist of two or more members of the independent professional review committee who shall be known as "reviewers" and who shall conduct the review. Under these circumstances, the patient may, pursuant to a valid authorization as described in section 6 of this act, authorize the treating psychologist to disclose to the reviewers the requested confidential information concerning his treatment. This information shall be disclosed only in accordance with the following procedure described in this section and shall not be disclosed to a third-party payor or any person other than the reviewers and shall not contain any reference to the patient's identification but rather shall refer to an identification number assigned by the third-party payor. If the patient gives a valid written authorization, the reviewers shall, pursuant to the following review procedure and within 20 days from their receipt of the review request from the State Board of Psychological Examiners, certify in writing to the third-party payor whether or not in their opinion the treatment in question is usual, customary or reasonable or if they are unable to make that determination. The treatment review shall take place as follows:

a. The treating psychologist shall provide in writing to the reviewers the following information: the case identification number; the status of the patient; duration and frequency of treatment; the diagnosis; the prognosis; and the level of functioning and the level of distress, both described by the terms mild, moderate, severe or extreme. If on the basis of this information the reviewers can certify that the treatment is usual, customary or reasonable, no further review shall be necessary at that time.

b. If the reviewers cannot make this determination from the information provided, the reviewers shall request the treating psychologist to provide a written statement describing bis customary mode of treatment for the particular diagnosis given. If, on the basis of this information, the reviewers can certify that the treatment is usual, customary or reasonable, no further review shall be conducted at that time.

c. If the reviewers cannot make this determination from the information provided, they shall request the treating psychologist to provide details and circumstances concerning the case under review, The reviewers shall then certify to the third-party payor their conclusion as to whether or not the *treatment* inquestion is usual, customary or reasonable, and the date and length of time of the consultation.

d. A negative conclusion by the reviewers pursuant to this section shall not be used retroactively as a basis for denying benefits for the treatment furnished prior to the review request by the thud-party payor, unless the claim for reimbursement involves fraud or was not filed in a timely manner.

L. 1985, c. 256, s. 4.

45:14B-35. Nat waiver of **privilege**

The authorization and disclosure of confidential information pursuant to the provisions of section 2 or 4 of this act shall not constitute a waiver of the privilege accorded by section 28 of **P.L. 1966,** c. 282 (C. 45: 14B-28), and the third-party payor and the members of the independent professional review committee are subject **to the** provisions of that section.

L. 1985, c. 256, s. 5.

45:14B-36. Valid authorization

A valid authorization **for the purpose** of this **act shall:**

a Be in writing;

b. Specify the nature of the information to be disclosed, the person authorized to disclose the information, to whom the information may be disclosed, the **specific** purposes for which the information may be used, both at the time of disclosure and at any time in the future;

c. Specify that the patient is aware of the statutory privilege accorded by section 28 of **P.L. 1966,** c. 282 (C. 45:14B-28) to confidential communications between a patient and a licensed psychologist;

d State that the consent is subject to revocation at any time;

e. **Be** signed by the patient or the person authorizing the disclosure. If the patient is adjudicated incompetent or is deceased, the authorization shall be signed by the patient's legally authorized representative. When the patient is more than 14 years of age but has not yet reached the age of majority, the authorization shall be signed by the patient and by the patient's parent or legal guardian. When the patient is less than 14 years of age, the authorization shall **be** signed only by the patient's parent or legal guardian; and

f. Contain the date upon which the authorization was signed.

L. 1985, c. 256, s. 6.

45:14B-37. Authorization restrictions

Any authorization executed pursuant to this act shall apply only to the disclosure of information which exists as of the date the authorization is signed and shall not be effective more than one year from that date.

L. 1985, c. 256, s. 7.

45:14B-38. Copy to authorizer

A copy of the authorization shall be provided to the person authorizing the disclosure.

L. 1985, c. 256, s. 8.

45:14B-39. Further disclosure limited

Information disclosed pursuant to section 2 **of this act shall** not be further disclosed by the third-party payor or to any other party or in any legal proceeding without valid authorization, unless disclosure is otherwise required by law or when relevant to legal disputes between the third-party payor and the patient with regard to a determination of the entitlement to, or the amount of, payment of benefits for psychological services.

L. 1985, c. 256, s. 9.

45:14B-40. For specified purposes only

Disclosure of information pursuant to section 2 or 4 of this act is limited to the purposes specified in the authorization. Information disclosed pursuant to section 2 shall not be revealed by a third-party payor to any of its directors, officers, employees or consultants other than those authorized by the third-party payor to effectuate the purposes specified in the authorization, except as provided in section 9 of this act.

L. 1985, c. 256, s. 10.

45:14B-41. Written revocation

A patient who authorizes disclosure of confidential information under section 2 or 4 of this act may revoke that authorization by providing a written revocation to the recipient named in the authorization and to the psychologist authorized to disclose the information. The revocation shall be effective upon receipt. After the effective date of revocation, no information may be disclosed pursuant to the authorization; however, information previously disclosed may be used for the purposes stated in the written authorization.

L. 1985, c. 256, s. 11.

45:14B-42. Violations; penalties

Any person who negligently violates the provisions of this act shall be liable in an amount equal to the damages sustained by the patient plus the costs of the action and reasonable attorney's fees. Any person who recklessly or intentionally violates the provisions of this act shall be liable in damages sustained by the patient in en amount not less than $5,000.00 plus the costs of the action and reasonable attorney's fees. In either case, either party is entitled to a trial by jury upon request. Any liability imposed for violation of this act is in addition to, and not in lieu of, any civil or administrative remedy, penalty, or sanction otherwise authorized by law.

L. 1985, c. 256, s. 12.

45:14B-43. Waiver void

Any consent or agreement purporting to waive the provisions of this act shall be against public policy **and void.**

L. 1985, c. 256, s. 13.

45:14B-44. Professional review committee

The State Board of Psychological Examiners shall promulgate **rules and** regulations to establish an independent professional review committee whose members shall serve for a three-year term. Members of the independent professional review committee shall be psychologists who have been Licensed in the State of New Jersey for the preceding five years and who are currently and have been for the preceding five years engaged for the majority of their professional work in the practice of psychotherapy. The independent professional review committee shall include three or more psychologists in each of the major theoretical orientations. The State Board of Psychological Examiners may fill vacancies on the committee which may from time to time occur, but no person who has served for a full term shall succeed himself.

L. 1985, c. 2.56, s. 14, eff. July 31, 1985.

45:14B-45. Rules, regulations; report

The State Board of Psychological Examiners shall promulgate rules and regulations to effectuate the purposes of this act, including the establishment of procedural standards for the independent professional review committee and shall seek input from all interested parties on all issues raised in this act A report shall be submitted by the State Board of Psychological Examiners to the Director of the Division of Consumer Affairs on the implementation of this act within a reasonable period of time.

L. 1985, c. 256, s. 15, eff. July 31, 1985.

45:14B-46. Regulatory authority unaffected

Nothing in this act shall be construed to limit the legal authority of the State Board of Psychological Examiners to regulate the practice of psychology in the State of New Jersey.

L. 1985, c. 256, s. 16.

45:14C-1. Short title

Sections 1 through 27 of this act shall be known and may be cited as "The State Plumbing License Law of 1968."

L.1968, c. 362, s. 1, eff. Dec. 26, 1968.

45:14C-2. Defiiitions

CHAPTER 20. MENTAL HEALTH INFORMATION.

Subchapter I. Definitions; General Provisions.

§ 6-2001. Definitions.

For purposes of this chapter:

(1) "Administrative information" means a client's name, age, sex, address, identifying number or numbers, dates and character of sessions (individual or group), and fees.

(2) "Client" means any individual who receives or has received professional services from a mental health professional in a professional capacity.

(3) "Client representative" means an individual specifically authorized by the client in writing or by the court as the legal representative of that client.

(4) "Data collector" means a person other than the client, mental health professional and mental health facility who regularly engages, in whale or in part, in the practice of assembling or evaluating client mental health information.

(5) "Diagnostic information" means a therapeutic characterization which is of the type that is found in the Diagnostic and Statistical Manual of Mental

Disorders of the American Psychiatric Association or any comparable professionally recognized diagnostic manual.

(6) "Disclose" means to communicate any information in any form (written, oral or recorded).

(7) "Group session" means the provision of professional services jointly to more than 1 client in a mental health facility.

(8) "Insurance transaction" means whenever a decision (be it adverse or otherwise) is rendered regarding an individual's eligibility for an insurance benefit or service.

(9) "Mental health information" means any written, recoded or oral information acquired, by a mental health professional in attending a client in a professional capacity which:

(A) Indicates the identity of a client; and

(B) Relates to the diagnosis or' treatment of a client's mental or emotional condition.

(10) "Mental health facility" means any hospital, clinic, office, nursing home, infirmary or similar entity where professional services are provided.

(11) "Mental health professional" means 'any of the following persons engaged in the provision of professional services:

(A) A person' licensed to practice medicine;

(B) A person licensed to practice psychology;

(C) A licensed social worker;

(D) A professional marriage, family, or child counselor;

(E) A rape crisis or sexual abuse counselor who has undergone at least 40 hours of training and is under the supervision of a licensed social worker, nurse, psychiatrist, psychologist, or psychotherapist;

(F) A licensed nurse who is a professional psychiatric nurse; or

.(G) Any person reasonably believed by the client to be a mental health professional within the meaning of subparagraphs (A) through (F) of this paragraph.

(12) "Person" means any governmental organization or agency or part thereof, individual, firm, partnership, copartnership, association or corporation.

(13) "Personal notes" means mental health information regarding a client which is limited to:

(A) Mental health information disclosed to the mental health professional in confidence by other persons on condition that such information not be disclosed to the client or other persons; and

(B) The mental health professional's speculations.

(14) 'Professional services" means any form of diagnosis or treatment relating to a mental or emotional condition that is provided by a mental health professional.

(15) "Third-party payor" means any person who provides accident and sickness benefits or medical, surgical or hospital benefits whether on an indemnity, reimbursement, service or prepaid basis, including, but not limited to, insurance carriers, governmental agencies and employers. (1973 Ed., § 6-1611; Mar. 3, 1979, D.C. Law Z-136, § 101, 25 DCR 5055; Mar. 25, 1986,

D.C. Law 6-99, § 1101(b), 33 DCR 729; Feb. 24, 1987, D.C. Law 6-174, § 2(a), 33 DCR 7228; July 22, 1992, D.C. Law 9-126, § 3, 39 DCR 3324; _____ 1995, D.C. Law 10- (Act 10-385), § 401(a), 42 DCR 53.)

Section references. — Tbis section is referred to in §§ 12-301, 14-307, and 21-2047.

Effect of amendments. — D.C. Law 9-126 inserted (E-1); and in (F) substituted "subparagraphs (A) through (E-l)" for "subparagraphs (A) through (E)".

D.C. Law 10- (Act 10-385), in (11), inserted present (E), deleted former (E-1), and redesignated former (E) and (F) as (F) and (G), respectively.

Legislative history of Law a-1.x -Law 2-136, the "District of Columbia Mental Health Information Act of 1978,' was introduced in Council and assigned Bill No. Z-144, which was referred to the Committee on the Judiciary. The Bill was adopted an first, amended first, second amended first, and second readings on July 11, 1978, July 25, 1978, September 19, 1978 and October 3, 1978, respectively. Signed by the Mayor on November 1, 1978, it was assigned Act No. 2-292 and transmitted to both Houses of Congress for its review.

Legislative history of Law 6-99. — Law 6-99, the "District of Columbia Health Occupations Revision Act of 1985," was introduced in Council and assigned Bill No. 6317, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on December 17, 1985, and January 14, 1986. respectively. Signed by the Mayor on January 28, 1986, it was assigned Act No. 6-127 and transmitted to both Houses of Congress for its review.

Legislative **history** of Law 6.174. — Law 6-174, the P.C. Mental Health Information Act of 1978 Temporary Amendment Act of 1986," was introduced in Council and assigned Bill No. 6-539. The Bill was adopted on first and second readings on October '7, 1986 and October 21, 1986, respectively. Signed by the Mayor on October 30, 1986, it was assigned Act No. 6-223 and transmitted to bath Houses of Congress for its review.

Legislative **history** of Law 9-126. — Law S-126, the "District of Columbia Health Occupations Revision Act of 1985 Professional Counselors Amendment Act of 1992," was introduced in Council and assigned Bill No. 9-197, which was referred to the Committee on Consumer and Regulatory Affairs. The Bill was adopted on first and second readings on April 7, 1992, and May 6, 1992, respectively. Signed by the Mayor on May 28, 1992, it was assigned Act NO. S-210 and transmitted to both Houses of Congress for its review. D.C. Law 9-126 became effective on July 22, 1992.

Legislative history of Law, 10- (Act 10-385). -Law 10- (Act 10-385), the "Anti-Sexual Abuse Act of 1994," was introduced in Council and assigned Bill No. 10-87, which was referred to the Committee on the Judiciary. Tbe Bill was adopted on first and second readings on November 1, 1994, and December 6, 1994, respectively. Signed by the Mayor on December 28, 1994, it was assigned Act No. 10-385 and transmitted to both Houses of Congress for its review. D.C. Law 10- (Act 10-385) is projected to become law on May 19, 1996.

Cited in Doe v. DiGenova, 779 F.2d 14 (D.C. Cir. 19851; In re T.M., 120 WLR 2541 (Super. ct. 1992).

§ 6-2002. Disclosures prohibited; exceptions.

(a) Except as specifically authorized by subchapter II, III, or IV of this chapter, no mental health professional, mental health facility, data collector or employee or agent of a mental health professional, mental health facility or data collector shall disclose or permit the disclosure of mental health information to any person, including an employer.

(b) Except as specifically authorized by subchapter II or IV of this chapter, no client in a group session shall disclose or permit the disclosure of mental health information relating to another client in the group session to any person.

(c) No violation of subsection (a) or (b) of this section occurs until a single act or series of acts taken together amount to a disclosure of mental health information. (1973 Ed;, § 6-1612; Mar. 3, 1979, D.C. Law 2-136, § 102, 25 DCR 5055.)

brought within 6 months of the denial, in whole or in part, of the disclosure by the independent mental health professional or the denial, in whole or in part, of disclosure to the independent mental health professional hy the mental health professional. In the event that a person is indigent and is unable to obtain the services of an independent mental health professional, he may institute an action in the Superior Court of the District of Columbia, without regard to the provisions of subsection (b) of this section: Provided, that the action is brought within 6 months of the denial, in whole or in part, of the disclosure by the mental health professional. If the person who instituted the action establishes that he executed a valid authorization which was transmitted to *the* mental health *professional prior* to the denial of disclosure by such mental health professional, the burden of proof shall then be placed upon the mental health professional to establish, by a preponderance of the evidence, that the denial of disclosure was in Conformity with paragraphs (1) and (2) *of* subsection (a) of this section.

(d) Any refusal or limitation on disclosure shall be noted in the client's record of mental health information including, but not limited to, the names of the mental health professionals involved, the date of the refusal or limitation, the requested disclosure and the actual disclosure, if any.

(e) This section shall not apply to disclosures under § 21-562 (concerning the disclosure of records of a client hospitalized in a public hospital for a mental illness) or court-related disclosures under subchapter IV of this chapter. (1973 Ed., § 6-1620; Mar. 3, 1979, D.C. Law 2-136, § 206, 25 DCB 5055.)

Section references. — This section is referred to in § 6-2011.

Legislative history of Law 2-136. — see note to § 6-2001.

§ 6-2017. Limited disclosure to 3rd-party payors.

(a) A mental health professional or mental health facility may disclose to a 3rd-party payor mental health information necessary to determine the client's entitlement to, or the amount of, payment benefits for professional services rendered: Provided, that the disclosure is pursuant to a valid authorization and that the information to be disclosed is Limited to:

(1) Administrative information;

(2) Diagnostic information;

(3) The status of the client (voluntary or involuntary);

(4) The reason for admission or continuing treatment; and

(5) A prognosis limited to the estimated time during which treatment might continue.

(b) In the event the 3rd-party payor questions the client's entitlement to or the amount of payment benefits following disclosure under subsection (a) of this section, the 3rd-party payor may, pursuant to *a* valid authorization, request an independent review of the client's record of mental health information by a mental health professional or professionals. Mental health information disclosed for the purpose of review shall not be disclosed to the 3rd-party

payor. (19'73 Ed., § 6-1621; Mar. 3, 1979, D.C. Law Z-136, § 207, 25 DCR 5055.)

Legislative history of Law 2-136. — See note to § 6-2001.

Conflicts between this section and federal Employees Health Benefits Act controlled by federal law. — Where the provisions of this section conflict with 5 U.S.C. §§ 8901-8914, the federal Employees Health Benefits Act, § 6-2075 expressly provides that the federal law will be supreme. District of Columbia Inst. of Mental Hygiene v. Medical Sew., App. D.C., 474 A.2d 831 (1984).

Subchapter IX. Exceptions.

§ 6-2021. Disclosures within a mental health facility.

Mental health information may be disclosed to other individuals employed at the individual mental. health facility when and to the extent necessary to facilitate the delivery of professional services to the client. (1973 Ed., § 6-1622; Mar. 3, 1979, D.C. Law 2-136, § 301, 25 DCR 5055.1

Legislative history of Law 2.138. -see not? to § 6.2001.

§ 6-2022. Disclosures required by law.

Mental health information may be disclosed by a mental health professional or mental health facility where necessary end, to the extent necessary to meet the requirements of § 21.586 (concerning financial responsibility for the care of hospitalized persons) or to meet the compulsory reporting provisions of District or federal law which attempt to promote human health and safety (1973 Ed:, § 6-1623; Mar. 3, 1979, D.C. Law Z-136, § 302, 25 DCR 5055.)

Legislative history of Law 2-136. — See note to § 6-2001.

§ 6-2023. Disclosures on an emergency basis.

.(a) Mental health information may be disclosed, on an emergency basis, to 1 or more of the following: The client's spouse, parent, legal guardian; a duly accredited officer 'or agent of the District of Columbia in charge of public health, an officer authorized to make arrests in the District of Columbia or an intended victim if the mental health professional reasonably believes that such disclosure is necessary to initiate or seek emergency hospitalization of the client under § 21-521 or to otherwise protect the client or another individual from a substantial risk of imminent and serious physical injury

(b) Mental health information disclosed to the Metropolitan Police Department pursuant to this section shall be maintained separately and shall not be made a part af any permanent police record. Such mental health information shall not be further disclosed except as a court-related disclosure pursuant to subchapter IV of this chapter. If no judicial action relating to the disclosure under this section is pending at the expiration of the statute of limitations governing the nature of the judicial action, the mental health information shall

be destroyed, If a judicial action relating to the disclosure under this section is pending at the expiration of the statute of limitations, the mental health information shall be destroyed at the termination of the judicial action. (1973 Ed., § 6-1624; Mar. 3, 1979, D.C. Law 2-136, § 303, 25 DCR 5055.)

section references. — This section is referred to in § 6-2004.

Legislative history of Law 2-136. — See note to § 6-2001.

§ 6-2024. Disclosures for collection of fees.

(a) A mental health professional or mental health facility may disclose the administrative information necessary for the co&action of his or its fee from the client to a person authorized by the mental health professional or mental health facility for the collection of a fee from such client if the client or client representative has received a written notification that the fee is due and has failed to arrange for payment with the mental health professional or mental health facility within a reasonable time after such notification.

(b) In the event of a claim in any civil action for the collection of such a fee, no additional mental health information, shall be disclosed in litigation, except to the extent necessary:

(1) To respond to a motion of the client or client representative for greater specificity; or

(2) To dispute a defense or counterclaim. (1973 Ed., § 6-1625; Mar. 3, 1979, D.C. Law Z-136, § 304, 25 DCR 5055.)

Legislative history of Law 2-136. -See note to § 6-2001.

§ 6-2025. Disclosures for research, auditing and program evaluation.

A mental health professional or mental health facility may disclose mental health information to qualified personnel, if necessary, for the purpose of conducting scientific research or management audits, financial audits or program evaluation of the mental health professional or mental health facility: Provided, that such personnel have demonstrated and provided assurances, in writing, of their ability to insure compliance with the requirements of this chapter. Such personnel shall not identify, directly or indirectly, an individual client in any reports of such research, audit or evaluation, or otherwise disclose client identities in any manner. (1973 Ed., § 6-1626; Mar. 3, 1979, D.C. Law 2-136, § 305, 25 DCR 5055.)

Legislative history of Law 2-136. — See note to § 6-2001.

§ 6-2026. Bedisclosure.

Mental health information disclosed pursuant to this subchapter shall not be redisclosed except as specifically authorized by subchapter II, III or IV of this

and anything else that the patient, program, or criminal justice agency deems pertinent (Id. § 2.35(b)).

Although obtaining a written consent form from the patient is the usual means of authorizing disclosures, the federal confidentiality rules provide a number of other mechanisms for doing so in appropriate circumstances. These are discussed in the following sections.

Court Order

A state or federal court may issue an order that authorizes a program to make a disclosure of patient-identifying information that would otherwise be prohibited. To accomplish their underlying goal of guaranteeing sufficient privacy so that patients will not be afraid to come forward for treatment, however, the federal confidentiality rules permit a court to issue one of these authorizing orders only after following certain procedures and making particular determinations specified by the regulations (42 C.F.R. 2.22 Title 42 §§ 2.63–2.67). In fact—and perhaps most important-a subpoena, search warrant, or arrest warrant. even when it is signed by a judge and says that it is a court order, is not sufficient, when standing alone, to require or even permit a program to make a disclosure (Id. § 2.61). Only a special authorizing order issued pursuant to the federal confidentiality law and regulations enables an alcohol or other drug program to disclose patient information to a court, law enforcement personnel, or anyone else (absent a consent form, of course). This is another major departure from the privacy rules governing other forms of health care records and remains a great source of confusion and consternation for the justice system and alcohol end other drug programs alike. It is also an extremely important protection. Because much alcohol ond other drug use is illegal, law enforcement authorities often have much greater interest in records of alcohol end other drug treatment than in any athcr health care records. The two examples at the beginning of this chapter illuminate that reality. The court order provision in the federal confidentiality rules hns served the important function of providing courts the parameters within which they can balance the need for maintaining confidentiality with the need for obtaining information in particular cases and make a reasoned decision that, to the maximum extent possible, satisfies tho sometimes competing goals of protecting privacy and seeking justice.

Court-ordcrod disclosures are sought most often in two types of cases: criminal law and family law (divorces, custody disputes,

child neglect, etc.). In criminal cases, an investigative, law enforcement, or prosecutorial agency seeking an order to authorize disclosures for purposes of investigating or prosecuting a patient must meet five stringent criteria:

> 1) The crime involved must be extremely serious, such as an act causing or threatening to cause death or serious injury (but not including possession or sale of illegal drugs); 2) the records sought must be likely to contain information of significance to the investigation or prosecution; 3) there must be no other practical way to obtain the information; 4) the public interest in disclosure must outweigh any actual or potential harm to the patient, the doctor–patient relationship, and the ability of the program to provide services to other patients; and 5) when law enforcement personnel seek the order the program, must have an opportunity to be represented by independent counsel. (Id. § 2.65)

Even if a court decides to issue an order authorizing disclosure for the purpose of investigating or prosecuting patients, the order must limit disclasurc and use of the information to those parts of the patient's record that are essential to fulfill the purpose of the order. Under no circumstances may a court authorize a program to turn over the entire patient record to a law enforcement, investigative, or prosecutorial agency. Disclosure must be restricted to those law enforcement and prosecutorial officials responsible for conducting the investigation or prosecution. Use must be limited to investigation of "extremely serious crime or suspected crime specified in the application."

These rules have been very successful in accomplishing their dual goals of protecting both privacy and the pursuit of justice. Courts have issued orders when necessary and denied them when not. As a result, except in a few egregious violations of the law, such as the Fairfax County case, patients hove not been scared away from obtaining the life-saving services that benefit thorn and all of society.

Courts have ordered records disclosed when they constituted important evidence and the other regulatory requirements were satisfied. In *State v. Rollinson* (1987), for example, the court ordered a treatment program to disclose a poticnt's admissions to several program staff that he had committed a homicide. The court, noting that the information contained in the records was not available elsewhere, ruled that the public interest in disclosure outweighed any possible damage to the treatment relationship.

When tho criteria hove not been met, however, courts have not hesitated to deny requests for orders authoring disclosures. This especially has been the case when the patient was the victim or another witness to a crime and defendants were seeking access to

their treatment records to impeach their credibility. In United States *v. Graham* (1977) and *United States v. Smith* (1986), the U.S. Circuit Courts of Appeals refused to issue orders authorizing disclosure of witnesses' alcoholism and heroin addiction treatment records. Both courts found that, because the witnesses had disclosed their histories of addiction and treatment and could be cross-examined about it, the public interest in maintaining the confidentiality of the records outweighed the defendants' need for the information.

The courts conduct a similar balancing test in family law cases. Thus, in cases such as *In re* Romance *M* (1993), a custody proceeding in which the court found that treatment records were relevant to the critical question of whether a mother's alcoholism prevented her from properly caring for her children, the courts ordinarily order records disclosed. In cases such as In *re Stephen F.* (1982), however, in which there was no allegation that a father's drug use was the cause of child neglect, the courts often **find that** any potential value of the records in the proceeding is outweighed by the need to maintain confidentiality.

Child Abuse and Neglect Reporting

As a result of clarifying amendments to the federal confidentiality rules in 1980 and 1987, respectively, the federal confidentiality rules "do not apply to the reporting under state law of incidents of suspected child abuse and neglect to the appropriate state or local authorities" (42 C.F.R. 2.22 Title 42 § 2.12[c][6]). Thus, all alcohol and other drug programs must comply strictly with the provisions of the mandatory child abuse and noglcct reporting laws in their stntcs.

However, the exemption for child abuse and neglect reporting applies only Lo initial reports of child abuse or neglect, not to requests or even subpoenas for additional information or records. even if the records arc sought for use in civil or criminal investigations or in proceedings resulting from the program's initial report. In this respect, the federal confidentiality rules treat requests for information related to abuse or neglect that is to bc used in court proceedings the same way that they treat other such requests: A court first must issue an appropriate order.

Thus, patient files must still be withhold from child protection agencies absent an appropriate court order or patient consent. Clients are often willing to consent to disclosures to aid investigations of suspected child abuse or neglect, as their refusal to cooperate fully with an investigation may result in loss of custody of their children.

This sensible approach has worked well. Staff of alcohol and other drug programs are able to bring suspected child abuse or ne-