

Chapter 1-A: Healthcare Information and Confidentiality

Author: Mary R. Giannini, JD, MBA

Mary R. Giannini recently retired from full-time practice as a partner with the law firm of Witherspoon Kelley, P.S., in Spokane. Her primary areas of practice and interest are health care, employment and corporate law. She graduated from Cornell University with a B.A. in biological sciences and an M.B.A. in health administration, and obtained her J.D. degree from the University of Idaho College of Law. She has previously served as the chair of the Health Law Section of the Washington State Bar Association, served on the Board of Directors of Washington State Society of Healthcare Attorneys, and was a member of the University of Idaho Law Advisory Council. She has served on the boards of a number of not-for-profit organizations and currently sits on the Charities Advisory Council of the Washington Secretary of State. She also works as in-house counsel and with compliance issues with Medication Review, Inc. a pharmacy services company in Spokane, Washington. She was named a Best Lawyer in America in Health Law. She is admitted to practice in Washington and Idaho.

Editor: Simon Vismantas

Simon Vismantas is an attorney licensed to practice in Washington and Utah. He earned is B.A. from the University of Washington in 2010, J.D. from the University of Utah in 2014, and is completing his LL.M. in Health Law from the University of Washington. Most recently, Simon has worked for Community Health Plan of Washington and the Washington State Hospital Association.

Updated: April 23, 2016

Date of Creation: January 6, 2012

© 2016 Washington State Society of Healthcare Attorneys and Washington State Hospital Association. All rights reserved.

Disclaimer: This publication is designed to provide accurate and authoritative information with respect to the subject matter covered. It is provided with the understanding that neither the publisher nor any editor, author, or contributor hereto, is engaged in rendering legal or other professional services. The information contained herein represents the views of those participating in the project, and not, when applicable, any governmental agency or

employer of such participant. Neither the publisher, nor any editor, author, or contributor hereto warrants that any information contained herein is complete or accurate. If legal advice or other expert assistance is required, the services of a competent licensed professional should be sought.

Editor's Notes: This chapter deals with general rules in Washington applicable to medical/health care records, including the requirements of confidentiality. This chapter addresses health information provisions of Washington State set out in 70.02 RCW (the Uniform Health Care Information Act). Federal statutes and regulations (specifically the Health Information Portability and Accountability Act ("HIPAA") and its amendments will be set out in a new chapter of this Manual. For information on informed consent and related topics, see chapter 2A, "Consent to Health Care – General Rules" and Chapter 2B, "Special Consent Rules." For a more detailed discussion of medical information, please consult the "Guide to the Release of Medical Information for Health Care Providers in Washington State," published by the Washington State Health Information Management Association.

Reference Date: The author prepared this chapter from reference materials that were available as of April 23, 2016.

Chapter Outline

A. Chapter Summary	1
B What Constitutes a Medical/Health Record	
C. Authorization to Disclose Medical/Health Records and Documentation.....	3
1. Disclosure with Patient Authorization.....	3
(a) General Rules.....	3
(b) Minors.....	3
(c) Adoption.....	4
(d) Death.....	5
(e) Fees.....	5
2. Authorization.....	5
(a) Elements and Timing.....	5
(b) Special Cases.....	6
3. Revocation of Authorization.....	6
4. Disclosure without Patient Authorization.....	6
(a) Permissive Disclosures.....	6
(b) Mandatory Disclosures.....	8
5. Patient Examination and Copying.....	8
6. Denying Access to Records.....	9
D. Responding to Subpoenas and Discovery Requests.....	9
1. Background.....	9
2. Notice Requirements.....	10
3. Attorney Requests.....	10
4. Response to Subpoenas.....	10
5. Resisting a Subpoena or Discovery Request.....	11
(a) When to Resist.....	11
(b) How to Resist.....	11
(c) When to Comply.....	11
6. Criminal Cases/Search Warrants.....	11
7. Certification of Medical/Health Records.....	12
E. Documenting Disclosure by the Health Care Provider	12
F. Correcting and Amending Medical/Health Records	12
G. Notice of Information Display	13
H. Retention and Security of Medical/Health Records.....	13
I. Electronic Medical/Health Records.....	14
J. Faxing Medical/Health Records	14
K. Specific Situations	15
1. Third-Party Payors.....	15
2. Coroners and Medical Examiners.....	15
3. Workers' Compensation.....	15
4. News Media.....	15
5. Personal Injury Cases; Child Abuse Reporting; Sexual Assault.....	16
6. Disciplinary Boards.....	16
L. Liability and Remedies.....	16

A. Chapter Summary

Medical/health records are considered confidential. Confidentiality is considered to enhance open and honest communication between patients and their physicians. The confidentiality of the medical/health record is recognized by a number of sources. The primary source for confidentiality and the requirements for the release of medical/health records in Washington is found in the Uniform Health Care Information Act 70.02 RCW (the “Act”), which Washington adopted in 1991. The Washington Legislature subsequently amended the Act several times to be more consistent with HIPAA. In 2014 the Legislature revised the Act to incorporate from other statutes various rules governing privacy and confidentiality of health care information in “special” circumstances, in particular rules governing mental/behavioral health information and health information related to AIDS, HIV and sexually transmitted diseases. The Legislature passed the 2014 amendments in separate bills, such that certain provisions (specifically RCW 70.02.010; RCW 70.02.230; and RCW 70.02.250) became effective in 2014, but will change again effective April of 2016.

The content of medical/health records may be divulged to specific individuals or entities under circumstances addressed in this chapter. The type of records requested and the person or entity requesting the records determines how and when medical records can be released. This chapter reviews the rules under the Act controlling the confidentiality and release of medical/health records, with more detail provided in Chapter II-2 of this manual about special rules controlling the confidentiality and release of certain medical/health records

The *Consent Manual*, produced by the Washington State Hospital Association, is recommended as a source of many standard forms of authorization to release health care information.

B. What Constitutes a Medical/Health Record?

A medical/health record is a compilation of health care information that identifies the patient, justifies the patient’s diagnosis and treatment, and documents the results of the patient’s treatment. Under the Act, the term “health care information” means the information generally kept in a patient’s medical/health record.¹ Health care information is defined as “any information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient and directly relates to the patient’s health care, including a patient’s deoxyribonucleic acid and identified sequence of chemical base pairs.”² Health care information also includes any required accounting of disclosures of health care information.³

The medical/health record serves a number of purposes. Medical/health records are maintained primarily to provide accurate and complete information about the care and treatment of a patient. Medical/health records enhance communication among the patient’s physician and other health care professionals treating the patient. Records also show the extent and quality of care for statistical, research and educational purposes and may be used for future review, study and evaluation of the care rendered to the patient. In addition, medical/health records provide information for billing and reimbursement. Finally, medical/health records are valuable aids in legal proceedings.

¹ RCW 70.02.010(16).

² *Id.*

³ *Id.*

Regulations relating to hospital licensure require that hospitals create medical/health records that:

- (a) identify the patient;
- (b) have clinical data to support the diagnosis, course and results of treatment for the patient;
- (c) have signed consent documents;
- (d) promote continuity of care;
- (e) have accurately written, signed, dated, and timed entries;
- (f) indicate authentication after the record is transcribed;
- (g) are promptly filed, accessible, and retained according to RCW 70.41.190 and RCW 5.46.010-920; and
- (h) include verbal orders that are accepted and transcribed by qualified personnel.⁴

The statutory requirements on retention of medical/health records address (1) how long medical/health records must be retained and (2) in what form they may be retained.⁵ For adult hospital patients, medical/health records must be retained for at least ten years following the most recent discharge of the patient.⁶ For minor hospital patients, medical/health records must be retained for whichever period is longer: ten years or three years after the minor turns eighteen years old.⁷

Retained medical/health records need not be original documents if a hospital can accurately reproduce the original record.⁸

The Washington legislature has found that healthcare information is personal and sensitive information to which patients must have access to make informed decisions about themselves and their care. As a general rule, medical/health records are the property of the hospital or the physician who keeps records of patients, but ownership is subject to the patient's interest in the information contained in the record. With ownership comes the obligations of record confidentiality, proper storage, protection, and rules governing disclosure and patient access. Although the Act does not elaborate on the ownership of medical records, it does make several findings recognizing the patient's (a) interests in privacy and health care; (b) need for access to his or her health care information; and (c) interest in the proper use and disclosure of the patient's medical record.⁹ The Act also recognizes the health care provider's interest in assuring that health care information is not improperly disclosed.¹⁰ The Joint Commission imposes similar requirements relating to the management and security of healthcare information.¹¹

⁴ WAC 246-320-166.

⁵ RCW 70.41.190.

⁶ *Id.*

⁷ *Id.*

⁸ RCW 5.46.010.

⁹ RCW 70.02.005.

¹⁰ *Id.*

¹¹ See "Information Management," The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: Effective January 2016*. Oak Brook, IL: Joint Commission Resources, 2016 ("The Joint Commission Manual").

C. Authorization to Disclose Medical/Health Records and Documentation

1. Disclosure with Patient Authorization

(a) General Rules

Except as otherwise provided in the Act, a health care provider (including individuals who assist a health care provider in the delivery of health care or an agent and employee of a health care provider) may not disclose health care information about a patient to any other person without an appropriate written authorization.¹² Such an authorization may be given by a patient who is competent. In the case of an incompetent patient (as defined in RCW 11.88.010(1)), the person who is legally authorized to consent to health care for the patient under the Informed Consent Statute (RCW 7.70.065) may exercise the rights of the patient under the Act.¹³ These surrogate decision-makers in order of priority include the patient's:

- appointed legal guardian
- durable Power of Attorney for Health Care Decisions;
- spouse or state registered domestic partner;
- adult children;
- parents; and
- adult brothers and sisters¹⁴.

No person in any category of surrogate decision-makers may provide consent if a decision maker in a higher category has refused to give consent.¹⁵ Unanimity is required where there is more than one person in the group of authorized decision-makers (for example, a patient with multiple adult siblings).¹⁶ A person authorized to act on behalf of a patient must do so in good faith to represent the best interests of the patient.¹⁷

(b) Minors

Generally, in the case of a minor patient, the patient's medical/health records may be released only with the consent of the patient's parent or legal guardian. However, a minor who is authorized by law to consent to health care without parental consent, may exercise the rights of the patient under the Act as to information pertaining to the health care to which the minor lawfully consented.¹⁸

In Washington, minors in at least the following categories may consent to treatment: (1) emancipated minors; (2) a minor married to a person over 18 years of age; (3) a minor 14 years or older seeking treatment for sexually transmitted diseases;¹⁹ (4) a minor 13 years or older seeking

¹² RCW 70.02.020.

¹³ RCW 70.02.130(1).

¹⁴ RCW 7.70.065(1).

¹⁵ RCW 7.70.065(1)-(2).

¹⁶ *Id.*

¹⁷ RCW 7.70.065(1)(c).

¹⁸ RCW 70.02.130.

¹⁹ RCW 70.24.110.

outpatient treatment for drug and alcohol abuse;²⁰ (5) a minor 13 years or older requesting outpatient treatment for mental illness;²¹ (6) a minor under the age of eighteen to voluntary termination of pregnancy as long as the fetus is not viable;²² and (7) a minor parent with sufficient capacity may consent to medical treatment for his/her child. Accordingly, a minor may authorize the release of the above health care information in the event that he/she consented to such treatment.

In cases where parental consent is required, a health care provider may rely, without incurring any civil or criminal liability for such reliance, on the representation of a parent that he or she is authorized to consent to health care for the minor patient, regardless of whether: (1) the parents are married, unmarried, or separated, (2) the consenting parent is or is not the custodial parent, or (3) the consent is or is not in full performance of any agreement between the parents or an order or decree under RCW 26.09.²³

(c) Adoption

The medical/health record reporting the birth of a child that is later adopted cannot be released to identify the birth mother without the consent of the birth mother.²⁴ Even so, every person, firm, society, association or corporation receiving, securing a home for, or otherwise caring for a minor must transmit to the prospective adopting parent prior to placement and must make available to all persons with whom the minor has been placed by adoption, a complete medical report containing all available information concerning the mental, physical, and sensory handicaps of the child.²⁵

The report cannot reveal the identity of the birth parents, but is required to include any available mental and physical health history of the birth parents that the adoptive parent needs to facilitate proper health care for the child and to maximize the developmental potential of the child.²⁶ Where available, the information provided must include: (1) a review of the birth family's and child's previous medical history, including x-rays, examinations, hospitalizations, and immunizations; (2) a physical examination of the child by a licensed physician with appropriate laboratory tests and x-rays; (3) a referral to a specialist if indicated; and (4) a written copy of the evaluation, with recommendations to the adoptive family.²⁷ Entities and persons obligated to provide such information must make reasonable efforts to locate information concerning the child's mental, physical and sensory handicap, but have no duty, beyond providing the information to explain or interpret the information regarding the child's present or future health status.²⁸

²⁰ RCW 70.96A.230.

²¹ RCW 71.34.530.

²² *Planned Parenthood v. Casey*, 505 U.S. 833, 879 (1992); *State v. Koome*, 84 Wn. 2d 901, 914, 530 P.2d 260, (1975); *see also*, RCW 9.02.100.

²³ RCW 70.02.130(1); *see also*, RCW 26.09.310.

²⁴ RCW 26.33.350.

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.*

(d) Death

The right of a patient to maintain the confidentiality of his/her medical/health records does not end upon the patient's death.²⁹ After a patient dies, his/her personal representative may authorize the release of the patient's health care information.³⁰ In the absence of a personal representative or after the personal representative has been discharged, the person who was authorized under the Informed Consent Statute, RCW 7.70.065, to make health care decisions on the patient's behalf while he/she was alive may authorize the release of the patient's health care information.³¹

(e) Fees

A health care provider may charge a reasonable fee for complying with a valid request to disclose a patient's health care information.³² In fact, a health care provider is not required to honor an authorization to disclose health care information until the fee is paid.³³

Pursuant to RCW 70.02.010(37), a reasonable fee includes the charges for duplicating or searching for the medical/health records both shall not exceed the statutory amount per page for the first 30 pages and the statutory amount per page for all other pages. In addition, a clerical fee for searching and handling may be charged not to exceed the statutory amount. The amounts may be and are adjusted biennially in accordance with changes in the CPI, all consumers, for Seattle-Tacoma metropolitan statistical area as determined by the Secretary of Health. The maximum amounts that may be charged are published biannually in the Washington Administrative Code.³⁴ Where editing of medical/health records by a health care provider is required by statute and is done by the provider personally, the fee for such editing may be the usual and customary charge for a basic office visit.³⁵

2. Authorization

(a) Elements and Timing

The essential elements to a valid authorization to disclose health care information are: (i) the authorization must be in writing, dated and signed by the patient (or other legally authorized representative); (ii) the authorization must identify the patient; (iii) it must also identify the information to be disclosed; (iv) the authorization must identify the name and institutional affiliation of the person or class of persons to whom the information is to be disclosed; and (v) the authorization must identify the health care provider or class of providers making the disclosure; and (vi) the authorization must contain an expiration date or an expiration event that relates to the patient or the purpose or use of the disclosure being authorized.³⁶

²⁹ RCW 70.02.140.

³⁰ *Id.*

³¹ *Id.*

³² RCW 70.02.030(2).

³³ *Id.*

³⁴ WAC 246-08-400.

³⁵ *Id.*

³⁶ RCW 70.02.030(3).

When an authorization is for disclosure of health care information to a financial institution or an employer for purposes other than payment, however, the authorization shall expire one year after it is signed, unless the patient renews the authorization.³⁷

If the patient is under the supervision of the Department of Corrections, an authorization related to treatment for mental health or drug or alcohol treatment expires at the end of the terms of supervision, unless the patient is part of a treatment program that requires continuing information exchange until the end of the period of treatment.³⁸

(b) Special Cases

Special rules apply in the case of authorizing the disclosure of health care information pertaining to alcohol or drug abuse,³⁹ mental illness,⁴⁰ sexually transmitted diseases (STDs),⁴¹ and AIDS/HIV.⁴² (See also material in Chapter 2.)

3. Revocation of Authorization

A patient may revoke an authorization to disclose health care information in writing at any time unless the information is needed to process payment for health care that has already been provided or other substantial action has been taken in reliance on the authorization.⁴³ A patient may not sue a health care provider for disclosures made in good-faith reliance on an authorization to release medical/health records if the health care provider had no actual notice of the revocation of the authorization.⁴⁴

4. Disclosure without Patient Authorization

The Act provides for disclosure of health care information by a health care provider without the patient's authorization under certain circumstances.⁴⁵ These disclosures can be categorized into permissive disclosures and mandatory disclosures.⁴⁶ Amendments to the Act in 2014 incorporated references to mental/behavioral health information and information related to AIDS and HIV and sexually transmitted diseases, discussed in more detail in Chapter 2.

(a) Permissive Disclosures

A health care provider or facility may disclose health care information about a patient without the patient's authorization to the extent necessary to the following persons under the following circumstances:

- a person reasonably believed to be providing the patient with health care;⁴⁷

³⁷ RCW 70.02.030(6).

³⁸ RCW 70.02.030(8).

³⁹ RCW 70.96A.150; 42 U.S.C. §§ 290dd-2.

⁴⁰ RCW 70.02.230; RCW 70.02.240.

⁴¹ RCW 70.02.220.

⁴² *Id.*

⁴³ RCW 70.02.040.

⁴⁴ *Id.*

⁴⁵ RCW 70.02.050; RCW 70.02.200; RCW 70.02.210

⁴⁶ *Id.*

⁴⁷ RCW 70.02.050.

- a person who needs the information for health care education or for planning, quality assurance, or peer review;⁴⁸
- a person who needs the information to provide administrative, legal, financial, or actuarial services to the health care provider, and the health care provider reasonably believes the recipient will not use the information for any other purpose and will protect the information;⁴⁹
- a person who needs the information to assist the health care provider in the delivery of health care;⁵⁰
- unless the patient directs otherwise in writing, to another health care provider who the provider reasonably believes previously gave health care, if deemed necessary by the provider to meet the patient's health care needs;⁵¹
- any person if the provider reasonably believes such disclosure will avoid or minimize an imminent danger to the health or safety of the patient or any other individual (obligation to make such a disclosure is not created by the Act); and the fact of admission for mental health services and records pertaining to mental health services are subject to restrictions in RCW 70.02.230.⁵²
- unless the patient directs otherwise in writing and in accord with good medical or other professional practice, verbally to immediate family members, a patient's state-registered domestic partner or to anyone known to have a close personal relationship with the patient;⁵³
- the successor in interest to the provider or facility;⁵⁴
- for research that an institutional review board has determined: (i) is sufficiently important to outweigh an invasion of patient privacy, (ii) is impracticable without identifiable patient information, (iii) contains reasonable redisclosure safeguards, (iv) contains reasonable safeguards concerning identification of any patient in the research report, and (v) contains procedures for removal or destruction of identifying information as soon as possible unless the board authorizes retention of the information for another project;⁵⁵
- a person who obtains information in conjunction with an audit of the provider to determine compliance with statutory, regulatory, fiscal, medical, or scientific standards; a third party payer program; or licensing, certification, or accreditation requirements if they agree to: (i) remove or destroy as soon as possible any identifying patient information and (ii) not to disclose it further except to complete the audit or to report fraud or other illegal conduct by the provider;⁵⁶
- an official of a prison or other custodial institution where the patient is detained;⁵⁷
- unless the patient has directed otherwise, to provide information concerning the presence and for the purpose of identification, the name, residence, sex, and the general health condition of a patient in a health care facility or who is receiving emergency care in a health care facility ("directory information");⁵⁸ and
- by a hospital or health care provider to fire, police, sheriff, or other public authority, that brought or caused to be brought, a patient to the facility or provider, if the disclosure is limited to name, residence, sex, age, occupation, condition, diagnosis, or extent and

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ RCW 70.02.200.

⁵² RCW 70.02.050.

⁵³ RCW 70.02.200.

⁵⁴ *Id.*

⁵⁵ RCW 70.02.210.

⁵⁶ RCW 70.02.200.

⁵⁷ RCW 70.02.200.

⁵⁸ *Id.*

location of injuries as determined by a physician and whether the patient was conscious when admitted;⁵⁹

- to federal, state or local law enforcement authorities when the health care provider or facility or third-party payor believes in good faith that the health care information disclosed is evidence of criminal conduct that occurred on the premises of the health care provider, facility or third-party payor;⁶⁰
- for payment;⁶¹
- to other health care providers, facilities or third-party payors for operations as described in RCW 70.02.010(17)(a) of the entity or person receiving the information if each entity has had a relationship with the patient whose information is being provided and the health care information pertains to that relationship.⁶²

(b) Mandatory Disclosures

A health care provider must disclose health care information about a patient without the patient's authorization to the following persons and entities under the following circumstances: (See RCW 70.02.200(2) and 70.02.050(2)).

- federal, state or local public health authorities if required by law to report health care information; when needed to determine compliance with state or federal licensure, certification or registration rules or laws; or when needed to protect the public health;
- federal, state, or local law enforcement authorities to the extent required by law;
- to federal, state and local law enforcement authorities upon request, if a patient is being treated for gunshot wounds and other injuries reasonably believed to have been intentionally inflicted or resulted from a criminal act; patient's name, residence, sex, age, condition, diagnosis, extent of injuries, patient status when admitted, name of provider, which the patient has transferred; and time and date of discharge;
- to county coroners and medical examiners for investigation of deaths; and
- pursuant to a discovery request or compulsory process in compliance with RCW 70.02.060⁶³ (see section D in this chapter).

5. Patient Examination and Copying

Upon written request from the patient and, if applicable, the payment of a reasonable fee (see section C.1(e) in this chapter), the patient may be allowed to examine or copy all or part of his/her health care information.⁶⁴ Within 15 working days from receipt by health care provider of the patient's request, the provider has five options to choose from.⁶⁵

- (a) The provider can make the health care information available to the patient to review during regular business hours and provide a copy to the patient, if requested.
- (b) If the requested information cannot be located, the provider may inform the patient that the health care information does not exist or cannot be found.
- (c) If the health care provider does not maintain a record of the health care information, the provider may advise the patient as to the name and address of the provider that has the information, if known.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ RCW 70.02.050.

⁶² RCW 70.02.200.

⁶³ RCW 70.02.200(2).

⁶⁴ RCW 70.02.080.

⁶⁵ *Id.*

- (d) The provider may advise the patient in writing why release of the health care information is being delayed and when it will be available or when the request will otherwise be handled, which must be within 21 working days from the receipt of the request.
- (e) The provider may deny the request, in whole or in part, in accordance with RCW 70.02.090 and inform the patient of the denial (see section C.6 in this chapter).⁶⁶

If the patient requests, the provider must explain any codes or abbreviations used in the health care information, but the Act does not obligate a provider to create a new record or to reformulate an existing record to conform to a patient's request.⁶⁷

6. Denying Access to Records

A health care provider may deny a patient access to part or all of his/her health care information if the health care provider reasonably believes that:

- knowledge of the health care information would be injurious to the health of the patient;
- knowledge of the information could reasonably be expected to lead to the identity of an individual who provided the confidential information and under the circumstances confidentiality was appropriate;
- knowledge of the information could reasonably be expected to cause danger to the life or safety of another;
- the health care information was compiled and used solely for litigation, quality assurance, peer review, or administrative purposes; or
- access to the health care information is otherwise prohibited by law.⁶⁸

If a patient's request to examine his/her health care information is denied in part, the provider, to the extent possible, must segregate information that can be disclosed from information that cannot be disclosed and let the patient examine and copy the former.⁶⁹

In the case of a denial of access to a patient's health care information because it would be injurious to the patient's health or because it would cause danger to the life or safety of another person the provider must advise the patient that he/she has the right to select another provider, at the patient's expense, who is licensed, certified, registered or otherwise authorized by law to treat the patient for the same condition, to examine the health care information.⁷⁰ On request of the patient, the information must be disclosed to such a provider.⁷¹

D. Responding to Subpoenas and Discovery Requests

1. Background

Discovery requests, such as subpoenas, subpoenas *duces tecum*, and interrogatories, may require a person to appear and give testimony or produce evidence.⁷² Ignoring a discovery request usually constitutes contempt of court.⁷³ However, a health care provider who receives a request for health care information may not respond to the subpoena

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ RCW 70.02.090(1).

⁶⁹ RCW 70.02.090(2).

⁷⁰ RCW 70.02.090(3).

⁷¹ *Id.*

⁷² RCW 70.02.060.

⁷³ *Id.*

or other request for discovery unless the person seeking the information complies with requirements set forth in RCW 70.02.060.

2. Notice Requirements

An attorney requesting medical/health records from a health care provider must give advance notice to the health care provider and to the patient before serving a discovery request for medical/health records.⁷⁴ The notice must indicate (1) the provider from whom the information is sought, (2) what information is sought, and (3) the date by which a protective order must be obtained to prevent the provider from honoring the request or subpoena.⁷⁵ The notice must be served at least 14 days before the subpoena or discovery request is served.⁷⁶ The notice may be in the form of a letter or a pleading.⁷⁷

The purpose of this notice requirement is to give the patient a chance to seek a protective order preventing or limiting disclosure of the medical record.⁷⁸ It is generally the responsibility of the patient to obtain a protective order, during the 14-day notice period, preventing or limiting the provider from responding to the discovery request.⁷⁹

3. Attorney Requests

The attorney for a patient is the legal representative of the patient. A health care provider may provide a copy of a patient's record to the patient's attorney, so long as the attorney provides an authorization to release the records, signed by the patient.⁸⁰

The attorney for a provider may review a patient's record, without the patient's consent, in connection with providing legal advice to the provider, assuming the provider reasonably believes the attorney will not use it for any other purpose and will protect the information.⁸¹

In general, any other attorney is entitled to review and to obtain a copy of a patient's record only (1) with the written consent of a patient or (2) by following the requirements of the Act relating to advance notice and service of discovery requests.⁸²

4. Response to Subpoenas

A provider may not disclose the patient's medical/health record if the person requesting the record has not complied with the 14-day notice requirements.⁸³ When a provider receives a discovery request at least 14 days after receiving the appropriate advance notice, the provider is required to comply with the discovery request unless the court has

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ RCW 70.02.030.

⁸¹ RCW 70.02.050(1)(b).

⁸² RCW 70.02.060.

⁸³ *Id.*

entered a protective order making compliance unnecessary.⁸⁴ If the provider has any question as to whether the party serving the discovery requested has complied with the 14-day notice requirement, it is often helpful to call the attorney responsible for serving the notice and discovery request.

If the information requested includes information concerning drug and alcohol abuse treatment, mental health treatment, HIV/AIDS or sexually transmitted diseases, additional rules apply to disclosure and health care information. Those rules are set out in RCW 70.96A (drug and alcohol abuse and abuse treatment); RCW 70.02.230 and 70.02.240 (mental health treatment); and RCW 70.02.220 and .300 (HIV/AIDS and sexually transmitted diseases).

5. Resisting a Subpoena or Discovery Request

(a) When to Resist

If the party requesting the record does not have the patient's authorization to release the record or has not complied with the 14-day advance notice requirements of the Act, or has not complied with special rules regarding alcohol and drug abuse, mental health or HIV/AIDS and sexually transmitted diseases, the provider is prohibited from complying with a subpoena or other request for discovery.⁸⁵

(b) How to Resist

If the provider reasonably believes that it is prohibited from complying with a discovery request, the provider should notify the party serving the discovery request.⁸⁶ In most cases, the party requesting the health care information will withdraw its request or issue a new discovery request that complies with the applicable statutory requirements.⁸⁷ If the party requesting the records insists that the provider comply with the discovery request, the provider may file a motion to quash the discovery request or a motion for a protective order.⁸⁸

If the party requesting the records is particularly insistent or if there is not time to obtain a motion to quash or motion for protective order, many providers have found that a cost-effective response is to provide the requested records directly to the court.⁸⁹ The records should be accompanied by a letter to the judge stating that the provider believes the records may be protected from discovery and asking the judge to review the matter and enter an order authorizing or prohibiting disclosure of the records.⁹⁰

(c) When to Comply

When a court orders the records to be disclosed, the provider will be expected to comply.⁹¹

6. Criminal Cases/Search Warrants

The 14-day notice requirement discussed in section D.2 of this chapter, applies to discovery requests in criminal as well as civil cases. However, the Act states that a provider must disclose health care information about a patient to federal, state, or local law enforcement "to the extent ... required by law."⁹²

⁸⁴ *Id.*

⁸⁵ RCW 70.02.060; RCW 70.02.220 - .260; RCW 70.02.300.

⁸⁶ *See, generally* FRCP 26; CR 26; FRCP 45; CR 45.

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.*

The 14-day notice period does not apply to search warrants. A search warrant may be issued by a magistrate upon a finding of probable cause in connection with an investigation of or a prosecution for, a homicide or felony, or for investigation of fraud and abuse by either federal authorities (Medicare) or state authorities (Medicaid).

7. Certification of Medical/Health Records

Upon request, the provider must certify the records provided.⁹³ The provider may charge a fee for certifying a record.⁹⁴ The certification should be attached to the record and state (1) the identity of the patient, (2) the kind of health care information involved, (3) the identity of the person to whom the information is being furnished, (4) the identity of the health care provider or facility furnishing the information, (5) the number of pages of the health care information, (6) the date on which the health care information is furnished and (7) that the certification is to fulfill the meet the requirements of the Act.⁹⁵

E. Documenting Disclosure by the Health Care Provider

Health care providers must document certain disclosures of health care information in the patient's medical/health record for a period of six years prior to the date on which an accounting is requested.⁹⁶ This requirement applies to disclosures made pursuant to a properly served discovery request.⁹⁷ In addition, copies of the patient's written consent and copies of any discovery requests (including copies of the 14-day notice) should be included in the medical/health record.⁹⁸

Disclosures need not be accounted for if the disclosure is: (1) to carry out treatment, payment and health care operations; (2) to patient of health care information about him or her; (3) incident to use or disclosure that is otherwise granted or permitted; (4) pursuant to authorization where the patient authorized the disclosure to him or herself; (5) of directory information (6) to persons involved in the patient's care; (7) for national security or intelligence purposes if an accounting is not permitted by law; (8) to correctional facilities or law enforcement if accounting is not permitted by law; (9) of limited data sets that exclude direct identifiers of the patient, patient's relatives, employers or household members.⁹⁹

F. Correcting and Amending Medical/Health Records

A patient may request, in writing, that a provider correct or amend the patient's medical/health record.¹⁰⁰ Within ten (10) days of receiving such a request, the provider shall:

- (1) make the requested correction or amendment and inform the patient of the action;
- (2) inform the patient if the record no longer exists or cannot be found;
- (3) if the provider no longer maintains the record, inform the patient and provide the patient with the name and address, if known, of the person who maintains the record;

⁹² RCW 70.02.200(a).

⁹³ RCW 70.02.070.

⁹⁴ RCW 36.18.016

⁹⁵ RCW 70.02.070.

⁹⁶ RCW 70.02.020(2).

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ RCW 70.02.100.

- (4) if the record is in use or unusual circumstances have delayed the handling of the amendment request, inform the patient and specify in writing the earliest date when the record will be available, not to exceed 21 days after receipt of the request; or
- (5) inform the patient in writing of the provider's refusal or correct or amend the record as requested and the patient's right to add a statement of disagreement.¹⁰¹

In completing the amendment, the provider needs to add the amending information as part of the health record and indicate where the amended areas of the medical/health record occur. If the provider refuses to make the patient's proposed correction or amendment, the provider shall permit the patient to file as part of the patient's record a concise statement of the amendment and indicate in the record where the disagreement is located.¹⁰²

G. Notice of Information Display

A health care provider must post a notice in a conspicuous place informing patients of the provider's practices relating to maintaining and to disclosing health care information. The Act states that the notice to patients should be substantially as follows:

NOTICE

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it at ...

The notice must be placed in a conspicuous place in the health care facility, on a consent form or with a billing or other notice to the patient.¹⁰³

H. Retention and Security of Medical/Health Records

The Act requires that health care providers adopt reasonable safeguards for the security of all health care information that it maintains.¹⁰⁴ Under the Act, the provider must maintain a record of health care information for at least one year (1) following receipt of a written disclosure authorization, (2) during the pendency of any request for examination and copying or (3) during the pendency of a patient's request for correction and amendment of a medical/health record.¹⁰⁵

There are several other Washington statutes and regulations that govern retention of medical/health records by certain health care providers, including hospice records and home health records,¹⁰⁶ nursing homes,¹⁰⁷ and private psychiatric and alcoholism hospitals.¹⁰⁸

The statute of limitations for actions for injuries relating to the provision of health care services requires that such actions be brought within three years of the alleged malpractice or within one year of the time the patient or legal representative discovers that the injury was caused by the alleged malpractice but not more than eight years after the

¹⁰¹ RCW 70.02.100; RCW 70.02.110.

¹⁰² *Id.*

¹⁰³ RCW 70.02.120.

¹⁰⁴ RCW 70.02.150.

¹⁰⁵ RCW 70.02.160.

¹⁰⁶ WAC 246-335-110.

¹⁰⁷ RCW 18.51.300.

¹⁰⁸ WAC 246-322-200.

alleged malpractice.¹⁰⁹ Because RCW 4.16.350 creates an eight-year statute of repose, medical/health records should be retained for at least eight years after the last contact with the patient. If the patient is a minor, the medical/health record should be retained for at least eight years following the patient's eighteenth birthday.

The Joint Commission requires that all entries in the medical/health record must be dated and authenticated and their authors must be identified.¹¹⁰ In order to comply with this requirement, an electronic medical/health record system must be capable of receiving, dating, recording, identifying the author, and authenticating all orders, including verbal order.¹¹¹

I. Electronic Medical/Health Records

Automation of patient records will dramatically change the way records function in patient care. The same rules that apply to disclosure of hard copies of medical/health records apply to disclosure of information contained in an electronic medical/health record system.

A provider is required to have reasonable safeguards for the security of health care information.¹¹² In the case of automated records, this may mean instituting security measures such as passwords, access codes, key cards, or similar security mechanisms. The provider should also have strict policies against disclosing or sharing passwords, access codes, key cards, and other user identifiers.

Other recommended safeguards include (1) monitoring the system, (2) changing passwords frequently, and (3) permitting users only one log-in at a time. Once a user of the system leaves a practice group or hospital, his or her access code should be deactivated and destroyed.

Access by each authorized user of the system should be restricted to those patient records related to the user's functions. Special safeguards should be in place to protect particularly sensitive records or parts of records, such as mental health records, HIV information, and drug and alcohol abuse information. Ideally, the system should be structured such that a person attempting to retrieve records beyond his or her clearance will be locked out of the system.

All individuals given access to the patient records should be required to sign a confidentiality agreement, acknowledging that he or she will have access to confidential information that may be protected from disclosure by state or federal law.

J. Faxing Medical/Health Records

Providers are often requested to FAX medical/health records. The same rules relating to providing copies of medical/health records apply to providing a copy of the medical/health record via FAX. In addition, it is recommended that the FAX cover sheet contain a confidentiality statement. In order to further protect the confidentiality of a medical/health record provided via FAX, the provider may want to call the recipient at the time the record is transmitted to inform the recipient that confidential information is being faxed.

¹⁰⁹ RCW 4.16.350.

¹¹⁰ Joint Commission Manual at RC-3, RC-4.

¹¹¹ *Id.*

¹¹² RCW 70.02.150. *See also*, HIPAA security provisions, Chapter ___ of this manual.

K. Specific Situations

1. Third-Party Payors

Health care information may be disclosed to a third-party payor without the patient's prior authorization if the disclosure of information is only for payment purposes.¹¹³ Third-party payors may not release health care information disclosed for payment purposes, except to the extent otherwise authorized by RCW 70.02.045 and 70.02.050. An accounting of disclosures to the patient for payment purposes is not required.¹¹⁴ If a patient specifically authorizes payment, the authorization may be indefinite in duration, and does not expire in any given period of time, as do some other authorizations.¹¹⁵

Additional language may be required to permit disclosure of records to third-party payors if those records contain information concerning drug and alcohol abuse treatment, mental health treatment, HIV/AIDS or sexually transmitted diseases, as discussed in Chapter II-2 of this manual.

2. Coroners and Medical Examiners

County coroners and medical examiners investigate certain suspicious or unusual deaths. Medical/health records shall be disclosed without patient authorization to county coroners and medical examiners for the purpose of investigating deaths.¹¹⁶ Reports and records of autopsies may be disclosed if done in compliance with RCW 68.50.105.

3. Workers' Compensation

The Act does not modify the requirements of RCW 51.36.060, the state workers' compensation program, which requires disclosure of relevant medical information concerning an employment-related injury or occupational disease to the employer, the patient's representative, and the Department of Labor and Industries, upon request. The workers' compensation law does not supersede the strict protections afforded to certain STD, mental health, and drug and alcohol abuse records.

4. News Media

The Act permits providers to disclose "directory information" unless the patient has instructed the provider not to make that disclosure.¹¹⁷ Directory information means information disclosing the presence, name, sex, residence, and general health condition of a patient.¹¹⁸ "General health condition" means health status using such terms as "critical," "poor," "fair," "good," or similar terms.¹¹⁹

¹¹³ RCW 70.02.030(4)(b); RCW 70.02.050(d).

¹¹⁴ RCW 70.02.020(2)(a).

¹¹⁵ RCW 70.02.030(6).

¹¹⁶ RCW 70.02.200(2)(a).

¹¹⁷ RCW 70.02.200(1)(e).

¹¹⁸ RCW 70.02.010(9).

¹¹⁹ RCW 70.02.010(13).

5. Personal Injury Cases; Child Abuse Reporting; Sexual Assault

A person who brings a legal action for personal injuries is deemed to have waived the physician-patient privilege ninety days after filing the action.¹²⁰ Despite this waiver, the defense in a personal injury action must comply with the requirements of the Act when requesting the plaintiff's medical/health records. The patient must authorize the disclosure in writing or the records may be provided if notice and a subpoena have been served on the provider, in accordance with the requirements of the Act and, if applicable, in accordance with the requirements of state and federal law relating to drug and alcohol abuse treatment records, mental health treatment records, and HIV/AIDS treatment records.¹²¹

Health care providers are required to report suspected cases of abuse of a child or vulnerable adults.¹²² This duty to report includes the duty to provide copies of the relevant medical/health records upon request by the investigating agency.¹²³

Rape crisis center records are not subject to discovery or compulsory process.¹²⁴ A court order is required before these records can be disclosed.¹²⁵

6. Disciplinary Boards

The Quality Assurance Commission and other professional licensing agencies are required to investigate complaints or reports of unprofessional conduct.¹²⁶ The investigating agency has the authority to subpoena medical/health records in connection with such an investigation.¹²⁷ The provider is required to comply with such requests for information.¹²⁸ It is recommended that all patient identifying information be removed from the medical/health records prior to disclosure if possible.¹²⁹

L. Liability and Remedies

A person who has complied with the requirements of the Act may bring an action against a health care provider or facility who has not complied with the requirements of the Act.¹³⁰ The court may order the provider to comply with the statute and may award actual damages but not consequential or incidental damages.¹³¹ The court will award reasonable attorneys' fees and all other expenses reasonably incurred to the prevailing party.¹³² The statute of limitations for actions alleging violation of RCW 70.02 is two years after the cause of action is discovered.¹³³ A violation of RCW 70.02 is not considered a violation of the consumer protection act (RCW 19.86).¹³⁴

¹²⁰ RCW 5.60.060(4)(b).

¹²¹ RCW 70.02.060.

¹²² RCW 26.44.030 (children); RCW 74.34.035 (vulnerable adults)

¹²³ RCW 26.44.030(14); RCW 74.34.035(10).

¹²⁴ RCW 70.125.065.

¹²⁵ *Id.*

¹²⁶ RCW 18.130.080

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ RCW 70.02.170.

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.*

In addition to remedies specifically provided in the Act, and in HIPAA, an individual may have a common law claim for invasion of privacy against a provider who wrongfully discloses confidential health care information.¹³⁵

¹³⁵ *Reid v. Pierce County*, 136 Wn. 2d 195, 206, 961 P.2d 333, 339 (1998) (holding that "the common law right of privacy exists in [Washington] and that individuals may bring a cause of action for invasion of that right.")