Disclosure of Health Information (1996)

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Background

Increasingly, health information management professionals face a dilemma: how to meet the needs of a variety of legitimate users of health information while protecting patients from unauthorized, inappropriate, or unnecessary intrusion into the highly personal data in health records.

Complete, accurate health information must be readily available for patient care, but patients must be assured that the information they share with healthcare professionals will remain confidential. Without such assurance, patients may withhold critical information that could affect the quality and outcome of care, as well as the reliability of the information.

Classification of Information

Generally, health information may be classified into two categories:

Nonconfidential

Nonconfidential information is that which is generally common knowledge, and there is no specific request by the patient to restrict disclosure. Nonconfidential information includes:

- Name of the patient
- Verification of hospitalization or outpatient services
- Dates of service

Note: Disclosure of any health information relating to alcohol and/or drug abuse is governed by specific federal statutes codified in 42 CFR, Ch. 1, Part 2 (1983), as outlined in the section of this brief titled "Disclosure of Alcohol/ Drug Abuse Information." Disclosure of information pertaining to mental health may be restricted by law in some states.

Confidential

Confidential information is made available during the course of a confidential relationship between the patient and healthcare professionals. Confidential information includes, but is not limited to, all clinical data and the patient's address on discharge if different from the address on admission.

Disclosure of Health Information

Health records (regardless of the media on which they are maintained) are the property of the healthcare provider, but the health information contained in the records belongs to the patient. Disclosure of health information must be done prudently to protect the patient's right to privacy.

Each healthcare facility must develop policies and procedures for disclosure of health information in accordance with federal and state laws. To assure consistent compliance with these policies and procedures, disclosure of health information should be made only by those appropriately trained and qualified to do so. AHIMA recommends that the responsibility for disclosure of health information be centralized under the direction of the facility's health information management professionals. Employees

responsible for information disclosure must be carefully trained and supervised to ensure their consistent compliance with the facility's policies.

Patient Care

Complete, accurate health information must be readily available for patient care. Information may be disclosed without patient authorization as required for continued care.

Nonpatient Care

Careful consideration must be given to any other disclosure of any health information, even that information generally considered to be nonconfidential. Although healthcare providers have no obligation to disclose this information, it may be disclosed to legitimate requesters on a "need-to-know" basis without the patient's authorization unless otherwise requested by the patient or his legal representative or prohibited by law. When disclosing this information, there should be evidence that the requester has a legitimate right to the information which is not inconsistent with the patient's best interests.

For purposes other than patient care, information considered to be confidential should be disclosed only upon written authorization by the patient or his legal representative or where such disclosure is authorized by federal or state law, subpoena, or court order. Disclosures to external requesters should be accompanied by a statement prohibiting use of the information for other than the stated purpose and requiring destruction of the information after the stated need has been fulfilled.

Revocation of Authorization

The patient or his/her legal representative has the right to revoke authorization to disclose information at any time. Revocation of authorization should be submitted in writing to the healthcare provider and should be maintained with the patient's health record. Revocation of authorization does not affect any health information disclosed prior to the provider's receipt of written notice of revocation.

Patient Acess

As owners of their health information, patients should have access to the information, unless otherwise prohibited by state law.

Disclosure of Adoption Information

Disclosure of information relating to adoption must be handled carefully, to assure protection of patient privacy and compliance with state law. Healthcare facilities should develop policies and procedures to address disclosure of adoption information, with consultation from legal counsel.

In general, requests from biological parents should be referred to the agency that handled the adoption. Parents may be given the name and telephone number of the adoption agency, but no further information should be disclosed by the healthcare provider. Parents should not be given access to the child's record.

Adopted children trying to trace their biological parents should be referred to the adoption agency. Children may be given the name and telephone number of the adoption agency, if known, but no information regarding the parents' identity should be disclosed by the healthcare provider.

If the state has an adoption history program, requesters should be referred to the program for assistance. In the absence of a such a program, children seeking medical history information should consult an attorney to obtain a court order for disclosure of this information. If emergent circumstances involving continued patient care do not allow time for a court order, summary information only (that does not identify the biological parent) may be abstracted from the record by the provider's health information management professional or designee.

The child should not be permitted to review the parent's record without the parent's written authorization. Access to or copies of the parent's record may be provided to the child's attending physician only with the parent's written authorization.

Disclosure of Alcohol/Drug Abuse Information

Disclosure of information relating to alcohol or drug abuse must be handled in compliance with federal regulations outlined in the Code of Federal Regulations, 42 CFR, Ch. 1, Part 2 (1983). These statutes pertain to any program or activity relating to alcohol or drug abuse education, training, treatment, rehabilitation, or research. The Department of Health and Human Services interprets these regulations to apply to (1) an individual or entity (other than a general medical facility) that provides alcohol or drug abuse diagnosis, treatment, or referral for treatment; (2) an identified unit within a general medical facility that provides alcohol and drug abuse diagnosis, treatment, or referral for treatment; or (3) medical personnel or other staff in a general medical facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment (42 CFR Part 2, Proposed Rules, *Federal Register*, Vol. 59, No. 159, August 18, 1994, p. 42562).

Facilities with these programs should consult legal counsel to develop a specific authorization for disclosure of health information form to comply with these federal regulations and any applicable state laws.

In compliance with federal law, records of the identity, diagnosis, prognosis, or treatment of any patient/client that are maintained in relation to any alcohol or drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the US may be disclosed only under the following conditions:

1. With written authorization from the patient/client and/or his parent, legal guardian, or person authorized under state law to act on his behalf or the executor, administrator, or personal representative of a deceased patient/client

2. Without patient/client authorization:

   a. To medical personnel to the extent necessary to meet a bona fide medical emergency

   b. To qualified individuals conducting scientific research, management audits, financial audits, or program evaluation, provided the identity of individual patients/clients is not disclosed in any reports resulting from these studies

   c. If authorized by court order granted after application showing good cause for the disclosure. The court will determine the extent to which any disclosure of all or any part of the record is necessary and impose appropriate safeguards against unauthorized disclosure. A subpoena alone is not sufficient for disclosure of this information. It must be accompanied by a court order.

Whenever copies of health records pertaining to alcohol or drug abuse are released or other written disclosure is made, the disclosure must be accompanied by a written statement substantially as follows:

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

A verbal disclosure may be accompanied or followed by such a notice.

The presence of a patient/client in a healthcare facility or residential facility for the treatment of alcohol or drug abuse may be acknowledged to callers and visitors with written authorization from the patient/client or his legal representative. Without such authorization, the patient/client's presence in the facility may be acknowledged only if it can be done in such a way as to not indicate that the patient/client is being treated for alcohol or drug abuse.

Redisclosure of Health Information

A healthcare provider's records may contain information about a patient from another healthcare provider. Such information is sent with patients who are transferred or referred to a facility for definitive treatment or continuing care. At times, a patient hospitalized treated in one facility may be referred to another facility for diagnostic testing or therapeutic treatment not available at the first facility. The resultant reports are sent to the referring facility to be incorporated into the patient's record.

Frequently, issues arise regarding who should maintain information generated by other healthcare facilities and who may disclose it upon request. Unless otherwise required by state law or regulation, AHIMA recommends the following:

If, during hospitalization at one facility, a patient is transported to another facility for diagnostic testing or therapeutic treatment, the resultant reports from the referral facility should be made part of the first facility's health record.

If information from another facility is used in the patient's diagnosis or treatment, the receiving facility should maintain that information permanently with the patient's health record. If the patient brings copies of prior health information with him, such copies should be returned to him, if he so requests. If this information was used in the patient's diagnosis or treatment, the facility should keep a copy of it with the patient's record.

A provider may redisclose health information from another provider facility without authorization from the patient or his legal representative if it is needed urgently for the patient's continuing care. If time permits, authorization from the patient or his legal representative should be obtained prior to redisclosure to a third party.

If a patient requests access to health information from another provider facility, the provider facility possessing the information should disclose it to the patient upon written request.

Unless otherwise required by law, no other redisclosures should be made. In response to a subpoena or other request, the healthcare provider should not disclose information from another provider facility, with the exception of outside test results that have been made part of the patient's record.

When information from health records is provided to authorized external users, this information should be accompanied by a statement:

- Prohibiting use of the information for other than the stated purpose
- Prohibiting disclosure by the recipient to any other party without written authorization from the patient or his legal representative unless such information is urgently needed for the patient's continuing care or otherwise required by state law
- Requiring destruction of the information after the stated need has been fulfilled

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Note: This practice brief replaces a series of earlier position statements issued in December 1993. For more detailed information, including sample forms, please refer to the AHIMA professional practice guidelines titled "Maintenance, Disclosure, and Redisclosure of Health Information."

Issued October 1996
