Redisclosure of Protected Health Information (PHI) (2018 Update)

Editor's Note: This update supersedes the 2013 Practice Brief "Redisclosure of Patient Health Information."

Redisclosure is the act of sharing or releasing health information that was received from another source, such as an external facility, a provider, or a health information exchange (HIE).

Identifying and classifying information received from another source is a critical step in determining whether an organization may redisclose the information. In most cases, redisclosure is determined by whether the information received from another source has been made a part of the patient's health record and included in the organization's designated record set (DRS). As defined by the HIPAA Privacy Rule, a DRS is a group of records maintained by or for a covered entity that is "used, in whole or in part, by or for the covered entity to make decisions about individuals."[1]

Historically, the challenge for covered entities has been to determine whether a particular document or set of information was used to make a decision about a patient and thus should be included in the DRS. With the evolution of electronic health records (EHRs), that challenge has become more complicated due to the increased volume of information received from outside sources, the Centers for Medicare and Medicaid Services' Promoting Interoperability Program, Direct Messaging, and participation in health information exchanges (HIEs).

This Practice Brief offers guidance for covered entities (CEs) and HIEs for the management of the redisclosure of protected health information (PHI) by outlining challenges and providing recommendations and best practices in compliance with federal and state regulations. This is an abridged version of this Practice Brief. The full version is available online in AHIMA's HIM Body of Knowledge.

Background

Long before the adoption of health IT, EHRs, and HIEs, healthcare organizations struggled with the alignment of the HIPAA Privacy Rule's definition of the designated record set (DRS) and identifying what types of documentation made up their DRS. Healthcare organizations must specifically define their DRS because individuals have a right to access PHI in a "designated record set."[2]

Health IT has only added to the challenges of defining the DRS. This is due to different EHR designs, functions, data structures within the systems, and interfaces to other information systems. For example, information shared electronically may make it difficult to determine if information received is used to make patient care decisions, what type of information and documents are received, and where the information is located when it is transmitted into the health record.

To summarize Department of Health and Human Services' (HHS) guidance, covered entities need to be very thoughtful in how they define their DRS. If a covered entity imports, or otherwise links, PHI from a health information exchange into their EHR, that information becomes part of the DRS—if the information fits within the definition of a DRS. Organizations should develop a multidisciplinary approach to make sure that all affected parties are involved in defining the organization's DRS.[3]

As organizations review and revise their DRS policies as part of information governance (IG) efforts, it is important to align these with other policies such as redisclosure, release of information, data management, and integration with an HIE.

Designated Record Set Definition

According to 45 CFR 164.501, a "designated record set" is defined as a group of records maintained by or for a covered entity that comprises the:

1. Medical records and billing records about individuals maintained by or for a covered healthcare provider;
2. Enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
3. Other records that are used, in whole or in part, by or for the covered entity to make decisions about individuals.

Increased Complexity with HIEs

With healthcare providers' increasing participation in HIEs, it is important to understand the complexity of issues surrounding redisclosure of PHI received via an HIE. The complexity is due to the multiple types of HIEs and the multiple ways that information is received from an HIE into an electronic health record (EHR). The information may be in a Consolidated-Clinical Document Architecture (C-CDA) format, but it may also be in discrete data fields. For example:

- **An HIE data repository model:** A provider may query the information within the HIE and "pull" information into the provider's EHR system.
- **A C-CDA HIE model:** Documents or data elements are automatically "pushed" into a patient's record from another treating provider, such as a hospital.
    - Depending upon the type of C-CDA implementation, the documents may be routed into a folder titled "outside" records or may be directly incorporated into a specific location within the patient's record.

It is more likely that a provider will review the documentation that is directly incorporated into the patient's record versus pushed into a folder designated for "outside" records. Organizations must be very deliberate in training providers to place information from an HIE into their EHR if the information is being utilized for the patients' healthcare, or at least note which information was reviewed and used for decision-making. If providers review the HIE information without placing it into their EHR or making a note about the reference, the medical record could be missing vital information that the provider used to determine care for the patient. With the traditional paper health record, a provider would write their initials on outside documentation to indicate that the information received was used in the care of the patient, thus making it subject to redisclosure. However, identifying if the information received from an outside source was reviewed by a provider is much more complex in the EHR. There are multiple ways to handle information received via an HIE for purposes of deciding whether to include the information as part of the DRS. For examples of ways to classify information received via an HIE, see the expanded online-only version of this Practice Brief in AHIMA's HIM Body of Knowledge at http://bok.ahima.org.

Below are some examples of ways to classify information received via an HIE. Please note that the examples below are not all-inclusive, as many variations and variables exist.

- Example 1: A provider may choose to classify each and every data element of information about the patient received from an outside source as included in its DRS. However, if the volume of information received is substantial, the provider may not review all of the information. Thus, this approach to classifying data could result in the release of many pages of additional information that the provider has never actually reviewed or relied upon in treating the patient.

- Example 2: A provider may work with its EHR vendor to find a way to track the documents and data elements that are reviewed by the provider and incorporate only those documents and data elements into the DRS for release. Alternatively, a provider may choose to make notations in the medical record of the information that was reviewed and relied upon to make treatment decisions. The challenge with this approach is finding a way to electronically track the documents and data elements reviewed by a provider and/or the need for additional notations by the provider.

- Example 3: A provider may designate those types of records routinely reviewed by providers, such as Admission, Discharge and Transfer (ADT) information or Lab and Rad reports, and automatically designate those particular record types as part of the designated record set, without regard to whether a particular provider actually reviewed a specific document or data element. One challenge with this approach could be a potential legal implication for a provider if it is presumed the provider had knowledge of all the information in the DRS, yet the provider did not have actual knowledge of certain data.

Each of the above examples and the many other variations of approaches to DRS designation has strengths and weaknesses.

Each healthcare organization must weigh the advantages and disadvantages based on their environment, costs, EHR and HIE capabilities, workflow considerations, policies, procedures, contract guidelines, legal considerations, and staff resources when choosing which information to classify as part of its DRS. Once these determinations are made, it is important that they be clearly documented in the DRS policy. It is also important that providers understand their roles, professional expectations, and clinical accountability to review available outside clinical documentation—and their responsibilities to identify if information was used during the course of the patient's care.

Developing transparency, partnership, and collaboration with the organization's HIE or EHR vendor (including Direct messaging) is critical. This includes knowing how the vendor will:

- Respond to requests from third parties and/or medical record subpoenas for records stored within their systems
- Provide technical support to the CEs when they receive a records request or subpoena
- Address redisclosure issues
- Provide for data quality, integrity, accuracy, and availability of information, including available audit logs and utilization reports
- Build future enhancements for patient engagement

Increased Receipt of Outside Health Information

Although redisclosure of PHI is necessary for patient care across the healthcare continuum, the practice often leads to questions about the appropriateness of disclosing information that originated from another healthcare facility—and whether to include it within the receiving covered entity's DRS. The HIPAA Privacy Rule does not expressly prohibit covered entities from redisclosing outside information within their DRS, but additional steps may be required for that redisclosure in accordance with state and federal regulations. Organizations will need to determine a process for identifying what information is utilized to make decisions. In some settings, this can be more challenging when multiple copies of PHI are sent and used by different individuals. For example, a skilled nursing facility (SNF) may receive one copy of health information to determine if a resident meets admission criteria, a second copy of health information sent by a hospital once the resident has been accepted for admission, and a third copy of health information that accompanies the resident during transfer. To add to the complexity, the records may come to the organizations in different formats. Arguably, components of all three copies of the records were used to make decisions about the admission and treatment of the resident and should, therefore, be part of the DRS. Health information professionals can play a critical role in challenges such as this by identifying the interdisciplinary uses of health information, streamlining the flow of information, and determining what components should be maintained in the DRS.

Redisclosure Scenario: HIE and Patient Request

A patient contacts an HIE requesting a copy of all information about her that has been contributed to the HIE from its various participants. The patient believes there is incorrect information about her in the HIE following a recent emergency department (ED) visit in which information retrieved from the HIE by ED staff was inaccurate.

In this scenario, the HIE participation agreements, business associate agreements (BAAs), policies, and operating procedures must include how the HIE handles:

- Patient requests for information or requests for access
- Amendments
- User access audit logs/reports
- User activity logs
- Procedures for when incorrect disclosures occur

In alignment with the HIE's participation agreements and contracts, HIE policies should be clear about information disclosed by the HIE versus information disclosed by the individual participants of the HIE; include a process for identifying users of the HIE who contributed information and a contact person for each individual participating provider or organization.

Legal Considerations

HIEs are typically business associates of covered entities. The ability of the HIE to redisclose PHI is derived from the language in the contract (participation agreement) and the BAA with the covered entity. Therefore, the HIE should have policies and procedures in place to safeguard the PHI and prevent redisclosure of PHI that it is not authorized for disclosure. Additionally, HIEs and their participants need to confirm whether there are laws that restrict the purposes for which PHI can be shared through the HIE. Some HIEs share PHI for purposes beyond treatment, such as syndromic surveillance and research. However, not all states allow for the sharing of PHI for such purposes. Therefore, an HIE and its participants must take steps to ensure the purposes for which they wish to exchange information is in compliance with federal and state laws.

For an overview of federal and state statutes impacting redisclosure of PHI, see the expanded online-only version of this Practice Brief in AHIMA's HIM Body of Knowledge.

Federal Statutes Impacting Redisclosure of PHI

Effective February 2, 2018, the Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) authorized changes to 42 CFR Part 2 to simplify the disclosure of substance use disorder patient records. The new regulations apply to all Part 2 programs and other lawful holders of Part 2 information. Protected information can only be exchanged electronically with the written consent of the patient or, if a qualified service organization agreement exists, between the Part 2 program and the HIE.

Under 42 CFR Part 2, entities who disclose substance use disorder records with written consent must include a written statement that the records shall not be redisclosed without further consent from the patient. Due to the adoption of electronic health records and the limited amount of free-text space, an abbreviated redisclosure notice was created. The updated standard or abbreviated notice of redisclosure is mandated to be used anytime written consent is required. See the table below for examples of both statements.

Difference Between Prior, Standard, and Abbreviated Notices

Prior Standard Notice	New Standard Notice	Abbreviated Notice
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.	This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is not sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime for any patient with a substance use disorder, except as provided at §§2.13(c)(5) and 2.65.	42 CFR Part 2 prohibits unauthorized disclosure of these records.

Lawful holders who receive Part 2 information with the written consent of the patient for healthcare operations and/or payment functions may redisclose the information to its contractors, subcontractors, or legal representatives only for the

purposes of healthcare operations and/or payment. Records are prohibited from disclosure to contractors, subcontractors, or legal representatives for treatment purposes including diagnosis, treatment, referral for treatment, care coordination, or case management. SAMHSA defined 17 types of activities related to payment and healthcare operations in the preamble to the final rule which justify redisclosure. A written contract is required between a lawful holder and contractors, subcontractors, or legal representatives when substance use records are redisclosed for healthcare operations activities or payment purposes. Per regulations, contracts must be in effect by February 2, 2020.[4]

What is a "Lawful Holder"?

A "lawful holder" of patient identifiable Part 2 information is an individual or entity (e.g., patients' treating providers, hospital emergency rooms, insurance companies, an individual or entity performing audits or evaluations, and individuals or entities conducting scientific research) who has received such information as the result of a Part 2-compliant patient consent, or consent exception, which includes the required notice which prohibits redisclosure.

Source: Department of Health and Human Services. "Confidentiality of Substance Use Disorder Patient Records." 42 CFR Part 2. *Federal Register* 82, no. 11 (January 18, 2017): 6,068. www.gpo.gov/fdsys/pkg/FR-2017-01-18/pdf/2017-00719.pdf.

Examples of State Statutes Impacting Redisclosure of PHI

Individual states may have their own laws or regulations relative to redisclosure for all or some particularly sensitive types of health information. State law may preempt HIPAA when the state law provides stricter confidentiality protections or provides patients with greater right of access to their health information. Therefore, organizations must understand their redisclosure responsibilities under all relevant federal and state laws.

Virginia, for example, established restrictions on the redisclosure of health records, affecting both healthcare providers and HIEs. The Virginia regulation states that the health records are "the property of the healthcare entity maintaining them" and that "No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure."

Nevada grants patients the right to have their health information excluded from HIEs, with some exceptions including those defined in HIPAA or otherwise required by state law and when a patient is enrolled in Medicaid or the Children's Health Insurance Program (CHIP). Nevada regulations state that there must be patient consent before records are retrieved from an HIE and that patients may request that a provider access their health information from the HIE at any time.

Balancing Redisclosure Limits and Patient Healthcare Needs

The challenge of many organizations is to review all applicable laws and then apply those rules to real-world scenarios. For example, a community hospital is destroyed by a tornado and all the hospital's health records are lost. A patient contacts another hospital where he once received care to see if that hospital has a copy of his old records that could be used by his current provider. The hospital determines it has the old records, but they are not part of the patient's DRS for that hospital.

In this scenario, it is important for the health information management (HIM) director to consider the patient care needs and how those needs can be balanced with the need to protect the hospital from liability for releasing records that are outside the scope of their DRS. Ideally, the HIM director would consult with the hospital's legal counsel to review the issue and possibly draft a disclaimer to address the liability issues of redisclosing the records while allowing the patient the potential care benefit.

Redisclosure Scenario: HIE and Provider Request

A patient is suing the ED physician at a facility where the patient was treated prior to giving birth to a baby born with a serious birth defect. The mother is alleging that the ED physician's use of a particular drug during her treatment is the cause of the baby's birth defect. The mother was 13 weeks pregnant at the time of a car crash that sent her to the ED unconscious. The mother's attorney has already obtained the hospital's health record and noted that there was no reference to his client's pregnancy in the hospital record. However, the attorney knows that the hospital participates in an HIE in which his client's OB/GYN also participates. The attorney issues a subpoena *duces tecum* to the HIE to obtain the information about his client

that was in the possession of the HIE at the time of his client's ED visit. The subpoena duces tecum also requests access logs from the HIE to indicate whether or not the ED physician logged in to the HIE and ran a query on his client at the day and time his client was brought to the hospital emergency department.

In this scenario, it would be ideal if the HIE had already itemized the information available in its access logs and knew exactly which data elements it could produce upon request. Additionally, the HIE would be best served by having a policy and procedure in place for producing the access log. The HIE should also have a policy and procedure in place that outlines whether the HIE can identify information, as it would have appeared to a participant's user at a particular time in history. The policy and procedure should detail how the information requested would be gathered and produced from the system. Furthermore, the policy would address whether the HIE would proactively notify affected participants prior to producing the requested information. The HIE should confirm that its release of information policy is consistent with any obligations of notification set forth in the HIE participation agreement and/or any BAAs with its participants.

The scenario above assumed the HIE was a repository model HIE. However, since HIEs may be structured in various ways, it is important to consider the HIE model when evaluating the content of policies and procedures. For example, a locator service model HIE would not have the same amount of information to provide in response to a subpoena. Its policies and procedures would be focused on access log information, such as whether a particular user initiated a query for the patient's name on the particular date and time, and if the audit log contained a copy of the queried information accessed by the user. For an example scenario of a patient transfer and subsequent subpoena, see the expanded, online-only version of this Practice Brief in AHIMA's HIM Body of Knowledge.

Redisclosure Scenario: Patient Transfer and Subsequent Subpoena

While out of town visiting relatives, a patient is involved in a car accident. She is taken to a local hospital and treated for injuries. Because the patient is unknown to the local doctors and her injuries are extensive, she receives a complete evaluation. Once stabilized, the patient wishes to be transferred to a local rehabilitation hospital to recover from her injuries.

The hospital that provided her with her primary care sends along a copy of the patient's entire health record when transferring her to the rehabilitation hospital. In addition, the rehabilitation hospital asks the patient to authorize her family physician to provide information on her past and current healthcare. The family physician opts to send the entire health record. Upon receiving both health records, staff members at the rehabilitation hospital choose to use only select information from the two health records in providing rehabilitation treatment to the patient. The remaining information is kept on file in the health record but is never used by the rehabilitation hospital to treat the patient.

A lawsuit is filed against the other driver in the car accident. The rehabilitation hospital receives a subpoena to release their patient's health record. In responding to the subpoena, the rehabilitation hospital chooses to disclose only the information within the transferred records that was actually used to treat the patient. Because the patient is attempting to prove that her injuries were the result of the accident and not a preexisting condition, records from the primary care hospital and family physician are also subpoenaed.

In this situation, it is appropriate for the rehabilitation hospital to redisclose only the information that was actually used to treat the patient as defined by the organization's definition of the legal health record. However, it should be noted that circumstances could exist that would require the rehabilitation hospital to redisclose all the records received from the transferring hospital and family physician. If the facility maintained the outside records, they could be asked to produce them. In the past, many facilities did not keep "all" of the outside records they received if they were not used for patient care. Generally, the records were sorted and only pertinent records maintained.

Hence, the records were not able to be produced in response to a subpoena. However, in today's electronic world, the volume of outside records received by healthcare providers has increased substantially. Additionally, the outside records are often received not in response to a request, but rather an automatic electronic push of information from another provider. As a result of the increased volume and new methods of receipt, records are less frequently sorted, and unreviewed and unnecessary records are not routinely discarded. Some organizations choose to file documents received from outside sources in a specific folder for such records within the patient's record. However, other healthcare organizations routinely incorporate certain outside information directly into their EHRs. In the circumstances in which the outside information is automatically incorporated into a provider's EHR, redisclosure of that information is almost certain to occur. Thus, it is more important than

ever that healthcare organizations have policies that clearly define the content of their medical records and the procedures for disclosure of those records, as well as incorporate information governance strategies to classify and inventory types of information received.

HIM and HIE Best Practices

There are many avenues in which organizations can receive outside health information. The users of the information are varied, as are the ways to navigate redisclosure issues. When determining organizational redisclosure policies and practices it is important that one's EHR has the ability to track documents and data elements within the DRS.

It is equally important for HIM professionals to develop policies and procedures that are aligned with federal and state regulations to address notifying third parties who have received redisclosed information if that information is updated/corrected after the redisclosure has occurred, and to review existing policies and procedures each time a new HIE relationship or a new source of outside PHI is established.

It is also recommended that HIM professionals classify and inventory types of information received, determine where the information is stored within the record, evaluate information that is routinely used versus information that is rarely used, and develop a multi-team approach or steering committee that includes individuals with verification of authority rights. HIM should determine what access log information is stored within an HIE and how log information will be retrieved.

Prior to joining an HIE, HIM should identify the purposes and methods by which information is disclosed by the HIE and confirm they align with applicable state and federal laws. Policies and procedures for working with HIEs should also be developed to coordinate updating/correcting, disclosing, and redisclosing PHI that has been shared with or through an HIE.

HIEs will need to review organizational disclosure and redisclosure policies and procedures, as well as review participation and BAAs for requirements in contacting affected participants prior to responding to a subpoena for information about an access or disclosure of PHI. For repository model HIEs, determine policies and procedures regarding handling patient access requests and communicate them to participants. And lastly, consult legal counsel when in doubt about a potential redisclosure.

Additional Reading

The following Practice Briefs offer related guidance on redisclosure. They are available online in the AHIMA HIM Body of Knowledge at http://bok.ahima.org.

- "Defining the Designated Record Set"
- "Notice of Privacy Practices"
- "Patient Access and Amendment to Health Records"
- "Understanding the Minimum Necessary Standard"
- "Fundamentals of the Legal Health Record and Designated Record Set"¢

Note

1. Department of Health and Human Services Office for Civil Rights. "HIPAA for Professionals." June 16, 2017. www.hhs.gov/hipaa/for-professionals/index.html.

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