NATIONAL INSTITUTE of FAMILY & LIFE ADVOCATES

Legal Tips

Volume XVII Number 12
December 2010

Release of Client/Patient Records

At Pregnancy Resource Centers (PRCs) and Pregnancy Resource Medical Clinics (PRMCs), client/patient records are confidential and cannot be disclosed except under certain circumstances. Under both federal and state law, patients have a right to access their medical records. This would arguably include a record of a self-tested urine pregnancy test at a PRC. HIPAA's (Health Insurance Portability and Accountability Act) Privacy Rule gives patients, with few exceptions, the right to inspect, review, and receive a copy of their medical records. More information about HIPAA's privacy provisions can be found at http://www.hhs.gov/ocr/privacy/.

A patient may also request that a copy of their records be sent to another provider. A nominal charge for the reasonable costs for copying and mailing the records is permissible. Some states have statutory limits on the allowable copying costs for medical records. To find out if your state has such limits go to http://www.lamblawoffice.com/medical-records-copying-charges.html.

A patient's right to authorize release of medical records is codified in many state statutes as well, so it is important to determine your state's specific law. For example, in California, medical records must be provided within 5 days after the request and in New York they must be provided within 10 days. In most cases, the copy must be provided within 30 days after the request.

There is an ongoing debate among PRCs and PRMCs about refusing to release medical records, under provisions of state conscience clauses, in the even the patient is going to use the records to obtain an abortion. **NIFLA** has concluded these conscience clause provisions that protect healthcare providers from participating in abortions probably do not extend protection to the release of medical records. The patient's right to her records would most likely prevail over an argument that providing those records would be the same as assisting in an abortion.

Centers may put in place a policy and procedure regarding the manner in which records can be requested and released. For example, it is wise to require the patient to come in and personally sign the Authorization and show identification in order to ensure that it is actually her requesting the information. Therefore, authorizations sent via fax should not be accepted.

Typical elements of a valid general release of records to be signed by the patient/client include:

1. Patient's name and identifying information;
2. Address of the health care professional or institution directed to release the information;
3. Description of the information to be released;
4. Identity of the party to be furnished the information;
5. Language authorizing release of information;
6. Signature of patient or authorized individual; and

7. Time period for which release remains valid.

Some state laws add other elements, such as specifying on the form the reasons for disclosure or a caveat that the authorization may be revoked. Failure to get the appropriate release for medical records may result in serious legal consequences. Twenty-one states punish disclosure of confidential information by revoking a physician's medical license or taking other disciplinary action. Below is a sample Release, but it is necessary for it to comply with your state laws, so please be sure to have this reviewed by a local attorney in your state.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

I request that health information regarding my care and treatment be released as set forth on this form and in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that:

1. I hereby authorize release of my information by the Pregnancy Resource Center/Clinic in any secure manner, including via facsimile, secure e-mail and telephonically.
2. I have the right to revoke this authorization at any time by writing to the healthcare providers listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3. I understand that signing this authorization is voluntary.
4. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE AGENCIES LISTED HEREIN.
5. Name and address of agencies to whom you are authorized to release information:

6. Specific information to be released:
   - ❑ Medical Records from ___ / ___ / _____ to ___ / ___ / _____
   - ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other healthcare providers.
   - ❑ Ultrasound Report
   - ❑ Verification of Positive Pregnancy Test
   - ❑ Other: _____
7. Date or event on which this authorization will expire: _____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

Patient's name: _____ Date of Birth: ____ / ____ / _____

_____ Date: ___ / ___ / _____ SSN: _____ - ____ - _____
(Patient Signature)

❑ Photo ID obtained ❑ Copy Attached

_____

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