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The Privacy Standards under the Health Insurance Portability and Accountability Act: A Practical Guide to Promote Order and Avoid Potential Chaos

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THE PRIVACY STANDARDS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT: A PRACTICAL GUIDE TO PROMOTE ORDER AND AVOID POTENTIAL CHAOS

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I. INTRODUCTION[1]

The Health Insurance Portability and Accountability Act ("HIPAA")[2] is the title of a complex law and series of regulations. While initially intended to address job-lock and claimed discriminatory practices in denying health insurance to persons with pre-existing medical conditions, the law has morphed into a maze of intertwined and interlocking puzzle pieces all intended to protect private health information, increase accessibility of health care, and streamline provider reimbursement through electronic transactions.[3] Pursuant to congressional directive, the HIPAA privacy rules, 45 C.F.R. parts 160 and 164 ("Privacy Standards"), establish a detailed, minimal threshold or floor designed to avoid improper dissemination of "individually identifiable health information."[4] Objectives of the Privacy Standards include to streamline and promote efficiency in the electronic information-sharing processes, to reduce costs in health care administration and billing functions, and to establish parameters and limitations on health information sharing.[5]

The Privacy Standards permit disclosure of personal health information under certain circumstances. As these standards are applied and interpreted, the courts and parties must remember that HIPAA does not elevate privacy of personal health information to the level of a constitutionally protected right. It does maintain historic treatment of this information as a legitimate privacy interest that is afforded a qualified level of protection against unauthorized disclosure.[6] Disclosure is permissible, for instance, pursuant to a valid consent for the pur-

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[1] This Article is adapted from a reference tool presented by the authors at the Autumn, 2003, West Virginia Judicial Conference. The authors thank all members of the West Virginia Judiciary, including Hon. David M. Pancake, Hon. Dan O'Hanlon and Kathleen Gross of the education staff for the Supreme Court of Appeals for that opportunity.

[2] Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified at 29 U.S.C. § 1162(2)(A)(v) (2000)).

[3] The United States Department of Health and Human Services has promulgated three sets of regulations to meet these laudable goals: the Privacy Standards; the Transaction Standards; and the Security Standards. 45 C.F.R. pts. 160, 162, 164. The first of these standards, The Privacy Standards, are the focus of this Article.

[4] 42 U.S.C. §1320d-2 (2000); 45 C.F.R. §§ 160.101-160.312, 164.102-164.534 (2003).

[5] 42 U.S.C. § 1320d-7 (2000).

[6] *E.g.*, S.C. Med. Ass'n v. Thompson, 327 F.3d 346 (4th Cir.) (upholding the constitutionality of HIPAA), *cert. denied*, 124 S. Ct. 464 (2003); Sherman v. Jones, 258 F. Supp. 2d. 440 (E.D. Va. 2003) (discussing a § 1983 action by prisoner for claimed improper publication of HIV status to other prisoners); Shaddox v. Bertani, 2 Cal. Rptr. 3d 808 (Ct. App. 2003) (police officer sued dentist after dentist made disclosure to police officials concerning chemical dependency of police officer); *In re* PPA Litig., 2003 WL 22203734, at *1 (N.J. Super. Ct. Law Div. Sept. 23, 2003) (challenging a health care record authorization proposed by defendants in state class action case for failure to comply with governing state law and HIPAA); Tapp v. Texas, 108 S.W.3d. 459 (Tex. Crim. App. 2003) (attempting to apply HIPAA prospectively to grand jury subpoena); Harmin v. Texas, No. 01-02-0035-CR, 2003 WL 21665488, at *1 (Tex. Crim. App. July 17, 2003) (claiming that a grand jury subpoena was in violation of HIPAA).

poses of carrying out health care treatment, payment, or health care operations; pursuant to a valid authorization;[7] pursuant to a written contract; or as permitted by law and regulation.[8] Courts will be confronted most commonly with challenges to either the form of consent, the scope of authorization, those exceptions expressly recognized by regulation, and assertions that HIPAA is non-applicable as either being silent or because state law is more stringent in a given application.

It is the objective of these authors to provide a practical application and reference tool for West Virginia practitioners as this area of the law evolves.[9]

II. OVERVIEW: PRIVACY AND DISPELLING THE MYTHS

When first enacted in 1996, Public Law 104-191 did not specifically regulate the privacy of personal, identifiable health information. Its first objective was to address job-lock created by health insurance pre-existing condition exclusion clauses.[10] Individual patient privacy, however, became an increasing concern as healthcare and health insurance reform measures resulted in greater information sharing through electronic information systems, which were accessible by individuals outside the realm of direct health care provider/patient care relationships. The explosion of the Internet, facsimile, and cellular phone communications in the 1990s triggered an effort to prevent avoidable, improper disclosure of and access to private information.

There are some myths and misconceptions regarding the scope and intent of this law. Dispelling these myths will be the obligation of courts and learned counsel.

A. *The Importance of Privacy Is Recognized and Preserved Through HIPAA*

The need and desire to preserve the confidential nature of physician-patient and health care provider-patient communications has been recognized since the inception of these honored, fiduciary relationships. Through the vehicle of confidential communications, health care providers discern and diagnose

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7 As discussed in Part IV *infra*, consent has a different meaning from authorization.

8 W. VA. CODE §§ 16-29-1, 57-5-4a to –5a (2003); 45 C.F.R. § 164.502(a)(1).

9 Large health plans with more than five million dollars in annual receipts were required to have a compliance program in place by April 14, 2003. Small health plans with less than five million dollars in annual receipts had until April 14, 2004 to become HIPAA compliant. Therefore, the impact and legal challenges arising from this law are yet to be seen. *See* CTR. FOR MEDICARE & MEDICAID SERV., DEP'T OF HEALTH & HUMAN SERV., HIPAA ADMINISTRATIVE SIMPLIFICATION COMPLIANCE DEADLINES, *available at* http://www.cms.hhs.gov/ hipaa/hipaa2 /general/deadlines.asp (last modified Feb. 12, 2004).

10 Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified at 29 U.S.C. § 1162(2)(A)(v) (2000)).

conditions, which patients might otherwise never disclose out of fear and misunderstanding. Lawmakers have recognized the valued commodity of privacy, which, once lost, can never entirely be recovered. An excerpt from the *Federal Register* demonstrates the recognition.[11]

> Privacy is a fundamental right. As such, it must be viewed differently than any ordinary economic good. The costs and benefits of a regulation must, of course, be considered as a means of identifying and weighing options. At the same time, it is important not to lose sight of the inherent meaning of privacy: it speaks to our individual and collective freedom.
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> A right to privacy in personal information has historically found expression in American law. All fifty states today recognize in tort law a common law or statutory right to privacy. Many states specifically provide a remedy for public revelation of private facts. Some states, such as California and Tennessee, have a right to privacy as a matter of state constitutional law. The multiple historical sources for legal rights to privacy are traced in many places, including Chapter 13 of Alan Westin's Privacy and Freedom and in Ellen Alderman & Caroline Kennedy, The Right to Privacy (1995).
>
> Throughout our nation's history, we have placed the rights of the individual at the forefront of our democracy. In the Declaration of Independence, we asserted the "unalienable right" to "life, liberty and the pursuit of happiness." Many of the most basic protections in the Constitution of the United States are imbued with an attempt to protect individual privacy while balancing it against the larger social purposes of the nation.
>
> To take but one example, the Fourth Amendment to the United States Constitution guarantees that "the right of the people to be secure in their persons, houses, papers and effects, against unreasonable searches and seizures, shall not be violated." By referring to the need for security of "persons" as well as "papers and effects" the Fourth Amendment suggests enduring values in American law that relate to privacy. The need for security of "persons" is consistent with obtaining patient consent before performing invasive medical procedures. The need for security in "papers and effects" underscores the importance of protecting information about the person, contained in sources such as per-

[11] Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462 (Dec. 28, 2000) (to be codified at 45 C.F.R. pts. 160, 164).

sonal diaries, medical records, or elsewhere. As is generally true for the right of privacy in information, the right is not absolute. The test instead is what constitutes an "unreasonable" search of the papers and effects.

The United States Supreme Court has upheld the constitutional protection of personal health information. In *Whalen v. Roe*, 429 U.S. 589 (1977), the Court analyzed a New York statute that created a database of persons who obtained drugs for which there was both a lawful and unlawful market. The Court, in upholding the statute, recognized at least two different kinds of interests within the constitutionally protected "zone of privacy." "One is the individual interest in avoiding disclosure of personal matters," such as this regulation principally addresses. This interest in avoiding disclosure, discussed in *Whalen* in the context of medical information, was found to be distinct from a different line of cases concerning "the interest in independence in making certain kinds of important decisions."

. . . .

The bottom line is clear. If we continually, gratuitously, reveal other people's privacies, we harm them and ourselves, we undermine the richness of the personal life, and we fuel a social atmosphere of mutual exploitation. Let me put it another way: Little in life is as precious as the freedom to say and do things with people you love that you would not say or do if someone else were present. And few experiences are as fundamental to liberty and autonomy as maintaining control over when, how, to whom, and where you disclose personal material. *Id.* at 240-241.

In 1890, Louis D. Brandeis and Samuel D. Warren defined the right to privacy as "the right to be let alone." *See* L. Brandeis, S. Warren, *The Right To Privacy,* 4 Harv. L. Rev. 193. More than a century later, privacy continues to play an important role in Americans' lives. In their book, *The Right to Privacy*, (Alfred A. Knopf, New York, 1995) Ellen Alderman and Caroline Kennedy describe the importance of privacy in this way:

> Privacy covers many things. It protects the solitude necessary for creative thought. It allows us the independence that is part of raising a family. It protects our right to be secure in our own homes and possessions, assured that the government cannot come barging in. Privacy also encompasses our right to self-determination and to define who we are.

> Although we live in a world of noisy self-confession, privacy allows us to keep certain facts to ourselves if we so choose. The right to privacy, it seems, is what makes us civilized.
>
> Or, as Cavoukian and Tapscott observed the right of privacy is: "the claim of individuals, groups, or institutions to determine for themselves when, how, and to what extent information about them is communicated." *See* A. Cavoukian, D. Tapscott, *Who Knows: Safeguarding Your Privacy in a Networked World*, Random House (1995).[12]

West Virginia, like other states, has historically protected the privacy of individual health information through common law and statutes, preserving the delicate balance between individual privacy interests and necessary judicial and state law enforcement and public health and safety interests, to maintain an orderly and civil society.[13] In many respects, the Privacy Standards merely compliment West Virginia law.

B. HIPAA Preemption Generally: HIPAA Does Not Preempt Consistent or More Stringent State Law

HIPAA, by its own terms, does not exclusively dominate the field of protecting individual privacy interests in health information.[14] HIPAA expressly has preemptive effect upon state law where it conflicts with state law or where there is a void within a state law provision concerning its subject matters.[15] Where state law is more stringent, state law applies.[16] HIPAA specifically does not preempt federal or state laws that require reporting of disease or injury, child abuse, birth, or death, or "for the conduct of public health surveillance, investigation or intervention."[17] HIPAA should be applied *in pari materia* with other federal and state laws, as in most instances the laws compliment one another.

Many of West Virginia's existing laws may co-exist with HIPAA without undue burden upon "covered entities"[18] and/or the legal system. A review of

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12 *Id.* at 82,464-65.

13 *See, e.g.*, W. VA. CODE §§ 57-5-4a to -4j, 16-29-1, 27-3-1 (2003); Keplinger v. Va. Elec. & Power Co., 537 S.E.2d 632 (W. Va. 2000); Morris v. Consolidation Coal Co., 446 S.E.2d 648 (W. Va. 1994); Nelson v. Ferguson, 399 S.E.2d 909 (W. Va. 1990); Allen v. Smith, 368 S.E.2d 924 (W. Va. 1988).

14 45 C.F.R. § 160.202-203 (2003).

15 *Id.*

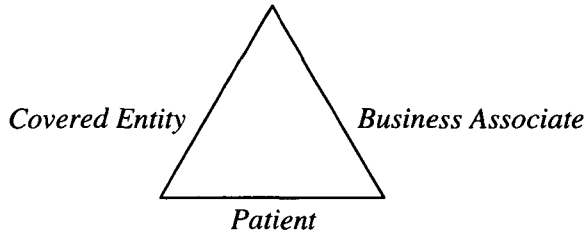
16 *Id.*

17 *Id.* § 160.203(c); *see also id.* § 164.512.

18 As discussed *infra*, the definition of covered entities includes entities other than simply

specific West Virginia statutes as they interplay with HIPAA is included in Part V of this Article.

C. *Entities Within the "HIPAA Triangle" Are the Only Entities Directly Regulated*



HIPAA does not apply outside of the context of a protected health care provider/health information source entity and an individual health care recipient relationship. It only applies to "covered entities" and the management and dissemination of health information by those covered entities and their business associates.

HIPAA therefore codifies and recognizes the three uniquely situated constituents that must have an open, information-dependent, tri-partite, interactive relationship in order for the health care system and economy to operate: the "Patient," the "Covered Entity" (health care provider/health care plan/health care clearinghouse), and the "Business Associate." These three players are readily identifiable by examination of their definitions.

1. Patient

The "patient" is the person who is the subject matter of "individually identifiable health information." "Individually identifiable health information" is a fancy, verbose way of describing all information that in any manner may identify the individual who has received health care services or could be used to identify that individual.[19] Examples of individually identifiable health information include, but are not limited to, patient name, address, demographics (birth date, social security number, etc.), diagnosis, and attending physicians. If the answer to the following question is affirmative, the information comes within the scope of this definition: On the face of the document or things, is it possible to ascertain that the individual person received health care services and/or has a certain health condition?

HIPAA applies to any written or oral communication. A covered entity may be permitted to make verbal disclosures, for instance, by telephone calls for

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health care providers. *See* Part II.C.2.

[19] 42 U.S.C. § 1320d(6) (2000); 45 C.F.R. § 160.103.

pre-certification for a given test or procedure. However, the nature and scope of disclosure still may be restricted, regardless of the method or manner of disclosure (oral versus written).

2. Covered Entity

HIPAA *only directly* regulates (1) health plans, (2) health care clearinghouses, and (3) health care providers, collectively referred to as "covered entities,"[20] which bill or transmit other information electronically for purposes of health care plan administration as participating providers.[21] In today's health care industry, absent a "cash only" practice, it is safe to assume that all health care providers are regulated by this law.

Covered entities are required to adopt, implement, monitor, and maintain compliance programs to ensure that the minimal protections under HIPAA for individually identifiable health information are in place and effective.[22] Merely having a written plan is not enough. Each covered entity is responsible for having a designated compliance officer who is responsible for oversight and coordination of a compliance program, including educating and training staff and responding to complaints from patients or patient representatives.[23] Implementing, monitoring, and maintaining security measures to protect private health information against unauthorized disclosure is mandatory, and a covered entity must be prepared, in the event of a site inspection or complaint, to demonstrate its compliance with HIPAA.[24]

A "health plan" is defined as any plan that pays for health care services such as Medicare, Medicaid, CHAMPUS, any federal or state health plan (such as PEIA), private health plans (such as Mountain State Blue Cross/Blue Shield), and employer self-funded health plans.[25] Health maintenance organizations fall within this definition.[26]

Insurance under which benefits for health care coverage are secondary or incidental, such as property or casualty insurance policies, are *not* "health plans and are not directly regulated by HIPAA."[27] However, the absence of direct

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20 42 U.S.C. § 1320d-1(a) (2000); 45 C.F.R. § 160.103.

21 *See* 45 C.F.R. § 160.103.

22 *Id.* § 164.530.

23 *Id.*

24 *Id.*

25 *Id.*

26 *Id.*

27 42 U.S.C.A. § 1320d(5) (West 2003); 45 C.F.R. § 160.103.

regulation does not mean that participants in these industries will not feel the impact of the law.[28]

A "health care clearinghouse" is any entity that compiles health care information, such as computer data processing centers and billing companies which aggregate and process computerized health information.[29]

A "health care provider" is anyone who furnishes, bills, or is paid for healthcare in the normal course of business, such as doctors, nurses, therapists, hospitals, medical technicians, nursing homes, rehabilitations centers, psychologists, pharmacists, and therapists.[30]

3. Business Associates

"Business associates" are those businesses, individuals, and entities that are required, as a part of the function and/or service performed *for* a covered entity, to have access to and knowledge of individually identifiable health information.[31] Examples include malpractice insurers, accountants, certain vendors, lawyers, and collection agencies. Some vendors can be deemed business associates of a covered entity through an agreement between the covered entity and another business associate. For example, a court reporter can be deemed a business associate to an attorney who is a business associate to a hospital client. Business associate obligations pursuant to HIPAA are generally discussed in Part II of this Article. The discussion in Part II is not intended to be comprehensive. Any person or entity who believes that they may fall within the definition of business associate should evaluate their relationship with each covered entity and confirm compliance with all regulatory provisions, as applicable.

D. *Legitimate Health Information Sharing in the Ordinary Course of Business of Covered Entities Is Permissible*

Within the HIPAA triangle, interactive information sharing is necessary for the orderly operation of the health care industry. Humanistically and pragmatically, the coordination of patient care in this highly specialized era must occur without unnecessary or overly burdensome restraint or delay. Health care providers must have confidence in the freedom to consult with one another and specialists within a single facility, at other facilities, and in other states and countries, if necessary, to promote the optimal outcome for a given patient's clinical situation.

From a societal perspective, there is an expectation among patients and significant others (spouses, partners, and family members) that basic communi-

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28 *See infra* Parts IV through VIII.

29 42 U.S.C. § 1320d(2) (2000); 45 C.F.R. § 160.103.

30 42 U.S.C. § 1320d(3); 45 C.F.R. § 160.103.

31 45 C.F.R. § 160.103.

cation occurs with them as they anxiously await news regarding care, treatment, options, and outcomes. In the experience of these authors, the seed of litigation is often fertilized by the absence of a desired or expected communication. Lost expectancies trigger emotional overreaction by even the most well-balanced person.

Economically, covered entities cannot survive without federal and state sponsored participating provider contracts and private third-party reimbursement programs. Individually identifiable health information must be given to payers in order to process payment claims. All businesses have to be paid to keep the doors open. Covered entities cannot survive in a litigious environment without the ability to defend against claims of negligence or malpractice using the information in records maintained in the ordinary course of operations. The examples of economic domino effect are countless.

Legalistically, discussion of a third party's confidential health information by health care providers (or their employees) over a cup of coffee in a local restaurant is inappropriate and may be outrageous.[32] Breach of confidentiality as a common-law cause of action is recognized in every state. These common-law causes of action are not abrogated by HIPAA.

HIPAA provides a national floor for the protection of privacy interests pursuant to Congress' right to control interstate commerce, and to promote, Equal Protection, Due Process, and First Amendment protections.[33] HIPAA was a reaction to out-of-control private information dissemination. The Secretary of Health and Human Services has specifically cited numerous examples of privacy breaches, just a few of which are quoted here:

> A Michigan-based health system accidentally posted the medical records of thousands of patients on the Internet.
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> A Utah-based pharmaceutical benefits management firm used patient data to solicit business for its owner, a drug store.
>
> An employee of the Tampa, Florida health department took a computer disk containing the names of 4,000 people who had tested positive for HIV, the virus that causes AIDS.
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> The health insurance claims forms of thousands of patients blew out of a truck on its way to a recycling center in East Hartford, Connecticut.

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[32] *See generally* Judy E. Zelin, Annotation, *Physician's Tort Liability for Unauthorized Disclosure of Confidential Information*, 48 A.L.R.4TH 668 (1986).

[33] U.S. CONST. art. I, § 8, cl. 3; U.S. CONST. amend. XIV; U.S. CONST. amend. I.

A patient in a Boston-area hospital discovered that her medical record had been read by more than 200 of the hospital's employees.

A Nevada woman who purchased a used computer discovered that the computer still contained the prescription records of the customers of the pharmacy that had previously owned the computer. The pharmacy database included names, addresses, social security numbers, and a list of all the medicines the customers had purchased.

A speculator bid $4000 for the patient records of a family practice in South Carolina. Among the businessman's uses of the purchased records was selling them back to the former patients.

In 1993, the Boston Globe reported that Johnson and Johnson marketed a list of 5 million names and addresses of elderly incontinent women.

A few weeks after an Orlando woman had her doctor perform some routine tests, she received a letter from a drug company promoting a treatment for her high cholesterol.

A banker who also sat on a county health board gained access to patients' records and identified several people with cancer and called in their mortgages.

A physician was diagnosed with AIDS at the hospital in which he practiced medicine. His surgical privileges were suspended.

A candidate for Congress nearly saw her campaign derailed when newspapers published the fact that she had sought psychiatric treatment after a suicide attempt.

A 30-year FBI veteran was put on administrative leave when, without his permission, his pharmacy released information about his treatment for depression.

Consumer Reports found that 40 percent of insurers disclose personal health information to lenders, employers, or marketers without customer permission.[34]

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[34] Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462, 82,467-68 (Dec. 28, 2000) (to be codified at 45 C.F.R. pts. 160, 164) (citations omitted).

No matter how or why an improper disclosure of private, personal health information is made, the potential or actual harm to the individual is the same. In the face of societal information-sharing evolution, the potential benefits and the real risks and occurrences of harm necessitate immediate and consistent application of all privacy laws.

E. Minimal Informed Consent Is Required from the Patient/Patient Representative Regarding Uses of Private Information Before Treatment

Generally speaking, but not as an absolute rule, under HIPAA, a health care provider may not disclose individually identifiable health information without the express consent of the person who is the subject of the information or that person's duly appointed legal representative or surrogate health care decision maker. Permitted disclosures and exceptions to this general rule are specifically defined in the regulations. When consent is necessary, express consent has to be obtained prior to the use or disclosure of individually identifiable health information for purposes including that of treatment, payment, or health care operations.[35]

"Consent" then, extends beyond the common-law requirement of informed consent for treatment[36] and into the realm of releasing health information even if for coordination of treatment with other providers, payment processing, or renting necessary medical equipment for use in a certain person's care. For a written consent to release information to be in compliance, the covered entity is obligated to disclose to the patient potential and actual intended uses of individual health information. For instance, the consent must authorize the covered entity to make disclosures necessary to carry out "treatment, payment, or health care operations."[37]

Consent should not be confused with "authorization."[38] The regulatory requirements for written authorization prior to disclosure of private health information are even more specific than those for written consent.[39] Except in the event of an emergency, the consent to release information must be obtained before information sharing in the context of delivering care and documenting the same. Authorizations to disclose information, generally, come into play after the treatment has been given and the patient permits disclosure of information for other than treatment payment or the health care operations of the provider.

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35 45 C.F.R. § 164.506(b)-(c) (2003).

36 *See* Cross v. Trapp, 294 S.E.2d 446 (W. Va. 1982).

37 45 C.F.R. § 164.506(c)(1).

38 Since "consent" is not synonymous with the "written authorization" for the disclosure of health information for other purposes, an entire section of this Article is devoted to written authorizations *infra* Part II.G.

39 *Compare* 45 C.F.R. § 164.506, *with id.* § 164.508.

Because of the administrative difficulties in oversight and implementation for covered entities, and since there is no harm in doing so, it is proper for a covered entity to incorporate the regulatory requirements for an authorization into any consent. The requirements for a valid authorization which may also be used in a consent are as follows: disclosure of the individual's right to refuse consent or to restrict the uses of health information,[40] disclosure of an individual's right to revoke consent at any time,[41] disclosure of how the individual health information may be disclosed and to whom it may be disclosed,[42] and a time limit (expiration date) for its validity.[43]

A consent or an authorization is invalid if

(a) by its own date and terms it has expired;[44]

(b) it has not been completed correctly;[45]

(c) it has been revoked and the covered entity has knowledge of the revocation;[46] or

(d) any information in a consent authorization is false.[47]

F. *There Is No New Federal Tort/Cause of Action Under HIPAA as to Covered Entities or Business Associates*

The Privacy Standards do not create a new, federal cause of action in tort or contract. The Office of Civil Rights ("OCR") is charged with enforcement of the Privacy Standards. Enforcement includes conducting random unannounced compliance surveys of covered entities.[48]

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40 *Id.* § 164.508(c).

41 *Id.* § 164.508(c)(2).

42 *Id.* § 164.508(c)(2)(iii); *id.* § 164.508 (c)(1)(ii).

43 *Id.* § 164.508(c)(v).

44 *Id.* § 164.508(b)(2).

45 *Id.*

46 *Id.* This is consistent with West Virginia statutory provisions regarding consent and revocation of consent. *See id.* §§ 16-9-2 (revocation of consent for anatomical gift); *id.* § 16-30C-8 to -9 (revocation of consent for do not resuscitate order); *id.* § 27-4-4 (revocable nature of voluntary admission for mental health treatment).

47 45 C.F.R. § 164.508(b)(2)(v).

48 A notable exception to the HIPAA disclosure prohibitions are whistleblowing provisions by patients and employees of covered entities. *See id.* § 164.502(j)(1)-(2)(ii); *infra* Part VI.A.

Federal regulators encourage informal resolution of patient complaints by individual covered entities through their privacy officers.[49] If, however, the OCR finds a covered entity in violation of HIPAA, the covered entity may face a continuum of civil and criminal penalties up to and including loss of its government participating provider contract/standing.[50]

Notwithstanding, HIPAA does grant to patients certain minimal assurances with respect to the sharing of individual health information. One minimal assurance is established by the threshold requirement of consent and/or authorization that specifically enumerates what information may be disclosed by the covered entity and the circumstances of such disclosure. While HIPAA does not create a federal cause of action, breach of its minimal assurances provisions may serve as an evidentiary basis for civil tort recovery in accordance with established state law recognizing the same as bona fide causes of action. [51]

HIPAA requires covered entities to maintain sufficient records to be able to account to an individual and the OCR of some information disclosures by the covered entities and their business associates.[52] Covered entities do not have to account for disclosures made to carry out treatment, payment, and healthcare operations.[53] Nor are they required to account for incidental disclosures,[54] disclosures made to the patient or the patient's representative, disclosures to law enforcement as required by law, disclosures compelled by court order, or disclosures made for compliance with certain healthcare oversight agency activities.[55]

HIPAA does not regulate business associates.[56] It also does not create a cause of action against business associates. The OCR cannot bring an enforcement action against a business associate. However, business associates, in order to be afforded the economic benefit of their relations with covered entities, must comply with the law by contractually agreeing with each covered entity with which they do business to implement safeguards to prevent unauthorized or inappropriate disclosures.[57] In this regard, business associates are required to maintain records of disclosures in order to enable the corresponding covered

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49 45 C.F.R. § 160.312 (2003).

50 42 U.S.C. § 1320d-5(a) (2000) (imposing a penalty of $100 per violation with a maximum of $25,000); *id.* § 1320d-6(a) (stating that willful violations may result in imprisonment of up to five years); 42 C.F.R. § 160 (2003) (civil penalties and procedures for investigations).

51 *See infra* Part IV.

52 45 C.F.R. § 164.528.

53 *Id.*

54 Incidental disclosures include, for instance, when a copier repairperson sees a page of a medical record on a copy machine that is being repaired.

55 45 C.F.R. § 164.528.

56 *Id.* § 160.102-103.

57 *Id.* § 164.504.

entity to account for the business associate's disclosures.[58] Business associates, for instance could face liability exposure for failure to meet their contractually agreed upon obligations.

G. *Sharing of Individually Identifiable Health Information Pursuant to a Valid Authorization Is Permissible*

Traditionally in litigation, an efficient means to obtain health information has been by written authorization, executed by the patient or her representation, for release of medical records and medical data.[59] This avenue still exists.

The Privacy Standards provide specific guidance regarding the constituent requirements of a valid authorization.[60] An authorization must contain the following: (1) a "specific" and "meaningful" description of the information authorized to be released; (2) the name or a description of the person or "class of persons" authorized to disclose information (i.e. either the name of the health care provider or a description such as "hospitals," "clinics," etc.); (3) the name or a description of the person or "class of persons" to whom the information can be disclosed (i.e. an attorney, the Prosecutor's Office, the Social Security Administration, etc.); (4) a description of the purpose for which the disclosed information will be used (i.e. litigation, law enforcement investigation, benefits determination, etc.); (5) an identified expiration date or event (i.e. "12 months from the date of execution"); (6) notice to the patient of his/her right to revoke the authorization and how to revoke the authorization; (7) notice that the released information may be re-disclosed; and (8) notice that the patient has the right to obtain a copy of the authorization.[61] Failure to contain these eight provisions renders the authorization invalid.[62]

As discussed *infra*, the Privacy Standards distinguish "psychotherapy notes" from all other private health information governed by HIPAA. The authorization requirements for release of psychotherapy notes slightly differ from other categories of information.

"Psychotherapy notes" are those notes recorded (in any medium) by a mental healthcare professional (i.e. psychiatrists, psychologists, social workers, licensed counselors, etc.) that document or analyze the contents of conversations during private counseling sessions or group/joint/family counseling sessions.[63] Authorizations for release of psychotherapy notes cannot be combined with au-

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58 *Id.*

59 W. VA. CODE § 16-29-1 (2003).

60 45 C.F.R. § 164.508.

61 *Id.*

62 *Id.*

63 *Id.* § 164.501.

thorizations for release of any other healthcare information.[64] A separate and conspicuously worded release for psychotherapy materials must be used.

H. *Legitimate Law Enforcement Activities Must Be Conducted Within HIPAA's Requirements or Covered Entities Cannot Disclose*

HIPAA provides structured guidance to covered entities regarding what has become the inconsistent, confusing, conflicting, and often times competing ethical and legal issues concerning the privacy interests of accused individuals, convicted criminals, victims of crime, and victims of domestic violence and elderly abuse. The Privacy Standards enumerate situation-specific parameters for disclosure, balancing privacy interests with public welfare, safety, and health and the legitimate furtherance of law enforcement activities, to promote an orderly society.[65] Involved professionals should be cognizant of the fact that if HIPAA is silent, state law governs.

For prosecutors and courts, an issue for close circumspection is the primary interests of an accused or incarcerated/convicted person versus a victim. Particularly in context with the USA PATRIOT Act,[66] ongoing questions will be presented for resolution as to whether privacy and due process rights are lessened or weakened because of an individual's status as a suspect, accused, convict, or for the broad interests of national security and public health, welfare, and safety.[67]

In this regard, public defenders, prosecutors, and all those impacted by the criminal judicial system should take heed of the following Executive Order entitled *To Protect the Privacy of Protected Health Information in Oversight Investigations*, issued by former President William J. Clinton prior to the catastrophic events of September 11, 2001, and prior to the effective date of the final Privacy Standards:

> It shall be the policy of the Government of the United States that law enforcement may not use protected health information concerning an individual that is discovered during the course of health oversight activities for unrelated civil, administrative, or

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64 *Id.* § 164.508(b)(3)(ii).

65 *Id.* § 164.512; *see infra* Part IV.

66 Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT Act) Act of 2001, Pub. L. No. 107-56, 115 Stat. 272 (2001) (codified as amended in scattered sections of U.S.C.A.).

67 *See, e.g.*, John E. Branch III, *Statutory Misinterpretation: The Foreign Intelligence Court of Review's Interpretation of the "Significant Purpose" Requirement of the Foreign Intelligence Surveillance Act*, 81 N.C. L. REV. 2075 (2003); David Cole, *Their Liberties, Our Security: Democracy and Double Standards*, 31 INT'L J. LEGAL INFO. 290 (2003); Rachel V. Stevens, Center for National Security Studies v. United States Department of Justice*: Keeping The USA Patriot Act in Check One Material Witness at a Time*, 81 N.C. L. REV. 2157 (2003).

> criminal investigations of a non-health oversight manner, except when the balance of relevant factors weighs clearly in favor of its use. That is, protected health information may not be so used unless the public interest and the need for disclosure clearly outweigh the potential for injury to the patient, to the physician patient relationship, and to the treatment services. Protecting the privacy of patients' protected health information promotes trust in the health care system. It improves the quality of health care by fostering an environment in which patients can feel more comfortable in providing health care professionals with accurate and detailed information about their personal health.[68]

All federal and state prosecutors and defense attorneys must be familiar with HIPAA and the restrictions imposed on law enforcement's investigative powers as well as those that exist under state law and are not otherwise pre-empted. The exclusionary, evidentiary, and sanction consequences of improperly obtained information is well known and well developed in federal and state common-law and jurisprudential analysis of constitutional protections.

I. Discovery of Individually Identifiable Health Information May Also Be Made Pursuant to an Order, Subpoena, or Discovery Request

The drafters of the Privacy Standards provided covered entities with the means of disclosure in response to legitimate and necessary operations of the judicial system. One misperception that exists is that HIPAA has no application once a lawsuit or legal action is pending. To the contrary, party and non-party covered entities still must perform certain analytical measures intended to prevent abuse of power by officers of the court and those in uniform. The analytical framework relating thereto is discussed in Parts V and VIII of this Article.

III. DEFINITIONS

A definitional framework is necessary to understand and apply HIPAA and its intertwined, interrelating provisions.

A. Covered Entities

The Privacy Standards apply to covered entities that engage in electronic transactions which include individually identifiable health information. As previously stated, a "covered entity" is a health plan; a health care clearinghouse; or a health care provider that transmits any health information in electronic form in connection with a transaction covered by this subchapter.[69]

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[68] Exec. Order No. 13,181, 65 Fed. Reg. 81,321 (Dec. 20, 2000).

[69] 45 C.F.R. § 160.102(a)(1) (2003); *see also id.* § 160.103 (defining health plan, health care

Any insurance plan that bills for or is paid for health care in the ordinary course of business is subject to these regulations. Examples include collection companies that collect bad debts on behalf of a health care provider and third-party private health insurers.

The following "excepted benefits programs" are *not* health plans: (1) plans for coverage only for accident, disability income insurance, or any combination thereof, including Social Security Disability Program; (2) plans for coverage issued as a supplement to liability insurance; (3) liability insurance plans, including general liability insurance and automobile liability insurance; (4) worker's compensation[70] or similar insurance plans; (5) automobile medical payment insurance; (6) credit-only insurance; (7) coverage for on-site medical clinics; and (8) other similar insurance coverage under which benefits for medical care are "secondary or incidental other insurance benefits."[71]

B. Transaction

A "transaction" is the transmission of health information between two parties for the purpose of carrying out financial or administrative activities related to health care.[72] Common examples of financial transactions include pre-certification exchanges, payment and remittance exchanges, claim status review, and submission of claims for payment.[73]

C. Health Care Provider

A "health care provider" is defined in the Privacy Standards as: "a provider of services . . . a provider of medical or health care services . . . *and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business*."[74]

"Health care provider," under the plain meaning of this language, means doctors, nurses, physical therapists, aides, volunteer emergency medical technicians, medical clinics, and any provider of health care services. It also, and importantly, applies not only to participating providers, but also to entities such as disability insurers who provide work hardening evaluations, individual providers of rehabilitation services, counselors, and other licensed professionals who provide services through Employee Assistance Programs.

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clearinghouse, and health care provider).

70 *See infra* Part IV.B.11.

71 45 C.F.R. § 160.103.

72 *Id.*

73 *Id.*

74 *Id.* (emphasis added).

D. *Individually Identifiable Health Information*

"Individually identifiable health information" is a long series of words that simply means certain data and information relating to payment for health care services as well as information regarding mental, physical, and emotional condition of a patient. By definition it includes any information, whether oral or recorded in any form or medium, that:

> (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
>
> (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and [t]hat identifies the individual.[75]

Every covered entity is obligated to protect the confidentiality of individually identifiable health information. Through contractual covenants, every business associate is obligated to preserve information within the scope and purpose of the business associate/covered entity relationship.[76]

E. *Business Associates*

Logically speaking, every covered entity historically has worked with third-party vendors, attorneys, insurers, processing companies, medical record copying services, medical record shredding and storage services, transcription services, and other members of various industries in order to engage in the orderly delivery of health care. Many business associates are professionals governed by professional ethical codes and licensure laws. However, where applicable, different professions have different ethical codes. Not all professions have effective enforcement mechanisms. Some have no ethical enforcement procedures at all. Most importantly, ethical codes do not have the force and effect of law.[77] There is no national licensure law. There is no applicable national professional ethical rule that has the force and effect of law.

Without a regulatory mechanism establishing a minimal and uniform set of obligations for these important non-covered entities that regularly have access to protected health information, HIPAA would be meaningless. No covered entity could comply with HIPAA because of the dependent relationships with business associates without recognition of and creation of this vehicle for disclosure.

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75 *Id.*

76 *Id.*

77 *See* Birthisel v. Tri-Cities Health Serv. Corp., 424 S.E.2d 606 (W. Va. 1992).

In recognition of the same, the "business associate" affiliation is exempted from the Privacy Standards provided that a business associate contractually agrees with the covered entity to comply with the law. A "business associate" is a person (entity business, etc.) that:

> (i) On behalf of such covered entity or of an organized health care plan arrangement . . . in which the covered entity participates, but other than in the capacity of such covered entity or arrangement, performs, or assists in the performance of:
>
> (A) A function or activity involving the use or disclosure of individually identifiable information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or
>
> (B) Any other function or activity regulated by this subchapter; or
>
> (ii) Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation . . . management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate or such covered entity or arrangement, to the person.[78]

Individuals or entities who have incidental access to individually identifiable health information are not business associates.[79] A janitor, copier repair person, or maintenance person is not a business associate.

As stated, but worth repeating, business associates are not directly regulated by the Privacy Standards. The Secretary of Health and Human Services does not have standing to bring a direct enforcement action against a business associate because there is no underlying participating provider contract or electronic transaction between a business associate and the government.[80]

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[78] 45 C.F.R. § 160.103.

[79] *See id.*

[80] Beyond the scope of the subject matter of this Article includes False Claims Act, wire fraud, and other such criminal violations a business associate could be subjected to which arise out of failure to comply with a business associate agreement, depending upon the context and specific facts presented.

Regarding the covered entity's written contract with a business associate[81] by implication, each individual patient is the intended third-party beneficiary of that contract. Privacy obligations are imputed to business associates through those contracts. A contract between the covered entity and a business associate must:

> (i) Establish the permitted and required uses and disclosures of such information by the business associate. The contract may not authorize the business associate to use or further disclose the information in a manner that would violate the requirements of this subpart . . . .
>
> . . . .
>
> (ii) Provide that the business associate will:
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> . . . .
>
> (D) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from, or created or received by the business associate on behalf of, the covered entity agrees to the same restrictions and conditions that apply to the business associate with respect to such information; . . . .[82]

One example of the complexity of the business associate covered entity is aptly described in the following:

> A health care provider, such as a hospital, has a professional liability policy with an insurer. The insurer will be considered a "business associate." When the health care provider is sued, the insurer hires defense counsel to handle the case. Defense counsel, in turn, hires court reporters for depositions and a record copy service to subpoena and copy medical records. The law firm is a subcontractor under the regulations, and the health care provider must ensure the firm agrees in writing to the same privacy restrictions as the insurer. If the health care provider hires the law firm directly, the firm is a "business associate." The court reporter and record copy service are then subcontractors. The health care provider must see that they agree to the same privacy protections as the law firm.

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81 45 C.F.R. § 164.504(e) (2003).

82 *Id.* § 164.504(e)(2)(i) – (ii).

> The health care provider is liable if the business associate does not comply with the contract, and it knows the associate is not complying and does not take reasonable steps to cure the breach or end the violation. And if the health care provider knows a subcontractor of the business associate is not complying, the provider is liable for violating the Privacy Regulations.[83]

A few suggestions regarding the manner in which to address the business associate issue procedurally in litigation are discussed in Part IX.

F. Personal Representative

A "personal representative" refers to legal representatives of a health care recipient. A personal representative has the right to access personal health information on behalf of a patient.

A personal representative for an adult or emancipated minor is a person who is authorized by law "to act on behalf of" the adult or emancipated minor "in making decisions related to health care."[84] The phrase "as authorized by law" is defined by individual state laws. Under West Virginia law, for example, a personal representative is an individual authorized by (1) a medical power of attorney document,[85] (2) by selection as a health care surrogate,[86] or (3) by appointment as a guardian.[87]

Regarding unemancipated minors, HIPAA defers to existing federal and state law for governing definition. A personal representative for an unemancipated minor is a person, such as a "parent, guardian, or other person acting in *loco parentis*," who is authorized by law to act on behalf of the minor in making healthcare decisions.[88] Exceptions to the authority of a parent, guardian, or other person acting in *loco parentis* to access health information of a minor are dependent upon existing state and federal laws, including case law.[89] In its comments on the Privacy Standards, the Department of Health and Human Services recognized the value placed upon parental decision-making for unemancipated minors and left the regulation of this area within the realm of state law.[90]

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83 Richard L. Antognini, *The Law of Unintended Consequences: HIPAA and Liability Insurers*, 69 DEF. COUN. J. 296, 300 (2002).

84 45 C.F.R. § 164.502(g)(2).

85 W.VA. CODE §§ 16-30-3, -6, -10 (2003).

86 *Id.* §§ 44A-1-2, 44A -3-1, 49-6B-1 to –4.

87 *Id.* §§ 16-30-6, -10.

88 45 C.F.R. 164.502(g)(3); *see* Belcher v. Charleston Area Med. Ctr., 422 S.E.2d 827 (W. Va. 1992).

89 *See* Parts III.F., VII, VIII, and IX.C.

90 *See* Standards for Privacy of Individually Identifiable Health Information, 67 Fed. Reg.

IV. POTENTIAL CAUSES OF ACTION IN WHICH HIPAA MAY BE PRESENTED AS A BASIS/UNDERLYING THRESHOLD FOR A CLAIM

Given the foregoing, while not an exhaustive list, examples of federal and state liability and legal challenges for HIPAA violations may be briefly overviewed as follows:

- Health care provider enforcement action under HIPAA with resulting civil and criminal penalties;
- Common-law breach of contract liability for business associates and subcontractors for failure to comply with express requirements;
- Tort of outrage, invasion of privacy under West Virginia common law for a covered entity's disclosure that does not comply with the express terms of a consent or authorization;
- Unfair Claims Practices Act exposure if an insurer business associate or subcontractor jeopardizes the defense by violating the Act such as through the failure to invoke necessary privileges to maintain the attorney client, quasi attorney client, and attorney work product privileges;
- Federal RICO (Racketeering Influenced and Corrupt Organizations Act) by a covered entity making claims that are of a knowing violation of HIPAA; and
- Writs of mandamus and habeas corpus by prisoners alleging violation of rights and interests while incarcerated.

V. SPECIFIC ISSUES AND APPLICATION FOR THE WEST VIRGINIA LEGAL SYSTEM

Courts have already addressed challenges with respect to the applicability of HIPAA in either affording or depriving individuals of constitutional rights and protections.[91] Regulations impacting the courts in civil, worker's compensa-

53,182 (Aug. 14, 2002) (to be codified at 45 C.F.R. pts 160, 164).

[91] *See, e.g.*, S.C. Med. Ass'n v. Thompson, 327 F.3d 346 (4th Cir.) (upholding the constitutionality of HIPAA), *cert. denied*, 124 S. Ct. 464 (2003); Sherman v. Jones, 258 F. Supp. 2d 440 (E.D. Va. 2003) (claiming wrongful disclosure of HIV status to other inmates); The Ass'n of Am. Physicians & Surgeons, Inc. v. U.S. Dep't of Health & Human Serv., 224 F. Supp. 2d 1115 (S.D. Tex. 2002) (discussing a declaratory judgment action seeking determination regarding application of privacy rules); United States *ex rel.* Stewart v. La. Clinic, No. 99-1767, 2002 WL 31819130 (E.D. La. Dec. 12, 2002) (discussing a *qui tam* related to investigation and disclosure of protected information); Elec. Data Sys. Corp. v. Miss. Div. of Medicaid, 853 So. 2d 1192 (Miss. 2003) (evaluat-

tion, and criminal law contexts as set forth in 45 C.F.R. §§ 164.510 and 164.512 are discussed in this Part. First, the standards are presented. Second, the standards and requirements are discussed in context with applicable West Virginia common and statutory law.

A. *45 C.F.R. § 164.510: "Emergency Circumstances" Permission to Disclose Limited Information*

The "emergency circumstances" exception addresses permissible disclosures, without consent or authorization, in the event of a bona fide emergency. It is important to understand a general premise of HIPAA: if a prior written consent or authorization has not been obtained, a covered entity cannot disclose even the individual's presence at its facility. Health care providers, however, are authorized to exercise professional judgment concerning the extent of information provided to family and significant others.[92]

The "emergency circumstances" exception entitles a covered entity to disclose certain information regarding the patient.[93] In the event of a bona fide emergency, a covered entity may publish an individual's name, location in the facility (such as room number), his/her condition in general terms (without disclosure of the nature of his/her specific medical information), and religious affiliation.[94] These general guidelines also apply in disaster relief circumstances.[95] Grand jury investigations, law enforcement investigations, and covert detective investigations are not emergency circumstances and a covered entity will not recognize an attempt to obtain individual information in those contexts in exclusive reliance upon an inquiry based upon an attempt to invoke this exception.

B. *45 C.F.R. § 164.512: "Uses and Disclosures for Which an Authorization or Opportunity to Agree or Object Is Not Required"*

This regulation's caption is somewhat misleading by implying that it addresses uses and disclosures of individually identifiable health information by a covered entity when the subject individual has not provided the authorization or has not been provided with the opportunity to agree to or reject the disclosure. As discussed below, however, while a valid authorization and/or an opportunity for the subject individual to object to disclosure is not required, certain findings

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ing qualified protective orders issued in processing claims matter); Tapp v. Texas, 108 S.W.3d 459 (Tex. Crim. App. 2003) (objecting to the release of blood alcohol test results in response to grand jury subpoena).

92 45 C.F.R. § 164.510(b)(3).

93 *Id* § 164.510(a)(3).

94 *Id.*

95 *Id.* § 164.510(b)(4).

must be apparent in the record before a covered entity may make disclosure under this regulation.

1. Standard No. 1: Required by Law

A covered entity may disclose protected health information to the extent that the use or disclosure is compliant with the requirements of a specific law. [96] One practical application of this standard includes the necessary disclosure in discovery responses, production, and testimony to defend against a case of malpractice or a complaint against a professional's license.[97]

Specific and enumerated circumstances as described in the standards are mandatory disclosures concerning: (1) a victim of abuse, neglect, or domestic violence;[98] (2) a disclosure for judicial and administrative proceedings;[99] or (3) a disclosure for law enforcement purposes.[100]

a. Victim of Abuse, Neglect, or Domestic Violence

i. Victim of Abuse or Neglect

HIPAA authorizes disclosure of personal health information for the reporting of actual or suspected abuse and neglect. In general there is no mandatory requirement that a covered entity obtain an authorization from the patient-victim or the patient-victim's personal representative before authorized disclosure pursuant to a mandatory reporting requirement under governing law. The reporting of actual or suspected abuse and neglect of children is distinguished from the reporting of actual or suspected abuse and neglect of an adult. In the case of the latter, notice to the adult victim may be required under certain circumstances to allow the adult victim the opportunity to object, in whole or in part, to the release of his/her protected health information, to the extent mandated by applicable state law.

Regarding victims of abuse or neglect, HIPAA's privacy disclosure requirements are straightforward. The covered entity may disclose in accordance with governing state law.[101] There is no qualification to this exception. It applies to all covered entities. The standard applies irrespective of the role the

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96 *Id.* § 164.512(a).

97 *Id.*

98 *Id.* § 164.512(c).

99 *Id.* § 164.512(e).

100 *Id.* § 164.512(f).

101 *Id.* § 164.512(c).

covered entity plays in delivery of health care versus claims processing or otherwise.[102]

West Virginia law mandates reporting by healthcare professionals (and others) of actual or suspected cases of abuse and neglect of children, incapacitated adults, and residential facility residents.[103] The Reports of Children Suspected to Be Abused or Neglected Act,[104] extends the mandatory reporting requirements for suspected cases of child abuse or neglect to classifications of professionals that may not be covered entities. The mandatory reporting requirements apply to "any medical, dental or mental health professional, christian science practitioner, religious healer, school teacher or other school personnel . . . peace officer or law-enforcement official, member of the clergy, circuit court judge, family law master, employee of the division of juvenile services or magistrate."[105] HIPAA does not apply to a non-covered entity that has a reporting obligation under West Virginia law.

The West Virginia Social Services for Adult Act[106] imposes a mandatory reporting requirement for suspected abuse of an incapacitated adult or nursing or residential facility resident upon "any medical, dental or mental health professional, christian science practitioner, religious healer, social service worker, law-enforcement officer, state or regional ombudsman or any employee of any nursing home or other residential facility."[107] Of these listed individuals, the various healthcare professionals (including social service workers), schools and school personnel, and nursing home or residential home workers come within HIPAA's definition of covered entity.[108]

None of these West Virginia statutes contain language requiring that the patient, the incapacitated adult, the resident of the residential facility or nursing home, or the patient's authorized representative (parent, guardian, healthcare surrogate, etc.) be notified by the individual making the report to law enforcement of actual or suspected abuse or neglect. Likewise, HIPAA imposes no consent, authorization or notice requirement. Obviously, by making disclosure alone, a reporting covered entity is publishing protected health information in the simplest form by disclosing that the patient is or has been under the care of the reporter.

Qualified immunity against civil liability is provided for by state law,[109] where reporting is made in good faith reliance upon the obligation to report.

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102 *See infra* Part V.B.7.

103 W. VA. CODE §§ 9-6-9, 49-6A-1 to -10 (2003).

104 *Id.* § 49-6A-2.

105 *Id.*

106 *Id.* § 9-6-9.

107 *Id.*

108 45 C.F.R. § 160.103 (2003).

109 W. VA. CODE §§ 9-6-12, 49-6A-6.

Any governing reporting requirement that mandates disclosure of individually identifiable health information[110] and to the extent that the reports are made in compliance with HIPAA and state law, entitles the reporter to qualified immunity protection.[111] Confidentiality privileges, with the exception of the attorney-client privilege, are expressly abrogated.[112] Reporting covered entities, health care providers, and law enforcement must recognize these laws that do not permit disclosure of personal health information beyond what is necessary to substantiate the reported suspicion of abuse or neglect and as required by governing state reporting laws.

ii. Domestic Violence

The West Virginia Domestic Violence Act[113] and the West Virginia Domestic Violence Prevention and Treatment Act[114] ("West Virginia Domestic Violence Acts") are not explicit in their application as to covered entities. These state laws govern rescue centers and agencies otherwise created for support and development of domestic violence intervention and prevention programs. Because of the express reference to, and therefore incorporation by reference of, the mandatory disclosure obligations of covered entities set forth in the West Virginia Missing Children Information Act,[115] the West Virginia Social Services for Adult Act,[116] and the West Virginia Reports of Children Suspected to Be Abused or Neglected Act,[117] disclosure by covered entities may occur in instances of domestic violence.[118]

The West Virginia Domestic Violence Acts do not have mandatory disclosure requirements.[119] However, the West Virginia Missing Children Information Act, Social Services for Adult Act and Reports of Children Suspected to be Abused or Neglect Act do. Since these public safety laws require reporting, cov-

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110 *Id.* § 49-6A-2 to –5.

111 *Id.* §§ 9-6-12, 49-6A-6.

112 *Id.* §§ 9-6-13, 49-6A-7.

113 *Id.* § 48-26-101 to -1102.

114 *Id.* § 48-27-101 to -1105.

115 *Id.* § 49-9-1 to -17.

116 *Id.* § 9-6-1 to -16.

117 *Id.* § 49-6A-1 to -10.

118 *Id.* § 48-26-701(a)(2)-(5).

119 45 C.F.R. § 164.501 (2003) (defining "required by law" as "a mandate contained in law that compels an entity to make a use or disclosure of protected health information and that is enforceable in a court of law").

ered entities making disclosures in conformance with those statutes must do so in a HIPAA compliant manner.[120]

Additionally, under HIPAA, covered entities may disclose protected information upon reasonable belief of domestic violence.[121] This disclosure may be to a government authority, including a social service or protective services agency under two specific circumstances.[122] These circumstances are: (1) disclosure upon consent of the individual or, as discussed in the previous paragraph, and (2) disclosure to the extent it is expressly authorized by the governing law. When either of these two circumstances are evident, disclosure still may not be made unless the covered entity has satisfied itself that one of the two following conditions are met: (1) Either, in the exercise of professional judgment of the covered entity, the disclosure is necessary to prevent serious harm to the individual victim or to potential victims, or (2) if the victim is incapacitated, information may be given to a law enforcement officer or other person authorized to receive the information provided that the information is not to be used adversely against the individual victim and the failure to disclose the information would materially and adversely impact the individual-victim.[123] The qualification that the information is not to be used adversely against the individual and the failure to disclose the information would materially and inversely impact the individual should properly cause a covered entity to pause and evaluate the consequences of disclosure.

Where disclosure is made by invoking this exception, HIPAA requires a covered entity to provide notice to the individual victim of disclosure unless making the disclosure is not in the best interests of the victim (would place him/her at risk of serious harm). No notice of disclosure is required to the victimizer even if the victimizer has the legal status of personal representative.[124] These provisions are not in conflict with West Virginia law.

Since HIPAA encourages notice to the victim, West Virginia Code section 48-26-701 offers guidance to covered entities to avoid challenges of improper disclosure. Compliance with West Virginia Code section 48-26-701 and obtaining written consent for disclosure should be considered. This can be applied in circumstances that do not apparently involve a real and immediate threat such as after initial crisis intervention.

West Virginia Code section 48-26-701(b) requires a copy of any written disclosure consent to be given to the individual giving consent. It is a good prac-

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120 *Id.* § 164.501; *id.* § 164.512(a).

121 *Id.* § 164.512(c)(i).

122 *Id.*

123 *Id.* § 164.512(c)(1)(iii)(A)-(B).

124 *Id.* § 164.512(c)(2).

tice for the form used to make disclosure to include an acknowledgement by this individual that he/she received a copy.[125]

The courts will necessarily be called upon to intervene in circumstances in which the individual victim is incapacitated or where a covered entity does not hold the professional judgment that disclosure is in the best interests of the individual and will not result in harm to the victim. If a covered entity does not hold the good faith belief that disclosure would be in the best interests of the victim of abuse, upon motion or sua sponte, a court still may enter a qualified protective order and issue a subpoena for the protected information pursuant to 45 C.F.R. § 160.512(e)(1).

As to the instances in which an individual is incapacitated, a covered entity that is subject to West Virginia Code section 9-6-9 must automatically disclose suspected abuse or neglect.[126] For those that are not subject to that law, an order complying with West Virginia Code section 48-26-701 will provide the requisite basis for publication and disclosure. To the extent that court intervention occurs, any order must include a finding that the disclosure is not to be used adversely against the victim and the failure to disclose the information would materially and adversely affect the individual victim.

2. Standard No. 2: Judicial and Administrative Proceedings

A covered entity may make disclosure of protected health information in the course of a judicial or administrative proceeding under certain circumstances. To be entitled to the exception permitting disclosure within this standard, the court and counsel must evaluate which, if any, of the express enumerated exceptions apply to the facts presented.[127]

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125 *Id.*

126 W. VA. CODE § 9-6-9 (2003) provides:

> (a) If any medical, dental or mental health professional, christian science practitioner, religious healer, social service worker, law-enforcement officer, state or regional ombudsman or any employee of any nursing home or other residential facility has reasonable cause to believe that an incapacitated adult or facility resident is or has been neglected, abused or placed in an emergency situation, or if such person observes an incapacitated adult or facility resident being subjected to conditions that are likely to result in abuse, neglect or an emergency situation, the person shall immediately report the circumstances pursuant to the provisions of section eleven of this article: Provided, That nothing in this article is intended to prevent individuals from reporting on their own behalf.
>
> (b) In addition to those persons and officials specifically required to report situations involving suspected abuse or neglect of an incapacitated adult or facility resident or the existence of an emergency situation, any other person may make such a report.

127 45 C.F.R. § 164.512(e)(1)-(2).

a. *Exception No. 1: Judicial and Administrative Proceedings*

A non-party covered entity may disclose protected health information in the course of any judicial or administrative proceeding provided that the exception is properly invoked by one of several mechanisms cloaked with the indicia of judicial or administrative authority.[128] These mechanisms include either an order which sets forth, on its face, that protected health information may be disclosed[129] or a subpoena, discovery request, or other lawful process without an order provided that "the covered entity receives satisfactory assurance" from the party seeking the information that the requesting party has made "reasonable efforts" to ensure that the individual who is the subject of the protected health information has either been given notice of the request or "that reasonable efforts have been made by such party to secure a qualified protective order that meets the requirements" of this standard.[130] This exception should be read and applied in context with Standard No. 3: Disclosures for Law Enforcement Purposes, discussed *infra*, for matters specifically dealing with grand jury subpoenas and other forms of criminal law process.

i. Exception 1A: An Order

An order must contain confidentiality restrictions regarding the dissemination within the given context and address specifically what, if any, of the information within materials ordered to be produced must be de-identified.[131] Most non-party covered entities (and in certain instances, a party covered entity) will request that the court either enter a qualified protective order that meets the requirements of this regulation or another regulation, such as those which are applicable with respect to an accused perpetrator of a crime.[132]

To comply with this standard, the dissemination may only be pursuant to a valid order. A valid order must (1) prohibit use or disclosure of the protected health information for any purpose other than the litigation or proceeding for which the information was requested and (2) mandate that the protected health information and all copies made be returned either to the covered entity or destroyed at the end of the litigation or proceeding.[133] A protective order and confidentiality acknowledgment executed by all persons to whom the protected in-

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128 If it is a party, the covered entity may rely upon and use the protected information concerning specific individual(s) or matters. *Id.* § 164.512 (e).

129 *Id.* § 164.512(e)(1).

130 *Id.*

131 "De-identified" simply means redaction of personal identifying information.

132 *See infra* Part V.B.3.a-b.

133 45 C.F.R. § 164.512(e)(1)(v).

formation is published is one manner in which to provide the necessary documentation of notice to all persons obligated to comply with the order.

ii. Exception 1B: "Satisfactory Assurance" Provisions

The provisions of the regulation that a covered entity may disclose upon "satisfactory assurance" that the party seeking the information has made reasonable efforts to ensure that the patient has been given "notice" of the requests for disclosure may be shown in a number of ways.

1. Notice

Notice may be shown by a written statement and accompanying documentation which demonstrates that the requesting party has made a good faith attempt to notify the patient in writing.[134] If the location of the patient is unknown, notice may be mailed to the individual's last known address.[135] A good faith attempt, for instance, may be by certified mail to a last known address. This notice must include sufficient information about the litigation or proceeding in which the protected health information is requested to permit the patient to raise an objection to the court or administrative tribunal in a timely manner.[136] Before the covered entity may respond to the request, the time, as provided for in the notice, for the individual to file any objections with the court or administrative tribunal must have elapsed with no objections being filed. If objections are filed, before the covered entity may produce the information, the objections must be brought on for hearing and resolved by the court or administrative tribunal with any subsequent disclosures consistent with any governing order.[137]

Counsel giving notice should inform all parties to the litigation, the court, and the covered entity of notice attempts and seek an order setting forth specific time frames for filing of objections. This order must be published by notice to the subject individual.

An alternate, efficient, and proper means to provide notice could be by issuance of a subpoena duces tecum upon the covered entity with service of the same upon the subject individual, notifying the subject individual of the date and time that production is to occur and the individual's right to object to and contest the disclosure before that date. The subpoena must be served upon the subject individual as well as upon the covered entity by a reliable means and one in which documentation of service and receipt is available to the covered entity and to the court, all in accordance with the governing law for issuance of a valid and

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134 *Id.* § 164.512(e)(1)(iii).

135 *Id.*

136 *Id.*

137 *Id.*

enforceable subpoena.[138] In West Virginia, all *Keplinger* requirements must be met absent a court order relieving the requesting party from those obligations for cause shown as provided by HIPAA.[139]

2. *Reasonable Efforts to Secure a Protective Order*

An alternate satisfactory assurance provision to notice is "that reasonable efforts have been made by [the requesting] party to secure a qualified protective order." The covered entity must receive a written statement from the requestor with accompanying documentation that shows that all parties in a dispute have entered into or are bound by an enforceable qualified protective order entered by the governing court or administrative tribunal, or that the party seeking the protected health information has moved the court or administrative tribunal for such a protective order.[140]

The subpoena avenue, however, may be the most efficient and protective manner in which a covered entity may wish to rely on before disclosing protected information. The governing court or tribunal may insist that a subpoena be served upon the subject individual if practical, even if there is a protective order, depending upon the issues presented. If there is no agreement upon a qualified protective order or the covered entity is precluded from disclosure because of the subject matter of the requested information (mental health records, HIV-related testing records, and substance abuse treatment records),[141] the subpoena process and conduction of a show-cause hearing would include provision of notice to the subject individual. This process confers with both West Virginia and federal regulation.[142] In circumstances in which the covered entity receives a subpoena without adequate assurances that the individual has received notice or the subpoena is for the disclosure of mental health, HIV, and/or substance abuse treatment records, the covered entity may send a notice to the subject individual prior to disclosure, send a written objection to the issuing party, file a motion to quash with the court, and proceed to secure an order.

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138 *E.g.*, Keplinger v. Va. Elec. & Power Co., 537 S.E.2d 632 (W. Va. 2000).

139 45 C.F.R. § 164.512(e)(1)(iii).

140 *Id.* § 164.512(e)(1)(ii)-(iii).

141 A subpoena, consent or written authorization, or court order is insufficient for mental health, HIV, or substance abuse treatment records. *See* W. VA. CODE §§ 16-3C-3, 27-3-1 (2003); *see also* 42 C.F.R. pt. 2 (2003).

142 *See* W. VA. CODE §§ 16-3C-3, 27-3-1; *see also* 42 C.F.R. pt. 2.

3. Standard No. 3: Disclosures for Law Enforcement Purposes[143]

There are several provisions within 45 C.F.R. § 164.512 that may relate to or impact law enforcement related activities. However, there is only one standard that bears this specific title. The standard with this title provides that certain disclosures of individual health information may be made by covered entities to law enforcement officials if certain conditions exist.[144]

a. Permitted Disclosure No. 1: Disclosure Pursuant to Process and as Otherwise Required by Law

There are two express circumstances addressed by the Privacy Standards within this category.[145]

i. Permitted Disclosure 1A: Reporting of Wounds or Other Physical Injuries[146]

Disclosure may be made without consent or authorization where applicable law mandates the reporting of wounds or other physical injuries such as communicable disease and violent death. A covered entity is obligated to make reports to comply with the law and in furtherance of overall public health, welfare, and safety.

Disclosures permitted under these circumstances are limited to the express disclosure requirements of an applicable governing public health and safety law such as communicable disease statutes.[147] Additionally, disclosure is permitted in accordance with mandatory disclosures concerning victims of abuse, neglect, or domestic violence, as discussed above.[148]

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[143] A "law enforcement official" is defined by the regulation as:

> [A]n officer or employee of any agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to:
>
> (1) Investigate or conduct an official inquiry into a potential violation of law; or
>
> (2) Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

45 C.F.R. § 164.501.

[144] *Id.* § 164.512(f).

[145] A court must carefully note the language of the exceptions. Some of the exceptions, such as this one, apply to covered entities. Other exceptions are limited in their application to only "health care covered entities." The distinction, as applicable, is addressed in this reference tool.

[146] 45 C.F.R. § 164.512(f)(1)(i).

[147] *Id.* § 164.512(b).

[148] 45 C.F.R. § 164.512(c); *see also supra* Part V.B.1.

ii. Permitted Disclosure 1B: Reporting with and as Limited by the Relevant Requirements of a Court Order or Request Bearing the Indicia of Judicial Authorization[149]

All covered entities are authorized by this exception to make disclosure without consent pursuant to a valid and lawful court order, court-ordered warrant, subpoena or summons, grand jury subpoena, or administrative request as discussed above. In order for the court order or request bearing the indicia of judicial authorization to withstand scrutiny, it must evidence that a judicial determination has been made that, "(1) [t]he information sought is relevant and material to a legitimate law enforcement inquiry, (2) the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought, and (3) de-identified information cannot reasonably be used."[150] In order to make these findings, the requesting party and covered entity must be prepared to present a proper record to the court. Any published order, warrant, or otherwise should contain evidence that the court has made findings addressing these three criteria.

The courts and law enforcement officials must be cognizant of restrictions imposed upon covered entities and disclosures of information pertaining to individuals receiving mental health and/or substance abuse treatment. These restrictions, discussed in greater detail in Part II, prohibit, in certain circumstances, the release of information, including whether a patient is located in the treatment facility. A subpoena or warrant in those circumstances is insufficient, and an order from a court of competent jurisdiction must be obtained prior to any disclosure by a covered entity.[151]

While not required by this exception, the court may exercise its protective order authority and likewise require the return or destruction of all copies of the protected health information produced pursuant to this standard, unless it is necessary to maintain the materials as evidence in support of a prosecution, jury conviction, or otherwise.

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149 45 C.F.R. § 164.512(f)(1).

150 *Id.*

151 W. VA. CODE § 27-3-1 (2003); Allen v. Smith, 368 S.E.2d 924 (W. Va. 1998); *see also* 42 C.F.R. pt. 2 (2003).

b. Permitted Disclosure No. 2: Identifying or Locating a Suspect, Fugitive, Material Witness, or Missing Person

A covered entity may, subject to certain qualifications, disclose limited protected health information in response to a law enforcement official's request made for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.[152] The qualifications applicable to this disclosure are restricted as to the information that the covered entity may provide in that context.

The covered entity is permitted to disclose only the following information regarding the suspect, fugitive, material witness, or missing person:

(A) Name and address;

(B) Date and place of birth;

(C) Social security number;

(D) ABO blood type and Rh factor;

(E) Type of injury;

(F) Date and time of treatment;

(G) Date and time of death, if applicable; and

(H) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.[153]

Disclosure may be without court order and may be accomplished verbally or by production of de-identified documents limited to containing the foregoing eight subject matters.[154]

There is one exception under HIPAA to this restriction. If the circumstances include infliction of wounds or physical injuries subject to a mandatory legal reporting requirement, such as abuse or neglect, or an order, warrant, subpoena, summons, or other legal process as defined in Permitted Disclosure No. 1 exists, then the covered entity may respond in accordance with the language of

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152 45 C.F.R. § 164.512(f)(2).

153 *Id.* § 164.512(f)(2)(i)(A)-(H).

154 *Id.*

the applicable permitted disclosure standard and any qualified protective order properly issued pursuant thereto.[155]

c. *Permitted Disclosure No. 3: DNA Analysis, Dental Records, Typing, Samples, and/or Other Body Fluids or Tissues*[156]

As to the standard "Disclosures for Law Enforcement Purposes," this section defines the parameters of the publication by covered entities of uniquely identifying DNA and other body fluid testing information. This regulation applies only in the context of locating and/or identifying a suspect, fugitive, material witness, or missing person.[157] The covered entity may only disclose those eight subject matters listed above.[158] The covered entity may not make disclosure, for instance, that it has DNA analysis in its possession. When in possession of unique body fluid analysis that may be used to identify a person, the covered entity may only release the ABO blood type and Rh factor of that suspect, fugitive, material witness, or missing person.[159] This will lead to further legal investigative process for securing original evidence to link the fugitive/criminal to a crime. The regulation does not prohibit disclosure, if proper legal process is used in those circumstances, such as an order pursuant to lawful authority of a court.[160] Covered entities still must be cognizant of common-law duties to preserve original evidence and avoid spoliation exposure.[161]

It is foreseeable that a covered entity may be in the possession of original evidence such as a bullet fragment that bears the DNA and other uniquely identifying information about an accused. This regulation does not authorize the covered entity to disclose the fact that this original evidence is in its possession. Subparagraphs A through H of 45 C.F.R. § 164.512(f)(2) does not include as an enumerated item identifying physical evidence as distinguished from identifying physical characteristics. This subparagraph does not incorporate by reference the permitted disclosures within 45 C.F.R. § 164.512(f)(1), that being a court order, warrant, subpoena or otherwise.

It is suggested by these authors, however, that this regulation is very limited in scope. It is limited to the initial identification or location activities concerning a suspect, fugitive, material witness, or missing person. It does not apply

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155 *Id.* § 164.512(f)(2); *see also supra* Part V.B.3.a.

156 45 C.F.R. § 164.512(f)(2)(ii).

157 *Id*

158 *Id.*

159 *Id.*

160 *See supra* Part V.B.3.a.

161 Hannah v. Heeter, 584 S.E.2d 560 (W. Va. 2003); Doe v Wal-Mart Stores, Inc., 558 S.E.2d 663 (W. Va. 2001); Tracy v. Cottrell, 524 S.E.2d 879 (W. Va. 1999).

once the status of that individual changes to become, for instance, a criminal defendant. Once the individual's status changes, another lawful exception may be invoked. Furthermore, once the accused is identified and located, the question of whether physical evidence exists and the process to obtain it is governed by other disclosure standards and lawful process and should not be constrained by HIPAA.

d. Permitted Disclosure No. 4: Victims of a Crime

Pursuant to this standard, with respect to victims of a crime, again, a covered entity is limited in that which it may disclose.[162] This permitted disclosure category applies where there is no mandatory reporting obligation by the covered entity. Mandatory reporting obligations have been discussed under Permitted Disclosure No. 1.[163] The "Victims of a Crime" exceptions address circumstances where there is no mandatory reporting law.

i. Permitted Disclosure 4A: Victim's Consent to Disclosure

A victim may consent to the disclosure by the covered entity.[164] An authorization, such as that described *supra* in Part II.G., may be customized for use in such circumstances. In obtaining this authorization, care should be exercised to avoid conduct that could be tantamount to duress or coercion. Also, unless already relied upon, the victim may verbally revoke this authorization.

ii. Permitted Disclosure 4B: Permitted Disclosure Absent Consent of Victim: Instances of Incapacitation or Other Emergency Circumstance

Unless mandated by other governing law such as an abuse and neglect reporting statute, the covered entity must obtain a victim's consent to disclose except where the victim is incapacitated or another "emergency circumstance" exists.[165] To facilitate the process, law enforcement officials should refer to 45 C.F.R. § 164.512(f)(3)(ii)(A)-(B). That regulation requires that the law enforcement officer be able to represent to the covered entity that (1) the "information is needed to determine whether a violation of the law by a person other than the victim has occurred," (2) the "information is not intended to be used against the victim," and (3) "immediate law enforcement activity that depends upon the

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162 45 C.F.R. § 164.512(f)(3).

163 *Id.* § 164.512(f)(1); *see also supra* Part V.B.3.a.

164 45 C.F.R. § 164.512(f)(3)(i).

165 *Id.* § 154.518(f)(3)(ii).

disclosure would be materially and adversely affected by waiting until the victim is able to agree to the disclosure."[166]

Once in receipt of this information, the covered entity then may exercise its professional judgment[167] and, upon a finding that disclosure is in the best interests of the victim, may make disclosure.[168] Importantly, this standard and disclosure exception affords victims the same protections envisioned in West Virginia law as discussed *supra* in Part V.B.1.a. This provision applies to verbal publications/disclosures as well as written disclosures. The exercise of professional judgment language is important, invoking a basis to claim that qualified immunity protection should be afforded to the reporter as it does when complying with state law mandatory reporting statutes.[169] The covered entity is cautioned to avoid making a legal conclusion based upon the representations of the law enforcement official. The prudent covered entity should evaluate the circumstances and document the decision-making analysis objectively in the record.

e. Permitted Disclosure No. 5: Decedents

The information that a covered entity may disclose concerning a decedent is addressed within the law enforcement standard.[170] A covered entity may disclose protected health information about an individual who has died to a law enforcement official. This disclosure may only be for the purpose of alerting the law enforcement official of the death if the covered entity has a suspicion that such death may have resulted from criminal conduct.[171] The covered entity is not required to make a legal finding or conclude that the death was the result of a crime. Reasonable suspicion is adequate.[172] This disclosure contains no restrictions such as those applicable to a fugitive, accused, missing person, or material witness.[173] This permitted disclosure is consistent with certain West Virginia statutes, specifically those mandating the reporting of deaths resulting from actual or suspected abuse or neglect.[174]

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166 *Id.* § 164.512(f)(3)(ii)(A)-(B).

167 *Id.* § 164.512(f)(3)(ii)(C).

168 *Id.*

169 *See, e.g.*, W. VA. CODE §§ 9-6-12, 49-6A-6 (2003).

170 45 C.F.R. § 164.512(f)(4).

171 *Id.*

172 *Id.*

173 *See supra* Part V.B.3.2.

174 W. VA. CODE § 49-6A-3 (2003).

f. Permitted Disclosure No. 6: Crime on a Covered Entity's Premises

Upon good faith belief that criminal conduct has occurred on its premises, a covered entity may disclose protected health information to law enforcement officials.[175] Without this exception, a covered entity would be vulnerable to the criminal activities of patients and third parties. A covered entity may provide health care sanctuary but must be protected against victimization. There are no qualifying limitations to this permitted disclosure other than the subjective good faith belief that criminal conduct has occurred.

g. Permitted Disclosure No. 7: Covered Health Care Provider's Reporting of Crime in Emergency Circumstances[176]

This exception contains some specific limiting provisions notable to all. This exception applies only to covered health care providers.[177] In other words, an emergency at any covered entity's premises remains governed by Permitted Disclosure No. 6, 45 C.F.R. § 164.512(f)(5). In order for the "covered health care provider's reporting of a crime in emergency circumstances" permitted disclosure to apply, the situation must (1) involve a covered health care provider, (2) acting in the course of delivering emergency health care in response to a medical emergency, and (3) be occurring somewhere *other than an emergency on its own premises*.[178] Under these circumstances, the covered health care provider may make a disclosure if necessary to alert law enforcement of the following:

> (A) The commission and nature of a crime;
>
> (B) The location of the crime or of the victim(s) of such crime; and
>
> (C) The identity, description, and location of the perpetrator of such crime.[179]

The qualifications as to a fugitive or suspect would necessarily have to be applied *in pari materia* with this provision.[180] These disclosures are those that

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175 45 C.F.R. § 164.512(f)(5).

176 *Id.* § 164.512(f)(6).

177 *Id.*

178 *Id.* § 164.512(f)(6)(i) (emphasis added).

179 *Id.* § 164.512(f)(6)(i)(A)-(C).

are made in the course of or immediately following the criminal conduct, and not those arising out of investigative activities occurring after the immediate critical time surrounding the crime.[181]

Finally, if the medical emergency is believed to be the result of abuse, neglect, or domestic violence of the individual in need of emergency health care, the identity, description, and location of the perpetrator may be provided consistent with West Virginia state law.[182] The protections afforded to vulnerable abuse and neglect victims are preserved as discussed under Standard No. 1., 45 C.F.R. § 164.512(c).[183]

4. Standard No. 4: Public Health Activities[184]

This standard affords qualified protection for those public health and safety subject matters that are considered significant to the orderly management and control of public health and safety in the flow of commerce and the promotion of the legitimate interest of disease and injury prevention. This standard relates to the investigation, control, and prevention of disease and adverse food, drug, and medical device reporting. Examples include mandatory Centers for Disease Control reporting of contagious and infections disease, such as pneumococcal pneumonia or SARS; mandatory birth and death recordings; adverse drug event reporting to the Food and Drug Administration; and medical device adverse event reporting to the Food and Drug Administration.[185]

Within this standard, a limitation is placed upon covered entity employers with respect to disclosures of occupational exposures/work-acquired/work-related illness or injury or disclosures made in accordance with Occupational Safety and Health Administration requirements.[186] The regulation addresses responsibilities of covered entity employers which includes the obligation to provide notice to all employees, either at the time medical care and treatment is given for the incident or by a conspicuous notice posted in the workplace, that protected health information may be disclosed concerning a work-related illness or injury or a workplace-related medical surveillance.[187] The provision of notice is the extent of the requirement. Consent is not mandated, but it would do no harm for a covered entity to obtain written consent before disclosure. The ap-

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180 *Id.* § 164.512(f)(2).

181 *See supra* Part V.B.3.b.

182 45 C.F.R. § 164.512(f)(6)(ii).

183 *See supra* Part V.B.1.

184 45 C.F.R. § 164.512(b).

185 *Id.*

186 *Id.* § 164.512(b)(1)(v)(A)(2)(B)-(D).

187 *Id.* § 164.512(b)(v).

parent concerns would include instances of occupational exposures and occupationally acquired disease that an employee may wish to keep confidential, but for which the employer is required to make disclosure.

5. Standard No. 5: Health Oversight Activities[188]

This standard relates to health enforcement and oversight activities such as those performed by the West Virginia Health Care Cost Authority, the Medicare Fiscal Intermediary, the Medicaid Quality Review Organization and the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO").[189] This standard compliments and does not infringe upon qualified or absolute privileges of other applicable laws.[190] Moreover, this standard allows information sharing by covered entities to those oversight agencies without restraint provided the terms of this standard are met. Necessarily included within this standard are disclosures required for professional licensure investigations[191] and peer review activities.

To qualify as a bona fide health oversight investigation, the investigation must arise from and be directly related to either, "the receipt of health care";[192] "a claim for public benefits related to health";[193] or "qualification for, or receipt of, public benefits or services when a patient's health is integral to the claim for public benefits or services."[194] The first item, receipt of health care, would include peer review, licensure complaints, and PRO investigations. The last two items would include activities such as quality monitoring utilization review as

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188 *Id.* § 164.512(d).

189 Interestingly, because accreditation through JCAHO is not mandated for all health-care providers, JACHO has developed business associate agreements it enters into with the covered entities it reviews. In this way, covered entities are doubly protected.

190 *E.g.*, The Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (2000); W. VA. CODE § 30-3C-1 to -4 (LEXIS through 2003 Second Extra. Sess.), *as amended by* H.D. 4587, 79th Leg. Sess., Reg. Sess. (W. Va. 2004) (enacted Apr. 1, 2004); *see also* OHIO REV. CODE ANN. §§ 1751.21 (Anderson 2002) (same); 35 PA. CONS. STAT. ANN. § 5701.905 (West 2003) (same).

191 For example, a few of the health care regulatory agencies and governing statutes which may mandate disclosure of protected information as an essential part of performance of necessary regulatory action are listed as follows: W. VA. CODE § 30-3-1 to -18 (2003) (West Virginia Medical Practice Act); *id.* § 30-7-1 to -18 (Registered Professional Nurses); *id.* § 30-7A-1 to -12 (Practical Nurses); *id.* § 16-29B-1 to -28 (West Virginia Health Care Authority); *id.* § 16-5B-1 to -13 (Hospitals and Similar Institutions); *id.* § 16-2D-1 to -15 (Certificate of Need); *id.* § 16-5J-1 to -10 (Clinical Laboratories Quality Assurance Act); *id.* § 16-5I-1 to -6 (Hospice Licensure Act); *id.* § 30-34-1 to -17 (Board of Respiratory Care Practitioners); *id.* § 30-16-1 to -22 (Chiropractors); *id.* § 30-5-1 to -25 (Pharmacists, Pharmacy Technicians, Pharmacy Interns and Pharmacies).

192 45 C.F.R. § 164.512 (d)(2)(i)-(iii).

193 *Id.*

194 *Id.*

well as individual information processing for purposes of investigating the applicability of charity care or a public sponsored health plan benefit.

The courts may be confronted with claims and challenges of waiver of applicable peer review or other qualified privileges following disclosure to third parties necessarily involved in these health care oversight and utilization review activities.[195] Covered entities may be expected to disclose, pursuant to this and other applicable laws as well as participating provider contracts necessitating publication of confidential information, to preserve applicable common-law privileges. The challenge for the court may include when and if the claim of privilege is overbroad and requires tailoring consistent with the Privacy Standards and with governing common and statutory law and applicable evidentiary rules and discovery privileges.[196] If protected health information was subject to a review by a process to which a privilege applies, the fact that the review occurred is not privileged.[197] The facts within the documented medical record are not privileged.[198] However, critical analysis, conclusions, thought processes, documents and things created within and for the purpose of peer review all may be privileged, depending upon governing law.[199]

6. Standard No. 6: About Decedents Made to Coroners, Medical Examiners, and Funeral Directors[200]

This standard applies to disclosures to coroners, medical examiners, and funeral directors.[201] The Privacy Standards allow a covered entity to disclose protected health information to a coroner or medical examiner for the purposes of identifying the deceased person, determining the cause of death, or for purposes of other authorized duties expressly authorized by law.[202]

In West Virginia, the Chief Medical Examiner, pursuant to express statutory authority, has appointed assistant medical examiners in each county in the

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195 *See, e.g.*, State *ex rel.* Brooks v. Zakaib, 588 S.E.2d 418 (W. Va. 2003). *But see* W. VA. CODE § 30-3C-1 (LEXIS through 2003 Second Extra. Sess.), *as amended by* H.D. 4587, 79th Leg. Sess., Reg. Sess. (W. Va. 2004) (enacted Apr. 1, 2004) (expanding this definition of peer review organizations).

196 *See* State *ex rel.* Brison v. Kaufman, 584 S.E.2d 480 (W. Va. 2003); State *ex rel.* Med. Assurance of W. Va., Inc. v. Recht, 583 S.E.2d 80 (W. Va. 2003); Feathers v. W. Va. Bd. of Med., 562 S.E.2d 488 (W. Va. 2001); State *ex rel.* Westbrook Health Servs., Inc. v. Hill, 550 S.E.2d 646 (W. Va. 2001); State *ex rel.* United Hosp. Ctr., Inc. v. Bedell, 484 S.E.2d 199 (W. Va. 1997).

197 *E.g.*, *State ex rel. Brooks*, 588 S.E.2d at 418; *Feathers*, 562 S.E.2d at 488.

198 *E.g.*, *State ex rel. Brooks*, 588 S.E.2d at 418; *Feathers*, 562 S.E.2d at 488.

199 *E.g.*, *State ex rel. Brooks*, 588 S.E.2d at 418; *Feathers*, 562 S.E.2d at 488; *see also* W. VA. CODE § 30-3C-3 (2003).

200 45 C.F.R. § 164.512(g) (2003).

201 *Id.* § 164.512(g)(1)-(2).

202 *Id.*

state.[203] Disclosures may be made to those duly appointed assistants under the HIPAA regulations.[204]

Special attention must be given to the provision that disclosure may be made "for purposes of other authorized duties expressly authorized under governing law." The detailed provisions in West Virginia law authorizing, for instance, tests of blood and body fluids, must be examined in context with this regulation.

West Virginia Code section 61-12-8 mandates disclosure of individual health information by covered entities to the medical examiner in certain circumstances. This Code provision provides that:

> When any person dies in this state from violence, or by apparent suicide, or suddenly when in apparent good health, or when unattended by a physician, or when an inmate of a public institution, or from some disease which might constitute a threat to public health, or in any suspicious, unusual or unnatural manner, the chief medical examiner, or his or her designee or the county medical examiner, or the coroner of the county in which death occurs *shall be immediately notified by the physician in attendance, or if no physician is in attendance, by any law-enforcement officer having knowledge of the death, or by the funeral director, or by any other person present or having knowledge.* Any physician or law-enforcement officer, funeral director or embalmer who willfully fails to comply with this notification requirement is guilty of a misdemeanor and, upon conviction, shall be fined not less than one hundred dollars nor more than five hundred dollars.[205]

No warrant, court order, or other form of court process is required to comply with either HIPAA or with this statute.[206] The governing West Virginia statute further provides:

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[203] W. VA. CODE § 61-12-7 (2003) (obligating Chief Medical Examiner to appoint for each county a county medical examiner).

[204] 45 C.F.R. § 164.512(g)(1). The following statutes and regulations are applicable to the duties and responsibilities of Chief Medical Examiners in West Virginia: W. VA. CODE § 16-4B-1 (2003) (autopsies on bodies of deceased persons); *id* § 16-19-4 (authorization by Chief Medical Examiner or local public health official for anatomical gift); *id.* § 16-19-5 (information regarding anatomical donation); *id.* § 17C-5B-2 (post-mortem tests for alcohol in persons killed in motor vehicle accidents); *id.* § 48-27A-1 (domestic violence fatality review team); *id.* § 49-5D-5 (multi-disciplinary child fatality review teams); *id.* § 61-12-3 *et seq.* (post-mortem examinations); W. VA. CODE ST. R. § 6-2-13 (2003) (direct authorization by Chief Medical Examiner to cremate); *id.* § 6-2-20 (child fatality multi-disciplinary teams); *id.* SERIES 36 (corneal transplants); *id.* SERIES 84 (medical examiner rules for post-mortem examinations).

[205] W. VA. CODE § 61-12-8(a) (2003) (emphasis added).

[206] *Id.*; 45 C.F.R. § 164.512(g)(l).

> Upon notice of a death under this section, the chief medical examiner, or his or her designee or the county medical examiner, *shall take charge of the body and any objects or articles* which, in his or her opinion, may be useful in establishing the cause or manner of death, and deliver them to the law-enforcement agency having jurisdiction in the case.[207]

This provision addresses subjects not included within the Privacy Standards, namely the property of the person and original evidence used for forensic purposes.[208]

The words "articles" and "objects" do not necessarily connote the same meaning as tissue, blood and body fluids in the possession of the health care provider covered entity. Neither does the subsequent language in West Virginia Code section 61-12-8(a), which authorizes medical examiners to have access to the health records maintained by a correctional institution, health care facility, or other entity at which the decedent received medical care until death.[209] The outstanding question then is the manner in which blood and body fluid that has been tested, the results of which are reported in the medical records lawfully provided to the examiner, is to be handled. HIPAA regulates disclosure of information relating to body fluids and tissues as discussed above.[210]

West Virginia Code section 61-12-8(a) employs the word "body," but does not specify "specimens, tissues, fluids, medical devices and/or samples" removed from the "body" pre-mortem. A valid question exists then as to whether, under HIPAA's restrictions concerning disclosures to coroners and with respect to suspects,[211] the possession of specimens removed from the body before death may be disclosed and released to law enforcement and/or the coroner absent court process.

Interpretive guidance with respect to application of this regulation is provided by several West Virginia Code provisions, which, depending upon the governing circumstances, may need to be referenced in addressing petitions for emergency judicial intervention or other legal process. These include:

- West Virginia Code section 17C-5B-1 (authorizing blood alcohol test within 12 hours of notice of vehicular death and before embalming);

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207 W. VA. CODE § 61-12-8(a) (emphasis added).

208 Section 61-12-8(a) automatically provides immunity from access by subpoena or otherwise of the protected health information obtained by the medical examiner and reviewed by him/her and, as such, is HIPAA compliant.

209 *See id.*

210 *See supra* Part V.B.3.c.

211 *See supra* Part V.B.3.b.

- West Virginia Code section 17C-5B-2 (instructing medical examiner to be the communicator of the blood testing results and establishing admissibility thereof, thereby relieving the covered entity of this obligation/burden and potential tension with HIPAA); and

- West Virginia Code section 61-12-10 (authorizing performance of medical examinations by coroner in instances of criminal investigation, preservation of forensic evidence and admissibility of the results and records at trial, thereby again relieving the covered entity of this obligation/burden and potential tension with HIPAA).

The obvious situation in which the coroner may request the actual blood/tissue secured by the covered entity, for instance, is in a case in which the coroner has conducted a urine and/or blood chemistry test for drugs, alcohol, and elicit substances and questions the validity of his/her findings. The pre-death specimens may then become material and necessary for forensic evaluation by all parties in the criminal process.

One manner in which to address these issues would be for the court to enter a qualified protective order requiring release of original body fluids, tissues, and samples by the covered entity to the coroner with a chain of custody log created to preserve the integrity of original evidence. The Privacy Standards provision at 45 C.F.R. § 164.512(f)(2)(ii) may only apply to live persons (suspect, fugitive, material witness or missing person). Given the breadth of 45 C.F.R. § 164.512(g) with respect to disclosure concerning a decedent, a logical conclusion may be that the Privacy Standards do not apply in this instance to body fluids, DNA, and other identifying information obtained from a corpse that state law governs. In West Virginia, in the absence of express state law to the contrary, this exercise of authority by the coroner is proper.

Lastly, concerning funeral directors, covered entities may make disclosures even before death, as necessary to carry out their duties with respect to the decedent.[212] Governing state law that may be, in some respects, more restrictive, is not encumbered by HIPAA. The courts may consider applicable West Virginia statutes and regulations when addressing questions regarding the same.

7. Standard No. 7: Anatomical Gift Purposes[213]

There is no restriction upon a covered entity's disclosure of information to fulfill anatomical gift purposes. Therefore, all West Virginia practitioners

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[212] 45 C.F.R. § 164.512(g)(2) (2003); W. VA. CODE § 30-6-1 to -32 (2003); W. VA. CODE ST. R. § 6-1-1 to –27 (2003).

[213] 45 C.F.R. § 164.512(h).

should comply with the Anatomical Gift Act and the associated disclosure requirements therein.[214]

8. Standard No. 8: Research Purposes[215]

This standard addresses the highly specialized area of investigational research such as that conducted by an institutional review board or privacy board. Disclosures are permissible within the detailed construct of those relationships.

9. Standard No. 9: To Avert a Serious Threat to Health or Safety: *Tarasoff* Revisited[216]

This standard deserves special attention by the judiciary, as it may be an important exception to invoke, particularly in the mental health arena, when an individual's condition and behavior creates a real risk to public health and safety.

To put this exception in context, an overview of West Virginia law is necessary. West Virginia Code section 27-3-1 permits disclosure by a covered health care entity of mental health information "[t]o protect against a clear and substantial danger of imminent injury by a patient or client to himself or another."[217] Since a covered health care entity may make disclosure of protected mental health information in these circumstances, it necessarily follows that a covered health care entity may make this disclosure concerning individuals who have not received mental health treatment. This conclusion is consistent with the Privacy Standards. HIPAA permits disclosure by any covered entity in circumstances wherein the covered entity holds the good faith belief[218] that disclosure "is necessary to prevent or to lessen a serious and imminent threat to the health or safety of a person or of the public."[219] Importantly, the Privacy Standards are not without qualification and, in fact, impose a specific limitation upon disclosure in this context.

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214 *See* W. VA. CODE § 16-3C-2 (2003) (confidentiality provisions of HIV statute applicable to donor tissues); *id.* § 16-19-1 to –14 (Anatomical Gift Act); *id.* § 16-19-9 (facilitation of communication to promote timely procurement and gift success); *id.* § 16-30-6 (anatomical gift issues with surrogate decision authority).

215 45 C.F.R. § 164.512(i).

216 *Id.* § 164.512(j); Tarasoff v. Regents of Univ. of Cal., 529 P.2d 553, 561 (Cal. 1974) (requiring disclosure of confidential information to prevent imminent danger to self or others).

217 W. VA. CODE § 27-3-1(b)(4) (2003).

218 The Privacy Standards create a presumption of good faith belief, based upon the covered entity's actual knowledge or upon reliance upon the credible representation of a person with apparent knowledge or authority. 45 C.F.R. § 164.512 (j)(4).

219 *Id.* § 164.512(j)(1)(i)(A).

HIPAA provides that disclosure may only be made "to a person or persons[220] *reasonably able* to prevent or lessen the threat, including the target of the threat."[221] By use of the word "person," disclosure is not limited to law enforcement. However, no disclosure may be made if the information is acquired during the course of treatment to reduce the propensity to commit criminal conduct or if obtained through a request for treatment.[222] In other words, a confession of a thought or plan in the course of therapy is insufficient to permit disclosure. A real and present propensity of the individual to act upon the thought or plan is required.[223] A real and present danger must exist. Assuming that a real and present danger exists, the covered entity may only disclose that information permissible as to fugitives, material witnesses, missing persons and suspects:

> (A) Name and address;
>
> (B) Date and place of birth;
>
> (C) Social security number;
>
> (D) ABO blood type and Rh factor;
>
> (E) Type of injury;
>
> (F) Date and time of treatment;
>
> (G) Date and time of death, if applicable; and
>
> (H) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.[224]

Another important qualification is provided for in this exception. If the individual is an escapee from a correctional institution or from lawful custody,

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220 Notably, this is not limited to law enforcement.

221 45 C.F.R. § 164.512(j)(1)(i)(B) (emphasis added).

222 *Id.* § 164.512(j)(2)(i)-(ii).

223 In the context of mental health care, West Virginia law authorizes a mental health professional to hold a voluntary patient for up to ninety-six hours if the professional has reason to believe that the patient poses a risk of harm to him/herself or others and so determines that a real need exists to institute involuntary commitment proceedings. W. VA. CODE § 27-4-3(c) (2003). This language presupposes that the patient/client is present in a facility.

224 45 C.F.R. § 164.512(f)(2)(i)(A)-(H); *see also id.* § 164.512(j)(3).

the restrictions do not apply.[225] Lawful custody could include an individual involuntarily committed to a mental health facility.[226] The fine line between disclosure and preservation of the dangerous patient's right to privacy is one with which the covered entity will be confronted.

Lastly, the rule is further qualified. This standard does not supercede Standard No. 3: Permitted Disclosures Nos. 3 and 4 as discussed *supra.*

10. Standard No. 10: Specialized Government Functions: The United States Patriot Act and National Security Interests Addressed[227]

This is the next to the last enumerated standard within 45 C.F.R. § 164.512. It is unlikely that state courts will be called upon to address certain subject matters therein which relate to armed forces personnel, national security and intelligence, and protective services for the President and others.[228]

There is a section within this regulation that addresses correctional facilities and law enforcement custodial situations. The regulation provides:

> (5) Correctional institutions and other law enforcement custodial situations.
>
> (i) A covered entity may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual protected health information about such inmate or individual, if the correctional institution or such law enforcement official represents that such protected health information is necessary for:
>
> (A) The provision of health care to such individuals;
>
> (B) The health and safety of such individual or other inmates;
>
> (C) The health and safety of the officers or employees of or others at the correctional institution;
>
> (D) The health and safety of such individuals and officers or other persons responsible for the transporting of

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225 *Id.* § 164.512(j)(1)(ii)(B).

226 *Id.* § 164.501; W. VA. CODE § 27-6A-1 to -9 (2003).

227 45 C.F.R. § 164.512(k).

228 *Id.*

> inmates or their transfer from one institution, facility, or setting to another;
>
> (E) Law enforcement on the premises of the correctional institution; and
>
> (F) The administration and maintenance of the safety, security, and good order of the correctional institution.
>
> (ii) A covered entity that is a correctional institution may use protected health information of individuals who are inmates for any purpose for which such protected health information may be disclosed.
>
> (iii) No application after release. For the purposes of this provision, an individual is no longer an inmate when released on parole, probation, supervised release, or otherwise is no longer in lawful custody.[229]

Applied in context with West Virginia laws concerning inmates and those in custody of law enforcement, the following application comments are made.

West Virginia Code section 7-8-2 authorizes the sheriff of every county, as keeper of the jail, to obtain any information necessary from the inmate in order to process health care benefit claims with covered entities to the extent that the inmate has a health condition which qualifies for benefit under a covered entity's plan.[230] Lawful custody also extends to those instances when a sheriff is required to transport mentally ill patients to treatment facilities.[231] Non-correctional institution covered entities may seek certification from the sheriff and/or his or her responsible designee of information consistent with items (A) through (F) of this Privacy Standard prior to release of the information and/or claim processing.

Given the silence of state law on the issue of whether the covered entity correctional institution may make re-disclosure for any purpose other than coordinating care or processing of billing statements, it is suggested that re-disclosure is not authorized by covered entity correctional institutions.

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229 *Id.* § 164.512(k)(5)(i)-(iii).

230 W. VA. CODE § 7-8-2(a)-(b) (2003).

231 *Id.* § 27-5-1(d).

11. Standard No. 11: Worker's Compensation Programs[232]

This is the last standard within this regulatory section. It permits any covered entity to make protected health information disclosures as necessary to comply with the laws relating to worker's compensation or other similar programs, concerning the specific subject matters of work-related injuries or illnesses without regard to fault.[233] Therefore, the orderly operation of the state's worker's compensation program is not infringed upon or impacted by the Privacy Standards. While not required, it is likely that certain covered entities will include worker's compensation release notifications in the consents for redisclosure, depending upon the institution and the primary purposes for which services are delivered to individuals. Of course, covered entity employers must still comply with Standard 4, *supra*.[234]

VI. SPECIAL EXCEPTIONS

A. *Whistleblowers, Their Attorneys, and Employee Victims of White Collar Crime*

HIPAA does not apply to disclosures made by whistleblowers, their attorneys, and victims of crime in the workplace.[235] If an employee of a covered entity *or* its business associate has the good faith belief that the covered entity has engaged in conduct "*that is unlawful or otherwise violates professional or clinical standards . . . provided by the covered entity* [such that it] *potentially endangers one or more patients, workers, or the public,*" then disclosure to an attorney for purposes of representation or disclosure to a health oversight agency, public health authority authorized by law to investigate the covered entity, or to an accreditation agency, may be made.[236] Examples could include disclosures to the Department of Health and Human Services and *qui tam* relator actions.

Additionally, if the employee is a victim of a crime, he/she may disclose protected health information to a law enforcement official provided that the protected health information disclosed is about the suspected perpetrator of the criminal act and the protected health information is limited to that which is reasonably practical in light of the purpose for which it is sought.[237] If this test is

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232 45 C.F.R. § 164.512(l).

233 *Id.*

234 *Id.* § 164.512(b)(1)(v)(A)-(D).

235 *Id.* § 164.502(j)(1)-(2)(ii).

236 *Id.* § 164.502(j)(1)(i)(ii)(A)-(B) (emphasis added).

237 *Id.* § 164.502(j)(2)(i)(ii).

met, then disclosure as permitted under Standard No. 3, Permitted Disclosure No. 4, above, applies. [238]

B. *Professional Licensure Agency Disclosures and Regulatory Agency Disclosures by Covered Entity/Business Associate Employees*

Consistent with the qualified immunity afforded to members of a given profession who may report unprofessional conduct of a peer[239] or a report of quality concerns or a compliance complaint to a state regulatory agency, this provision, by its plain meaning, provides an avenue to make such disclosures. This provision states that there is no disclosure restriction if:

> The workforce member or business associate believes in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public.[240]

An example would include a business associate in the position to have notice of a violation of the Emergency Medical Treatment and Active Labor Act[241] or a violation of the West Virginia Medical State Practice Act for Physicians,[242] Pharmacists,[243] Registered Nurses,[244] or any licensed professional or a professional with the good faith belief that malpractice has occurred. Disclosures may be made to accreditation agencies such as the JCAHO and the state enforcement agency contractually obligated pursuant to the state's Medicaid participation program. This important provision encourages peer introspection and peer reporting of quality concerns without fear of retribution or consequences. "Good faith belief" is a subjective measure and one likely to be afforded a substantial glass ceiling given the interests of public and patient safety.

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238 *Id.* § 164.512(f)(3).

239 *E.g.*, 42 U.S.C. §§ 11101-11152 (2000); W. VA. CODE § 30-3C-3 to -4 (2003).

240 45 C.F.R. § 164.502 (j)(1)(i), (ii)(A)-(B).

241 42 U.S.C. § 1395dd (2000), *as amended by* Medicare, Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

242 W. VA. CODE § 30-3-1to –18 (2003).

243 *Id.* § 30-5-1 to -25.

244 *Id.* § 30-7-1 to -18.

VII. THE PATIENT'S RIGHT OF ACCESS AND THE RIGHT TO AMEND THE HEALTH INFORMATION RECORD

The individual whose health information is recorded in a covered entity's documents is afforded a right of access to his/her private health information and right to obtain an accounting of who has had access to his/her personal health information.[245] Also, the individual is afforded the right to amend the record.[246]

In West Virginia, the patient's right to access his/her health records is governed by West Virginia Code section 16-29-1. For non-mental health records, a patient or his/her representative may execute an authorization and obtain the records.[247] As to mental health records, the patient or his/her authorized agent, upon written request, can obtain a "summary" of the records following termination of the treatment program. The underlying rationale for distinguishing mental health records and allowing the patient to receive only a summary, rather than the entire record, is that certain information documented by the mental health care provider related to the patient may be detrimental or an impediment within the law enforcement standard, on the patient's care and treatment. The mental health care professional is afforded the option of selecting portions of the actual record that the patient can see and what to summarize.[248]

HIPAA takes a broader view of a patient's right of access. The patient or his/her personal representative has the right to request access to the covered entity's entire record at any time, even while treatment is ongoing.[249] HIPAA does not distinguish between medical and mental health records, with the exception of psychotherapy notes.[250] The covered entity has a fixed time limit to respond to a request for access.[251]

The covered entity may deny access in limited circumstances. If access is denied, the covered entity must put the denial in writing and give a copy of it to the patient or his/her personal representative.[252] Permissible reasons for a denying access include (1) the information to which the patient seeks access to constitutes "psychotherapy notes";[253] (2) the information sought was "compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative

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245 45 C.F.R. § 164.528.

246 *Id.* § 164.526.

247 W. VA. CODE § 16-29-1 (2003).

248 *Id.* § 16-29-1(b).

249 45 C.F.R. § 164.524(a)(1).

250 *Id.* § 164.524(a)(1)(i).

251 *Id.* § 164.524(b)(2).

252 *Id.* § 164.524(d).

253 *Id.* § 164.524(a)(1)(i).

action or proceeding";[254] (3) the record sought contains information from someone other than a covered entity under a promise of confidentiality;[255] (4) information contained in the record, if accessed, is reasonably likely to endanger the life or physical safety of the patient or another person;[256] (5) the record references another person (other than a health care provider) and access by the patient to the record is "likely to cause substantial harm to such other person";[257] (6) the request to access made by the patient's personal representative and such information is reasonably likely to cause serious harm to the patient or another person;[258] (7) the right to access has been suspended pursuant to the Clinical Laboratory Improvement Amendments of 1988[259] or the Privacy Act;[260] or the request is by an inmate of a correctional facility to the correctional facility or a health care provider acting under the direction of the correctional facility and such information, if disclosed to the inmate, could place at risk the health, safety, security, or custody of the inmate or others, including without exception employees of the correctional facility or law enforcement charged with transporting the inmate.[261]

It is within the discretion of the covered entity to provide a summary of those portions of records to which access is denied.[262] The patient may invoke the right to have the denial of access reviewed by another licensed health care professional chosen by the covered entity under certain limited circumstances.[263] These include when access has been denied on any of the following grounds:

> (i) A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person;
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> (ii) The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

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254 *Id.* § 164.524(a)(1)(ii).

255 *Id.* § 164.524(a)(2)(v).

256 *Id.* § 164.524(a)(3)(i).

257 *Id.* § 164.524 (a)(3)(ii).

258 *Id.* § 164.524 (a)(3)(iii).

259 42 U.S.C. § 263(a) (2000); 42 C.F.R. § 493.3(a)(2) (2003).

260 5 U.S.C. § 552(a) (2000).

261 45 C.F.R. § 164.524(a)(2)(ii), (iv).

262 *Id.* § 164.524(c)(2)(ii).

263 *Id.* § 164.524(a)(4).

> (iii) The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.[264]

The covered entity must abide by the decision of the health care provider who reviews the original denial.

This discussion clearly reveals that West Virginia Code section 16-29-1 is partially pre-empted by HIPAA. The patient or the patient's personal representative may access and inspect medical and mental health records at any time, including during treatment, with limited exceptions. To the extent that psychotherapy notes are involved, both West Virginia Code section 16-29-1 and HIPAA allow the mental health professional to provide only a summary and to refuse access, depending upon documented circumstances.[265]

In addition to the right of access, HIPAA affords a patient a limited right to amend the record.[266] This right to amend exists for as long as a protected health record is retained by the covered entity.[267] Importantly, it is not an absolute right and may result in a dramatic paradigm shift in how health information is maintained, used, and viewed.

Before HIPAA, an individual did not have a federally recognized right to amend the record created by covered entities. The individual provided source information either directly by communicating verbally or indirectly by allowing examinations, tests, and procedures to be performed. In fact, under West Virginia law, the medical record is the property of the health care provider.[268] The medical record is a legal document describing the information relied upon in diagnosis and treatment. Documents provided by the individual patient, such as a medication list or medical power of attorney, may be placed into the record but generally, no individual patient was permitted to make written entries in the record. HIPAA creates a whole new world in this regard. HIPAA affords patients the qualified right to amend the record and to demand that certain entries be made, modified, or amended.[269]

To invoke this right, all the patient has to do is ask. In response, covered entities are permitted to require that the request be in writing and that the indi-

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264 *Id.* § 164.524(a)(3)(i)-(iii).

265 *Id.* § 164.524 (c)(2)(ii); *see also* W. VA. CODE § 16-29-1 (2003).

266 *Id.* § 164.526.

267 *Id.*

268 W. VA. CODE § 57-5-4j to -5a (2003); *id.* § 16-29-1.

269 45 C.F.R. § 164.526.

vidual provide the reason for amendment.[270] Once the covered entity receives the written request, it is obligated to timely respond.[271] The covered entity may either grant or deny the request, in whole or in part.

If the covered entity denies any part of an amendment request, the covered entity must provide the individual with the reason for the denial to amend.[272] HIPAA recognizes the following as legitimate reasons for denying a request: (1) the portion of the record that the patient wants to amend is not part of the official record maintained by the covered entity,[273] (2) the information the patient seeks to amend is not part of the record created by the covered entity,[274] (3) the information the patient seeks to amend is part of "psychotherapy notes" within the record,[275] (4) the information that the patient seeks to amend is not part of the record accessible to the patient under the Privacy Standards,[276] or (5) the information already in the record is accurate and complete.[277] It is the last item, the conclusion that the record is accurate and complete, that may cause the greatest conflict between covered entities and individuals seeking to amend. The medical record should not become a venting platform for an emotional catharsis.

Health care providers and covered entities must still appreciate that communications exchanged in the context of any request to amend may be admissible in a subsequent legal matter and may voluntarily elect to permit the desired amendment in order to allow a patient's complaints to be memorialized. This minimizes a "he said, she said" credibility dispute in the future when memories have faded.

Also, if a covered entity denies a request to amend, in whole or in part, then the requesting person has the right to send a written response to the denial to the covered entity. The covered entity then has the right to send a written rebuttal.[278] All of these publications between the individual and the covered entity, including the initial request, the denial, the response, and the rebuttal, become part of the official record and are to be included with any subsequent disclosures.[279] Moreover, a covered entity that is informed by another covered entity

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270 *Id.* § 164.526(b)(1).

271 *Id.* § 164.526(b)(2)(i) (requiring the covered entity to respond within sixty days of receiving the request).

272 *Id.* § 164.526(d)(1)(i).

273 *Id.* § 164.526(a)(2)(ii).

274 *Id.* § 164.526(a)(2)(i).

275 *Id.* § 164.526(a)(2)(iii).

276 *Id.*

277 *Id.* § 164.526(a)(2)(iv).

278 *Id.* § 164.526(d)(1)-(3).

279 *Id.* § 164.526(d)(4)-(5).

that its records have been amended by the patient (or the patient's personal representative) must similarly amend its own records.[280]

Therefore, the amendment in several respects triggers a domino effect. If a request to amend is granted, in whole or in part, all amendments become a part of the permanent record. The covered entity is obligated to exchange the amendment with individuals or covered entities that may have received information from the initial record and relied on the un-amended information to the individual's detriment.[281] Reliance to the individual patient's detriment may create interesting legal questions and exposures.

This amendment process will create more than mere academic exercise for the courts as to discovery; causes of action, such as spoliation or intentional infliction of emotional distress; admissibility of evidence, and otherwise.

VIII. THE INTERPLAY BETWEEN HIPAA AND CERTAIN PRIVACY PROVISIONS OF WEST VIRGINIA LAW

With the foregoing overview of the Privacy Standards, some additional specific areas of West Virginia law will now be discussed.

A. *Disclosure, Consent, Authorizations, and Records Afforded Heightened Confidentiality Protection*

West Virginia has afforded mental health care records greater protection than other health care records for many years.[282] The definition of "confidential information" found in the Mental Health Act, West Virginia Code section 27-3-1, for example, extends even to acknowledging whether an individual has ever sought mental health services.

> Communications and information obtained in the course of treatment or evaluation of any client or patient shall be deemed to be "confidential information" and shall include the fact that a person is or has been a client or patient, information transmitted by a patient or client or family thereof for purposes relating to diagnosis or treatment, information transmitted by persons participating in the accomplishment of the objectives of diagnosis or treatment, all diagnoses or opinions formed regarding a client's or patient's physical, mental or emotional condition; any advice, instructions or prescriptions issued in the course of diagnosis or treatment, and any record or characterization of the mat-

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280 *Id.* § 164.526(e).

281 *Id.* § 164.526(c)(3).

282 *See* W. VA. CODE § 27-3-1 to -2 (2003); Nelson v. Ferguson, 399 S.E.2d 909 (W. Va. 1990); Allen v. Smith, 368 S.E.2d 924 (W. Va. 1988).

> ters hereinbefore described. It does not include information which does not identify a client or patient, information from which a person acquainted with a client or patient would not recognize such client or patient, and uncoded information from which there is no possible means to identify a client or patient.[283]

Section 27-3-1 prohibits a mental health care provider from disclosing confidential information absent the patient or the patient's authorized alternate decision-maker's written authorization. The only exceptions to this general prohibition are disclosures made (1) for purposes of mental hygiene proceedings, (2) for involuntary examinations for determination of criminal competency pursuant to West Virginia Code section 27-6A-1, (3) for compliance with an order of a court of competent jurisdiction based upon the express finding by the court that the information is "sufficiently relevant to a proceeding . . . to outweigh" the patient's right of confidentiality, (4) for the express purpose of protecting the patient or others from "clear and substantial danger of imminent injury" resulting from the patient's conduct (commonly referred to as a "duty to warn"),[284] and (5) for the purpose of the health care provider's "treatment and internal review purposes"[285] or "to other health professionals involved in treatment of the patient."

As discussed above, HIPAA likewise distinguishes mental health care records from other private health information but to a much more limited extent than West Virginia law. Rather than afford blanket protection to all mental health records, the Privacy Standards focus on "psychotherapy notes," which are defined as follows:

> [N]otes recorded (in any medium) by a mental healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session that are separated from the rest of the individual's medical record.[286]

In contrast to the definition of confidential information found within West Virginia Code section 27-3-1, the term "psychotherapy notes" does not include "medication and prescription monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, [and] results of clinical tests." The term also does not include any summary of the "[d]iagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date."[287]

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283 W. VA. CODE § 27-3-1(a).

284 *See supra* Part V.B.9.

285 *See supra* Part V.B.5.

286 45 C.F.R. § 164.501.

287 *Id.*

As discussed, HIPAA requires covered entities to obtain authorizations specific to the release of psychotherapy notes before disclosing them. An authorization for the release of psychotherapy notes cannot be combined with any other authorization for records.[288] The Privacy Standards provide more stringent standards related to a valid authorization for the release of information. However, no psychotherapy note specific authorization is required for publication for healthcare oversight (by such entities as the Centers for Medicaid and Medicare Services and the Department of Health and Human Services)[289] or for reporting deaths to the coroner or medical examiner.[290]

Comparing West Virginia Code section 27-3-1 with the Privacy Standards, West Virginia law is the more stringent in most respects. Where state law is stricter, it applies, as HIPAA will not preempt a law that gives more protection.[291] West Virginia law prohibits disclosure of mental health information, absent an authorization, for payment purposes which would be authorized under HIPAA. It also prohibits, absent the patient's authorization or the patient's consent, any disclosure to relatives of the patient or others who may be involved in the patient's care (e.g., in the course of family therapy). Finally, it prohibits even acknowledging whether an individual has sought care or treatment absent an authorization or court order.

Because West Virginia law is not preempted by HIPAA in the manner in which mental health records may be obtained, including the insufficiency of a subpoena to compel their production, courts can anticipate that mental health covered entities will continue filing motions to quash in response to subpoenas served without accompanying valid authorizations or court orders.

Substance abuse records are managed differently from health and psychotherapy records. With the exception of records related to the treatment of minors for substance abuse, West Virginia does not have a statute that expressly addresses the confidentiality of substance abuse treatment records in the context of what a health care provider covered entity may or is prohibited from disclosing and under what circumstances. The exception for records related to the substance abuse treatment of minors is found in West Virginia Code section 16-29-1(b) which provides:

> Nothing in this article shall be construed to require a health care provider responsible for diagnosis, treatment or administering health care services in the case of minors for birth control, prenatal care, drug rehabilitation or related services or venereal disease according to any provision of this code, to release patient records of such diagnosis, treatment or provision of health care

288 *Id.* § 164.508(b)(3)(ii); *see also id.* § 164.528.

289 *See supra* Part V.B.5.

290 45 C.F.R. § 164.508(a)(2); *see also id.* § 164.512 (g); *see supra* Part V.B.6.

291 *See supra* Part II.B.

> as aforesaid to a parent or guardian, without prior written consent therefor from the patient, nor shall anything in this article be construed to apply to persons regulated under the provisions of chapter eighteen of this code or the rules and regulations established thereunder.[292]

Although there is no comparable language to West Virginia Code section 16-29-1(b) for adults, West Virginia Code section 27-3-1's provisions, relating to confidential mental health records, may be read to apply to adult substance abuse treatment record. The definition of "confidential information" found in West Virginia Code section 27-3-1 includes information needed for mental hygiene proceedings pursuant to West Virginia Code section 27-5-1, which include involuntary commitments for addiction. Moreover, treatment for alcohol and substance abuse and dependence frequently involves some form of mental health treatment.[293] Additionally, West Virginia Code section 60A-5-504 provides that:

> No mental health organization or hospital shall be compelled in any state or local civil, criminal, administrative, legislative or other proceeding to furnish the name or identity of any person voluntarily requesting treatment for or rehabilitation from addiction to or dependency upon the use of a controlled substance as defined in article one . . . of this chapter.[294]

It is a public health and safety policy to encourage individuals, adults and minors, to seek treatment for substance abuse. The quoted state law provisions are in concert with this policy. The West Virginia statutory language cited herein and case law interpreting those statutes, afford greater protection to substance abuse treatment records than do the Privacy Standards, which are largely silent regarding this classification of records. West Virginia statutes are consistent with other federal regulations dealing with alcohol and drug abuse treatment that were not preempted by the Privacy Standards.[295] Notably, the federal regulations pertaining to the confidentiality of alcohol and drug abuse treatment records require both a subpoena and a court order prior to compelled publication by a covered care provider; neither one alone is sufficient.[296] For these reasons, in the absence of the individual's express authorization or that of a legal representative

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292 W. VA. CODE § 16-29-1(b) (2003).

293 Recognizing the psychological component of addiction, the DSM-IV, published by the American Psychiatric Association, includes in its diagnostic classifications of mental disorders those involving substance abuse and dependence.

294 W. VA. CODE § 60A-5-504(d) (2003).

295 42 C.F.R. pt. 2 (2003).

296 *Id.* § 2.61(a).

to release substance abuse records, a covered entity will move to quash subpoenas and seek a court order.

B. Treatment Records of Minors

As previously discussed in Part III.F., HIPAA contemplates restricting access to information regarding an unemancipated minor. Under HIPAA, an unemancipated minor has the right to act alone and without a parent, guardian, or other person acting *in loco parentis* serving as a personal representative pertaining to publication of his/her personal health information, if:

> (A) The minor consents to such health care service, no other consent to such health care service is required by law, regardless of whether the consent of another person has also been obtained; and the minor has not requested that such person be treated as the personal representative;
>
> (B) The minor may lawfully obtain such healthcare service without the consent of a parent, guardian, or other person acting *in loco parentis*, and the minor, a court, or another person authorized by law consents to such health care service; or
>
> (C) A parent, guardian, or other person acting in *loco parentis* to an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.[297]

However, even under those parameters, "if State or other law" either permits or prohibits access by a parent, guardian, or other person acting in *loco parentis*, then the "State or other law" governs.[298] Similarly, if "State or other law" is silent on the issue of whether a parent, guardian, or other person acting in *loco parentis* may have access to protected health information, then HIPAA allows a licensed health care professional, "in the exercise of [his/her] professional judgment" to decide whether access to information will be granted or denied so long as such decision is otherwise consistent with State or other law.[299] Additionally, if the parent, guardian, or other person acting in *loco parentis* is suspected of abusing or neglecting the minor, the right to access[300] and amend[301] the record may be restricted.

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297 45 C.F.R. § 164.502(g)(3)(i)(A)-(C).

298 *Id.* § 164.502(g)(3)(ii)(A)-(B).

299 *Id.* § 164.502(g)(3)(ii)(C).

300 *Id.* § 164.524(a)(3)(iii).

301 *Id.* § 164.526(a)(2)(iii)

West Virginia law addresses parental access to records. For example, as it relates to the right of access to medical information between custodial and non-custodial parents, absent a court order limiting the non-custodial parent's rights further, West Virginia domestic relations statutes provide that each parent has equal access subject to the recognized privacy rights of the minor child.[302] The privacy rights of unemancipated minors are recognized by West Virginia Code section 16-29-1[303] and West Virginia Code section 16-4-10.[304] In addition to those code sections, privacy rights of unemancipated minors are also protected, rather than preempted by HIPAA, by:

- West Virginia Code section 60A-5-504(e): Cooperative arrangements; confidentiality; treatment of minor without knowledge or consent of parent or guardian;[305]
- West Virginia Code section 48-9-301: Court-ordered investigation;[306]

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302 W. VA. CODE § 48-9-601 (2003).

303 *Id.* § 16-29-1(b) ("Nothing in this article shall be construed to require a health care provider responsible for the diagnosis, treatment or administering health care services in the case of minors for birth control, prenatal care, drug rehabilitation or related services or venereal disease according to any provision of this code, to release patient records of such diagnosis, treatment or provision of health care as aforesaid to a parent or guardian, without prior written consent therefor from the patient, nor shall anything in this article be construed to apply to persons regulated under the provisions of chapter eighteen . . . of this code or the rules and regulations established thereunder.").

304 *Id.* § 16-4-10 ("Notwithstanding any other provision of law, any licensed physician may examine, diagnose, or treat any minor with his or her consent for any venereal disease without the knowledge or consent of the minor's parent or guardian. The physician shall not incur any civil or criminal liability in connection therewith except for negligence or willful injury.").

305 *Id.* § 60A-5-504(e) ("Notwithstanding any other provision of law, any licensed physician or competent medically trained person under his direction may examine, diagnose, and treat any minor at his or her request for any addiction to or dependency upon the use of a controlled substance as defined in article one of this chapter without the knowledge or consent of the minor's parent or guardian. Such physician and such other persons shall not incur any civil or criminal liability in connection therewith except for negligence or willful injury."); *see also* 42 C.F.R. § 2.14 (2003) (protecting as confidential the records of unemancipated minors treated for alcohol or drug abuse).

306 This section provides:

> (a) In its discretion, the court may order a written investigation and report to assist it in determining any issue relevant to proceedings under this article.
>
> (b) In preparing the report concerning a child, the investigator may consult any person who may have information about the child and the potential parenting or custodian arrangements. Upon order of the court, the investigator may refer the child to professional personnel for diagnosis. The investigator may consult with and obtain information from medical, psychiatric or other expert persons who have served the child in the past without obtaining the consent of the parent or the child's custodian; but the child's consent must be obtained if the

- West Virginia Code section 16-2F-3 and -4: Parental Notification required for abortions performed on unemancipated minor; waiver.[307]

In addition to a minor's right to access, West Virginia has specific laws governing unemancipated minors and the consent to treatment. West Virginia law pertaining to the voluntary hospitalization of children between the ages of twelve and eighteen requires the child's consent be obtained prior to treatment.[308] Read in conjunction with HIPAA, the child's authorization for release of information must be obtained before disclosures are made by a health care covered entity. The parent or guardian's signature alone may not be sufficient. Similarly, in those instances where the child is deemed a "mature minor" for healthcare decision purposes and his/her decisions related to healthcare override any conflicting decisions by a parent or guardian, the minor's authorization for release of information must be obtained before disclosures are made.[309]

In the context of legal proceedings where access to records is sought by way of valid authorization, it is imperative for counsel to be aware of those in-

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child has reached the age of twelve, unless the court finds that the child lacks mental capacity to consent. If the requirements of subsection (c) of this section are fulfilled, the investigator's report may be received in evidence at the hearing.

W. VA. CODE § 48-9-301 (a)-(b).

307 Section 16-2F-3 provides:

> No physician may perform an abortion upon an unemancipated minor unless such physician has given or caused to be given at least twenty-four hours actual notice to one of the parents or to the legal guardian of the pregnant minor of his intention to perform the abortion, or, if the parent or guardian cannot be found and notified after a reasonable effort so to do, without first having given at least forty-eight hours constructive notice computed from the time of mailing to the parent or to the legal guardian of the minor: Provided, that prior to giving the notification required by this section the physician shall advise the unemancipated minor of the right of petition to the circuit court for waive of notification; Provided, however, That any such notification may be waived by a duly acknowledged writing signed by a parent or the guardian of the minor.

Id. § 16-2F-3(a).

Section 16-2F-4 provides:

> A minor who objects to such notice being given to her parent or legal guardian may petition for a waiver of such notice to the circuit court of the county in which the minor resides or in which the abortion is to be performed, or to the judge of either of such courts. Such minor may so petition and proceed in her own right or, at her option, by a next friend.

Id. § 16-2F-4(a).

308 *Id.* § 27-4-1(b).

309 *Id.* § 16-30-3(o); Belcher v. Charleston Area Med. Ctr., 422 S.E.2d 827 (W. Va. 1992).

stances when the minor's signature must be obtained. Out of an abundance of caution, it is prudent to obtain the signature of both the minor and the custodial parent or guardian on authorization forms.

C. *HIV Testing and Sexually Transmitted Disease Records*

Federal regulators did not include any specific reference to testing and treatment records for the Human Immunodeficiency Virus ("HIV") in the Privacy Standards. However, as with other individually identifiable health information, the HIPAA Privacy Standards must be read in conjunction with State laws pertaining to HIV-related testing and treatment to identify and resolve issues of compatibility, tension, and preemption.

In 1988, the West Virginia Legislature enacted the AIDS-Related Medical Testing and Records Confidentiality Act ("Act"), West Virginia Code section 16-3C-1 *et seq.* The law provides specific protections for HIV-related testing, including defining when testing may occur, when notification of results to third parties is permitted and what public health oversight activities mandate disclosure. The West Virginia HIV Act is not preempted by HIPAA, in part, with respect to the provisions for reporting of disease for public health surveillance and investigation.[310]

Specific testing and treatment record disclosure provisions are found at West Virginia Code section 16-3C-3. Absent a court order, this statute prohibits the disclosure of non de-identified HIV-related test information, including test results, except disclosures made to:

(1) The subject of the test;

(2) The victim of the crimes of sexual abuse, sexual assault, incest or sexual molestation at the request of the victim or the victim's legal guardian, or of the parent or legal guardian of the victim if the victim is an infant where disclosure of the HIV-related test results of the convicted sex offender are requested;

(3) Any person who secures a specific release of test results executed by the subject of the test;

(4) A funeral director or an authorized agent or employee of a health facility or health care provider if the funeral establishment, health facility or health care provider itself is authorized to obtain the test results, the agent or employee provides patient care or handles or processes specimens of body fluids or tissues and the agent or em-

310 45 C.F.R. § 160.203(c) (2003); W. VA. CODE § 16-3C-1 to -9 (2003).

ployee has a need to know such information: Provided, That such funeral director, agent or employee shall maintain the confidentiality of such information;

(5) Licensed medical personnel or appropriate health care personnel providing care to the subject of the test, when knowledge of the test results is necessary or useful to provide appropriate care or treatment, in an appropriate manner: Provided, That such personnel shall maintain the confidentiality of such test results. The entry on a patient's chart of an HIV-related illness by the attending or other treating physician or other health care provider shall not constitute a breach of confidentiality requirements imposed by this article;

(6) The bureau or the centers for disease control of the United States public health service in accordance with reporting requirements for a diagnosed case of AIDS, or a related condition;

(7) A health facility or health care provider which procures, processes, distributes or uses: (A) A human body part from a deceased person with respect to medical information regarding that person; (B) semen provided prior to the effective date of this article for the purpose of artificial insemination; (C) blood or blood products for transfusion or injection; or (D) human body parts for transplant with respect to medical information regarding the donor or recipient;

(8) Health facility staff committees or accreditation or oversight review organizations, which are conducting program monitoring, program evaluation or service reviews so long as any identity remains anonymous.[311]

If a person seeks HIV test results through a court order, then all pleadings must use a pseudonym to refer to the test subject (person) and, if possible, the court shall notify the test subject (person) of the request in advance to afford the person opportunity to file an objection.[312] When considering the request to compel the test results, during an *in camera* hearing, West Virginia law requires the court to apply a balancing test and to make specific findings including that

311 W. VA. CODE § 16-3C-3(a)(1)-(8).

312 *Id.* § 16-3C-3(a)(9).

the public interest in disclosing the information outweighs the privacy interests of the test subject and that there is no less intrusive means for addressing the need for the information than compelling disclosure.[313] If the court orders the test results disclosed, then the court must also order express restrictions identifying who may have access to the test results and the purposes for which access will be granted, and prohibiting re-disclosure.[314] These procedures are complimentary to that which is required for court ordered disclosure of personal health information under HIPAA.[315]

The Act also requires that HIV test related records which are disclosed be accompanied by a statement notifying the recipient that the records are subject to specific protections:

> This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.[316]

Although a "general authorization" is not sufficient under the Act for disclosure of HIV-related test records, the Act only requires that the authorization (1) specifically designate that HIV test results are being sought, (2) be signed and dated, (3) identify to whom the test results may be released, and (4) identify when the authorization expires.[317]

These requirements are not as stringent as what is required by HIPAA. West Virginia law, for instance, does not require that the written authorization describe the purpose for which the disclosed test results will be used.[318] It also does not require that the authorization notify the test subject that he/she has the right to revoke the authorization and how to effectuate such revocation or notify the test subject that the patient has the right to obtain a copy of the authorization.[319]

In application of HIPAA's disclosure exception for public health and safety purposes,[320] the West Virginia Bureau of Public Health is authorized by

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313 *Id.* § 16-3C-3(a)(9)(i).

314 *Id.*

315 *See supra* Part V.B.3.

316 W. VA. CODE § 16-3C-3(c).

317 *Id.* § 16-3C-1(q).

318 *See id.*

319 45 C.F.R. § 164.508 (2003).

320 *See* Part V.B.3, 4, and 9.

state law to notify those "individuals named or identified as spouses, sex partners or contacts, or persons who have shared needles" with a test subject during the ten years preceding a positive test result of their "risk of having acquired the HIV infection as a result of possible exchange of body fluids."[321] The identity of the test subject must "remain confidential."[322]

West Virginia law allows for "substituted consent" for the administration of testing and release of HIV-related test results.[323] Read in conjunction with HIPAA, West Virginia law expands the definition of a "personal representative" for an incapacitated adult to include a person holding a durable power of attorney for health care decisions; the person's duly appointed legal guardian; or the person's next-of-kin in the following order of preference: spouse, parent, adult child, sibling, uncle or aunt, and grandparent.[324]

The Act is silent regarding the rights of minors pertaining to their HIV-related testing. It is evident from the language in the Sexually Transmitted Disease Act, West Virginia Code section 16-4-1, that the Acquired Immune Deficiency Syndrome ("AIDS") is deemed a sexually transmitted disease. Only to the extent that the provisions of West Virginia Code section 16-3C-1 *et seq.* are more stringent than the requirements of West Virginia Code section 16-4-1 *et seq.*, do they apply.[325] Consequently, because minors can seek testing and treatment for sexually transmitted disease without the consent of their parents,[326] and because a parent cannot obtain records pertaining to the treatment of their child for sexually transmitted diseases without the child's consent,[327] it follows that these same restrictions apply to HIV-related testing and treatment records. West Virginia law, in this regard, is more restrictive than HIPAA.[328]

Additionally, West Virginia law is more restrictive than HIPAA concerning publication of HIV-related test results for payment purposes. These disclosures cannot be made absent consent or authorization for release.[329] West Virginia law prohibits disclosure to relatives or friends involved in the patient's care without the patient's authorization. It also mandates a written notice to accompany the personal health information that prohibits re-disclosure absent the patient's authorization or a court order permitting re-disclosure.[330]

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321 W. VA. CODE § 16-3C-3(d).

322 *Id.*

323 *Id.* § 16-3C-4.

324 *Id.* § 16-30-1 to -25.

325 *Id.* § 16-4-1.

326 *Id.* § 16-4-10.

327 *Id.* § 16-29-1.

328 *Id.* § 16-3C-5.

329 *Id.* § 16-3C-3.

330 *Id.* § 16-3C-3(c).

IX. LITIGATION PRACTICE SUGGESTIONS

HIPAA affords an opportunity to address issues that frequently result in discovery disputes and delays in the orderly progression of a litigated matter or administrative process.

A. *Discovery Suggestions and Scheduling/Case Management Orders*

As to a covered entity, once litigation is filed against it, HIPAA does not preclude disclosure of the involved plaintiff's health information in the course of that proceeding.[331] Prior to litigation, business associate agreements are necessary as between covered entities, their insurers, and attorneys.

In civil litigation matters, general notice provisions in written discovery and in deposition notices may be considered, whether or not the matter involves a covered entity as a named party. In written interrogatories and requests for production, a general statement may be used that any protected health information obtained or provided by the response of the party may be re-disclosed in the course of this litigation. Likewise, a general statement may be made conspicuously on the face of deposition notices that otherwise protected health information may be discussed during that setting. These notices promote a means of addressing privacy issues early in a case, rather than later, to avoid inefficiency and unnecessary expense in subsequent deposition discovery.

Professionalism demands proper disclosure from one party to another. One significant source of frustration, unnecessary cost, lost efficiency, and hazard to the general reputation of the legal profession is unnecessary gamesmanship that is played in discovery posturing. All experienced counsel know and understand that surprises and new information may evolve over the life of a case. Unfounded posturing leads to loss of credibility with the court and one another. Courts and counsel may use HIPAA in a positive, proactive manner to decrease the frequency of this kind of "stand off."

When a matter is ripe for case management, a mandatory meet and confer conference with counsel pursuant to Rule 16[332] is suggested as one mechanism by which to identify and address foreseeable privacy issues early in the litigation. Even if unknown at that time, by placing this subject on the agenda at the time of the initial scheduling conference, it may sensitize and heighten the awareness of counsel to these issues.

Courts also may require the parties to notify them, before any Rule 16 conference, of then known and/or foreseeable issues concerning matters of privilege or protected health information. The following issues may be raised and the

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331 45 C.F.R. § 160.512 (2003); *see generally* W. VA. CODE § 57-5-4a to -4j (2003); Keplinger v. Va. Elec. & Power Co., 537 S.E.2d 632 (W. Va. 2000); Morris v. Consolidation Coal Co., 446 S.E.2d 648 (W. Va. 1994).

332 W. VA. R. CIV. P. 16; W. VA. R. CRIM. P. 16; W. VA. TRIAL. CT. R. 40.03.

parties charged with the obligation to present at the hearing must be prepared to discuss the then known and/or foreseeable subjects with the court:

- Matters of privilege including but not necessarily limited to: trade secret privilege; attorney client communication/quasi attorney client communication privilege; protected health information confidentiality privilege; and third party interests concerning the same (such as other patients, other insurance claims, etc.);

- Proposed qualified protective orders;

- Proposed time frame for discovery of matters of privilege in order for the parties to brief the same and, if necessary, prepare privilege logs;

- Proposed joint authorization for collection of medical records, billing records, and things that contain individually identifiable health information;

- Proposed party charged with de-identification obligations; and

- Proposed joint subpoena duces tecum notice for third parties in compliance with the Privacy Standards and West Virginia law, such as *Keplinger v. Virginia Electric & Power Company.* [333]

B. Evidentiary Matters

HIPAA is not an evidentiary standard. Issues of admissibility, relevancy, and probative value should not be confused with the Privacy Standard. With respect to admissibility, the court retains its sanction authority for failure to disclose and for improperly acquired information.[334] HIPAA does not create any additional evidentiary requirement for admissibility of individually identifiable health information. It does not, for instance, bar publication of acquired information to the jury. Issues of de-identification, publication, *in camera* hearings, and admissibility are governed by West Virginia law and its evidentiary requirements.

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[333] 537 S.E.2d 632; *see also* W. VA. CODE § 57-5-4a to -4j; *Morris*, 446 S.E.2d at 648.

[334] W. VA. R. CRIM. P. 16(d)(2); *see also* W. VA. R. CIV. P. 37; Kincaid v. S. W. Va. Clinic, Inc., 475 S.E.2d 145 (W. Va. 1996); McDougal v. McCammon, 455 S.E.2d 788 (W. Va. 1995); State v. Weaver, 382 S.E.2d 327 (W. Va. 1989); State v. Myers, 370 S.E.2d 336 (W. Va. 1988); Bell v. Inland Mut. Ins. Co., 332 S.E.2d 127 (W. Va. 1985).

C. *Family Law Matters*

Rule 55 of the West Virginia Rules of Practice and Procedure for Family Courts expressly requires the parties to any action within the family court's jurisdiction to seek court orders for the release of confidential records:

> Unless the person who is the subject of confidential records waives confidentiality in writing, such records may not be obtained by subpoena; but only by court order and upon full compliance with statutory and case law requirements. Such records include, but are not limited to: confidential medical and educational records; and confidential records of the West Virginia Department of Health and Human Resources, the Office of Social Services; the Office of Economic Services; the child support enforcement agency; West Virginia juvenile court proceedings; mental health treatment and counseling; substance abuse treatment; and domestic violence shelters.[335]

This requirement affords greater control by the family court of those instances, for example, when parties seek to use the health information of their spouses or children as evidence in custody disputes. As with the circuit courts in civil litigation, the family courts may wish to maximize the issues addressed with the party litigants during the Rule 24 scheduling conferences to include:

- Proposed Qualified Protective Orders, to include appointments of guardian(s) *ad litem*, and specific restrictions on access to individually identifiable health information within the court's files, pursuant to Rule 6;

- Proposed time frame for discovery of specific matters of privilege in order for the parties to brief the same and, if necessary, prepare privilege logs;

- Proposed joint authorization for collection of medical records, billing records, and things which contain individually identifiable health information;

- Proposed party charged with de-identification obligations; and

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335 W. VA. R. PRAC. & PROC. FOR FAM. CT. 55 (2003).

- Proposed joint subpoena duces tecum notice for third parties in compliance with the Privacy Standards and West Virginia law, such as *Keplinger v. Virginia Electric & Power Co.* [336]

X. CONCLUSION

A burden and responsibility is now placed upon the legal system arising out of a law that was first conceived to address job-lock due to insurance contract pre-existing condition exclusion clauses. HIPAA impacts every individual as each of us is a patient and nearly all seek health care or some service by one or more covered entity. The full and practical impact of the law, its enforcement, and its interpretive meaning now become the responsibility of the legal system. Careful evaluation of the meaning of "individually identifiable health information" within the context of the specific type of legal case/issue presented must be given more than mere cursory consideration by the courts, counsel, law enforcement and all participants in the judicial system.

336 537 S.E.2d 632; *see also* W. VA. CODE § 57-5-4a to -4j; *Morris*, 446 S.E.2d at 648.