Responding To Subpoenas - HIPAA Requirements

Opposing Attorney Subpoena

The law gives opposing attorneys the right to obtain medical records by filing the request with the court which allows the patient to object to their disclosure. If there is no objection, usually the case, then the attorney can send you a subpoena after waiting 15 days that you are required to complete. You do not need an Authorization for these disclosures of PHI and you can respond to all requests* in the Subpoena. It is always a good idea to notify the patient of the Subpoena so that they have an opportunity to object to having their PHI disclosed.

The opposing attorney's Subpoena will include a:

"Notice of Production" and/or **"HIPAA Release".**

HIPAA has Increased Protections for Psychotherapy Notes

Definition: Psychotherapy notes means notes recorded (in any medium) by a health care 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 and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

*** Psychotherapy Notes are not discoverable and can only be released with a valid Authorization to another therapist. Patients and their legal representatives do not have a right to receive copies, direct copies to other individuals or otherwise receive these protected notes.**

Patient's Attorney Subpoena

The patient's attorney will send you a Subpoena that **must include a valid HIPAA Authorization**. There are two items you need to review on all Authorization Forms, first that it contains all 9 Required Elements, see chart, and that Sensitive Protected Health Information (sPHI) must have a second action by the patient to be released.

The second step could be that the information is initialed, circled, checked or written in. **You cannot send sPHI if there is not a 2nd Step involved** for the patient, so a statement that sPHI is included in this Authorization is not sufficient for HIPAA purposes.

sPHI includes, but is not limited to:

- Information about a Mental Illness or Developmental Disability
- Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about Communicable Diseases
- Information about Venereal Disease(s)
- Information about Substance (i.e., alcohol or drug) Abuse
- Information about Genetic Testing
- Information about Child Abuse and Neglect
- Information about Abuse of an Adult with a Disability
- Domestic Abuse/Violence
- Information about Sexual Assault
- Information about Artificial Insemination

AUTHORIZATION FORMS
REQUIRED ELEMENTS

Authorization Core Elements
(Privacy Rule, 45C.F.R. §164.508(c)(1))

1. Description of PHI to be used or disclosed (identifying the information in a specific and meaningful manner).
2. The name(s) or other specific identification of person(s) or class of persons authorized to make the requested use or disclosure.
3. The name(s) or other specific identification of the person(s) or class of persons who may use the PHI or to whom the covered entity may make the requested disclosure.
4. Description of each purpose of the requested use or disclosure. [Research: note that this element must be research study specific, not for future unspecified research.]
5. Authorization expiration date or event that relates to the individual or to the purpose of the use or disclosure [the terms "end of the case" or "none" may be used for research.]
6. Signature of the individual **and** date. If the Authorization is signed by an individual's personal representative, a description of the representative's authority to act for the individual.

Authorization Required Statements
(Privacy Rule,45 C.F.R. § 164.508(c)(2))

7. The individual's right to revoke Authorization in writing and either (1) the exceptions to the right to revoke and a description of how the individual may revoke Authorization or (2) reference to the corresponding section(s) of the covered entity's Notice of Privacy Practices.
8. Notice of the covered entity's ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the Authorization, and, if applicable, consequences of refusing to sign the Authorization.
9. The potential for the PHI to be re-disclosed by the recipient and no longer protected by the Privacy Rule. This statement does not require an analysis of risk for re-disclosure but may be a general statement that the Privacy Rule may no longer protect health information.

Allowable Fees: Opposing and Patient Attorney Requests.
State Allowable Fees plus Postage Apply. It is no longer required that the OCR patient allowable fees to be extended to attorneys.

See Next Page For Example HIPAA Compliant Authorization

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		SS#	

TO: (Name, Address, Phone of **Recipient** of Records)						
Name				Phone		
Address						
City/State Zip						

RECORDS FROM: (Who is **Releasing** the Records)						
Name				Phone		
Address						
City/State Zip						

For the Following Purposes:

☐	Continued Medical Care	☐	Personal Information	☐	Legal Follow-up
☐	Disability Insurance	☐	Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

☐	Please send the entire Medical Record (all information) to the above named recipient.				
☐	Office Notes and Reports	☐	Diagnostic Reports	☐	Billing Statements
☐	Rx History	☐	Transcribed Hospital Reports	☐	Laboratory Reports
☐	Others Listed Here:				

You must check "yes" or "no" if you authorize the release of Sensitive Protected Health Information, test results, records or communications specific to:

	Yes	No
HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases	☐	☐
Mental Health Information and/or Records	☐	☐
Domestic Violence	☐	☐
Genetic Testing Information and/or records	☐	☐
Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind information is to be disclosed.) Describe:	☐	☐
Other:		

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Personal Representative: _____

Print Name of Personal Representative (if applicable): _____

Relationship to patient: _____