Clinical Records & Confidentiality

Clinical Record

Q. How is a clinical record defined? What is considered a part of the clinical record?

The Baker Act defines the clinical record to mean all parts of the record required to be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by a facility which pertains to the patient's hospitalization and treatment.

Q. Does a person have a right to see his or her own clinical record?

YES. The Baker Act requires that persons have reasonable access to their clinical records, unless such access is determined by the person's physician to be harmful to the person. Facilities and mental health professionals should make every possible effort to ensure persons have this access. Facilities should have policies and procedures addressing what is "reasonable access", what is "harmful", who makes the decision to permit access, who is authorized to restrict access, how the record will be reviewed to determine if harmful material is included, how the record's integrity will be protected, and if a copy of the record will be provided to the person, if requested.

Q. Could give me an ADA citation or at least indicate the broad ADA principle having to do with a person accessing his/her own clinical record? How about equal access to Medicaid funded transportation?

The Chris Doe case was filed by the ACLU and the Advocacy Center for Persons with Disabilities in federal court.

> **Chris DOE, et al v.Dr. Carlos Stincer, et al, Case No. 96-2191-CIV-MORENO. U.S.** District Court Judge Frederico Moreno permanently blocked the state from enforcing a Florida statute that exempts certain medical records from disclosure to patients. The court held that those provisions discriminate illegally against persons with mental disabilities in Florida. The case filed by the ACLU and the Advocacy Center for Persons with Disabilities was filed in 1996 after the Florida Legislature enacted a statute that exempted hospitals from the requirement to disclose to patients certain records of treatment for any "mental or emotional condition" at health facilities, restricting patient access to records of their treatment when they had been involuntarily hospitalized under the Baker Act. The U.S. District Court held that the exemption improperly discriminates against the mentally disabled and is prohibited by the ADA

Another case of the Anchorage Pioneer Home (APH) settlement in which residents with disabilities having equal access to transportation services apply? Clearly stated that it would be clearly discriminatory by Medicaid to deny a person who is Medicaid eligible, for a Medicaid eligible service and at a Medicaid eligible provider solely because of an acute mental illness.

YOUR RIGHTS UNDER THE AMERICANS WITH DISABILTIES ACT

What Is the Americans with Disabilities Act?

The Americans with Disabilities Act (ADA) of 1990 provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, state and local government services, public accommodations, transportation, and telecommunications.

Who Is Protected Under the ADA?

The ADA protects *qualified individuals with disabilities*. An *individual with a disability* is a person who has a physical or **mental impairment** that substantially limits major life activities; has a record of such an impairment; or is regarded as having such an impairment. *Major life activities* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. Under the ADA, *a qualified individual with a disability* is an individual with a disability who meets the essential eligibility requirements for receipt of services or participation in programs or activities. Whether a particular condition constitutes a disability within the meaning of the ADA requires a case-by-case determination. *Physical or mental* ***impairments*** **include, but are not limited to:** visual, speech, and hearing impairments; mental retardation, **emotional illness**, and specific learning disabilities; cerebral palsy; epilepsy; muscular dystrophy; **multiple sclerosis**; orthopedic conditions; cancer; heart disease; diabetes; and contagious and noncontagious diseases such as tuberculosis and HIV disease (whether symptomatic or asymptomatic).

What Is Title II of the ADA?

Title II of the ADA prohibits discrimination against *qualified individuals with disabilities* on the basis of disability in all programs, activities, and services of public entities. Public entities include state and local governments and their departments and agencies. Title II applies to all activities, services and programs of a public entity. The Office for Civil Rights (OCR) within the U.S. Department of Health and Human Services has been designated enforcement responsibility under Title II of the ADA for state and local health care and human service agencies.

Specific Requirements

Public entities **may not**:

X Refuse to allow a person with a disability to participate in, or benefit from, their services, programs or activities because the person has a disability.

X Apply eligibility criteria for participation in programs, activities and services that screen out or tend to screen out individuals with disabilities, unless they can establish that such criteria are necessary for the provision of services, programs or activities.

X Provide services or benefits to individuals with disabilities through programs that are separate or different, unless the separate programs are necessary to ensure that the benefits and services are equally effective.

Public entities **must**:

X Provide services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

X Make reasonable modifications in their policies, practices and procedures to avoid discrimination on the basis of disability, unless they can demonstrate that a modification would fundamentally alter the nature of their service, program or activity.
X Ensure that individuals with disabilities are not excluded from services, programs and activities because buildings are inaccessible.
X Provide auxiliary aids to individuals with disabilities, at no additional cost, where necessary to ensure effective communication with individuals with hearing, vision, or speech impairments. (Auxiliary aids include such services or devices as: qualified interpreters, assistive listening headsets, television captioning and decoders, telecommunications devices for the deaf [TDDs], videotext displays, readers, taped texts, brailled materials, and large print materials.)

Q. Also, does a facility need an individual to sign a release in order to provide the individual with his own records?

Regarding your question as to whether an individual needs to sign a release in order for a facility to provide the individual with his own records, there is no prohibition to this practice, assuming it applies to all patients served by the facility. The Baker Act and HIPAA allow for a person access to his/her own records, but the FAC requires facilities to develop its own policies and procedures to carry out this duty, as follows:

> **394.4615 Clinical records; confidentiality.**--
> (10) Patients shall have reasonable access to their clinical records, unless such access is determined by the patient's physician to be harmful to the patient. If the patient's right to inspect his or her clinical record is restricted by the facility, written notice of such restriction shall be given to the patient and the patient's guardian, guardian advocate, attorney, and representative. In addition, the restriction shall be recorded in the clinical record, together with the reasons for it. The restriction of a patient's right to inspect his or her clinical record shall expire after 7 days but may be renewed, after review, for subsequent 7-day periods.
>
> **65E-5.250 Clinical Records; Confidentiality.**
> (5) Each receiving facility shall develop detailed policies and procedures governing release of records to each person requesting release, including criteria for determining what type of information may be harmful to the person, establishing a reasonable time for responding to requests for access, and identifying methods of providing access that ensure clinical support to the person while securing the integrity of the record.

The following summary of a federal appellate case may also be of interest:

> **Chris DOE, et al v.Dr. Carlos Stincer, et al, Case No. 96-2191-CIV-MORENO. U.S.** District Court Judge Frederico Moreno permanently blocked the state from enforcing a Florida statute that exempts certain medical records from disclosure to patients. The court held that those provisions discriminate illegally against persons with mental disabilities in Florida. The case filed by the ACLU and the Advocacy Center for Persons with Disabilities was filed in 1996 after the Florida Legislature enacted a statute that exempted hospitals from the requirement to

disclose to patients certain records of treatment for any "mental or emotional condition" at health facilities, restricting patient access to records of their treatment when they had been involuntarily hospitalized under the Baker Act. The U.S. District Court held that the exemption improperly discriminates against the mentally disabled and is prohibited by the ADA

Q. I can't find any information in the law or rules that address the issue of wite-out and corrections on BA forms and records. We frequently get BAs through our ED from law enforcement that are incomplete, have errors or wite out has been used and it doesn't get caught by the ED so 8 hours later when the person arrives on our inpatient unit, the nurses are refusing to accept the individual on the basis that the BA is illegal and the officer is not on duty anymore so it becomes a huge ordeal for the staff and the individual that has been BA'd. Do you have any information I could share with my staff that might help us better deal with these situations when they happen? I realize no one is going to go to jail because they used wite-out but does it really make the BA entirely invalid? Are we holding a patient illegally when we admit them to the unit and discover that the LEO used wite-out to correct a word?

A. The Baker Act statute doesn't address this issue directly. The Rules implementing the statute allude to your issue, even if they don't specifically mention corrections in the following section:

> **65E-5.180 Right to Quality Treatment.**
> The following standards shall be required in the provision of quality mental health treatment:
> (2) Each facility and service provider, using nationally accepted accrediting standards for guidance, shall adopt written professional standards of quality, accuracy, completeness, and timeliness for all diagnostic reports, evaluations, assessments, examinations, and other procedures provided to persons under the authority of Chapter 394, Part I, F.S. Facilities shall monitor the implementation of those standards to assure the quality of all diagnostic products. Standards shall include and specify provisions addressing:
> (c) The dating, accuracy and the completeness of reports;
> (e) Reports shall be legible and understandable;

Standards for clinical records adopted by the JCAHO and CMS for the federal Conditions of Participation may also apply. Further, these issues may be contained in standards of nursing practice.

However, if you are only referring to the law enforcement form, this is not a medical record and wouldn't be required to follow the same standards as medical records. While the form is required by law to be placed in the individual's medical record, it should be placed in the record in the same condition you receive it. There is nothing that would keep you from asking the officer to come back to the hospital the next day to remedy the situation, but you couldn't require him/her to do so. Only if there if there is reason to believe that someone has deliberately altered the form to misrepresent the facts should your staff be concerned. A simple correction wouldn't be a problem.

In any case, the federal EMTALA law and the state's Baker Act statute are very explicit that you must accept the person, regardless of whether the form is complete, whether it is a copy instead of the original, or any other reason.

> **394.462 Transportation.**
> **(1)TRANSPORTATION TO A RECEIVING FACILITY.—**
> (j)The nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination.

A BA-52a form completed by a law enforcement officer isn't invalidated by the officer's use of wite-out and you wouldn't be keeping a patient illegally by accepting the individual under such a form or a copy of a form.

Q. Our facility will be going live with Electronic Medical Records. Is it okay to have bar codes with the hospital logo on the mandatory Baker Act forms so they can be scanned into the electronic record after a person's discharge?

Yes. Generally, the mandatory forms cannot be altered. In this situation the mandatory form is not being altered; only a logo and bar code is added .for purposes of electronic recording keeping or preprinting the name and address of the receiving facility to the form. However, retyping the form/changing the format in any significant way is not acceptable. Over 120,000 of these forms are inputted by USF/FMHI staff each year and they can't be searching for the data elements to input.

Q. We have an electronic medical record whereby we can download directly into the chart an electronically signed BA 52b and be signed by en e-pad. Can we copy this form and give this to LEO? Technically there is no "hard copy" with an "original" signature, since it is all done electronically.

A. The Baker Act makes no reference to "originals" and all references to "originals" have been removed from the rule and the forms. DCF has actively encouraged the use of electronic medical records and the technology has progressed faster than the law or rules. As long as the mental health professional's initiation form (BA-52b) replicates the form adopted in rule, there shouldn't be any problem with lack of a hard copy with an "original" signature. If the law enforcement officer hesitates, there should be no reason why the initiated professional couldn't initial next to the electronic signature on the copied completed form.

Q. How is tele-psychiatry and e-therapy dealt with under the Baker Act?

I learned that our CMHC has initiated the use of Skype to provide telemedicine services to people living in the rural part of our area to connect individuals with the psychiatrists for their routine medication management and emergency medication management appointments on non-scheduled days. They are looking at expanding the use of Skype to do individual counseling, consultation with physician offices and hospitals, and children services. They propose using it for Baker Act purposes. We know that the Baker Act rule was written and revised long before such technology was available. Are there any legal ramifications

forbidding the use of Skype or another telemedicine (vendor operated) platform? Are other states using this technology to assess acute mental illness?

As you probably know, the Baker Act law was revised a couple of years ago permitting the 2nd opinion on a BA-32 to be performed by a psychiatrist or psychologist by electronic means. It defined "electronic means" to be “A form of telecommunication that requires all parties to maintain visual as well as audio communication.”

An attorney could take a position that since the Baker Act was changed to allow for the 2nd opinion, it doesn't permit it under other circumstances. However, other than the above, the Baker Act law and rules are silent as to the use of telemedicine for purposes of performing other functions such as the Mandatory Initial Involuntary Examination, diagnostic assessment, treatment planning, medication, etc.

The DCF website has the following FAQ's about Telepsychiatry that might assist:

1. **What is telepsychiatry?** Telepsychiatry is the delivery of psychiatric examination and consultation services via a live videoconference between a doctor and a person receiving services. Telepsychiatry is one example of telemedicine.

2. **What does Chapter 458, Florida Statutes (F.S.), which governs medical practice, say about telepsychiatry? Is telepsychiatry covered by Medicaid?** Not currently, but the draft 2010 Florida Medicaid Community Behavioral Health Handbook allows for reimbursement at the rate of $60 per event for telepsychiatry services, described as "[p]sychiatric medication management services through use of interactive telecommunications equipment." After telepsychiatry has been added to the Handbook, fee-for-service Medicaid will be able to receive reimbursement for it for services other than an initial psychiatric examination. The Medicaid PSN, Pre-paid and HMO Plans do not currently reimburse for telepsychiatry.

3. What does the American Psychiatric Association (APA) say about telepsychiatry? (Retrieved from: American Psychiatric Association)

- "Telepsychiatry, or telemedicine, is a specifically defined form of video conferencing that can provide psychiatric services to patients living in remote locations or otherwise underserved areas. It can connect patients, psychiatrists, physicians, and other healthcare professionals through the use of television cameras and microphones. Telemedicine currently provides an array of services, including but not limited to diagnosis and assessment; medication management; and individual and group therapy. It also provides an opportunity for consultative services between psychiatrists, primary care physicians and other healthcare providers. Telepsychiatry is also being used to provide patients with second opinions in areas where only one psychiatrist is available.
- Telepsychiatry has been shown to improve collaborative services between professionals. Studies indicate that healthcare professionals feel telepsychiatry has given them an opportunity to work more effectively as a team.
- Patients surveyed say they felt that the communication between their physicians had improved their outcomes. There are a few barriers to providing telepsychiatry services. Reimbursement is still difficult to receive, especially through third-party payers, and licensure [for psychiatrists to provide services across state lines] can be difficult to obtain.

- Overall, telepsychiatry provides increased access to services and has helped enhance the provision of services to families with children and other patients who are homebound. Patients participating in telepsychiatry say they are satisfied with the care they are receiving and that they feel telepsychiatry is a reliable form of practice."

4. **May telepsychiatry be used for an examination that forms the basis of a professional certificate initiating Baker Act involuntary examination?** Yes. All that is required in statute for an authorized professional to initiate involuntary examination by certificate is that the professional "has examined a person within the preceding 48 hours (s. 394.463(2)(a)3, F.S., (2009))," and concludes that the individual meets criteria for examination. However, professionals should exercise caution to ensure that their clinical decisions meet appropriate standards of care.

5. **May an involuntary examination be completed at an emergency department (ED) that is not part of a hospital designated as a Baker Act receiving facility?** Yes, if the individual examined is receiving emergency medical services at the emergency department (ED) and the involuntary examination is completed by a professional authorized to complete such examinations.

   - If the ED is part of a Baker Act receiving facility, these professionals would include psychiatrists, clinical psychologists, or ED attending physicians.
   - If the ED is not part of Baker Act receiving facility, then these authorized professionals would include any physician.
   - The Baker Act authorizes law enforcement to transport an individual to an emergency department (ED) that is not a Baker Act receiving facility if the individual has a concurrent non-psychiatric medical emergency (s. 394.462(1)(h), F.S.(2009)). In this event, a psychiatrist, clinical psychologist, or ED attending physician who examines the individual at the hospital has authority to determine that the individual does not meet criteria for involuntary placement, and therefore to approve the individual's release directly from the ED (s. 394.463(2)(g), F.S.(2009)).

6. **May telepsychiatry be used for the initial mandatory involuntary examination that is part of the Baker Act involuntary examination process?** Yes. The Baker Act requires an initial examination by a physician (not necessarily a psychiatrist) or clinical psychologist at the receiving facility "without unnecessary delay" (s. 394.463(2)(f), F.S.(2009)). Applicable rule requires that this be a "face-to-face examination of the person in a timely manner to determine if the person meets criteria for release (65E-5.2801, F.A.C.)." Telepsychiatry permits face-to-face visual and audio contact without an in-person examination. Interpreting this requirement to prohibit telepsychiatry could create the kind of unnecessary delay that the Legislature hoped to avoid.

7. **May telepsychiatry be used in an examination that forms the basis for approval of release from involuntary examination?** Yes. All that is required for release is that the individual meet criteria for release as established by "the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician (s. 394.463(2)(f), F.S., (2009))." Since telepsychiatry is an accepted part of psychiatric practice, there is nothing to prevent a psychiatrist from basing his or her approval for release on a telepsychiatric examination.

8. **May telepsychiatry be used for the examination that forms the basis of the first opinion supporting involuntary inpatient placement?** No. The Baker Act requires that the petition for involuntary inpatient placement "must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours." The phrase "personally examined" is not defined, and, in isolation, could conceivably be interpreted to include telepsychiatry. However, the same subparagraph goes on to specify that "[a]ny second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means." (s. 394.467(2), F.S.(2009)) "Electronic means" is defined as "a form of telecommunication that requires all parties to maintain visual as well as audio communication (s. 394.455(38), F.S.(2009))." This is clearly a reference to telepsychiatry. Since telepsychiatry is authorized explicitly for the second opinion, but not mentioned with regard to the first opinion, the Legislature appears to have considered the appropriateness of telepsychiatry for both opinions and only deemed it appropriate for the second opinion.

9. **May telepsychiatry be used for the examination that forms the basis of the second opinion supporting involuntary inpatient placement?** Yes. This is discussed in the response to the previous question.

10. **May telepsychiatry be used for the examination that forms the basis of the first opinion supporting involuntary outpatient placement?** No. The same language regarding "electronic means" used to authorize telepsychiatry for the second (but not first) opinion supporting involuntary inpatient placement is used to authorize the use of telepsychiatry for the second (but not first) opinion supporting involuntary outpatient placement. (s. 394.4655(2)(a), F.S.(2009))

11. **May telepsychiatry be used for the examination that forms the basis of the second opinion supporting involuntary outpatient placement?** Yes. This is discussed in the response to the previous question.

Sherri Morgan, Associate Counsel, LDF and Ethics and Professional Review for the National Association of Social Workers in Washington DC has prepared an interesting legal document on Internet therapy. As long as there isn't a prohibition in the law and the practice is consistent with professional standards of the personnel using telepsychiatry, the practice wouldn't be opposed by DCF. Unless specifically prohibited, SAMH/HQ has promoted the use of technology to advance electronic records, communications, and other practices not anticipated when the law and rule were developed.

Q. Since we are now on electronic records, our treatment plans are also. Since we need to have the patient review, make comments and sign the treatment plan how we would do this since we are paperless? We thought we could review the plan via the computer, we could type their comments for them on to the plan and then state the patient signed it by using two patient identifiers as we use in any electronic signature for patients. Would this meet the standard for the baker act with relationship to the patient acknowledging the treatment plan?

DCF has consistently supported hospital efforts to develop electronic medical records. The law never makes reference to originals of documents and all references to originals in the rule and forms have been removed. However, the law states the person must have had an opportunity to assist in preparing/reviewing the treatment plan prior to its implementation and must have a space for the person's comments. What you propose would meet the statutory requirements. It would be best to include the person's own words to reflect that he/she actually understood the contents of the plan and agreed to it.

Q. When a person is admitted voluntarily, the documents are completed in the Computerized Patient Record and signed via electronic signature pad. Our question is whether the involuntary forms can have a digital signature as we were considering having these forms available in the Computerized Patient Record. If they require a pen and ink signature, then we will not be able to do this.

A. DCF is encouraging the use of electronic medical records. When forms need to be modified to incorporate a bar code for scanning, that has been acceptable. Electronic signatures are accepted by IRS and by the courts, not to mention many other settings.

Q. A psychiatrist who was ordered to perform an independent expert examination pursuant to an involuntary placement hearing is requesting a copy of the inpatient record to take with him for his review. Is there any provision which would allow this, outside of patient consent or order of the Court?

Since the independent expert is appointed by the court and would be a witness for the individual's defense, access to the record is implied. Review of existing clinical records is a normal part of a psychiatric examination. Provisions of law include:

> **394.467 Involuntary inpatient placement.—**
> (4) APPOINTMENT OF COUNSEL.--Within 1 court working day after the filing of a petition for involuntary inpatient placement, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of such appointment. Any attorney representing the patient shall have access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.
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> (6) HEARING ON INVOLUNTARY INPATIENT PLACEMENT.--
> (a)2. The court may appoint a general or special magistrate to preside at the hearing. One of the professionals who executed the involuntary inpatient placement certificate shall be a witness. The patient and the patient's guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall provide for one. The independent expert's report shall be confidential and not discoverable, unless the expert is to be called as **a witness for the patient** at the hearing.
>
> **394.4615 Clinical records; confidentiality.**--
> (2) The clinical record shall be released when:

(a) The patient or the patient's guardian authorizes the release. The guardian or guardian advocate shall be provided access to the appropriate clinical records of the patient. The patient or the patient's guardian or guardian advocate may authorize the release of information and clinical records to appropriate persons to ensure the continuity of the patient's health care or mental health care.
(b) The patient is represented by counsel and the records are needed by the patient's counsel for adequate representation.
(c) The court orders such release. In determining whether there is good cause for disclosure, the court shall weigh the need for the information to be disclosed against the possible harm of disclosure to the person to whom such information pertains.

If you are asking if the psychiatrist can remove a copy of the record from the premises of the receiving facility rather than access the record itself, the above provisions don't address this issue. However, copies of charts (or information from the charts) are frequently sent to other entities outside the organization creating the record with the consent of the person or an order of the court. The psychiatrist's request would be handled the same.

Confidentiality

Q. Could you provide me with information about when a court can order the release of clinical records from a Baker Act receiving facility and whether it is the same from an outpatient therapist?

Summaries of several appellate cases are included below that clearly distinguish between the authority of the court to order release of Baker Act records after a good cause hearing and the lack of authority to order release of other psychiatric records in an outpatient context.

Jaffee v. Redmond, 518 U.S. 1 (1996), When Congress enacted the Federal Rules of Evidence in 1975, it expressly left the development of evidentiary privileges to the courts. The "privilege of a witness... shall be governed by the principles of the common law as they may be interpreted... in the light of reason and experience." Under these common-law principles, the law favors compelling witnesses to give whatever evidence they can, unless there is some other "public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth."

The psychotherapist-patient privilege, like the attorney-client and spousal privileges, flows from society's desire to facilitate certain relationships of confidence and trust. "Effective psychotherapy... depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communication made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede disclosure of the confidential relationship necessary for successful treatment." These are the important societal interests the psychotherapist-patient privilege works to protect.

By contrast, if there existed no privilege for communications between psychotherapists and their patients, people would decide not to seek treatment for mental illness, particularly illnesses and traumas that are likely to result in litigation. If there were no privilege, evidence such as that sought from Redmond by Allen's estate would not likely arise in the first place, and would remain out of court just as if it were privileged.

The court rejected the use of in camera inspections as a means to balance the competing interests of the criminal defendant and the witness, saying that "making the promise of confidentiality contingent upon a trial judge's later devaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege."

The Court also had no trouble applying it to therapy provided by a licensed clinical social worker. Social workers provide a significant amount of mental health treatment. Their clients often are of modest means and cannot afford the assistance of psychiatrists and psychologists. The vast majority of states explicitly extend a testimonial privilege to social workers. Thus, the Court saw no reason to delimit the privilege so as to exclude social workers from the privilege.

Katlein v. State, 731 So2d 87 (4th DCA 1999). The court set out a mechanism for determining when it is appropriate for a court to order the release of Baker Act records. The party seeking the records must first make a threshold showing that the privileged records are likely to contain relevant evidence. "The defendant must advance a good faith factual basis which is not merely a desperate grasping at a straw." In other words, no fishing expedition. If a showing is made that the records are likely to contain relevant evidence, the court will do an in camera inspection. If the court concludes after inspecting the records that they contain relevant information, it should then allow the parties access to them in order to determine whether disclosure of the information to the trier of fact is required to ensure a fair trial. The burden is on the party seeking disclosure to demonstrate that disclosure is required.

State v. Famiglietti, 817 So. 2d 901 (Fla. 3rd DCA 2002). A defendant in a criminal case cannot invade the psychotherapist/patient privilege even if the defendant established a reasonable probability that the privileged material contain evidence necessary to his or her defense. The psychotherapist-patient privilege is an unqualified privilege. No Federal constitutional principle mandates the invasion of the psychotherapist-patient privilege. The court in *State v.Pinder* erred in concluding that due process requires a balancing of the interest protected by the privilege against the defendant's need for the privileged material. The Legislature, in providing for the unqualified privilege balanced society's need for the privilege against the possible loss of potentially probative evidence. The Legislature determined that the interests protected by the privilege outweighed any possible need for the privileged material. Consequently, the Fourth District erred in holding that courts should engage the balancing test. The plurality opinion below was therefore correct in holding that communication shielded by the psychotherapist-patient privilege is not subject to compelled disclosure.

Q. A man is being held in a local Baker Act receiving facility. His sister is his court-appointed guardian, and she has asked the hospital for his records. The hospital's Risk Manager says they don't have to provide those records until after discharge, per 395.3025(1). However, 395.3025(2) clearly states that the previous section does not apply to records maintained at any facility governed by the provisions of 394.4615. Is the hospital correct?

The hospital is not correct. All hospitals are required to uphold the rights of persons held under the Baker Act, regardless of whether the hospital is designated. With regard to access to records:

> 395.3025 Patient and personnel records; copies; examination.--
> (1) Any licensed facility shall, upon written request, and only after discharge of the patient…
> (2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615.
> (3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.

The Baker Act provides that:

> 394.4615 Clinical records; confidentiality.--
> (2) The clinical record shall be released when:
> (a) The patient or the patient's guardian authorizes the release. The guardian or guardian advocate shall be provided access to the appropriate clinical records of the patient. The patient or the patient's guardian or guardian advocate may authorize the release of information and clinical records to appropriate persons to ensure the continuity of the patient's health care or mental health care.

Finally, there is a federal case out of Miami brought by the ACLU and the Advocacy Center that confirms the ADA prohibits separate regulations governing medical and psychiatric disabilities:

> Chris DOE, et al v.Dr. Carlos Stincer, et al, Case No. 96-2191-CIV-MORENO. U.S. District Court Judge Frederico Moreno permanently blocked the state from enforcing a Florida statute that exempts certain medical records from disclosure to patients. The court held that those provisions discriminate illegally against persons with mental disabilities in Florida. The case filed by the ACLU and the Advocacy Center for Persons with Disabilities was filed in 1996 after the Florida Legislature enacted a statute that exempted hospitals from the requirement to disclose to patients certain records of treatment for any "mental or emotional condition" at health facilities, restricting patient access to records of their treatment when they had been involuntarily hospitalized under the Baker Act. The U.S. District Court held that the exemption improperly discriminates against the mentally disabled and is prohibited by the ADA

If the guardianship is a plenary rather than limited, the guardian has all rights the person would have if capacitated. HIPAA yields to state law regarding substitute decision-makers who are standing in the shoes of the patient.

Q. Medicaid transport providers are requiring a copy of the BA initiation form as a condition of processing billing. Further, Medicaid and private insurers are requiring a copy of the BA initiation form to pre-certification a person's admission and continued stay. Does this violate confidentiality?

Historically, just the physician notes and clinical justification have been required for the above. HIPAA allows the sharing of confidential records for the purpose of payment, but defers to state laws when the state laws are more protective of a patient's privacy. The Baker Act doesn't make such an exception. The Baker Act forms have generally been considered "confidential and exempt" from disclosure under chapter 394.4615, FS.

> 394.4615 Clinical records; confidentiality.--
> (1) A clinical record shall be maintained for each patient. The record shall include data pertaining to admission and such other information as may be required under rules of the department. A clinical record is confidential and exempt from the provisions of s. 119.07(1). Unless waived by express and informed consent, by the patient or the patient's guardian or guardian advocate or, if the patient is deceased, by the patient's personal representative or the family member who stands next in line of intestate succession, the confidential status of the clinical record shall not be lost by either authorized or unauthorized disclosure to any person, organization, or agency.
> (7) Any person, agency, or entity receiving information pursuant to this section shall maintain such information as confidential and exempt from the provisions of s. 119.07(1).

This issue should be referred to one of your corporate attorney's to ultimately provide you the legal advice needed on this issue.

Q. I am with the Clerk of Court. Regarding confidentiality, addresses the information that is not to be disclosed by the facility. I have been informed by administrative personnel that there is nothing in the statutes that precludes me from acknowledging the existence of a mental health case or Marchman Act should I receive an inquiry. What is your view on this policy?

The two Attorney General Opinions below deal with Baker Act and Marchman Act files in the care of the Clerk of Court:

> AGO 91-10 Regarding the inspection and copying requirements of Baker Act and Marchman Act records possessed by the clerk of court. 1991 WL 528139 (Fla. A.G.) Attorney General Robert A. Butterworth advised the Clerk of the Court for Lee County, FL that Baker Act patients' clinical records produced pursuant to section 394.459(9), Fla. Stat. are specifically made confidential and are exempt from being inspected and copied by the public pursuant to section 119, Fla. Stat. Generally, when materials are filed with the clerk of court, such records are open to the public. AGO 89-94 concluded that in the absence of a specific statutory

provision or court rule making a record confidential or dictating the manner of its release and absent a court order closing a particular court record, probate records filed with the clerk of court are subject to Ch. 119, F.S. The records created pursuant to the Baker and Marchman Acts are confidential and exempt from s. 119.07(1), F.S., when placed in the possession of the clerk of court.

AGO 97-67 Regarding the clerk's authority to maintain confidentiality of confidential information contained in the official records. It is the clerk's responsibility to devise a method to ensure the integrity of the Official Records while also maintaining the confidential status of information contained within. Nothing in the Public Records Law or the statures governing the duties of the clerk authorizes the clerk to alter or destroy Official Records. However, the statute does impose a duty on the clerk to prevent the release of confidential material that may be contained in the Official Records. There is nothing that precludes the clerk from altering reproductions of the Official Records to protect confidential information. The manner in which this is to be accomplished rests within the sound discretion of the clerk.

Facilities would be prevented from acknowledging whether a person was or wasn't currently or had ever been a patient. How this applies to the Clerk of Court, other than as explained by the AG above is unclear.

Q. One of my students told me that a newspaper cited that his sister was admitted to the hospital under the Baker Act. He thought this would be information that would be protected under HIPAA. My first reaction was that because the Act refers to a legal action, it may not have protection under health care law, but I'm really not sure how to respond to the student.

Actually HIPAA defers to any state law that might be more protective of a person's privacy. Of course, what you describe would not be more protective. However, law enforcement is not a covered entity under HIPAA because it is not a health care provider, except the medical units located in county jails that provide treatment to inmates. While HIPAA is not the governing factor as it relates to law enforcement, the Baker Act alludes to some privacy and the Attorney General on several occasions has rendered formal written opinions on the subject. The Baker Act states:

394.4615(7) Any person, agency, or entity receiving information pursuant to this section shall maintain such information as confidential and exempt from the provisions of s. 119.07(1).

A summary of two Florida Attorney General opinions addressing this issue are found below. They generally state that while the official Baker and Marchman Act forms completed by law enforcement officers are confidential and exempt from the public records law, the incident reports completed by the officers associated with taking the person into custody are not exempt – these are public records. While law enforcement couldn't refuse to release such incident reports in response to a specific request, a law enforcement agency should not casually including them in with all other reports for public review

AGO 93-51 Regarding Whether Law Enforcement Records under the Baker Act are Public Records. A law enforcement officer's event or incident report prepared after a specific "crime" has been committed which contains information given during the initial reporting of the crime, and which is filed with the law enforcement agency as a record of that event, is not confidential and is a public record subject to inspection and copying pursuant to ch. 119, F.S. However, the written report detailing the circumstances under which the person was taken into custody and is made a part of the patient's clinical record is confidential and exempt from the provisions of the Public Records Law.

AGO 86-101 Regarding whether the statutorily required report of law enforcement officer under the Baker Act are exempt from disclosure. A law enforcement agency prepares an "event form", and "incident report narrative form," and a separate "Report of Law Enforcement Officer" form when a person is taken into custody under the Baker Act. Only the latter "Report of Law Enforcement Officer" form, which is statutorily required to be included in the clinical record of a patient is confidential and statutorily declared not to be a public record. Other event forms or incident reports which appear to be analogous to crime and arrest reports are public records.

Q. If photo ID's of new admissions are taken for security and safety reasons (for internal purposes and to give to law enforcement if someone escapes or elopes), is that a violation of the Baker Act if prior permission of the person hadn't been obtained?

The Baker Act law and rules make no reference to photographs. However, the photograph becomes part of the "clinical record" which is defined as all parts of the record required to be maintained and including all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by a facility which pertains to the person's hospitalization and treatment".

Therefore 394.4615, FAC and 65E-5.250, FAC governing confidentiality of clinical records would apply. In this case, the photographs would be confidential unless waived by express and informed consent by the person or his/her legally authorized substitute decision-maker. The law provides for several specific exceptions. One of which is found in 394.467(8), FS governing RETURN OF PATIENTS that states "When a patient at a treatment facility leaves the facility without authorization, the administrator may authorized a search for the patient and the return of the patient to the facility. The administrator may request the assistance of a law enforcement agency in the search for and return of the patient". In such cases, there is no prohibition of the use of a photograph in assisting the law enforcement agency to search for the person.

In these circumstances, releasing the photograph only to law enforcement at a time of unauthorized absence from the hospital is acceptable, assuming the person meets the involuntary placement criteria.

Q. If a person needs medications but refuses them and has been determined by a physician not to have capacity to make his or her own treatment decisions, can a

facility staff legally call a family member or close friend to be a health care proxy without his/her consent?

Yes. A facility can contact the person highest on the list of eligible proxies to seek his or her involvement. The federal HIPAA law recognizes state statutory authority to designate persons who will "stand in the shoes of the person", such as guardians, guardian advocates, and health care surrogates and proxies. Chapter 765, FS states that a person from the following list, in the order of listing, can be selected by the provider, to act as proxy:

(a) The judicially appointed guardian of the patient or the guardian advocate of the person having a developmental disability as defined in s. 393.063, who has been authorized to consent to medical treatment, if such guardian has previously been appointed; however, this paragraph shall not be construed to require such appointment before a treatment decision can be made under this subsection;
(b) The patient's spouse;
(c) An adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation;
(d) A parent of the patient;
(e) The adult sibling of the patient or, if the patient has more than one sibling, a majority of the adult siblings who are reasonably available for consultation;
(f) An adult relative of the patient who has exhibited special care and concern for the patient and who has maintained regular contact with the patient and who is familiar with the patient's activities, health, and religious or moral beliefs; or
(g) A close friend of the patient.
(h) A clinical social worker licensed pursuant to chapter 491, or who is a graduate of a court-approved guardianship program. Such a proxy must be selected by the provider's bioethics committee and must not be employed by the provider. If the provider does not have a bioethics committee, then such a proxy may be chosen through an arrangement with the bioethics committee of another provider. The proxy will be notified that, upon request, the provider shall make available a second physician, not involved in the patient's care to assist the proxy in evaluating treatment. Decisions to withhold or withdraw life-prolonging procedures will be reviewed by the facility's bioethics committee. Documentation of efforts to locate proxies from prior classes must be recorded in the patient record.

Q. The Baker Act rules indicate that when a person has not executed an advance directive, health care decisions may be made by an eligible proxy during the interim period between the time the person is determined by the physician to be Incompetent to consent to treatment and the time a guardian advocate is appointed by a court to provide express and informed consent. Would there be any conflict with HIPAA allowing a proxy to make decisions, since the person did not have an advance directive?

No. HIPAA defers to the state laws in recognizing those individuals who are authorized to "stand in the shoes of the person" for decision-making purposes in each state. This includes guardians, guardian advocates, and health care surrogates/proxies in Florida.

Q. Can information from a psychiatric clinical record be released in response to a subpoena?

NO. A court order is required. In determining whether there is good cause for disclosure, the court must weigh the need for the information to be disclosed against the possible harm of disclosure to the person to whom the information pertains.

Q. Can a member of a Local Advocacy Council see a clinical record without the patient's consent?

YES. A Council member, showing a picture identification, has the authority to visit with any patient and to see legal and clinical records in designated receiving and treatment facilities

Q. If a person has declared an intention to harm other people, does the Baker Act require the administrator to release this information?

NO. The Baker Act authorizes, but doesn't require, the facility administrator to release sufficient information to provide adequate warding to the person threatened with harm by the patient. However, case law suggests a stronger case for protecting an intended victim.

Q. If a patient in a receiving or treatment facility confesses to committing a crime, does the facility have a responsibility to inform law enforcement?

NO. The facility has no right to notify law enforcement of a person's acknowledgement of any past crime. This may be a treatment issue, in which the person is encouraged to notify law enforcement on their own accord or the facility may wish to share the information with the person's attorney.

Q. Can a Guardian Advocate review the contents of the clinical record?

YES. The Baker Act requires that the Guardian Advocate be given access to the appropriate clinical records of the patient and may also authorize the release of information and clinical records to appropriate persons to ensure the continuity of the patient's health care or mental health care.

Q. Can the Public Defender and State Attorney access the clinical record?

The Public Defender can have access to the clinical record, the patient, and the staff in preparing for the involuntary placement hearing. The law doesn't expressly permit this same access to the State Attorney prior to the Involuntary Inpatient Placement hearing, although it does for Involuntary Outpatient Placement hearings. In some circuits, the State Attorney has access, while not in others. In any case, the clinical record is always available at the time of the hearing and is, at that time, available to the State Attorney.

Q. When we have an actively psychotic client being Baker Act'd from our mental health center to the hospital, are we legally able to provide the hospital with information we have regarding the client? What are the parameters as to what we can share and what are the limitations?

The federal HIPAA law and the state Baker Act law apply. First, HIPAA permits the sharing of information for purposes of treatment – this is one of the exceptions, along with operations and payment issues. However, HIPAA yields to state statutes that may have more stringent privacy laws. If the patient isn't willing or able to provide informed consent for you to release information, the hospital should determine if the person should have a health care proxy designated for purposes of consenting to treatment as well as release of information. However, if the patient has no relative or close friend who could serve as proxy, this might not be possible. Much of the information about the person's current psychiatric condition and history can appropriately be included on the BA-52 form, including attachments as necessary, to justify the initiation of the involuntary examination. Inclusion on that document might be the easiest way to communicate the necessary information.

Q. Is there a requirement for facilities to give notice when a foreign national is held involuntarily under the Baker Act?

Yes. The State Department's website on Consular Notification and Access provides excellent information on this requirement, based on the Vienna Convention. The State Department website is: http://travel/state.gov/law/consular/consular_753.html
The following FAQ's from that website may be helpful:

> Q. If we have a foreign national detained in a hospital, do we have to provide consular notification?
> A. Yes, if the foreign national is detained pursuant to governmental authority (law enforcement, judicial, or administrative) and is not free to leave. He/she must be treated like a foreign national in detention, and appropriate notification must be provided.
>
> Q. When we notify the consulate, should we tell them the reasons for the detention?
> A. Generally you may use your discretion in deciding how much information to provide consistent with privacy considerations and the applicable international agreements. Under the VCCR, the reasons for the detention do not have to be provided in the initial communication. The detainee may or may not want this information communicated. Thus we suggest that it not be provided unless requested specifically by the consular officer, or if the detainee authorizes the disclosure. Different requirements may apply if there is a relevant bilateral agreement. (Some of the bilateral agreements require that the reasons for the detention be provided upon request.) If a consular official insists that he/she is entitled to information about an alien that the alien does not want disclosed, the Department of State can provide guidance.

When a non-US citizen (i.e. a British citizen) is involuntary for examination, are there any other notifications of his/her admission that need to take place in addition to AHCA and the LAC?

Yes, one additional notification is required for Foreign Nationals. These are individuals who are citizens of another country, even if they have dual citizenship with the United States. The Vienna Convention is clear in the treaty itself that the consulate must be notified anytime a foreign national is detained by law enforcement. The "Blue Book" that provides all the procedures allegedly is even more explicit in that such notification must be made even when any hospital (such as a Baker Act receiving facility) detains a person under any legal or administrative hold.

There is even more documentation supporting such notification for British citizens in the Anglo-American Agreement of 1953 which is a bi-lateral treaty between Britain and the United States that governs arrests of British nationals by American law enforcement. Rebecca Budgen is with the British Consulate Office in Orlando -- should you need to reach Rebecca directly, her phone number is 407 254-3300.

The State Department's website on Consular Notification and Access provides all the information you could need on this subject. However, I've listed two of the FAQ's below that are most critical:

> Q. If we have a foreign national detained in a hospital, do we have to provide consular notification?
> A. Yes, if the foreign national is detained pursuant to governmental authority (law enforcement, judicial, or administrative) and is not free to leave. He/she must be treated like a foreign national in detention, and appropriate notification must be provided.
>
> Q. When we notify the consulate, should we tell them the reasons for the detention?
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You can get any information from the State Department website at:

> The State Department website is: http://travel/state.gov/law/consular/consular_753.html or The U.S. State Department website is at www.state.gov Please check the following specific website www.state.gov/law/consular/consular_636.html

It has extensive information about Consular Notification and Access for foreign nationals, including great Frequently Asked Questions on every possible issue, phone and fax numbers for foreign embassies and consulates in the US, a poster with the legal notice in many languages, training materials, etc.

The home page has a great deal of information on Consular Notification and Access, part of which includes official instructions for Federal, State, and Local law enforcement and other officials concerning the rights of Foreign Nationals in the United States. You'll also find numerous free tools and resources designed to increase public awareness of our consular notification and access obligations.

You'll find information and guidance regarding:

- The arrest and detention of foreign nationals
- The deaths of foreign nationals
- The appointment of guardians for minors or incompetent adults who are foreign nationals
- Related issues pertaining to consular services to foreign nationals in the US

All levels of law enforcement must ensure that foreign governments can extend appropriate consular services to their nationals in the U.S. and that the U.S. complies with its legal obligations to such governments. It is essential that U.S. citizens be offered the same consular services when they are detained abroad. To require that of other countries, it is equally important that we provide this courtesy here.

These instructions must be followed by all federal, state, and local government officials, whether law enforcement, judicial, or other, insofar as they pertain to foreign nationals subject to such officials' authority or to matters within such officials' competence.

Your cooperation in ensuring that foreign nationals in the United States are treated in accordance with these instructions permits the U.S. to comply with its consular legal obligations domestically and will ensure that the U.S. can insist upon rigorous compliance by foreign governments with respect to U.S. citizens abroad.

To read further, please click on the links below:

- Consular Notification and Access
- Basic Instructions
- Detailed Instructions
- Mandatory Notification Countries and Jurisdictions
- Frequently Asked Questions
- Foreign Language Translations of Consular Notification Statements
- Legal Material
- Contact Information for Foreign Consular Offices in the U.S.
- Suggested Fax Sheet for Notifying Consular Officers of Arrests or Detentions
- Suggested Fax Sheet for Notifying Consular Officers of Death/Serious Injuries
- Identification of Foreign Consular Officers in the U.S.
- Training Resources
- All Consular Notification Requirements Remain in Effect
- Training and Outreach: State Department Activities to Advance CNA Awareness and Compliance
- CNA Process flowchart in .pdf format (Color version) and (Black and White version)

There is extensive training and educational materials on the website.
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Q. I have a question about a suicide note which was presented by family members to a law enforcement officer who initiated Baker Act. This individual was eventually released from the Baker Act and later committed suicide. The sister of the deceased wants the original note as it was addressed to the family. Law enforcement has provided her with a copy, still she wants the original. Can the facility release the original or must it remain in the chart as part of the law enforcement initiated Baker Act?

There is nothing in the Baker Act law or rules that require the original of any document, especially such a note. There really wasn't any legal reason to have the note in the clinical record in the first place, but once there, a copy should suffice to keep the record intact. It certainly wouldn't be an issue of confidentiality either because the Baker Act specifically authorizes, when the patient is deceased, the patient's personal representative or the family member who stands next in line of intestate succession to access the record or authorize release of information from the record. On the surface, it seems like a kindness to allow the family to have the handwritten note. You may want to consult with your attorney to be sure that the original note wouldn't be needed in case of any subsequent litigation against the facility. The facility may also want to ensure that law enforcement and/or the medical examiner wouldn't need the original note for any kind of investigation. There might even be some way of certifying the copy to be kept in the record as a true copy of the original.

Q. If an individual is seen by a psychiatrist and deemed incompetent can a facility notify the "Emergency Contact" from Screening when it is obvious this individual cannot notify anyone themselves because of their current mental status? Some times we have information on file or these individuals are known to us and we know family. We are only wishing to notify someone of the clients' whereabouts and their safety or verify their admission if family is calling to find them. Sometimes individuals are transferred not once but twice to get to us – very confusing for family or friends.

The current statute requires that you notify the person's representative unless he/she specifically objects to the notice being given. The law doesn't require express and informed consent for the notification of the representative to be made. It is presumed that the notice will be given unless the person overtly refuses. Further, it is only this initial notice of admission that can be waived – all other statutorily required notices must be given to the representative regardless of any objection raised by the person. These can include giving a copy of the notice of rights of persons in a facility, a copy of the inventory of personal effects, and notice of the right to file on behalf of the person a petition for a writ of habeas corpus. None of the above notices have to wait until after a psychiatrist has evaluated the person – they can be made at screening. Listing the emergency contact as the person's representative would assist in providing the legal basis for these notices.

Q. Can I provide a copy of the clinical record to the patient without going through medical records? Also, when a patient is unable to sign or refuses to sign consents, specifically for financial, can we still call in pre-cert info?

The Baker Act guarantees an adult patient access to his/her clinical records, including a copy of the involuntary examination form that may have initiated the admission, as follows:

> **394.4615(10) Clinical records; confidentiality.**-- Patients shall have reasonable access to their clinical records, unless such access is determined by the patient's physician to be harmful to the patient. If the patient's right to inspect his or her clinical record is restricted by the facility, written notice of such restriction shall be given to the patient and the patient's guardian, guardian advocate, attorney, and representative. In addition, the restriction shall be recorded in the clinical record, together with the reasons for it. The restriction of a patient's right to inspect his or her clinical record shall expire after 7 days but may be renewed, after review, for subsequent 7-day periods.

This is even supported by the hospital licensing law that defers governance of psychiatric hospital records to the above statute, as follows:

> **395.3025 Patient and personnel records; copies; examination.--**
> (1) Any licensed facility shall, upon written request, and only after discharge of the patient…
> (2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615. *[see above]*
> (3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.

A federal case brought under the Americans with Disability law held that discriminatory policies that apply more stringent limits to release of information to persons with psychiatric diagnoses from those with medical diagnoses violates ADA.

> **Chris DOE, et al v.Dr. Carlos Stincer, et al, Case No. 96-2191-CIV-MORENO. U.S.** District Court Judge Frederico Moreno permanently blocked the state from enforcing a Florida statute that exempts certain medical records from disclosure to patients. The court held that those provisions discriminate illegally against persons with mental disabilities in Florida. The case filed by the ACLU and the Advocacy Center for Persons with Disabilities was filed in 1996 after the Florida Legislature enacted a statute that exempted hospitals from the requirement to disclose to patients certain records of treatment for any "mental or emotional condition" at health facilities, restricting patient access to records of their treatment when they had been involuntarily hospitalized under the Baker Act. The U.S. District Court held that the exemption improperly discriminates against the mentally disabled and is prohibited by the ADA

A person has a right to review and obtain a copy of his or her clinical record. The clinical record is defined in the Baker Act as:

> **394.455(3) "Clinical record"** means all parts of the record required to be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by a facility which pertains to the patient's hospitalization or treatment.

With regard to your question about providing information to insurance companies without the consent of the patient/legal representatives, this is one of the exemptions from the protections of the HIPAA law. While no such exemption is explicitly stated in the Baker Act, it is a universal practice to seek out pre-certification as well as filing bills for services rendered without written consent. However, whenever a person has an adult family member or close personal friend present at arrival to the hospital, a physician may determine the person to be incompetent to consent and a health care proxy can provide consent on behalf of the person. Having consent is always better than not when possible.

While your organization can't have policies that are more stringent than those guaranteed by federal and state law, it is always good to verify that your organization doesn't have some procedure for you to follow in releasing the requested records.

Q. Does a health care surrogate have any privileged access to protected health information after the death of the person to whom the information pertains?

You'll have to defer to an attorney as to whether the confidentiality of a person's medical records survives that person's death. It appears that it does according to the above provision that only authorizes the personal representative or family members standing next in line of intestate succession to access the record. Of course, a Medical Examiner and perhaps others have access to records under separate statutes. However, Chapter 765, FS governing Advance Directives doesn't mention access to records after a person's death except for organ donations.

> **394.4615 Clinical records; confidentiality.--**
> (1) A clinical record shall be maintained for each patient. The record shall include data pertaining to admission and such other information as may be required under rules of the department. A clinical record is confidential and exempt from the provisions of s. 119.07(1). Unless waived by express and informed consent, by the patient or the patient's guardian or guardian advocate **or, if the patient is deceased, by the patient's personal representative or the family member who stands next in line of intestate succession,** the confidential status of the clinical record shall not be lost by either authorized or unauthorized disclosure to any person, organization, or agency.

Q. If a patient is under involuntary status and is actively receiving community case management services, is the hospital permitted to contact the case manager without the patient's consent?

The Florida Administrative Code provides the following guidance regarding your question:

> **65E-5.130 Continuity of Care Management System.**

Persons receiving case management services.
(1**) At the time of admission receiving facilities shall inquire of the person** or significant others as to the existence of any advance directives and as to **the identity of the person's case manager. If a case manager for the person is identified, the administrator or designee shall request the person's authorization to notify the person's case manager or the case management agency of the person's admission to the facility. If authorized, such notification shall be made within 12 hours** to the published 24- hour telephone listing for the case manager or case management agency. This inquiry, notification, and the identity of the case manager or case management agency, if any, shall be documented on the face sheet or other prominent location in the person's clinical record.
(2) A department funded mental health case manager, when notified by a receiving facility that a client has been admitted, shall visit that person as soon as possible but no later than two working days after notification to assist with discharge and aftercare planning to the least restrictive, appropriate and available placement. If the person is located in a receiving facility outside of the case manager's district or region of residence, the department funded mental health case manager may substitute a telephone contact for a face-to-face visit which shall be documented in the case management record and in the person's clinical record at the receiving facility.

Therefore, authorization of the person is required to make this notification regardless of whether the person is voluntary or involuntary – competent or incompetent to consent. When the rules were written in 1998, there was some insistence on consent being required in the circumstances you mentioned, despite the statute providing the following:

394.4615 Clinical records; confidentiality.--
(3) Information from the clinical record may be released in the following circumstances:
(b) When the administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, **an aftercare treatment provider,** or an employee or agent of the department **is necessary for treatment of the patient**, maintenance of adequate records, compilation of treatment data, **aftercare planning,** or evaluation of programs.

Q. I have received several calls from detectives within different police agencies seeking assistance from receiving facilities and CSUs regarding missing persons. A person was missing and a detective had a lead that she may have been Baker Acted. The detective needed to make a positive ID that the person on this person; they were not requesting any medical records or evidence of treatment, they just wanted to ensure she was there so they could take her off of the missing person national registry. Is there anything in the law that could assist law enforcement in locating a missing person once baker acted and in the care of a receiving facility/CSU? Any information will be greatly appreciated.

A. There are several documents dealing with the release of information by health care professionals and facilities to law enforcement. The federal HIPAA law allows information on missing persons to be released to law enforcement personnel. However,

the state's Baker Act and Marchman Act don't have this specific exception. Generally, the federal law defers to state laws if the state law is more protective of privacy.

Most health care facilities will urge an individual in their care to consent to this release of information or to encourage the individual to speak directly with a family member who has reporting him/her as missing. The Baker Act actually requires notice of the admission of a person on involuntary admission, unless the person requests that no notification be made.

> **394.4599 Notice.**
> **(1)VOLUNTARY PATIENTS.—**Notice of a voluntary patient's admission shall only be given at the request of the patient, except that in an emergency, notice shall be given as determined by the facility.
> **(2)INVOLUNTARY PATIENTS.—**
> (b)A receiving facility shall give prompt notice of the whereabouts of a patient who is being involuntarily held for examination, by telephone or in person within 24 hours after the patient's arrival at the facility, unless the patient requests that no notification be made. Contact attempts shall be documented in the patient's clinical record and shall begin as soon as reasonably possible after the patient's arrival. Notice that a patient is being admitted as an involuntary patient shall be given to the Florida local advocacy council no later than the next working day after the patient is admitted.

Staff at most receiving facilities believe it is cruel to families to have them believing their loved one may be missing or harmed when actually safe in a receiving facility. They also believe having law enforcement agencies having to use personnel and equipment to search for an individual known by the facility to be safe is poor public policy. As a result, DCF has proposed legislation that would remove the phrase "unless the patient requests no notification be made" from the above provision. However, this will take legislative action.

As a result, most facilities have the receptionist forward such calls from law enforcement to a supervisor/administrator who will generally tell the officer to "keep looking" if the person is not at the facility or "there is no need to worry" if the person is at the facility. Officers should not share any information derived from such communication with the family except that the person is safe.

Q. A School Resource Officer initiated an involuntary examination on a 14 yr. old. who was transported to an adolescent unit where she was retained for a few days. The school is now inquiring about the absence of this student and is requesting documentation evidencing that the student was in fact "Baker Acted". They have no cooperation from the student's mother. Can a school request the paperwork from law enforcement? Although public record, is a minor protected from such disclosure? If law enforcement initiates an involuntary exam. on a child or adolescent while in the school, would you recommend that police provide a copy of the form to the school? Is there any way to ameliorate this dilemma, protect minors and meet the request of the school? Any information you can provide will be greatly appreciated.

A. The Florida Attorney General has issued two opinions on this subject. Both indicate that the Baker Act forms (initiation and transport) are confidential and exempt from the state's public record law. They cannot be released. However, any other forms prepared by law enforcement, such as incident reports, are public records and anyone can ask for them, including the school personnel. Some agencies include the same information on the incident report forms as on the official Baker Act forms. Other agencies only reference the BA-52A form on the incident report form but don't include any information. Others do something in between.

There is no difference between an agency's responsibilities to a minor as to an adult with regard to the Baker Act.The officer should seek a legal opinion from the attorney representing his/her agency. There is a general counsel to a sheriff in a different part of the state who believes that even the incident reports must be kept confidential -- that the Attorney General is "just another attorney".

Q. I'm an attorney representing a receiving facility. Our practice is to protect the client's confidentiality and we do NOT call law enforcement at discharge. We have a contract with the County Sheriff's Office for "jail holds" – obviously if someone is arrested first, then transported to us, they are then discharged back to the jail. Can you confirm that our practice of refusing to reveal confidential client information for a BA at discharge in these cases is the proper practice?

A. The law makes no mention of notice of release being made to a law enforcement agency when the involuntary examination was initiated by a law enforcement officer, assuming there are no criminal charges:

> **394.463(3), FS NOTICE OF RELEASE.—**Notice of the release shall be given to the patient's guardian or representative, to any person who executed a certificate admitting the patient to the receiving facility, and to any court which ordered the patient's evaluation.

As you can see, the state's Baker Act only references courts which ordered the person's evaluation and any person who executed a certificate. Only mental health professionals execute certificates – law enforcement officer complete reports.

The attorney for a mental health center in another part of the state has advised his client that sharing information by noticing an individual's release, without consent, with a mental health professional who initiated the examination might violate HIPAA. The federal or state law governing privacy that provides the greatest protection on a given privacy issue would take precedence. However, in answer to your question about noticing law enforcement officers, it doesn't appear the Baker Act establishes any such duty.

When a person with criminal charges is in your facility for involuntary examination or involuntary placement, the following sections of the Baker Act apply:

> **394.463(2), FS Involuntary examination.**
> (i)Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1.The patient shall be released, **unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;**
2.The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
3.**The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient**, and, if such consent is given, the patient shall be admitted as a voluntary patient; or
4.A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

394.469 Discharge of involuntary patients.
(1)POWER TO DISCHARGE.—At any time a patient is found to no longer meet the criteria for involuntary placement, the administrator shall:
(a)Discharge the patient, unless the patient is under a criminal charge, in which case the patient shall be transferred to the custody of the appropriate law enforcement officer;
(b)Transfer the patient to voluntary status on his or her own authority or at the patient's request, unless the patient is under criminal charge or adjudicated incapacitated; or
(c)Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.
(2)NOTICE.—Notice of discharge or transfer of a patient shall be given as provided in s. 394.4599.

The above statutory provisions require you to transfer custody of a person with criminal charges back to law enforcement once you've determined the person doesn't meet involuntary criteria. This, by necessity, requires you to contact the appropriate law enforcement agency. You wouldn't provide any information about the person's psychiatric condition.

Q. I have a question about law enforcement officers serving warrants. If an officer had a person under the Baker Act and he knew they had a warrant, could the CSU let him know when the person was being released so they could pick them up on the warrant? Secondly, if they did bring a Baker Acted person who also had been arrested for a misdemeanor can the center let them know when they are being discharged so they can bring them to booking? Facility staff indicated that both HIPAA and 42 CRF protected this information and they were not able to notify law enforcement. Staff use the federal rules of 42 CRF for their entire Baker Act facility when it comes to confidentiality even though few of their clients are there for substance abuse. I don't believe this is correct. Could you clarify?

A. You ask about the use of 42 CFR for persons with mental illness. This is intended for protection of substance abuse information and should only be used for that purpose. If a

person under the Baker Act is also being assessed or treated for a substance abuse impairment, the information related to the substance abuse issue would be protected by 42CFR and chapter 397, FS, but not the information related to mental illness. The designation status of a facility is not the deciding factor as to which law prevails – the diagnosis and services a person receives is.

Regarding the serving of warrants, HIPAA does make a distinction between warrants issued by a judge and those of an administrative nature. That is incorporated in the document I previously forwarded from the HIPAA website (also attached here) so I won't repeat it again. This seems to be a non-issue since law enforcement already knows the person is in the facility – they brought the person there in the first place. This is no violation of confidentiality as long as no clinical information is shared – just that the person is there and will be released at a specified time. The latter is required by the Baker Act statute and isn't in conflict with other federal or state laws.

One hospital administrator has staff inform the individual that an officer is in the lobby asking to serve a warrant. She says that in 90% of the time, the individual agrees to the service and the person is brought off the unit to receive the warrant and placed back onto the unit afterward. If the person is to be taken to jail instead of just being given a notice to appear, the hospital staff notifies law enforcement of the pending release.

Q. I am a Licensed Mental Health Counselor needing clarification. If a client either inpatient and/or outpatient informs a provider that they committed a criminal act and/or was a part of a criminal act. Or a client tells a counselor they have a warrant and/or receives information the client has a warrant, does the counselor have a responsibility to inform law enforcement?

A. The federal 11th Circuit Court of Appeals case from 2008 found that while therapist can report incidents to authorities that could lead to violence, that information can't be used to help convict their patient. However, the information can be used to support a civil commitment – just not a criminal conviction. A therapist has no duty to assist in apprehension of patients for past crimes (other than child abuse, etc.).

The federal website HIPAA.gov has excellent information in the frequently asked questions link. HIPAA allows for a significant amount of information to be shared by health care providers with law enforcement. Regarding the serving of warrants, HIPAA does make a distinction between warrants issued by a judge and those of an administrative nature. This seems to be a non-issue since law enforcement generally already knows the person is in the facility – they brought the person there in the first place. This is no violation of confidentiality as long as no clinical information is shared – just that the person is there and will be released at a specified time. The latter is required by the Baker Act statute and isn't in conflict with other federal or state laws.

HIPAA

Q. What can and cannot be said to family members whose loved one was Baker Acted and sent to a receiving facility? The common scenario is the loved one was Baker Acted in the community unbeknown to the family and sent to their local ED

for medical evaluation. On calling or visiting the ED what can the emergency room say as to their status and location? Is it a breach of HIPAA to state that they were sent to BA receiving facility?

A. The Baker Act has a provision in the Confidentiality section that states:

> **394.4615 Clinical records; confidentiality.**
> (9) Nothing in this section is intended to prohibit the parent or next of kin of a person who is held in or treated under a mental health facility or program from requesting and receiving information limited to a summary of that person's treatment plan and current physical and mental condition. Release of such information shall be in accordance with the code of ethics of the profession involved.

As you pointed out, federal HIPAA is a consideration as well. John Petrila, who is an attorney and a national expert on HIPAA provided a valued response as follows:

> Q. The Baker Act states "the parent or next-of-kin of an individual held in a mental health facility or program may request a summary of the person's treatment plan and current physical and mental condition. Release of this information must be in accordance with the code of ethics of the professional involved." Does that statement violate HIPAA? The individual held in the facility is incompetent and has a court appointed guardian advocate making mental health decisions and medical decisions if authorized. Would the guardian have to authorize the facility to release the summary to the parents or next-of-kin? Does the Baker Act conflict with federal laws in that regard?
>
> A. Here is a link to guidance from the Department of Health and Human Services on the question you pose below. As it illustrates, the Florida law you cite below does not appear to me to be at odds with HIPAA. Also note, given the guidance, that if a person is incapacitated, HIPAA permits sharing information in some circumstances with family members. HIPAA does not require informed consent for situations in which a family member is provided the limited information HIPAA permits to be shared, and so I infer from this that it is not necessary for a court appointed guardian advocate to authorize the release of information.
> http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/provider_ffg.pdf

Based on the HIPAA website, it is permissible to tell the parents or next of kin limited information about the person's location and condition. One should always attempt to obtain express and informed consent from a competent adult when possible, but sometimes the person isn't competent to do so or has already been transferred to another facility. It should always been the minimum information necessary and be in accord with the professional's code of ethics.

Q. Do you think facilities are allowed to charge for copies of the clinical record under the Baker Act?

A. Yes, the federal law provides for such a copying fee and the Baker Act is silent on the issue. The Baker Act guarantees "reasonable access" by a person to his/her clinical records and I think this guarantee would prohibit charging of a fee for staff time to review

the chart. However the Baker Act law and rule is silent as to a facility's responsibility to make copies of the record or fees to be charged for such copies.

> 395**.3025 Patient and personnel records; copies; examination.--**
> (1) Any licensed facility shall, upon written request, and only after discharge of the patient…
> (2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615.
> (3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.
>
> **394.4615 Clinical records; confidentiality.**
> (10)Patients shall have **reasonable access** to their clinical records, unless such access is determined by the patient's physician to be harmful to the patient. If the patient's right to inspect his or her clinical record is restricted by the facility, written notice of such restriction shall be given to the patient and the patient's guardian, guardian advocate, attorney, and representative. In addition, the restriction shall be recorded in the clinical record, together with the reasons for it. The restriction of a patient's right to inspect his or her clinical record shall expire after 7 days but may be renewed, after review, for subsequent 7-day periods.
>
> **65E-5.250 Clinical Records; Confidentiality.**
> (4) When a person's access to his or her clinical record or any part of his or her record is restricted by written order of the attending physician such restriction shall be documented in the person's clinical record. If the request is denied or such access is restricted, a written response shall be provided to the person. Recommended form CF-MH 3110, Feb. 05, "Restriction of Person's Access to Own Record," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for such documentation.
> (5) Each receiving facility shall develop detailed policies and procedures governing release of records to each person requesting release, including criteria for determining what type of information may be harmful to the person, establishing a reasonable time for responding to requests for access, and identifying methods of providing access that ensure clinical support to the person while securing the integrity of the record.

The issue of access to and copies of clinical records is also governed by the federal HIPAA law and it would generally prevail over state law if more protective of a person's privacy or rights. The federal government's HIPAA website has the following information about a person's access to his/her own records:

> **Your Medical Records**
> The Privacy Rule gives you, with few exceptions, the right to inspect, review, **and receive a copy of your medical records** and billing records that are held by health plans and health care providers covered by the Privacy Rule.
>
> **Access**
> Only you or your personal representative has the right to access your records. A

health care provider or health plan may send copies of your records to another provider or health plan as needed for treatment or payment or as authorized by you. However, the Privacy Rule does not require the health care provider or health plan to share information with other providers or plans.

Charges
A provider cannot deny you a copy of your records because you have not paid for the services you have received. Even so, **a provider may charge for the reasonable costs for copying and mailing the records. The provider cannot charge you a fee for searching for or retrieving your records.**

Provider's Psychotherapy Notes
You do not have the right to access a provider's psychotherapy notes. Psychotherapy notes are notes taken by a mental health professional during a conversation with the patient and kept separate from the patient's medical and billing records. *(see my note below).* The Privacy Rule also does not permit the provider to make most disclosures of psychotherapy notes about you without your authorization.

Correcting information
If you think the information in your medical or billing record is incorrect, you can request that the health care provider or health plan amend the record. The health care provider or health plan must respond to your request. If it created the information, it must amend the information if it is inaccurate or incomplete. If the provider or plan does not agree to your request, you have the right to submit a statement of disagreement that the provider or plan must add to your record.

For further information on this topic, please refer to 45 C.F.R. §§ 164.508, 164.524 and 164.526, and OCR's Frequently Asked Questions.

The above section protecting a provider's "psychotherapy notes" seems to be in conflict with a federal ADA case that found such refusal to release psychiatric records to be a violation of the ADA, a brief summary of the court's ruling is as follows:

Chris DOE, et al v.Dr. Carlos Stincer, et al, Case No. 96-2191-CIV-MORENO. U.S. District Court Judge Frederico Moreno permanently blocked the state from enforcing a Florida statute that exempts certain medical records from disclosure to patients. The court held that those provisions discriminate illegally against persons with mental disabilities in Florida. The case filed by the ACLU and the Advocacy Center for Persons with Disabilities was filed in 1996 after the Florida Legislature enacted a statute that exempted hospitals from the requirement to disclose to patients certain records of treatment for any "mental or emotional condition" at health facilities, restricting patient access to records of their treatment when they had been involuntarily hospitalized under the Baker Act. The U.S. District Court held that the exemption improperly discriminates against the mentally disabled and is prohibited by the ADA

Q. I have a question about the need of releases of information as it pertains to continuity of care. This would include telephone and electronic contacts to ALFs and nursing homes for possible placement. There is a computer program (ECIN)

that many of our major hospital use where information is sent electronically to nursing homes and ALFs. Does this comply with the confidentiality provisions of the law?

A. HIPAA exempts personal health information for purposes of treatment, billing, or operations. Referral for aftercare treatment would fit this exemption. The Baker Act confidentiality provisions include the following:

> **394.4615 Clinical records; confidentiality.**
> (3)Information from the clinical record may be released in the following circumstances:
> (b)When the administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, **an aftercare treatment provider,** or an employee or agent of the department is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, **aftercare planning,** or evaluation of programs.

While it might be preferable to make one referral at a time to reduce the sharing of information to those aftercare facilities that won't be accepting the transfer, this isn't always practical. Given that hospital ED's only have 12 hours to transfer the individual to a receiving facility after medical stabilization and receiving facilities only have 72 hours before the individual must be released (unless converted to voluntary or petition files), such an electronic program may be the only way to comply with the law.

The facilities that send and receive this clinical information are all HIPAA compliant and must maintain the confidentiality of the information unless specifically exempted under federal or state law. I expect that we'll see many practice changes occur due to dramatic changes in electronic means of communication that can make operations far more efficient. It is incumbent on all of those providers to not let efficiency outweigh sensitivity to very private information.

Q. A family member brought the patient into our facility and he is under the Baker Act. The family calls during the day and wants to see how the patient is. Are we able to talk to them since the person is under the Baker Act? We have always been told that we can. When they are voluntary or involuntary, then we need to get consent or proxy.

A. The Baker Act section governing confidentiality has the following provisions:

> 394.4615 Clinical records; confidentiality.
> (8)Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to this section is not subject to civil or criminal liability for such release.
> (9)Nothing in this section is intended to prohibit the parent or next of kin of a person who is held in or treated under a mental health facility or program from requesting and receiving information limited to a summary of that person's treatment plan and current physical and mental condition. Release of such information shall be in accordance with the code of ethics of the profession involved.

However, a question was raised about a year ago as to whether this permitted limited release of information to a parent of an adult patient would pass scrutiny under the federal HIPAA law. John Petrila is a nationally known expert in HIPAA, is an attorney, and is based at USF/Florida Mental Health Institute. His response to this question is below:

> Here is a link to guidance from the Department of Health and Human Services on the question you pose below. As it illustrates, the Florida law you cite below does not appear to me to be at odds with HIPAA. Also note, given the guidance, that if a person is incapacitated, HIPAA permits sharing information in some circumstances with family members. HIPAA does not require informed consent for situations in which a family member is provided the limited information HIPAA permits to be shared, and so I infer from this that it is not necessary for a court appointed guardian advocate to authorize the release of information. http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/provider_ffg.pdf

The above question was specific to a Guardian Advocate, but the HIPAA.gov website has many FAQ's having to do with sharing limited information with family and friends without prior patient consent.

Q. The following is in the Baker Act confidentiality provisions. Doesn't it conflict with HIPAA?

> (9) Nothing in this section is intended to prohibit the parent or next of kin of a person who is held in or treated under a mental health facility or program from requesting and receiving information limited to a summary of that person's treatment plan and current physical and mental condition. Release of such information shall be in accordance with the code of ethics of the profession involved.

This provision was initially enacted for "parents" around 1990 and expanded to also include "next of kin" in 1996. Only later came the federal HIPAA law. While HIPAA often defers to state statutes such as in release of information to substitute decision-makers, typically which ever statute is most protective of a person's privacy prevails. The state Baker Act statute may be in conflict with the Federal HIPAA law in this regard, although if the parent/next of kin of the person determined to be incompetent to consent to treatment is named as the person's proxy, such information can then be shared.

Q. Does the HIPAA Privacy Rule allow staff of a facility or hospital to provide protected health information to law enforcement in the course of making a police report of an alleged battery by a patient? I'd like to hear your response because it really isn't terribly clear to me. However, I've attached information from the website HIPAA.gov that specifically addresses information that staff of health care facilities can provide to law enforcement without consent of the patient.

A. Law enforcement doesn't usually need clinical information. They just need to carry out their duties to arrest or serve warrants, etc. In any case, the minimum necessary

information to allow the officer to carry out his/her duties would be expected. If the state attorney needs additional information to that necessary to file a battery complaint, a court order can be obtained after a good cause hearing. Even the Marchman Act that has an elevated level of confidentiality allows the following in cases where a crime has been threatened or committed on the premises or against the personnel:

> The restrictions on disclosure and use in this section do not apply to communications from provider personnel to law enforcement officers which:
> 1.Are directly related to an individual's commission of a crime on the premises of the provider or against provider personnel or to a threat to commit such a crime; and
> 2.Are limited to the circumstances of the incident, including the status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

The following information from the HIPAA website regarding sharing of information with law enforcement might be helpful:

1. To comply with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, or a grand jury subpoena. The Rule recognizes that the legal process in obtaining a court order and the secrecy of the grand jury process provides protections for the individual's private information (45 CFR 164.512(f)(1)(ii)(A)-(B)).
2. To respond to an administrative request, such as an administrative subpoena or investigative demand or other written request from a law enforcement official. Because an administrative request may be made without judicial involvement, the Rule requires all administrative requests to include or be accompanied by a written statement that the information requested is relevant and material, specific and limited in scope, and de-identified information cannot be used (45 CFR 164.512(f)(1)(ii)(C)).
3. To respond to a request for PHI for purposes of identifying or locating a suspect, fugitive, material witness or missing person; but the covered entity must limit disclosures of PHI to name and address, date and place of birth, social security number, ABO blood type and rh factor, type of injury, date and time of treatment, date and time of death, and a description of distinguishing physical characteristics. Other information related to the individual's DNA, dental records, body fluid or tissue typing, samples, or analysis cannot be disclosed under this provision, but may be disclosed in response to a court order, warrant, or written administrative request (45 CFR 164.512(f)(2)). This same limited information may be reported to law enforcement:
    - About a suspected perpetrator of a crime when the report is made by the victim who is a member of the covered entity's workforce (45 CFR 164.502(j)(2));
    - To identify or apprehend an individual who has admitted participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to a victim, provided that the admission was not made in the course of or based on the individual's request for therapy, counseling, or treatment related to the propensity to commit this type of violent act (45 CFR 164.512(j)(1)(ii)(A), (j)(2)-(3)).
4. To respond to a request for PHI about a victim of a crime, and the victim agrees. If, because of an emergency or the person's incapacity, the individual cannot agree, the covered entity may disclose the PHI if law enforcement officials represent that the PHI is not intended to be used against the victim, is needed to determine whether another person broke the law, the investigation would be materially and adversely affected by

waiting until the victim could agree, and the covered entity believes in its professional judgment that doing so is in the best interests of the individual whose information is requested (45 CFR 164.512(f)(3)). Where child abuse victims or adult victims of abuse, neglect or domestic violence are concerned, other provisions of the Rule apply:

- Child abuse or neglect may be reported to any law enforcement official authorized by law to receive such reports and the agreement of the individual is not required (45 CFR 164.512(b)(1)(ii)).
- Adult abuse, neglect, or domestic violence may be reported to a law enforcement official authorized by law to receive such reports (45 CFR 164.512(c)):
  If the individual agrees;
  If the report is required by law; or
  If expressly authorized by law, and based on the exercise of professional judgment, the report is necessary to prevent serious harm to the individual or others, or in certain other emergency situations (see 45 CFR 164.512(c)(1)(iii)(B)).
  Notice to the individual of the report may be required (see 45 CFR 164.512(c)(2)).

5. To report PHI to law enforcement when required by law to do so (45 CFR 164.512(f)(1)(i)). For example, state laws commonly require health care providers to report incidents of gunshot or stab wounds, or other violent injuries; and the Rule permits disclosures of PHI as necessary to comply with these laws.
6. To alert law enforcement to the death of the individual, when there is a suspicion that death resulted from criminal conduct (45 CFR 164.512(f)(4)). Information about a decedent may also be shared with medical examiners or coroners to assist them in identifying the decedent, determining the cause of death, or to carry out their other authorized duties (45 CFR 164.512(g)(1)).
7. To report PHI that the covered entity in good faith believes to be evidence of a crime that occurred on the covered entity's premises (45 CFR 164.512(f)(5)).
8. When responding to an off-site medical emergency, as necessary to alert law enforcement about criminal activity, specifically, the commission and nature of the crime, the location of the crime or any victims, and the identity, description, and location of the perpetrator of the crime (45 CFR 164.512(f)(6)). This provision does not apply if the covered health care provider believes that the individual in need of the emergency medical care is the victim of abuse, neglect or domestic violence; see above Adult abuse, neglect, or domestic violence for when reports to law enforcement are allowed under 45 CFR 164.512(c).
9. When consistent with applicable law and ethical standards:

- To a law enforcement officially reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public (45 CFR 164.512(j)(1)(i)); or
- To identify or apprehend an individual who appears to have escaped from lawful custody (45 CFR 164.512(j)(1)(ii)(B)).
- For certain other specialized governmental law enforcement purposes, such as:
- To federal officials authorized to conduct intelligence, counter-intelligence, and other national security activities under the National Security Act (45 CFR 164.512(k)(2)) or to provide protective services to the President and others and conduct related investigations (45 CFR 164.512(k)(3));
- To respond to a request for PHI by a correctional institution or a law enforcement official having lawful custody of an inmate or others if they represent such PHI is

needed to provide health care to the individual; for the health and safety of the individual, other inmates, officers or employees of or others at a correctional institution or responsible for the transporting or transferring inmates; or for the administration and maintenance of the safety, security, and good order of the correctional facility, including law enforcement on the premises of the facility (45 CFR 164.512(k)(5)).

Except when required by law, the disclosures to law enforcement summarized above are subject to a minimum necessary determination by the covered entity (45 CFR 164.502(b), 164.514(d)). When reasonable to do so, the covered entity may rely upon the representations of the law enforcement official (as a public officer) as to what information is the minimum necessary for their lawful purpose (45 CFR 164.514(d)(3)(iii)(A)). Moreover, if the law enforcement official making the request for information is not known to the covered entity, the covered entity must verify the identity and authority of such person prior to disclosing the information (45 CFR 164.514(h)).

A. There are several additional documents that would help:

1. An extensive document written by John Petrila, J.D., a professor at the Department of Mental Health Law & Policy at USF/Florida Mental Health Institute for the Federal Bureau of Justice Assistance3 and the National Council of State Governments on the issue of release of health information to the justice system, including law enforcement.
2. An article also written by John Petrila titled “Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems” for the federal Center for Mental Health Services
3. Information downloaded directly from the FAQ’s on the HIPAA.gov website about what can be released by health care providers to law enforcement. You’ll notice that there is a difference between information released on a warrant signed by a judge and an administrative warrant.

The federal law generally defers to state laws if state statutes are more protective of a person’s privacy than the federal law. Even though HIPAA allows a great deal of information to be shared, there are a few other laws governing the issue. If the information is about a person’s substance abuse condition, 42 CFR and the State’s Marchman Act is more restrictive in limiting information that can be released to law enforcement.

The Marchman Act limits release of substance abuse information to law enforcement to situations when related to client’s commission of a crime on premises of the provider or against provider personnel or to a threat to commit such crime. Information released is limited to client name/address, client status, circumstances of the incident, & client’s last known whereabouts. If additional information is required for criminal investigation or prosecution, a circuit court judge can (after a good cause hearing) authorize some or all of the information only if all the following are met:

- Extremely serious crime
- Likelihood records will be of substantial value
- Other ways of obtaining information not available or effective.
- Potential injury to client & provider is outweighed by public interest and need for disclosure.

One more document containing information that may be helpful to you with **substance abuse** confidentiality was provided by a major substance abuse agency in Florida has the following information in its policies and procedures governing disclosure of information to law enforcement:

> **Court Orders:**
> Disclosure of patient identifying information is permitted if a court order is issued. Such a court order authorizes the disclosure of information that would ordinarily be prohibited by 42 U.S.C. 290ee-3, 42U.S.C. 290dd-3, and 42 CFR Part 2. The court order must be accompanies by a subpoena or a similar legal mandate to compel disclosure.
>
> **Incompetent Patients**
> In the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his/her own affairs, any consent which is required may be given by the guardian or other person authorized under State law to act on the patient's behalf.
>
> **Disclosure to Law Enforcement Officers Possessing Arrest Warrants**
> If a law enforcement officer comes to the program with an arrest warrant and is seeking a patient on program premises, staff must not interfere with or impede the said patient's arrest. The law enforcement officer is allowed to enter the facility. Staff, however, is prohibited by federal regulations from aiding or identifying the patient unless the law enforcement officer is in possession of a court order. The officer is allowed to stand on the premises and serve the arrest warrant on anyone he/she believes is the person sought. If the law enforcement officer is serving a subpoena, the staff and patients are not authorized to accept it. The officer should be directed to serve the subpoena on the Chief Administrative Officer of the program.
>
> **Disclosures related to the Initiation or Substantiation of a Crime**
> Information from alcohol and drug abuse patient records shall not be disclosed for the purpose of initiating or substantiating any criminal charges against a patient. Patient records or other identifying information shall not be disclosed in response to a law enforcement request that is related to the investigation or prosecution of a crime unless such disclosure is authorized by a court order.

You should run all this information by your General Counsel to be sure that you get a legal opinion on how this information applies to any given situation and your own policies and procedures.

Q. Does the HIPAA Privacy Rule address when a person may not be the appropriate person to control an individual's protected health information?

Generally, no. The Rule defers to State and other laws that address the fitness of a person to act on an individual's behalf. However, a covered entity does not have to treat a personal representative as the individual when it reasonably believes, in the exercise

of professional judgment, the individual is subject to domestic violence, abuse or neglect by the personal representative, or doing so would otherwise endanger the individual.

Q. How does the HIPAA Privacy Rule change the laws concerning consent for treatment?

The Privacy Rule relates to uses and disclosures of protected health information, not to whether a person consents to the health care itself. As such, the Privacy Rule does not affect informed consent for treatment, which is addressed by State law.

Q. Does the HIPAA Privacy Rule change the way in which a person can grant another person health care power of attorney?

No. Nothing in the Privacy Rule changes the way in which an individual grants another person power of attorney for health care decisions. State law (or other law) regarding health care powers of attorney continue to apply. The intent of the provisions regarding personal representatives was to complement, not interfere with or change, current practice regarding health care powers of attorney or the designation of other personal representatives. Such designations are formal, legal actions which give others the ability to exercise the rights of, or make treatment decisions related to an individual. The Privacy Rule provisions regarding personal representatives generally grant persons, who have authority to make health care decisions for an individual under other law, the ability to exercise the rights of that individual with respect to health information.

Q. I have a question regarding information between DCF state forensic and civil facilities. Even though this may be acceptable per the confidentiality sections of Chapters 394 and 916, would HIPAA allow the exchange of information between Florida State Hospital and South Florida State Hospital (a GEO facility) regarding individual patients including their names?

The following are FAQ's downloaded from the federal government's HIPAA website that might help give some direction:

> Does a physician need a patient's written authorization to send a copy of the patient's medical record to a specialist or other health care provider who will treat the patient?
>
> > No. The HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment of the individual. See 45 CFR 164.506 and the definition of "treatment" at 45 CFR 164.501.
>
> Is a hospital permitted to contact another hospital or health care facility, such as a nursing home, to which a patient will be transferred for continued care, without the patient's authorization?

> Yes. The HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment or payment purposes, as well as to another covered entity for certain health care operations of that entity. See 45 CFR 164.506 and the definitions of "treatment," "payment," and "health care operations" at 45 CFR 164.501.

HIPAA clearly exempts treatment, operations, and funding issues from other protected types of communication.

Q. What do the Florida statutes say about whether inpatient Baker Acts are automatically 'No Pubs' or not. Local facilities use No Pub status, where absolutely no information or even acknowledgment of them at the facility as a patient is shared, the operator won't even put a caller through to the room. The operators say they have no information about anyone by that name for No Pub patients. Family members are given a number assigned to those No Pub patients and must have it to get told even if the patient is here in our facility. So, it's a little different than HIPAA. I believe that if the patients are in a mental health setting in a hospital they are 'No Pubs' but no one seems to have a definitive answer about when the patient is receiving medical treatment in the hospital and happens to be a Baker Act. Can you address that for me, or refer me to someplace I might be able to find it?

A. The Baker Act law and rule doesn't make any reference to "No Pub" status of persons in psychiatric units of hospitals or other receiving facilities. The law does prohibit making available any information incorporated in an individual's clinical record without express and informed consent of a competent adult or his/her legally authorized substitute decision-maker. This would include the person's name and presence in the hospital.

The Florida Administrative Code does permit a competent adult to waive this confidentiality and to identify which persons, if any, can be informed that he/she is in the facility

> **65E-5.250, FAC Clinical Records; Confidentiality.**
> (1) Except as otherwise provided by law, verbal or written information about a person shall only be released when the competent person, or a duly authorized legal decision-maker such as guardian, guardian advocate, or health care surrogate or proxy provides consent to such release. When such information is released, a copy of a signed authorization form shall be retained in the person's clinical record. Recommended form CF-MH 3044, Feb. 05, "Authorization for Release of Information," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used as documentation. Consent or authorization forms may not be altered in any way after signature by the person or other authorized decision-maker nor may a person or other authorized decision-maker be allowed to sign a blank form.
> (2) Facility staff shall inform each person that he or she has the right to waive, in writing, the confidentiality of his or her presence in a receiving or treatment facility and to communicate with all or a group of individuals as specified by the

person. Recommended form CF-MH 3048, Feb. 05, "Confidentiality Agreement," as referenced in subsection 65E-5.190(1), F.A.C., may be used for this purpose.

The referenced form may be used or your facility can amend the form to better meet your requirements. Regarding your original question about a person under a Baker Act who is receiving medical treatment, there shouldn't be any difference than what is listed above.

Q. I'm an attorney for DCF. Do you know if HIPAA prevents the department from releasing medical records of children in our care when they are requesting them as part of a dependency proceeding? It would seem to me that these judges would need these records in order to rule. I wonder if there is an exception for this purpose?

HIPAA defers to state law when the state law is more protective of a person's privacy. Otherwise, HIPAA prevails.

If the department is the legal guardian of the child in our care, we always would have the authority of consenting to the release of information on behalf of the child.

Otherwise, the parent or legal guardian of the child would have the same right to decide on release of medical records as they would to the consent to examine or treat their child. If refusing to sign a release or documented as being unavailable, I believe a court order might be needed. A court order always is sufficient to allow release of medical information.

You are much more familiar with the dependency laws than I am, however, chapter 39 would prevail over anything in the Baker Act. Some provisions that might apply are:

> **39.402 Placement in a shelter.**
> (11)(b)The court shall request that the parents consent to provide access to the child's medical records and provide information to the court, the department or its contract agencies, and any guardian ad litem or attorney for the child. If a parent is unavailable or unable to consent or withholds consent and the court determines access to the records and information is necessary to provide services to the child, the court shall issue an order granting access. The court may also order the parents to provide all known medical information to

The following applies to the provision of examination and treatment (especially psychotropic medications) and address the provision of medical records to the court.

> **39.407 Medical, psychiatric, and psychological examination and treatment of child; physical, mental, or substance abuse examination of person with or requesting child custody.**
> (1)When any child is removed from the home and maintained in an out-of-home placement, the department is authorized to have a medical screening performed on the child without authorization from the court and without consent from a parent or legal custodian. Such medical screening shall be performed by a licensed health care professional and shall be to examine the child for injury, illness, and communicable diseases and to determine the need for immunization.

The department shall by rule establish the invasiveness of the medical procedures authorized to be performed under this subsection. In no case does this subsection authorize the department to consent to medical treatment for such children.
(2)When the department has performed the medical screening authorized by subsection (1), or when it is otherwise determined by a licensed health care professional that a child who is in an out-of-home placement, but who has not been committed to the department, is in need of medical treatment, including the need for immunization, consent for medical treatment shall be obtained in the following manner:
(a)1.Consent to medical treatment shall be obtained from a parent or legal custodian of the child; or
2.A court order for such treatment shall be obtained.
(b)If a parent or legal custodian of the child is unavailable and his or her whereabouts cannot be reasonably ascertained, and it is after normal working hours so that a court order cannot reasonably be obtained, an authorized agent of the department shall have the authority to consent to necessary medical treatment, including immunization, for the child. The authority of the department to consent to medical treatment in this circumstance shall be limited to the time reasonably necessary to obtain court authorization.
(c)If a parent or legal custodian of the child is available but refuses to consent to the necessary treatment, including immunization, a court order shall be required unless the situation meets the definition of an emergency in s. 743.064 or the treatment needed is related to suspected abuse, abandonment, or neglect of the child by a parent, caregiver, or legal custodian. In such case, the department shall have the authority to consent to necessary medical treatment. This authority is limited to the time reasonably necessary to obtain court authorization.
In no case shall the department consent to sterilization, abortion, or termination of life support.
(3)(a)1.Except as otherwise provided in subparagraph (b)1. or paragraph (e), before the department provides psychotropic medications to a child in its custody, the prescribing physician shall attempt to obtain express and informed consent, as defined in s. 394.455(9) and as described in s. 394.459(3)(a), from the child's parent or legal guardian. The department must take steps necessary to facilitate the inclusion of the parent in the child's consultation with the physician. However, if the parental rights of the parent have been terminated, the parent's location or identity is unknown or cannot reasonably be ascertained, or the parent declines to give express and informed consent, the department may, after consultation with the prescribing physician, seek court authorization to provide the psychotropic medications to the child. **Unless parental rights have been terminated and if it is possible to do so, the department shall continue to involve the parent in the decisionmaking process regarding the provision of psychotropic medications. If, at any time, a parent whose parental rights have not been terminated provides express and informed consent to the provision of a psychotropic medication, the requirements of this section that the department seek court authorization do not apply to that medication until such time as the parent no longer consents.**
2.Any time the department seeks a medical evaluation to determine the need to initiate or continue a psychotropic medication for a child, the department must provide to the evaluating physician all pertinent medical information known to the department concerning that child.

(b)1.If a child who is removed from the home under s. 39.401 is receiving prescribed psychotropic medication at the time of removal and parental authorization to continue providing the medication cannot be obtained, the department may take possession of the remaining medication and may continue to provide the medication as prescribed until the shelter hearing, if it is determined that the medication is a current prescription for that child and the medication is in its original container.
2.If the department continues to provide the psychotropic medication to a child when parental authorization cannot be obtained, the department shall notify the parent or legal guardian as soon as possible that the medication is being provided to the child as provided in subparagraph 1. **The child's official departmental record must include the reason parental authorization was not initially obtained and an explanation of why the medication is necessary for the child's well-being.**
3.If the department is advised by a physician licensed under chapter 458 or chapter 459 that the child should continue the psychotropic medication and parental authorization has not been obtained, the department shall **request court authorization at the shelter hearing** to continue to provide the psychotropic medication **and shall provide to the court any information in its possession in support of the request.** Any authorization granted at the shelter hearing may extend only until the arraignment hearing on the petition for adjudication of dependency or 28 days following the date of removal, whichever occurs sooner.
4.Before filing the dependency petition, the department shall ensure that the child is evaluated by a physician licensed under chapter 458 or chapter 459 to determine whether it is appropriate to continue the psychotropic medication. If, as a result of the evaluation, the department seeks court authorization to continue the psychotropic medication, a motion for such continued authorization shall be filed at the same time as the dependency petition, within 21 days after the shelter hearing.
(c)Except as provided in paragraphs (b) and (e), **the department must file a motion seeking the court's authorization to initially provide or continue to provide psychotropic medication to a child in its legal custody. The motion must be supported by a written report prepared by the department which describes the efforts made to enable the prescribing physician to obtain express and informed consent for providing the medication to the child and other treatments considered or recommended for the child. In addition, the motion must be supported by the prescribing physician's signed medical report providing:**
1.The name of the child, the name and range of the dosage of the psychotropic medication, and that there is a need to prescribe psychotropic medication to the child based upon a diagnosed condition for which such medication is being prescribed.
2.A statement indicating that the physician has reviewed all medical information concerning the child which has been provided.
3.A statement indicating that the psychotropic medication, at its prescribed dosage, is appropriate for treating the child's diagnosed medical condition, as well as the behaviors and symptoms the medication, at its prescribed dosage, is expected to address.
4.An explanation of the nature and purpose of the treatment; the recognized side effects, risks, and contraindications of the medication; drug-interaction

precautions; the possible effects of stopping the medication; and how the treatment will be monitored, followed by a statement indicating that this explanation was provided to the child if age appropriate and to the child's caregiver.

5.Documentation addressing whether the psychotropic medication will replace or supplement any other currently prescribed medications or treatments; the length of time the child is expected to be taking the medication; and any additional medical, mental health, behavioral, counseling, or other services that the prescribing physician recommends.

(d)1.The department must notify all parties of the proposed action taken under paragraph (c) in writing or by whatever other method best ensures that all parties receive notification of the proposed action within 48 hours after the motion is filed. If any party objects to the department's motion, that party shall file the objection within 2 working days after being notified of the department's motion. If any party files an objection to the authorization of the proposed psychotropic medication, the court shall hold a hearing as soon as possible before authorizing the department to initially provide or to continue providing psychotropic medication to a child in the legal custody of the department. At such hearing and notwithstanding s. 90.803, the medical report described in paragraph (c) is admissible in evidence. The prescribing physician need not attend the hearing or testify unless the court specifically orders such attendance or testimony, or a party subpoenas the physician to attend the hearing or provide testimony. If, after considering any testimony received, the court finds that the department's motion and the physician's medical report meet the requirements of this subsection and that it is in the child's best interests, the court may order that the department provide or continue to provide the psychotropic medication to the child without additional testimony or evidence. At any hearing held under this paragraph, the court shall further inquire of the department as to whether additional medical, mental health, behavioral, counseling, or other services are being provided to the child by the department which the prescribing physician considers to be necessary or beneficial in treating the child's medical condition and which the physician recommends or expects to provide to the child in concert with the medication. The court may order additional medical consultation, including consultation with the MedConsult line at the University of Florida, if available, or require the department to obtain a second opinion within a reasonable timeframe as established by the court, not to exceed 21 calendar days, after such order based upon consideration of the best interests of the child. The department must make a referral for an appointment for a second opinion with a physician within 1 working day. The court may not order the discontinuation of prescribed psychotropic medication if such order is contrary to the decision of the prescribing physician unless the court first obtains an opinion from a licensed psychiatrist, if available, or, if not available, a physician licensed under chapter 458 or chapter 459, stating that more likely than not, discontinuing the medication would not cause significant harm to the child. If, however, the prescribing psychiatrist specializes in mental health care for children and adolescents, the court may not order the discontinuation of prescribed psychotropic medication unless the required opinion is also from a psychiatrist who specializes in mental health care for children and adolescents. The court may also order the discontinuation of prescribed psychotropic medication if a child's treating physician, licensed under chapter 458 or chapter 459, states that continuing the

prescribed psychotropic medication would cause significant harm to the child due to a diagnosed nonpsychiatric medical condition.
2.The burden of proof at any hearing held under this paragraph shall be by a preponderance of the evidence.
(e)1.If the child's prescribing physician certifies in the signed medical report required in paragraph (c) that delay in providing a prescribed psychotropic medication would more likely than not cause significant harm to the child, the medication may be provided in advance of the issuance of a court order. In such event, the medical report must provide the specific reasons why the child may experience significant harm and the nature and the extent of the potential harm. The department must submit a motion seeking continuation of the medication and the physician's medical report to the court, the child's guardian ad litem, and all other parties within 3 working days after the department commences providing the medication to the child. The department shall seek the order at the next regularly scheduled court hearing required under this chapter, or within 30 days after the date of the prescription, whichever occurs sooner. If any party objects to the department's motion, the court shall hold a hearing within 7 days.
2.Psychotropic medications may be administered in advance of a court order in hospitals, crisis stabilization units, and in statewide inpatient psychiatric programs. Within 3 working days after the medication is begun, the department must seek court authorization as described in paragraph (c).
(f)1.The department shall fully inform the court of the child's medical and behavioral status as part of the social services report prepared for each judicial review hearing held for a child for whom psychotropic medication has been prescribed or provided under this subsection. As a part of the information provided to the court, the department shall furnish copies of all pertinent medical records concerning the child which have been generated since the previous hearing. On its own motion or on good cause shown by any party, including any guardian ad litem, attorney, or attorney ad litem who has been appointed to represent the child or the child's interests, the court may review the status more frequently than required in this subsection.
2.The court may, in the best interests of the child, order the department to obtain a medical opinion addressing whether the continued use of the medication under the circumstances is safe and medically appropriate.
(g)The department shall adopt rules to ensure that children receive timely access to clinically appropriate psychotropic medications. These rules must include, but need not be limited to, the process for determining which adjunctive services are needed, the uniform process for facilitating the prescribing physician's ability to obtain the express and informed consent of a child's parent or guardian, the procedures for obtaining court authorization for the provision of a psychotropic medication, the frequency of medical monitoring and reporting on the status of the child to the court, how the child's parents will be involved in the treatment-planning process if their parental rights have not been terminated, and how caretakers are to be provided information contained in the physician's signed medical report. The rules must also include uniform forms to be used in requesting court authorization for the use of a psychotropic medication and provide for the integration of each child's treatment plan and case plan. The department must begin the formal rulemaking process within 90 days after the effective date of this act.
(4)(a)A judge may order a child in an out-of-home placement to be examined by a licensed health care professional.

Even if the court's dependency records are sealed, HIPAA shouldn't be a problem. If a guardian provides consents or a court order to produce the records is available, the release to the courts should be done.

Public Records

O. I received a call from a person who was taken into custody under the Baker Act which was eventually rescinded. She wanted to know if the Baker Act is a public record?

Yes and no. Baker and Marchman Act records in the clerk of courts office are not public records and must be kept confidential. A mental health professional's records are protected under the Baker Act and under the federal HIPAA law and must remain confidential. The Baker Act forms prepared by law enforcement officers also are confidential and can't be released. However, the law enforcement incident report form is a public record and it may include much of the same information as on the BA-52a and 3100 forms. This is governed by two Attorney General Opinions, as follows:

> **AGO 93-51 Regarding Whether Law Enforcement Records under the Baker Act are Public Records**. A law enforcement officer's event or incident report prepared after a specific "crime" has been committed which contains information given during the initial reporting of the crime, and which is filed with the law enforcement agency as a record of that event, is not confidential and is a public record subject to inspection and copying pursuant to ch. 119, F.S. However, the written report detailing the circumstances under which the person was taken into custody and is made a part of the patient's clinical record is confidential and exempt from the provisions of the Public Records Law.
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> **AGO 86-101 Regarding whether the statutorily required report of law enforcement officer under the Baker Act are exempt from disclosure.** A law enforcement agency prepares an "event form", and "incident report narrative form," and a separate "Report of Law Enforcement Officer" form when a person is taken into custody under the Baker Act. Only the latter "Report of Law Enforcement Officer" form, which is statutorily required to be included in the clinical record of a patient is confidential and statutorily declared not to be a public record. Other event forms or incident reports which appear to be analogous to crime and arrest reports are public records.

Any public record has to be retained a certain length of time, but can be destroyed after that time under certain circumstances and with authorization.

Q. Are petitions for involuntary examination and/or ex parte orders for involuntary examination public record?

The Florida Attorney General issued an opinion (AGO 91-10) on February 1, 1991 stating that records produced pursuant to the Baker Act and Marchman Act are specifically made confidential and are exempt from the inspection and copying requirements of ch. 119, F.S. It goes on to state that the public records made

confidential by law or which are prohibited from being inspected by the public are exempt from the inspection requirements of the public records law. Bottom line – Records created pursuant to the Baker and Marchman Act continue to be confidential and exempt when placed in possession of the clerk of court. This opinion also references AGO 89-94 dealing with this subject.

Other cases include:

> **AGO 97-67** Regarding the clerk's authority to maintain confidentiality of confidential information contained in the official records. It is the clerk's responsibility to devise a method to ensure the integrity of the Official Records while also maintaining the confidential status of information contained within. Nothing in the Public Records Law or the statures governing the duties of the clerk authorizes the clerk to alter or destroy Official Records. However, the statute does impose a duty on the clerk to prevent the release of confidential material that may be contained in the Official Records. There is nothing that precludes the clerk from altering reproductions of the Official Records to protect confidential information. The manner in which this is to be accomplished rests within the sound discretion of the clerk.
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> **Community Psychiatric Centers of Florida, Inc. v. Michael Bevelacqua**, 673 So. 2d 948 (Fla. 4th DCA 1996). The Fourth District Court of Appeals held that the clinical records of Baker Act patients at a receiving facility who allegedly witnessed a personal injury to another patient, could not be examined by the injured person's attorney to determine the witnesses identities since the clinical records of the Baker Act patients are confidential and the witnesses nor their guardians waived their rights to have the clinical records remain confidential. The Fourth District Court of Appeals held the trial court erred in holding that the witness' failure to file objections to their names being disclosed by the hospital was the equivalent of the witness express and informed consent. The Fourth District Court of Appeals held that the clinical records of the Baker Act patients were confidential and the confidentiality of those records may only be waived by the patient or their guardian's express and informed consent. The policy purpose for having the express and informed consent of the patient or their guardian waive the confidentiality of Baker Act clinical records is to protect the privacy of the Baker Act patient.
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> **The Tribune Company v. In re D.M.L, patient and Anclote Manor Hospital**, Appellees, 566 So. 2d 1333 (Fla. 2d DCA 1990). The Second District Court of Appeals held that a Baker Act hearing is a closed hearing where the media and the public can not attend the hearing due to the Baker Act hearing containing the clinical record of the patient which is not a public record and which is deemed confidential pursuant to section, 394.459(9), Fla. Stat. The policy purpose for having a closed Baker Act hearing is to avoid substantial injury to patient's liberty interest and to their individual dignity.

Staff in the Office of the State Court Administrator offered the following information on this topic:

> Section 394.4615, Florida Statutes (2006) makes the clinical records of Baker Act patients confidential and exempt from public disclosure, and provides that

unless waived by the patient or other authorized persons, the confidentiality of clinical records is not lost by authorized or unauthorized disclosure to any person, organization, or agency. AGO 91-10 opined that such clinical records remain confidential when filed with the clerk of court.

While clinical records are confidential when placed in the court file, petitions and orders in Baker Act cases are not protected from public disclosure. See e.g., sections 394.4655(3)(involuntary outpatient placement petitions) and 394.467(3)(involuntary inpatient placement petitions), neither of which provides for confidentiality.

In re: Interim Policy on Electronic Release of Court Records, AOSC06-21 (June 30, 2006) imposes a moratorium on the electronic release of court records, with stated exceptions. One exception is progress docket information, including the name of a party, and lists of indices of judgments, orders, pleadings, motions, notices or other documents in the court file. Under the moratorium, while the actual filings and orders in Baker Act cases are not accessible online, progress docket information, which is public record, is accessible. Compare Patterson v. Tribune Co., 146 So.2d 623 (Fla. 2d DCA 1962)(holding that the progress docket, which revealed the identity of a committed narcotic, was not public record under now-repealed section 398.18(1), which permitted inspection of records in voluntary commitment proceedings only to the petitioner, his or her counsel or narcotics officers).

Section 28.2221(5)(a), Florida Statutes (2006), provides that no clerk of court may place an image or copy of a public record on a publicly available Internet website for general public display if that image or copy is of a court file, record or paper relating to matters or cases governed by the Florida Rules of Family Law, the Florida Rules of Juvenile Procedure, or the Florida Probate Rules. While Baker Act cases are not specifically governed by the Florida Probate Rules, it appears that Baker Act cases in some circuits are filed and maintained in the probate division, and these circuits apparently may elect to protect docket information in Baker Act cases from public disclosure under the authority stated in section 28.2221 (5)(a). Other circuits do make docket information available online in Baker Act cases. In light of the absence of statutory provisions making Baker Act court records, other than clinical records, confidential, such availability does not violate Florida law.

However, one Clerk of Courts emphatically stated that none of the Baker/Marchman names would be on his website. He even has a prepared statement for the staff to use if someone asks about a particular file – "we are unable to respond as to whether we have or don't have such a record". If he receives a request for Baker or Marchman Act files, he will release no less than a month's quantity at a time, with all identifiers redacted. Of course, the requester has to pay a dollar a page to access the information

Q. I'm the legal advisor for a city Police Department and have a question about records generated by my agency regarding Baker Acts. I know that the form 52 itself is not disclosable, as it is included within the definition of clinical record. However, the other records we generate here are clearly not included within this definition and so far a cursory examination of public records law has yet to

disclose an exemption. What is your understanding of their public records status and, if they are exempt, which specific statute permits such exemption?

You are correct about the Baker (and Marchman) Act forms being exempt from disclosure under Florida's public records laws. However, the Florida Attorney General has determined that law enforcement generated incident reports are public records and must be released upon request. The following two summaries may assist you.

> **AGO 93-51** Regarding Whether Law Enforcement Records under the Baker Act are Public Records. A law enforcement officer's event or incident report prepared after a specific "crime" has been committed which contains information given during the initial reporting of the crime, and which is filed with the law enforcement agency as a record of that event, is not confidential and is a public record subject to inspection and copying pursuant to ch. 119, F.S. However, the written report detailing the circumstances under which the person was taken into custody and is made a part of the patient's clinical record is confidential and exempt from the provisions of the Public Records Law.
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> **AGO 86-101** Regarding whether the statutorily required report of law enforcement officer under the Baker Act are exempt from disclosure. A law enforcement agency prepares an "event form", and "incident report narrative form," and a separate "Report of Law Enforcement Officer" form when a person is taken into custody under the Baker Act. Only the latter "Report of Law Enforcement Officer" form, which is statutorily required to be included in the clinical record of a patient is confidential and statutorily declared not to be a public record. Other event forms or incident reports which appear to be analogous to crime and arrest reports are public records.

Q. **I'm a law enforcement officer and need to know whether our Baker Act records are public? I was reading up on public records law in relation to the Baker Act. I am not very clear on the BA-52 form – it appears to be exempt from public records but not the law enforcement event form and incident report narrative form. I believe if the event form and incident report narrative form contains information about the persons' mental health status that does not preclude it from the public. Could you please comment?**

A. Florida's Constitution and strong public records law protect the right of the public to have access to records unless specifically protected. Since the Attorney General is the chief attorney in the state and state agencies such as DCF defer to the AG for direction, the attached opinions prevail unless a new opinion in rendered or the current statutes are amended. In any case, you need to rely on the advice of counsel.

You expressed concern about how your incident reports have been mis-used against persons who have undergone an involuntary examination under the Baker Act. Summaries of two Florida Attorney General Opinions are listed below that may assist you.

> AGO 93-51 Regarding Whether Law Enforcement Records under the Baker Act are Public Records. A law enforcement officer's event or incident report

prepared after a specific "crime" has been committed which contains information given during the initial reporting of the crime, and which is filed with the law enforcement agency as a record of that event, is not confidential and is a public record subject to inspection and copying pursuant to ch. 119, F.S. However, the written report detailing the circumstances under which the person was taken into custody and is made a part of the patient's clinical record is confidential and exempt from the provisions of the Public Records Law.

AGO 86-101 Regarding whether the statutorily required report of law enforcement officer under the Baker Act are exempt from disclosure. A law enforcement agency prepares an "event form", and "incident report narrative form," and a separate "Report of Law Enforcement Officer" form when a person is taken into custody under the Baker Act. Only the latter "Report of Law Enforcement Officer" form, which is statutorily required to be included in the clinical record of a patient is confidential and statutorily declared not to be a public record. Other event forms or incident reports which appear to be analogous to crime and arrest reports are public records.

While the following three AG Opinions (summaries only) don't relate to law enforcement, they do address the issue of public records vs. confidential records under the Baker Act:

AGO 91-10 Regarding the inspection and copying requirements of Baker Act and Marchman Act records possessed by the clerk of court. 1991 WL 528139 (Fla. A.G.) Attorney General Robert A. Butterworth advised the Clerk of the Court for Lee County, FL that Baker Act patients' clinical records produced pursuant to section 394.459(9), Fla. Stat. are specifically made confidential and are exempt from being inspected and copied by the public pursuant to section 119, Fla. Stat. Generally, when materials are filed with the clerk of court, such records are open to the public. AGO 89-94 concluded that in the absence of a specific statutory provision or court rule making a record confidential or dictating the manner of its release and absent a court order closing a particular court record, probate records filed with the clerk of court are subject to Ch. 119, F.S. The records created pursuant to the Baker and Marchman Acts are confidential and exempt from s. 119.07(1), F.S., when placed in the possession of the clerk of court.

AGO 97-67 Regarding the clerk's authority to maintain confidentiality of confidential information contained in the official records. It is the clerk's responsibility to devise a method to ensure the integrity of the Official Records while also maintaining the confidential status of information contained within. Nothing in the Public Records Law or the statures governing the duties of the clerk authorizes the clerk to alter or destroy Official Records. However, the statute does impose a duty on the clerk to prevent the release of confidential material that may be contained in the Official Records. There is nothing that precludes the clerk from altering reproductions of the Official Records to protect confidential information. The manner in which this is to be accomplished rests within the sound discretion of the clerk.

The Tribune Company v. In re D.M.L, patient and Anclote Manor Hospital, Appellees, 566 So. 2d 1333 (Fla. 2d DCA 1990). The Second District Court of Appeals held that a Baker Act hearing is a closed hearing where the media and the public can not attend the hearing due to the Baker Act hearing containing the

clinical record of the patient which is not a public record and which is deemed confidential pursuant to section, 394.459(9), Fla. Stat. The policy purpose for having a closed Baker Act hearing is to avoid substantial injury to patient's liberty interest and to their individual dignity.

Q. Are reports arising from AHCA investigations of complaints regarding private hospitals part of the public record?

Every governmental record is public except where there is a specific statutory reference making a particular type of record "confidential and exempt from the provisions of s. 119.07(1)" to exclude it from public scrutiny.

Chapter 394, Part IV also has some similar exemptions for QA programs for public receiving facilities, as follows:

> **394.907 Community mental health centers; quality assurance programs.—**
> (1) As used in this section, the term "community mental health center" means a publicly funded, not-for-profit center that contracts with the department for the provision of inpatient, outpatient, day treatment, or emergency services.
> (2) Any community mental health center and any facility licensed pursuant to s. 394.875 shall have an ongoing quality assurance program. The purpose of the quality assurance program shall be to objectively and systematically monitor and evaluate the appropriateness and quality of client care, to ensure that services are rendered consistent with reasonable, prevailing professional standards and to resolve identified problems.
> (3) Each facility shall develop a written plan that addresses the minimum guidelines for the quality assurance program. Such guidelines shall include, but are not limited to:
> (a) Standards for the provision of client care and treatment practices;
> (b) Procedures for the maintenance of client records;
> (c) Policies and procedures for staff development;
> (d) Standards for facility safety and maintenance;
> (e) Procedures for peer review and resource utilization;
> (f) Policies and procedures for adverse incident reporting to include verification of corrective action to remediate or minimize incidents and for reporting such incidents to the department by a timeframe as prescribed by rule.
> Such plan shall be submitted to the governing board for approval and a copy provided to the department.
> (4) The quality assurance program shall be directly responsible to the executive director of the facility and shall be subject to review by the governing board of the agency.
> (5) Each facility shall designate a quality assurance manager who is an employee of the agency or under contract with the agency.
> (6) Incident reporting shall be the affirmative duty of all staff. Any person filing an incident report shall not be subject to any civil action by virtue of such incident report.
> (7) The department shall have access to all records necessary to determine licensee compliance with the provisions of this section. The records of quality assurance programs which relate solely to actions taken in carrying out the provisions of this section, and records obtained by the department to determine

licensee compliance with this section, are confidential and exempt from s. 119.07(1). Such records are not admissible in any civil or administrative action, except in disciplinary proceedings by the Department of Business and Professional Regulation and the appropriate regulatory board, nor shall such records be available to the public as part of the record of investigation for, and prosecution in disciplinary proceedings made available to the public by the Department of Business and Professional Regulation or the appropriate regulatory board. Meetings or portions of meetings of quality assurance program committees that relate solely to actions taken pursuant to this section are exempt from s. 286.011.

The state law governing hospitals and other facilities licensed by AHCA are somewhat different. You specifically ask about complaint investigations, as follows:

395.1046 Complaint investigation procedures.--
(1) In addition to the requirements of s. 408.811, the agency shall investigate any complaint against a hospital for any violation of s. 395.1041 which the agency reasonably believes to be legally sufficient. A complaint is legally sufficient if it contains ultimate facts showing that a violation of this chapter, or any rule adopted under this chapter by the agency, has occurred. The agency may investigate, or continue to investigate, and may take appropriate final action on a complaint, even though the original complainant withdraws his or her complaint or otherwise indicates his or her desire not to cause it to be investigated to completion. When an investigation of any person or facility is undertaken, the agency shall notify such person in writing of the investigation and inform the person or facility in writing of the substance, the facts showing that a violation has occurred, and the source of any complaint filed against him or her. The agency may conduct an investigation without notification to any person if the act under investigation is a criminal offense. The agency shall have access to all records necessary for the investigation of the complaint.
(2) The agency or its agent shall expeditiously investigate each complaint against a hospital for a violation of s. 395.1041. When its investigation is complete, the agency shall prepare an investigative report. The report shall contain the investigative findings and the recommendations of the agency concerning the existence of probable cause.
(3) The complaint and all information obtained by the agency during an investigation conducted pursuant to this section are exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution <u>until 10 days after probable cause has been found</u> to exist by the agency, or until the person who is the subject of the investigation waives his or her privilege of confidentiality, whichever occurs first. In cases where the agency finds that the complaint is not legally sufficient or when the agency determines that no probable cause exists, all records pertaining thereto are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. However, the complaint and a summary of the agency's findings shall be available, although information therein identifying an individual shall not be disclosed.

However, there are additional public records exemptions related to risk management, peer review, and clinical records in Chapter 395 governing licensed hospitals -- I've included some of those exemptions below:

395.3025 Patient and personnel records; copies; examination.--
(1) Any licensed facility shall, upon written request, and only after discharge of the patient, furnish, in a timely manner, without delays for legal review, to any person admitted therein for care and treatment or treated thereat, or to any such person's guardian, curator, or personal representative, or in the absence of one of those persons, to the next of kin of a decedent or the parent of a minor, or to anyone designated by such person in writing, a true and correct copy of all patient records, including X rays, and insurance information concerning such person, which records are in the possession of the licensed facility, provided the person requesting such records agrees to pay a charge. The exclusive charge for copies of patient records may include sales tax and actual postage, and, except for nonpaper records that are subject to a charge not to exceed $2, may not exceed $1 per page. A fee of up to $1 may be charged for each year of records requested. These charges shall apply to all records furnished, whether directly from the facility or from a copy service providing these services on behalf of the facility. However, a patient whose records are copied or searched for the purpose of continuing to receive medical care is not required to pay a charge for copying or for the search. The licensed facility shall further allow any such person to examine the original records in its possession, or microforms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed to assure that the records will not be damaged, destroyed, or altered.
(2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615.
(3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.
(4) Patient records are confidential and must not be disclosed without the consent of the patient or his or her legal representative, but appropriate disclosure may be made without such consent to:
(a) Licensed facility personnel, attending physicians, or other health care practitioners and providers currently involved in the care or treatment of the patient for use only in connection with the treatment of the patient.
(b) Licensed facility personnel only for administrative purposes or risk management and quality assurance functions.
(c) The agency, for purposes of health care cost containment.
(d) In any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice by the party seeking such records to the patient or his or her legal representative.
(e) The agency upon subpoena issued pursuant to s. 456.071, but the records obtained thereby must be used solely for the purpose of the agency and the appropriate professional board in its investigation, prosecution, and appeal of disciplinary proceedings. If the agency requests copies of the records, the facility shall charge no more than its actual copying costs, including reasonable staff time. The records must be sealed and must not be available to the public pursuant to s. 119.07(1) or any other statute providing access to records, nor may they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency must make available, upon written request by a practitioner against whom probable cause

has been found, any such records that form the basis of the determination of probable cause.
(f) The Department of Health or its agent, for the purpose of establishing and maintaining a trauma registry and for the purpose of ensuring that hospitals and trauma centers are in compliance with the standards and rules established under ss. 395.401, 395.4015, 395.4025, 395.404, 395.4045, and 395.405, and for the purpose of monitoring patient outcome at hospitals and trauma centers that provide trauma care services.
(g) The Department of Children and Family Services or its agent, for the purpose of investigations of cases of abuse, neglect, or exploitation of children or vulnerable adults.
(h) A local trauma agency or a regional trauma agency that performs quality assurance activities, a panel or committee assembled to assist a local trauma agency, or a regional trauma agency performing quality assurance activities. Patient records obtained under this paragraph are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
(7)(a) If the content of any record of patient treatment is provided under this section, the recipient, if other than the patient or the patient's representative, may use such information only for the purpose provided and may not further disclose any information to any other person or entity, unless expressly permitted by the written consent of the patient. A general authorization for the release of medical information is not sufficient for this purpose. The content of such patient treatment record is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
(b) Absent a specific written release or authorization permitting utilization of patient information for solicitation or marketing the sale of goods or services, any use of that information for those purposes is prohibited.
(8) Patient records at hospitals and ambulatory surgical centers are exempt from disclosure under s. 119.07(1), except as provided by subsections (1)-(5).
(9) A licensed facility may prescribe the content and custody of limited-access records which the facility may maintain on its employees. Such records shall be limited to information regarding evaluations of employee performance, including records forming the basis for evaluation and subsequent actions, and shall be open to inspection only by the employee and by officials of the facility who are responsible for the supervision of the employee. The custodian of limited-access employee records shall release information from such records to other employers or only upon authorization in writing from the employee or upon order of a court of competent jurisdiction. Any facility releasing such records pursuant to this part shall be considered to be acting in good faith and may not be held liable for information contained in such records, absent a showing that the facility maliciously falsified such records. Such limited-access employee records are exempt from the provisions of s. 119.07(1) for a period of 5 years from the date such records are designated limited-access records.
(10) The home addresses, telephone numbers, and photographs of employees of any licensed facility who provide direct patient care or security services; the home addresses, telephone numbers, and places of employment of the spouses and children of such persons; and the names and locations of schools and day care facilities attended by the children of such persons are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. However, any state or federal agency that is authorized to have access to such information by any provision of law shall be granted such access in the furtherance of its

statutory duties, notwithstanding the provisions of this subsection. The Department of Financial Services, or an agent, employee, or independent contractor of the department who is auditing for unclaimed property pursuant to chapter 717, shall be granted access to the name, address, and social security number of any employee owed unclaimed property.
(11) The home addresses, telephone numbers, and photographs of employees of any licensed facility who have a reasonable belief, based upon specific circumstances that have been reported in accordance with the procedure adopted by the facility, that release of the information may be used to threaten, intimidate, harass, inflict violence upon, or defraud the employee or any member of the employee's family; the home addresses, telephone numbers, and places of employment of the spouses and children of such persons; and the names and locations of schools and day care facilities attended by the children of such persons are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. However, any state or federal agency that is authorized to have access to such information by any provision of law shall be granted such access in the furtherance of its statutory duties, notwithstanding the provisions of this subsection. The licensed facility shall maintain the confidentiality of the personal information only if the employee submits a written request for confidentiality to the licensed facility.

395.0193 Licensed facilities; peer review; disciplinary powers; agency or partnership with physicians.--
(1) It is the intent of the Legislature that good faith participants in the process of investigating and disciplining physicians pursuant to the state-mandated peer review process shall, in addition to receiving immunity from retaliatory tort suits pursuant to s. 456.073(12), be protected from federal antitrust suits filed under the Sherman Anti-Trust Act, 15 U.S.C.A. ss. 1 et seq. Such intent is within the public policy of the state to secure the provision of quality medical services to the public.
(2) Each licensed facility, as a condition of licensure, shall provide for peer review of physicians who deliver health care services at the facility. Each licensed facility shall develop written, binding procedures by which such peer review shall be conducted. Such procedures shall include:
(a) Mechanism for choosing the membership of the body or bodies that conduct peer review.
(b) Adoption of rules of order for the peer review process.
(c) Fair review of the case with the physician involved.
(d) Mechanism to identify and avoid conflict of interest on the part of the peer review panel members.
(e) Recording of agendas and minutes which do not contain confidential material, for review by the Division of Health Quality Assurance of the agency.
(f) Review, at least annually, of the peer review procedures by the governing board of the licensed facility.
(g) Focus of the peer review process on review of professional practices at the facility to reduce morbidity and mortality and to improve patient care.
(3) If reasonable belief exists that conduct by a staff member or physician who delivers health care services at the licensed facility may constitute one or more grounds for discipline as provided in this subsection, a peer review panel shall investigate and determine whether grounds for discipline exist with respect to such staff member or physician. The governing board of any licensed facility,

after considering the recommendations of its peer review panel, shall suspend, deny, revoke, or curtail the privileges, or reprimand, counsel, or require education, of any such staff member or physician after a final determination has been made that one or more of the following grounds exist:
(a) Incompetence.
(b) Being found to be a habitual user of intoxicants or drugs to the extent that he or she is deemed dangerous to himself, herself, or others.
(c) Mental or physical impairment which may adversely affect patient care.
(d) Being found liable by a court of competent jurisdiction for medical negligence or malpractice involving negligent conduct.
(e) One or more settlements exceeding $10,000 for medical negligence or malpractice involving negligent conduct by the staff member.
(f) Medical negligence other than as specified in paragraph (d) or paragraph (e).
(g) Failure to comply with the policies, procedures, or directives of the risk management program or any quality assurance committees of any licensed facility.
(4) Pursuant to ss. 458.337 and 459.016, any disciplinary actions taken under subsection (3) shall be reported in writing to the Division of Health Quality Assurance of the agency within 30 working days after its initial occurrence, regardless of the pendency of appeals to the governing board of the hospital. The notification shall identify the disciplined practitioner, the action taken, and the reason for such action. All final disciplinary actions taken under subsection (3), if different from those which were reported to the agency within 30 days after the initial occurrence, shall be reported within 10 working days to the Division of Health Quality Assurance of the agency in writing and shall specify the disciplinary action taken and the specific grounds therefor. The division shall review each report and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case s. 456.073 shall apply. The reports are not subject to inspection under s. 119.07(1) even if the division's investigation results in a finding of probable cause.
(5) There shall be no monetary liability on the part of, and no cause of action for damages against, any licensed facility, its governing board or governing board members, peer review panel, medical staff, or disciplinary body, or its agents, investigators, witnesses, or employees; a committee of a hospital; or any other person, for any action taken without intentional fraud in carrying out the provisions of this section.
(6) For a single incident or series of isolated incidents that are nonwillful violations of the reporting requirements of this section or part II of chapter 408, the agency shall first seek to obtain corrective action by the facility. If correction is not demonstrated within the timeframe established by the agency or if there is a pattern of nonwillful violations of this section or part II of chapter 408, the agency may impose an administrative fine, not to exceed $5,000 for any violation of the reporting requirements of this section or part II of chapter 408. The administrative fine for repeated nonwillful violations may not exceed $10,000 for any violation. The administrative fine for each intentional and willful violation may not exceed $25,000 per violation, per day. The fine for an intentional and willful violation of this section or part II of chapter 408 may not exceed $250,000. In determining the amount of fine to be levied, the agency shall be guided by s. 395.1065(2)(b).
(7) The proceedings and records of peer review panels, committees, and governing boards or agent thereof which relate solely to actions taken in carrying

out this section are not subject to inspection under s. 119.07(1); and meetings held pursuant to achieving the objectives of such panels, committees, and governing boards are not open to the public under the provisions of chapter 286.

395.0197 Internal risk management program.--

(1) Every licensed facility shall, as a part of its administrative functions, establish an internal risk management program that includes all of the following components:

(a) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents to patients.

(b) The development of appropriate measures to minimize the risk of adverse incidents to patients, including, but not limited to:

1. Risk management and risk prevention education and training of all nonphysician personnel as follows:

a. Such education and training of all nonphysician personnel as part of their initial orientation; and

b. At least 1 hour of such education and training annually for all personnel of the licensed facility working in clinical areas and providing patient care, except those persons licensed as health care practitioners who are required to complete continuing education coursework pursuant to chapter 456 or the respective practice act.

2. A prohibition, except when emergency circumstances require otherwise, against a staff member of the licensed facility attending a patient in the recovery room, unless the staff member is authorized to attend the patient in the recovery room and is in the company of at least one other person. However, a licensed facility is exempt from the two-person requirement if it has:

a. Live visual observation;

b. Electronic observation; or

c. Any other reasonable measure taken to ensure patient protection and privacy.

3. A prohibition against an unlicensed person from assisting or participating in any surgical procedure unless the facility has authorized the person to do so following a competency assessment, and such assistance or participation is done under the direct and immediate supervision of a licensed physician and is not otherwise an activity that may only be performed by a licensed health care practitioner.

4. Development, implementation, and ongoing evaluation of procedures, protocols, and systems to accurately identify patients, planned procedures, and the correct site of the planned procedure so as to minimize the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition.

(c) The analysis of patient grievances that relate to patient care and the quality of medical services.

(d) A system for informing a patient or an individual identified pursuant to s. 765.401(1) that the patient was the subject of an adverse incident, as defined in subsection (5). Such notice shall be given by an appropriately trained person designated by the licensed facility as soon as practicable to allow the patient an opportunity to minimize damage or injury.

(e) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report adverse incidents to the

risk manager, or to his or her designee, within 3 business days after their occurrence.
(2) The internal risk management program is the responsibility of the governing board of the health care facility. Each licensed facility shall hire a risk manager, licensed under s. 395.10974, who is responsible for implementation and oversight of such facility's internal risk management program as required by this section. A risk manager must not be made responsible for more than four internal risk management programs in separate licensed facilities, unless the facilities are under one corporate ownership or the risk management programs are in rural hospitals.
(3) In addition to the programs mandated by this section, other innovative approaches intended to reduce the frequency and severity of medical malpractice and patient injury claims shall be encouraged and their implementation and operation facilitated. Such additional approaches may include extending internal risk management programs to health care providers' offices and the assuming of provider liability by a licensed health care facility for acts or omissions occurring within the licensed facility. Each licensed facility shall annually report to the agency and the Department of Health the name and judgments entered against each health care practitioner for which it assumes liability. The agency and Department of Health, in their respective annual reports, shall include statistics that report the number of licensed facilities that assume such liability and the number of health care practitioners, by profession, for whom they assume liability.
(4) The agency shall adopt rules governing the establishment of internal risk management programs to meet the needs of individual licensed facilities. Each internal risk management program shall include the use of incident reports to be filed with an individual of responsibility who is competent in risk management techniques in the employ of each licensed facility, such as an insurance coordinator, or who is retained by the licensed facility as a consultant. The individual responsible for the risk management program shall have free access to all medical records of the licensed facility. The incident reports are part of the workpapers of the attorney defending the licensed facility in litigation relating to the licensed facility and are subject to discovery, but are not admissible as evidence in court. A person filing an incident report is not subject to civil suit by virtue of such incident report. As a part of each internal risk management program, the incident reports shall be used to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct the problem areas.
(5) For purposes of reporting to the agency pursuant to this section, the term "adverse incident" means an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which:
(a) Results in one of the following injuries:
1. Death;
2. Brain or spinal damage;
3. Permanent disfigurement;
4. Fracture or dislocation of bones or joints;
5. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility;

6. Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent; or
7. Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition prior to the adverse incident;
(b) Was the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition;
(c) Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process; or
(d) Was a procedure to remove unplanned foreign objects remaining from a surgical procedure.
(6)(a) Each licensed facility subject to this section shall submit an annual report to the agency summarizing the incident reports that have been filed in the facility for that year. The report shall include:
1. The total number of adverse incidents.
2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries, and the number of incidents occurring within each category.
3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.
4. A code number using the health care professional's licensure number and a separate code number identifying all other individuals directly involved in adverse incidents to patients, the relationship of the individual to the licensed facility, and the number of incidents in which each individual has been directly involved. Each licensed facility shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.
5. A description of all malpractice claims filed against the licensed facility, including the total number of pending and closed claims and the nature of the incident which led to, the persons involved in, and the status and disposition of each claim. Each report shall update status and disposition for all prior reports.
(b) The information reported to the agency pursuant to paragraph (a) which relates to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.
(c) The report submitted to the agency shall also contain the name and license number of the risk manager of the licensed facility, a copy of its policy and procedures which govern the measures taken by the facility and its risk manager to reduce the risk of injuries and adverse incidents, and the results of such measures. The annual report is confidential and is not available to the public pursuant to s. 119.07(1) or any other law providing access to public records. The annual report is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The annual report is not available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made

available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause.
h) The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.
The agency may grant extensions to this reporting requirement for more than 15 days upon justification submitted in writing by the facility administrator to the agency. The agency may require an additional, final report. These reports shall not be available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.
(13) The agency shall have access to all licensed facility records necessary to carry out the provisions of this section. The records obtained by the agency under subsection (6), subsection (7), or subsection (9) are not available to the public under s. 119.07(1), nor shall they be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall records obtained pursuant to s. 456.071 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause, except that, with respect to medical review committee records, s. 766.101 controls.
(14) The meetings of the committees and governing board of a licensed facility held solely for the purpose of achieving the objectives of risk management as provided by this section shall not be open to the public under the provisions of chapter 286. The records of such meetings are confidential and exempt from s. 119.07(1), except as provided in subsection (13).

395.3035 Confidentiality of hospital records and meetings.--
(1) All meetings of a governing board of a public hospital and all public hospital records shall be open and available to the public in accordance with s. 286.011 and s. 24(b), Art. I of the State Constitution and chapter 119 and s. 24(a), Art. I of the State Constitution, respectively, unless made confidential or exempt by law.
(2) The following records and information of any hospital that is subject to chapter 119 and s. 24(a), Art. I of the State Constitution are confidential and

exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Contracts for managed care arrangements under which the public hospital provides health care services, including preferred provider organization contracts, health maintenance organization contracts, exclusive provider organization contracts, and alliance network arrangements, and any documents directly relating to the negotiation, performance, and implementation of any such contracts for managed care or alliance network arrangements. As used in this paragraph, the term "managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services. Managed-care techniques most often include one or more of the following: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

(b) A strategic plan the disclosure of which would be reasonably likely to be used by a competitor to frustrate, circumvent, or exploit the purpose of the plan before it is implemented and which is not otherwise known or cannot otherwise be legally obtained by the competitor. However, documents that are submitted to the hospital's governing board as part of the board's approval of the hospital's budget, and the budget itself, are not confidential and exempt.

(c) Trade secrets, as defined in s. 688.002, including reimbursement methodologies and rates.

(d) Documents, offers, and contracts, not including contracts for managed care, that are the product of negotiations with nongovernmental entities for the payment for services when such negotiations concern services that are or may reasonably be expected by the hospital's governing board to be provided by competitors of the hospital. If the governing board is required to vote on the documents, offers, or contracts, this exemption expires 30 days prior to the date of the meeting at which the hospital's governing board is scheduled to take the vote.

(3) Those portions of a governing board meeting at which negotiations for contracts with nongovernmental entities occur or are reported on when such negotiations or reports concern services that are or may reasonably be expected by the hospital's governing board to be provided by competitors of the hospital are exempt from the provisions of s. 286.011 and s. 24(b), Art. I of the State Constitution. All governing board meetings at which the board is scheduled to vote to accept, reject, or amend contracts, except managed care contracts, shall be open to the public. All portions of any board meeting which are closed to the public shall be recorded by a certified court reporter. The reporter shall record the times of commencement and termination of the meeting, all discussion and proceedings, the names of all persons present at any time, and the names of all persons speaking. No portion of the meeting shall be off the record. The court reporter's notes shall be fully transcribed and maintained by the hospital records custodian within a reasonable time after the meeting. The transcript shall become public 1 year after the termination or completion of the term of the contract to which such negotiations relate or, if no contract was executed, 1 year after termination of the negotiations.

(4)(a) Those portions of a board meeting at which one or more written strategic plans that are confidential pursuant to subsection (2) are discussed, reported on, modified, or approved by the governing board are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.
(b) All portions of any board meeting which are closed to the public pursuant to this subsection shall be recorded by a certified court reporter. The reporter shall record the times of commencement and termination of the meeting, all discussion and proceedings, the names of all persons present at any time, and the names of all persons speaking. No portion of the meeting shall be off the record. The court reporter's notes shall be fully transcribed and maintained by the hospital records custodian within a reasonable time after the meeting. The closed meeting shall be restricted to discussion, reports, modification, or approval of a written strategic plan. The transcript shall become public 3 years after the date of the board meeting or at an earlier date if the strategic plan discussed, reported on, modified, or approved at the meeting has been publicly disclosed by the hospital or implemented to the extent that confidentiality of the strategic plan is no longer necessary. If a discrete part of a strategic plan has been publicly disclosed by the hospital or has been implemented to the extent that confidentiality of that portion of the plan is no longer necessary, then the hospital shall redact the transcript and release only that part which records discussion of the nonconfidential part of the strategic plan, unless such disclosure would divulge any part of the strategic plan that remains confidential.
(c) This subsection does not allow the boards of two separate public entities to meet together in a closed meeting to discuss, report on, modify, or approve the implementation of a strategic plan that affects both public entities.
(5) Any public records, such as tape recordings, minutes, and notes, generated at any governing board meeting or portion of a governing board meeting which is closed to the public pursuant to this section are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. All such records shall be retained and shall cease to be exempt at the same time as the transcript of the meeting becomes available to the public.

Bottom line is that this isn't an easy issue. The Florida Constitution and Chapter 119, FS make Florida the most transparent state in the country regarding governmental records. The Governor and the Attorney General each have offices of Public Records and the Florida First Amendment Foundation exists for the sole purpose of full compliance with the letter and spirit of open government. However, if there is the magic exemption language in the statute, the record can be withheld totally or for a specific period of time as designated in the law.

Duty to Warn

Q. If a patient in a Baker Act Receiving Facility discloses information that poses a possible risk of harm to a potential victim, is there a duty to warn the intended victim?

The Baker Act permits such disclosure, but does not create a duty to warn.
HIPAA and professional codes of ethics also permit such release. Even though no duty to warn exists in Florida, a legitimate threat should always be taken seriously and

warning provided to the intended victim, assuming this is also the position of the facility's attorney, risk manager or compliance officer.

> **394.4615 Clinical records; confidentiality.--**
> (3) Information from the clinical record may be released in the following circumstances:
> (a) When a patient has declared an intention to harm other persons. When such declaration has been made, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient.

Federal and state appellate courts have further addressed this issue. Many people believe that the Tarasoff v. Regents of California case applies to Florida. However, since Florida law makes such disclosure permissive rather than mandatory, courts to date have found no liability for failure to disclose such a threat, as follows:

> **BOYNTON V. BURGLASS, 590 So. 2d 446 (Fla. 3d DCA 1991).** Issue was whether a mental health professional has a common law duty to warn the intended victim of a patient's potential for future dangerousness. The Boynton majority refused to follow Tarasoff.
>
> **GREEN v. Ross, 691 So. 2d 542 (FLA. 2d DCA 1997).** The second District agreed with, and relied upon, the majority opinion in Boynton.

However, Florida's 1st DCA did establish a "duty to inform" the guardians of a minor of such threats, as follows:

> **RUTH O'KEEFE, v. DAVID A. OREA, M.D. AND PSYCHIATRIC CONSULTANTS, P.A..** 1st DCA Case No. 96-3519 Opinion filed January 12, 1998). Action by mother of psychiatrist's patient, alleging medical negligence, where 17-year old patient attacked both parents, also patients of psychiatrist, and killed father, after being released from hospital. Complaint stated cause of action for medical negligence, where defendant had duty to warn parents concerning their son's condition, as result of fiduciary relationship between defendant and parents of patient, as well as physician-patient relationship between defendant and parents. Allegations that defendant knew or should have known of patient's history of learning and behavioral disorders, knew the patient physically attacked three people before emergency admission to hospital, knew patient demonstrated increasingly psychotic behavior not controlled by medication, knew patient require constant supervision and was markedly agitated and hostile to his parents, and that, despite this information, discharged the patient to parents' custody. Defendant had duty to inform parents about the patient's diagnosis, including diagnosis of other physicians who had observed patient, personal treatment recommendations, recommendations of other physicians, nurse's notes concerning patient's hallucinations, violence, threats to staff, suicidal tendencies, and fact that two make guards were required to control him.

A federal appellate court ruled as follows:

> **9th U.S. Circuit Court of Appeals** (August 2003) ruled that psychiatrists can't testify against patients who make dangerous or threatening confessions during

> therapy. It ruled that although psychiatrists are sometimes required to report incidents to authorities that could lead to violence, an en banc panel ruled that prosecutors couldn't use testimony from doctors to help convict their patients. The court concluded that the gain from refusing to recognize a dangerous-patient exception to the psychotherapist-patient testimonial privilege in federal criminal trials outweighs the gain from recognizing the exception. The court stated that although incarceration is one way to eliminate a threat of imminent harm, in many cases treatment is a longer lasting and more effective solution. A criminal conviction with the help of a psychotherapist's testimony is almost sure to spell the end of any patient's willingness to undergo further treatment for mental health problems. The court did note that its ruling doesn't extend to proceedings in civil court over whether the patient should be committed to a hospital.

It is important to know that while a current threat to harm may be reportable, confessions of past crimes are not. This issue could cause much liability exposure to a facility or professional. Any question should be posed to an attorney representing the facility. Information in this message may assist that attorney in advising his/her client.