

CREATION, MAINTENANCE AND DISCLOSURE OF HEALTH INFORMATION

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SCOPE

This Chapter reviews legal requirements for physicians and health care facilities in Florida that govern the creation, maintenance and disclosure of medical information on patients. Record keeping requirements imposed by federal and state statutes and regulations, The Joint Commission of Accreditation of Healthcare Organizations (JCAHO) requirements, Board of Medicine rulings and case law are covered. Disclosure prohibitions and exceptions are covered, as well as the rights of minors. Exceptions that may be encountered because of litigation, including subpoenas and search warrants are also reviewed and discussed.

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§26.01 Confidentiality of Medical Records: Historical Basis

The requirement to maintain the confidentiality of information provided by a patient to a physician, or any health care practitioner for that matter, is not a new one. It did not arise from federal or state laws. Professionals have long acknowledged the necessity of preserving patient confidentiality. This chapter begins with a summary of the historical basis for protecting the patient’s private medical information.

§26.02. Ethical Basis for Confidentiality

The health care community has an ethical duty to preserve the confidentiality of information obtained from their patients during care and treatment. The basis for this duty is that society encourages and benefits from people who seek health care treatment. However, they would resist disclosing intimate information necessary for their proper care and treatment unless they were assured of confidentiality.

[1] Hippocratic Oath

Written in the fifth century B.C., the Hippocratic Oath incorporated this ethical duty of confidentiality for physicians in that, it stated in pertinent part:

Whatever, in connection with my professional practice, or not in connection with it, I see or hear in the life of men, which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret.

- See Section III for the full text of this historic oath applicable to physicians.

[2] Florence Nightingale Pledge

- See Section III for the text of this historic pledge applicable to nurses.

[3] AMA Principles of Medical Ethics

In 1803, Thomas Perceval, an English physician, philosopher and writer, published his “code of Medical Ethics” which also included this duty of confidentiality. The AMA’s first adopted Code of Ethics was rooted in Perceval’s Code reaffirmed this principle. Currently in Section 5.05 of the AMA’s Principles of Medical Ethics, this principle is codified as follows:

Confidentiality. The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature

of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.

These principles were also codified in 1989 in the AMA's Patient Bill of Rights.

- See Section III for details.

[4] AHA Patient's Bill of Rights

Published in 1973, the American Hospital Association's (AHA) Patient's Bill of Rights, Article 6 applies this ethical duty to hospitals, in that it states:

“the patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.”

- See Section III for details.

[5] Other Health Care Providers

This ethical duty of confidentiality extends to other health care providers as well. American Dental Association (ADA), Principles of Ethics and Code of Professional Conduct states:

“Dentists shall safeguard the confidentiality of patient records.”

- See Section III for details.

American Nursing Association (ANA), Code for Nurses with Interpretive Statements states:

“The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.”

- See Section III for details.

[6] The Joint Commission of Accreditation of Healthcare Organizations (JCAHO)

JCAHO is a private organization that inspects and accredits hospitals to establish a consistency of care among hospitals nationwide. Although JCAHO certification is voluntary, it has become accepted as a benchmark for a hospital's quality of care and is relied upon by courts to help establish the standard of care.

To obtain JCAHO accreditation, the hospital must maintain adequate medical records. The information must be readily available and accessible for prompt retrieval and kept confidential and secure. The JCAHO requires that a medical record must be sufficiently detailed and organized to enable:

- (1) The practitioner responsible for the patient to provide continuing care to the patient, determine later what the patient's condition was at a specific time, and review the diagnostic and therapeutic procedures performed and the patient's response to treatment.
- (2) A consultant to render an opinion after examination of the patient and review of the medical record.
- (3) Another practitioner to assume the care of the patient at any time.
- (4) The retrieval of pertinent information required for utilization review and quality assessment and improvement activities.

§26.03 Legal Basis for Confidentiality

Although ethical principles are not laws, the Courts have regularly ruled such to be legal duties requiring health care professionals to preserve the confidentiality of patient information obtained during the course of care and treatment.

[1] State Laws

- (1) **Common Law** — Courts have held that a physician's disclosure of medical information to the hospital insurer without the patient's consent constituted a *breach of an implied condition of the patient-physician contract*. Courts have also, adopted an invasion of privacy theory, concluding that a physician's disclosure of information obtained in the course of treatment constituted *tortious conduct*. It has also been reasoned that patients have a right to rely on the ethical standard of the medical profession as an expressed warranty of confidentiality. (See *Hammonds v. Aetna Casualty & Surety Co.*, 243 F.Supp. 793 (N.D. Ohio 1965); *MacDonald v. Clinger*, 84 A.D. 2d 482, 446 N.Y.S. 2d 801 (1982); *Doe v. Roe*, 93 Misc. 2d 201, 400 N.Y.S. 2d 688 (Sup. Ct. 1977).

• See Section III for additional information.

- (2) **Florida Statutes** — (General Patient Records)

Health Care Practitioner's office patient records — Section 455.667(5), Florida Statutes states in pertinent part:

... such records may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient or the patient's legal representative or other health care practitioners. . . .

- See Section III for details.

[2] **Historical Sources**

- See Section III for additional historical sources.

§26.04 Regulatory Compliance for Medical Records in Florida

[1] **Legal Requirements for Medical Records in Florida in General**

Florida statutes, the Florida Administrative Code (F.A.C.) and case law, largely govern confidentiality of medical records in Florida. Other standards, laws, rules and regulations also come into play, such as licensing and accreditation standards (i.e., JCAHO standards) and Federal laws (i.e. HIPAA).

Statutes are enacted by the Florida legislature. Statutes govern our behavior. They touch every part of our lives from the way we drive to our business activities to how we use our property. The Florida Administrative Code further governs our behavior by setting forth the mechanism for complying with certain statutes. Florida courts, in turn, interpret the statutes and provisions of the Administrative Code. The interplay between the three sources of law is evident in the context of medical records.

[2] **Professional Practice Acts**

[A] **(Medical Practice) Section 458.331, Florida Statutes states:**

Grounds for disciplinary action; action by the board and department—

- (l) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:
- (m) Failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and report of consultations and hospitalizations.

[B] **(Osteopathic Medicine) Section 459.015, Florida Statutes states:**

Grounds for disciplinary action by the board;

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(o) Failing to keep written medical records justifying the course of treatment of the patient, including but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and report of consultations and hospitalizations.

[C] **(Chiropractic) Section 460.413, Florida Statutes provides:**

Grounds for disciplinary action by the board;

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be including, but not limited to, patient histories, examination results, test results, X-rays, and diagnosis of a disease, condition or injury. X-rays need not be retained for more than 4 years.

[3] **Hospital Licensing and Regulation**

Various state agencies require hospitals to maintain medical records on each patient. These records are used to evaluate the nature and level for care provided, thus facilitate protection of health safety of hospital patient. Medical records are relied upon by licensing agencies in the evaluation of health care providers and/or facilities, and when deficient, are used as a basis for denying, suspending, or terminating a facility's legal right to operate.

[4] **The Joint Commission of Accreditation of Healthcare Organizations (JCAHO)**

JCAHO inspects and accredits hospitals to establish a consistency of care among hospitals nationwide. Although JCAHO certification is voluntary, it has become accepted as a benchmark for a hospital's quality of care and is relied upon by courts to help establish the standard of care.

To obtain JCAHO accreditation, the hospital must maintain adequate medical records. The information must be readily available and accessible for prompt retrieval and kept confidential and secure. The JCAHO requires that a medical record must be sufficiently detailed and organized to enable:

- a. The practitioner responsible for the patient to provide continuing care to the patient, determine later what the patient's condition was at a specific time, and review the diagnostic and therapeutic procedures performed and the patient's response to treatment.
- b. A consultant to render an opinion after examination of the patient and review of the medical record.

- c. Another practitioner to assume the care of the patient at any time.
- d. The retrieval of pertinent information required for utilization review and quality assessment and improvement activities.

§26.05 What is a Medical Record?

Section 64B8-9.003 of the Florida Administrative Code sets forth the information that a physician is required to put in a medical record:

(3) The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

In addition, Section 456.057(1), Fla. Stat. defines a “records owner” as:

... Any health care practitioner who generates a medical record after making a physical or mental examination of, or administering treatment or dispensing legend drugs to, any person; any health care practitioner to whom records are transferred by a previous records owner; or any health care practitioner's employer, including but not limited to, group practices and staff-model health maintenance organizations, provided the employment contract or agreement between the employer and the health care practitioner designates the employer as the records owner.

In addition to setting forth the requirements for medical records, the Florida Statutes and the Florida Administrative Code also provide that medical records shall be kept confidential.

§26.06 The Purpose of Medical Records

Why are health care practitioners required to keep medical records? The answer can be found in Section 64B8-9.003 of the Florida Administrative Code, which provides:

Medical records are maintained for the following purposes:

- (a) To serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment.

- (b) To furnish documentary evidence of the course of the patient’s medical evaluation, treatment, and change in condition.
- (c) To document communication between the practitioner responsible for the patient and any other health care professional who contributes to the patient’s care.
- (d) To assist in protecting the legal interest of the patient, the hospital, and the practitioner responsible for the patient.

In other words, medical records are maintained for the benefit and safety of the patient. The Florida Statutes further protect the patient by providing that physicians may be subject to disciplinary action if they fail to keep adequate medical records (§§ 458.331(m), 459.015(o), Fla. Stat.). This chapter examines the requirements pertaining to confidentiality found in Florida statutes, the Florida Administrative Code and case law.

§26.07 Statutory Requirements: Health Care Practitioners Duty to Protect Confidentiality and to Retain Records

[1] Protecting Confidentiality: Section 456.057, Florida Statutes.

Two provisions within section 456.057, Fla. Stat., protect confidentiality. The first, section 456.057(5), Fla. Stat., prohibits furnishing medical records to and/or discussing the medical condition of a patient with, “. . . any person other than the patient or the patient’s legal representative or other health care practitioners and providers involved in the care or treatment of the patient, except upon written authorization of the patient.” A very narrow exception to this rule exists, which is discussed below.

The second provision, which is found in section 456.057(6), Fla. Stat., provides that information disclosed by a patient to a health care practitioner during care and treatment is confidential. Disclosure of the information is limited to “. . . other health care practitioners and providers involved in the care or treatment of the patient, or if permitted by written authorization from the patient or compelled by subpoena at a deposition, evidentiary hearing, or trial for which proper notice has been given.”

[A] Who is governed by the statute?

1. Medical doctors;
2. Osteopathic doctors;
3. Chiropractors;
4. Acupuncturists;
5. Podiatrists;
6. Naturopathists;

7. Optometrists;
8. Nurses;
9. Dentists;
10. Midwives;
11. Speech pathologists;
12. Audiologists;
13. Occupational therapists;
14. Dieticians;
15. Providers of orthotics,
16. Massage therapists;
17. Prosthetics and pedorthics;
18. Physical therapists;
19. Hearing aides dispensers; and
20. Psychologists, counselors, psychotherapists.

[B] Exceptions

- (1) **Worker's Compensation.** Section 456.057(5) contains an exception for workers' compensation cases to the rule prohibiting disclosure of medical records or patient condition information. Section 440.13(4)(c), Fla. Stat., provides that medical records must be released, upon request, to an employer, workers' compensation insurance carrier or an attorney for either. In addition, the medical condition of the injured employee must be discussed, upon request, with those persons. Disclosure must be limited to the condition or injury at issue.
- (2) **Medical Negligence Actions and Administrative Proceedings.** Section 456.057(6) contains an exception to the confidentiality rule for medical negligence actions or administrative proceedings in which the practitioner is or expects to be a defendant. The statute provides that in those cases, the information disclosed by the patient is not confidential.
- (3) **Disclosure to the Department of Health.** Section 456.057(7) provides three circumstances in which the Department of Health may obtain patient records without written authorization from the patient. However, in all three cases, the Department must obtain a subpoena for the records. The types of cases in which the Department may obtain patient records are as follows:
 - (a) Excessive or inappropriate prescription of controlled substances;

- (b) Inadequate medical care; or
- (c) Fraud and abuse.

While the Department of Health may obtain patient records without the patient's authorization, the Department must still maintain the confidentiality of the medical records under section 456.057(8). The consequences of willfully failing to keep patient records are set forth in section 456.082, Fla. Stat. The willful failure to keep the information confidential is a first-degree misdemeanor. In addition, the person may be removed from office, employment, or the contractual relationship. Finally, the statute provides that the patient, if injured by the willful disclosure may bring a lawsuit to recover damages, attorneys' fees and costs.

[C] Additional Confidentiality Requirements Placed on Health Care Practitioners under the Florida Statutes.

- (1) **Policies and Procedures:** Section 456.057(9), Fla. Stat., requires all records owners to develop and implement policies and procedures to protect the confidentiality and security of medical records. The statute also requires the record owner to train all employees in the policies and procedures.
- (2) **Accounting:** Section 456.057(10) requires records owners to maintain a record of all disclosures of information (i.e. an accounting) to third parties, including the purpose of the disclosure request. The accounting may be maintained in the medical record. The statute also provides that the third parties are prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representative.
- (3) **Relocation or Termination of Practice:** Section 456.058, Fla. Stat., provides that the boards of acupuncture, medicine, osteopathic medicine, chiropractic medicine, podiatry, optometry, nursing, pharmacy, dentistry, optical devices, physical therapy, and psychology, shall develop rules (found in the F.A.C.) for the disposition of the medical records, which are in existence at the time the practitioner dies, terminates practice, or relocates and is no longer available to patients. At a minimum, the rules developed by the respective boards must provide that the records be retained for at least 2 years after the practitioner's death, termination of practice, or relocation. In the case of the death of the practitioner, the rules shall provide for the disposition of such records by the estate of the practitioner. These rules are discussed below.

[2] The Florida Administrative Code

Few sections of the Florida Administrative Code set forth rules to protect the confidentiality of medical records. Those sections that pertain to confidentiality requirements for practitioners are discussed below. Additional sections regarding confidentiality for mental health providers and health care facilities are discussed in other portions of this Chapter.

[3] Physicians (M.D.): §§64B8-10.001, 64B8-10.002, F.A.C.**[A] Deceased Physicians:**

Section 64B8-10.001, F.A.C., requires the executor, administrator, personal representative or survivor of a deceased medical doctor:

- (a) To retain medical records of any patient of the physician for at least a two (2) years from the date of the death of the physician.
- (b) To publish a notice that the physician's medical records are available to the patients or their duly constituted representative from a specific person at a certain location. The notice must be published within one (1) month from the date of death of the physician.
- (c) To publish, each week for four (4) consecutive weeks, a notice that the physician's medical records will be disposed of or destroyed one (1) month or later from the last day of the fourth week of publication of notice. This notice must be published at the conclusion of a 22-month period of time from the date of the physician's death, or thereafter.

[B] Physicians Relocating or Terminating Practice

Pursuant to section 64B8-10.002, F.A.C., a licensed medical doctor is required to:

- (a) Maintain full and total responsibility for and control of all files and records relating to his patients and his medical practice. All such records shall remain confidential except as otherwise provided by law and shall be maintained in the licensed physician's office or in the possession of the licensed physician.
- (b) Keep adequate written medical records for a period of at least five years from the last patient contact. Adequate records are defined in section 458.331(1)(m), Fla. Stat., which is discussed above.
- (c) Notify patients through publication when he terminates or relocates his practice and is no longer available to patients. The notice should be published once during each week for four (4) consecutive weeks. The notice must contain the date of termination, sale, or relocation and an address at

which the records may be obtained from the physician or from another licensed physician or osteopathic physician. In addition, the physician may, but is not required to, place a sign in a conspicuous location on the facade of the physician's office or notify patients by letter of the termination, sale, or relocation of the practice. The sign or notice must advise the licensed physician's patients of their opportunity to transfer or receive their records.

- (d) The times specified may not be long enough to protect the physician. Physicians should consult their malpractice insurance carriers or attorneys.

[4] Osteopathic Physicians: §§64B15-15.001, 64B15-15.002, 64B15-15.004

[A] Content and Retention: Section 64B15-15.004, F.A.C., provides the requirements for the content and retention of medical records maintained by osteopathic physicians. The rule provides that the osteopathic physician must:

- (a) Maintain written legible records on each patient. Such written records shall contain, at a minimum: patient histories; examination results; test results; records of drugs prescribed, dispensed or administered; reports of consultations; and reports of hospitalizations.
- (b) When records are released or transferred, maintain either the original records or copies. The physician must also make a notation in the retained records indicating to whom the records were released or transferred. However, whenever patient records are released or transferred directly to another Florida licensed physician, or licensed health care provider it is sufficient for the releasing or transferring osteopathic physician to maintain a listing of each patient whose records have been released or transferred and the name of the physician or licensed health care provider who received the records. The listing must be maintained for five (5) years.
- (c) Maintain the written record of a patient for at least five (5) years from the date the patient was last examined or treated by the osteopathic physician. However, the period may be shortened due to the death of the osteopathic physician. See below.

[B] Deceased Physicians:

Section 64B15-15.001, F.A.C., sets forth the rules for retention of a deceased physician's records. The executor, administrator, personal representative or survivor of a deceased osteopathic physician must:

- (a) Retain medical records of any patient for at least two (2) years from the date of the death of the physician.
- (b) Publish, within one (1) month from the date of death of the osteopathic physician, a notice that the osteopathic physician's medical records are available to the patients or their duly constituted representative from a specific person at a certain location.

[C] Termination of Practice

Section 64B15-15.002, F.A.C., sets forth the requirements for handling patient records when the practice is terminated. The rule provides:

- (a) When the practice is voluntarily terminated, the physician must notify patients by publishing a notice, which shall contain the date of termination and an address at which the records may be obtained.
- (b) When a physician's practice is involuntarily terminated (i.e. suspension) the physician shall immediately notify patients by publishing a notice, which must contain the date of termination and an address at which the records may be obtained.
- (c) In either case, the physician must place in a conspicuous location in or on the facade of the office a sign, announcing the termination of the practice. The sign must be placed 30 days prior to the termination, when such termination is voluntary, and must remain until the termination date. When the termination of practice is involuntary, the physician must immediately cause the sign to be placed and must remain in place for 30 days.
- (d) Both the notice and sign must advise the physician's patients of their opportunity to transfer or receive their records.
- (e) The osteopathic physician shall provide for the retention of medical records of any patient for at least two (2) years from the date his practice is sold or otherwise terminated. In the event that the osteopathic physician does not personally retain the medical records, then he must publish a notice that provides the address at which the records shall be retained for the two (2) year period.
- (f) Physicians whose patient records are maintained by an institution or health care entity are exempt from this rule.

[5] **Podiatrists: §§64B18-15.001, F.A.C.**

[A] **Retention of Records**

A podiatrist must maintain medical records for at least four (4) years after the date of the patient's last appointment with the podiatrist. The time periods change if the podiatrist dies, terminates or relocates his practice.

[B] **Deceased Podiatrists**

The executor, administrator, personal representative or survivor of a deceased podiatrist must:

- (a) Retain medical records of any patient for at least two (2) years from the date of the death of the podiatrist.
- (b) Publish a notice, within one (1) month from the date of death of the podiatrist, stating that the podiatrist's medical records are available to the patients or their duly constituted representative from a specific person at a certain location.
- (c) Publish a notice, at the conclusion of a twenty-two (22) month period of time from the date of the podiatrist's death, or thereafter, once during each week for four (4) consecutive weeks, stating that the podiatrist's medical records will be disposed of or destroyed one (1) month or later from the last day of the fourth week of publication.

[C] **Relocation or Termination of Practice**

A podiatrist, who terminates his practice or relocates and is no longer available to his patients, must:

- (a) Ensure that the medical records of his patients are retained for at least 2 years following such termination of practice or relocation.
- (b) If the podiatrist does not transfer his practice to another podiatrist or physician, the podiatrist must provide written notice of the termination or relocation to all patients who have received treatment within the sixty (60) days prior to the termination or relocation and who require active, ongoing treatment. The notice must inform the patients that the podiatrist's medical records are available to the patients or their duly constituted representative from a specific person at a certain location.
- (c) In all other cases, at least sixty (60) days prior to the date of a podiatrist's termination of practice or relocation, the podiatrist must publish a notice once during each week for four (4) consecutive weeks, stating that the

podiatrist's medical records are available to the patients or their duly constituted representative from a specific person at a certain location.

- (d) Publish a notice at the conclusion of a twenty-two (22) month period of time from the date of the podiatrist's termination of practice or relocation, or thereafter, once during each week for four (4) consecutive weeks, stating that the podiatrist's medical records will be disposed of or destroyed one (1) month or later from the last day of the fourth week of publication.

[6] Optometrists: §§64B13-3, F.A.C.

[A] Confidentiality and Disclosure

Section 64B13-3.001 requires an optometrist to keep patient information confidential. All reports and records relating to the patient, including those records relating to the identity, examination, and treatment of the patient, are considered "patient records." Without written authorization of the patient, patient records may not be released to and the condition of the patient may not be discussed with any person other than the patient or his legal representative or other optometrists, medical physicians or osteopathic physicians, who are involved in the diagnosis and treatment of that patient. However, this rule does not prohibit an optometrist from providing copies of a patient prescription, if done in accordance with Section 463.012, Florida Statutes, or Rule 64B13-3.012, F.A.C. It is the responsibility of the optometrist to ensure that his or her employees do not violate the confidentiality of patient records.

[B] Retention

Section 64B13-3.003 requires an optometrist to maintain full and independent responsibility and control over all records relating to his or her patients and his or her optometric practice. All records must be maintained in the licensed practitioner's office or solely in the possession of the licensed practitioner, and the licensed practitioner shall not share, delegate, or relinquish either possession of the records or his or her responsibility or control over those records with or to any entity which is not itself an optometrist.

An optometrist must keep records for at least five (5) years after the last entry. Upon the discontinuance of his or her practice, the licensed practitioner shall either transfer all patient records which are less than five years old to an eye care practitioner, where they may be obtained by patients, or he or she shall keep them in his or her possession for at least five years and make them available to be obtained by patients.

[C] Discontinued Practice

When an optometrist discontinues his practice, he must publish a notice indicating that the licensed practitioner's patient records are available from a specified eye care practitioner at a certain location. The notice shall be published once during each week for four (4) consecutive weeks.

[D] Deceased Optometrist

The executor, administrator, personal representative, or survivor of a deceased optometrist must:

- (a) Retain patient records concerning any patient for at least five (5) years from the date of death of the optometrist.
- (b) Publish a notice, within one (1) month from the date of the optometrist's death, indicating the location at which patients may obtain their patient records. The notice shall be published once during each week for four (4) consecutive weeks.

[7] Midwives

[A] Statutory Requirements

Section 467.019, Fla. Stat. sets forth the following requirements for patient records of midwives:

- (1) Patient records must contain documentation of each consultation, referral, transport, transfer of care, and emergency care rendered by the midwife and must include all subsequent updates and copy of the birth certificate. These records shall be kept on file for a minimum of five (5) years following the date of the last entry in the records.
- (2) Within 90 days after the death of a midwife, the estate or agent must place all patient records of the deceased midwife in the care of another licensed midwife who shall ensure that each patient is notified in writing.
- (3) A licensed midwife who is or has been employed by a practice or facility, such as a birth center, which maintains patient records as records belonging to the facility may review patient records on the premises of the practice or facility as necessary for statistical purposes.

[B] Florida Administrative Code Requirements

Section 64B24-7.014, F.A.C., sets forth the rules for patient records.

- (1) **Content and Retention:** The record must contain the name, address and telephone number of patient; the informed consent form and all docu-

mentation of all care given during the prenatal, intrapartum and postpartum period relevant to midwifery services; the emergency care plan; documentation of all consultations, referrals, transport, transfer of care and emergency care rendered, and all subsequent updates; a copy of the birth certificate form submitted to the registrar of vital statistics.

Patient records must be kept for a minimum of five (5) years from date of last entry in records.

[C] Confidentiality

Patient records are confidential and may not be released unless authorized by the patient in writing. This confidentiality prohibits review of the records by providers, other than providers actually involved in care or treatment of the patient. Maintenance of patient records by a deceased licensed midwife's estate, authorized agent of the estate or by a successor-owner midwife of a practice does not authorize review of patient records. However, limited review for the purpose of obtaining a patient's name, address and last date of treatment in order to comply with this rule is permitted.

[D] Termination or Relocation of Practice

Medical records of a licensed midwife who is terminating or relocating her practice shall be retained by the licensed midwife or authorized agent and made available to patients for five (5) years from the date of the last entry in the records.

Within one month of termination or relocation of practice, the midwife must publish a notice that advises patients of the midwife's termination or relocation. The notice must advise patients that they may obtain copies of their medical records and specify the name, address and telephone number of the person from whom copies of records may be obtained. The notice shall appear at least once a week for 4 consecutive weeks.

Patient records must be available at reasonable times at a location within the county where the midwife practices or practiced.

[E] Birthing Center Records

When a licensed midwife has been employed by a practice or facility, such as a birth center, and the laws and rules of that practice/facility maintain that the patients' records belong to the facility, the licensed midwife shall be allowed to review on the premises of the practice/facility the patients records as needed for statistical information. Alternatively, the facility may provide the required infor-

mation in writing to the licensed midwife at reasonable and customary cost to the midwife.

[8] **Dentists: §466.018, Fla. Stat.**

[A] **Records Requirement**

Every dentist shall maintain written dental records and medical history records, which justify the course of treatment of the patient. The records shall include, but not be limited to, patient history, examination results, test results, and, if taken, X-rays.

[B] **Retention**

All patient records kept in accordance with this section shall be maintained for a period of 4 years from the date of the patient's last appointment.

[9] **Hospitals, Ambulatory Surgical Centers and Mobile Surgical Facilities**

[A] **Statutory Requirements: §395.3025, Fla. Stat.**

- (1) **Confidentiality:** Section 395.3025(4), Fla. Stat., provides that patient records are confidential and must not be disclosed without the consent of the patient.
- (2) **Exceptions:** Section 395.3025(4)(a) - (k), Fla. Stat., sets forth the types of disclosures that a hospital may make without the consent of the patient.
 - (a) Licensed facility personnel and attending physicians for use 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 Health Care Administration, 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 for Health Care Administration upon subpoena 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.
 - (f) The Department of Health or its agent, for the purpose of establishing and maintaining a trauma registry and data collection for the registry.

- (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) The State Long-Term Care Ombudsman Council and the local long-term care ombudsman councils, with respect to the records of a patient who has been admitted from a nursing home or long-term care facility, when the councils are conducting an investigation involving the patient. However, the hospital may not make the disclosure until the patient or his representative has been advised that disclosure may be made and the patient has not objected.
 - (i) A local trauma agency or a regional trauma agency that performs quality assurance activities.
 - (j) Organ procurement organizations, tissue banks, and eye banks required to conduct death records reviews.
 - (k) The Medicaid Fraud Control Unit in the Department of Legal Affairs.
 - (l) The Department of Health for epidemiological investigations
- (3) **Confidentiality Must Be Maintained:** If patient records or information is released under one of the exceptions above, 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.
- (4) **Exemption from Public Records Laws:** Patient records at hospitals and ambulatory surgical centers are exempt from disclosure under the public records laws (subject to the exceptions set forth above).
- (5) **Disclosure to the Patient:** Section 395.3025(1) provides that hospitals and other licensed facilities must furnish, in a timely manner, without delays for legal review, to any patient treated at the facility or his or her representative a true and correct copy of all patient records in the facility's possession, including X rays, and insurance information concerning such person. The request must be in writing and only after discharge.
- (6) **Charges for Copies:** The person requesting the records must agree to pay a charge. The charge for copies of patient records may include sales tax and actual postage, and, except for nonpaper records which 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 fur-

nished, 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.

[B] Florida Administrative Code Requirements: §59A-3.214, F.A.C.

- (1) **Health Information Processes:** Each hospital shall establish processes to obtain, manage, and utilize information to enhance and improve individual and organizational performance in patient care, governance, management, and support processes.
- (2) **Requirement to Maintain a Medical Record:** Each hospital shall maintain a current and complete medical record for every patient seeking care or service. The medical record shall contain information required for completion of birth, death and still birth certificates and additional information, which is provided in the Appendix to this Section. The Rule provides additional requirements for patients undergoing operative and invasive procedures. These requirements are also in the Appendix.
- (3) **Health Information System:** Each hospital shall have a patient information system and medical records department. The medical records department is required to:
 - (a) Maintain a system of identification and filing to ensure the prompt location of a patient's medical record. Patient records may be stored on electronic medium such as optical imaging, computer, or microfilm;
 - (b) Centralize all appropriate clinical information relating to a patient's hospital stay in the patient's medical record;
 - (c) Index, and maintain on a current basis, all medical records according to disease, operation and physician.
- (4) **Confidentiality:** Patient records are privileged and confidential and may not be disclosed without the consent of the patient.
- (5) **Exceptions:** Disclosure may be made without consent to:
 - (a) Hospital personnel for use in connection with the treatment of the patient;

- (b) Hospital personnel only for internal hospital administrative purposes associated with the treatment, including risk management and quality assurance functions;
 - (c) The Agency for Health Care Administration;
 - (d) In any civil or criminal action, 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 legal representative; or
 - (e) The Department of Health may examine patient records for the purpose of epidemiological investigations.
- (6) **Disclosure to the Patient:** Any licensed facility shall, upon request, and only after discharge of the patient, furnish to any patient treated in the facility, or to any patient's representative, a true and correct copy of all of the patient's records, including X-rays, which are in the possession of the licensed facility, provided the person requesting such records agrees to pay a reasonable charge for copying the records (see above). Progress notes and consultation reports of a psychiatric or substance abuse nature concerning the care and treatment performed by the licensed facility are exempted from this requirement.

§26.08 Liability for Improper Release

Under Section 456.057(14), Florida Statutes, any person or entity issued a permit, registration, certificate or license by the Department of Health, who violates the provisions of Section 456 of the Florida Statutes, shall be disciplined by the appropriate licensing authority.

1. For physicians, the penalties for failure to maintain record confidentiality can be steep. The first offense for failing to comply with obligations regarding ownership and control of medical records, patient records can result in a letter of concern to two weeks suspension followed by fines from \$1,000 to \$5,000 as cited in Section 64B8-8, F.A.C. The second offense can result in a similar suspension and \$5,000-\$10,000 fine.
2. Failure to maintain confidentiality of communications between a patient and a psychiatrist can result in a \$5,000 administrative fine and reprimand to suspension and a \$10,000 administrative fine or denial. The second offence may result in suspension or revocation. Section 64B8-8, F.A.C.

§26.09 Special Issues with Medical Records

[1] Medicare Conditions of Participation

[A] Healthcare providers must meet the Medicare Conditions of Participation to qualify for and maintain Medicare certification. These Conditions of

Participation apply to ambulatory care surgical services, health maintenance organizations, home health agencies, hospices, hospitals (including psychiatric hospitals), long-term care facilities, and specialized providers such as comprehensive outpatient rehabilitation facilities, organ procurement organizations, and rural primary care hospitals. A provider organization that fails to comply with the Conditions of Participation may be excluded from participation in the Medicare program.

- [B] Hospitals and other healthcare facilities that adopt electronic medical records must implement appropriate measures to comply with the Conditions of Participation. Such measures will be very different from those needed for paper records. When such healthcare providers participate in network or remote-access arrangements, the implications of those arrangements for the facility's compliance with the Conditions of Participation must be carefully reviewed so that any necessary changes can be made or safeguards can be added before implementation of the arrangement, preventing a hospital or healthcare facility from discovering later that the arrangement jeopardizes its Medicare certification.
- [C] The Medicare Conditions of Participation for hospitals permit authentication of medical records by signature, written initials or computer entry. A hospital must have a system of record identification and maintenance to ensure the integrity of authentication and protect the security of patient record entries. There is no express restriction on the permissible media for creating or storing medical records. Thus, the Medicare program permits computer-based medical records that meet the criteria set forth in the Conditions of Participation.
- [D] Healthcare providers participating in the Medicare program must safeguard patient records against loss, destruction, or unauthorized use. There must be written policies and procedures in place that govern the use and removal of records and the conditions for release of information. Such policies and procedures will vary according to the particular type of network or remote-access arrangements in which a provider participates. It is noteworthy that rural primary care hospitals that are members of a rural health network, as defined by the regulations, must have in effect an agreement to participate with other hospitals and facilities in the communications system of the network, including its system for electronic sharing of patient data if it has such a system in operation.
- [E] Thus, the Conditions of Participation permit the sharing of patient information and records electronically by authorized healthcare professionals within

an integrated delivery network so long as such information sharing is implemented in a manner that does not compromise the ability of participating healthcare providers to safeguard medical records appropriately or comply with other applicable Conditions of Participation.

- A summary of relevant Conditions of Participation concerning patient medical records is included in Sections II and III.

§26.10 Accreditation Requirements

- a. Although accreditation by national accrediting entities, such as the Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”) is viewed as voluntary, such accreditation standards have been incorporated at least partially into the hospital licensure standards of several jurisdictions. Moreover, a hospital is deemed to meet certain of the Medical Conditions of Participation if it is accredited by the JCAHO.
- b. The use of computer technology in the delivery of healthcare has been recognized by accrediting entities that have promulgated standards relating to clinical information management with which hospitals or other healthcare facilities must comply in order to receive accreditation.
- c. For example, the JCAHO has promulgated standards for hospitals, healthcare networks and ambulatory care centers. Information Management Standard 6.1 for Health Care Networks requires appropriate mechanisms for access to patient medical records. Implementation examples suggested by the JCAHO to comply with this standard include transferring patient records to the point of service within the network and electronic transmission of such records by computer and modem.
- d. Information Management Standard I.M.2 for both Hospitals and Health Care Networks provides for the security, confidentiality and integrity of medical records. Hospitals and healthcare networks are required to safeguard patient records against loss, destruction tampering and unauthorized access and use.
- e. In addition, Information Management Standard 6 for Hospitals requires adequate integration and interpretation capabilities. Implementation examples to comply with this standard include linkage of internal information systems and establishing standards for transmission of orders, clinical observations and data.
- f. The applicable accreditation standards relating to the management of information should be reviewed by provider organizations participating in remote-access or network arrangements in order to ensure compliance. A provider organization’s failure to meet JCAHO standards not only could result in loss of accreditation, but such failure could also be used as evidence of the provider’s failure to meet the standard of care in maintaining the confidentiality and security of patient information and records.

A summary of the relevant accreditation standards for ambulatory care centers, hospitals, health-care networks, and rehabilitation facilities with implementation examples, as appropriate, is included in the Appendix to Section II.

§26.11 “Super-Confidential” Records

Mental health, substance abuse and HIV testing records are given even greater protection under the law than ordinary medical information and records.

[1] Mental Health Records Requirements for Individual Practitioners and Health Facilities

[A] Requirements for Individual Mental Health Practitioners

The key statute for protecting the confidentiality of mental health records is section 456.059, Florida Statutes, which provides that communications between a patient and a psychiatrist shall be held confidential and shall not be disclosed except upon the request of the patient or the patient’s legal representative.

An exception is provided for threats made by the patient towards another.

[B] Exception for Release of Information on Psychiatric and Mental Health Patients

Section 456.059, Florida Statutes, allows the release of otherwise privileged psychiatric and mental health information on patients by the physician under the following circumstances:

- (1) A patient is engaged in a treatment relationship with a psychiatrist;
- (2) Such patient has made an actual threat to physically harm an identifiable victim or victims; and
- (3) The treating psychiatrist makes a clinical judgment that the patient has the apparent capability to commit such an act and that it is more likely than not that in the near future the patient will carry out that threat, the psychiatrist may disclose patient communications to the extent necessary to warn any potential victim or to communicate the threat to a law enforcement agency. No civil or criminal action shall be instituted, and there shall be no liability on account of disclosure of otherwise confidential communications by a psychiatrist in disclosing a threat. . . .

[C] Requirements Found in the Florida Administrative Code (FAC)

The requirements for psychological records are found in sections 64B19-19.0025, 64B19-19.003, 64B19-19.004 and 64B19-19.005, F.A.C.

- (1) **Basic Requirements:** The requirements for chronicling and documenting services are in section 64B19-19.0025, F.A.C.
- (2) **Confidentiality:** §64B19-19.006, F.A.C.
 - (a) Psychologists may disclose that information only with the written consent of the service user. The only exceptions to this general rule occur in those situations when nondisclosure on the part of the psychologist would violate the law. If there are limits to the maintenance of confidentiality, however, the licensed psychologist shall inform the service user of those limitations and obtain a written statement from the service user which acknowledges the psychologist's advice in those regards.
 - (b) In cases where an evaluation is performed upon a person by a psychologist for use by a third party, the psychologist must explain to the person being evaluated the limits of confidentiality in that specific situation, document that such information was explained and understood by the person being evaluated, and obtain written informed consent to all aspects of the testing and evaluative procedures.
 - (c) This rule recognizes that minors and legally incapacitated individuals cannot give informed consent under the law. Psychologists, nonetheless, owe a duty of confidentiality to minor and legally incapacitated service users. This does not mean that the psychologist may not impart the psychologist's own evaluation, assessment, analysis, diagnosis, or recommendations regarding the minor or legally incapacitated individual to the service user's guardian or to any court of law.
 - (d) The licensed psychologist shall maintain the confidentiality of all psychological records in the licensed psychologist's possession or under the licensed psychologist's control except as otherwise provided by law or pursuant to written and signed authorization of a service user specifically requesting or authorizing release or disclosure.
 - (e) The licensed psychologist shall also ensure that no person working for the psychologist, whether as an employee, an independent contractor, or a volunteer violates the confidentiality of the service user.
- (3) **Maintenance and Retention:** §64B19-19.003, F.A.C.
 - (a) The licensed psychologist must maintain full and total responsibility for and control of all psychological records.
 - (b) Complete records must be retained for a minimum of 3 years after (a) the completion of planned services or (b) the date of last contact with the user, whichever event occurs later in time. Thereafter, either the complete

psychological records or a summary of those psychological records shall be retained for an additional 4 years.

- (c) Records do not have to be retained if the psychologist's patients were assigned to the psychologist by a business entity which agrees to maintain and retain the confidentiality of the psychological records.

(4) Termination or Relocation of Practice: §64B19-19.004, F.A.C.

The psychologist must publish a notice that contains the date of termination or relocation of practice and an address at which the psychological records of the patients may be obtained by them, their legal representatives, or licensed mental health professionals designated by patients in writing, to receive the patient's records.

(5) Deceased Psychologist: §64B19-19.004, F.A.C.

The executor, administrator, personal representative or survivor of a deceased licensed psychologist must:

- (a) Ensure the retention of psychological records for a period of at least two (2) years and two (2) months from the date of the licensed psychologist's death.
- (b) Publish a notice regarding the death, within 1 month of the licensed psychologist's death, weekly for four (4) consecutive weeks and shall advise of the licensed psychologist's death. The notice must also state the address from which patients, their legal representative, or licensed mental health professionals designated by the patient in writing, may obtain the patient's psychological records.
- (c) At the conclusion of 24 months from the date of the licensed psychologist's death, publish a notice, advising that the psychological records will be destroyed on a date specified which may not be any sooner than 1 month from the last day of the last week of the publication of the notice. This notice shall also be published once a week for four (4) consecutive weeks. On the date specified in the notice, the executor, administrator, personal representative or survivor shall destroy unclaimed psychological records.

[2] Requirements for Facilities Making Mental Health Records

- (1) Under section 394.4615, Fla. Stat., psychiatric facility records must be disclosed when:
 - (a) The patient or the patient's guardian authorizes the release.

- (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.
 - (d) The patient is committed to, or is to be returned to, the Department of Corrections from the Department of Children and Family Services, and the Department of Corrections requests such records.
- (2) Psychiatric facility records may be disclosed when:
- (a) 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.
 - (b) The administrator of the facility or secretary of the Department of Children and Family Services deems release to a qualified researcher, 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.

[3] **Substance Abuse (Alcohol and Drug Abuse) Records**

[A] **Basic Requirements**

Section 397.501, Florida Statutes, sets forth a bill of rights for substance abuse clients.

The records pertaining to the identity, diagnosis, and prognosis of and service provision to any individual client are confidential. Records may not be disclosed without the written consent of the client/patient.

[B] **Exceptions:**

The following exceptions are provided by law to the disclosure of substance abuse records that are otherwise privileged. They may be disclosed:

- (1) To medical personnel in a medical emergency.
- (2) To service provider personnel if such personnel need to know the information in order to carry out duties relating to the provision of services to a client.
- (3) Some scientific research, provided appropriate safeguards are in place.
- (4) Audits or evaluations on behalf of any federal, state, or local government agency, or third-party payor providing financial assistance or reimbursement to the service provider. Client names and identifying information may not be disclosed.

- (5) Upon court order.
- (6) Certain disclosures to law enforcement personnel.
- (7) Reporting of incidents of suspected child abuse and neglect to the appropriate state or local authorities as required by law.

[4] HIV Testing, Aids and Sexually Transmitted Disease Records

[A] Statutory Requirements

No person in Florida may order an HIV test without first obtaining the informed consent of the person upon whom the test is being performed. Informed consent includes explanation that positive test results will be reported to the county health department. Consent need not be in writing if the medical record documents that consent was given. Section 381.004(3), Fla. Stat.

[B] Test Results

An “HIV test result” includes only laboratory reports of an HIV test entered into a medical record on or after July 6, 1988 or any note in a medical record of such a test. Section 381.004(2)(a) and (b), Fla. Stat.

- (1) HIV test results include negative as well as positive HIV test results and the fact that an HIV test has been performed on an identified person. Section 381.004(3)(e)
- (2) HIV test results does not include patient reports of an HIV test result and clinical observations of AIDS or its symptoms. Section 64D-2.002(18), F.A.C.

[C] Permitted Disclosures

- (1) **Patient Release.** Consent for disclosure by the subject may be obtained in a “legally effective release”. Section 381.004(3)(e)(1-2), Fla. Stat.
- (2) **Authorized agents or employees of providers and facilities.** Personnel within a single facility or provider are authorized to disclose to each other on a “need to know” basis.
- (3) **Health care consultation.** Health care providers that are not employees of the same provider or facility may disclose HIV test results to each other without the subject’s consent provided they are involved in the care or treatment of the test subject and the consultation is for the purpose of the patient’s diagnosis or treatment. 381.004(3)(e)(4), Fla. Stat.; 64D-2.003(2)(e) F.A.C.
- (4) **Department of Health.** The Department may share HIV test results “in accordance with rules for reporting and controlling the spread of disease, as permitted by state law.” 381.004(3)(e)(5), Fla. Stat.

- (5) **Transfer of body parts.** Health care facilities and providers who transfer body parts and semen for the purposes of artificial insemination may disclose HIV test results to each other. 381.0041, Fla. Stat.; 64D-2.005, F.A.C.
- (6) **Research.** HIV test results may be disclosed to authorized medical and epidemiological researchers who are then prohibited from disclosing any identifying characteristics or information regarding test subjects. 381.004(3)(e)(8), Fla. Stat.
- (7) **Court Orders.** Subpoenas are not sufficient under Florida law for the release of HIV test results. A court order must be obtained and this process is not easily accomplished. A “compelling need” must be demonstrated by the individual seeking the results and the court must balance this need against the test subject’s privacy rights as well as public policy interests in privacy.
- (8) **Workers’ Compensation.** An administrative law judge of compensation claims of the Division of Workers’ Compensation may authorize disclosure but only upon a finding that the person seeking the test results has demonstrated a compelling need.
- (9) **Custodians of Children.** Under Section 381.004(3)(e)(11) Fla. Stat. and 64D-2.003(2)(n), F.A.C., there are three classes of persons allowed access to HIV test results:
 - (a) Department personnel and other employees “directly involved in the placement , care, control or custody” of the tested child who demonstrate a need to know.
 - (b) Adoptive parents of the tested subject.
 - (c) An adult custodian, relative or other person responsible for the child’s welfare if the parent or legal guardian cannot be reasonably located and informed of the test result.

[D] Other Exceptions to the “No Disclosure” Rule

Section 456.061, Fla. Stat., provides an exception to the general rule that substance abuse and sexually transmitted disease records must be kept confidential. The statutes provides that a practitioner shall not be civilly or criminally liable for disclosure of confidential information to a sexual or needle-sharing partner, under the following circumstances:

- (1) If a patient of the practitioner who has tested positive for human immunodeficiency virus discloses to the practitioner the identity of a sexual partner or a needle-sharing partner;

- (2) The practitioner recommends the patient notify the sexual partner or the needle-sharing partner of the positive test and refrain from engaging in sexual or drug activity in a manner likely to transmit the virus and the patient refuses, and the practitioner informs the patient of his or her intent to inform the sexual partner or needle-sharing partner; and
- (3) If pursuant to a perceived civil duty or the ethical guidelines of the profession, the practitioner reasonably and in good faith advises the sexual partner or the needle-sharing partner of the patient of the positive test and facts concerning the transmission of the virus. However, any notification of a sexual partner or a needle-sharing partner pursuant to this section shall be done in accordance with protocols developed pursuant to rule of the Department of Health.

The statute also protects practitioners from liability for failing to disclose information relating to a positive test result for human immunodeficiency virus of a patient to a sexual partner or a needle-sharing partner.

§26.12 Medical Records and Litigation

[1] Medical Records and Litigation: Overview and General Rule

[A] The medical record is a confidential document. Access to a patient's medical record should be restricted to the patient, the patient's authorized representative, and the attending physician and facility staff members with a legitimate need for such access.

[B] Litigation presents a special situation whereby health care professionals and providers may be required to produce a patient's medical records. But before doing so, a health care professional or provider should be aware of what can be produced, as well as the legal procedures and requirements governing that production. (This section will discuss the technical procedures and requirements governing production of medical records. Sections "D" and "F" cover what can be produced in response to litigation discovery requests).

[2] Litigation Exceptions: Subpoenas, Warrants and Releases

[A] Subpoenas: Civil, Criminal, and Governmental Agency - Recognition of Valid Subpoenas and Methods of Challenge

(1) Subpoenas in civil actions

- (a) Parties to civil actions for monetary damages may obtain documentation from individuals or entities who are not parties to the action under the

Florida Rules of Civil Procedure. Rule 1.351 of the Florida Rules of Civil Procedure controls the production of documents without deposition.

(b) General procedure

1. A party desiring production is required to serve on all other parties a notice of the intent to serve a subpoena with a copy of the proposed subpoena designating the items to be produced. A party may file an objection to the production of the documents with the court within ten days of the service of the notice. If an objection is filed, production shall not be made until the objection is resolved by the court.
2. If no party makes an objection, the attorney representing the party issuing the notice may then issue the subpoena or an unrepresented party may request the clerk of the court to issue the subpoena. Upon receipt of the subpoena, the non-party may produce the requested documentation or object to the production request.
3. The non-party may request reasonable costs in advance of preparing copies and may only be required to produce documents in the county of the residence or business place of the non-party, or where the documents are normally held.

(c) General reasons for objection to production:

1. **Confidentiality:** Requested materials are deemed confidential by statute or decisional law. Examples include confidential patient records (unless waived by the patient), quality assurance and peer review records. For special cases involving waiver of confidentiality by patients, see part 3 below.
2. **Privilege.** Common privileges include:
 - a. attorney — client
 - b. psychotherapist — patient
 - c. sexual assault counselor — victim
 - d. domestic violence advocate — victim
 - e. husband — wife
 - f. clergy
 - g. accountant — client
 - h. trade secrets
3. **Waiver of Privilege:** Note, a waiver of privilege can occur by voluntary disclosure.

(d) Challenges to Subpoenas. Challenges to subpoenas in civil actions are undertaken by filing an objection to the subpoena with the court. The party requesting the documents must then schedule a hearing requesting that the court compel the production of the documents.

(2) Subpoenas in Criminal Cases

(a) Subpoena authority.

1. The Office of the State Attorney is given broad authority to summon witnesses and require that they produce documentation. Pursuant to Section 27.04 of the Florida Statutes, the State Attorney may summon witnesses to appear in court or in other convenient places in the State Attorney's judicial circuit, and at such convenient times as designated in the summons.
2. Once an individual is charged with a crime, that individual also has authority to subpoena documents and individuals.

(b) Notice to the patient.

The State Attorney may subpoena medical records of a patient undergoing criminal investigation as long as the patient or the patient's legal representative is given notice before the subpoena is issued as required by Sections 395.3025(4)(d) and 456.057 of the Florida Statutes.

(c) Challenges to Criminal Subpoenas.

1. Generally, subpoenas from the State Attorney or a defendant can be challenged on the same general principles as subpoenas issued in civil actions. An exception is instanter subpoenas issued by the State Attorney's office. Instanter subpoenas require immediate production of documents. An individual receiving an instanter subpoena should verbally object or state a privilege, if one exists, but turn over the requested documents. Subsequently, a formal objection should be filed. Production of documents under such circumstances does not constitute a waiver of privilege.
2. Once the issuance of a subpoena is objected to, the party who sought issuance of the subpoena has the obligation to present evidence to the trial court to demonstrate the relevancy of the records of the criminal proceedings.
3. Individuals and entities receiving subpoenas for patient records should always confirm that patient has received notice.
4. Privileges noted in outline for civil cases are applicable.

5. Confidentiality of peer review records is recognized and honored by the courts.
- (3) Subpoenas From Governmental Agencies — State.
- (a) Authority to obtain documents and information subpoena powers.
 1. General subpoena authority (Section 456.071 of the Florida Statutes) of the Department of Health through its enforcement agreement with the Agency for Health Care Administration (AHCA), recently transferred to the Florida Department of Health (DOH).
 2. Utilized to obtain patient records from physicians when the State has a release.
 3. *Carrow v. DPR*, 453 So. 2d 842 (Fla. 1st DCA 1984); held that the circuit court is the exclusive forum for subpoena enforcement proceedings under Section 120.58 of Florida Statutes.
 4. Patient records obtained by AHCA are not subject to public records law.
 - (b) Reasonable cause subpoenas (Section 456.057(7), Florida Statutes).
 1. Utilized to obtain patient records from physicians when AHCA has not obtained a release.
 2. There have been several cases that have opined on the agency's authority to do this, including: *Nach v. DPR*, 528 So. 2d 908 (Fla. 2d DCA 1988) and *Fagan v. DPR*, 534 So. 2d 802 (Fla. 3d DCA 1988).
 - (c) Subpoenas for hospital patient records (Section 395.3025(4)(f), Florida Statutes).
 1. The Agency for Health Care Administration is authorized to obtain records to be used solely for investigation and disciplinary proceeding. A patient release is not required.
 2. Adverse or untoward incidents/Case reviews.
 - a. Adverse or untoward incident reported under Section 395.0197(6), Florida Statutes (Code 15 reports) and case reviews of annual reports may be reviewed and "all licensed facility records necessary" may be obtained pursuant to Section 395.0197(11). These records do not become public and are not discoverable nor admissible. The physician may obtain them if they form the basis of a finding of probable cause.
 - (d) Subpoenas during evidentiary hearings before the Division of Administrative Hearings.

- (1) Subpoenas are issued by the Administrative Law Judge of the Division of Administrative Hearings in blank with the exception of the style of the case, case number, and the name, address and telephone number of the attorney or party requesting the subpoena. A party then completes the subpoena and arranges for the service of same.
- (2) Any party, or person on whom a subpoena is served, or to whom a subpoena is directed, may file a Motion to Quash or for Protective Order with the Hearing Officer before whom the case is pending. Rule 60Q-2.021, which is generally controlled by the provisions of Section 120.569(2)(k).
- (3) The Agency may also attempt to require the production of materials that may be considered privileged. Chapter 395 of the Florida Statutes requires that hospitals report information concerning adverse and untoward incidents that occur in the facility, as well as disciplinary actions taken against the privileges of physicians.

When an adverse and untoward incident is reported to the Agency under the provisions of Section 395.0197 of the Florida Statutes, the Agency is obligated to review the incident to determine whether it potentially involved conduct by a health care professional who is subject to a disciplinary action. Section 395.0197(13) provides that the Agency has access to “all licensed facility records necessary to carry out the provisions of this section.” Further, when an action taken against the privileges of a physician is reported to the Agency under Section 395.0193 of the Florida Statutes, the Agency is required to review the report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action. When the Agency conducts an investigation based upon a hospital report, under either of these statutory subsections, the Agency may attempt to subpoena documents that may be considered privileged as constituting “peer review materials.” In determining how to respond to such a subpoena, the facility should initially analyze what documents may constitute protected and privileged “peer review records.” In *Cruger v. Love*, 599 So. 2d 111 (Fla. 1992), the Florida Supreme Court adopted a broad definition of records that are privileged as “peer review” records. The court carefully reviewed previous court decisions before adopting a broad definition as to the scope of documents that could be considered privileged. The Florida Supreme Court stated:

“We hold that the privilege provided by sections 766.101(5) and 395.011(9), Florida Statutes, protects *any document considered by the Committee or Board as part of its decision-making process*. The policy of encouraging full candor in peer review proceedings is advance only if all documents considered by the Committee or Board *during the peer review or credentialing process* are protected. The Committee members and those providing information to the Committee must be able to operate without fear of reprisal. Similarly, it is essential that doctor’s seeking hospital privileges disclose all pertinent information to the Committee. Physicians who fear that information provided in an application might some day be used against them by a third party, will be reluctant to fully detail matters that the Committee should consider. Accordingly, we find that a physician’s application for staff privileges is a record of the Committee or Board for purposes of the statutory privilege.” *Cruger*, 599 So. 2d at 114 (emphasis supplied).

Therefore, with the espousal of this broad definition of privileged materials, it is clear that facilities may assert a “peer review privilege” over not only those documents considered in a disciplinary action against staff privileges and the transcript or minutes of such proceedings, but also applications that a physician filed to obtain hospital privileges.

When “peer review” documents are sought by the Agency, the Agency will assert that the confidentiality provisions of Sections 766.101 and 395.0193 are not applicable. The Agency will likely assert that it has the opportunity to obtain even privileged documents under the provisions of Section 458.337, which requires that hospitals and other organizations that engage in peer review activities report disciplinary actions to the Agency.

Section 458.337(3) provides that organizations that take disciplinary actions based upon peer review:

“ . . . shall, upon department subpoena, provide copies of the records concerning the action to the Department. However, those records shall be used solely for the purpose of the department and the board in disciplinary proceedings. The records shall otherwise be confidential and exempt from § 119.07(1).

These records shall not be subject to discovery or introduction into evidence in any administrative or civil action”

This statutory provision is part of the Medical Practices Act. A similar provision appears at Section 459.016 of the Florida Statutes, the Osteopathic Medical Practice Act. These statutory provisions, as well as the two provisions cited by the *Cruger* court, address the confidentiality of “peer review” records.

Section 395.0193, Florida Statutes, provides in pertinent part:

“The investigations, proceedings, and records of the peer review panel, a committee of a hospital, a disciplinary board, or a governing board or agent thereof with whom there is a specific written contract for that purpose, as described in this section shall not be subject to discovery or introduction into evidence in any civil or administrative action against a provider of professional health services.”

Section 766.101, Florida Statutes, provides in pertinent part:

“(5) The investigations, proceedings, and records of a committee as described in the preceding subsections, shall not be subject to discovery or introduction into evidence in any civil or administrative action against a provider of professional health services.”

If the Agency asserts that it is entitled to peer review records under Sections 458.337 or 459.016, a facility or hospital could respond by maintaining that such documents are privileged, even in administrative proceedings.

- (e) Challenges to subpoenas (Section 120.569, Florida Statutes).
 - (1) **Motions to Quash** (Section 120.569(2)(k)1) — A person subject to an agency subpoena *may* request the agency to invalidate the subpoena on the grounds that it was not lawfully issued, is unreasonably broad in scope, or requires the production of irrelevant material. If the agency declines, resolution lies in circuit court (see *Carrow, Id.*).
 - (2) **Enforcement** (Section 120.569(2)(k)2) — If the party subject to the subpoena refuses to honor it (or does nothing), the agency may seek enforcement by filing a petition in the circuit court. The court may award any costs and fees to prevailing party.
 - (3) Subpoenas From Governmental Agencies — Federal.
 - a. 42 CFR §1006.1 authorizes the office of the Inspector General to issue subpoenas in health care investigations. Subpoenas should

specify the description of the documents required to be produced. Objections may be filed to the subpoenas. If the individual directed to produce documents fails to do so, an enforcement action may be brought in the District Court of the United States in the district where the subpoena person is found, resides or transacts business.

- b. Additional subpoena authority for the Federal government is available in criminal investigations. In any investigation involving an act or activity of federal health care offense, the Attorney General or his designee may issue a subpoena under 18 USCA § 3486. The subpoena must describe the objects required to be produced and provide a return date of reasonable time. If the individual fails to comply with the subpoena, the Attorney General may invoke the aid of any court in the United States within the jurisdiction of the investigation. The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, and if so ordered, give testimony. Any failure to obey the order of the court may be punished as contempt.
- c. Individuals objecting may raise confidentiality and privilege issues, similar to those available to object to state-issued subpoenas.

(4) Search warrants.

- a. Both state and governmental entities have authority to conduct searches via search warrant. A search warrant is an order issued by a magistrate or judge authorizing law enforcement officers to search a particular place for specific types of documents or tangible things. Items that may be seized pursuant to a warrant include evidence of a crime, contraband, and property designed or intended for use or which has been used as the means of committing a crime. A search warrant typically is granted to government investigators on an ex parte basis without notice to the party whose property is to be searched.

1. Limitations on searches and seizures.

A search warrant is not carte blanche to seize every document and piece of personal property from the place specified in the warrant. Nor does it enable officers to search places beyond those described in the warrant. The Fourth Amendment to

the U.S. Constitution requires that search warrants describe with particularity the place to be searched. Officers may search the entire geographic area designated in the warrant. Officers are also permitted to conduct a “protective sweep” of the premises to ensure their safety. Computer data may be searched. Officers may remain on the premises only as long as necessary to complete the search. Officers may question individuals. However, an officer has not “seized” an individual unless, in view of all circumstances, a reasonable person would have believed that he was not free to leave. Disruption of normal business activities is not unreasonable.

2. Procedural matters.

- a. **Federal.** Federal Rule of Criminal Procedure 41(d) requires that federal officers deliver a copy of the search warrant to the owner of the premises that have been searched. However, a failure to deliver a copy of the warrant is not a sufficiently serious defective void and otherwise valid search. Federal rules also require that federal officers provide a receipt for any property seized.
- b. **State.** Under Section 933.01 of the Florida Statutes, a search warrant may be authorized by any judge having jurisdiction over the place or thing to be searched. A proper affidavit must be issued to obtain the warrant. The affidavit must support probable cause of the commission of a crime. A copy of the search warrant shall be delivered to the person named in the warrant or in his absence to some other person in charge of or living on the premises. A written inventory must be provided of items seized. Obstruction or resistance to an officer serving or attempting to serve a warrant is a misdemeanor of the first degree.

(5) Inspection Authority.

- (a) In many instances, the Federal government does not utilize subpoenas to obtain documentation. Instead, it utilizes its inspection authority found in numerous regulatory acts. Initially, it should also be noted that in some health care investigations, the responsibility for conducting investigations on behalf of the Federal government is transferred to a state “survey agency”. For

example, investigations of violations of the Emergency Medical Treatment Act and Active Labor Act are conducted by the State of Florida, Agency for Health Care Administration, on behalf of the United States Health Care Finance Administration.

- (b) Federal authorities have significant inspection authority to investigate potential violations of health care regulations. Similarly, state authorities have significant inspection authority. Under the provisions of Section 456.069, the Department of Health has the authority to inspect in a lawful manner at all reasonable hours, any establishment at which the services of a licensee authorized to prescribe controlled substances specified in Chapter 893 of the Florida Statutes are offered, for the purpose of determining if any of the provisions of this part, or any practice act of a profession or any rule adopted thereunder is being violated; or for the purpose of securing such other evidence as may be needed for prosecution.

§26.13 Special Cases Involving Confidentiality of Medical Information and Records

[1] Minor's Records

- [A] Florida Statute Section 456.057 governs ownership and control of patient records maintained by private health care practitioners (i.e. physicians). Section 456.057(5) states in relevant part:

...except as provided in this section and in 440.13(4)(c), such records may not be furnished to, ... any person other than the patient or the *patient's legal representative* or other health care practitioners and providers involved in the care and treatment of the patient, except upon written authorization of the patient....

- (1) The term "legal representative" is not defined in this particular section. However, a definition is provided in sections 409.901 and 710.102, Fla. Stat. Both statutes define "legal representative" as *an individual's guardian, personal representative or conservator*.
- (2) The term "guardian" is defined in section 744.102(8), Fla. Stat. as one who has been appointed to act on behalf of the minor. Under § 744.301(1), Fla. Stat. a mother and father jointly are natural guardians of their own and their adopted children during minority.
- (3) **General Rule:** The parents of a minor child are a child's legal representatives and may have access to the child's medical records held by a private

physician. Note, however, that there are several limitations and exceptions to this general rule.

[B] Divorced Parent’s Rights — § 61.13(2)(b)3, Fla. Stat.

- (1) Florida Statute Section 61.13(2)(b)3 provides that access to the medical records and other information pertaining to a minor child *may not be denied to a parent because the parent is not the child’s primary residential parent*. However, when a court had ordered one parent to have sole parental responsibility, access may be denied to the other parent.
- (2) Florida Statute Section 744.301(1) provides that the type of custody ordered by the court governs the determination of guardianship. Section 744.301(1) states in pertinent part:

If the marriage is dissolved the natural guardian ship shall belong to the parent to whom custody of the child is awarded. If the parents are given joint custody they both shall continue as natural guardians. If the marriage is dissolved and neither the father nor the mother is given custody of the child, neither shall act as guardian of the child.

- (3) **General rule:** Access to all records will be permitted if one has at least partial parental responsibility for the child (i.e. has some legal custody of the child).

[C] Records Held by Hospitals

- (1) Section 395.3025(1), Florida Statutes, provides in relevant part:

Any licensed facility shall, upon written request, and only after the 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 records....*
- (2) This statute, which is more specific than section 456.057, seems to give full access to the parent of a minor child, if the child does not have an appointed guardian, curator, or personal representative.
- (3) Note, however, that this section does not apply to psychiatric or substance abuse facilities. Records for such facilities are governed by separate statutes.

[D] Access to Mental Health Records

Section 394.4615, Florida Statutes, governs and states in pertinent part:

- (1) ...Unless waived by expressed and informed consent, *by the patient or the patient's guardian or guardian advocate...* the confidential status of the clinical record shall not be lost....
- (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.

* * * *

- (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 in section 456.057, access by the minor's parents is not specifically mentioned in this provision. An interpretation of the term "patient's guardian" is required. As discussed above, the term seems to depend upon the legal custody of the child and the presence or absence of an appointed guardian.

[E] Substance Abuse Services

Section 397.501, Florida Statutes, states in relevant part:

- (7)(a) The records of service providers which pertain to the identity, diagnosis, and prognosis of and service provision to any individual client are confidential in accordance with this chapter and with applicable federal confidentiality regulations and are exempt from the provisions of Florida Statute section 119.07(1) and Article 1, section 24(a), of the State Constitution. Such records may not be disclosed without the written consent of the client to whom they pertain....

(7)(e)1. Since a minor acting alone has the legal capacity to voluntarily apply for and obtain substance abuse treatment, only the minor client may give any written consent for disclosure. This restriction includes, but is not limited to, any disclosure of client identifying information to the parent, legal guardian, or custodian of a minor client for the purpose of obtaining financial reimbursement.

[*Note:* The promise of confidentiality was most probably included to encourage the minor to seek treatment.]

(7)(e)2. When the consent of a parent, legal guardian, or custodian is required under this chapter in order for a minor to obtain substance abuse treatment, any written consent for disclosure must be given by both the minor and the parent, legal guardian, or custodian.

General Rule: Consent of the minor patient is always required.

[F] **Treatment for Sexually Transmissible Diseases**

Section 384.30, Florida Statutes, provides in pertinent part:

(1) ...Each health care professional may examine and provide treatment for sexually transmissible diseases to any minor, if the physician, health care professional, or facility is qualified to provide such treatment. The consent of the parents or guardians of a minor is not a prerequisite for an examination or treatment.

[*Note:* The promise of confidentiality was most probably included to encourage the minor to seek treatment.]

(2) The fact of consultation, examination, and treatment of a minor for a sexually transmissible disease is confidential and exempt from the provisions section 119.07(1) and shall not be divulged in any direct or indirect manner, such as sending a bill for services rendered to a parent or guardian, except as provided in section 384.29.

General Rule: Consent of the minor patient is always required.

[G] **HIV Testing**

Section 381.004, Florida Statutes, states in relevant part:

(3)(e) Except as provided in this section, the identity of any person upon whom a test has been performed and test results are confidential and exempt from the provisions of s.119.07

(1). No person who has obtained or has knowledge of a test result pursuant to this section may disclose or be compelled to disclose the identity of any person upon whom a test is performed, or the results of such a test in a manner which permits identification of the subject of the test, except to the following persons:

1. The subject of the test or the subject's legally authorized representative....

The exception under subsection (3)(e)1 provides for disclosure to any adult custodian, any adult relative, or any person responsible for the child's welfare, if the minor child did not seek to be tested for evaluation for a possible STD and if a reasonable attempt has been made to locate and inform the legal guardian of a test result.

[H] Pregnancy and Abortion

- (1) Chapter 390, Florida Statutes covers pregnancy and Chapter 797 governs abortion. Neither statute discusses medical records or confidentiality.
- (2) There is case law that provides confidentiality to minors under the right to privacy guaranteed by the state constitution (*B.B. v. State*, 659 So. 2d 256 (Fla. 1995)).

[2] Worker's Compensation Laws and Confidentiality of Medical Information

[A] Overview of The Florida Worker's Compensation Law

(1) Legislative Intent

- (a) **Goal:** To ensure the quick and efficient delivery of disability and medical benefits to an injured worker and to facilitate the worker's return to gainful employment at a reasonable cost to the employer.
 - (b) This can be achieved through an efficient, self-executing system, which is not an economic or administrative burden.
 - (c) Cases shall be decided on the merits
- (2) These laws are based on the mutual renunciation of common law rights and defenses by employers and employees, including confidentiality of medical records.

- (3) Workers' compensation laws should not be liberally construed resulting in favor to either the employer or employee. Instead, construe these laws in accordance with the basic principles of statutory construction.

[B] Workers' Compensation Managed Care Arrangement

- (1) Governed by Florida Statute section 440.134
- (2) If parties enter into a direct or indirect written agreement, this section authorizes arrangements between a health care provider, group of health care providers, health care facility, a group of providers of health care and health care facilities, an insurer with exclusive provider organization approval, or a licensed health maintenance organization and an insurer, to provide and manage appropriate remedial treatment, care, and attendance to injured workers.

[C] Access to Medical Records

- (1) Section 440.13(4), Florida Statutes, provides in pertinent part:
 - (b) Each medical report or bill obtained or received by the employer, the carrier, or injured employee, or the attorney for the employer, carrier, or injured employee, with respect to the remedial treatment or care of the injured employee... must be filed with the Division of Workers' Compensation pursuant to rules adopted by the division. The health care provider shall also furnish to the injured employee or to his or her attorney, on demand, a copy of his or her office chart, records, and reports.... Each such health care provider shall provide to the division any additional information about the remedial treatment, care, and attendance that the division reasonably requests.
 - (c) It is the policy for the administration of the workers' compensation system that there be reasonable access to medical information by all parties to facilitate the self-executing features of the law. ...Upon the request of the employer, the carrier, or the attorney for either of them, the medical records of an injured employee must be furnished to those persons and the medical condition of the injured employee must be discussed with those persons, if the records and the discussions are restricted to conditions relating to the workplace injury. Any such discussions may be held before or after the filing of a claim without the knowledge, consent, or presence of any other party or his or her agent or representative....

(2) Identifying Information

- (a) Florida Statute section 440.125 provides that an injured employee's medical records and medical reports and information identifying the employee in medical bills held by the Division of Workers' Compensation are confidential and exempt from the public records law.
- (b) Florida Statutes section 440.132 provides that investigatory and examination records of the Agency for Healthcare Administration be held confidential and exempt during an investigation. However, the parts of the medical records, which specifically identify patients, must remain confidential and exempt, even after investigation is completed or ceases to be active.

[D] Drug Free Workplace

(1) Legislative intent in promoting drug-free workplaces

- (a) Allows employers to maximize productivity, enhance competitive positions, and reach desired levels of success without costs, delays, and tragedies associated with work-related accidents resulting from drug abuse by employees.
- (b) Employees who elect to engage in drug abuse face the risk of both unemployment and the forfeiture of workers' compensation benefits.

(2) Confidentiality in a drug-free workplace - section 440.102(8) states in relevant part:

- (a) . . .All information, interviews, reports, statements, memoranda, and drug test results, written or otherwise, received or produced as a result of a drug-testing program are *confidential* and exempt from the provisions of section 119.07(1) and section (section 24(a), Art. I of the State Constitution, and *may not be used* or received in evidence, obtained in discovery, or disclosed in any public or private proceedings, except in accordance with this section or in determining compensability under this chapter.
- (b) Employers, laboratories, medical review officers, employee assistance programs, drug rehabilitation programs, and their agents *may not release* any information concerning drug test results obtained pursuant to this section without a *written consent form signed voluntarily by the person tested* unless such release is compelled. . . .

(c) Information on drug test results *shall not be used in any criminal proceeding against the employee or job applicant*. Information released contrary to this section is *inadmissible* as evidence in any such criminal proceeding.

(d) This subsection *does not prohibit an employer, agent of an employer . . . from having access to employee drug test information* or from using such information when consulting with legal counsel in connection with actions brought under or related to this section or when information is relevant to its defense in a civil or administrative matter.

(3) Consent Form Requirements:

(a) The name of the person who is authorized to obtain the information;

(b) The purpose of the disclosure;

(c) The precise information to be disclosed;

(d) The duration of the consent; and

(e) The signature of the person authorizing release.

(4) Not to be released in a criminal proceeding.

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