CLOSING YOUR MEDICAL PRACTICE

Dear Doctor:

Attached is information that will guide you as you prepare to close your practice. As you review the materials, please contact your personal attorney and your accountant for specific instructions.

Section 1 Medical Society of the State of New York

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- 1.2 Release of Medical Records
- 1.3 HIV Related Information
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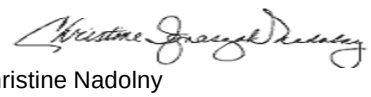
- 4.1 Public Health Law § 17
- 4.2 Public Health Law § 18

Section 5 New York State Department of Health

- 5.1 Memorandum: Reasonable Charge for Copies of Health Care Records/Patient Information

If you should have any questions, please contact me at (716) 852-1811 ext. 101, or via email at chris@eriemds.org

Sincerely,



Christine Nadolny
Executive Director

SECTION 1

Medical Society of the State of New York

Medical Society of the State of New York

Correspondence

MEDICAL SOCIETY OF THE STATE OF NEW YORK
420 Lakeville Road, PO Box 5404, Lake Success, NY 11042 (516) 488-6100
Fax (516) 488-8389

Donald R. Moy
General Counsel

I am sending you this letter summarizing the advice that our office gives to a physician who plans to retire or close his/her medical practice.

The first matter of importance concerns notification to active patients of your intention to close your practice. Active patients include those patients for whom the physician has initiated medical care or treatment for a specific injury, illness or condition and who will require continuing care fro such injury, illness or condition. The safest method for notifying such patients is by sending a certified letter, return receipt requested. You may also, however, notify them personally. The purpose of providing notice is to protect yourself from the possibility of being charged with abandonment by either a patient (in a malpractice lawsuit) or the State Board of Professional Medical Conduct. The notice enables patients requiring continuing medical care to arrange for treatment elsewhere without disruption of treatment.

With respect to the medical records of your patients, such records may be left in the safekeeping of the physician succeeding your practice. If you do this, the records are still your property and the information contained therein remains confidential. The succeeding physician may not utilize the records unless he receives consent from the patient. Consent would be implied if the patient decides to be treated by the succeeding physicians.

It is also important to note that a physician must retain patient records for certain applicable time periods. Medical records must be retained for the period required by Section 6530(32) of the Education Law.

According to the section, unprofessional conduct includes:

> "Failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Unless otherwise provided by law, all patient records must be retained for <u>at least six years</u>. Obstetrical records and records of minor patients must be retained for at least six years, and until one year after the minor patient reaches the age of eighteen years."

An intentional violation of this section of the Education Law can constitute grounds for disciplinary proceedings of professional misconduct.

According to the aforementioned section, you can destroy records if a minimum period of six years has elapsed from the last date of treatment. Keep in mind that this is a minimum requirement. You may keep records for a period longer than six years. It is generally recommended that records be kept at least seven years as an additional safeguard. Two exceptions provided in the Educational Law include records relating to the treatment of infants (patients who were under 18 at the time of treatment) and obstetric records. Records relating to the treatment of infants should be kept for at least six years or until the infant reaches 19 years of age, whichever is longer. Obstetric records should be retained until the infant reaches 19 years of age.

If the physician has signed HMO or managed care agreements, check them. Some HMO agreements may require the physician to retain. Copies of medical records of HMO enrollees for a period longer than as stated above. As an example, some HMO agreements provide that records of a minor patient must be retained for six years or six years after the minor attains 18 years of age, whichever is longer.

It is advisable that physicians maintain all Medicare patient records for ten (10) years to protect themselves in the event there is a Medicare False Claims Act investigation. The False Claims Act permits the government to commence action up to 10 years after the date in which the claim was submitted for payment.

The requirement regarding retaining medical records should not be confused with the statute of limitations. The statute of limitations is the period of time in which a plaintiff will be able to bring a lawsuit without being time barred. After July 1, 1975, the statute of limitations for a medical malpractice action has been two years, six months from the date of the alleged malpractice. Prior to July 1, 1975, the statute of limitations for a medical malpractice action was three years.

The statute of limitations has an exception to it in regard to actions brought on behalf of minors. Again, July 1, 1975 is the watershed date because of changes in the statute of limitation law. In an action brought on behalf of a minor for malpractice which occurred prior to July 1, 1975, the statue of limitations does not begin to run until after a minor reaches the age of majority (18 years of age). Technically, this suspension in time in which a minor is able to commence a lawsuit is called “tolling”. If the alleged malpractice occurred after July 1, 1975, the maximum time “within which the action must be commenced shall not be extended… beyond ten years” after the incident took place, (Civil Practice Law and Rules, Section 208).

The following examples will illustrate how these rules apply to minors:

EXAMPLE 1

SITUATION	APPLICABLE LAW
- Alleged malpractice occurred in 1970 to a five-year old child.	- Statute of limitations of three years

In Example 1, the child would have the right to sue until three years after he reaches his 18th birthday.

EXAMPLE 2

SITUATION	APPLICABLE LAW
- Alleged malpractice occurred in 1977 to a five-year old child	- Minors are subject to a statute of limitations of 10 years under the tolling provision for any medical malpractice which occurred to a minor after July 1, 1975.

In Example 2, the child who was five years old at the time of the alleged malpractice will be able to sue only until his 15th birthday.

Physicians are advised to retain their medical records for the duration of the statute of limitations. While section 6530(32) is not to be confused with the statute of limitations, buy complying with Section 6530(32), the physician also protects himself under the statute of limitations.

It is conceivable that a medical malpractice action can be commenced after six years in an action where the plaintiff alleges that a foreign medical object was left in his body. In an alleged "foreign object" case, the plaintiff has until one year after the discovery of the foreign object, or of the date of the discovery of facts which would reasonably lead to the discovery of the foreign object, in which to bring the action.

In view of the above section of the Education Law, if you decide to entrust your patient records with a succeeding physician, an agreement should be made requiring that physician to retain the records for the time period specified in the statute. Additionally, you should have an agreement permitting you to have access to the records upon request. Please see the attached "Reminder" for a list of the principles that the succeeding physician should agree to undertake.

Assuming you leave your records with the succeeding physician, if a former patient chooses to be treated by a different physician and requests in writing that his records be sent to that physician, Section 17 of the Public Health Law requires the succeeding to comply with the request. This requirement is also applicable to you if you decide to keep the records in your possession.

With specific reference to HIV related information, Public Health Law Section 2782 provides that no person who obtains confidential HIV related information in the course of providing any health or social services may disclose or be compelled to disclose such information, subject to enumerated exemptions. Among the exemptions, Section 2780 subdivision (2) provides that HIV related information may be released pursuant to a specific release either developed or approved by the Department of Health. Section 63.110 of the regulations of the Department of Health provides a form approved by the Department of Health to release HIV related information. A copy of a summary on the release of confidential information which includes the specific release form approved by the Department of Health is enclosed.

It should be noted that as of January 1, 1987, Section 18 of the Public Health Law, went into effect. This law, which supplements Section 17 of the Public Health Law, provides a patient with direct access to his of her own medical records.

Section 18 of the Public Health Law gives patients the right to inspect and/or receive copies of their medical records. A provider may deny access if (a) the provider determines that the requested review of the information can reasonably be expected to cause harm to the subject or others, (b) the information requested constitutes "personal notes" (c) the data was disclosed in confidence by persons other than the patient, and (d) the parents or guardian of an infant seek information pertaining to the treatment of an infant and the provider determines that access would have a detrimental effect on the provider's professional relationship with the infant. In cases where the denial of access is disputed, the matter is reviewed by a Medical Records Access Review Committee. In the event access is denied because of a determination that access would cause harm to the patient or access would have a detrimental effect on the professional relationship with an infant, there is a right to judicial review.

If your former patients' medical records are to be entrusted for safekeeping with a succeeding physician, it is suggested that requests for copies of these medical records be sent directly to you. This will enable you to deny access if, in your opinion, disclosure of the records would be detrimental to the patient's well-being. It would also enable you to protect against disclosure of psychiatric records, personal notes, and any information received in confidence from persons other than the patient.

If you decide that you want to surrender your DEA number, you may do so by writing the Drug Enforcement Administration and asking the Agency to withdraw your number. The DEA Certificate may be surrendered to the DEA. You should mark the word "void" on the certificate before surrendering it. The letter of withdrawal should state the reason why you no longer plan to use your DEA number. The Drug Enforcement Administration may be reached by writing:

Drug Enforcement Administration
New York Field Division

Registration Unit
99 10th Avenue
New York, New York 10011
(212) 337-1593

Any unopened bottles of controlled substances may be returned to the manufacturer of distributor for a refund. Open bottles or samples of controlled substances must be surrendered to the New York State Department of Health, Bureau of Controlled Substances. Surrender forms may be obtained by contacting:

New York State Department of Health
Bureau of Controlled Substances
433 River Street, Suite 303
Troy, New York 12180
(518) 402-0708

Copies of surrender forms must be kept for five years.

Regarding your license, under New York State Law, a physician's license to practice medicine is valid for life. You must, however, register the license biennially (once every two years). According to a regulation of the Commissioner of Education, 8 N.Y.C.R.R. Section 59.8, a licensee who is not in active practice may allow the registration to lapse without being subject to any late fee by notifying the Department of Education of the licensee's cessation of practice. If, at any time in the future, the licensee decides to resume his practice, the registration may be issued without any additional late fee.

A licensee who is not registered may no longer practice his profession in any degree. It is suggested that any physician who moves should notify the Department of Education of his forwarding address. The Registration Unit of the Department of Education may be reached by writing:

Registration Unit
State Education Department
Division of Professional Licensing Service
Cultural Education Center
Empire Plaza
Albany, New York 12230
(518)474-4234

With respect to your medical liability insurance, if you have a claims policy, you should contact your liability carrier to determine if you are entitled to "tail coverage" at no additional charge. Physicians with occurrence coverage do not need to obtain tail coverage because the policy covers claims arising from incidences that occurred while the policy was in force, no matter when the claim is reported. Under a claims made policy, however, that claim is covered only if the claims both occur and are reported while the coverage is in force. Example, a policy is in force from 1982 to 1986 at which time it is cancelled. Two years

later, in 1988, a claim is instituted based upon treatment provided in 1983. An occurrence policy would cove the claim because the policy was in force in 1983. If tail coverage is not in effect, a claims made policy would not cover the claim because although the policy was in force at the time the incident occurred, the claim was reported after the policy was cancelled in 1988. The "tail coverage" provides coverage for claims that may be brought after you retire. Depending upon your policy the number of years you have had continuous claims made coverage and your age, you may be entitled to tail coverage at no additional charge. In addition, you should always keep a copy of you liability policy in the event any problems that might arise later.

As a reminder, you should review all contracts that you have with managed care plans and all contracts that you have with vendors and suppliers of your office. It is possible that managed care plans contracts include provisions that require you to provide notice to the plan upon your decision to withdraw from the practice f medicine. It may also be advisable that you notify hospitals that you have an affiliation or privileges.

Finally, I have enclosed a sample letter that physicians may want to utilize when notifying patients on their intent to close their practice. ***Physicians are advised that this form letter is for general information only and is <u>not</u> intended as legal advice. Physicians are advised to contact their private attorney prior to using any form letter.***

I trust this information will be of assistance.

Very truly yours,

Donald R. May
Vice President & General Counsel

DRM/mn
Enclosures
Updated 6/03

REMINDER – Physicians who entrust their records with a succeeding physician should have the succeeding physician agree in writing"

1. The records are the property of the physician who prepared the records and the succeeding physician holds the records for safekeeping only.
2. The physician owner of the records is entitled access to his/her records during business hours.
3. The physician who holds the records for safekeeping should not commingle them with his/her own records, but records held for safekeeping should be separately stored.
4. Because of the physician-patient confidentiality requirements, the physician who holds the records for safekeeping should not access the records without the patients consent. With the patient's consent, the safekeeping physician may review the records and incorporate information and history from his/her own records, but the original record should continue to be separately store (3 above).
5. The medical records should be retained for at least the period of time required by Educational Law section 6530(32) – Six years from the last date of treatment. For records relating to care or treatment for a specific illness, injury or medical condition over a period of time, the entire record for the care or treatment relating to the illness, injury or medical condition should be retained for at least six years from the last date of treatment. Records relating to minor patients (a patient under 18 years of age at the time or treatment) and obstetric records should be kept until the minor patient is 19 years of age, or six years, whichever period is longer. Although the law requires records to be kept for not less than six years, the Office of General Counsel recommends seven years.
6. If the physician has signed HMO or managed care agreements, check them. Some HMO agreements may require the physician to retain copies of medical records of HMO enrollees for a period longer than as stated above. As an example, some HMO agreements provide that records of a minor patient must be retained for six years or six years after the minor attains 18 years of age, whichever is longer. [Under the Federal Mammography Quality Standards Act (MQSA), the period of time that mammograms and associated records must be retained is stricter than the State law requirements. If the mammograms are the last mammograms performed by the facility, the mammograms and associated record must be retained for ten year. If additional mammograms have been performed the earlier mammograms should be retained at least six years].
7. If the patient requests that copies of the records be made available to the patient or to a designated physician, the succeeding physician must make copies available in accordance with legal requirements. The law permits a charge of up to 75 cents per page. For x-rays and other records that cannot be photocopied, the law permits a "reasonable" charge, but the charge for duplication should no exceed

the costs incurred. [Mammograms – The Federal MASA, and state law, Public Health Law section 17 and 18 require a physician to release the original mammogram. A physician may retain a duplicate of the mammogram but may not impose a charge for the costs incurred to duplicate the mammogram].

It should be understood that even if the above principles are included in a written agreement between the physician and the succeeding physician, the physician may suffer adverse consequences including adverse financial consequences in the event of a third party payer audit if the succeeding physician fails to comply with the agreement To avoid this risk, the physician may consider personally retaining his/her records.

LETTER FOR PHYSICIANS DISCONTINUING PRACTICE

Dear _____:

Please be advised that because of _____ I am
(my retirement, reasons of health, etc.)
discontinuing the practice of medicine on _____, 20__. I shall not be able to attend you professionally after that date.

Upon my discontinuation of practice, Dr. _____ has agreed to assume my practice, and copies of the records will be kept in his office. Since the records are *confidential,* Dr. _____ will only hold these records for safe keeping purposes and will not otherwise have access to the records without your consent.

I suggest that you arrange to place yourself under the care of Dr. _____ or any other physician of your choice.

If you choose not to be placed under the care of Dr. _____, copies of your records will be sent to the physician you designate. Since the records are confidential, your written authorization to make them available to another physician is required. For this reason, I am including at the end of this letter an authorization form. Please complete the form and return it to Dr. _____.

I am sorry that I cannot continue as your physician. I extend to you my best wishes for your future health and happiness.

Very truly yours,

_____, M.D.

AUTHORIZATION TO TRANSFER RECORDS

Date:_____

Dear Dr. _____:

I hereby authorize you to transfer or make available to myself or to Dr. _____, at _____
(address)
all records and reports relating to my case.

Signed:_____
(patient)

Medical Society of the State of New York

Release of Medical Records

MEDICAL SOCIETY OF THE STATE OF NEW YORK
420 Lakeville Road, PO Box 5404, Lake Success, NY 11042 (516) 488-6100
Fax (516) 488-8389

Office of General Counsel

RELEASE OF MEDICAL RECORDS

SUMMARY OF §18 OF THE PUBLIC HEALTH LAW

Section 18 of the Public Health Law, which gives patients direct access to patient information, became effective on January 1, 1987. This memorandum will provide the verbatim language of §18, broken down by each subdivision of the law, and will summarize the general implication of some of the more vital provisions.

Subdivision 1 of §18 provides definitions of terms:

"1. Definitions. For the purpose of this section:

(a) "Committee" means a medical access review committee appointed pursuant to subdivision four of this section.
(b) "Health care provider" or "provider" means a "health care facility" or a "health care practitioner" as defined by this subdivision.
(c) "Health care facility" or "facility" means a hospital as defined in article twenty-eight of this chapter, a home care services agency and defined in article thirty-sex of this chapter, a hospice as defined in article forty of this chapter, a health maintenance organization as defined in article forty-four of this chapter, and a shared health facility as defined in article forty-seven of this chapter.
(d) "Health care practitioner" or "practitioner" means a person licensed under article one hundred thirty-one, one hundred thirty-one-B, one hundred thirty-two, one hundred thirty-three, one hundred thirty-six, one hundred thirty-nine, one hundred forty-one, one hundred forty-three, one hundred forty-four, one hundred forty-one, one hundred fifty-three, one hundred fifty-four, one hundred fifty-sex or one hundred fifty-nine of the education law or a person certified under section twenty-five hundred sixty of this chapter.
(e) "Patient information" or "information" means any information concerning or relating to the examination, health assessment including, but not limited to a health assessment for insurance and employment purposes or treatment of an identifiable subject maintained or possessed by a health care facility

or health care practitioner who has provided or is providing services for assessment of a health condition including, but not limited to, a health assessment for insurance and employment purposes or has treated or is treating such subject, except

(i) information and clinical records subject to the provisions of section 23.05 or 33.13 of the mental hygiene law,

(ii) personal notes and observations of a health care practitioner, provided that such personal notes and observations are maintained by the practitioner and not disclosed by the practitioner to any other person after January first, nineteen hundred eighty-seven,

(iii) information maintained by a practitioner, concerning or relating to the prior examination or treatment of a subject received from another practitioner, provided however, that such information may be requested by the subject directly from such other practitioner in accordance with the provisions of this section, and

(iv) data disclosed to a practitioner in confidence by other persons on the basis of an express condition that such data would never be disclosed to the subject or other persons, provided that such data has never been disclosed to any other person. If at any time such personal notes and observations or such data is disclosed, it shall be considered patient information for purpose of this section. For the purposes of this subdivision, "disclosure to any other person" shall not include disclosures made to practitioners as part of a consultation or referral during the treatment of the subject, to persons reviewing information or records in the ordinary course of ensuring that a provider is in compliance with applicable quality of care, licensure or accreditation standards, to an employee or official of a federal, state, or local agency for the sole purpose of conducting an audit in the course of his or her official duties, to the statewide planning and research cooperative system, to other persons pursuant to a court order, to governmental agencies, insurance companies licensed pursuant to the insurance law and other third parties requiring information necessary for payments to be made to or on behalf of patients, to qualified researchers, to the state board for professional medical conduct when such board requests such information in the exercise of its statutory function, to an insurance carrier insuring, or an attorney consulted by, a health care provider, or to a health maintenance organization certified pursuant to article forty-four of this chapter or licenses pursuant to the insurance law, or to the committee or a court pursuant to the provisions of this section.

For purposes of this subdivision treatment of a subject shall not include diagnostic service and except mammography performed by a practitioner at the request of another health care practitioner provided, however, that such

information and mammograms may be requested by the subject directly from the practitioner at whose request such diagnostic services were performed, in accordance with the provision of this section.

(f) "Personal notes and observations" means a practitioner's speculations, impressions (other than tentative or actual diagnosis) and reminders, provided such data as maintained by a practitioner.
(g) "Qualified person" means any properly identified subject, or a guardian appointed under article eighty-one of the mental hygiene law, or a parents of an infant, or a guardian of an infant appointed under article seventeen of the surrogate's court procedure act or other legally appointed guardian of an infant who may be entitled to request access to a clinical record under paragraph (c) of subdivision who of this section, or a distribute of any deceased subject for whom no personal representative, as defined in the estates, powers and trusts law, has been appointed, or an attorney representing a qualified person or the subject's estate who holds a power of attorney from the qualified person or the subject's estate explicitly authorizing the holder to execute a written request for patient information under this section. A qualified person shall be deemed a "personal representative of the individual" for purposes of the federal health insurance portability and accountability act of 1996 and its implementing regulations.
(h) "Subject" means n individual concerning whom patient information is maintained or possessed by a health care provider.
(i) "Treating practitioner" means that health care practitioner who has primary responsibility for the care of the subject within the health care facility or if such practitioner is unavailable, a practitioner designated by such facility."

DISCUSSION:

Keeping in mind that the basic purpose of §18 is to provide access to "qualified persons" to "patient information" concerning the examination or treatment of a "subject", the key terms to understand are "patient information" and "personal notes and observations".

"Patient Information" means any information concerning or relating to the examination or treatment of an identifiable subject maintained or possessed by a health practitioner who has treated or is treating the subject. As a result of a 1990 amendment, "patient information" now includes "health assessments". It should be understood that what is NOT patient information. For the purpose of §18, patient information does not include:

(i) Information and clinical records subject to §23.05 or §33.13 of the Mental Hygiene Law. Section 23.05 pertains to records involving the identity, diagnosis, prognosis, or treatment in connection with substance abuse services. Section 33.13 pertains to clinical records for each patient maintained at a facility licensed or operated by the Office of

Mental Health or the Office of Mental Retardation and Developmental Disabilities.

(ii) Personal notes and observations of a health care practitioner.

(iii) Information maintained by a practitioner concerning or relating to the prior examination or treatment of a subject received from another practitioner, provided such information may be requested directly from such other practitioner.

(iv) Data disclosed to the practitioner in confidence by other persons on the basis of an express condition that such data would never be disclosed to any other person.

Both "personal notes and observations" and "confidential data" [(ii)] and (iv) above] become "patient information', and thereby subject to release pursuant to §18, if such information is "disclosed to any other person". The definition of "patient information" includes an extensive list of types of disclosures that are <u>not</u> considered a "disclosure to any other person" that will convert "personal notes" or confidential data" to "patient information". This list includes disclosures to governmental agencies and third party payors required for audit or reimbursement purposes.

"2. Access by qualified persons.

(a) Subject to the provisions of subdivision three of this section, upon written request of any subject, a health care provider shall provide an opportunity, within ten days, for such subject to inspect any patient information concerning or relating to the examination or treatment of such subject in the possession of such health care provider.

(b) Subject to the provisions of subdivision three of this section, upon the written request of the committee for an incompetent appointed pursuant to article seventy-eight of the mental hygiene law, a health care provider shall provide an opportunity, within ten days, for the inspection by such committee of any patient information concerning the incompetent subject in the possession of such health care provider.

(c) Subject to the provisions of subdivision three of this section and except as otherwise provided by law, upon the written request of a parent or guardian of an infant appointed pursuant to article seventeen of the surrogate's court procedure act, or any other legally appointed guardian, a health care provider shall provide an opportunity, within ten days, for such parent or guardian to inspect any patient information maintained or possessed by such provider concerning care and treatment of the infant for which the consent of such parent or guardian was obtained or where care was provided without consent in an emergency which was the result of accidental injury or the unexpected onset of serious illness; provided, however, that such parent or guardian shall not be entitled to inspect or make copies of any patient information concerning the care and treatment of an infant where the health care provider determines that access to the information requested by such parent or guardian would have detrimental

effect on the provider's professional relationship with the infant, or on the care and treatment of the infant, or on the infant's relationship with his or her parents or guardian.

(d) Subject to the provisions of subdivision three of this section, upon the written request of any qualified person, a health care provider shall furnish to such person, within a reasonable time, a copy of any patient information requested, and original mammograms requested, which the person is authorized to inspect pursuant to this subdivision.

(e) (i) The provider may impose a reasonable charge for all inspections and copies, not exceeding the costs incurred by such provider, provided, however, that a provider may not impose a charge for copying an original mammogram when the original has been furnished to any qualified person and provided, further, that any charge for furnishing an original mammogram pursuant to this section shall not exceed the documented costs associated therewith. However, the reasonable charge for paper copies shall not exceed seventy-five cents per page. A qualified person shall not be denied access to patient information solely because of inability to pay.

(f) A provider may place reasonable limitations on the time, place, and frequency of any inspections of patient information.

(g) In the event that a practitioner does not have space available to permit the inspection of patient information, the practitioner may, in the alternative, furnish a qualified person a copy of such information within ten days.

(h) A provider may request the opportunity to review the patient information with the qualified person requesting such information, but such review shall not be a prerequisite for furnishing the information.

(i) A provider may make available for inspection either the original or a copy of patient information."

DISCUSSION:

Subdivision 2 of §18 requires the practitioner to provide a "qualified person" an opportunity to inspect patient information within ten days of a written request.

Paragraph (c) of subdivision 2 requires a health care provider to provide a parent or guardian of an infant with patient information concerning the care or treatment of an infant for which the consent of the parent or guardian was obtained or where care was provided without consent in an emergency. The paragraph pertains to treatment of persons under 18 years of age, since a person 18 years of age or older, may give effective consent for his/her own medical treatment. Also, pursuant to law, regardless of age, a person who is a parent of a child or is married may give effective consent for himself/herself; regardless of age, a person who is married or has borne a child may give effective consent for the medical treatment of his/her child; and, regardless of age, any person who is pregnant may give effective consent for prenatal medical care.

The health care provider need not provide the parent or guardian with patient information regarding the infant, where the infant has provided effective consent on his/her own behalf. Furthermore, paragraph (c) of subdivision 2 provides that access to infant records may be denied where other laws provide the infant with confidentiality rights, e.g. §17 of the Public Health Law provides that records concerning the treatment for an infant patient for venereal disease or the performance of an abortion upon such infant patient shall not be released or in any manner made available to the parent or guardian of the infant.

In addition to the above, paragraph (c) of subdivision 2 authorizes the health care provider to withhold patient information regarding an infant patient if it is determined by the health care provider that the release of the information would have a detrimental effect on the professional relationship with the infant, or on the care and treatment of the infant or on the infant's relationship with his or her parents or guardian. It is anticipated that many physicians who provide patients under 18 years with medical consultation, care of treatment in such matters as contraception or other sexually related health matters, will rely on this provision to preserve the confidential interests of the infant. In addition, pertaining to the rights of infant patients, see paragraph (c) of subdivision 3 of §18.

Paragraph (e) provides that a "reasonable charge" may be imposed. The provider may impose a reasonable charge for all inspections and copies, not exceeding the costs incurred by the provider. The general rule is that the reasonable charge for "paper copies", such as photocopies, may not exceed 75 cents per page. Records such as x-rays, which cannot be photocopied are not subject to the 75 center per page limitation but are, nevertheless, subject to the restriction that the charge imposed may not exceed the costs incurred for copying. If the qualified person requests the original mammogram the health care provider may retain a copy of the mammogram but may not impose a charge for copying the original mammogram. A qualified person may not be denied access to patient information because of inability to pay.

As an alternative to permitting the qualified person to inspect the records on the premises, pursuant to paragraph (g) of subdivision 2, if the health care provider does not have the available space or facilities, he/she may furnish the qualified person with a copy of the records within ten days.

"3. Limitations on access.

(a) Upon receipt of a written request by a qualified person to inspect or copy patient information, a practitioner may review the information requested. Unless the practitioner determines pursuant to paragraph (d) of this subdivision that (i) the requested review of the information can reasonably be expected to cause substantial and identifiable harm to the subject or other which would outweigh the qualified person's right to access to the information, or (ii) the material requested would have a detrimental effect as defined in subdivision two of this section,

review of such patient information shall be permitted or copies provided.

(b) Upon receipt of a written request by a qualified person to inspect patient information maintained by a facility, the facility shall inform the treating practitioner of request. The treating practitioner may review the information requested. Unless the treating practitioner determines, pursuant to paragraph (d) of this subdivision that the requested review of the information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right of access to the information or would have a detrimental effect as defined in subdivision two of this section, review of such patient information shall be permitted or copies provided.

(c) A subject over the age of twelve years may be notified of any request by a qualified person to review his/her patient information, and, if the subject objects to disclosure, the provider may deny the request. In the case of a facility, the treating practitioner shall be consulted.

(d) The provider may deny access to all or a part of the information and may grant access to a prepared summary of the information if, after consideration of all the attendant facts and circumstances, the provider determines that (i) the request to review all or a part of the patient information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified persons right of access to the information, or would have a detrimental effect as defined in subdivision two of this section, or (ii) the material requested is personal notes observations. In conducting such review, the provider may consider, among other things' the following factors: (i) the need for, and the fact of, continuing care and treatment; (ii) the extent to which the knowledge of the information may be harmful to the health or safety of the subject or others; (iii) the extent to which the information contains sensitive material disclosed in confidence to the practitioner or treating practitioner by family members, friends, and other persons; (iv) the extent to which the information contains sensitive materials disclosed to the practitioner or the treating practitioner by the subject which would be injurious to the subject's relationships with other persons, except when the subject is requesting information concerning himself or herself; and (v) in the case of a minor making a request for access pursuant to subdivision two of this section, the age of the subject.

(e) In the event of a denial of access, the qualified person shall be informed by the provider of such denial, and whether the denial is based on the reasonable expectation that release of the information can reasonable be expected to cause substantial and identifiable harm to the subject or others which outweighs the qualified person's right of access to the information or on the reasonable expectation that release of the information would have a detrimental effect as defined in subdivision two of this section, or on the basis that the materials sought to be reviewed constitute personal notes and observations, and of the qualified person's right to obtain, without cost, a review of the

denial by the appropriate medical record access review committee. If the qualified person requests such review, the provider shall, within ten days of receipt of such request transmit the information including personal notes and observations as defined herein, to the chairman of the appropriate committee with a statement setting forth the specific reasons for which access was denied. After an in camera review of the materials provided and after providing all parties a reasonable opportunity to be heard, the committee shall promptly make a written determination whether the requested review of the information can reasonable be expected to cause substantial and identifiable harm to the subject or others which outweighs the qualified person's right of access to the information pursuant to paragraph (d) of this subdivision of whether the requested review would have detrimental effect as defined in subdivision two of this section, or whether all or part of the materials sought to be reviewed constitute personal notes and observations, and shall accordingly determine whether access to all or part of such materials shall be granted. In the event that the committee determines that the request for access shall be granted in whole or in part, the committee shall notify all parties and the provider shall grant access pursuant to such determination.

(f) In the event that access is denied in whole or in part because the requested review of information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right of access to the information, or would have a detrimental effect as defined in subdivision two of this section, the committee shall notify the qualified person of his or her right to seek judicial review of the provider's determination pursuant to this section: provided however, that a determination by the committee as to whether materials sought to be reviewed constitute personal notes and observations shall not be the subject of judicial review. Within thirty days of receiving notification as such decision, the qualified person may commence, upon notice, a special proceeding in supreme court for a judgment requiring the provider to make available the information for inspection or copying. The court upon such application and after an in camera review of the materials provided including the determination and record of the committee, and after providing all parties an opportunity to be heard, shall determine whether there exists a reasonable basis for the denial of access. The relief available pursuant to this section shall be limited to a judgment requiring the provider to make available to the qualified person the requested information for inspection or copying."

(g) Where the written request for patient information under this section is signed by a distribute of a deceased subject for whom a personal representative has not been appointed, or from the holder of a power of attorney from such a distribute, a copy of a certified copy of the certificate of death of the subject shall be attached to the written request.

(h) Where the written request for patient information under this section is signed by the holder of a power of attorney, a copy of the power of attorney shall be attached to the written request. A written request under this subdivision shall be subject to the duration and terms of the power of attorney.

(i) The release of patient information shall be subject to : (i) article twenty-seven-F of this chapter in the case of confidential HIV-related information; (ii) section seventeen of this article and sections twenty-three hundred one, twenty-three hundred six and twenty-three hundred eight of this chapter in the case of termination of a pregnancy and treatment for a sexually transmitted disease; (iii) article thirty-three of the mental hygiene law; and (iv) any other provisions of law creating special requirements relating to the release of patient information, including the federal health insurance portability and accountability act of 1996 and its implementing regulations.

DISCUSSION

Subdivision 3 lists the limitations on access. The limitations on access include:

(i) the information can reasonably be expected to cause substantial and identifiable harm to the subject or others

(ii) the material requested is personal notes and observations, or

(iii) the information requested would have detrimental effect as defined in subdivision 2 (i.e., detrimental effect on provider's professional relationship with an infant or on the care of treatment of the infant).

Paragraph (b) of subdivision 3 provides that when a qualified person makes a request to inspect patient information maintained by a facility, the facility must inform the treating physician of the request. The treating physician may thereby review the information requested in order to determine if the request should be granted or denied. Paragraph (c) of subdivision 3 provides that a subject over the age of 12 years may be notified of any request of a qualified person, and, if he objects to the disclosure, the provider may deny the request. In a facility, the treating practitioner must be notified.

Paragraph (d) lists the factors which a practitioner should evaluate in determining whether access should be denied.

Paragraph (e) provides that a request is denied, the practitioner must provide the qualified person with the reasons for the denial. If the denial of access is based upon the reasonable expectation that release of the information can cause substantial harm, or, the release, of the information, can have a detrimental effect (as in the case of an infant), or the materials sought constitute personal notes and observations, the qualified person may request a review by a medical record access committee (see definitions, subdivisions). The committee will make a determination after an in camera (private) review of the disputed material, and after allowing each party to be heard.

If the committee affirms the practitioner's denial of access, judicial review is available in some cases. If the denial of access is based upon the reasonable expectation that the release of the information can cause substantial harm, or that the release of the information may have detrimental effect, the qualified person may seek judicial review. The court's determination is to be based upon an in camera review of the material. Both parties must be provided an opportunity to be heard. According to subdivision (f), the court will uphold the determination of the medical record access review committee if it finds a reasonable basis to deny access. A denial of access based upon the committee's determination that the material constitutes "personal notes and observations" is not subject to judicial review.

The only relief available, pursuant to §18 of the Public Health Law is a judgment requiring the practitioner to grant access to the patient information. No other relief is available, e.g. money damages. Section 18 of the Public Health Law does not create an action for damages.

Paragraph (g) provides that where a written request for patient information is made by a distribute of a deceased subject for whom a personal representative has not been appointed or from the holder of a power of attorney from the distribute, a copy of a certified copy of the certificate of death of the subject should e attached to the written request. The term "distribute" means a person who is entitled to take or share in the property of a decedent under the laws governing descent and distribution. See Estates Powers and Trusts Law §1-2.5, §4-1.1.

Paragraph (h) provides that where a written request for patient information is signed by a holder of a power of attorney, a copy of the power of attorney should be attached to the written request.

"4. Medical record access review committees. The commissioner shall appoint medical record access review committees to hear appeals of the denial of access to patient information as provided in paragraph (e) of subdivision three of this section. Members of such committees shall be appointed by the commissioner from a list of nominees submitted statewide associations of providers in the particular licensed profession involved; provided, however, that, with respect to patient information maintained by a psychiatrist, the list of nominees shall be composed of psychiatrists. In the case of the licensed physicians, such association shall be the Medical Society of the State of New York. Such medical record access review committees shall consist of no less than three or more than five licensed professionals. The commissioner shall promulgate rules and regulations necessary to effectuate the provisions of this subdivision."

DISCUSSION

This subdivision provides for the appointment of the Medical Record Access Review Committees. In the case of licensed physicians, the medical record access committee shall be appointed from a list of nominees submitted by the Medical Society of the State of New York.

"5. Annual report. The commissioner shall submit an annual report on or before December thirty-first to the governor and the legislature. Such report shall include, but not be limited to, the number of requests for committee review of providers' denial of access and the committees' determination thereon."

DISCUSSION

Subdivision 5 calls for an annual report to include determinations by the medical record access review committees.

"6. Disclosure to third persons. Whenever a health care provider, as otherwise authorized by law, discloses patient information to a person or entity other than the subject of such information or to other qualified persons, either a copt of the subject's written authorization shall be added to the patient information or the name and address of such third party and notation of the purpose for the disclosure shall be indicated in the file or record of such subject's patient information maintained by the provider provided, however, that for disclosures made to government agencies making payments on behalf of patients or to insurance companies licensed pursuant to the insurance law such a notation shall only be entered at the time the disclosure is first made. This subdivision shall not apply to disclosure to practitioners or other personnel employed by or under contract with the facility, or to government agencies for purposes of facility inspections or professional conduct investigations. Any disclosure made pursuant to this section shall be limited to that information necessary in light of the reason for disclosure. Information so disclosed should be kept confidential by the party receiving such information and the limitations on such disclosure in this section shall apply to such party."

DISCUSSION

Subdivision 6 requires certain procedures to be followed when a provider disclosed patient information to third parties. These procedures include inserting a copy of the patient's written authorization or inserting a notation of the third party receiving the information and the purpose of the disclosure.

"7. Applicability of federal law. Whenever federal law or applicable federal regulations restrict or, as a condition for the receipt of federal aid, require that the release of patient information be more restrictive than is provided under this section, the provisions of federal law or federal regulations shall be controlling."

DISCUSSION

This subdivision clarifies that whenever federal law is applicable and such federal provisions regarding the release of patient information is more restrictive, the federal law shall control.

As an example, Federal Regulations 42 CFR Part 2 provides more restrictive confidentiality requirements regarding records involving the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to drug abuse prevention or alcoholism or alcohol abuse education, training, treatment, rehabilitation or research, which is conducted, regulated or directly or indirectly assisted by any department or agency of the United States (federal assistance includes the allowance by the Internal Revenue Service of income tax deductions for contributions to the program or through the granting of tax exempt status to the program). Any federally assisted program that provides alcohol or drug abuse diagnosis, treatment, or referral for treatment should be familiar with the confidentiality requirements of the Federal regulations.

"8. Challenges to accuracy. A qualified person may challenge the accuracy of information maintained in the patient information and may require that a brief written statement prepared by him or her concerning the challenged information be inserted into the patient information. This statement shall become a permanent part of the patient information and shall be released whenever the information at issue is released. This subdivision shall apply only to factual statements and shall not include a provider's observations, inferences or conclusions. A facility may place reasonable restrictions on the time and frequency of any challenges to accuracy."

DISCUSSION

Subdivision 8 entitles a qualified person to challenge the accuracy of "factual statements". The right to challenge factual statements does not include the right to challenge "observations, inferences or conclusions" of the licensed practitioner. While just what types of "factual statements" may be challenged remains open to question, it seems obvious that this subdivision is not intended to enable to qualified person to challenge the accuracy of statements of the practitioner relating to the practitioner's diagnosis or treatment.

"9. Waivers void. Any agreement by an individual to waive any right to inspect, copy or seek correction of patient information as provided for in this section shall be deemed to be void as against public policy and wholly unenforceable."

DISCUSSION

Subdivision 9 provides that waivers of the right to inspect records are void.

"10. Nothing contained in this section shall restrict, expand or in any way limit the disclosure of any information pursuant to articles twenty-three, thirty-one and forty-five of the civil practice law and rules or section six hundred seventy-seven of the county law."

DISCUSSION

Subdivision 10 provides that §18 does not expand, restrict, or modify other laws pertaining to disclosure of records.

"11. No proceeding shall be brought or penalty assessed, except as provided for in this section, against a health care provider, who in good faith, denies access to patient information."

DISCUSSION

Subdivision 11 emphasizes that the only remedy for a health care provider's denial of access to patient information is through the process of review by the medical record access review committee, and in some cases, judicial review of the determination of the medical record access review committee.

"12. Immunity from liability. No health care provider shall be subjected to civil liability arising solely from granting or providing access to any patient information in accordance with this section."

DISCUSSION

Subdivision 12 was added by an amendment that became effective on August 7, 1987. The purpose of the subdivision is to expressly state that the health care provider will not be subject to civil liability for providing access to records in accordance with §18.

NOTE: Physicians who have medical records with confidential HIV-Related Information should be familiar with Article 27-F of the Public Health law and implementing regulations of the Department of Health regarding HIV and AIDS Related Information.

If a health care provider furnishes copies of x-rays, the seventy five cents per page maximum charge limitation does not apply. In such a case, the health care provider may impose a "reasonable charge" for copies, but such charge may not exceed the actual costs of the x-ray.

Additionally, a patient shall not be denied access to their records solely because they are unable to pay. Therefore, an indigent patient may be entitled to a free

copy of their medical records, copy. A patient's medical records cannot be withheld due to a past due account.

Finally, a health care provider in not permitted to charge a search and retrieval fee in addition to the maximum per charge copying fee of seventy five cents. However, the fee limitations contained in the Public Health law do not prohibit a provider from charging postage, shipping, or required sales taxes since these items fall outside the purview of the statue. McCrossan v. Buffalo Heart Group, 69 N.Y.S.2d 852 (4th Dept. 1999).

NYS Health Department Timeline

Patients are entitled to a copy of their medical records, or the transfer of those records within a "reasonable period" which the NYS Health Department says is 14 days from the date of request.

References:

Donald J. Moy, Esq., Medical Society of the State of New York

Legal Guidelines for Medical Offices – August 2002, MSCE

State of New York Department of Health Memorandum, Reasonable Charge for Copies of *Health Care Records/Patient Information*, located at http://www.health.state.ny.us/nysdoh/opmc/dohmemo.htm

Medical Society of the State of New York

HIV Related Information

MEDICAL SOCIETY OF THE STATE OF NEW YORK
420 Lakeville Road, PO Box 5404, Lake Success, NY 11042 (516) 488-6100
Fax (516) 488-8389

OFFICE OF GENERAL COUNSEL

CONFIDENTIAL HIV-RELATED INFORMATION

Article 27-F of the Public Health Law and regulations implementing the statute, 10 New York Code Rules and Regulations Part 63, provide strict confidentiality requirements regarding HIV-Related Information.

"Confidential HIV-Related Information" means "any information, in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV-related information, concerning whether an individual has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify an individual as having one or more of such conditions, including information pertaining to such individual's contacts".

In accordance with the law, the term "protected person" means the person who is the subject of an HIV-related test or who has been diagnosed as having HIV infection, AIDS or AIDS related illness"-

The statute and regulation provide that no person who obtains confidential HIV-related information in the course of providing any health or social service or pursuant to a release of confidential HIV-related information may disclose or be compelled to disclose such information; EXCEPT to the following:

1. The protected individual or, when the protected individual lacks capacity to consent, a person authorized by law to consent to health care for the individual.

   [DISCUSSION – The "protected individual" is the subject of the HIV-related test or HIV-related information. This exception generally means that the confidential HIV-related information may be disclosed to the subject or patient.]

2. Any person to whom disclosure is authorized pursuant to a specific release form which has been developed or approved by the New York State Department of Health.

[DISCUSSION – A specific release form developed by the Department of Health may be obtained by contacting the General Counsel's Office at (516) 488-6100, EXT. 352. Please note that this exception does not permit disclosure of confidential HIV-related information pursuant to general release].

3. An agent or employee of a health facility or health care provider if:
   (i) the agent or employee is authorized to access medical records;
   (ii) the health care facility or health care provider itself is authorized to obtain the HIV-related information; and
   (iii) the agent or employee provides health care to the protected individual or maintains or processes medical records for billing or reimbursement.

4. A health care provider or health facility when knowledge of the HIV-related information is necessary to provide appropriate care or treatment to the protected individual or a child of the individual.

5. A health facility or health care provider, in relation to the procurement, processing, distributing or use of a human body or human body part, including organs, tissues, eyes, bones, arteries, blood, semem, or other body fluids, for use in medical education, research, therapy, or for transplantation to individuals.

6. Health facility staff committees, or accreditation or oversight review organizations authorized to access medical records, provided that such committees or organizations may only disclose confidential HIV-related information:
   (i) back to the facility or provider of a health or social service;
   (ii) to carry out the monitoring, evaluation or service review for which it was obtained; or
   (iii) to a Federal, State or local government agency when the person providing health or social services is regulated, supervised or monitored by the government agency or when the governmental agency administers the health program or a social services program to the records in the ordinary course of business and such access is necessary for the regulation, supervision, monitoring administration or provision of services.

7. A Federal, State, Country or local health officer when such disclosure is mandated by law.

8. Agencies authorized by law to receive children for adoption or foster care in connection with the adoption or foster care of a child.

9. Third party reimbursers or their agents to the extent necessary to reimburse health care providers, including health facilities, for health services, provided that, an otherwise appropriate authorization for such disclosure has been secured.

10. An insurance institution, for other than the purpose set forth in paragraph (9), provided that the insurance institution secures a dated and written authorization that indicates the health care providers, health facilities, insurance institutions, and other persons are authorized to disclose information about the protected individual, the nature of the information to be disclosed, the purposes for which information is to be disclosed and which is signed by:

    (i) the protected individual;
    (ii) if the protected individual lacks capacity to consent, the person authorized by law to consent for such individual; or
    (iii) if the protected individual is deceased, the beneficiary or claimant for benefits under an insurance policy, a health services plan or an employee welfare plan covering the protected individual

11. To a funeral director upon taking charge of the remains of a deceased person when such funeral director has access in the ordinary course of business to HIV-related information on the death certificate of the deceased individual;

12. Any person to whom disclosure is ordered by a court pursuant to requirements of law.

    [DISCUSSION – Generally a court may grand an order for disclosure of HIV-related information only on a showing: (a) a compelling need for disclosure of the information for the adjudication of a criminal or civil proceeding; (b) a clear and imminent danger to an individual whose life or health may unknowingly be at significant risk as a result of contact with the individual to whom the information pertains; (c) upon application of a state, county or local health officer, a clear and imminent danger to the public health; or (d) that the applicant is lawfully entitled to the disclosure and the disclosure is consistent with law.]

13. An employee or agent of the Division of Probation and Correctional Alternatives, Division of Parole, Commission of Correction, or any local probation department, to the extend the employee or agent is authorized

to access records containing such information in order to carry the division's powers and duties with respect to the protected person.

14. A medical director of a local correctional facility to the extent the medical director is authorized to access records to carry out his/her functions relating to the protected person;

15. An employee or agent of the New York City Board of Corrections so that the board may continue to access of inmates who die while in the custody of the New York City Department of Corrections.

16. A law guardian appointed by a court for the purpose of representing the minor.

[DISCUSSION – Although physicians should be familiar with all the exceptions, the exceptions that arise most often in the delivery of medical care and services include paragraphs 1, 2, 3, 4, 5, 9, and 10].

Subpoenas

Note that no exception is made to authorize the release of confidential HIV-related information upon the subpoena of the information. A New York State Court recently help that a physician violated the confidentiality requirements of the statute when the physician released HIV-related information pursuant to a subpoena. The court held that the physician's defense, that the disclosure was justified because of the subpoena, was an inadequate defense because the statute makes no exception for disclosure of confidential HIV-related information upon subpoena. A physician should contact an attorney if served with a subpoena to disclose medical information, and the medical information includes confidential HIV-related information.

Prohibition Against Re-disclosure

Subject to the exceptions listed below, when confidential HIV-Related Information is disclosed, a written statement prohibiting re-disclosure should accompany the disclosure. The statement should include the following language or substantially similar language:

"This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State

law may result in a fine or jail sentence or both. A general authorization for the release of medical or other medical information is not good except in limited circumstances set forth in this Part. Disclosure of confidential HIV information that occurs as the result of a general authorization for the release of other information will be in violation of the State law and may result in a fine or a jail sentence or both."

If and oral disclosure is necessary, the written non-redisclosure statement must be sent as soon as possible but not later than 10 days.

The non-redisclosure statement is not required in the following circumstances:

- Release of confidential HIV-related information to the protected person, or when the protected person lacks the capacity to consent, to a person authorized by law to consent to health care for the person;
- Releases made by a physician or public health official to a contact [see Contact Notification below]
- Release made by a physician to a person authorized by law to consent to the health care of the protected person when the disclosure is medically necessary and, after counseling as to the need for disclosure, the physician believes the protected person will not inform the person authorized by law to consent to health care.

Notation in Medical Record of Disclosures

A notation should be made in the medical record of the protected individual of disclosures of confidential HIV-related information made upon request. Except, the following disclosures do not require notation in the medical record:

- disclosures made under (3), to an agent or employee of a health facility or health care providers if (i) the agent or employee is authorized to access medical records; (ii) the health care facility or health care provider itself is authorized to obtain the HIV-related information and (iii) the agent or employee provides health care to the

protected individual or maintains or processes medical records for billing or reimbursement;
- disclosures made to persons reviewing information or records in the ordinary course of ensuring that the health facility is in compliance with applicable quality of care standards or any authorized program evaluation, program monitoring or service review, or to

governmental agents requiring information necessary for payments to be made on behalf of patients.

For disclosures to insurance institutions, a notation need only be entered in the medical record at the time disclosure is first made.

Any HIV related information obtained pursuant to section 390.15 of the criminal procedure law or section 374.1 of the family court act by either a court order or consent of protected individual shall not be recorded in the medical record unless the protected individual consents.

Contact Notification

A "contact" is defined by the statute and regulations as an "identified spouse or sex partner of the protected individual or a person identified as having shared hypodermic needles or syringes with the protected individual. Pursuant to the statute and regulations a physician may disclose HIV-related information, without the consent of the protected person, to a contact or public health officer for the purpose of notifying the contact when:

(i) the physician reasonably believes disclosure is medically appropriate and a significant risk of infection exists to the contact; and
(ii) the protected person has been counseled to notify his/her contacts and the physician reasonably believes the protected person will not inform the contacts.

The physician must inform the protected person of the physician's intent to disclose, and inform the protected person that he/she may choose whether the physician or health officer will notify the contact. Thy physician must honor the protected person's choice. Notification must be in person, except when circumstances compel.

When disclosure is made to the protected person's contact, the identity of the protected person may not be disclosed to the contact.

The person notifying the contact (whether the physician or public health officer) must provide counseling or make referrals for counseling. Counseling must address matters including coping emotionally with potential exposure to HIV, an explanation regarding the nature of HIV infection and HIV-related illness, availability of anonymous and confidential testing, information on preventing exposure or transmission of HIV infection, information regarding discrimination problems that might occur as the result of HIV-related information, and legal protection against such disclosure.

If the protected person is deceased and the physician reasonably believes the protected person did not inform his/her contacts and reasonably believes that disclosure is medically appropriate and that a significant risk of infection exists, the physician may notify the contact or request the public health officer to notify the contact. Notification must be in person, except where circumstances reasonably prevent doing so, and the identity of the deceased may not be disclosed. The person notifying the contact must provide counseling.

[DISCUSSION – The law does not compel a physician to notify the protected person's contacts but authorizes the physician to notify contacts or a public health officer for the purpose of notifying contacts. A physician is under no legal obligation to identify or locate contacts. Any decision or action by a physician relating to contact notification must be recorded in the protected person's medical record.]

Penalties and Immunities

According to §2783 of the Public Health Law, a person who makes a wrongful disclosure of HIV-related information may be subject to a civil penalty up to $5,000 for each occurrence. A willful violation of law is a crime and is punishable as a misdemeanor.

A number of New York Courts have held that the penalties provided by statute are not the sole remedies to an injured party but that the breach of confidentiality may give rise to a civil action for damages.

The statute provides that there shall be no criminal sanction or civil liability or no cause of action for damages on the account of:

a) the failure to disclose HIV-related information to a contact or a person authorized by law to consent to health care for the protected individual;
b) Disclosure of confidential HIV-related information to a contact or person authorized pursuant to law to consent to health care for a protected individual, when carried out in good faith and without malice, and in compliance with the law;

[DISCUSSION – As previously discussed in "contact notification" a physician is under no legal obligation to disclose HIV-related information to a contact of the HIV infected patient. Accordingly, the law makes it clear that there is no criminal or civil liability and no cause of action for damages for the failure of a physician to disclose confidential HIV information to a contact. However a physician "may" notify a contact or a public health official for purposes of contact notification if the procedures required by law are followed. A physician has immunity for disclosing confidential HIV-related information to a contact only if such disclosure is in good faith and if all the procedures required by law are strictly followed.]

c) The disclosure of confidential HIV-related information to any person, agency or office authorized to receive such information, when carried out in good faith and without malice, is in compliance with the statute.

[DISCUSSION – Physicians should be cautious in making any disclosure of confidential HIV-related information because immunity is available only if the statute is followed.]

Prenatal Care

The following are some Prenatal Care HIV regulations which can be found under Title 10 of The Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) :

- Section 405.21 (c) (4) provides a hospital shall ensure the transfer to the newborn's medical record of the mother's HIV test result.
- Section 405.21 (c) (8) provides that all hospitals that provide prenatal care arrange for effective prenatal activities including community outreach programs either directly or in collaboration with community-based providers and practitioners who provide prenatal care and services to women in the hospital.
- Section 405.21 (c) (8) (h) provides that a prenatal care program shall include providing HIV counseling and recommending voluntary testing to pregnant women. Counseling and/or testing, if accepted, shall be provided pursuant to Public Health Law, article 27-F. Information regarding the woman's HIV counseling and HIV status must be transferred as part of her medical history to the labor and delivery site. Women with positive test results shall be referred to the necessary health and social services within a clinically appropriate time.

The regulations above can also be found included in Section 754.7 which pertains to birth center services.

All Prenatal Facilities:

- If prenatal services are provided on site, that center must provide the pregnant woman with HIV counseling and inform the pregnant woman that voluntary HIV testing is recommended. 10 NYCRR 751.5 (a) (16);
- All counseling and testing, if accepted, shall be done in accordance with all regulations previously discussed under Public Health Law Article 27-F;
- The HIV related information of the pregnant woman must be transferred as part of her medical history to the facility which will deliver the baby. 10 NYCRR 751.5 (a) (16);
- Women with positive HIV test results shall be referred to the necessary health and social services within a clinically appropriate time.

Newborn HIV Screening

Section 2500-f of the Public Health Law provides:

1. In order to improve health outcomes of newborns, and to improve access to care and treatment for newborns infected with or exposed to human immunodeficiency virus (HIV) and their mothers, the commissioner shall establish a comprehensive program for testing of newborns for the presence of human immunodeficiency virus and/or the presence of antibodies to such virus.
2. The commissioner shall promulgate regulations governing the implementation of the program required pursuant to subdivision one of this section, including the administration of testing, counseling, tracking, disclosure of test results pursuant to section twenty-seven hundred eighty-two of this chapter, follow-up reviews, and educational activities relating to such testing.

Regulations pertaining to the comprehensive newborn HIV screening program were set forth in the January 29, 1997 New York Register, and became effective February 1, 1997.

Section 69-1.3 of Title 10 NYCRR provides that the chief executive officer shall ensure that a satisfactory specimen is submitted to the testing laboratory for each newborn born in the hospital within the first 28 days of life with no specimen having been previously collected, and that the following procedures are carried out. Section 69-1.3(1) provides that "in addition too all applicable preceding requirements for HIV testing the following specific procedures shall be carried out":

1. obtain a history of HIV testing and treatment from the mother to enable counseling consistent with such history and knowledge of her own HIV status, and document such history in the medical record;
2. the newborn HIV test result shall be maintained securely and confidentially in the medical record of the newborn in accordance with Public Health Law, article 27-F;
3. the chief executive officer or his designee shall transmit to the responsible physician a copy of the newborn's HIV test result, and, at the request of the responsible physician, shall transmit the result to an HIV specialized care center;
4. make referrals as necessary for follow-up of HIV positive newborns who cannot be located;

5. ensure that data required by the department for program evaluation and, in the case of HIV positive newborns, for patient follow-up, is collected and provided to authorized staff at the department; and
6. submit to the department information on the prior HIV testing and treatment history of the mother for the purposes of medical audits; such information shall be kept confidential as required by Public Health Law, section 206 (1) (j).

Similar provisions apply to birth attendants as set forth in Section 69-1.4 of the regulations.

Section 69-1.5 provides that among the duties of the responsible physician includes the following:

g. in the case of newborns who test positive for HIV antibodies, in addition to applicable preceding requirements:

1. provide or arrange for post-test counseling for the mother or, if the mother lacks capacity to consent to health care for the newborn, for the person authorized by law to give such consent;
2. provide or arrange for health care, case management and other social services as needed for the newborn;
3. maintain the newborn HIV test result securely and confidentially in the medical record of the newborn in accordance with Public Health Law, article 27-F;
4. provide the mother with referrals for health and social services as needed and transfer a copy of the newborn's HIV test result to the mother's physician as permitted by Public Health Law, article 27-F;
5. submit specimens, as specified by the testing laboratory, to the testing laboratory to determine the HIV infection status of the infant; or submit documentation of such test results from a permitted laboratory; or

6. refer the mother and newborn to an HIV specialized care center for provision of the services required by paragraphs (1) through (5) of this subdivision.

Similar provisions apply to specialized care centers as set forth in Section 69-1.7 of the regulations.

Medical Society of the State of New York

Mammography

MEDICAL SOCIETY OF THE STATE OF NEW YORK
420 Lakeville Road, PO Box 5404, Lake Success, NY 11042 (516) 488-6100
Fax (516) 488-8389

OFFICE OF GENERAL COUNSEL

MAMMOGRAHY

Federal Law – The Mammography Quality Standards Act (MQSA) was enacted on October 27, 1992 to establish national quality standards for mammography. The MSQA requires that, to provide mammography services legally after October 1, 1994, all facilities, except facilities of the Department of Veteran Affairs, must be accredited by an approved accreditation body and certified by the Secretary of Health and Human Services (HHS). The authority to approve accreditation bodies and to certify facilities was delegated by HHS to the Food and Drug Administration (FDA).

Operating under interim regulations, the FDA approved the American College of Radiology (ACR) as an accrediting body. It is not the purpose of this summary to discuss in detail the requirements of the MQSA. Physicians who are seeking information regarding MQSA accreditation standards should contact the ACR.

The purpose of this summary is to familiarize physicians with the record keeping requirements under the MQSA. FDA's final regulation implementing the MQSA requires each mammography facility to maintain films and reports at least 5 years or until the patient requests them or requests their transfer. If no additional mammograms of the patient are performed at the facility the film and records must be retained for not less than ten years. This means that if the facility as taken a series of mammograms for a patient the older mammograms must be retained fro 5 years. The latest mammograms must be retained for at least ten years. If there is only one mammogram for a patient, it must be kept at least ten years.

If the State law requires a longer retention period, the State law must be followed. Generally New York law requires that medical records be retained for at least six years (in the case of a minor patient the records must be kept for at least six years or until the minor reaches 19 years of age, whichever is longer). This means a mammogram must be kept at least 6 years (the New York law requirement) or ten years if it is the last mammogram taken at the facility (the MQSA requirement).

[It should be kept in mind that contract requirements, including HMO contracts, may require medical records to be retained for a longer period of time.]

Under interim regulations of the MQSA, the physician is required to transfer the original film in accordance with the patient's request if the patient requests the permanent transfer of the film to another facility, practice or herself. Under the final regulation, effective April 28, 1999, a patient may request the transfer of the original film whether on a temporary or permanent basis.

The MQSA regulations provide that if the patient requests a transfer of eh original film, the facility is under no obligation to make copies of the film they are required to transfer [but as discussed below, it is recommended that, if at all feasible, a copy of eh original be retained].

STATE LAW – Amendments to Public Health Law section 17 and 18.

On August 5, 1998, Chapter 576 was signed into law which amends Public Health Law sections 17 and 18 to require physicians to provide the original mammogram rather than a copy thereof when requested. The amendments will take effect on April 28, 1999. Under the Federal Law, the "Mammography Quality Standards Act" physicians are required to transfer the original mammogram when the patient permanently transfers her care. Effective April 28, 1999, federal regulations will be expanded to require the transfer of the original mammogram whenever requested by the patient, regardless whether the transfer is permanent or temporary. The amendments to Public Health Law sections 17 and 18 are intended to coincide with the Federal requirements.

Amendments to Public Health Law Section 18

Public Health Law section 18 generally requires physicians, other health care practitioners and hospitals to provide a copy of patient information directly to the "qualified person" upon written request. A "qualified person" includes the patient, a guardian legally appointed on behalf of an incompetent patient, parent of a minor patient, a guardian legally appointed on behalf of a minor patient of an attorney representing or acting on the behalf of the patient or the patient's estate. In the case of a mammogram, the amendment requires that the original mammogram be provided when requested. Under the existing law a physician or healthcare provider may limit access to the patient records. Such limitations on access will continue to apply to original mammograms as well as to copies of other patient records. Public Health Law section 18 permits a physician or health care provider to charge up to 75 cents a page for "paper copies" (records that are photocopied). In case of records that cannot be photocopied, such as an X-ray, a "reasonable fee" may be imposed which may not exceed the costs incurred to copy the records. . In the case of mammograms, the amendment provides that a physician or health care provider may not impose a charge for copying an original mammogram when the original has been furnished to a qualifying person. The amendment also provides that any charge for "furnishing" an original

may not exceed the cost associated therewith. Evidently, the term "furnishing" refers to the delivery costs, and permits the physician to impose a charge in order to be reimbursed for documented delivery costs such as mailing costs.

Amendments to Public Health Law 17

Public Health Law section 17 generally requires a physician or hospital to transfer a copy of the medical records to any other designated physician or hospital when requested in writing by any competent patient, parent or guardian of a minor patient, or guardian legally appointed on behalf of an incompetent patient. In the case of a mammogram, the amendment requires that the original mammogram be provided when requested. Similar to section 18, it appears that the New York Legislature intended that a physician or health care provider would not be permitted to impose a charge for copying an original mammogram when the original mammogram is released pursuant to a request under section17. However, the language of the amendment curiously reads (the underlined portion indicates language added by the amendment):

> "Either the physician or hospital incurring the expense of providing copies of x-rays, medical records and test records including all laboratory tests pursuant to the provisions of this section may impose a reasonable charge to be paid by the person requesting eh release and deliverance of such records as reimbursement for such expenses, provided, however that the physician or hospital may not impose a charge for copying and original mammogram when the original has been released or delivered to any competent patient, parent or guardian of an infant, a guardian appointed pursuant to article eighty-one of the mental hygiene law, or a conservator of a consevatee and provided, further, that any charge for delivering an original mammogram pursuant to this section shall not exceed the documented costs associated therewith. However, the reasonable charge for paper copies shall not exceed [75 cents per page]. A release of records under this section shall not be defined solely because of inability to pay."

The language of the amendment is curious because section 17 applies to the transfer of medical records to any other designated physician or hospital. Section 18, not section 17, applies to the release of records to the patient, parent guardian of an infant, etc. Evidently the language is the result of a drafting error. Perhaps, the amendment should have been worded as follows. "… provided, however, that the physician or hospital may not impose a charge for copying an original mammogram when the original has been released or delivered to any other designated physician or hospital…".

The omission although apparently inadvertent) of language prohibiting the imposition of a reasonable charge for copying an original mammogram when the original has been released or delivered to another designated physician or hospital may lead to the inference that no such prohibition exists in such situation (except for the general requirement that a release may not be denied because of

inability to pay). It may be argued that the statute must be interpreted to carry out the clear intent of the Legislature which was to prohibit the imposition of a reasonable charge in connection with the copying of mammograms. On the other hand, it may be argued that the statutory language is clear and unambiguous and must be literally interpreted. It is a general rule of construction that omissions in a statute, where the statute is clear an explicit in its language, cannot be supplied by construction, and can only be remedied by the Legislature, McKinney's Statute section 74, section 363. Courts have recognized exceptions to the rule, however, and in some cases have held that where the legislative intent is clear and the omission was caused by inadvertence, a court may correct the inadvertence to carry out legislative intent.[1]

The Medical Society has requested an opinion from the New York State Department of Health regarding the manner that it interprets the statute. While the interpretation of Public Health Law section 17 remains unclear, perhaps, as a practical matter, it makes little difference whether section 17 is interpreted as prohibiting a physician to impose a reasonable charge for copying a mammogram. If a patient requests release of the original mammogram to another designated physician pursuant to Public Health Law section 17 and the physician who is requested to release the original seeks to charge the patient a reasonable charge for the copy, the patient would likely request that the original mammogram be released to her directly as required by Public Health Law section18. Public Health Law section 18 expressly states that the physician may not impose a charge for copying an original mammogram when the original has been furnished to any "qualified person".

The amendment permits a charge for "delivering" the original mammogram, provided that the charge not exceed the documented costs involved with the delivery.

Neither section 17 or 18 prohibits the physician from imposing a reasonable charge when the patient requests the release of a copy of a mammogram rather than the original mammogram. However, it is likely that in most instances, the patient will request a transfer of the original mammogram, as contemplated by the statutes.

Recognizing that physicians could not charge for copying a mammogram when the original has been transferred or released, the Legislature amended the section 6532(32) of the Education Law to provide that a physician is under no obligation to maintain the original or a copy in such circumstances. As amended section 6530(32) provides that professional misconduct by a physician includes (the underlines indicate language added by the amendment):

> "Failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, provided, however, that a physician who transfers an original mammogram to a medical institution, or to a physician or health care provider of the patient or to the patient directly, as otherwise provided by law, shall have no obligation

under this section to maintain the original or a copy thereof. Unless otherwise provided by law, all patient records must be retained for at least six years, and until one year after the minor patient reaches the age of eighteen years."

Despite the provision, it is recommended that a copy of the mammogram be retained for at least the above stated time period, when the original is transferred. The medical records including a copy of the mammogram may be vital in the defense of a medical malpractice case. Where the original mammogram has been released pursuant to a written request under Public Health Law section 17 or 18, the written request should be maintained in the patient record. If the physician fails to maintain a copy of the mammogram, it may be difficult, if not impossible, to locate the copy in the event a medical malpractice claim is brought. The Medical Liability Mutual Insurance Company concurs with this recommendation. Another reason that a copy of the mammogram should be retained is that contracts of HMO's and health care plans typically require a physician to maintain copies of medical records (frequently for a longer period of time required by section 6530(32) of the Education Law). It is not clear whether the HMO of health care plan would excuse the physician for failing to maintain a copy of the mammogram.

Summaries of Public Health Law section 17 and 18 are available by calling the Office of General Counsel at MSSNY, (516) 488-6100 ext.352 or 322.

1/21/99
Mammog

[1] e.g. Standard Accident Ins. Co. v Newman 47 N.Y.S. 2d 804 (1944), affirmed 51 N.Y.S. 2d 767.

Medical Society of the State of New York

AIDS Legislation - 1999

MEDICAL SOCIETY OF THE STATE OF NEW YORK
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OFFICE OF GENERAL COUNSEL

SUMMARY OF NEW AIDS LEGISLATION

Legislation, which amends Article 21 of the Public Health Law to requite reporting HIV infection and partner notification was signed into law by Governor Pataki, and will be effective as of January 3, 1999.

A new Section 2130 requires physicians or other persons authorized by law to order diagnostic tests or make a medical diagnosis, or any laboratory performing such tests to report cases of HIV, AIDS or HIV related illnesses to the Commissioner of Heath. Such reports shall include information identifying the protected individual as well as names of any contacts known to the physician or provided to the physician by the infected person. Section 2780 (10) has been amended to define "contact" as:

> "An identified spouse or sex partner of the protected individual, person identified as having shared hypodermic needles or syringes with the protected individual, or a person who the protected individual may have exposed to HIV under circumstances that present a risk of transmission of HIV, as determined by the commissioner." (emphasis added)

The importance of the expansion of the term "contact" should be noted, since the term is no longer limited to a sex partner, spouse, or one sharing needles with the protected individual. The term "contact" has been expanded to include anyone who may be exposed to HIV under circumstances that present a risk of transmission.

The commissioner is required to forward a report of AIDS and HIV infection to the health commissioner (or to the district health officer if there is no commissioner) of the municipality where the infection occurred.

Section 2131 provided that if the contact resides in a county or district from where the protected individual is found, the contact report shall be referred to the health officer of the county or district where the contact resides. The officer must

then make a good faith effort to notify the contact and comply with 2133 which pertains to contact tracings.

Section 2132 provides that if a coroner, pathologist, medical examiner, or other person qualified to conduct an examination of a deceased person discovers that at the time of death the individual was afflicted with AIDS, HIV or HIV related illness, a report must be made according to this title as if the diagnosis had been made prior to his death.

Section 2133 provides for contact tracing. If the municipal health commissioner or the department's district health officer determines that a case merits contact tracing, they must notify the known contacts. In notifying any identified contact, the physicians or public health officer must not disclose the identity of the protected individual or any other contacts. Such notifications should be made in person except where circumstances reasonably prevent doing so. In cases of domestic violence, a protocol for the identification and screenings for victims of domestic violence who may be either a protected individual or a contact must be developed and utilized for the purposes of contact notification.

The contract shall be informed of the following:

- the nature of HIV;
- the known routes of transmission, if applicable;
- risks of prenatal and perinatal transmission, if applicable;
- actions that can be taken by the contact to limit further transmission of the virus;
- other facilities which provide counseling and treatment.

Section 2134 provides that all medical information which is disclosed pursuant to this article including diagnosis of HIV infection may be made only to:

a) the protected individual; or
b) the municipal health commissioner or district health officer (if such commissioner or officer is not the examining physician); or
c) without specifically revealing the identity of the protected individual contacts as defined in this article.

All information obtained pursuant to this article shall be confidential except in so far as is necessary to carry out the provisions of this article.

Section 2136 provides that any good faith reporting or disclosure made pursuant to this title will not constitute libel or slander or a violation of the right of privacy or privileged communication. Therefore, any person who in good faith complies with this title will be immune from civil or criminal liability for any action taken in compliance with its provisions. Additionally, no criminal or civil liability will arise as against any protected individual solely for his/her failure to cooperate in contact tracing pursuant to this new law.

No provisions contained in this new law shall be interpreted to eliminate the anonymous testing option, which was provided for in Section 2781 of this chapter.

SECTION 2

Medical Liability Mutual Insurance Company

Medical Liability Mutual Insurance Company

Correspondence

MEMORANDUM

Fager & Amsler, LLP, Attorneys at Law
2 Clinton Square
Syracuse, NY 13202
(315) 428-1380

Discontinuing Your Practice

Enclosed please find information and a sample letter for physicians who are discontinuing their practice. The letter is a model that you may adapt to your own particular situation. Please retype it on your own letterhead. The letter should be sent return receipt requested to all of your active patients (usually those who have been seen within the past year). Copies of both the letter and the return receipt should be kept in the patient's medical record. When drafting the letter, please remember that the choice of a termination date depends upon a number of factors, including the nature of the patient's condition, the availability of alternate medical care providers, and your own personal circumstances.

Please feel free to contact an attorney at Fager & Amsler in Syracuse (315-428-1380 or 877-426-9555), Latham (518-786-2880) or Long Island (516-794-7340).

SELLING OR CLOSING YOUR PRACTICE

If you are thinking about discontinuing your practice - whether due to moving out of the area, retirement or disability - you should be aware of some basic procedural principles and legal concerns. By following these guidelines, you should be able to properly discontinue your professional relationship with your patients while assisting them to obtain continuity of care.

1. Notify your patients: To avoid a claim of abandonment by a former patient or the State Office of Professional Medical Conduct, you should notify your **active** patients of your intention to withdraw from practice. **Active** patients are, in most cases, those patients who have been treated within the last year. Of course, special circumstances may warrant notification of other patients.

   As a general rule, patients should receive written notification at least 60 days prior to your practice termination date.[1] A copy of this notice should be retained in the patient's medical record. We strongly recommend the notice be sent certified mail, return receipt requested. The return receipt should also be retained in the patient's file.

   Although you are under no legal obligation to directly refer your active patients to the care of another physician, you may offer to assist the patient in the transition. A termination of treatment notice should include the following:

   a) advise the patient of the importance of continued care;
   b) refer the patient to the appropriate county medical society or local hospital (name and telephone number), to obtain a list of local practitioners; or
   c) advise the patient that you will be available to continue to provide medical services until the termination date;
   d) provide a method which would enable your former patients to contact you or a custodian of the records, in order to have their records released to a subsequent treating physician, i.e. address, phone number, or form letter;
   e) if you are selling your practice, you should inform the patient that the physician who is purchasing your practice will retain and be the custodian of the records unless or until the patient provides written authorization to send a copy of the records to another physician.

2. Retaining your medical records: The importance of a complete, well-documented and unaltered medical record in the defense of an action cannot be overstated. It is extremely important that you retain the original medical records of all of your patients, not just the 'active' ones, for the statutorily required periods of time, as required by the Education Law. Please see the attached memorandum regarding Retention and Release of Medical Records.

3. Notify MLMIC: MLMIC's Underwriting Department has recommended the following:

   a) Send MLMIC's Underwriting Department written notification of your intention to discontinue your practice as soon as possible. Tell the underwriter the date you wish to have your policy canceled and the reason.

   b) If you have a "claims made" policy, it is strongly recommended that you obtain a Reporting Endorsement or "Tail" to protect yourself for claims that are reported to MLMIC after you cancel your policy. Upon your death, a free "tail" will be issued to your estate once MLMIC receives notification from the executor/administrator of your estate.

[1] The choice of a termination date that is reasonable for both patient and physician depends on a number of factors, including the nature of the patients' conditions and the availability of other qualified physicians.

4. That Extra Mile: If your office remains open after you have terminated your practice, you can keep your MLMIC policy in force for an additional 2 or 3 months. This is important due to the risks you incur if a staff member renews a prescription or inadvertently gives advice to patients on the telephone. If you choose to continue insurance your insurance coverage, indemnification should be available for you in the event of a lawsuit as long as the allegations are generally covered and not excluded under your MLMIC policy.

5. If you are selling or dissolving your practice and transferring your records to the custody of another physician, you should obtain legal counsel to prepare a written agreement with that physician. You should consult with your attorney regarding current legal requirements, including whether the replacement physician must have a "business associate" agreement under the Health Insurance Portability and Accountability Act ("HIPAA"). The written agreement should address the following issues:

   a) Your replacement must either provide patients with a copy of their records upon proof of appropriate patient authorization, or must notify you to obtain approval of each patient request, depending upon your desire/intent.

   b) Your replacement must maintain your records for the time periods required by State and Federal law, AND must maintain patient confidentiality by not looking at the records unless or until the patient chooses to seek treatment with him/her. This physician is not entitled to do anything with the records beyond storing them for the appropriate time periods.

   c) Your replacement must maintain your records in a safe and secure environment, preferably in a waterproof and fireproof area.

   d) In the event of any civil proceeding or governmental agency investigation or proceeding, you must be given access to and/or a copy of or, if necessary, the original records in order to either comply with such requests or defend yourself.

The information presented above should not be considered as definitive legal advice and does not summarize everything that must be attended to when discontinuing your practice. Obviously, the facts of each situation may differ or other questions may arise. If you intend to sell your practice rather than simply closing your office, there are other technical and legal issues to consider beyond those discussed in this memorandum.

If the discontinuance of practice is predicated upon a physician's death, the surviving spouse or the executor/administrator of the estate should be aware of the legal issues involved in order to best manage the assets of the estate.

Please feel free to contact the attorneys at the Fager & Amsler nearest you, in Syracuse (315-428-1380 or 877-426-9555), Latham (518-786-2880) or Long Island (516-794-7340). However, we recommend that you consult your own personal attorney for advice beyond that which Fager & Amsler is able to afford you.

Medical Liability Mutual Insurance Company

Letter to Patient

Letter for Physicians Discontinuing Practice

Dear _____:

Please be advised that because of ___(my retirement, reasons of health, etc.), I am discontinuing the practice of medicine on _____. I will no longer be able to provide your medical care after that date.

Since you will require continued care, I suggest that you arrange to place yourself under the care of another physician. If you are not acquainted with another physician, I suggest that you contact the _____ Medical Society (telephone number _____). Please do not use my name as your physician for such things as laboratory tests or x-rays. I will not be equipped to handle any reports that might be sent to me.

I shall make my records of your case available to the physician you designate. Since these records are confidential, I shall require a HIPAA compliant written authorization to make them available to another physician.

I am sorry that I cannot continue as your physician. I extend to you my best wishes for your future health and happiness.

Yours very truly,

_____, M.D.

Medical Liability Mutual Insurance Company
Fager & Amsler, LLP, Attorneys at Law

Medical Access to Records/Fees

Fees for Copying Medical Records: HIPAA permits you to impose reasonable, cost-based fees. Under HIPAA, those fees are limited to only the cost of copying (including supplies and labor) and postage, if the patient requests that the copy be mailed. The fee may not include costs associated with searching for and retrieving the requested information. The fee can include the actual costs of postage or mailing. See, 45 CFR §164.524. You should maintain documentation to substantiate that your copying fee is reasonably related to your copying costs. New York law further limits the maximum amount you may charge for copying **up to** 75 cents per page plus actual fees for mailing or postage.

Fees may be charged for releasing records to a treating hospital or physician, to a patient, to an insurance company, and to the patient's attorney or qualified representative. If the patient has agreed to receive a summary or explanation of his or her protected health information, the covered entity may also charge a fee for preparation of the summary or explanation. You may not deny a patient's request solely due to inability to pay either your bill for services or for the requested copy of the records.

The charge for x-rays, photographs and videotapes must be the actual cost of duplication. According to both State and Federal regulations, the charge for the release of original mammography films must be limited to the actual, documented cost of mailing the original films. The patient may only be charged the actual costs associated with releasing the original mammography films, not the cost of copying them for your retention.

Release of Medical Records to Attorneys or Courts

An attorney's request letter must be accompanied by a properly signed, witnessed and recently dated HIPAA compliant authorization which contains an expiration date or event.[2] If for any reason you question the validity of the signature on the authorization, you may contact the person submitting it for further information, or you may request that the signature be notarized. The authorization must be signed by the patient or the patient's legal representative. Legal representatives include the following:

1. parent or legal guardian of a minor, except as indicated below;
2. the conservator or committee of an incompetent;
3. a guardian appointed under Article 81 of the Mental Hygiene Law;
4. a health care proxy agent;
5. the administrator or executor of a deceased person, who should produce a copy of a court-issued document known as Letters of Administration or Letters Testamentary appointing him/her to represent the estate;
6. an attorney who represents the patient or the estate of the deceased patient.

Release of Records Involving Minor Patients:

Generally speaking, the signature of a parent or legal guardian is required to release medical records of minor patients. In certain situations, however, minor patients are authorized by law to give effective consent and in such cases authorization to release information, even to a

[2] HIPAA mandates that authorizations comply with all the requirements set forth in 45 CFR §164.508(c).

parent, must be sought directly from the minor patient. Authorization from the minor patient must be obtained to release the following information:

1. Sex-related treatment, such as contraception, abortion, pregnancy or sexually transmitted diseases or information regarding HIV testing;
2. Drug and alcohol treatment. A parent may not access the records unless the parent gave consent for the treatment in accordance with State law. The signatures of both the minor and the parent are required in those instances. 42 C.F.R. Part 2.14(b)-(d).
3. Psychiatric outpatient treatment. Pursuant to Mental Hygiene Law §§33.16 and 33.21, a minor who meets certain criteria may receive psychiatric outpatient treatment without parental consent. A parent's authorization to obtain records in these circumstances may not be valid without the minor's consent or a court order.
4. In addition, where the parent, guardian or person acting in place of a parent agrees to permit confidentiality between the minor and provider with respect to the health care service, the parent should not be given access to the minor's medical record..

Attached is a memorandum which more fully discusses the issues of consent to medical treatment and release of medical information involving minor patients.

What information should be released in response to a written request?

Under HIPAA, individuals may access protected health information about themselves that is contained in a "designated record set." If handwritten progress notes are used to make decisions about a patient's health care, then they are considered to be part of the record and must be released.

HIPAA permits you to deny a patient access to certain limited types of information and in certain limited circumstances. Access can be denied where:

1. Access requested is reasonably likely to endanger the life or physical safety of the individual or another person;
2. The authorization form or subpoena does not comply with HIPAA's requirements;
3. The information requested was compiled in anticipation of civil, criminal, or administrative actions or proceedings;
4. The party requesting the information is not the legal representative of a deceased patient;
5. The information requested is beyond the minimum necessary for the purpose expressed in a patient's HIPAA authorization;
6. When the protected health information makes reference to another person (unless such other person is a health care provider) and the access requested is reasonably likely to cause substantial harm to such other person;
7. When the request for access is made by the individual's personal representative and the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person;

8. When the protected health information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information;

9. Where the information sought consists of psychotherapy notes as defined in 45 CFR §164.508. These are defined as notes recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a private, group, joint or family counseling session and are kept separate from the rest of the individual's medical record. There is no absolute right of access to psychotherapy notes and therefore access may be denied.

What can be provided? A list of medications and prescriptions, monitoring, the times and dates of counseling sessions, treatment modalities, frequency of treatment furnished, results of clinical tests and any summary of: diagnosis, functioning, treatment plan, symptoms, prognosis and progress to date all constitute appropriate information to be released.

In all cases, a licensed health care professional must make the determination in the exercise of professional judgment. If you do deny access, you must, to the extent possible, give the individual access to any other protected health information requested which you have not denied. See, 45 CFR §164.524. Further, the patient under both state and federal law have a right to appeal the denial through procedures established under HIPAA and Public Health Law §18.

Responding to Subpoenas for Medical Records

A subpoena is a judicial command issued in connection with a court case or an administrative proceeding. Subpoenas may be issued to provide records for trial or deposition, in proceedings before the Grand Jury or in connection with various agency investigations. An attorney representing a party in an action is empowered to issue a subpoena without a court order. CPLR §2302(a). Subpoenas must be responded to promptly. **Note** that unlike other requests, you should provide copies of all records in your possession which are responsive to the subpoena (including your personal notes and records of other providers). You cannot charge copying fees for providing records in response to a subpoena. Most subpoenas will be accompanied by a check for statutory witness fees and mileage in a nominal amount.

Subpoenas must carefully be reviewed to ascertain whether it is proper to release the patient's medical record. Subpoenas are common where the patient has brought a lawsuit for personal injuries. The law provides that by bringing the claim for personal injuries, the patient has waived his or her right to confidentiality of medical information. If the underlying legal action does not involve a civil claim for personal injuries (for example, a divorce action or a criminal action), then you should contact legal counsel before releasing any records.

CAUTION: HIPAA requires that before releasing protected health information in response to a subpoena, you must receive satisfactory written assurances that a reasonable effort has been made to place the patient on notice of the subpoena, or that reasonable efforts have been made to secure a qualified protective order. See, 45 CFR §164.512(e).

You may never release HIV related information and records of alcohol and drug treatment programs in response to a subpoena. The law states that such information can ONLY be released pursuant to a specifically tailored patient authorization or a court order. A "so ordered" subpoena is not a "court order" for these purposes. If you receive a

subpoena requesting a record containing either HIV or drug/alcohol information, you should immediately contact legal counsel.

Subpoenas for Mental Hygiene Records: The Mental Hygiene Law states that such records may only be disclosed by a specific authorization or a court order. If you receive a subpoena for mental hygiene records, you should immediately contact legal counsel.

Out of State Subpoenas: Out of state subpoenas are not automatically valid in New York State. In order to release the record, a subpoena issued from an attorney or court outside New York State **must** either be accompanied by 1) a HIPAA compliant patient authorization, or 2) a New York State court order.

Subpoenas in Unusual Situations: If you receive a Grand Jury or Family Court subpoena, a subpoena from an administrative agency, a Federal court subpoena, or a subpoena in any other unusual situation, you should contact legal counsel. Fager & Amsler will advise you about how to proceed.

How to Comply with a Subpoena

Most subpoenas may be complied with by providing a certified copy of the medical record. The record should be sent to the presiding judge by some method which ensures a delivery receipt (e.g., certified mail, overnight courier). You should place the records in a sealed envelope with a copy of the subpoena affixed on top of that envelope and enclose it in a second envelope addressed to the judge or court.

Should you have any difficulty determining whether it is appropriate in any given circumstance to release a copy of your patient's medical record, feel free to contact the attorneys at Fager and Amsler in Syracuse (315-428-1380 or 877-426-9555), Latham (518-786-2880) or Long Island (516-794-7340).

MEMORANDUM

Fager & Amsler, LLP, Attorneys at Law
2 Clinton Square
Syracuse, NY 13202
(315) 428-1380

This legal memorandum is written in response to your questions concerning the release and retention of medical records.

2.4 What Comprises the Medical Record?

A medical record must include sufficient information to accurately reflect and justify the evaluation, treatment and prognosis of the patient [Education Law §6530 (32)]. The record should include the following:

1. identifying data
2. chief complaint
3. present illness
4. detailed past medical, social and family history, including allergies
5. physical examination and diagnosis
6. clinical laboratory reports, diagnostic test reports, original mammography films, radiology reports and films, and electronic fetal monitor strips or other prenatal testing
7. treatments, treatment plans, advice and recommendations
8. notes of all telephone conversations and recommendations made
9. videotapes of procedures performed and photographs of patients (these are considered to be part of the medical record for both retention and patient access purposes).
10. insurance examination reports, including independent medical examinations (IME)
11. referral letters from other physicians and referral letters which you have generated to other physicians.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires you to establish a "designated record set". The designated record set at a minimum must include those medical and billing records that are used, in whole or in part, to make decisions about individuals. See, 45 CFR §164.501. Certain items may not be part of your "designated record set" if you do not use them to make decisions about the individual (e.g., personal notes, comments and reminders on Post-its or other paper which are not intended to be part of the record).

The importance of a complete, well-documented and unaltered medical record cannot be overstated. Missing portions of a record present a serious problem in defending a lawsuit. This is particularly true of missing x-rays or fetal monitor strips. If an entire record is missing, it may be interpreted to mean that the record contained information detrimental to the defendant physician's case, and that the physician intentionally destroyed the record.

2.5 Record Retention

Patient records must be retained for **at least** the longest time period required by State and Federal law. Several considerations come into play, including:

1. whether the patient is an adult or a minor
2. the statute of limitations for a medical malpractice action
3. requirements imposed under the New York State Education Law, by the Department of Health, by Medicare and Medicaid
4. the Mammography Quality Standards Act
5. the statute of limitations applicable to federal health care fraud offenses
6. requirements for tracking medical devices pursuant to the Safe Medical Devices Act of 1990 (21 C.F.R. §821 et seq)

These considerations are discussed below.

Statute of Limitations:

The statute of limitations generally begins to run from the date upon which the malpractice (act, omission, or failure) is committed, subject to certain exceptions. See, CPLR §214-a. Note, however, that New York law requires the filing of a summons and complaint to commence a lawsuit. A defendant can be served up to eight months after the papers are filed. Therefore, even though the statute of limitations may seem to have expired, the plaintiff may be entitled to additional time to actually serve you with legal papers.

Minors: The statute of limitations expires upon the age of majority (18 years of age in New York) or death *plus* two and one half years, with a maximum time limit of ten years. CPLR §§ 208, 214-a.

Adults: The statute expires 2 ½ years from the act of malpractice.

Exceptions to the general rules outlined above are as follows:

Continuous Treatment: When a physician continues to treat a patient for the **same** condition which gave rise to the malpractice, the statute of limitations does not begin to run until either a) the termination of the professional relationship or b) the physician no longer treats the patient for that condition. Treatment does not include "examinations undertaken at the request of the patient for the sole purpose of ascertaining the state of the patient's condition." Some courts have held that the statute does not begin to run until the time of the patient's last appointment, even if the patient did not keep the appointment. The date of last treatment may include the last prescription given to a patient.

Foreign Body: When a malpractice action is based on a "foreign body" unintentionally left in the plaintiff's person, "the action may be commenced within one year of the date of such discovery or of the date of the discovery of facts which would reasonably lead to such discovery, whichever is earlier." A "foreign body" does not include a prosthetic aid or device or an IUD. It must be something introduced into the patient's body by the physician that was not meant to be retained in the patient's body.

Fraud: Concealment of the injury and/or cause thereof extends the statute to one year from the date of discovery of the fraud or the date when, by the facts known, the fraud could reasonably be discovered.

Time Periods for Retaining Records

There may be rare situations where the recommended record retention time can be reduced. In practice, however, it can be confusing to shorten the retention period. Most retention periods are calculated from the last date of treatment. Therefore, it is important to consider whether the last contact with the patient was an office visit, telephone conversation, or a prescription renewal. **We recommend retaining medical records for the longest applicable time period, as follows:**

Obstetrical Records and Records of Minor Patients:	**Until the minor reaches age 22 OR 10 years from the date of the last payment, whichever is longer.** **If the birth was viable, but the child did not survive, then retain records for 10 years from the last date of payment.**
Adult Patients (non-obstetrical)	**10 years from the date of last payment.**
Mammograms	**10 years from the date of last payment.**
Medical Devices[1]	**Useful life of the medical device, or until the device is no longer in use due to removal, return to the manufacturer or death of the patient.**

Hospitals and HMOs: Hospitals are required to retain medical records for at least six years from the date of discharge or three years after the patient reaches age 18, whichever is longer, or at least six years after death. *10 NYCRR §405.10.* Tissue slides and original tissue blocks must be maintained and preserved in the hospital, in accordance with State regulations, since they cannot be duplicated. Generally, they should not be altered or re-cut without first consulting legal counsel. HMOs are required to retain adult medical records for six years after the last date of treatment and in the case of a minor, six years after the age of majority (18 +6 = 24th birthday). *10 NYCRR §98.12.*

Any questions about retaining medical records, especially for less time than outlined above, may be addressed to an attorney at Fager & Amsler ***prior*** to the destruction of any record.

2.6 Computerized Records

Counsel to the New York State Department of Health, Office of Professional Medical Conduct, has set forth requirements regarding the use and maintenance of office records on electronic/magnetic media. These requirements are:

1. The patient record must accurately reflect the patient's evaluation and treatment;
2. Computer discs must be retained for the same statutory periods as paper records;
3. Patients must have access to and obtain a copy of their records upon request, in compliance with Public Health Law §18;

[1] Includes "trackable" medical devices. A "trackable" medical device is a device that is designated by Federal regulations as well as class II or class III and which meets one of three criteria: failure would likely cause serious adverse health consequences, or a device intended to remain in the human body for more than one year, or a device that is a life-sustaining or life supporting device and is used outside a facility. *21 C.F.R. §821.1 (a).*

4. It must be possible to transfer a copy of the record to another physician, hospital or other health care facility as requested, in compliance with Public Health Law §17;
5. Records must be in readable form and a copy made available for government agencies upon their request.
6. A system must be in place to ensure the integrity of the medical records so that they are not lost, destroyed or altered, and the patient's confidentiality is protected.
7. Employee access to the records must be limited to the minimum necessary to carry out the required task.

2.7 Electronic/Magnetic Preservation of Records

Medical records may be maintained on microfilm or other electronic/magnetic media as long as you comply with the legal requirements outlined above. An opinion obtained from the Office of Professional Medical Conduct (OPMC) states that original paper medical records, including those scanned into an electronic storage system using an optical scanner do not have to be retained after scanning.

There are risks associated with electronic/magnetic preservation of records. Microfilmed records, particularly x-ray films, can be difficult to read. During the transfer from paper to another medium, pages may be omitted entirely or in part. The company that does the transfer should have a system in place to spot check that all records have been copied before the originals are destroyed If a chart is difficult to read, or worse, pages are missing, a plaintiff's attorney might use this to imply that the doctor selectively discarded damaging evidence.[2] If pages and/or entire records are missing, or records are lost, promptly notify the company, document the loss and retain proof of this notification in your files. Remember to check with your business attorney to determine whether a business associate agreement is required with the transfer company in order to comply with HIPAA requirements.

2.8 Requests for Medical Records

Release of personal medical information is governed by both HIPAA and the New York Public Health Law. Both the federal and state statutes must be considered prior to releasing any protected health information to a third party.

The New York Public Health Law requires that upon receipt of a written request of any competent patient, parent or guardian of an infant, a guardian appointed pursuant to Article 81 of the Mental Hygiene Law, or conservator of a conservatee, or any other "qualified person" (which includes an attorney representing or acting on behalf of a patient or the patient's estate), an examining, consulting or treating physician or hospital must release and deliver, exclusive of personal notes of the said physician or hospital, copies of all patient information, including x-rays, medical records and test results and original mammograms. The law requires physicians to comply with such written requests within 10 days.

Release of Original Films: Generally, original x-ray films and records should never be released, except to a court under court order, pursuant to a subpoena which complies with HIPAA's requirements, to your defense counsel or, in extenuating circumstances, to a health care provider for urgent care and treatment of the patient when copies are inadequate. **However, Federal and State law require that original mammography films must be released if the patient requests them. When you receive a request for an original mammogram, you should release the original to the patient after making a copy at no charge to the patient and retain that copy for your files. If you do not retain a copy of the**

[2] Destroying or losing medical documentation could result in harsh consequences. For example, in Baglio v. St. John's Queens Hospital, fetal monitor slips were missing or lost. The appellate court sanctioned the responsible party (defendant) by striking the defendant's answer, resulting in a verdict for plaintiff.

Films, your defense may be compromised and you may be in violations of Education Law §6530 (32), which requires you to retain a complete and accurate medical record.

Fees for Copying Medical Records: HIPPA permits you to impose reasonable, cost-based fees. Under HIPPA, fees permitted under New York State law are presumed to be reasonable. See, 45 CFR §164.524. New York law limits the maximum amount you may charge for copying **up to** 75 cents per page never be denied because of an inability to pay. You should maintain documentation to substantiate that your copying fee is reasonably to your copying costs.

Fees may be charged for releasing records to a treating hospital or physician, to a patient, to an insurance company, and to the patient's attorney or qualified representative. If the patient has agreed to receive a summary or explanation of his or her protected health information, the covered entity may also charge a fee for preparation of the summary or explanation. You may not deny a patient's request solely due to inability to pay either your bill for services or for the requested copy of the records.

The charge for x-rays, photographs and videotapes must be the actual cost of duplication. According to both State and Federal regulations, the charge for the release of original mammography films must be limited to the actual, documented cost of mailing the original films. The patient may only be charged the actual costs associated with releasing the original mammography films, not the cost of copying them for your retention.

2.9 Release of Medical Records – General Rules

A medical record may be released to a third party upon receipt of a signed, properly completed and recently dated HIPPA compliant authorization. It must be executed by the patient or a person designated as a "qualified person" under section 18 of the Public Health Law, which includes the following list of individuals:

1. parent or legally appointed guardian of a minor, expected as indicated in the section;
2. the conservator or committee of an incompetent
3. a guardian appointed under Article 81 of the Mental Hygiene Law;
4. the administrator or executor of a deceased person, who should produce a copy of a court issued document known as Letters of Administration or Letter Testamentary appointing him/her to represent the estate;
5. a distribute of the estate of the deceased patient, who should sign an affidavit indicating that no estate representative has been appointed. A distribute is also required to produce a *copy* of a certified copy of the patient's death certificate.

If for any reason you question the validity of the signature on these forms, you may contact the person submitting it for further information, or you may request that the signature be notarized.

Attorneys. An attorney at law may obtain a copy of a patient's medical record by either providing properly signed, recently dated HIPPA compliant authorization or a power of attorney from executed by a "qualified person" which explicitly authorizes the holder to execute a written request for the medical record.

3 In addition to the above individuals, a health care proxy agent may execute a written authorization for release of the patient's medical record if the patient lacks capacity.

2.10 Release of Records Involving Minor Patients:

Generally speaking, the signature of a parent or legal guardian is required to release medical records of minor patients. In certain situations, however, minor patients are authorized by law to give effective consent and in such cases authorization to release information, even to a parent, must be sought directly from the minor patient. Authorization from the minor patient must be obtained to release the following information:

1. Sex-related treatment, such as contraception, abortion, pregnancy or sexually transmitted diseases or information regarding HIV testing;
2. Drug and alcohol treatment. A parent may not access the records unless the parent gave consent for the treatment in accordance with State law. The signatures of both the minor and the parent are required in those instances. 42 C.F.R. Part 2.14(b)-(d).
3. Psychiatric outpatient treatment. Pursuant to Mental Hygiene Law §§33.16 and 33.21, a minor who meets certain criteria may receive psychiatric outpatient treatment without parental consent. A parent's authorization to obtain records in these circumstances may not be valid without the minor's consent or a court order.
4. In addition, where the parent, guardian or person acting in place of a parent agrees to permit confidentiality between the minor and provider with respect to the health care service, the parent should not be given access to the minor's medical record.

Note that under section 18(3)(c) of the Public Health Law, minor over the age of twelve years may be notified of any request by a qualified person to review his/her patient information, and, if the minor objects to disclosure, the provider may deny the request. In the case of a facility, the treating practitioner shall be consulted.

2.11 What Information Should be Released in Response to a Written Request?

Under HIPAA, individuals may access protected health information about themselves that is contained in a "designated record set." If handwritten progress notes are used to make decisions about a patient's health care, then they are considered to be part of the record and must be released. If records of prior treatment providers are maintained as part of the patient's medical record, then they are likely to fall within the definition of "designated record set".

HIPAA permits you to deny a patient access to certain limited types of information and in certain limited circumstances. Access can be denied where:

1. The requested access is reasonably likely to endanger the life or physical safety of the individual or another person;
2. The authorization form or subpoena does not comply with HIPAA's requirements;
3. The information requested was compiled in anticipation of civil, criminal, or administrative actions or proceedings;
4. The party requesting the information is not the legal representative of a deceased patient;
5. The information requested is beyond the minimum necessary for the purpose expressed in a patient's HIPAA authorization;
6. The protected health information makes reference to another person (unless such other person is a health care provider) and access is reasonably likely to cause substantial harm to such other person;

7. The request for access is made by the individual's personal representative and access is reasonably likely to cause substantial harm to the individual or another person;

8. The protected health information was obtained from someone other than a health care provider under a promise of confidentiality and access would be reasonably likely to reveal the source of the information;

9. Special Rules for Psychotherapy Notes. Psychotherapy notes are specifically defined in 45 CFR §164.508. These are notes recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a private, group, joint or family counseling session and are kept separate from the rest of the individual's medical record. There is no absolute right of access to psychotherapy notes and therefore access may be denied. Note that the following information does not fall within the definition of "psychotherapy notes" and therefore should be released upon receipt of a proper authorization: medications and prescriptions, monitoring, the times and dates of counseling sessions, treatment modalities, frequency of treatment furnished, results of clinical tests and any summary of: diagnosis, functioning, treatment plan, symptoms, prognosis and progress to date.

In all cases, a licensed health care professional must make the determination in the exercise of professional judgment. If you do deny access, you must, to the extent possible, give the individual access to any other protected health information requested which you have not denied. See, 45 CFR §164.524. Further, the patient under both state and federal law have a right to appeal the denial through procedures established under HIPAA and Public Health Law §18.

2.12 Subpoenas for Medical Records.

A subpoena is a judicial command issued in connection with a court case or an administrative proceeding. Subpoenas may be issued to provide records for trial or deposition, in proceedings before the Grand Jury or in connection with various agency investigations. An attorney representing a party in an action is empowered to issue a subpoena without a court order. CPLR §2302(a). Subpoenas must be responded to promptly. **Note** that if a subpoena requests "all records" or "the entire record", you should provide **all** responsive records in your possession (including personal notes and records of other treatment providers) unless there is a legal prohibition (such as HIV information, records of psychiatric treatment and records of alcohol/substances abuse programs). You cannot charge copying fees for providing records in response to a subpoena. Most subpoenas will be accompanied by a check for statutory witness fees and mileage in a nominal amount.

Subpoenas must carefully be reviewed to ascertain whether it is proper to release the patient's medical record. Subpoenas are common where the patient has brought a lawsuit for personal injuries. The law provides that by bringing the claim for personal injuries, the patient has waived his or her right to confidentiality of medical information. If the underlying legal action does not involve a civil claim for personal injuries (for example, a divorce action or a criminal action), then you should contact legal counsel before releasing any records.

CAUTION: HIPAA requires that before releasing protected health information in response to a subpoena, one of four conditions must be satisfied: you must have a patient authorization; or you must receive satisfactory written assurances that a reasonable effort has been made to place the patient on notice of the subpoena; or you must receive written assurances that reasonable efforts have been made to secure a qualified protective order; or you must have a court order. See, 45 CFR §164.512(e). New York State law requires that a subpoena for medical records must be accompanied by a patient's authorization, which would satisfy these HIPAA requirements.

You may never release HIV related information and records of alcohol and drug treatment programs in response to a subpoena. The law states that such information can ONLY be released pursuant to a specifically tailored patient authorization or a court order. A "so ordered" subpoena is not a "court order" for these purposes. If you receive a subpoena requesting a record containing either HIV or drug/alcohol information, you should immediately contact legal counsel.

Subpoenas for Psychiatric and Mental Hygiene Records: The Mental Hygiene Law states that such records may only be disclosed by a specific authorization or a court order. Records of psychiatric treatment are also entitled to special protection. If you receive a subpoena for such records, you should immediately contact legal counsel.

Out of State Subpoenas: Subpoenas from other state courts are not automatically valid in New York State. In order to release the record, a subpoena issued from an attorney or court outside New York State **must** either be accompanied by 1) a HIPAA compliant patient authorization, or 2) a New York State court order.

Subpoenas in Unusual Situations: If you receive a Grand Jury or Family Court subpoena, a subpoena from an administrative agency, a Federal court subpoena, or a subpoena in any other unusual situation, you should contact legal counsel regarding how to proceed.

How to Comply with a Subpoena

Most subpoenas may be complied with by providing a certified copy of the medical record. If you do not have a certification form, you may contact Fager & Amsler to obtain one. The record should be sent to the presiding judge by some method which ensures a delivery receipt (e.g., certified mail, overnight courier). You should place the records in a sealed envelope with a copy of the subpoena affixed on top of that envelope and enclose it in a second envelope addressed to the judge or court at the address listed on the subpoena.

Should you have any difficulty determining whether it is appropriate in any given circumstance to release a copy of your patient's medical record, feel free to contact the attorneys at Fager and Amsler in Syracuse (315-428-1380 or 877-426-9555), Latham (518-786-2880) or Long Island (516-794-7340).

This document is a sample only and is not intended as a substitute for independent legal advice. The specific facts that apply to your situation may require different contract provisions. You should consult with your attorney concerning the preparation of your medical records storage agreement.

MEDICAL RECORDS STORAGE AGREEMENT

This Medical Records Storage Agreement (the "Agreement"), effective as of May 1, 2002 (the "Effective Date"), between _____ (PRACTICE) with offices at _____ and _____ (M.D., P.C.) with offices at _____.

WHEREAS, M.D., P.C. is a professional services corporation organized under New York law for the purpose of providing health services; and

WHEREAS, PRACTICE is closing its office which will cease providing medical or health services effective _____ (Closure Date);

WHEREAS, the parties wish to provide for the storage and safekeeping of medical records for those patients who have specifically requested that medical records be copied and made available to M.D., P.C. for future care; and

WHEREAS, M.D., P.C. has advised PRACTICE that M.D., P.C. has the ability and capacity to store medical records in a confidential manner and in a safe and accessible location in accordance with applicable New York Public Health Law and federal regulation.

NOW, THEREFORE, PRACTICE AND M.D., P.C. agree as follows:

1. **Storage of Records**

   a. From time to time, PRACTICE patients have made written requests for their original medical records to be copied be PRACTICE for use by M.D., P.C. to treat those patients (the "Medical Records"). PRACTICE has/will transfer custody and possession of the original Medical Records relating to those patients to M.D., P.C. and PRACTICE and M.D., P.C. will enter in ratification of this Agreement under which M.D., P.C. will acknowledge receipt of the Medical Records. Name of patents who have issued requests are listed on Exhibit "A".

   b. M.D., P.C. will store and maintain the Medical Records in a confidential, safe, and accessible manner in compliance with all State and Federal laws. M.D., P.C. also agrees that M.D., P.C. will store, maintain the confidentiality of, restrict access to and release the medical records in compliance with all laws, rules and regulations applicable to the retention and storage of patient records. In particular,

but not in limitation of the generality of the foregoing, M.D., P.C. will obtain special consents to the release of records relating to drug and alcohol abuse treatment, HIV related matters, records of psychiatric treatment and the like which maybe required by applicable law, rule or regulation. M.D., P.C. shall assure the confidentiality of the Medical Records and shall allow access to Medical Records only pursuant to this Agreement or as permitted by law. M.D., P.C. shall make no use of the Medical Records for any purpose except this Agreement. PRACTICE does not intend this Agreement to be, nor shall the Agreement be interpreted as, a sale or transfer of title to the Medical Records to M.D., P.C. or to any third party.

c. M.D., P.C. shall store and maintain the Medical Records pursuant to the applicable retention period, as set forth in the annexed Exhibit "B".

2. **Access to Records by PRACTICE**

PRACTICE may request access to or copies of specific Medical Records when reasonably necessary, including but not limited to, responding to any claim, inquiry or request related to quality of care (including medical malpractice), licensure or accreditation standards, insurance, or billing audit, or similar reasons, and M.D., P.C. shall permit such access, upon reasonable prior notice, during regular business hours to PRACTICE or its representative. M.D., P.C. shall copy Medical Records upon PRACTICE'S request promptly but not later than two (2) business days of such request. In such event, PRACTICE shall pay M.D., P.C. the reasonable copying charges as allowed by law. M.D., P.C. shall also permit access to any Medical Records in accordance with applicable law, rules and regulations to appropriate federal and state government agencies.

3. **Access to Records by M.D., P.C.; Transfer of Copies of Records**

a. Upon receipt of a proper written authorization, consent or request of a patient or a patient's representative, M.D., P.C. and its employees may have access to and the use of the Medical Records for such patient but M.D., P.C. shall retain the original Medical Records in a separate and distinct file or portion thereof that clearly distinguishes services furnished to patients to patients before the Closure Date. Such separate and segregated file shall be created by use of a separated distinctively colored file or divider or such other means as the parties may agree upon writing.

b. Upon receipt of a proper written authorization, consent or request of a patient or a patient's representative, M.D., P.C. shall transmit copies of the Medical Records in accordance with such authorization but shall retain the original Medical Records pursuant to this Agreement. M.D., P.C. may impose a reasonable charge for copying as allowed by law. In no event shall M.D., P.C. release or deliver original Medical Records to any party other than practice.

4. **Termination**

a. Expiration of Record Retention Period. Unless terminated sooner as provided in Section 4(b), this Agreement shall govern the use, inspection, copying and transfer of each patient's Medical Records until the expiration of the record retention period for such Medical Records as set forth in Exhibit "B". At any time after the expiration of the applicable records retention period, PRACTICE may on reasonable notice to M.D., P.C. request that the Medical Records be made available for pickup by PRACTICE. If PRACTICE has not elected to pick up the Medical Records within one (1) year after the expiration of the applicable record retention period, M.D., P.C. may destroy such patient's Medical Records, provided it shall have given at least thirty (30) days prior written notice to PRACTICE, which notice shall bear the following legend conspicuously on the outside of the envelope containing the notice: **Important**:
Request to Destroy Old Medical Records. During such 30-day period PRACTICE may either pick up the Medical Records involved or, for good cause shown, request M.D., P.C. to maintain such patient's Medical Records for an additional period not to exceed one year.

b. For Cause.

i. In the event either party shall intentionally breach any of its material obligations under this Agreement, the non-breaching party may elect to terminate this Agreement upon thirty (30) days after written notice specifying in reasonable detail the nature and extent of the breach, provided that in the event the breach involved is capable of being cured and is cured during such (30) day period, the termination notice shall be deemed rescinded and this Agreement shall continue in force in accordance with its terms; and

ii. In the event either party shall breach any of its material obligations under this Agreement on more than three (3) occasions in any rolling twelve (12) month period, the non-breaching party may elect to terminate this Agreement upon thirty (30) days after written notice specifying in reasonable detail the nature and extent of the breach.

iii. If either party shall elect to terminate this Agreement, M.D., P.C. shall transfer and deliver at PRACTICE's direction and expense all original Medical Records (without retaining copies of any Medical Records other than those released to M.D., P.C. under Section 3(a) above) then remaining in M.D., P.C.'s possession to PRACTICE at such location as PRACTICE shall reasonable specify. M.D., P.C. may retain copies of Medical Records delivered to it under Section 3(a) above, which Medical Records shall be copied at M.D., P.C's expense.

iv. Not withstanding anything contained in this Agreement to the contrary, neither party may terminate this Agreement if the other party can demonstrate that is has materially complied with the applicable provisions of law governing the storage, use, confidentiality, inspection, copying or transfer of Medical records.

5. **Closing or Transfer of Site by M.D., P.C.**.If, during the term of this Agreement, M.D., P.C. intends to cease or transfer operations at the Site, M.D., P.C. will give prior notice to PRACTICE (in no event less than thirty (30) says prior to the intended date of such cessation or transfer). Upon PRACTICE's consent, which shall not be unreasonably withheld or delayed, in the event of transfer, M.D., P.C. may assign all of its rights and obligations under the Agreement the successor entity, if any, provided that such entity shall execute and deliver to PRACTICE a written undertaking to assume the obligations of M.D., P.C. hereunder.

6. **Miscellaneous**

a. Notices given by one party to the under the Agreement shall be in writing and either personally delivered, delivered by mail or by a recognized courier or overnight delivery service which issues a delivery receipt, addressed as follows:

If to PRACTICE:

If to M.D., P.C.:

By notice to the other party, either party may change the address to which future notices shall be sent.

b. This Agreement may be amended or assigned only with the prior written approval of both parties; this Agreement shall be governed by the laws of the State of New York. Notices shall be given by certified mail, return receipt requested, postage and registry fees prepaid or by Federal Express or other nationally recognized over night courier service to the address for the party to receive such notice specified at the beginning of this Agreement. Each party by notice to the other may change the address to which future notices shall be sent.

c. This Agreement constitutes the final and complete expression of the parties understanding and agreement with respect to its subject matter and it supersedes all prior or contemporaneous negotiations, discussions or understandings, all of which are merged into this Agreement.

d. In any action in which PRACTICE and M.D., P.C. are adverse parties and relating to this Agreement, the party prevailing in such action shall be entitled to recover it reasonable attorney's fees and expenses from the non-prevailing party.

IN WITNESS OF, the parties have executed and delivered this Agreement on the dates set forth below.

Dated:_____ By: _____

Dated: _____ By: _____

SECTION 3

Medical Society of the County of Erie

Medical Society of the County of Erie

Correspondence

Closing Your Practice

As you begin to think about closing your practice, there are a number of issues that you must consider before you close your door the last time. As a service to you we have produced this series of articles which we hope will clarify your responsibilities as assist you during this transition.

Our recommendations should not be construed as legally binding. The reader should contract his/her own attorney for specific advice.

Part 1 – The Medical Record

Under New York State law, it is well settled that records taken by a doctor in the examination and treatment of a patient are property belonging to a doctor. Gerson v. New York's Women's Medical, P.C., 249 A.D.2d 465 (2nd Dept. 1988). As a physician, the records you produce detailing a patient's treatment are your records, and not the patients. Since these records belong to you as a treating physician, New York State law dictates the period of time these records must be kept after your treatment of a patient ends or you close your practice. These laws are stated in section 6530 of the New York State Education Law.

As the physician who has provided medical care, it is your responsibility under § 6530(32) of the New York State Education Law to maintain the original copy of all records for certain applicable time periods. Currently this section specifies that unprofessional conduct includes:

> "Failing to maintain a record for each patient which accurately reflects the valuation and treatment of the patient. Unless otherwise provided by law, all records must be retained for at least six (6) years. Obstetrical records and records of minor patients must be retained for at least six years, and until one year after the minor patient reaches the age of eighteen (18) years."

You are entitled to destroy records if a minimum period of six (6) years has elapsed from the last date of treatment. You may keep them for a longer period of time. The Medical Liability Mutual Insurance Company recommends a period of 10 years as an added safeguard.

However, the New York Code, Rules, and Regulations impose additional time period requirements upon physicians which are longer than those imposed by § 6530 of the New York State Educational Law. Under 8 N.Y.C.R.R. § 29.2, obstetrical records and the records of minor patients must be retained fro at least six years, and until one year after the minor patient reaches the are of 21 years. Therefore, it is recommended that physicians who treat infants and minors retain their records until their patients reach the age of 22.

This requirement should not be confused with the statute of limitations, which is the period of time in which a plaintiff will be able to bring a lawsuit without being

time barred. Currently that time limit is two years and six months from the date of the alleged malpractice. A plaintiff who was an infant at the time of the alleged may commence an action two years and six months after he or she reaches the age of 18 provided that 10 years has not passed since the date of the alleged malpractice. If ten years has passed since the date of the alleged malpractice, an infant-patient may be precluded from bringing a lawsuit even though the infant-patient has not yet reached the age of 18. Therefore, it is especially important that physicians who treat infants retain their patient records until their patients reach the age of 22. Maintaining and infant-patient's records until he or she reaches the age of 22 ensures compliance with New York State law and guarantees that original patient records will be available to defend against potential malpractice suits.

Notification of Patients/Access to Medical Records

Of utmost concern is the notification of patients as to your plans, thereby eliminating the possibility of being charged with the patient abandonment. We highly recommend that notification be done utilizing certified mail, return receipt requested. If you elect to use first class postage, the United States Postal Service will guarantee delivery or forwarding to a new address for a period of 18 months. If there is no forwarding address, the letter will be returned to you as "undeliverable". If returned, you should maintain the unopened letter in the patient chart as proof that en attempt had been made to notify the patient.

Your letter should be mailed to allow sufficient time for the patient to locate a new physician, and should offer a patient referral resource center (such as the Medical Society) or the names, addresses and phone numbers of physicians who are willing to provide continuing care. Also included should be a HIPAA compliant form for the authorization of a transfer of medical records to a new physician.

While developing such a letter, it is wise to develop a computerized Access database of all patients (active and non-active) which will assist you during the next few months. This database will be a reproducible record of your activities prior to closure and could be of significant importance if sometime later there would be an allegation of professional misconduct or if a lawsuit is filed.

To assist you, we have compiled a list of data fields that you may wish to utilize. They include:

a) Patient Social Security Number
b) Patient Last Name
c) Patient First Name
d) Date of Last Visit
e) Date of Notification Letter Mailed
f) Notification Returned as "Undeliverable"
g) Record Release Date
h) Released to

i) Custodian Name
j) Date to be Destroyed
k) Method of Destruction

Custodianship of Medical Records

When closing your practice, it is extremely important to provide your patients with sufficient advance notice so that they can either arrange for a copy of their records to be transferred, or obtain a copy of their medical records for themselves. Upon the closure of your practice and contingent on the express consent of your patient, a copy of your patient's records may be transferred to their new physician. If your patient has not yet obtained a new physician, you may provide them with a copy of their medical records. In either case, you are required to maintain the original records. However, if you decide to place your medical records under the custodianship of another physician, the following guidelines must be strictly adhered to:

a) The medical records are the property of the originating physician
b) The medical records are in the possession of the custodian for safekeeping only.
c) The originating physician is entitled to those records
d) The custodial physician may not co-mingle them with his own records. They must be stored separately.
e) The custodial physician must retain the records for the time specified under the statute of limitations
f) Due to issues of patient confidentiality (HIPAA) the custodial physician must not access the records without the patient's express consent.
g) The custodial physician must provide copies of the medical records in accordance with NTS legal requirements.

When a physician grants custody of his medical records to another physician, complications may arise. The HIPAA privacy standard prevents a health care provider from disclosing to anyone a patients protected health information without that patient's consent. Therefore, it is crucial that a physician who has custody of another physician's records not unlawfully access the records without the patient's consent. Due to the possible risks associated with custodianship, it is recommended that physicians properly store their medical records themselves, rather than enter into custodial arrangements with other physicians.

Charges for Copying Medical Records

Under New York State Public Health Law § 18 (2) (e):

a) The health care provider may impose a reasonable charge for all copies, not exceeding the costs incurred by such provider.
b) The reasonable charge for paper copies shall not exceed seventy five cents.

If a health care provider furnishes copies of x-rays, the seventy five cents per page maximum charge limitation does not apply. In such a case, the health care provider may impose a "reasonable charge" for copies, but such charge may not exceed the actual costs of the x-ray.

Additionally, a patient shall not be denied access to their records solely because they are unable to pay. Therefore, an indigent patient may be entitled to a free copy of their medical records, whereas a patient with the ability to pay would not be entitled to a free copy. A patient's medical records cannot be withheld due to a past due account.

Finally, a health care provider is not permitted to charge a search and retrieval fee in addition to the maximum per charge copying fee of seventy five cents. However, the fee limitations contained in the Public Health law do not prohibit a provider from charging postage, shipping or required sales taxes since these items fall outside the purview of the statute. McCrossan v. Buffalo Heart Group, 695 N.Y.S.2d 852(4th Dept. 1999).

NYS Health Department Timeline

Patients are entitled to a copy of their medical records, or the transfer of those records within a "reasonable period" which the NYS Health Department says is 14 days from the date of request.

References:

Donald J. Moy, Esq., Medical Society of the State of New York

Legal Guidelines for the Medical Office – August 2002, MSCE

State of New York Department of Health Memorandum, Reasonable Charge for Copies of Health Care Records/Patient Information.

Medical Society of the County of Erie

Letter Templates

Section 3.2.1 **Colleagues**

[date]

[inside address]

Dear Dr [name]:*

The time has come! [Date] will be my last day of practice.

It has been my distinct pleasure to have known you and worked with you throughout the years. Keep up the good work.

Sincerely,

[name], MD

Section 3.2.2 **Employees**

[date]

[inside address]

Dear [name]:

In [—][weeks/months], [I/we] plan to close [my/our] medical practice. The _last day open will be [date]. You have been a member of a very capable and _supportive team, for which [I/we] thank you.

It is [my/our] hope that you will remain through the last day of operation. However, [I/we] realize that you must think of your next opportunity for employment and take advantage of any opening when it occurs. Those who remain employed at [name of practice] until the final day will receive a bonus check equivalent to [—] [weeks'/months'] salary. [I/We] hope you will be among those remaining until the last day.

You may expect a favorable reference for your excellent work and loyalty.

On [date], we will meet from [—] o'clock to [—] o'clock to resolve any _questions you might have about this process. We will discuss such topics as _[—].* Please prepare your questions in advance so that our time may be used productively.

The last day to schedule patients for appointments will be [date].

Thank you for everything you have done to make [my/our] [life/lives] and that of our patients more rewarding.

Gratefully,

[name], MD

Section 3.2.3 **Patients**

[date]

[inside address]

Dear [name]:

After [date], I will no longer be able to care for your medical needs. I plan _to [—].*

Assisting you with your medical care has made my life satisfying and _productive. I hope my family and hobbies will help fill any void.

Enclosed is an authorization for the release of your medical records. Please complete the [form/forms], sign [it/them], and return [it/them] to the office. I can then send your records to any physician you select.

The following local physicians have indicated to me that they are willing to accept new patients: [—].†

I offer this list only for your convenience. You need not select from this list. Please consider other factors, such as your medical insurance, when selecting another physician.

I hope this notice will give you ample time to attend to prescription refills, _transfer of records, and, for those who wish, a final visit with me!

Yours truly,

[name], MD

Section 3.2.4 **Hospitals**

[inside address]

RE: Voluntary withdrawal of admitting privileges

Dear [name]:*

On [date] I plan to retire from medical practice. It is with mixed emotions that I request that my [specialty] admitting privileges be withdrawn.

Please ensure that the hospital records reflect that this is a voluntary withdrawal of privileges. It is my pleasure to have been able to serve my patients at [name of hospital].

Sincerely,

[name], MD

Section 3.2.5 **Professional Societies**

[date]

[inside address]

Dear [name]:

I plan to stop practicing medicine on [date]. Place my records with the society into inactive status after this time.

Please send any future correspondence to me to [street address, city, state, zip code].

It has been my pleasure to have been a member of [name of society].

Sincerely,

[name], MD

Section 3.2.6 Liability Insurers

[date]

[inside address]

Re: Termination of professional liability insurance [policy number]

To Whom It May Concern:

My last day of active medical practice will be [date]. Please end my professional liability insurance at [—] o'clock on the same date.

If there is an unearned premium to be refunded to me, please send it to [street address, city, state, zip code].

Please contact me immediately concerning termination of this insurance and the possibility of obtaining other types of coverage. [—]*

Sincerely,

[name], MD

Section 3.2.7 Insurance Companies

(date]

[inside address]

RE: Closing of medical practice

To Whom It May Concern:

On [date] I plan to cease practicing. You will continue to receive insurance claim forms for [—] [weeks/months] afterwards as we follow up on unpaid, pending, and unfiled claims. However, there will be no dates of service after [date as above]. This information is sent for your protection and mine.

After [date] any correspondence from you, including remittances, should be sent to [street address, city, state, zip code].

Thank you for your attention to this matter.

Yours truly,

[name], MD

Section 3.2.8 Other Insurers

[date]

[inside address]

Re: Termination of insurance coverage [policy number]

To Whom It May Concern:

After [date] I will no longer require your insurance coverage as I am closing my medical practice.

Please contact me before [date] so that we can tie up all loose ends concerning this matter.

Sincerely,

[name], MD

Section 3.2.9 Specialty Board

[date]

[inside address]

To Whom It May Concern:

After [date] I will no longer practice medicine.

Accordingly, please move my name from active to inactive status.

Sincerely,

[name], MD

Section 3.2.10 **DEA**

[date]

[inside address]

Re: Voluntary surrendering of DEA privileges [DEA number]

To Whom It May Concern:

I would like to surrender my DEA privileges as I plan to close my office and stop practicing medicine on [date].

Please provide me with instructions for the disposal of narcotics and other _classified drugs in my possession. Thank you for your assistance.

Yours truly,

[name], MD

Section 3.2.11 Lessor

[date]

[inside address]

RE: Vacating rental office space

Dear [name]:

[I/we] plan to vacate the rental space at [street address, city, state] on [date].

According to the lease, [I/We] must provide [—] days' notice, which [I/we] [am/are] [providing at this time/regretfully cannot provide].*

The final rent check will be sent to you as usual on [date]. If there are any _contingencies to be settled, please contact [name].

Sincerely,

[name], MD

Section 3.2.12 Utilities

[date]

[inside address]

Re: Discontinuation of [—]* service

To Whom It May Concern:

[I/We] plan to vacate the office space at [street address, city, state] on [date].

Please arrange for service to be disconnected by [date].

The final statement for service may be sent to [street address, city, state, zip code]. Thank you for your assistance.

Yours truly,

[name], MD

Section 3.2.13 Records – Advisory to Patients

[date]

[inside address]

Dear [name]:

Medical records from [name of practice] that were not transferred to another physician are now in storage. [—] is the name of the storage facility. It is _located at [street address, city, state, zip code].

To retrieve your medical records, please telephone [name of facility] at least _[—] hours in advance of pickup. The telephone number of the facility is _[telephone number].

Sincerely,

[name], MD

Section 3.2.14 Records – Microfilm Inquiry

[date]

[inside address]

To Whom It May Concern:

[My/Our] medical practice office will close permanently on [date] and [I/we] would like information about your microfilm services, including storage and retrieval.

Please provide [me/us] with information regarding the cost of microfilming, storing, and retrieving medical records. The records are, on average, [—] by _[—]* and there are approximately [—] of them.

Easy of retrieval with proper authorization is very important. If additional _information is required, please contact [name] at [telephone number]. Thank _you for any help you can give concerning this matter.

Sincerely,

[name], MD

Section 3.2.15 Records – Storage Inquiry

[date]

[inside address]

To Whom It May Concern:

[Name of practice] will close permanently on [date].

[I/We] [am/are] in search of a clean, secure storage facility that will hold the remaining patient records after the office closes.

The facility must be able to retrieve patient records with proper written _authorization on a case-by-case basis. It is hoped that this can be done easily and with no more than [—]* advance notice.

Please provide [me/us] with information on the services offered by your firm, as well as the associated costs. If additional information is required, please contact [name].

Sincerely,

[name], MD

Section 3.2.16 Termination of Corporation

[date]

[inside address]

To Whom It May Concern:

[Name of corporation] ceased doing business on [date]. [I/We] would like to _terminate the corporation.

Please provide [me/us] with the necessary guidance to achieve this end. _Thank you for your assistance.

Sincerely,

[name], MD

Section 3.2.17 Termination of Services

[date]

[inside address]

To Whom It May Concern:

[Name of practice] will close permanently on [date] and will no longer require regular [—]* service after this date.

The final pickup should take place, as scheduled, on [date]. Thank you for your past service.

Sincerely,

[name]

Section 3.2.18 Termination of Subscriptions

[date]

[inside address]

To Whom It May Concern:

After [date], please cancel the subscriptions to the following publications: _[—].*

Refund the unused portion of the payments to [name of practice]. Please contact [name] if you have further questions.

Sincerely,

[name], MD

Section 3.2.19 Equipment & Supplies: Auction

[date]

[inside address]

Dear [name]:

[I/We] [closed/will close] [my/our] medical practice on [date] and would like to have all of the equipment, furniture, fixtures, and unopened supplies (except for medication) auctioned.

Please contact [name] as soon as possible to discuss the process and costs.

Sincerely,

[name], MD

Section 3.2.20 **Equipment & Supplies: Sale**

[date]

[inside address]

To Whom It May Concern:

[I/We] have been informed that your firm purchases used medical equipment and unused, unopened medical supplies.

[My/Our] practice [closed/will close] on [date] and [I/we] would like to make _an appointment for someone to come out and view the furniture, fixtures, _equipment, and other supplies and to advise [me/us] on their disposition.

Please contact [name] at [telephone number] concerning this matter.

Sincerely,

[name], MD

Section 3.2.21 **Equipment & Supplies: Donation**

[date]

[inside address]

To Whom It May Concern:

[I/We] [closed/will close] [my/our] practice on [date] and would like to donate all of the equipment and unopened medical supplies to [name of organization].

A general list of furniture, equipment, and other supplies is enclosed for your review. If you wish to send someone to appraise these items, please contact [name] at [telephone number].

Cordially,

[name], MD

Enclosure

Section 3.2.22 Uncollected Accounts: Patients

[date]

[inside address]

Dear [name]:

[Name of billing company/collection agency] has been authorized to collect all funds owed to [name of practice].

Sincerely,

[name], MD

Section 3.2.23 Uncollected Accounts: Billing/Collection Agency Inquiry

[date]

[inside address]

To Whom It May Concern:

[I/We] closed [name of practice] on [date] and have more than [—] uncollected accounts totaling approximately [$—].

If your firm is interested in pursuing the collection of these funds, please contact [name].

Sincerely,

[name], MD

Section 3.2.24 Uncollected Accounts: Donation to Charity

[date]

[inside address]

Dear [name]:

[I/We] recently closed [name of practice] and turned over all the uncollected accounts to [name of billing company/collection agency].

[I/We] have instructed [name of billing company/collection agency] to forward all funds collected, less their fee, to you, [name of charity]. Please provide [me/us] with an annual statement of donations for tax purposes.

If you have questions, please contact [name].

Sincerely yours,

[name], MD

SECTION 4

NYS LEGISLATION

NYS LEGISLATION

Public Health Law §17

MCKINNEY'S CONSOLIDATED LAWS OF NEW YORK ANNOTATED
PUBLIC HEALTH LAW
CHAPTER 45 OF THE CONSOLIDATED LAWS
ARTICLE 1-SHORT TITLE DEFINITIONS: GENERAL PROVISIONS
TITLE II-GENERAL PROVISIONS
§ 17. Release of medical records.

Upon the written request of any competent patient, parent or guardian of an infant, a guardian appointed pursuant to article eighty-one of the mental hygiene law, or conservator of a conservatee, an examining, consulting or treating physician or hospital must release and deliver, exclusive of personal notes of the said physician or hospital, copies of all x-rays, medical records and test records including all laboratory tests regarding that patient to any other designated physician or hospital provided, however, that such records concerning the treatment of an infant patient for venereal disease or the performance of an abortion operation upon such infant patient shall not be released or in any manner be made available to the parent or guardian of such infant, and provided, further, that original mammograms, rather than copies thereof, shall be released and delivered. Either the physician or hospital incurring the expense of providing copies of x-rays, medical records and test records including all laboratory tests pursuant to the provisions of this section may impose a reasonable charge to be paid by the person requesting the release and deliverance of such records as reimbursement for such expenses, provided, however, that the physician or hospital may not impose a charge for copying an original mammogram when the original has been released or delivered to any competent patient, parent or guardian of an infant, a guardian appointed pursuant to article eighty-one of the mental hygiene law, or a conservator of a conservatee and provided, further, that any charge for delivering an original mammogram pursuant to this section shall not exceed the documented costs associated therewith. However, the reasonable charge for paper copies shall not exceed seventy-five cents per page. A release of records under this section shall not be denied solely because of inability to pay. For the purposes of this section the term "laboratory tests" shall include but not be limited to tests and examinations administered in clinical laboratories or blood banks as those terms are defined in section five hundred seventy-one of this chapter.

NYS LEGISLATION

Public Health Law §18

Access to Patient Information
Section 18: Access to Patient Information

Effective January 1, 1987, patients and other qualified persons are granted access to health care records by Section 18 of the Public Health Law, which was enacted in Chapter 497 of the Laws of 1986. Section 18 contains the procedures for making records available and the conditions under which a provider can deny access. If access is denied, the patients or other qualified persons are afforded the right of appeal to Medical Record Access Review Committees, committees consisting of peers of the practitioner who denied the access. Committees are established for each licensed health care profession.

Basic Provisions

Section 18 of the Public Health Law applies to records maintained by health care facilities licensed by the Department of Health. These include hospitals, home care facilities, hospices, health maintenance organizations and shared health facilities. Its provisions also apply to health care practitioners, including physicians, physician assistants, specialist assistants, audiologists, chiropractors, dentists, dental hygienists, midwives, occupational therapists, optometrists, ophthalmic dispensers, physical therapists, physical therapist assistants, nurses, podiatrists, psychologists, social workers and speech pathologists. The law describes such facilities and practitioners as "providers." Health care practitioners not specifically included in this paragraph are not covered by Section 18.

The law permits access by "qualified persons." "Qualified persons" include the patient or an incapacitated adult patient's legal guardian. A parent or legal guardian of a minor may access the minor's records when the parent or guardian consented to the care and treatment described in the record or when the care was provided without consent in an emergency resulting from an accidental injury or the unexpected onset of serious illness. "Qualified persons" include holders of health care proxies for living patients, the executors and administrators of estates of deceased patients, and if there is no will, the distributees of the estate under the Estates, Powers and Trusts Law. An attorney representing a "qualified person" is also a "qualified person," provided that the attorney has a signed power of attorney specifically authorizing the attorney to request medical records. Health care providers, insurance companies, other corporate entities and attorneys lacking a power of attorney are not qualified persons.

Section 18 requires that within 10 days of a written request for access to records, the provider must give the qualified person the opportunity to inspect the records. Providers must also provide copies of records if copies are requested. Providers are permitted to charge reasonable fees to recover costs for inspections and copying. However, a qualified person cannot be denied access to information solely because of inability to pay.

The law also states that access to the following records or parts of records may be denied:

* personal notes and observations maintained by the practitioner;
* information that was disclosed to the practitioner under the condition that it would be kept confidential and it has been kept confidential since then;
* information about the treatment of a minor that, in the opinion of the practitioner, should not be disclosed to the parents or guardians (a patient over the age of twelve may be told that his/her parents or guardians have requested the patient's records, and if the patient objects, the provider may deny the request);
* information that the practitioner determines may reasonably be expected to substantially harm the patient or others;
* substance abuse program records and clinical records of facilities licensed or operated by the Office of Mental Health (these records may be disclosed pursuant to a separate process in Section 33.16 of the Mental Hygiene Law);
* information obtained from other examining or treating practitioners which may be requested from the other practitioners directly;
* when other provisions of law prevent their release. For example, Section 17 of the Public Health Law prohibits the release to parents or guardians of records concerning the treatment of a minor for venereal

disease or for performance of an abortion.

Section 18 requires a provider who denies access to part or all of a record to inform the qualified person, which of the above reasons caused the denial.

Mammogram Films

Under Section 18 a qualified person has the right to obtain original mammogram films. The provider may not impose a copy charge for original mammograms, but may charge the actual documented cost for furnishing the films. Once the original films have been provided, the health care provider is no longer required to maintain a copy.

Appeals of Denials to Access

If a provider denies access to part or all of a record, the qualified person has the right to appeal the denial and the law requires the provider to inform the qualified person of that right. Medical Record Access Review Committees (MRARCs) will review appeals. Each committee is composed of peers of the licensed practitioners who denied access to the records.

Under the Law, the Commissioner of Health appoints the MRARCs and the appeals process is conducted under regulations established by the Commissioner. Subpart 50-3 of the Rules and Regulations of the Department of Health has been promulgated effective January 1, 1987.

The rule requires providers to give qualified persons, at the time of denial, a form approved by the Department. The form advises the qualified person of the right to appeal and the method for initiating an appeal. A copy of this form may be obtained from the API Coordinator. Once obtained, providers may copy the form and give it to qualified persons. If providers wish to develop their own form, that form must contain the same information and be approved by the Department of Health's Access to Patient Information Coordinator (API Coordinator).

The qualified person sends this form to the API Coordinator. Upon receiving a request for appeal, the API Coordinator will inform the provider and chairperson of the appropriate MRARC. The provider has 10 days to forward the copies of the records and a brief explanation for the denial to the MRARC chairperson. The MRARC will meet to review the appeal within 90 days of receiving the records. At least 15 days advance notice will be given to all parties. The provider and qualifiedpersons may be present at the meeting and both may have representatives.

The MRARC will issue a written decision with copies to the provider and qualified person. The patient records will be returned to the provider. If the MRARC decides that the qualified person should have access to the records, the provider will be directed by the MRARC to grant the access.

Decisions of the MRARCs, except for determinations regarding access to practitioner's personal notes and observations, may be challenged in the State courts. MRARC decisions regarding personal notes and observations are final.

Health Care Facilities

Under the law, if a patient requests records from a health care facility, the facility must consult with the "treating practitioner." The "treating practitioner" is the practitioner who has primary responsibility for the care of the patient. He/she must decide whether or not access to the information may be provided. Individual facilities must decide who the "treating practitioner" is for each request. If the requested records include multiple disciplines, the facility may choose to have either a single practitioner who had the primary responsibility for patient care decide the entire matter or have a practitioner in each profession make the determination for that practitioner's portion of the records.

If a patient is denied access to all or portions of a facility's records, and the patient appeals the denial, the appeal will be reviewed by the MRARC representing the discipline of the "treating practitioner" who made

the determination to deny access. If more than one "treating practitioner" made the denial, committees representing each discipline will be convened.

Subpart 50-3 of the Department of Health's Rules and Regulations Indicates that providers may be present at MRARC meetings when appeals are deliberated. Since the definition of providers includes both health care facilities and individual health care practitioners, it is possible for both the representative of the health care facility and the "treating practitioner" to be present for an MRARC meeting.

Confidentiality

Subpart 50-3 of the Department of Health's Rules and Regulations requires that patient records be kept confidential. At MRARC meetings, only the provider, the qualified persons, their representatives, the committee members and the API Coordinator may be present. The rule also requires that all information is safeguarded and the MRARC deliberations and records are confidential.

Personal Notes and Observations

Section 18 of the Public Health Law permits providers to deny access to personal notes and observations. The Law defines personal notes and observations as "a practitioner's speculations, impressions (other than tentative or actual diagnosis) and reminders, provided such data is maintained by a provider."

It has been suggested that handwritten portions of health care records may all be considered "personal notes and observations" and may be withheld from qualified persons, but this interpretation is overbroad. Consequently, Subpart 50-3 of the Department of Health's Rules and Regulations states "Handwritten notes and observations shall not be presumed to be personal notes and observations."

Information for Providers

Providers should thoroughly read the law and regulations to understand their rights and obligations.

Providers who deny access to part or all of the records are required to inform qualified persons of their right to appeal. An official denial and appeal form or an alternative form approved by the Department of Health's API Coordinator must be given to a qualified person at the time access to records is denied.

Relationship Between Section 18 and Federal Regulations

In some instances where a patient or a patient's personal representative has no right to access health information under State law, a right of access may nevertheless exist under federal law. Health care providers that are required to comply with the federal law known as the Health Insurance Portability and Accountability Act (HIPAA) generally must provide patients with access to all medical records and billing records. Many of the exceptions that exist in Statelaw do not exist in the federal law; the federal law does, however, have an exception for psychotherapy notes.

Any qualified person who may access records on behalf of a patient under State law is a personal representative with a right of access under federal law. Parents have a right of access to their children's medical records under federal law to the same extent that they have that right under State law.

If a right of access exists under federal law, the procedure for exercising that right of access should be written in the provider's Notice of Privacy Practices. The provider should have a reviewing official to make final determinations. New York does not enforce HIPAA. HIPAA is enforced by the Office for Civil Rights in the United States Department of Health & Human Services.

Further Information

Persons seeking further information regarding this process may contact:
API Coordinator
New York State Department of Health
433 River Street, Suite 303
Troy, New York 12180-2299

For Physicians, Osteopaths and Physician Assistants, call: (800) 663-6114.

For other Health Care Providers (Chiropractors, Dentists, Nurses, Physical Therapists, Podiatrists, Psychologists, Social Workers, etc.) call: (518) 402-1039.

SECTION 5

NYS DEPARTMENT OF HEALTH