



LEGAL GUIDELINES
FOR THE
MEDICAL OFFICE

A Publication of the Health Law Committee, MSCE

These recommendations should not be construed to be legally binding. The reader should contact his/her personal attorney and malpractice carrier for specific advice.

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TABLE OF CONTENTS

INTRODUCTION	1
§1 PREAMBLE	2
§2 SUMMONS, SUBPOENAS, AUDITS	3
Summons & Complaint	
Subpoenas	
Types of Subpoena	
Subpoena for Testimony	
Subpoena for Documents	
Sources of Subpoenas	
What Can Be Obtained	
How Subpoenas Are Served	
Managing Documents in Subpoenas	
Covering Expenses for Subpoenas	
Failure to Comply with a Subpoena	
Audits of the Medical Record	
Department of Health – Requests for Information	
County of Erie Health Department – Services for the Elderly	
§3 TESTIMONY BY PHYSICIAN	7
Testimony Limited to Facts of Case	
Testimony to Render an Expert Opinion	
Expectations for the Physician Witness	
Arrangements for Medical Testimony	
Compensation for Medical Testimony	
Compensation for Physicians	
Compensable Services Performed by Physicians	
Patient Resources to Cover Physician Services	
Attorney Resources to Cover Physician Services	
Keeping Physician Fees Independent of Case Outcome	
Establishing the Level of Compensation	
Dispute Resolution for Physicians and Attorneys	
§4 CONFIDENTIALITY	11
Confidentiality for Office Personnel	
Privacy Limits in Patient Confidentiality	
Release of Medical Information by State Mandate	
Penalties for Breaches of Confidentiality	
Disclosure Pursuant to Authorization	
§5 THE MEDICAL RECORD	15
Documentation and Patient Rights	
Documentation in the Medical Record	
Amendment or Modification of a Medical Record	
Retention of a Patient’s Medical Record	
Disposal of a Patient’s Medical Record	
Patients’ Rights Regarding Their Medical Record	

THE MEDICAL RECORD (CONTINUED)

	Patient Authorization for Record Release	17
	Documenting the Release of a Medical Record	
	Discharging a Patient from a Physician’s Practice	
	Disclosure of Data Between Medical Colleagues	
	Precautions When Releasing Medical Data	
	Medical Records and Professional Misconduct	
	General Limits to Medical Record Release	
	Denying Access	
	Discretionary Release of Protected Health Information by The Physician	
	Releasing Protected Health Information to a Malpractice Carrier	
	Minors’ Medical Records	
	HIV and AIDS Record Authorization	
	Genetic Information Release Authorization	
	Special Protection for Psychotherapy Records	
	Preparing & Delivering Medical Records	
	Medical Record Preparation	
	Identifying Data in a Medical Report	
	Clinical Data Format for Medical Records	
	Interpretive Statements in Medical Reports	
	Expenses for Copying & Summarizing Records	
	Cybersecurity	
§6	PATIENTS WITH DISABILITIES & PATIENTS WITH LIMITED ENGLISH PROFICIENCY (“LEP”)	27
	Disabilities – Title III of the American with Disabilities Act (ADA)	
	Limited English Proficiency – Title VI of the Civil Rights Act of 1964	
§7	ELECTRONIC DATA TRANSFER & TELEMEDICINE	29
	Telemedicine	
	Precautions in Faxing Medical Information	
	Security & Accuracy in Electronic Medicine	
	Minimizing Liability in Electronic Transfers	
	The Physician-Patient Relationship in E-Medicine	
§8	GUARDIANSHIP	32
§9	STARK LAW & RULES	33
	Federal Anti-Kickback Law	
	NYS Anti-Referral Law	
§10	PATIENTS IN NEED OF MENTAL HEALTH TREATMENT	35
	Patients in Need of Involuntary Psychiatric Treatment	
	Article 9.41 of the Mental Hygiene Law	
	Article 9.45 of the Mental Hygiene Law – When Persuasion Fails	
	Transfer from a Hospital Without Mental Health Facilities	
	Hospitals Having Mental Health Facilities	
	Patient Rights	
	Assisted Outpatient Treatment	

§11	RIGHT TO DIE / LIMITATION OF TREATMENT	37
	Do Not Resuscitate (DNR)	
	Do Not Intubate (DNI)	
	Advance Directives (Living Will / Health Care Proxy)	
	Ordinary & Extraordinary Measures to Prolong Life	
	Palliative Care / Comfort Care	
§12	WORKERS' COMPENSATION	39
§13	NO FAULT	41
	APPENDIX:	42
#1 -	Subpoena for Documents (Judicial Subpoena Duces Tenum)	
#2 -	Subpoena to Testify (Subpoena Ad Testificandum)	
#3 -	Model Agreement for Record Review & Testimony	
#4 -	OCA 960 (HIPAA Release of Medical Records)	
#5	NYSDOH Form 2557 (Release of HIV-Related Information)	

INTRODUCTION

Purpose: These Guidelines are intended to help physicians and their office personnel understand and operate within the legal parameters that apply to their practice. The guidelines herein reflect established ethical principles from our respective professions to which we all subscribe. The Guidelines were compiled by attorney and physician members of the Medical Society's Health Law Committee. They are intended to be gender neutral and have been prepared in loose leaf format to permit page updates.

Disclaimer: We ask that you treat this document as a general outline only and not as a comprehensive compilation of the subject. It covers broad generalizations, which should not be taken as specific legal advice for individual circumstances.

§1.0 PREAMBLE to the Guidelines

The Committee recommends physicians and attorneys discuss predictable issues in advance so as to anticipate a resolution before problems develop.

Among the key references used by our Committee in the preparation of this manual were: (1) The Canons of Ethics of the New York State Bar Association, (2) The Principles of Professional Conduct from the Medical Society of the State of New York, (3) Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association, (4) The American Medical Association and American Bar Association Statement on Inter-professional Relations for Physicians and Attorneys, (5) The Redbook of New York Civil Practice Law and Rules, and (6) The Health Insurance Portability and Accountability Act (HIPAA).

Questions should be directed to the offices of the Medical Society at (716) 852-1810. **Contact your personal attorney and malpractice carrier for specific advice.**

§2.0 SUMMONS, SUBPOENAS, AUDITS

As with any professionals working with complex issues, physicians are variously at risk for summonses, subpoenas, or audits. Their importance should be understood ahead of time so that they can be handled efficiently.

§2.1 Summons and Complaint

This document often signals the start of a malpractice suit where the physician may be the principle defendant. This by itself is no reason to panic, but it certainly requires that the physician immediately contact his malpractice insurance carrier, so that work can start on a defense strategy. It is also recommended that the physician **not** contact plaintiff's counsel prior to contacting the liability insurance carrier.

§2.2 Subpoenas

Subpoenas should not be confused with a Summons and Complaint. Unlike a Summons, a subpoena does not imply the initiation of a lawsuit against the addressee. The term simply means "a command to appear". The physician has a duty to respond and as the treating physician may have the duty to testify on behalf of the patient. A subpoena should be viewed as a request for pertinent medical records or factual testimony to explain to a jury the practical meaning of the patient's medical history.

§2.2.1 Types of Subpoena

The law recognizes two types of subpoenas: (1) a subpoena to testify ("Subpoena ad Testificandum") and (2) a subpoena to produce specified items or documents ("Duces Tecum"). (Appendix #1, #2). A party that wants a physician to both testify and to produce specified items or documents must explicitly state this in one subpoena or serve two subpoenas. **A physician that has been served with a subpoena should consult his attorney in a timely manner to obtain advice and guidance regarding compliance issues with this document.**

§2.2.2 Subpoena for Testimony

A subpoena to testify requires the attendance of a particular person to testify about the facts in a case. A stand-in substitute is not acceptable. Instructions usually come with the subpoena, giving the time and place for the appearance.

Assuming "reasonable notice" in advance, the individual named is expected to appear as specified or suffer legal consequences. It is good practice to call the issuing attorney to confirm the appearance details since subsequent rescheduling is common. However, it is important to confine such conversations to the details relating to the time and place of appearance.

When the time specified for a Court appearance creates an undue hardship for the physician, he should contact his attorney to work with the issuing attorney to negotiate a compromise. Subsequent continuation dates generally fall under the same subpoena and require the physician's attendance assuming reasonable notice.

§2.2.3 Subpoena for Documents

A second form of subpoena deals mainly with documents and records. This specifies the production of particular books, papers or other items pertinent to the case. Such document subpoenas can often be handled by a non-physician substitute who is capable of testifying to the origin purpose, and custody of the documents.

In other cases, a document subpoena may require not only the particular medical records but also the personal appearance of the physician who wrote those records. The physician may be needed to verify the authenticity of the documentation.

A subpoena for documents usually describes what items are needed, where they must be sent, and the date by which they must be received. The subpoenaed physician should contact his attorney if he is in doubt about the best way to comply with a subpoena.

§2.2.4 Sources of Subpoenas

Among the agents authorized to generate subpoenas are:

- a. A presiding judge;
- b. The Attorney General;
- c. The Clerk of the Court;
- d. The legal officer in an administrative proceeding;
- e. An arbitration referee;
- f. The designated officer of a board, commission, or committee established by law to make a judgment;
- g. Attorneys.

§2.2.5 What Can Be Obtained

A subpoena for documents in a medical case provides for the inspection, examination, and audit of specified medical records. The issuing party may have the right to obtain such materials under reasonable terms and conditions. The physician should bear in mind that certain medical records are accorded special protection. A subpoena may not be sufficient to release those records. **When in doubt, contact your malpractice carrier.**

§2.2.6 How Subpoenas are Served

According to New York statute, a subpoena for medical records should be served

no closer than three days before the time fixed for production unless otherwise ordered by the court. A subpoena for testimony theoretically carries a similar minimum interval prior to the scheduled appearance but in reality most attorneys give as much advance notice as possible to reduce disruptions.

A delivery person may serve a subpoena face-to-face, by registered mail, or by affixing the subpoena to the door of the person's last known address. The issuing party should try to notify the subpoenaed person, as a courtesy immediately upon learning that a court appearance is no longer required.

§2.2.7 Managing Documents in Subpoenas

Prior to sending any documents out, the physician should review all records in response to any request. Subpoenaed documents can be delivered any time before the day fixed for production. The individual receiving the subpoenaed documents should provide a written receipt confirming delivery. Documents should be delivered in a sealed package labeled with the title of the action, the date fixed for production, and the name and address of the requesting attorney. The best practice would be to deliver the documents directly to the Court.

§2.2.8 Covering Expenses for Subpoenas

The issuing party is expected to pay any witness testifying to the facts of a case, whether a physician or otherwise, a nominal one-day fee of \$15, currently set by the New York State statute. Travel expenses incurred outside the city are to be paid at a rate of \$0.23 per mile, also according to statute. Most authorities suggest physicians be compensated whenever they give testimony beyond simple fact. See Section 6.0 for additional discussion of physician compensation in legal proceedings.

With document subpoenas, the issuing party should pay for copying and mailing. The individual who receives the subpoenaed documents should provide a receipt on delivery. The issuing party then has the right to retain the delivered documents. New York State statute currently specifies 75 cents (\$.75) per page for copying medical documents. This fee does not apply to documents subpoenaed for trial where the Court often specifies originals.

The committee suggests that you contact the attorney to determine if an electronic copy of the records would be acceptable. If so, the maximum charge allowed is for production of the record only.

§2.2.8 Failure to Comply with a Subpoena

Failure to comply with a subpoena, whether issued by a judge, a court clerk, or an attorney functioning as a court officer, is considered contempt of Court. Even non-judicial subpoenas can be returned to a court to be so ruled. Punishment for contempt

includes a monetary penalty up to \$50.00 along with the payment of damages incurred by the involved parties when proceedings must be canceled because of the witness's failure to appear.

Being charged with contempt of court is a serious matter. In extreme cases an arrest warrant can be issued by the court against the recalcitrant witness. Although very unlikely to go to such lengths, the Court nevertheless has the authority to commit an **uncooperative** witness to jail until **there has been compliance with the subpoena.**

§2.3 Audits of the Medical Record

A demand to audit a physician's records may seem less serious than a subpoena but this can still involve severe consequences. Such requests are becoming more common.

The significance of an audit may not always be evident at the time of the audit request. **Contact your personal attorney for specific advice** to help plan a response.

§2.4 Department of Health – Requests for Information

Failure to comply with proper request for records is likely to be construed as misconduct. Such requests should not be taken lightly, and physicians should contact their personal attorney **prior to contacting any governmental entity concerning any inquires received.**

§2.5 County of Erie Health Department – Services for the Elderly

The County of Erie has the limited authority to review medical records to determine if a patient is subject to abuse and/or neglect. Since you are a mandated reporter, if you receive such a request, we suggest you **contact your personal attorney for specific advice.**

§3.0 TESTIMONY BY PHYSICIANS

When a physician is called to testify in Court, it may be as either a fact witness or to render an expert opinion. In either case, preparation is required, and the timing of the testimony should keep the disruption of patient care to a minimum. An appropriate compensation level should be negotiated in advance.

§3.1 Testimony Limited to Facts of the Case

The treating physician who has a therapeutic relationship with a patient thereby incurs the obligation to assist that patient with factual medical testimony in a Court proceeding. The patient's attorney can call the physician to testify about pertinent medical facts so a jury can better understand the case. Under these circumstances the physician is acting strictly as a "witness to fact". Where the case involves alleged malpractice committed by another healthcare provider, the physician should consider whether he may be implicated and **contact your personal attorney for specific advice**. This is different from being an expert witness. See 3.2

§3.2 Testimony to Render an Expert Opinion

A physician who need not be the treating physician may be asked to testify in order to provide an expert medical opinion. The physician being called to testify should immediately seek clarification from the requesting attorney about which witness role is expected. A physician is not required to prepare and deliver an expert opinion without appropriate compensation. See section 3.5 for details.

§3.3 Expectations for the Physician Witness

Any witness in a Court proceeding is expected to behave in a dignified and forthright manner while answering truthfully.

Physicians should also be knowledgeable in their subject area and be ready to describe the medical facts no matter whether they prove favorable or unfavorable to the involved parties.

§3.4 Arrangements for Medical Testimony

The physician called in to testify ought to be given as much advance notice as possible beyond the 3-day statutory minimum, so as to avoid having to inconvenience patients. The physician witness should in turn avoid rescheduling office patients or hospital procedures until the testimony date has been finalized.

In circumstances where the schedule remains a problem, the physician ought to call the requesting attorney immediately to consider an alternative appearance time outside the usual hours. If no mutually convenient time can be agreed upon,

consideration should be given to video testimony. The physician's testimony will proceed more effectively if the attorney or a representative meets the physician prior to testifying to discuss details and expectations about the case. However, a physician is not obligated to meet with the attorney prior to testimony.

This Committee recommends that the location and timing of the Court appearance be communicated more than once to avoid confusion. A telephone call on the day before testimony can often correct oversights. Look to the "Model Agreement for Records Review and Testimony" at the end of this manual (Appendix #3) for additional guidance in preparing for medical testimony.

§3.5 Compensation for Medical Testimony

A physician serving as a factual witness can expect to be paid only the usual statutory witness fee (\$15 attendance fee) and travel expenses. A physician acting as a fact witness may request a higher rate of reimbursement but if the request is refused, he is still obligated to testify.

When the physician serves as a medical expert to provide a medical opinion, it is customary for the requesting attorney to compensate the physician for expert testimony and its preparation. The level of compensation should be based on the physician's training and experience, the prevailing community consultative fees, the complexity of the medical issues involved, research and preparation time, and the time actually spent testifying.

Compensation should never be linked, or even give the appearance of linkage, to the outcome of the litigation. Depending on a prior agreement with the requesting attorney, the abrupt cancellation of the physician's expected testimony ought to be compensated at least partially because of the disruption it causes to the schedule of patient visits in the office.

§3.6 Compensation for Physicians

Physicians providing complex medical opinions to assist an attorney in the preparation of a legal case have the right to expect reasonable compensation for their time in preparing and testifying based on their usual hourly consultative fee. The final compensation to an expert witness also depends on the overall complexity of the case under review.

Beyond merely testifying during trial, physicians are entitled to compensation for time spent on record review, examinations, reports, telephone conferences, consultations, testing, rendering an expert opinion, and for usual travel expenses.

Fees should not be so low as to be punitive and discourage physicians from

participating in the litigation process, not should they be so high as to make it impossible for the plaintiff to afford an effective expert witness. Physicians and attorneys should discuss in advance anticipated compensation for the physician expert witness. The final agreement should be in writing if possible. Failing such prior agreement, the physician can use the court or personal counsel to negotiate compensation.

§3.7 Compensable Services Performed by Physicians

The following physician services are eligible for consideration in negotiations for fair compensation:

- a. Medical reports which provide not just medical facts but also complex opinions about the meaning of those facts;
- b. The physician's personal appearance for a pre-trial or telephone conference in preparation for a case where complex medical opinions were discussed;
- c. The physician's personal appearance in court to provide expert testimony beyond the simple verification of facts;
- d. Extraordinary clerical or administrative expenses incurred by the physician's office in preparation for an unusually complicated case;
- e. Lost office income when office visits must be abruptly cancelled to allow an urgent court appearance of the physician to render a complex medical opinion;
- f. Lost office income from an open office schedule created when the requesting attorney has abruptly canceled an expected physician Court appearance.

§3.8 Patient Resources to Cover Physician Services

The physician should understand that the patient is ultimately responsible for the expenses and compensation needed for witnesses to advance his case. When a physician serves merely as a fact witness, basic expenses are regulated by New York State statute. For a physician serving in an expert role, compensation comes out of the overall budget for the case, which has finite limits.

§3.9 Attorney Resources to Cover Physician Services

There are relatively rare circumstances in which the requesting attorney carries the responsibility for certain types of physician compensation. For example, the requesting attorney may negotiate in advance the payment of extra expenses incurred when the testifying physician finds it necessary to retain an additional outside consultant to round out legal arguments.

§3.10 Keeping Physician Fees Independent of Case Outcome

Attorneys are accustomed to contingency arrangements in which their

compensation is dependent upon the success of their efforts to help their clients. Physicians cannot accept contingency arrangements and still remain objective in their opinions about the diagnosis and treatment in a particular case.

Specific fee arrangements can be negotiated between the physician and the attorney, but in no instance should the physician's compensation depend on the value of the award the patient received on settling the case.

Even a suggestion of a link between the physician's level of compensation and the success of a recovery action must be avoided. The physician should be paid for his preparation time and effort, not for the particular medical opinion rendered.

§3.11 Establishing the Level of Compensation

When the physician renders a complex medical opinion in a summary medical report or in direct Court testimony, his services should be compensated at the usual and customary rate for such specialized medical consultations.

Fees, which appear distinctly above the customary charge, are likely to lead to dissatisfaction or disagreement between the professionals involved. The final compensation to the physician must be mitigated by the overall complexity of the case.

§3.12 Dispute Resolution for Physicians and Attorneys

Despite our best efforts to avoid them, misunderstanding and disputes between professionals can still occur. Such problems should be handled in a dignified and orderly fashion. A calm but candid discussion on neutral ground between the protagonists can often stimulate a compromise. Failing that, negotiators experienced with the particular issue at hand can sometimes fashion a settlement. The Court can sometimes be helpful in providing a satisfactory compromise.

If the dispute continues unresolved, the opposing parties should appeal to their professional organizations, attorneys to the Bar Association of Erie County, and physicians to the Board of the Erie County Medical Society. In difficult cases, the matter can be brought to the Medical Society's Health Law Committee, which has an equal representation of attorneys and physicians. Recommendations from professional organizations are considered advisory only and cannot be legally binding.

§4.0 CONFIDENTIALITY

Various medical, legal, and consumer authorities agree that information acquired from the patient by a physician in the course of treatment must remain confidential within defined legal constraints. The United States Constitution, New York State law, the Principles of Medical Ethics of the American Medical Association, and the doctor-patient contract all specify such confidentiality.

The patient is guaranteed the right to privacy which extends to his entire medical record. This rule of confidentiality extends beyond the written word to the spoken word as well, making it an ethical breach for a physician to discuss a patient's medical history in public either intentionally or inadvertently. Federal legislation known as HIPAA (Health Insurance Portability and Accountability Act) extends medical confidentiality to health information in any communication form, whether written, oral, or electronic.

Other laws impose additional restrictions on the disclosure of medical information therefore, it is important that you consult your liability carrier or your personal attorney.

§4.1 Confidentiality for Office Personnel

As with the medical malpractice rule of "captain-of-the-ship", any breakdown in medical record security, no matter what the cause might be, falls ultimately under the responsibility of the attending physician. The physician bears the full weight of responsibility for insuring that everything and everyone working in a medical office meets standards of patient confidentiality. Discretion in speaking or behavior should be modeled, so as to avoid causing any offense or revealing private information.

A good motto for medical office staff would be: "What you learn here stays here." The physical configuration of office workspaces may have to be modified to keep patients and visitors from overhearing sensitive conversations between staff members or on the phone, or from having the ability to observe inappropriate medical records. Medical record files and computerized databases must be locked to all but specifically authorized staff members. Even patient financial information must remain in confidence.

New office staff members should be thoroughly educated about patient confidentiality and should sign an agreement indicating their understanding and willingness to follow privacy rules. Current staff members should be reminded at intervals about their responsibility to protect medical information. Staff members should avoid casual public conversations about the medical problems of their patients anywhere outside the office so bystanders will not be tempted to overhear sensitive details. It is advisable to provide educational training sessions to staff members on the importance of maintaining confidentiality, document staff attendance at these sessions, and maintain that documentation.

Confidentiality must extend to vendors, subcontractors, students, or interns who might visit the office environment. Drug vendors should not be given information about medication used by specific patients. Use of a business associate agreement is advisable and may be mandatory depending on the nature of the vendor's access to patient information.

Any clinical research protocols underway in the office must specifically address privacy.

§4.2 Privacy Limits in Patient Confidentiality

The patient's right to medical confidentiality is by no means absolute. Patients themselves may waive confidentiality by authorizing the release of their medical information to a party they designate. Release is also implied when the patient or the physician requests a specialty consultation outside the immediate coverage group.

Medical information can and should be released in an emergency situation when the patient's welfare might hang in the balance. Physicians need to be aware of HIPAA laws, as well as be mindful of a patient's medical needs. Physicians are also reminded that the law mandates the reporting of suspected abuse.

In certain non-medical circumstances, the law will yield to competing interests and allow access to a patient's medical information even without prior patient authorization.

§4.3 Release of Medical Information by State Mandate

Certain New York State laws mandate the release of medical information even without the patient's prior approval when the interests of the general community take precedence. The regular disclosure of medical information to public health agencies has become an essential part of contemporary health care practice and should not be considered an invasion of patient privacy.

The following are reasons for physician disclosure of medical information to State agencies without prior patient authorization:

- a. To the individual who is the subject of the information
- b. For treatment, payment and health care operations,
- c. To another covered entity involved with the treating the patient (e.g. the referring physician),
- d. For legally authorized health oversight activities, such as audits and investigations (e.g. the government agency which licenses the provider),
- e. Where required by law, including statute or order signed by a Court),
- f. Injuries resulting from child abuse, neglect, or domestic violence to the appropriate public health authority or social services agency,

- g. When an individual is incapacitated or in an emergency, and it is in the best interests of the patient, as determined by the health care provider in the exercise of clinical judgment. The PHI that may be disclosed under this provision includes the patient's name, location in a health care provider's facility, and limited and general information regarding the person's condition.
- h. To law enforcement when:
 - i. Required by law, or pursuant to a Court order, subpoena or an "administrative request", such as a subpoena or summons. The information sought must be relevant and limited to the inquiry.
 - ii. To identify or locate a suspect, fugitive, material witness or missing person.
 - iii. In response to law enforcement about criminal conduct on the premises of a HIPAA covered entity.
 - iv. Where necessary to prevent or lessen a serious and imminent physical threat to a person, or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat).
 - v. To certain governmental programs providing public benefits or for enrollment in a government benefit program if the sharing of information is required or expressly authorized by statute or regulation, or other limited circumstances.
 - vi. To a public health authority (e.g.- State and local health departments, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), the Occupational Safety and Health Administration (OSHA) to carry out public health interventions where a person who is at risk of contracting or spreading a disease or condition.
 - vii. Uses and disclosures with the individual present. If the individual is present for, or otherwise available prior to, a use or disclosure permitted in this section and has the capacity to make health care decisions, the covered entity may use or disclose the protected health information if it:
 - a. Obtains the individual's agreement,
 - b. Provides the individual with the opportunity to object to the disclosure, and the individual does not express an objection; or
 - c. Reasonably infers from the circumstances, based on the exercise of professional judgement, that the individual does not object to the disclosure.

§4.4 Penalties for Breaches of Confidentiality

Practitioners who fail to adhere to the principle of medical confidentiality are subject to discipline for professional misconduct through monetary fines, public

reprimand, license suspension, or in extreme cases, license revocation. Besides such professional actions, a physician may face HIPAA imposed civil penalties per violation.

There are also federal criminal penalties for health care providers or other covered entities who disclose or obtain patient medical information under false pretenses. When inappropriate monetary gain or malicious intent are involved, substantial financial fines can be imposed as well as time in prison.

§4.5 Disclosure Pursuant to Authorization

HIPAA and New York State laws have various requirements for the disclosure of Protected Health Information (PHI) pursuant to an authorization. It is advisable to use the form created by the New York State's Office of Court Administration (OCA 960), included as Appendix #4. Any authorization form must be complete, and disclosure must be made in accordance with any restrictions or limitations noted on the authorization.

§5.0 The Medical Record

Medical Records contain sensitive and personal information, the privacy of which should be carefully safeguarded. Confidentiality of patients' medical information has always been an important principle in medicine. On April 14, 2003, the Privacy Regulations under the Health Insurance Portability and Accountability Act (HIPAA) took effect. These new Federal standards provide patients with increased access to their medical records and more control over how their protected health information is used as disclosed. Physicians must now comply with HIPAA as well as New York State law regarding when and how medical records may be released.

§5.1 Documentation and Patient Rights

Physicians and their office staff are required to be diligent in maintaining an accurate record while complying with the guidelines set forth by HIPAA.

§5.1.1 Documentation in the Medical Record

Accurate and detailed documentation at all stages in the production of the medical record is necessary for the medical practice to provide optimal care to their patients while protecting themselves from any allegations which may occur in the course of caring for patients. All entries must be accurately identified as to the patient, the treating physician, the location, and the date of service. Attention must be given that each page of the record is marked accordingly. In more acute settings as in the hospital, the time of day should also be indicated for each entry.

However, it may become critical at some point to have the time of day indicated when documenting telephone communications with both patients and other physicians or facilities regarding patients. Attention should be given to this matter in whatever system is utilized for documenting messages.

The physician's signature on a medical record entry should be recognizable, handwritten in black ink, never printed or stamped, with a date and time written in the same hand, including an Electronic Medical Record (EMR) signature. This Committee remind physicians emphatically that a completed medical record entry should never be altered at a later date for any reason. If an inaccuracy in the old record must be set right, a clearly dated and signed addendum can be added later, however, the sooner the better.

§ 5.1.2 Amendment or Modification of a Medical Record

It is best that a record, including an EMR, be completed contemporaneously with

treatment and exam. If you feel the record needs to be changed or amended, the following procedure should be followed:

- a. Do not erase or white out,
- b. Do it as soon as possible, preferably before the next visit or entry in the chart,
- c. Put a line through the entry to be changed. Write "ERROR" and the date that the change is made. If additional entries are made, put a date on each entry and initial it.

Recognize that a patient has the right to review the record, and with limitations to amend or correct a record. Under HIPAA, a patient has the right to request that a provider amend his or her medical record. Under New York law, the patient has the right to write a short statement to be included in the medical record. The patient does not have the right under either law to have information removed from the record. Do not let the patient alter your existing record.

Think about why you are making a change. Does it relate to patient care to are you "reacting" to some person or circumstance that would be more appropriate to document elsewhere. Be careful because some paper acts like carbon paper, and the result in a note or notes can appear on other documents inadvertently.

§5.1.3 Retention of a Patient's Medical Record

Most medical authorities and agencies, including various medical malpractice carriers, recommend that physicians retain their patient records for at least 10 years after payment is received for the last treatment encounter. It should be noted that obstetrical records and records of minor patients must be retained for at least 6 years, and until one year after the minor patient reaches the age of 21.

For this purpose, retention is important for both living and deceased patients. Representatives of a deceased physician should also be aware of this. Keeping patient records intact is also very important for tax purposed and for fraud and abuse audits. Physicians planning retirement in the near future should consider turning over their patient records to a commercial security agency for safekeeping until the 10 year retention interval has lapsed.

In addition to providing critical information for future patient care, your medical record is a shield in a malpractice claim against you.

§5.1.3a Disposal of a Patient's Medical Record

New York General Business Law § 399-h establishes guidelines for the disposal of records containing personal identifying information. "Personal Identifying Information" includes:

- a. A social security number,

- b. A driver's license number or a non-driver's identification card number,
- c. Mother's maiden name,
- d. Any financial services account number or code,
- e. Any savings/checking account number or code, or
- f. Any electronic serial number.

Records that may contain this information include papers, designs, drawings, Maps, photos, letters, must be:

- a. Destroyed by shredding, destroying, or making records unreadable,
- b. Have eliminated the personal identifying information on the document, or
- c. Have implemented the accepted industry practice that the company believes will ensure protection of personal identifying information.

The New York State Attorney General has enforcement powers for this law. As such the Attorney General may seek an injunction from a court without providing proof that any person has in fact been injured or damaged by violation of this law. The Court can impose a civil penalty of up to \$5,000.00 (five thousand dollars) for a single violation. Acts arising out of the same incident constitute a single violation.

§5.1.4 Patients' Rights Regarding Their Medical Record

HIPAA and New York State Law generally give patients the right to:

- a. Inspect and obtain a copy of their protected health information;
- b. Control, with certain limitations, the release of their protected health information through authorization;
- b. Request an "accounting of disclosures"- that is, a list describing with whom and why their protected health information has been shared.

This list does not need to include disclosures made pursuant to a patient's authorization.

There are other exceptions as well, and include:

- a. A request to add an addendum, or to amend their medical record, which in certain instances the physician may deny,
- b. Request restrictions on certain uses or disclosure of their protected health information,
- c. Receive a copy of the physician's practice's "Notice of Privacy Practices".

Protected health information should not be used for research or marketing purposes especially when economic gain is involved, without first obtaining the express written consent of the patient.

§5.1.5 Patient Authorization for Record Release

New York State Public Health Law requires that physicians release a copy of a

patient's medical record to a "qualified person" upon receiving a written request. Qualified persons include:

- a. a competent adult patient, legal representatives of an incapacitated patient,
- b. a parent or guardian of a minor patient, or
- c. an attorney representing the patient in a Court action, or
- d. a distributee of any deceased subject for whom no personal representative, as defined in the New York State Estates, Powers and Trusts Law, has been appointed; or
- e. an attorney representing a qualified person or the subject's estate who hold 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.

HIPAA has established authorization requirements that must be followed to allow the release of a patient's information. Core elements of a HIPAA compliant authorization include:

- a. Description of PHI ("Protected Health Information") to be used or disclosed;
- b. The name(s) or other specific identification of the person(s) or class of persons who may use the PHI or to whom the covered entity may make the requested disclosure;
- c. Authorization expiration date or event that relates to the individual or to the purpose of the disclosure;
- d. Signature of the individual and date. If the authorization is signed by an individual's personal representative, a description of the representative's authority to act for the individual and copies of the documents giving that person authority if appropriate;

The authorization should clearly note:

- a. That the individual has a right to revoke his authorization in writing,
- b. The covered entity's ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the Authorization, and
- d. The potential for the PHI to be re-disclosed by the recipient and no longer protected by the Privacy Rule;

A copy of the Department of Health ("DOH") Form Number 2557 which complies with HIPAA can be found as Appendix #5. This Committee recommends that each practice make copies of this Authorization, available.

§5.1.6 Documenting the Release of a Medical Record

The requirements of HIPAA demand that physicians obtain written authorization from their patients or from the patient's legal representative prior to release for most

purposes other than treatment, payment, or health care operations.

Furthermore, HIPAA requires the physician to give a patient or a patient's representative an accounting of certain disclosures, so the practice must document all disclosures by use of an "audit trail".

§5.1.7 Discharging a Patient from a Physician's Practice

When a physician releases a patient from his practice, the following considerations should come into play:

- a. The patient should be given fair warning to allow ample opportunity to make alternative plans, typically a minimum 30-day notice according to most authorities;
- b. If an agent (sometimes referred to as a proxy) has been named for the patient, notice should be sent to the agent as well to avoid later confusion;
- c. The physician should, but is not obligated to, provide an explanation for severing the therapeutic relationship;
- d. The patient should be advised to contact their medical insurance company for the names of other available physicians with similar credentials or be made aware that the Medical Society offers a listing (identified as "Find a Physician") on its website www.wnydocs.org.

§5.2 Disclosure of Data Between Medical Colleagues

Protected health information can be exchanged freely between medical professionals for the purpose of medical diagnosis, treatment, payment, or quality control.

All patients should receive a copy of the Notice of Privacy Practices from their medical professional or their medical group practice.

§5.2.1 Precautions When Releasing Medical Data

The freedom to release protected health information is largely controlled by the authorization provided by the patient and dictated by the mandates of HIPAA and New York State Public Health Law as described above in § 5.1.4 and §5.1.5.

In addition, physician practices can take steps to ensure that their practices comply with the regulations without the expense of adding any new technology to their office by observing the following:

- a. The standards of medical confidentiality apply equally to private and public sector entities;
- b. The practice must remain open to external review of its confidentiality policies and procedures;
- c. Subcontractors working with the practice must adhere to the same confidentiality and privacy rules as applied to the practice;
- d. Appoint a HIPAA Privacy Officer who is versed in the privacy and

security laws to provide initial and yearly training to staff and physicians who will ensure that the practice complies with all HIPAA laws and regulations.

§5.3 Medical Records and Professional Misconduct

The New York State Board of Regents in its capacity as regulator of licensed professionals in the State has included in its definition of professional misconduct a physician's failure, upon receipt of a written request, to make available to the patient the patient's medical records and copies of the medical record, and copies of the reports, test records, evaluations, or x-rays relating to the patient which are in the possession of the physician.

In addition, misconduct is assumed if the physician makes record release contingent upon payment by the patient for medical services previously performed. The Board says that payment for professional services to which such records relate may not be required as a condition for releasing medical records.

The Office of Professional Medical Conduct (OPMC) will vigorously discipline physicians who violate these rules. In extreme circumstances, this agency has the power to summarily suspend a physician's license even before a full hearing has taken place. Thus, this committee strongly recommends that patient medical records requests be taken very seriously, and that the physician personally monitor the timeliness of such response whenever it has been delegated.

The OPMC continuously oversees appeals from patients who feel they have been denied access to their medical records. These requests often exceed 100 calls per week, 20% of which are from persons who are unable to obtain records from medical offices that have been permanently closed. The OPMC will assist patients in locating such lost medical records. The rest of the calls to the OPMC under this heading deal with misunderstandings about the rules pertaining to medical record access and release.

§5.4 General Limits to Medical Record Release

Physicians in doubt about the propriety of releasing their patient's records should withhold such records until they have assured themselves that release is proper. It may be necessary for the physician to contact a medical malpractice carrier or **your personal attorney for specific legal advice** on how best to proceed. A compromise may have to be fashioned to allow the requesting party limited access to necessary data.

The practitioner should not disclose confidential information in a Court proceeding unless the patient explicitly waives his privacy privilege, or unless the patient puts his medical status into issue as with a malpractice action or with a personal injury claim. A Court may be required to weigh the value of breaking medical confidentiality against the potential injustice created by withholding such information from the

proceedings.

§5.4.1 Denying Access

In certain cases, a physician may deny access to all or part of a patient's medical record, providing instead only a generalized summary, if in the physician's opinion, full disclosure could reasonably be expected to harm the patient or other people involved in the case, thereby superseding the right of access.

§5.4.2 Discretionary Release of Protected Health Information by the Physician

In certain unique instances the physician is allowed to exercise professional discretion to disclose protected health information if withholding such information would constitute a clear and imminent danger to the patient, the patient's family, or to any other involved person. This prerogative is particularly important for psychiatrists who may be caring for patients with serious mental disorders that could lead potentially to suicide or physical assaults.

The practitioner making such a judgment must be prepared to defend the decision. Although the responsibility for releasing medical information rests solely with the attending physician, the wise professional will **consult your personal attorney for specific advice** before taking such unusual action. In some cases, a compromise may have to be fashioned by the Court official.

§5.4.3 Releasing Protected Health Information to a Malpractice Carrier

Under the HIPAA Privacy Rule, covered health care providers are permitted to make disclosure of protected health information without patient authorization if the disclosure is for "health care operations" purposes. The definition of "health care operations" in the Rule includes "business management and general administrative activities." According to information provided by Health and Human Services, disclosures by a covered provider to a professional liability carrier for the purpose of obtaining or maintaining medical liability coverage, including the reporting of adverse events, fall under the category of "business management and general administrative activities." Therefore, to conduct the operation of their medical practice physicians may make disclosures of protected health information to their malpractice or professional liability carrier without patient authorization.

§5.5.1 Minors' Medical Records

Patients who are minors represent a special category of medical confidentiality. A parent or guardian can sign a general authorization for the release of the medical records of their child, but this does not automatically give the parent or guardian access to all information. Patients over the age of 12 have the right to ask physicians treating them to withhold medical information they consider private no matter who might be requesting such information, even the patient's parents or guardians. The physician may

or may not agree to the request, except a physician is prohibited from disclosing a minor's sexual history, contraception and abortion history, or other especially sensitive medical information without permission. The physician has the responsibility to withhold medical information which, if released to the requesting party, would be detrimental to the patient's health and welfare, to the physician's ability to continue treatment, or to a continuing healthy relationship between the minor patient and his parents or guardians. The physician has an equally heavy responsibility on the other hand, to release medical information about a young patient even against the patient's wishes if withholding such data would likely be detrimental to the young patient's ultimate welfare. In complex cases, the court may have to assist the patient, the physician, and the requesting party to arrive at a compromise, which is equally balanced for all the involved interests. If the physician believes that he is presented with such a situation, the physician should **consult your personal attorney for specific advice.**

The non-custodial parent or guardian of a divorced or separated couple still retains the right to inspect and understand the medical data pertaining to their child, as long as basic parental visitation rights have not been blocked by the Court. The physician may still prevent the release of a minor's medical record to either or both requesting parents or guardians if in the physician's considered opinion, medical information release would likely result in detrimental effect on the child's general welfare.

The treating physician is not obliged to keep the non-custodial parent or guardian continuously informed of on-going medical developments unless the parent or guardian specifically requests such updates.

Custodial v. Non-Custodial Rights to Records – this area is extremely fact sensitive; please **consult your personal attorney for specific advice.**

§5.5.2 HIV and AIDS Record Authorization

HIV and AIDS information should be released if indicated on the HIPAA compliant authorization provided by the patient. It is not enough for the practitioner to withhold or redact only that portion of the medical record dealing with AIDS, because the patient might still claim that unauthorized disclosure occurred through selective non-disclosure.

The Committee recommends that HIV and AIDS information be kept on a separate page in the medical record and released only with a properly signed New York State Department of Health Form #2557 or Office of Court Administration (“OCA”) Form 960, with the appropriate HIV section properly completed. In the absence of a specific release, Public Health Law Article 27-F and the Department of Health Regulations allow disclosure of only an anonymous tabulation of AIDS data and only under defined circumstances.

§5.5.3 Genetic Information Release Authorization

Physicians should obtain a compliant authorization from their patients before they release confidential genetic information under most circumstances.

§5.5.4 Special Protection for Psychotherapy Records

In most instances, psychotherapy notes used exclusively by a psychotherapist are held to a higher standard of protection under New York State law. They are not considered part of the usual medical record. It is assumed the patient never intended these records to be shared with anyone else. These records should be filed separately and guarded from unauthorized inspection. Only the patient's written permission on a HIPAA compliant authorization or a specific Court order would allow release from the therapist's control.

§5.6 Preparing and Delivering Medical Records

The physician, through his trained medical staff or a medical record service should attend to the following details in preparing and delivering the requested medical records:

- a. Be sure a written authorization by the patient or his legal representative has been received before proceeding;
- b. The physician ought to respond within 10-14 business days from receipt of a written authorization for record release;
- c. Photocopies of the record should be as clear as possible;
- d. In particular, signatures and initials should be legible;
- e. The treating physician must certify that the copies are exact;
- f. Be sure all requested documents are finally included;
- g. Number each page and add the patient's name to the top of the page
- h. Indicate the total number of pages on the outside;
- i. Release original records **only under specific Court order;**
- j. Keep a detailed contents list of the original record;
- k. Use only hand delivery for original medical records;
- l. Get a written receipt on delivery of the documents.

§5.7 Medical Report Preparation

There are occasions when a requesting attorney requires a written report summarizing pertinent aspects of the medical history rather than asking for the original records.

The attorney's letter requesting a medical report from the attending physician or

consultant should be concise. A summary of the medical facts in the case should be included to the extent known by the requesting attorney. The attorney should specify important medical issues to be addressed in the report.

§5.7.2 Identifying Data in a Medical Report

The physician's medical report in response to an attorney's request should include basic identification and demographics:

- a. The patient's name, date of birth, and age.
- b. The dates of hospitalization or out-patient contact.
- c. The date of hospital discharge or last office visit.
- d. Where an interview and examination took place, if any.
- e. Who was present during the interview and examination.
- f. The patient's condition at the last physician encounters.
- g. Interim developments since the last exam if known.

§5.7.3 Clinical Data Format for Medical Reports

The physician should also include in a medical report all relevant history, physical, and laboratory data:

- a. An accurate summary of the patient's chief symptoms;
- b. The events leading to the patient's injury or illness;
- c. Pertinent details of the general medical history;
- d. A summary of related previous treatments, if any;
- e. A summary of the physical examination of the patient;
- f. Any unusual or special procedures used during the examination;
- g. A summary of pertinent laboratory test results.

§5.7.4 Interpretive Statements in Medical Reports

Depending on the specific issues raised by the requesting attorney, the medical report may include any or all, of the following summary or interpretive statements:

- a. The physician's initial and final diagnostic impressions.
- b. An estimate of the subjectivity of the patient's symptoms.
- c. An effort to define the cause of the patient's problems.
- d. An estimate of the patient's expected medical prognosis.
- e. The degree of physical disability and its likely duration.
- f. Expected limitations for the patient's future employment.
- g. Physical limitations expected for usual daily activities.
- h. Recommendations for any additional helpful treatments.
- i. Any other unique and pertinent aspects of the case.

§5.8 Expenses for Copying and Summarizing Records

The following are considerations for compensation to physicians in preparing medical record copies and summary reports:

- a. To avoid subsequent misunderstandings or disputes, compensation should generally be negotiated well in advance of starting a medical summary project.
- b. The maximum for photocopying medical records as set by the New York State Department of Health is 75 cents (\$.75) per page. When an electronic copy is acceptable, the maximum allowable charge is for the production of the copy only.
- c. New York State Health Laws do not allow a physician to bill for search and retrieval expenses related to medical records.
- d. Such fees do not apply for items replicated by other than photocopying as with x-rays or computer data disks, but these must not be charged at more than their actual cost.
- e. A patient's inability to pay for photocopying or a past due account with the physician can never be sufficient reasons for withholding the patient's data.
- f. The physician should expect payment for preparing a medical summary report based on the typical community standards for his specialty consultative fees.
- g. An associated Court appearance should be compensated based on typical community fees, the complexity of the case, and the actual time spent on the witness stand.

§5.9 Cybersecurity

Medical practices that store or transfer protected health information (“PHI”) electronically must comply with the Security Standards for the Protection of Electronic Protected Health Information (HIPAA Security Rule), which is a national set of security standards for protecting health information that is held or transferred in electronic form. The Security Rule protects all individually identifiable health information that a medical practice creates, receives, maintains or transmits in electronic form. The Security Rule calls this information “electronic protected health information” (e-PHI).

As a general summary, the Security Rule requires that medical practices:

- a. Ensure the confidentiality, integrity, and availability of all e-PHI they create, receive, maintain or transmit;
- b. Identify and protect against reasonably anticipated threats to the Security or integrity of the information;
- c. Protect against reasonably anticipated, impermissible uses or Disclosures; and
- d. Ensure compliance by staff.

To achieve these goals, a practice needs to regularly perform an analysis of its security risks, and then implement administrative, physical, and technical safeguards to respond to the identified risks. The practice must also document its security policies and procedures. More details on these requirements are available at <https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html>. It may be advisable to consult with an IT security/compliance professional for assistance.

Practices should develop a culture of IT security, which includes, but is not limited to:

- a. Regular staff training on IT security.
- b. Use of strong passwords that are frequently changed.
- c. Transmitting e-PHI only on approved and properly encrypted devices.
- d. Limiting each employee's access to patient information to the extent necessary to perform job duties **which are reviewed regularly.**
- e. Have strong data backup practices and a disaster recovery plan.
- f. Install and maintain anti-virus software.
- g. Use of a firewall to protect against intrusions.
- h. Limiting and securing physical access to devices, servers, and other machines where e-PHI is stored.
- i. Having policies and procedures developed to address physical, administrative and technical controls.
- j. Third-party vendor management.
- k. Regulator risk adjustment.

Devoting time and resources to IT security in addition to being mandated by HIPAA, is necessary to prevent data breaches and cybercrime. Medical practices are targets for cybercriminals. If there is a data breach or other cyber-attack, it can lead to an investigation by the Office of Civil Rights (OCR), and if a practice is found to be in violation of HIPAA, the practice may be fined. Further, timely notification of patients affected by a breach and government agencies is required by both Federal law (HITECH amendment to HIPAA) and New York State law (NY General Business Law §899-aa) and potentially under other laws and regulations. Establishing a culture of cyber security in accordance with the security practices required by the HIPAA Security Rule can help prevent cybercrime. In the event of a data breach or cybercrime incident, physicians are to consult with an attorney experienced in these issues immediately for specific legal advice.

The purchase of cyber insurance is also recommended. Cyber insurance can cover among other items, attorneys' fees incurred if there is a government investigation, certain IT costs, the costs of notifying patients who are affected by a data breach, and other monetary losses from cybercrime.

If you have any questions about cybersecurity threats, contact a cybersecurity expert, attorney and cyber-insurance carrier.

§6.0 Patients with Disabilities & Patients with Limited English Proficiency (“LEP”)

In some instances, physicians have a legal obligation to provide reasonable accommodations in order to ensure that patients with disabilities and/or patients with limited language proficiency (“LEP”) have legal access to medical professionals and to medical care. **Given that it can be challenging for practitioners to determine their legal responsibilities to their patients with special needs, physicians are encouraged to speak with their attorney regarding specific issues that arise in their clinical practice.**

§6.1 Disabilities – Title III of the Americans with Disabilities Act (ADA)

Title III of the ADA protects disabled persons from discrimination and assures them access to places of public accommodation. Places of Public Accommodation include hospitals, clinics and physician offices. Disabled persons include those who are speech or hearing impaired. The need for clear communication between physician and patient applies to all patients but the ADA imposes statutory requirement with respect to the disabled. Meeting these requirements often requires “auxiliary aides and services” which may include special interpreters. Neither the patient nor the patient’s insurer may be charged for such services but under some circumstances the cost may qualify for an income tax deduction.

If a physician has frequent contact with persons who are sight or hearing impaired, it can be cost effective to have some routinely used documents prepared in Braille and available, or to have interpreters readily accessible. The law gives physicians with infrequent contact the opportunity to show that costly accommodation would be an undue burden on their practices. Less costly accommodation for the hearing impaired may be found through telephonic service companies which, for example, in New York State provide a Telecommunications Relay Service for voice or text communications. The company may offer other alternatives as well. As with any statutory obligation, the cost of compliance should be measured against the cost of defending against a charge of non-compliance. The potential for malpractice liability exists where means to ensure the sight or hearing-impaired patient’s understanding of instructions are not employed.

§6.2 Limited English Proficiency – Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Acts of 1964 prohibits entities that receive Federal

financial assistance, directly or indirectly, from discriminating against any individual on the basis of race, color, or national origin. This Law requires physicians who participate in Federal healthcare programs to ensure that persons of Limited English Proficiency (LEP) can meaningfully access the physicians' services. The most important step in meeting this obligation is for a physician to provide the language assistance necessary to ensure effective communication between the physician and the LEP person at no cost to the LEP person.

The type and extent of assistance that a physician must offer depends upon many factors, including the physician's resources and the size of a particular LEP population with the physician's treatment area. Acceptable methods of facilitating communication include hiring bilingual staff or formally engaging interpreters (in person or via telephone services). The Federal government has specifically advised that a physician may expose himself to liability under Title VI of the Civil Rights Act if the physician uses friends or family members as interpreters, because this could compromise the effectiveness of the service and violate the LEP person's confidentiality. If an LEP person refuses or declines the right to utilize free interpreter services, a physician should document the refusal in the LEP person's chart. Even if an LEP person insists on using a friend or family member as an interpreter, the physician should suggest that a trained interpreter participate in the conversation to ensure accurate interpretation. Additionally, a physician participating in Federal healthcare programs must translate written materials that the physician ordinarily distributes to the public into languages of LEP persons that make up a significant proportion of the population served by the physician. There is significant guidance on LEP issues at www.hhs.gov/ocr/lep.

§ 7.0 ELECTRONIC DATA TRANSFER & TELEMEDICINE

Technology is rapidly changing allowing physicians to deliver services at a distance using remote computer and video transmissions.

§7.1 Telemedicine

Telemedicine is the practice of medicine via electronic communications such as video conferencing and e-mail. Features unique to telemedicine include:

- a. The geographic separation of provider(s) and patients,
- b. The use of technology to accumulate, save and disseminate information, and
- c. The utilization of interactive technologies to evaluate, diagnose, and/or treat the patient.

Advances in technology have the potential for improving patient care and patient access to care. However, physicians should remember that professional standards remain the same, regardless of whether the patient is seen through electronic communications or in their offices. Generally, New York State laws that govern the practice of medicine apply within the context of telemedicine and include issues such as the standard of care, licensure to practice medicine, availability of care, and confidentiality.

§7.2 Precautions in Faxing Medical Information

Physicians often underestimate the privacy issues related to the common practice of faxing medical information. Although very convenient, fax communications may not be secure. Just the fact that the fax machine is typically located in an open central meeting point in the office makes it easy for prying eyes to read sensitive documents. Human error inevitably results in occasionally sending a fax to the wrong destination, sometimes without the sending office being aware if there is no callback verification. Fax transfers can be intercepted and read by hackers.

Physicians can improve office fax security with prior planning. Unless there is a critical need, extremely sensitive medical material ought not to be faxed at all but rather sent by protected mail or courier. The fax machine should be positioned in a protected corner and put under the exclusive control of a fax management person. Make sure your fax machine automatically prints a verification number upon completion of the transfer and that you use a detailed cover page which includes not only the usual office identification data but also bold warnings to call back immediately if a document is received in error.

§7.3 Security and Accuracy in Electronic Medicine

Security and accuracy in E-medicine cannot be guaranteed. Technology offers no assurance of complete security. Otherwise effective electronic medical services can be disrupted by hidden software and hardware deficiencies over which the physician has no control. Suboptimal data resolution associated with an inadequate communication bandwidth can hamper the physician's ability to deliver a high-quality consultation.

Breaches in the confidentiality of medical data can occur when it must be routed through intermediary vendors or consultants.

Authorities at the distant communication site may not recognize a physician's professional credentials. Technical and physician expenses may go unpaid because of a lack of prior negotiation and planning for reimbursement.

§7.4 Minimizing Liability in Electronic Transfers

Physicians should select software and hardware already proven successful in the wider marketplace, thoroughly evaluated in medical situations, simple and straightforward in design and objectives, and easy to maintain and modify. The use of novel E-medicine technologies should be limited to those areas where there is a demonstrated need for remote medical services such as in rural communities or developing countries.

The anticipated technical and professional expenses for such services should be negotiated in advance, using perhaps a research grant or a capitated insurance contract whenever the usual reimbursement resources are lacking. Local **licensing** and **credentialing** for a physician involved in E-medicine services should be arranged in detail before going live.

Substantial planning should be devoted to security so that even routine medical data is protected by passwords and coding to the highest practical level. Physicians should strive for an even greater level of record documentation in E-medicine endeavors than they would use in face-to-face encounters.

Physicians should warn their patients in advance about potential privacy issues in the use of a particular E-medicine service. Patients should be told in advance about how their electronic messages will be handled and by whom. They should be told where their messages and answers are to be stored, and what the expected turnaround time should be for such exchanges. Both parties should be able to track who has read their messages.

Limits ought to be set at the outset to control the complexity of medical transactions in a particular electronic format. Physicians should avoid establishing a

true physician-patient contract during electronic communications without a clear definition of the continuing responsibilities of both parties. A formal written patient consent for participation in electronic transfers may be necessary. This would outline the rules for patient and doctor interaction.

§7.5 The Physician-Patient Relationship in E-Medicine

Physician must realize that a doctor-patient relationship is generally assumed to be present for most electronic communications involving medical advice. For the doctor-patient relationship to form, the physician must evaluate the patient in some way, but this can happen merely in an electronic conversation without the need for a physical examination.

Once such a therapeutic relationship has been formed, the physician is bound by oath to provide advice and assistance to his patient consistent with local standards. In cases in which there are no definable local standards of care as in interstate communications, a “reasonable and prudent” standard is assumed.

For the doctor-patient relationship to pertain, the patient is expected to indicate the intention of following the physician’s advice and recommendations. The patient is also supposed to cease any further efforts to procure medical advice and treatment from some other source if the patient wants to keep the original therapeutic relationship in effect.

Providing a diagnosis solely based on an electronic communication is widely construed as providing care, since a patient is likely to act upon information. Once a care plan is started in good faith, the physician is obliged to see it through to a satisfactory conclusion. If the diagnosis provided by a physician over an electronic medium proves incorrect, and especially if it causes harm to the patient, a legitimate claim of negligence could be made against the physician.

8.0 Guardianship

The process of appointing a guardian involves an interplay of legal, medical, psychological and ethical considerations. Guardianship is obtained through following Article 81 of the Mental Hygiene Law, which became effective in 1993 and which established specific procedures for the appointment of a guardian*. The guardian's powers are tailored to the individual needs of the person for personal care or property and financial management, or any combination thereof. In order for a guardian to be appointed, the person must either agree to the appointment of a guardian or be found by the Court upon a showing of clear and convincing evidence to be incapacitated. To determine incapacity, Article 81 focuses on the person's functional level and decision-making ability. Evaluation by a psychiatrist is often helpful in making that determination.

Guardianship may become an issue if a patient, who is believed to lack capacity needs help with managing finances and/or cannot make informed health care decisions. For example, a guardian may be helpful in applying for public benefits for the incapacitated person or making decisions concerning the incapacitated person's place of abode. Unless a guardian knows the incapacitated person's wishes concerning health care, a guardian may only make routine health care decisions. If, however, the patient has appointed a health care agent, that agent can make any decision that the patient would have made regarding health care.

*The scope of this section does not include guardianships of infants or guardianships of mentally retarded or developmentally disabled persons, which are governed by the Surrogate's Court Procedure Act.

§9.0 STARK LAW AND RULES

The Federal legislation commonly referred to as “Stark” restricts physician referral practices. (See 42 United States Code (“USC”) §1395 nn. The Stark Law provides that a physician with an ownership or investment interest in, or compensation agreement with, an entity is prohibited from making referral to that entity for the furnishing of “designated health services” for which Medicare payments would otherwise be made. The term “designated health services” initially was defined in 1989 to include only clinical laboratory services, but the term was expanded in subsequent 1993 legislation (“Stark II”) to include physical therapy services, occupational therapy services, radiology or other diagnostic services, radiation therapy services, the furnish of durable medical equipment and supplies, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics and prosthetic devices, home health services, outpatient prescription drugs, and inpatient and outpatient hospital services.

Lengthy and complex regulations have been issued in an effort to develop a common sense approach to reduce the burden and restrictive nature of the Stark Law.

Today, there has been little federal enforcement of any aspect of the Stark Law. At the same time, a number of whistle-blower lawsuits filed under the Federal Civil False Claims Acts have raised Stark Law issues, asserting that a claim submitted in violation of the Stark Law is a false claim for the purposes of the False Claims Act. Thus, enforcement by these whistle-blowers and the United States Attorneys responsible for prosecuting these actions remain a greater practical risk than does any national enforcement program.

§9.1 FEDERAL ANTI-KICKBACK LAW

The federal Anti-Kickback Law is a separate and distinct statute that prohibits the knowing and willful offer or payment of remuneration, directly or indirectly, to any person in return for referring (or to induce such person to refer) an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment will be made in whole or in part under a federal health program. See 42 U.S.C. §1320a-7b(b). Criminal and civil penalties apply to violations of the Anti-Kickback Law, which carves out certain practices that will not subject providers to liability. There are also safe harbor regulations that protect certain specified arrangements from prosecution under the Anti-Kickback Law. An arrangement must meet all of the elements of a safe harbor to be protected from prosecution, although failure to comply with a safe harbor does not mean that the statute has necessarily been violated.

§9.2 NYS ANTI-REFERRAL LAW

Like the Stark Law, its New York State counterpart (the Health Care Practitioner Referrals Law) generally prohibits the referral of patients by a “practitioner” for certain

services (clinical laboratory, pharmacy, radiation therapy, x-ray or imaging, and physical therapy services) where the referring practitioner, or an immediate family member, has a “financial relationship,” including a “compensation agreement,” with the second practitioner or entity. See NY Public Health Law §238-a.

The NYS “MiniStark” Law is an “all payer” law and accordingly not limited to Medicare or Medicaid. A second distinction is that the NYS referral prohibition applies not only to physicians but to other health practitioners, such as dentists, podiatrists, chiropractors, nurses, midwives, physician assistants, physical therapists and optometrists.

§10.0 PATIENTS IN NEED OF MENTAL HEALTH TREATMENT

§10.1 Patients in Need of Involuntary Psychiatric Treatment

Subject to the privacy restrictions in HIPAA, the Public Health Law and the Mental Hygiene Law, when a patient is unwilling to accept recommended psychiatric treatment it is often helpful to involve the family. Often family members can persuade a person to go to an ER for evaluation, or in some other way help move the patient towards treatment. When a person is psychotic, or demented, sometimes the family can apply gentle pressure until treatment is accepted. Such pressure should be frequent and persistent, but not allowing of major arguments. It is important, of course, to distinguish between the need for treatment and the need for urgent treatment. Very urgent treatment is considered necessary where there are threats of suicide or homicide, or serious behaviors that prevent the person from functioning.

If a person is mentally ill and threatening harm to self or others, and unwilling to go voluntarily to an Emergency Room, there are basically two courses of action.

§10.1.1 Article 9.41 of the Mental Hygiene Law

The police, under Article 9.41 of the Mental Hygiene Law, are authorized to bring a person with symptoms of serious mental illness to a hospital for evaluation and/or admission. This course of action is the one that leads to the most prompt response.

§10.1.2 Article 9.45 of the Mental Hygiene Law – When Persuasion Fails

Crisis Services, at 716-834-3131 will come and talk to an ill person, make recommendations, and can under Article 9.45 of the Mental Hygiene Law have the police transport a mentally ill person to the hospital. US and NY court decisions have generally required that a person be dangerous to himself or others when considering involuntary commitment to a hospital and that the danger be “imminent.” Most often, transportation to the hospital is done by ambulance.

§10.1.3 Transfer From A Hospital Without Mental Health Facilities

Under Article 9.57 a physician may authorize transportation from a hospital without mental health facilities to one with such facilities. It is possible to arrange a 2 Physician Certificate, including a petitioner from the hospital, two physicians from the originating hospital, and with the agreement of a physician in the intended mental health receiving hospital. Others, including the treating psychiatrist may order involuntary transportation to an admitting hospital.

Under COBRA, it is forbidden to send a patient from a hospital bed to a receiving hospital emergency room. Arrangements for admission must be in place and an intact care plan must be set up before a patient is transferred to a mental health inpatient unit.

§10.1.4 Hospitals Having Mental Health Facilities

The Erie County Medical Center is the only local hospital with emergency mental health hospitalization services. Under Article 9.39, a physician at these hospitals may affect an involuntary admission.

§10.2 Patient Rights

When admitting involuntarily a patient has the right to petition the court for release, and must be informed of his rights. The patient has the right to be represented by the Mental Hygiene Legal Services and may refuse medication. A Court has to order the administration of medication in such circumstances after a full hearing.

A patient also retains full civil rights, and cannot be considered incompetent, unless a court has declared that to be the case.

§10.3 Assisted Outpatient Treatment (AOT)

New York State has enacted legislation that provides for court-ordered assisted outpatient treatment [AOT] for mentally ill people who, because of their treatment history and present problems, are unlikely to survive safely in the community without supervision. This complex process can lead to a person being directed into treatment through the local AOT program. Further information about this program can be found by contacting your County at the follow numbers: Erie County Department of Mental Health (716) 858-8530; Niagara County Mental Health Services (716) 439-7140; Allegany County Counseling Center (585) 593-6300; Cattaraugus County Health Department (716) 373-8050; Chautauqua County Mental Health (716) 661-8330; Genesee County Health Department (585) 344-2580; Orleans County Health Department (585) 589-3278 or Wyoming County Health Department (585) 786-8890.

§11.0 RIGHT TO DIE/LIMITATION OF TREATMENT

§11.1 Do Not Resuscitate (DNR)

All hospitals and institutions have policies and procedures in place for Do Not Resuscitate orders. Intubation is a form of resuscitation.

§11.1.1 Do Not Intubate (DNI)

Requests not to intubate are probably the most violated requests, willfully or unintentionally. Extraordinary care should be taken to ensure compliance. The need for resuscitation arises during an emergency and the signed DNR/DNI may not be available at the time.

§11.2 Advance Directives (Living Will / Health Care Proxy)

Similar policies as those for DNRs are in place, but this is probably the most violated request, whether willfully or unintentionally. Extraordinary care should be taken to ensure compliance. The need for intubation many times arises in emergency situations and the signed document may not be available at the time.

§11.3 Ordinary and Extraordinary Measures to Prolong Life

Euthanasia must be clearly distinguished from a decision to forgo aggressive medical treatment. In circumstances where death is imminent and inevitable, one can refuse treatment which can cause burdensome prolongation of life. Under New York State law a competent adult has the right to accept or reject medical treatment (including life-sustaining measures). Adults with capacity can and should be encouraged to create advance directives to be used if they become incapacitated to make medical decisions at a later date.

When dealing with minors, the consent of the parent or legal guardian and the minor must be obtained. **Contact your personal attorney for specific advice.** See Public Health Law §2967.

§11.4 Palliative Care/Comfort Care

Patients and families can seek out comfort care when a decision has been made that further aggressive treatment is futile. Comfort care can be instituted in combination with conventional treatment and the focus slowly shifted as the condition worsens. The provision of pain medication is legally acceptable even if it may hasten death as long as the intent is to relieve pain and not to hasten death.

There should be a clear distinction between "euthanasia" and allowing a patient to die. This distinction should be made clear in the minds of the physician, staff and the family with discussions. This is particularly important if the patient is unable to make such decisions.

§12.0 WORKERS' COMPENSATION

Workers' Compensation physician services in New York State are compensated to the physician under the Equal Fee For Equal Services principle, with no payment differentials in relation to Specialty Board certification. Since 1995 physician fees have been provided by Medicode, a subsidiary of Medical Data Research, a consultant firm in Salt Lake City known as Ingenix, PO Box 27116, Salt Lake City, UT 84127-0116. (800) 464-3649. Under law, with very few exceptions (i.e. NY Teachers) physicians may not collect or receive a fee from an injured or sick worker for treatment related to the worker's employment.

Physician fees may be calculated from the Relative Value (RV) x Conversion Factor (CF). The CF is defined by postal codes.

To obtain authorization from the Workers' Compensation Board (WCB) the NY licensed physician is required to make an application by way of an endorsement from the County Medical Society of the county in which the physician's office is located. Medical reports must be filed with the district office of the WCB. Report forms can be obtained at the WCB website www.wcb.state.ny.us. The Buffalo office is:

Workers' Compensation Board
107 Delaware Ave #3
Buffalo, NY 14202
(866) 211-0645

Attending physician statements must be filed within 48 hours of the initial treatment. A progress report is expected within 15 days of the preliminary report. The progress report should contain a more complete description of the illness/injury and treatment. During continuing treatment, progress reports should be filed every 45 days. These reports should be filed with the WCB, the employer/insurance carrier, and the claimant's legal representative or the claimant. Bills to insurance carriers should be submitted on C-4 or HCFA 1500 and include:

Patient's name and WCB case # Employer's name and address Date of accident, dates of each treatment for injury Carrier Case # Physician's WCB specialty rating, WCB authorization #, physician SS #. WCB code # and dollar amount
Copies of medical reports (consultation, operative, radiology).

For anticipated service charges in excess of \$500, advance authorization is requested on line #4 of the WC C-4 form. If the insurance carrier does not respond to the telephone and written authorization request within 30 days, the WCB Chair may authorize services without a guarantee of payment if the patient's condition is eventually found to be non-compensable. The bill to the insurance carrier is expected to be paid within 45 days from submission unless the carrier contests through the revised medical

bill resolution procedure.

If a bill to insurance is controverted, such as when the employer disputes the validity of a claim that an injury occurred on the job, the insurance carrier may send a "Notice of Controversy" on a WC Form C-7. A specific written explanation may be given to the provider as well. If Medical Reports are not filed within 90 days, or if prior authorization for a service greater than \$500 is not obtained, or if the treatment is unrelated to the illness/injury, a "Notice of Treatment Issue/Disputed Bill Issue" on C-81 may be sent. If the patient has other health insurance and "Notice of Decision" is made that employer is not liable, this should be sent to the other health insurer. Private Insurers may use the date of the WC "Notice of Decision", to start their own submission requirement. To avoid delay and private insurance denials, simultaneous filing to WC carrier and private insurance may help to notify the private insurer of the potential for a claim should WC controvert its liability. If this is done, and the private insurer refuses an appropriate claim, contact MSSNY Socio-Economics at (516) 488-6100.

If the insurance carrier disputes the fee, the carrier must submit a written explanation and the physician has 120 days from receipt of the notice to request an arbitration hearing. During this time the physician should contact the carrier and submit additional records to resolve the dispute if possible. If the carrier does not object to the bill within 45 days and the bill is not paid, or if the claim which is legally controverted and resolved in the physician's favor has not been paid in 30 days from the resolution of the legally controverted claim, the physicians should use an HP-1 Form to request an administrative award. An HP-1 Part A is used for non-payment. HP-1 Part B is used for payment dispute where the physician is not satisfied that the payment is correct. These are sent to:

Workers' Compensation Board
Disputed Medical Bill Unit
20 Park St.
Albany, NY 12207
(800) 781-2362

Arbitration panels with three physicians with one each representing WCB, Carrier, and County Medical Society offer binding decisions regarding the appropriate payment. Fees are charged to support the cost of arbitration process as required by the NYS Health Reform Act (HCRA). When a claim is challenged on the basis of validity, an Administrative Law Judge takes testimony and determines the compensability, the amount and the duration of the award. Interest is paid beginning 30 days from the filing of the award to the date of payment.

For further information, www.mssny.org and download "MSSNY'S NYS Workers' Compensation Guide"

§13 NO FAULT

The Comprehensive Motor Vehicle Insurance Reparations Act (Article 51, NYS Insurance Law) requires No-Fault insurance for lost wages and medical care for drivers, passengers, and pedestrians injured by the owner's car. Additionally, liability for potential harm to other people and property, and uninsured motorist protections are also required. Motorcycles do not need No-Fault, but they have liability for damages to other people and property such as pedestrians struck by the motorcycle. Excluded from benefits are intoxicated/impaired drivers, intentional injuries, injury during crimes such as felony or theft of the vehicle, injuries while racing vehicles or injuries to the owner of an uninsured vehicle. Crash details are expected to be submitted to insurance by the vehicle owner within 30 days. The time limit for claim submission for medical care is 45 days. Payment for services is at the Workers' Compensation fee schedule, even if the patient does not submit a No-Fault claim. If the physician is billing for services, three options are available. These include billing the patient directly, executing an "Authorization to Pay", or taking assignment and billing the no-fault insurance carrier. In any case, fees may not exceed the workers' compensation schedule for the region. If the patient directly submission for medical care is 45 days. Payment for services is at the Workers' Compensation fee schedule, even if the patient does not submit a No-Fault claim. If the physician is billing for services, three options are available. These include billing the patient directly, executing an "Authorization to Pay", or taking assignment and billing the no-fault insurance carrier. In any case, fees may not exceed the workers' compensation schedule for the region.

If a pedestrian is struck by an un-insured vehicle and the pedestrian does drive additionally, if the pedestrian does not own an auto, the claim, may be filed with the insurance carrier for any auto owned by the patients family. If no insurance is available to bill in the family, the police should be notified, and claims may be submitted to Motor Vehicle Accident Indemnification Corp., 110 William St., New York, NY 10083 (212) 791-1280. Insurers must pay within 30 days or make 2% per month interest payments. Basic No-Fault benefits must cover up to \$50,000 in medical expenses and lost earnings. Physicians must collect the deductible portion of the insurance payment directly from the patient. No-Fault arbitration is available if the insurer does not pay the entire claim, is delayed in payment, or fails to notify the physician regarding denial.

The denial form should be signed on the back and mailed with \$40 to: New York Insurance Case Management Center, American Arbitration Association, 65 Broadway, New York, NY 10006, (917) 438-1500. If a No-Fault claim is denied by the carrier, the assigned benefits should be withdrawn in a written rescission letter to the carrier before billing the patient.

For further information, www.mssny.org and download "MSSNY's NYS No-Fault Guide"

SUPREME COURT
COUNTY OF _____

Plaintiff,

-against-

Defendant.

The People of the State of New York

TO: _____

S A M P L E

Index No. _____

**JUDICIAL SUBPOENA
DUCES TECUM**

WE COMMAND YOU, that all business and excuses being laid aside, you and each of you appear and attend before _____ at _____ on the _____ day of _____, 20____ at _____ o'clock, in the _____ noon, and at any recessed or adjourned date to give testimony in this action on the part of _____ and that you bring with you, and produce at the time and place aforesaid, a certain _____ now in your custody, and all other deeds, evidences and writings, which you have in your custody or power, concerning the premises.

Failure to comply with this subpoena is punishable as a contempt of Court and shall make you liable to the person on whose behalf this subpoena was issued for a penalty not to exceed fifty dollars and all damages sustained by reason of your failure to comply.

WITNESS. Honorable _____ one of the _____ of said Court, at _____ the _____ day of _____, 20_____.

Attorney for

STATE OF NEW YORK
SUPREME COURT; COUNTY OF []

Index No. []

[]
Plaintiffs

-vs-

[]
Defendants

**SUBPOENA
AD TESTIFICANDUM**

The People of the State of New York

TO: []

WE COMMAND YOU, that all business and excuses being laid aside that you appear and attend before The Honorable [], [], Part [], Buffalo, New York 14202; on the [] day of [], 20[] at **a.m.** and at any recessed or adjourned date thereafter to give testimony in this action on the part of [], defendant herein.

Failure to comply with this Subpoena is punishable as a contempt of court, and shall make you liable to the person on whose behalf this Subpoena was issued for a penalty not exceeding fifty dollars and damages sustained by reason of the failure to comply.

WITNESS, Hon. [], one of the Justices of this Court, at Buffalo, New York, the [] day of [], 20[].

TO WITNESS:

As soon as you receive this subpoena, and for your convenience, please call this attorney, [], **Esq.** at this telephone number -.

[], Esq.

Attorneys for Defendant
[]

**DO NOT APPEAR IN COURT BEFORE
YOU TALK TO ATTORNEY [].**

Model Contract for Record Review and Testimony

(Physician name and address) (Attorney name and address) (Case Identification)
This confirms my commitment to provide expert medical advice on behalf of your client, _____ (name of client) _____. As we have already discussed, I will provide services according to following terms: **Services:** Depending on the need, I am prepared to review all pertinent records including the Summons and Complaint, Bill of Particulars, hospital records, office records, depositions, and written opinions of other experts. If necessary, I will conduct an independent examination of the patient to provide another opinion about the degree of disability. I will prepare an expert opinion about all aspects of this case within my specialty area. I will deliver a verbal summary to you by telephone or personal interview. If asked, I will prepare a written summary. I agree to prepare necessary information for testimony at a deposition, videoconference, or a courtroom appearance. **Completion of the Work:** As we discussed, I should receive the records for my review by (date of delivery). I will prepare a verbal summary by (date of verbal summary). If you require a written summary, I will need (# days) additional days to complete it. I would like at least (# days) to get ready for testimony. **Compensation:** We both understand that payment for my services is not contingent upon the outcome of the case. My rate of compensation is based on customary consultative fees for my specialty in this community. For any patient examinations, I will bill my usual consultative or procedure fee. Other services such as record review, verbal or written summaries, and personal testimony will be billed at an hourly rate of \$ (rate). I expect reimbursement for unusual travel and administrative expenses. Unforeseen expenses are to be negotiated on completion. As we discussed, I prefer an initial retainer of \$ (initial), an intermediate payment of \$ (intermediate), and a final payment of \$ (final). The total compensation will be \$ (total). I expect to receive my final payment within 30 days of completion. **Other Details:** The records for my review should be delivered to (delivery address). I prefer that patient exams be performed at (site address). I plan to give you my verbal opinion before I initiate any written summary. You can arrange mutually acceptable meeting times through my secretary (secretary's full name, phone number with extension). The best meeting times for me are (list days of the week and best times). I expect as much advance notice as possible for a personal appearance to avoid inconveniencing my patients. Should you find it necessary to cancel my scheduled testimony abruptly, I will bill you for at least a part of the original time.

Physician Name (typed):

Attorney Name (typed):

Date:

Signatures:

Physician _____

Attorney _____



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

Medical Record from (insert date) _____ to (insert date) _____

Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Other: _____ Include: (Indicate by Initialing)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____

Initials Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire:
--	--

12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
--	---

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law. Date: _____

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

**Instructions for the Use
of the HIPAA-compliant Authorization Form to
Release Health Information Needed for Litigation**

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act (“HIPAA”) and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as “at the conclusion of my court case” or provide a specific date amount of time, such as “3 years from this date”.

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Authorization for Release of Health Information and Confidential HIV-Related Information*

New York State Department of Health
AIDS Institute

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; or by special court order. Under New York State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

My HIV-related information
 My non-HIV health information
 Both (non-HIV health and HIV-related information)

Name and address of facility/person disclosing HIV-related information: _____ _____
Name of person whose information will be released: _____
Name and address of person signing this form (if other than above): _____ _____
Relationship to person whose information will be released: _____
Describe information to be released: _____
Reason for release of information: _____
Time Period During Which Release of Information is Authorized: From: _____ To: _____
Exceptions to the right to revoke consent, if any: _____ _____
Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences): _____ _____

Please sign below only if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.	
Signature _____	Date _____

* This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.

**Authorization for Release of Health Information
and Confidential HIV-Related Information***

**Complete information for each facility/person to be given general information and/or HIV-related information.
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release health and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

Date _____

If legal representative, indicate relationship to subject:

Print Name _____

Client/Patient Number _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

**Authorization for Release of Health Information
and Confidential HIV-Related Information***

**Complete information for each facility/person to be given general information and/or HIV-related information.
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

If any/all of this page is completed, please sign below:	
Signature _____ <small>(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)</small>	Date _____
Client/Patient Number _____	

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**