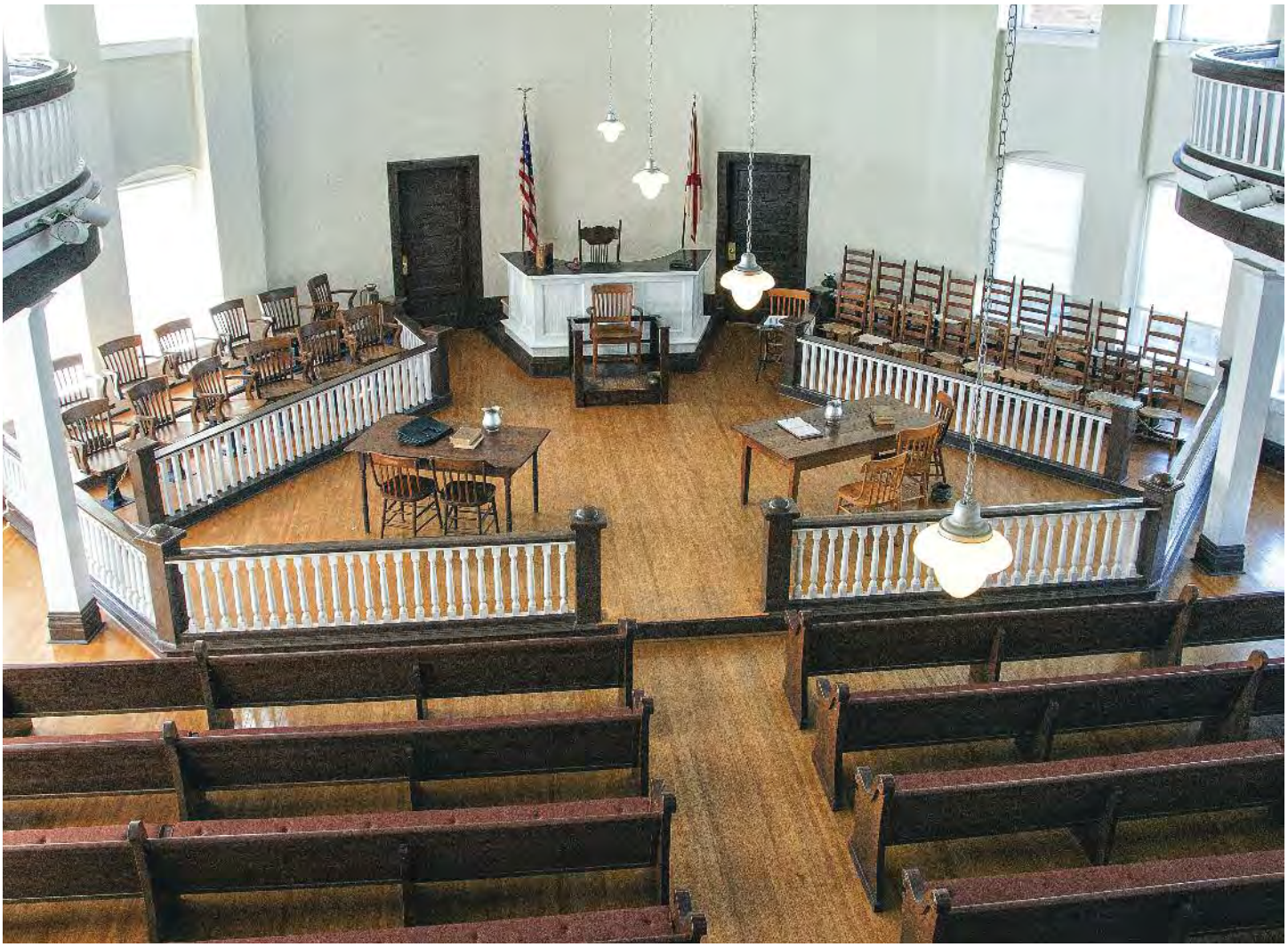
THE ALABAMA LAWYER

NOVEMBER 2016 | VOLUME 77, NUMBER 6



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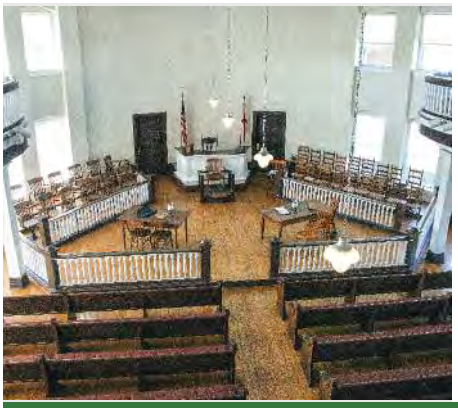


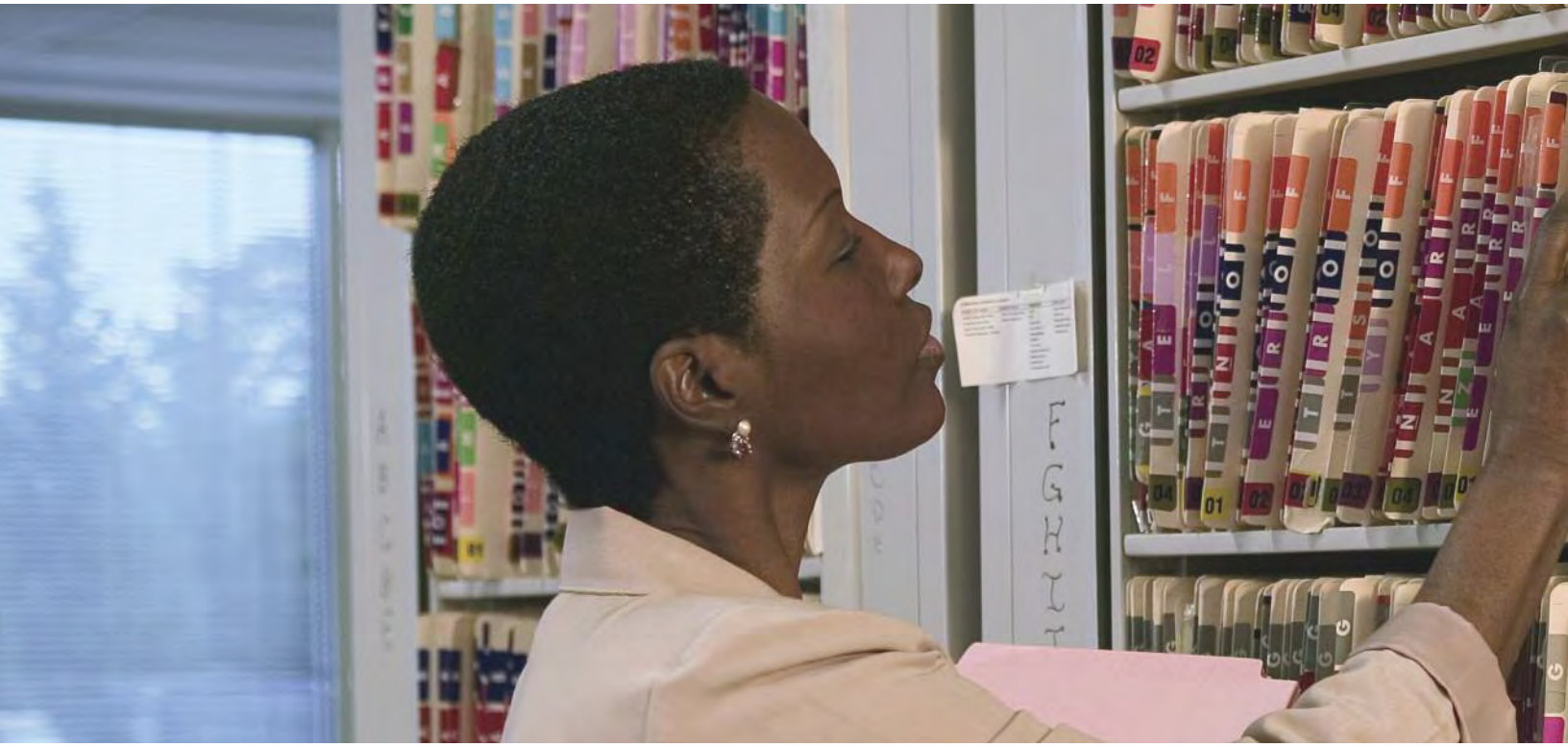
On The Cover

Pictured on the cover is the courtroom in the Monroe County Courthouse, where real lawyers tried real cases, one or more of which inspired Harper Lee to create Atticus Finch and the novel, *To Kill a Mockingbird*.

Photo by Alabama State Bar member Steven L. Atha, Birmingham, *satha@mindspring.com*

FEATURE ARTICLES

COLUMNS



Alabama Medical Records

PART 1

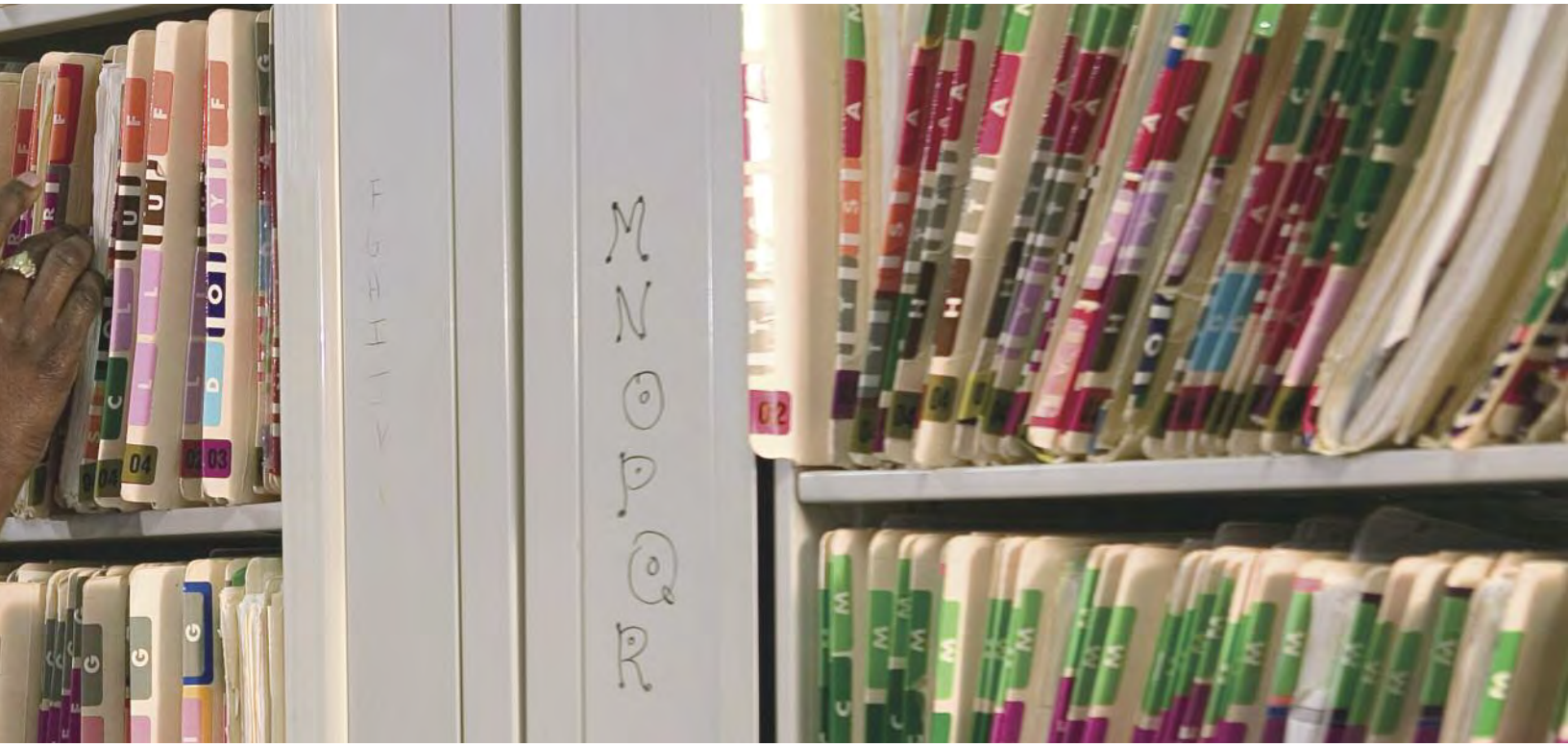
By David G. Wirtes, Jr. and George M. Dent, III

Introduction

This article addresses five topics: 1. The sources of duties to create and maintain accurate medical records, 2. Accessibility to such records, 3. Discoverability of such records, 4. Admissibility into evidence of such records and 5. Exceptions to discoverability and admissibility.

Section I outlines the state, federal and voluntary bases of duties to create and maintain accurate medical records. Section II discusses accessibility to medical records; Section III discusses discoverability; Section IV discusses admissibility and Section V surveys the exceptions to discoverability and admissibility–such as when records contain quality assurance or peer review matters–and catalogues many of the controlling state and federal reported decisions.

Why be concerned with these varying requirements? Because we presently are in the midst of great changes in the way judges, lawyers and litigants must understand and use medical records in litigation. Changes from traditional paper medical records to electronic medical records systems are occurring across the spectrum of healthcare providers, as intended by the Health Information Technology for Economic and Clinical Health ("HITECH" Act), which was enacted as part of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, 123 Stat. 115 (commonly known as "The Stimulus" or "The Recovery Act"). Congress, through HITECH, provided more than $50 billion for healthcare providers to transition from paper to electronic medical records systems.[1] As these changes unfold, problems concerning obtaining *complete* and *accurate* patient records for use in litigation have become commonplace.[2] Our goal is to marshal the hodgepodge of state and federal statutes, regulations, Joint Commission standards and common law decisions into one relatively comprehensive guide. We scrupulously avoid editorializing with the express hope our article becomes a useful tool for all judges and lawyers in this state.



Part 1

Duty to Create and Maintain Accurate Medical Records

There are three fundamental sources of duty for creation, maintenance and access to accurate medical records. They are found in: (A) Alabama's statutes and administrative regulations governing: (1) physicians, (2) nurses, (3) hospitals, (4) nursing facilities and (5) assisted living facilities; (B) federal Medicare and Medicaid regulations applying to: (1) participating hospitals, (2) nursing facilities, (3) assisted living facilities and (4) other specialties; and (C) voluntary standards such as accreditation guidelines issued by the Joint Commission ("JC"[3]), and universal standards established by the American Society for Testing and Materials ("ASTM").[4]

A. Alabama Statutes and Administrative Regulations

1. Physicians

Pursuant to the regulatory authority granted in § 34-24-311, *Ala. Code* 1975, the Alabama Medical Licensure Commission ("AMLC"), together with the Alabama Board of Medical Examiners ("ABME"), jointly promulgate regulations concerning physicians' duties to create, maintain and provide access to medical records. The duties are mandatory, as shown by § 34-24-360 (22), which gives the AMLC "the power and duty to suspend, revoke, or restrict" a physician's license to practice for failing to maintain a patient's medical record to the commission's "minimum standards."[5] The AMLC, (specifically relying on § 34-24-360(22)'s "minimum standard" provision), promulgated baseline standards concerning the creation, maintenance and accessibility of medical records that "every physician licensed ... in Alabama shall maintain for each of his or her patients."[6] Rule 545-X-4-.08(1), *Ala. Admin. Code*, requires physicians to "maintain legible well documented records reflecting the history, findings, diagnosis and course of treatment in the care of a patient ... for such period as may be necessary to treat the patient and for such additional time as may be required for medical legal purposes." Further, records must: (a) "reflect examinations, vital signs, and tests obtained, performed, or ordered and the findings or results of each"[7]; (b) "indicate the medications prescribed, dispensed, or administered and the quantity and strength of each"[8]; (c) "reflect the treatment performed or recommended"[9]; and (d) "document the patient's progress during the course of treatment."[10]

Section 34-24-504, regarding "Patient Medical Records," requires all physicians licensed by the state to protect patients' medical information and, specifically to "comply with all laws, rules, and regulations governing the maintenance of patient medical records,

including patient confidentiality requirements, regardless of the state where the medical records of any patient within this state are maintained." Rule 545-X-4.06(11) explains that the AMLC has "the power and duty to suspend, revoke, or restrict" a physician's license for "[u]nprofessional conduct," such as "[i]ntentionally, knowingly or willfully causing or permitting a false or misleading representation of a material fact to be entered on any medical record of a patient,"[11] and "[f]ailing or refusing to maintain adequate records on a patient or patients."[12]

2. Nurses

The Board of Nursing ("BoN") has statutory authority to adopt regulations and standards governing the licensure and conduct of nurses,[13] and to "deny, revoke, or suspend any license" for various infractions, e.g., if a nurse is found "guilty of unprofessional conduct of a character likely to deceive, defraud, or injure the public in matters pertaining to health."[14]

Alabama Administrative Code Chapter 610-X-6 establishes the duties owed by registered nurses ("RNs") and licensed professional nurses ("LPNs") relative to medical records. These regulations define both comprehensive assessments (performed by RNs)[15] and Focused Assessments (performed by RNs and LPNs alike).[16]

The BoN's standards require nurses to "[r]espect the dignity and rights of patients," including their right to the "[p]rotection of confidential information, unless disclosure is required by law."[17] The BoN pertinently requires nurses to "[a]ccept individual responsibility and accountability for accurate, complete, and legible documentation related to ... [p]atient care records."[18] Like physicians, RNs and LPNs risk severe sanctions for non-compliance with the regulatory requirements."[19]

3. Hospitals

Article 2 of Chapter 21 of Title 22 of the *Alabama Code of 1975* governs the "[l]icensing of hospitals, nursing homes, and other health care institutions."[20] An entity must apply for and obtain a license from the state Board of Health ("BoH") to "establish, conduct or maintain any hospital as defined in Section 22-21-20."[21]

Section 22-21-28 empowers the BoH "to make and enforce, ... modify, amend, and rescind, reasonable rules and regulations governing the operation and conduct of hospitals as defined in Section 22-21-20. All such regulations shall set uniform minimum standards applicable alike to all hospitals of like kind and purpose ...."[22] The BoH may suspend or revoke a license for "[v]iolation of any of the provisions of this article or the rules and regulations issued pursuant thereto."[23] *Alabama Administrative Code* Chapter 420-5-7 establishes the pertinent BoH regulations concerning hospitals' duties to create and maintain medical records. Hospitals' duties concerning medical records services are catalogued at Rule 420-5-7-.13(1)-(5).[24] For example, "[t]he hospital shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries."[25] "Medical records shall be accurately written, promptly completed, properly filed and retained, and accessible."[26] "All patient medical record entries shall be legible, complete, dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures."[27]

4. Nursing Facilities

The definition of "hospitals" in § 22-21-20 includes "skilled nursing facilities, intermediate care facilities, assisted living facilities, and specialty care assisted living facilities rising to the level of intermediate care." The Alabama Supreme Court held that a nursing home is a hospital for purposes of the Alabama Medical Liability Act ("AMLA").[28] Thus, the statutes quoted above regarding the BoH's licensure and governance of hospitals also apply to nursing facilities.

Alabama Administrative Code Chapter 420-5-10 outlines the duties imposed on nursing facilities by the BoH for creation and maintenance of medical records, which are detailed in Rule 420-5-10-.03(32)-(36).[29] Among other requirements, the records must be "in accordance with accepted professional standards and practices" and must be complete, accurately documented, readily accessible and systematically organized.[30] The "facility must safeguard clinical record information against loss, destruction, or unauthorized use" and also must clinical record must be retained for five years.[31]

5. Assisted Living Facilities

Assisted living facilities are also within the statutory definition of hospitals[32] and thus subject to the

licensing and other provisions of Article 2 of the Hospitals and Other Health Care Facilities Chapter of the *Alabama Code*. The duties imposed upon assisted living facilities to create and maintain medical records are found in Rule 420-5-4-.05(1)-(3).[33] Records necessary for care, including care plans and admissions and examination records, "shall be accessible to the direct care staff at all times," "shall be current" and "shall be retained in the facility for at least three years after a resident's death or discharge."[34] Such facilities are required to create and maintain incident reports for specified incidents with specified contents.[35] The records shall be confidential, but "[a] resident or his or her legal guardian may grant permission to any other individual to review the resident's confidential records by signing a standard release."[36]

When a healthcare provider destroys, hides, conceals, alters or tampers with medical records, they risk suffering adverse evidentiary inferences at trial, and they may be liable in tort for spoliation.

B. Alabama Common Law

The duties owed by healthcare providers to create, maintain and provide accurate medical records also spring from Alabama common law. When a healthcare provider destroys, hides, conceals, alters or tampers with medical records, they risk suffering adverse evidentiary inferences at trial, and they may be liable in tort for spoliation. An overview of the common law of spoliation of evidence appears in the Alabama Pattern Jury Charge on Spoliation of Evidence by a Defendant.[37] This instruction allows a jury to consider whether a defendant intentionally destroyed, hid, concealed, altered or tampered with evidence and, if the jury so finds, to draw "such inferences that you believe are reasonable from the wrongful conduct."[38]

Another Alabama Pattern Jury charge[39] outlines the common law tort claim of spoliation recognized in *Smith v. Atkinson*, 771 So. 2d 429 (Ala. 2000) (recognizing a cause of action against a third-party that spoliates evidence vital to a plaintiff's claim against another).

Our supreme court has applied these common law spoliation principles to the attempted or successful alteration or destruction of medical records, as reflected in *May v. Moore*, 424 So. 2d 596 (Ala. 1982), and *Campbell v. Williams*, 638 So. 2d 804 (Ala. 1994).[40]

C. Federal Medicare/Medicaid Regulations

The United States conditions the payment of Medicare and Medicaid funds to various healthcare providers on the providers' compliance with stringent requirements to create and maintain accurate medical records. The regulations setting forth these conditions are in the "Public Health" regulations, Title 42 of the *Code of Federal Regulations*. Chapter IV (Parts 400-699) of Title 42 gives the regulations pertinent to the Centers for Medicare and Medicaid Services ("CMMS"), a division of the Department of Health and Human Services ("HHS").

CMMS imposes particularized medical records requirements upon hospitals,[41] Ambulatory Care Centers ("ACC"),[42] hospices,[43] elder care facilities,[44] home health services,[45] rural health clinics,[46] laboratories[47] and "End-Stage Renal Disease Facilities,"[48] as well as "Specialized Providers," which encompasses Comprehensive Outpatient Rehabilitation Facilities ("CORFs"),[49] Critical Access Hospitals,[50] "Clinics, Rehabilitation Agencies and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services,"[51] Community Mental Health Centers[52] and psychiatric hospitals.[53]

D. Joint Commission Standards

1. Medical Records Standards, Generally

The Joint Commission accredits more than 21,000 healthcare organizations and programs including general, psychiatric, children's and rehabilitation hospitals; critical care hospitals; home healthcare organizations; nursing homes and other long-term care facilities; ambulatory care providers, clinical laboratories and other specialty healthcare providers.[54]

Accreditation by the Joint Commission requires adherence to standards as are set forth in organization-specific accreditation manuals. The Joint Commission performs periodic accreditation reviews of healthcare providers' compliance with its standards. Among criteria surveyed for accreditation are medical records services.

The Comprehensive Accreditation Manual for Hospitals ("CAMH"), effective January 2016, states that it is "a one-stop resource to help your hospital achieve or maintain continuous compliance with the joint commissions standards." CAMH p. HM - 1. Pertinent here are the chapters on Information Management ("IM") and, especially, Record of Care, Treatment and Services ("RC").

Standard IM.01.01.01 covers "hospital plans for managing information," including Elements of Performance standards.[55] STANDARD IM.02.01.03 provides: "The hospital maintains the security and integrity of health information." CAMH, p. IM-6. The introduction to this standard says that "[e]ven simple mistakes, such as writing the incorrect date of service or diagnosis, can undermine data integrity just as easily as intentional breaches. For these reasons, an examination of the use of paper and electronic information systems is considered in the hospital's approach to maintaining the security and integrity of health information." *Id*. Under the Elements of Performance for this standard, numbers 6 and 7 are especially pertinent to the integrity of health care records. They provide: "6. The hospital protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction," and "7. The hospital controls the intentional destruction of health information." CAMH, p. IM - 7.

Standard IM.02.02.01 provides: "The hospital effectively manages the collection of health information." Elements of Performance 1 requires "uniform data sets to standardize data collection throughout the hospital."

A highly detailed document when seen in its entirety, the record of care comprises all data and information gathered about a patient from the moment he or she enters the hospital to the moment of discharge or transfer.

Elements of Performance 2 requires "standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations." CAMH, IM - 7.

Standard IM.02.02.03 provides: "The hospital retrieves, disseminates, and transmits health information in useful formats." *Id.*, IM - 8. Standard IM.03.01.01 provides: "Knowledge-based information resources are available, current, and authoritative." Standard CAMH, p. IM-9 provides: "The hospital maintains accurate health information." This requires both that the hospital's health information be accurate and that the hospital maintain it.

2. Record of Care, Treatment and Services

The overview of this chapter tells how important it is:

> The "Record of Care, Treatment, and Services" (RC) chapter contains a wealth of information about the components of a complete medical record. A highly detailed document when seen in its entirety, the record of care comprises all data and information gathered about a patient from the moment he or she enters the hospital to the moment of discharge or transfer. As such, the record of care functions not only as a historical record of a patient's episode(s) of care, but also as a method of communication between practitioners and staff that can facilitate the continuity of care and aid in clinical decision-making.
>
> CAMH, p. RC - 1.[56]

3. Sentinel Events Records

An important part of the accreditation process is the Joint Commission's review of responses to "sentinel events." The Commission defines a sentinel event as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof ... [including] any process variation for which a recurrence would carry a significant chance of a serious

adverse outcome." The purpose of its sentinel event policy is explained this way:

> The Joint Commission adopted a formal Sentinel Event Policy in 1996 to help hospitals that experience serious adverse events, improve safety, and learn from those sentinel events. Careful investigation and analysis of patient safety events, as well as strong corrective actions that provide effective and sustained system improvement, is essential to reduce risk and prevent patient harm. The Sentinel Event Policy explains how the Joint Commission partners with hospitals that have experienced a serious patient safety event to protect the patient, improve systems and prevent further harm.

CAMH SE - 1. The chapter defines sentinel event as follows:

> A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:
>
> - Death
> - Permanent harm
> - Severe temporary harm, which is defined as "critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires a transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition."[57]

The Joint Commission prescribes the following responses to sentinel events:

> Such events are considered "sentinel" because they signal a need for immediate investigation and response. All sentinel events must be reviewed by the hospital and are subject to review by the Joint Commission. Accredited hospitals are expected to identify and respond appropriately to all sentinel events (as defined by the Joint Commission) occurring in the hospital or associated with services that the hospital provides. An appropriate response includes all of the following:
>
> - A formalized team response that stabilizes the patient, discloses the event to the patient and family and provides support for the family as well as staff involved in the event
> - Notification of hospital leadership
> - Immediate investigation
> - Completion of a comprehensive systematic analysis for identifying the causal and contributory factors
> - Identification of corrective actions to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors
> - Timeline for implementation of corrective actions
> - Systemic improvement

This chapter has further sections on the Goals of the Sentinel Event Policy, Responding to Sentinel Events, the Sentinel Event Database, Determination That a Sentinel Event Is Subject to Review, Optional On-Site Review of a Sentinel Event, Disclosable Information, the Joint Commission's Response, Sentinel Event Measure of Success (SE MOS), Handling Sentinel Event-Related Documents, Oversight of the Sentinel Event Policy, Survey Process and an Appendix on Accreditation Requirements Related to Sentinel Events. CAMH SE - 4-17.

E. ASTM Standards

"[E]vidence of a defendant's compliance with applicable industry standards may be relevant and admissible for purposes of determining whether a defendant breached a duty of care it owed an injured plaintiff."[58]

The American Society for Testing and Materials ("ASTM") is a globally recognized leader in the development and delivery of voluntary consensus standards. ASTM employs more than 140 Technical Standards writing committees which have promulgated more than 12,000 ASTM standards used around the world to, among other things, enhance health and safety.[59] Pertinent here, ASTM has standards concerning electronic medical records:

- Standard Practice for Content and Structure of the Electronic Health Record[60]
- Standard Specification for Audit and Disclosure Logs for Use in Health Information Systems[61]

- Standard Guide for Confidentiality, Privacy, Access and Data Security Principles for Health Information Including Electronic Health Records[62]
- Standard Specification for Coded Values Used in the Electronic Health Record[63]
- Standard Practice for View of Emergency Medical Care in the Electronic Health Record[64]
- Standard Practice for Defining and Implementing Pharmacotherapy Information Services within the Electronic Health Record (EHR) Environment and Networked Architectures[65]

PART 2

Access to Medical Records

Patient access to medical records was traditionally governed by state law; however, federal law now plays an increasingly important role, especially with the advent of the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") now codified at 42 U.S.C. §§ 1320d-1, *et seq.*, with implementing regulations at 45 C.F.R. Part 160, 164, as augmented by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), now codified at 42 U.S.C., §§ 17935, *et seq.*, with implementing regulations at 45 C.F.R. 164.524, *et seq.*

A. *Alabama Code*

In Alabama, access to medical records is governed in the first instance by state statutes and state regulations. Section 12-21-6.1, *Ala. Code* 1975, defines the meaning of various terms related to the "Reproduction and delivery of medical records."[66]

Section 34-26-2, *Ala. Code* 1975 and Rule 503, Ala. R. Evid. protect from disclosure (and admission into evidence) records of confidential relations and communications between patients and psychologists, psychiatrists and other psychotherapists.[67] Section 22-11A-22, *Ala. Code* 1975, likewise cloaks medical records of persons with sexually transmitted diseases protection from public disclosure and admission into evidence.[68] Section 22-50-62, *Ala. Code* 1975, cloaks mental health records compiled by Alabama Department of Mental Health and Mental Retardation with additional special protections.[69]

B. Alabama Administrative Regulations

Regulations promulgated by the State Board of Medical Examiners and the Medical Licensure Commission also specify the duties of Alabama's physicians to make medical records accessible to their patients:

1. Alabama Administrative Code § 545-X-4-.08

Joint Guidelines of the State Board of Medical Examiners and Medical Licensure Commission for Medical Records Management.

(2) Access. On the request of a patient, and with the authorization of the patient, a physician should provide a copy or a summary of the medical record to the patient or to another physician, attorney or other person designated by the patient. By state law, a physician is allowed to condition the release of copies of medical records on the payment by the requesting party of the reasonable costs of reproducing the record. Reasonable cost as defined by law may not exceed one dollar ($1.00) per page for the first twenty-five (25) pages, fifty cents ($.50) per page for each page in excess of twenty-five (25) pages, a search fee of five dollars ($5.00) plus the actual cost of mailing the record. In addition, the actual costs of reproducing x-rays or other special records may be included. For medical records provided in an electronic file, a flat fee that would not exceed the cost of providing the records in paper form may be charged. Records subpoenaed by the State Board of Medical Examiners are exempt from this law. Physicians charging for the cost of reproduction of medical records should give primary consideration to the ethical and professional duties owed to other physicians and to their patients, and waive copying charges when appropriate.

C. Alabama Common Law

In *Horne v. Patton*, 291 Ala. 701, 287 So. 2d 824 (1974), the supreme court held that a complaint

alleging that a doctor improperly disclosed the plaintiff's medical information to the plaintiff's employer, resulting in his being fired, stated causes of action for breach of fiduciary duty, invasion of privacy and breach of implied contract. The court wrote "[I]t must be concluded that a medical doctor is under a general duty not to make extra-judicial disclosures of information acquired in the course of the doctor-patient relationship and that a breach of that duty will give rise to a cause of action." *Horne* was followed in *Mull v. String*, 448 So. 2d 952 (Ala. 1989), and *Crippen v. Charter Southland Hospital, Inc.*, 534 So. 2d 286 (Ala. 1988).[70]

The regulations allow a health care provider to "obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations."

D. HIPAA

In 1996, Congress enacted, and President Clinton signed into law, the Health Insurance Portability And Accountability Act ("HIPAA"), Pub. L. 104-191. Section 244 of that Act added to the U.S. Code a section on "False Statements Relating to Health Care Matters."[71] That section made it a federal crime to, "in any matter involving a health care benefit program, knowingly and willfully ... make[] any materially false, fictitious or fraudulent statements or representations ... in connection with the delivery of ... health care ... services ...."[72] The Department of Health and Human Services ("HHS") adopted regulations regarding the privacy of individually identifiable health information.[73] "Individually identifiable health information is information that ... [i]s created or received by a health care provider ... and [r]elates to the past, present, or future physical or mental health or condition of an individual; [or] the provision of health care to an individual; ... and [T]hat identifies the individual ...."[74] Further, "protected health information" is individually identifiable health information that is transmitted or maintained in electronic media or in any other form or medium.[75]

HIPAA mandates that a health care provider "may not use or disclose protected health information" except as allowed by other provisions such as disclosing the information to the individual patient or for further treatment of the individual or for payment for the health care provider's services.[76] The regulations allow a health care provider to "obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations."[77]

Pursuant to these regulations, every health care provider now provides patients with a HIPAA Privacy Notice to sign. These notices derive from the regulation giving "an individual ... a right to adequate notice of the uses and disclosures of protected health information that may be made by the covered entity, and of the individual's rights and the covered entity's legal duties with respect to protected health information."[78] The notice must have a header or other prominent display of the following: "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."[79]

"[A]n individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set."[80] There are exceptions for psychotherapy notes and information for use in a civil, criminal or administrative action or proceeding.[81] The HIPAA regulations also include Security Standards for the protection of electronic protected health information.[82]

In short, HIPAA provides a *federal* baseline of health information privacy protections, which states are free to rise above in order to best protect their citizens. HIPAA and the standards promulgated by HHS expressly supersede any contrary provision of state law except as provided in 42 U.S.C. § 1320(d)-(7)(a)(2). Under that exception, HIPAA and its standards expressly do not preempt contrary state law if the state law "relates to the privacy of individually

identifiable health information," and is "more stringent" than HIPAA's requirements.[83] Many reported decisions address the scope and effect of HIPAA's preemption provision.[84]

HIPAA's implementing regulations at 42 CFR § 482.13 give patients a right of access to their medical records. Entitled "Condition of participation: Patient's rights," this section begins: "A hospital must protect and promote each patient's rights." Paragraph (a) gives a standard for giving patients notice of their rights. Paragraph (b) gives a standard for exercise of rights. Paragraph (c) gives a standard for privacy safety. Paragraph (d), the standard for confidentiality of patient records, grants a patient "the right to access information contained in his or her clinical records within a reasonable time frame."[85] Most importantly, "[T]he hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record-keeping system permits."[86]

Most importantly, "[T]he hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits."

The HIPAA regulation applicable to judicial proceedings is 45 C.F.R. § 164.512(e)(1) which defines the circumstances when a covered healthcare provider may reveal protected health information in the course of judicial proceedings.[87] Specifically, disclosure of protected health information is permissible only under the following conditions:

> (i) In response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order; or
>
> (ii) In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if:
>
> (A) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iii) of this section, from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request; or
>
> (B) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iv) of this section, from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order that meets the requirements of paragraph (e)(1)(v) of this section.[88]

45 C.F.R. § 164.512(e)(i),(ii). When producing such information, healthcare providers must produce only the minimum information necessary.[89]

E. HITECH

Congress promulgated HITECH with the intention that new electronic medical records be afforded the same protections provided by HIPAA.[90] Under HITECH, a patient has the "right to obtain from [their healthcare providers] a copy of [their medical records] in an electronic format," 42 U.S.C. § 17935(e)(1), and the healthcare provider is permitted to bill "only the cost of ... [c]opying, including the cost of supplies for and labor of copying," 45 C.F.R. 164.524(c)(4)(i). This is all part of the comprehensive push by Congress to move our country's healthcare providers to easily accessible electronic health records under HITECH.

Lawyers representing patients are equally entitled to obtain clients' electronic health information. "The final rule adopts the proposed amendment Section 164.524(c)(3) to expressly provide that, if requested by an individual, a covered entity must transmit the copy of protected health information directly to another person designated by the individual." Federal Register Jan. 25, 2013, vol. 78, no. 17, page 5634.[91] ▲

Endnotes

1. American Recovery and Reinvestment Act of 2009: implementation plans available at *http://www.hhs.gov/recovery/reports/plans/hhs_implementation_plans.pdf.*

2. See, *e.g.*, Chad P. Brouillard, THE FIRST WAVE. Emerging Trends in Electronic Health Record Liability, 52 No. 7 DRI For Defense, 39 (July 2010) (article surveys areas of medical liability involving electronic health records and catalogs new risks impacting medical providers' practices and standard of care issues); Note, *Electronic Medical Records and E-Discovery: With New Technology Come New Challenges,* 5 Hastings Sci. & Tech. L.J. 245, 249 (Summer 2013)("... new and different challenges have arisen during the transition from paper medical records to electronic medical records. A major question that medical care providers face is how to produce a single patient's electronic medical record to the lawyer.").
3. The American Hospital Association, the American College of Physicians, the American College of Surgeons, the Canadian Medical Association, and the American Medical Association formed the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 1951 as a not-for-profit corporation. Joint Commission on Accreditation of Healthcare Organizations Corporate Overview Brochure *(http://www.jcaho.org/about+us/coporate+brochure.htm)*. The Joint Commission on Accreditation of Healthcare Organizations in 2007 shortened its name to The Joint Commission. *The Joint Commission: Over a century of quality and safety*, .pdf *(http://www.jointcommission.org/about_us/history.aspx)*. Facts about the Joint Commission on Accreditation of Healthcare Organizations *(http://www.jcaho.org/about+us/index.htm)*.
4. *https://www.astm.org/ABOUT/full_overview.html.*
5. Section 34-24-360(22), Ala. Code 1975.
6. Ala. Admin. Code r. 545-X-4-.09, which governs "Minimum Standards For Medical Records," provides:

   The maintenance of adequate medical records is an integral part of good medical care. Adequate records are necessary to ensure continuity of care, not only by the physician who maintains a particular record, but by other medical professionals. Therefore, every physician licensed to practice medicine in Alabama shall maintain for each of his or her patients, a record which, in order to meet the minimum standard for medical records, shall: (1) be legible, and written in the English language; (2) contain only those terms and abbreviations that are or should be comprehensive [sic] to other medical professionals; (3) contain adequate identification of the patient; (4) indicate the date any professional service was provided; (5) contain pertinent information concerning the patient's condition; (6) reflect examinations, vital signs, and tests obtained, performed, or ordered and the findings or results of each; (7) indicate the initial diagnosis and the patient's initial reason for seeking the physician's services; (8) indicate the medications prescribed, dispensed, or administered and the quantity and strength of each; (9) reflect the treatment performed or recommended; (10) document the patient's progress during the course of treatment; and (11) include all patient records received from other health care providers, if those records formed the basis for a treatment decision by the physician.
7. Ala. Admin. Code r. 545-X-4-.09(6).
8. Ala. Admin. Code r. 545-X-4.09(8).
9. Ala. Admin. Code r. 545-X-4.09(9).
10. Ala. Admin. Code r. 545-X-4-.09(10).
11. Ala. Admin. Code r. 545-X-4.06(2).
12. Ala. Admin. Code r. 545-X-4-.06(11).
13. Ala. Code § 34-21-2 (1975), which governs the Board of Nursing generally, provides that: "(j) The board may: (1) Adopt and, from time to time, revise such rules and regulations, not inconsistent with law, as may be necessary to carry out this chapter and (21) Adopt standards for registered and practical nursing practice ...."
14. Ala. Code § 34-21-25(b)(1)g. (1975).
15. Ala. Admin. Code r. 610-X-6-.01(02) defines "Assessment, Comprehensive [as] the systematic collection and analysis of data including the physical, psychological, social, cultural and spiritual aspects of the patient by the registered nurse for the purpose of judging a patient's health and illness status and actual or potential health needs. Comprehensive assessment includes patient history, physical examination, analysis of the data collected, development of the patient plan of care, implementation and evaluation of the plan of care."
16. Ala. Admin. Code r. 610-X-6-.01(03), defines, "Assessment, Focused [as] [a]n appraisal of a patient's status and specific complaint through observation and collection of objective and subjective data by the registered nurse or licensed practical nurse. Focused assessment involves identification of normal and abnormal findings, anticipation and recognition of changes or potential changes in patient's health status, and may contribute to a comprehensive assessment performed by the registered nurse."
17. Ala. Admin. Code r. 610-X-6-.03(11).
18. Ala. Admin. Code r. 610-X-6-.03(15).
19. Ala. Admin. Code r. 610-X-8 authorizes the BoN to "reprimand, fine, probate, suspend, revoke and/or otherwise discipline" any RN or LPN found "guilty of unprofessional conduct of a character likely to deceive, defraud, or injure the public in matters pertaining to health, as demonstrated by one or more of the following: ... (a) Failure to practice nursing in accordance with the standards adopted by the Board ..., (f) Falsifying, altering, destroying, or attempting to destroy patient, employer, or employee records [,or] ... (h) Failure to respect or safeguard the patient's dignity, right to privacy, and confidential health information unless disclosure is required by law."
20. Ala. Code § 22-21-21(1975). The article's purpose is "to promote the public health, safety, and welfare by providing for the development, establishment, and enforcement of standards for the treatment and care of individuals in institutions within the purview of this article and the establishment, construction, maintenance, and operation of such institutions which will promote safe and adequate treatment and care of individuals in such institutions."
21. Ala. Code § 22-21-22 and § 22-21-23(1975). The BoH "may grant licenses for the operation of hospitals which are found to comply with the provisions of this article and any regulations lawfully promulgated by the State Board of Health." Ala. Code § 22-21-25(a) (1975).
22. Ala. Code § 22-21-28(a) (1975).
23. Ala. Code § 22-21-25(b)(1) (1975).
24. Ala. Admin. Code § 420-5-7-.13, "Medical Record Services."
25. Ala. Admin. Code r. 420-5-7-.13(3).
26. Ala. Admin. Code r. 420-5-7-.13(3).
27. Ala. Admin. Code r. 420-5-7-.13(4)(a).
28. *Husby v. South Alabama Nursing Home, Inc.*, 712 So. 2d 750, 753 (Ala. 1998); *Ex parte Northport Health Service, Inc.*, 682 So. 2d 52, 55 (Ala. 1996).
29. Ala. Code § 420-5-10-.03(32)-(36) "Administrative Management."
30. Ala. Admin. Code r. 420-5-10-.03(32).
31. Ala. Admin. Code r. 420-5-10-.03(33),(34).
32. Ala. Code § 22-21-20 (1975).
33. Ala. Admin. Code r. 420-5-4-.05, "Records And Reports."
34. Ala. Admin. Code r. 420-5-4-.05(1)(c).

35. Ala. Admin. Code r. 420-5-4-.05(3)(f).
36. Ala. Admin. Code r. 420-5-4-.05(e).
37. *Alabama Pattern Jury Instructions Civil* (3d ed. 2015), No. 15.12, "Spoliation of Evidence by Defendant [PL]."
38. *Id.*
39. *Alabama Pattern Jury Instructions Civil* (3d ed. 2015) No. 15-13, "Spoliation - Tort Claim [PL]."
40. Reference should also be made to the potential application of § 13A-10-129(a), Ala. Code 1975, "Tampering With Physical Evidence" and § 13A-10-130(a)(3), Ala. Code 1975 "Interfering With Judicial Proceedings."
41. See 42 CFR § 482.24, *et seq*.
42. See 42 CFR § 416.47, *et seq*.
43. See 42 CFR § 418.104, *et seq*.
44. See 42 CFR § 460.210, *et seq*.
45. See 42 CFR § 484.48, *et seq*.
46. See 42 CFR § 491.10, *et seq*.
47. See 42 CFR § 493.1105, *et seq*.
48. See 42 CFR § 494.170, *et seq*.
49. See 42 CFR §§ 485.50 - 485.74.
50. See 42 CFR §§ 485.601 - 485.647.
51. See 42 CFR §§ 485.701 - 485.729.
52. See 42 CFR §§ 485.900 - 485.918.
53. See 42 CFR §§ 482.1 through 482.23, 482.25 through 482.57 and 482.60 through 482.61.
54. Facts about the Joint Commission on Accreditation of Healthcare Organizations (*http://www.jcaho.org/about+us/index.htm*).
55. Those "elements" provide: "1. The hospital identifies the internal and external information needed to provide safe, quality care; 2. The hospital identifies how data and information enter, flow within, and leave the organization; 3. The hospital uses the identified information to guide development of processes to manage information; 4. Staff and licensed independent practitioners, selected by the hospital, participate in the assessment, selection, integration, and use of information management systems for the delivery of care, treatment, and services." CAMH, pp. IM - 3-4.
56. Standard RC.01.01.01 provides: "The hospital maintains complete and accurate medical records for each individual patient." Standard RC.01.02.01 provides: "Entries in the medical record are authenticated." Standard RC.01.03.01 provides: "Documentation in the medical record is entered in a timely manner." Standard RC.01.04.01 provides: "The hospital audits its medical records." Standard RC.01.05.01 provides: "The hospital retains its medical records." Standard RC.02.01.01 provides: "The medical record contains information that reflects the patient's care, treatment, and services." Element of Performance No. 2 for RC.02.01.01 is critical: 2. The medical record contains the following clinical information: • The reason(s) for admission for care, treatment, and services; • The patient's initial diagnosis, diagnostic impression(s), or condition(s); • Any findings of assessments and reassessments (*See also* PC.01.02.01, EPs 1 and 4; PC.03.01.03, EPs 1 and 8 ["PC" is Provision of Care, Treatment and Services, a chapter of its own]); • Any allergies to food; • Any allergies to medication; • Any conclusions or impressions drawn from the patient's medical history and physical examination; • Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections).

    Standard RC.02.01.03 provides: "The patient's medical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia." Standard RC.02.01.07 provides: "The medical record contains a summary list for each patient who receives continuing ambulatory care services." Standard RC.02.03.07 provides: "Qualified staff receive and record verbal orders." The Elements of Performance for this standard are important. They include: 1. The hospital identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation; 2. Only authorized staff receive and record verbal orders; 3. Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders; 4. Verbal orders are authenticated within the time frame specified by law and regulation. ...

    Standard RC.02.04.01 provides: "The hospital documents the patient's discharge information."
57. An event is also considered sentinel if it is one of the following:
    - Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED)
    - Unanticipated death of a full-term infant
    - Discharge of an infant to the wrong family
    - Abduction of any patient receiving care, treatment, and services
    - Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient
    - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
    - Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital
    - Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital
    - Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
    - Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
    - Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
    - Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
    - Fire, flame, or unanticipated smoke, or flashes occurring during an episode of patient care
    - Any intrapartum (related to the birth process) maternal death
    - Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in any of the following: Permanent harm or severe temporary harm

    CAMH SE - 1-3 (footnotes omitted).
58. *Galaxy Cable, Inc. v. Davis*, 58 So. 3d 93, 99 (Ala. 2010) citing *Standard Plan, Inc. v. Tucker*, 582 So. 2d 1024 (Ala. 1991); *King v. National Spa & Pool Inst., Inc.*, 570 So. 2d 612 (Ala. 1990).
59. *Id.*
60. ASTM E1384-07 (2013)
61. ASTM E2147-01 (2013)

62. ASTM-E1869-04 (2014)
63. ASTM E1633-08A (2013)
64. ASTM E1744-04 (2010)
65. ASTM E2538-06 (2011)
66. See Ala. Code § 12-21-6.1 (1975).
67. Ala. Code § 34-26-2 (1975) Confidential relations between licensed psychologists, licensed psychiatrists, or licensed
68. Ala. Code § 22-11A-22 (1975). Medical records of persons infected with sexually transmitted diseases confidential; penalty for release.
69. Ala. Code § 22-50-62 (1975). Disclosure of information.
70. See also, Lonette, E. Lamb, *To Tell or Not To Tell: Physicians Liability for Disclosure of Confidential Information About a Patient*, 13 CUMB. L. Rev. 617 (1983); Judy E. Zelin, *Annotation, Tort Liability for Unauthorized Disclosure of Confidential Information About Patient*, 48 ALR 4th 668 (1986 & Supp.)(collecting state and federal cases in which courts have considered whether tort liability exists when a physician or other medical practitioner makes an unauthorized disclosure of health information).
71. Pub. L 104-191, § 244, adopting 18 U.S.C. § 1035.
72. 18 U.S.C. § 1035(a)(2).
73. The privacy rule is found in parts 160 and 164 of 45 CFR.
74. 45 CFR § 160.103, Definition of "individually identifiable health information."
75. *Id*., definition of "protected health information."
76. 45 CFR § 164.502.
77. 45 CFR § 153.506(b)(1). "Health care operations" is defined in 42 CFR § 164.501 to include matters such as "[c]onducting quality assessment and improvement activities," "[r]eviewing the competence or qualifications of health care professionals," and other similar activities.
78. 45 CFR § 164.520(a)(1).
79. 45 CFR § 164.520(b)(1)(i).
80. 45 CFR § 164.524(a)(1).
81. 45 CFR § 164.524(a)(1)(i) and (ii).
82. Part 164, Subpart C, 45 CFR §§ 164.302 through 164.318 and Appendix A to Subpart C.
83. "More stringent" is defined in 45 C.F.R. § 160.202.
84. See, *e.g.*, *Moreland v. Austin*, 670 SE 2d 68, 71-72 (Ga. 2008) ("we find that HIPAA preempts Georgia law with regard to ex parte communications between defense counsel and plaintiff's prior treating physicians because HIPAA affords patients more control over their medical records when it comes to informal contacts between litigants and physicians. HIPAA ... prevents a medical provider from disseminating a patient's medical information in litigation, whether orally or in writing, without obtaining a court order or the patient's express consent, or fulfilling certain other procedural requirements designed to safeguard against improper use of the information."). See, also, David G. Wirtes, Jr., R. Edwin Lamberth, Joanna Gomez, *An Important Consequence of HIPAA: No More Ex Parte Communications Between Defense Attorneys And Plaintiffs' Treating Physicians*, 27 Am. Jnl. Trial Adv. 1 (Summer 2003).
85. 42 CFR § 482.13(a)-(d).
86. 42 CFR § 482.13(d)(2).
87. 45 C.F.R. § 164.512(e).
88. 45 C.F.R. § 164.512(e)(I), (II).
89. 45 C.F.R. § 164.512(b)(1).
90. See HITECH Act, Subtitle D, Part 2, § 13421:

    Sec. 13421. Relationship to Other Laws.

    (a) Application of HIPAA State Preemption.—Section 1178 of the Social Security Act (42 U.S.C. 1320d–7) shall apply to a provision or requirement under this subtitle in the same manner that such section applies to a provision or requirement under part C of title XI of such Act or a standard or implementation specification adopted or established under sections 1172 through 1174 of such Act.

    (b) Health Insurance Portability and Accountability Act.—The standards governing the privacy and security of individually identifiable health information promulgated by the Secretary under sections 262(a) and 264 of the Health Insurance Portability and Accountability Act of 1996 shall remain in effect to the extent that they are consistent with this subtitle. The Secretary shall by rule amend such Federal regulations as required to make such regulations consistent with this subtitle.

    (c) Construction.—Nothing in this subtitle shall constitute a waiver of any privilege otherwise applicable to an individual with respect to the protected health information of such individual.
91. Note that "fees charged to incur a profit from the disclosure of protected health information are not allowed. We believe allowing a profit margin would not be consistent with the language contained in Section 13405 of the HITECH Act." 78 F.R. 5566, 5607 (Jan. 25, 2013).

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