

**HOSPITAL MEDICAL RECORDS**

**By**

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\*The author acknowledges the work of Kim H. Roeder of Powell, Goldstein, Frazer & Murphy in Atlanta and the author of the Hospital Medical Records Chapter in the 1992 edition of the Georgia Hospital Law Manual which has been updated for this edition.

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## HOSPITAL MEDICAL RECORDS

### I. INTRODUCTION: NATURE AND PURPOSE OF MEDICAL RECORD

The medical records of a hospital are among the most vital documents maintained by the institution. They can also be among the most controversial. Developments in widely divergent areas have impacted the content and confidentiality of these records.

Surging technological advances and the constantly increasing sophistication of medical care can produce voluminous medical records. The greater interest of patients, as consumers of medical and hospital services, in the decisions and actions affecting them and their bodies generates greater numbers of patient requests to inspect and copy their medical records. Third party payment systems, malpractice litigation, peer review and quality assurance programs, HMO and PRO development, and the steady growth of research programs and government regulation all contribute to increase the number and variety of requests for access to and information about patient medical records. On the other hand, greater concern for the patient's rights of privacy and the confidentiality of the patient's medical record have initiated efforts to make those records more secure and access to them more carefully regulated. Many of these ideas and developments are in conflict, but they all intersect at the medical record, making it the subject of attention, interest and controversy.

Essentially, the hospital medical records is a documentary reservoir of information about the patient, the patient's medical condition and the treatment received at the hospital. The function of the record is to serve as the point of collection of the factual information and medical judgments about the patient. This case of information satisfies numerous purposes within the hospital:

(1) The record provides a data base with respect to each patient's care. The Patient's physical examination, medical history and laboratory tests results all go into the medical record. In making decisions concerning the patient's care in the hospital, the physician needs factual and medical information about the patient. It is the medical record which serves as the collection point for that information.

(2) The record serves as a medium for communication among the professionals involved with the patient's medical care. The attending physician writes orders for implementation by the nursing staff. Consulting physicians enter their diagnoses for the benefit of the attending physician. Nurses enter their notes and observations which aid the physician in assessing the patient's progress. When the health care professionals communicate verbally about the patient, the medical record documents that communication.

(2) The record provides input for statistical data. Lengthy of stay, readmission frequency, complication rates and other statistical information may be gleaned from the medical record for statistical analysis and research. The statistics may relate to an individual patient, to a group of patients within a single hospital or to a broader study. In large part, however, the medical record serves as the primary data collection point in all cases.

(4) The record provides the data needed for institutional evaluation, licensure, and accreditation. It may also provide information for peer review, utilization review, quality assurance programs and other efforts designed to evaluate the nature and level of patient care rendered in the institution and by his physicians.

(5) In the event of a dispute, the medical record may provide documentary evidence relevant to that dispute. If the patient brings suit against his physician or the hospital, the medical record is the primary document indicating the care rendered.

The role and purpose of the medical record influence its form, its content, the type of security to which it should be subjected and the length of its retention. Although there are numerous laws and regulations which impact upon the medical record and the activities of the medical record administrator, they should not obscure the primary function of the record, which must identify the patient, support the diagnosis, justify the treatment and document accurately the results of that treatment.

## **II. RECORDS REQUIRED: LEGAL AND ACCREDITATION STANDARDS**

The content of the medical record is influenced by many factors -- regulatory and accreditation requirements, reports which the hospital may be required to make, and the uses and purposes of the record as perceived by the institution and its physicians.

### **A. DHR Regulations**

The Georgia Department of Human Resources is by statute<sup>1</sup> given the power and authority to make reasonable, reports and regulations for the protection of the health of hospital patients. Pursuant to that authority DHR has promulgated regulations that specify certain records to be kept by each hospital.

#### **1. Medical Records<sup>2</sup>**

Every hospital is required to maintain for each patient a medical record maintaining sufficient information to validate the patient's diagnosis and to establish the basis upon which treatment is given. Those records must normally contain the following:

- a. Admission and discharge data
  - (1) Name, address, birth date, sex, martial status, and similar information
  - (2) Date and time of admission
  - (3) Date and time of discharge
  - (4) Admitting diagnosis
  - (5) Final diagnosis
  - (6) Condition on discharge

- (7) Attending physician's signature
- b. History and physical examination
  - (1) Personal history
  - (2) Family history
  - (3) Physical examination
  - (4) Psychiatric examination (if applicable)
- c. Treatment
  - (1) Practitioner's orders
  - (2) Progress notes
  - (3) Nurses notes
  - (4) Medication
  - (5) Temperature, pulse and respiration (T.P.R.)(graphic chart)
  - (6) Special examinations and reports
  - (7) Operation record (if applicable)
  - (8) Anesthesia record (if applicable)
  - (9) Consultation (if applicable)
  - (10) autopsy findings when performed
  - (11) Discharge summary
  - (12) Dental records - if dental services are performed a complete dental chart with dental diagnosis, treatment, proscription and progress notes shall be a part of the medical record

The regulations set forth several time requirements<sup>3</sup> for the recording of information in the patient's record. The admitting diagnosis must be recorded at the time of admission or within 24 hours thereafter. All orders on patients must be signed by the practitioner giving them. Telephone orders must be signed by the practitioner within 48 hours. The patient's history and physical examination must be recorded or dictated within 24 hours after the information becomes available. Practitioner's progress notes, signed by the attending practitioner, shall be written for all patients as needed, but at least weekly. There is no mention in the DHR regulations about use of a rubber stamp in lieu of manual signature. The regulations state that the various records must be "signed" by the practitioner.

## **2. Statistical and Operational Records<sup>4</sup>**

The hospital records relating to patient statistics and the institution's operations must be kept current and in such a manner that they will easily yield the following information:

- a. Daily admission and disposition record
- b. Monthly and yearly totals of admissions and discharges, excluding newborn

- c. Number of patient days per month and year
- d. Monthly and annual occupancy rate
- e. Number of beds and bassinets
- f. Number of births and fetal deaths
- g. Number of deaths
- h. Average census, daily, monthly and annual
- i. Number of autopsies

## **B. Required Reports**

As discussed in more detail below<sup>5</sup>, Georgia law requires that hospitals report various facts and events to governmental agencies, such as information relating to births, deaths and fetal deaths, release of bodies to third parties or the disposition of those bodies by the hospital, incidents of suspected child abuse, and diagnoses of venereal disease and other diseases classified by DHR as “notifiable.” Such mandatory reporting requirements logically affect both the content of the medical records and the manner in which they are kept. The medical record administrator must maintain current information about those required reports to assure that the hospital’s record keeping policies generate the information and retain the facts needed for the reports.

## **C. JCAHO Standards**

The Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”), in its Accreditation Manual for Hospitals (1991 edition)(“AMH”), sets forth minimum requirements for medical records<sup>6</sup>, which must contain (a) identification data (when not obtainable, the reason for absence of the information must be entered in the record); (b) the medical history of the patient; (c) the report of the relevant physical examination; (d) diagnostic and therapeutic orders; (e) evidence of appropriate informed consent (when consent is not obtainable, the reason for not obtaining it must be entered in the record); (f) clinical observations, including the results of therapy; (g) reports of procedures, tests and the results thereof; (h) a summary of the patient’s psychosocial needs, as appropriate to the age of the patient; and (i) conclusions at termination of hospitalization or evaluation/treatment. The medical record must also document periodic review of the planned course of action for the patient while in the hospital.

Medical records of children and adolescents must also contain (a) an evaluation of the patient’s developmental age; (b) consideration of educational needs and daily activities; (c) the patient’s immunization status; and (d) the family’s expectations for, and involvements in, the assessment, treatment and continuous care of the patient.

The JCAHO Standards discuss in detail the type of information expected for each category of entry. The Accreditation Manual is updated and published annually. The current edition should be reviewed regularly to assure compliance with the Standards.

## **D. Medicare Conditions of Participation**

In order for a hospital to be reimbursed under the Medicare program, it must first fit within the statutory definition of a “hospital.”<sup>7</sup> That definition requires in part that the institution maintain a diagnostic record on every patient. Moreover, the institution must enter into an agreement to accept and be governed by the Medicare Conditions of Participation.

The Conditions, found in the Medicare regulations, contain extensive provisions relating to a hospital’s medical record department.<sup>8</sup> A medical record must be maintained for every patient admitted for care in the hospital. The records must be kept confidential, and only authorized personnel may have access to the record. According to the Conditions, written consent of the patient is accepted as authority for release of medical information, but medical records are not to be removed from the hospital environment except in accordance with Federal or State laws, court orders or subpoenas. Medical records must be preserved in either original or “legally reproduced” form for at least five years.

Medical records must obtain sufficient information to justify admission and continued hospitalization, support the diagnosis and describe the patient’s progress. Entries must be legible, signed (by name and discipline) and dated.

These same Medicare regulations require that a hospital’s medical records contain the following information: history and physical examination (performed no more than 7 days prior to admission or within 48 hours after admission); admitting diagnosis; consultations; documentation of complications, infections, and drug or anesthesia reactions, executed consent forms; physician’s orders, nurses notes, treatment and medication records, and laboratory reports; discharge summary; and final diagnosis (with completion of medical record within thirty days of discharge).

Hospitals that participate in the Medicare program must regularly review the Conditions of Participation as they relate to those records. The failure to satisfy the applicable conditions may jeopardize a hospital’s reimbursement.

#### **E. Purpose and Function**

In addition to the state statutes and regulations specifying the content of medical records, laws and regulations requiring various reports, and the JCAHO Standards, the purpose and function of the medical record should JCAHO influence greatly its form, nature and content. The physicians on the medical staff should have great input into the nature and content of the record. They will be making significant input into the record’s content, and make important use of the information contained in it. The medical record must, therefore, satisfy the needs of the physicians in rendering patient care as well as satisfy the applicable legal and accreditation requirements.

### **III. RETENTION AND DESTRUCTION**

Medical records tend to be voluminous, and every hospital is faced with the problem of storage and deciding how long a particular medical record should be retained. Under the Georgia DHR regulations, hospital medical records may be preserved as “original records, microfilms or other

usable forms” so long as they are sufficient to afford a basis for a complete audit of the professional information contained in the record.<sup>9</sup> If retaining the records for the period of time deemed appropriate creates storage problems, therefore, microfilm or some other reduction process may be used to reduce storage requirements. Although the regulation suggests that a record could be placed on microfilm almost immediately, any delay and inconvenience in recalling a microfilm record as compared to the original form of record should influence the decision to place a record on microfilm. The regulations do not state whether computer software is a “usable form” of record preservation.

The length of time that a record is retained by a hospital depends upon the potential use of the record and specific legal requirements. DHR regulations require hospitals to retain all medical records for at least six years after a patient’s discharge.<sup>10</sup> In the case of a patient with multiple admissions, a conservative view would suggest retention of the records for six years after the most recent discharge. If the patient is a minor at the time of the discharge, the regulation states that the hospital records shall be retained until the patient’s 27th birthday. This regulation was promulgated, however, at a time when the age of majority in Georgia was 21 years. Since that date, the age of majority has been lowered to 18.<sup>11</sup> Although the language of the regulation has not been amended, it is obvious that it was intended to require retention for six years after a minor patient reached the age of majority. The purpose of both the regulation and the age of majority law should be satisfied if medical records are retained until a minor patient reaches the age of 24.

In addition to the regulatory requirements, the uses which may be made of the record should be considered in determining periods of retention. For example, teaching hospitals may want to retain records for more than six years in order to study changing teaching techniques and procedure results. The hospital’s involvement in peer review and quality assurance programs may suggest lengthy retention periods for certain medical records. If a hospital is involved in research or experimentation involving human subjects it must consider special retention periods for the applicable medical records. The results of medical experimentation may not become apparent for many years. Semi-permanent retention of those patient records may be appropriate.

Because medical records are often helpful in defense of a malpractice case, the statute of limitations must be considered. In Georgia, the statute of limitation for medical malpractice is generally two years.<sup>12</sup> That is, a suit based on any act of malpractice must be filed within two years after the injury or death arising from the act of malpractice occurred. Even if the patient did not discover the injury or the negligent act, nonmedical malpractice suit may be brought more than five years after the negligent act. Neither the two-year nor the five year period applies, however, where a foreign object has been left in the patient’s body.<sup>13</sup> In that circumstance, the suit must be brought within one year after the negligent or wrongful act or omission is discovered.

In addition, as part of the Medical Malpractice Reform Act of 1987, the Georgia legislature enacted provisions that may alter the period of time during which a medical malpractice action may be brought on behalf of a minor or incompetent person.<sup>14</sup> The Act includes provisions applying the two year malpractice statute of limitations to incompetents and minors over the age of five. The statute of limitations for minors younger than five is also two years, but measured from the child’s

fifth birthday. Finally, the Act includes a five year “statue of repose” beyond which no malpractice action may be brought.

In most instances, therefore, retention of the record for the period of six years (or six years beyond majority) required by DHR regulations should be appropriate for malpractice defense use. However, since the “foreign body” exception and other special circumstances may suspend the running of the statute of limitations for a period of time that cannot be determined in advance, it is practically impossible to determine a specific date upon which a medical record may be destroyed with certainty that a future need for it will not arise. Each hospital, in consultation with its own attorneys, must establish retention periods and destruction dates.

Federal record retention requirements relating to records generally may affect the medical records and should be considered in determining retention and destruction schedules for all hospital records, including the medical records.<sup>15</sup> The medical staff bylaws and policies of the medical staff may also affect the period of time that a hospital retains its medical records and the form it uses for that retention. Retention guidelines are from time to time published by industry associations and professional societies, such as the American Hospital Authority and the American College of Radiology, and will give additional guidance in establishing retention policies.

In addition to licensure sanctions or civil liability resulting from the unavailability of important evidence, improper destruction of medical records may result in criminal penalties. Any person who, with the intent to conceal a material fact relating to a potential claim, knowingly and willfully destroys, alters, or falsifies a patient’s record is guilty of a misdemeanor.<sup>16</sup> This provision applies to all patient health records, such as medical records, prescriptions and x-rays, and applies to records of all health care providers, including hospitals, nursing homes and private physician’s offices.

#### **IV. CONFIDENTIALITY; RELEASE OF INFORMATION**

##### **A. Confidentiality and Privilege**

The information contained in medical records is frequently labeled “confidential,” and the communications between patient and physician are often characterized as “privileged.” Although the concepts of confidentiality and privilege are similar, they are not the same. The patient-physician communications is “privileged” in that, unless there is a waiver of the privilege by the patient, the physician cannot be compelled to reveal those communications in response to a subpoena or compelled to testify about the communications in court. The concept of the privileged communication, therefore, arises in the context of legal proceedings, whether judicial or administrative in nature. Consistent with this concept, the Georgia privileged communication statute<sup>17</sup> is found in the law of evidence.

The notion that a medical record is “confidential” is more associated with the concept that the information is private, should remain secure and should not be made public. If a hospital were to

disclose information from a patient's medical record improperly, the patient may have a claim based upon the wrongful release of confidential information.

Even though there is a difference between confidentiality and privilege, it is difficult to discuss specific medical records without seeming to disregard the distinction. The same information is often subject to both doctrines - there is a substantial overlap between them. Authors, legislators and judges frequently discuss the concepts together or as if they were the same. And the mere fact that a communication is the subject of a privileged communication statute is some indication that the information contained in that communication is special and should be afforded special attention and rights.

## **B. Sources of Confidentiality**

### **1. General Legal Principles**

Although there are statutes and regulations which specifically identify patient records as confidential or privileged, medical ethics and general legal principles may also establish the confidential nature of information contained in medical records. These sources of confidentiality can generally be categorized as ethical considerations, laws relating to defamation (libel and slander), laws relating to a patient's right of privacy and personal security, and a potential contractual obligation to keep the information confidential.

a. Ethical Considerations. The Hippocratic Oath states the principles that many physicians identify as the source of confidentiality:

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

The ethical principle is based on the concept that the relationship between a patient and physician is a delicate and intimate one, and the relationship is more secure, leading to better patient care, if the information divulged by the patient in receiving that care is kept secret.<sup>18</sup> Patients would be reluctant to discuss some problems with their physicians or reveal intimate information that the physician needs to know in order to render appropriate care if the patient did not feel that the information would remain confidential.<sup>19</sup> The patient's confidence that information revealed to a physician will remain secure encourages candid disclosures which are necessary for proper care and treatment. This is as true in the hospital as in the physician's office.<sup>20</sup>

b. Defamation (Libel and Slander). Each person has the right to live free from false and malicious public statements about him and free from unwarranted invasions to his personal privacy. Violations of these rights may give a patient a claim against the person violating the rights. These claims are generally based on the legal theory of defamation or invasion of right of privacy.

Defamation involves communicating false or malicious information about another person. The communication can result in a claim for libel (if the communication is written) or slander (if the communication is oral). In Georgia, libel is defined as

a false and malicious defamation of another, expressed in print, writing, pictures or signs, intending to injure the reputation of an individual, and exposing him to public hatred, contempt or ridicule.<sup>21</sup>

In order for a libel to occur, the libelous matter must be published.<sup>22</sup>

Slander, or “oral defamation,” may take of four forms.<sup>23</sup>

1. Imputing to another a crime punishable by law;
2. Charging another with having some contagious disorder, or being the subject of some debasing act which may exclude him from society.
3. Charges made against another in reference to his trade, office, or being profession, calculated to injure him therein; or
4. Any disparaging words productive of special damages following naturally therefrom.

Although it may be theoretically possible for a patient to base a claim against a hospital on defamation, it is unlikely that release of information from a medical record will produce a successful claim.<sup>24</sup> First, truth is an absolute defense to a libel or slander claim,. If the information is substantially true and the publication is made in good faith, no defamation claim can be asserted by the patient.<sup>25</sup> Second, many communications are “privileged,” or publishable even though they might otherwise constitute defamation. Privileged communications in this area include statements made in the bona fide performance of a public or private (whether legal or moral) duty, statements made with the bona fide intent to protect the speaker’s own interest, and comments upon the acts of public figures in their public capacity and in reference to that capacity.<sup>26</sup> Third, the patient must prove malice. The absence of malice may eliminate the damages in many defamation actions and, in the case of privileged communications, it may bar recovery.<sup>27</sup>

c. Right of Privacy. The right of privacy is often referred to as the “right to be left alone.” It was first discussed as a separate private legal right in an 1890 Harvard Law Review article<sup>28</sup>, and since then has become widely accepted, both among legal scholars and courts. Invasion of the right of privacy is now said to consist of four different torts: (1) intrusion upon a person’s seclusion or into his private affairs; (2) public disclosure of embarrassing private facts; (3) publicity which places a person in a false light in the public eye; and (4) the appropriation of a person’s name or likeness for another’s advantage.<sup>29</sup>

One of the earliest and leading cases recognizing the right of privacy was decided by the Georgia Supreme Court in 1905. In Pavesich v. New England Life Insurance Co.,<sup>30</sup> the Georgia Court rejected the approach taken by a New York court which had refused to recognize the right<sup>31</sup>, and became the first State Supreme Court to recognize the individual's right to privacy. In that case, an insurance company used a photograph of Mr. Pavesich to advertise its policies. Mr. Pavesich had in fact never owned one of the defendant's policies nor had he ever made any of the statements attributed to him in the ad. In its decision, the Georgia Supreme Court stated:

The right of privacy is embraced within the absolute rights of personal security and personal liberty.

Personal security includes the right to exist and the rights to the enjoyment of life while existing, and is invaded not only by deprivation of life, but also by a deprivation of those things which are necessary to the enjoyment of life according to the nature, temperament, and lawful desires of the individual.

Personal liberty includes not only freedom from physical restraint, but also the right "to be let alone" to determine one's mode of life, whether it shall be a life of publicity or of privacy, and to order one's life and manage one's affairs in a manner that may be most agreeable to him, so long as he does not violate the rights of others or the public . . .

The right of privacy may be viewed either expressly or by implication, except as to those matters which law or public policy demands shall be kept private; but a waiver authorizes an invasion of the right only to such an extent as is necessarily to be inferred from the purpose for which the waiver is made. A waiver for one purpose and in favor of one person or class does not authorize an invasion for all purposes or by all persons and classes . . .

Publication of a picture of a person, without his consent, as a part of an advertisement, for the purpose of exploiting the publisher's business, is a violation of the right of privacy of the person whose pictures is reproduced . . .

In Bazemore v. Savannah Hospital<sup>32</sup>, the Georgia courts extended the right of privacy to the public disclosure of private facts. The Bazemore's child was born with its heart outside of its body and was carried by the family physician to Savannah Hospital for an operation. The operation was unsuccessful and the child died. The hospital permitted photographs of the nude child and its unusual medical condition to be taken. The photographs were later published in the local newspaper. The Georgia Supreme Court refused to dismiss the case brought by the Bazemores, recognizing that they had properly stated a claim for invasion of their rights of privacy.

In McDaniel v. Atlanta Coca-Cola Bottling Co.<sup>33</sup>, the Court of Appeals specifically recognized another element of violation of a person's right of privacy, the element consisting of intrusion into his physical solitude or seclusion. Mrs. McDaniel claimed that, while a patient at Emory Hospital, defendant placed a microphone in her hospital room which allowed a person in

another room to listen to her private conversations. The court rejected arguments by the defendant that publication or commercialization of the information obtained was a necessary element of violation of the right of privacy. The court said that “publication or commercialization may aggregate, but the individual’s right to privacy is invaded and violated nevertheless in the original act of intrusion.” It would not be necessary, therefore, for information in a patient’s medical record to be publicized or used for a commercial purpose before the patient would have a claim for violation of his right of privacy. Mere intrusion, or allowing unauthorized persons access to the record, may be sufficient.

In the context of the hospital medical record and use of information in that record, the most likely right of privacy violation would involve the public disclosure of private facts. In Dennis v. Adcock<sup>34</sup> the Georgia Court of Appeals indicated that unauthorized publicity about the contents of medical records, such as “the patient’s state of health, his anatomical debilities, and the opinions, diagnoses and tests of his doctors” would constitute an invasion of the personal privacy of the patient. This idea was most clearly pronounced by a Missouri court which said that if there is any right of privacy at all, it should include the right to obtain treatment in a hospital for an individual personal condition without personal publicity.<sup>35</sup>

The right of privacy is not, however, absolute. If the person consents to the invasion of his right of privacy, he cannot complain about that invasion.<sup>36</sup> If the person is a public figure or involved in a matter of public interest, his right of privacy may be lost or substantially curtailed. It may be either the person or an event in which he is involved that affects the privacy right. If an individual has become a “public personage,” or a celebrity, information may be publicized about him without creating liability for invasion of a right of privacy. If an individual is involved in a newsworthy event, such as a murder or calamity, publication of information about the individual may involve the public interest and not constitute a violation of his right of privacy.<sup>37</sup> Moreover, only “unwarranted” invasions of a person’s right of privacy give rise to liability. Thus a “warranted” invasion of the right does not create liability. The right of privacy does not prohibit the communication of a private matter if the publication is made under circumstances which would render it a privileged communication under the law of libel and slander.<sup>38</sup>

d. Contract. Although the Georgia courts have not acted in this area, there is law in other jurisdictions which indicates that a physician may have a contractual duty to his patient to keep information in the medical record confidential. In an Alabama case,<sup>39</sup> a physician furnished medical information to his patient’s employer without the patient’s consent. When the patient lost his job, he filed suit against the doctors based in part upon breach of contract. The court refused to dismiss the contract claim, suggesting that it had found no case which had rejected the implied contract of confidentiality, and that general public knowledge of the principle of secrecy in medical ethics may well create a reasonable expectation by the patient that his physician agrees to keep in confidence all information given by the patient. In an Ohio federal court case,<sup>40</sup> an insurance company persuaded a doctor to release information from the patient’s medical record. The court suggested that one of the implied provisions of the contract between patient and physician was that confidential information obtained as a part of the physician-patient relationship was not to be disclosed without the patient’s permission.

These cases seem consistent with a physician's ethical obligations which require that information obtained from patients be kept confidential unless (1) the physician is required to reveal the information by law or (2) it becomes necessary to release the information in order to protect the welfare of the individual or community.<sup>41</sup>

## **2. Specific Statutes and Regulations**

The confidential nature of medical records is in many instances specified by statute or regulation, either state or federal. As discussed above, there is a distinction between privileged communications and confidential information, although the concepts are similar and are often combined and confused. The following identification of statutes and regulations includes both those which identify records as confidential and those which relate to privileged communications.

a. Patient-Psychiatrist Communications. O.C.G.A. § 24-9-21 states that there are certain admissions and communications excluded from consideration of public policy. The statute includes communications between psychiatrist and patient within the category. The privileged nature of the communication extends beyond the death of the patient.<sup>42</sup> In order for the communication to be protected, however, the relationship of psychiatrist and patient must exist, such as that which arises when a patient sees a psychiatrist on his own volition for the purpose of gaining professional psychiatric assistance.<sup>43</sup> If the psychiatrist is appointed by a court to examine a person, the required relationship does not arise, and the psychiatrist may be called upon to testify about statements made to him during the course of his examination.<sup>44</sup>

b. Patient-Physician Communications. Georgia law was amended in 1978 to include physician-patient communications within the scope of confidentiality. The law was again amended in 1986 to extend the same protection to hospital and health care facility records. O.C.G.A. § 24-9-40 states that no licensed physician and no hospital or health care facility shall be required to release any medical information concerning a patient except (a) to DHR, when required in the administration of public health programs pursuant to O.C.G.A. § 31-12-2 (governing the reporting of certain diseases) and when authorized or required by law, statute or unlawful regulation; or (b) on written authorization or other waiver by the patient; or (c) on appropriate court order or subpoena. If a physician or health care facility does release information pursuant to a written authorization or other waiver by the patient, pursuant to a court order or subpoena, or as otherwise required by a valid law or regulation, the physician or institution shall not be held liable to the patient or any other person. Moreover, the privilege which attaches to the communications between a patient and physician or health care facility is waived to the extent that the patient places his care or treatment or the nature and extent of his injuries at issue in any civil or criminal proceedings. This subsection of the code does not apply to patient-psychiatrist communications or to hospitals in which the patient was treated solely for mental illness.

The provision of the Code is of questionable value to patients. Probably the most frequently used method of obtaining medical information without patient authorization is by subpoena. It is not difficult to obtain a subpoena once court action has been initiated.<sup>45</sup> If the privilege does not

protect the information from subpoena, therefore, the patient may not have the protection which the statute at first reading appears to grant.

The law relating to pretrial discovery in civil litigation allows the parties to discover any relevant information “not privileged.”<sup>46</sup> The fact that patient-physician communications are treated as a part of the Georgia statute relating to confidential communications generally may be sufficient to make the communication “privileged” within the meaning of the discovery statute, therefore not subject to discovery. The statement in the confidential communication statute itself however, stating that those communications can be released pursuant to subpoena, may create an exception to the discovery rule. The Court of Appeals in Orr v. Sievert<sup>47</sup> interpreted the implied waiver that arises when a patient places her or her medical condition at issue in a suit as an exception to the discovery rule. After such an implied waiver, the patient may not complain that physicians or health care facilities released relevant medical information pursuant to a discovery request.

c. Licensed Psychologist. Communications with licensed psychologists are also accorded special protection. “The confidential relations and communications between licensed psychologist and client are placed upon the same basis as those provided by law between attorney and client.” In 1995, the Georgia legislature accorded protection of communications between the client and a (1) licensed clinical social worker, (2) clinical nurse specialists in psychiatric/mental health, (3) licensed marriage and family therapist, and (4) licensed professional counselor during the psychotherapeutic relationship as well as communications among these health care professionals.<sup>48</sup>

The statutes making attorney-client communications privileged<sup>49</sup> are the same statutes which identify psychiatrist-patient communications as privileged. To a large extent, therefore, a patient’s (or client’s) communications to a licensed psychologist are treated the same as a patient’s communications to his psychiatrist. The privilege may, however, be broader than that. Communications to an attorney pending or in anticipation of employment may not be heard by a court. An attorney may not disclose the advice or counsel he gives to his client nor may he testify about any information he may have acquired from his client as an attorney.<sup>50</sup> These broader rules appear to apply to the relationship between client and licensed psychologist. In order for the psychologist-patient privilege to arise, the patient must voluntarily seek treatment from the psychologist.<sup>51</sup>

It should also be noted that it is “confidential” communications that are protected and that the protection only extends to “communication.” The mere fact that a person is a client of a licensed psychologist is not subject to the privilege. Thus, a licensed psychologist may, for example, be required to produce his check stubs which may show deposits of patient payments and his daily appointment book.<sup>52</sup>

Confidential communications to other mental health professionals are not privileged under this Code section. The Court of Appeals has strictly construed the statute, and refused to extend any privilege to confidential communications between clients and “social workers/counselors” or between clients and “clinical chaplains” or “behavior specialists.”<sup>53</sup>

d. Drug Dependent Person. Any communication by a drug dependent person to an authorized employee of a person holding a license under the Georgia Drug Abuse Treatment and Education Act is confidential.<sup>54</sup> Unless, however, the communications are also privileged under other state laws, the records may be obtained by a court order after a full and fair show-cause hearing. The Department of Human Resources may also have access to the records for licensing purposes.

e. Alcoholics, Drug Dependent Individuals and Drug Abusers. Any facility utilized for the diagnosis, care, treatment or hospitalization of persons who are alcoholics, drug dependent individuals or drug abusers, and any other hospital or facility within the State of Georgia approved for such purpose by the Department of Human Resources, is subject to additional confidentiality provisions imposed by state law.<sup>55</sup>

Provisions of that Chapter require that a clinical record for each patient be maintained.<sup>56</sup> The record must include data relating to admission and other information as required pursuant to regulations of the Department of Human Resources. The clinical record includes all medical records, progress notes, charts, admission and discharge data and all other information recorded by a facility which pertains to a patient's hospitalization and treatment.<sup>57</sup> The clinical record "shall not be a public record and no part of it shall be released" unless pursuant to one of the exceptions<sup>58</sup> set forth in the Act. The exceptions are as follows:

1. A copy of the record may be released to any person designated in writing by the patient or, if appropriate, his parent or guardian. If the patient is deceased, then a copy of the record may be released pursuant to a valid subpoena of a coroner or medical examiner.
2. When a patient is admitted, a copy of his record from another facility or kept by a private practitioner may be released to the admitting facility. The record or information from the record may be released to any facility, community mental health center or private practitioner to whom the patient is transferred.
3. A copy of the record may be disclosed to any employee or staff member of the facility when necessary for the proper treatment of the patient.
4. A copy of the record shall be released to the patient's attorney if the attorney requests the record and the patient or the patient's legal guardian consents to the release.
5. If the physician treating the patient determines that a bona fide medical emergency exists, the chief medical officer of the facility may release a copy of the patient's record to the treating physician or psychologist.
6. A copy of the patient's record may be released pursuant to a subpoena only if that subpoena is accompanied by the order of a court of competent

jurisdiction ordering the release of the record after a full and fair cause hearing. A subpoena alone is not sufficient to release records under this exception. If the subpoena is accompanied by a court order, the facility should inquire about the authority and jurisdiction of the court. If the order does not recite on its face that a full and fair show cause hearing has been held, further inquiry about that requirement should also be made. Reference in the statute to the order of a “court” would appear to exclude orders issued by administrative or other agencies or bodies, such as the Workers’ Compensation Board.

7. If a hearing is held under the Act, a copy of the records shall be produced at that hearing at the request of the patient or his attorney.
8. A copy of patient records may be released to certain medical agencies, societies and committees for purposes of advancing medical research or medical education, or to achieve the most effective use of manpower or facilities, in the interest of reducing rates of morbidity or mortality.
9. A copy of the record may be released to the legal representative of a deceased patient’s estate except for matters privileged under the laws of Georgia.
10. If a law enforcement officer in the course of investigating the commission of a crime on the premises of a health care facility or against the facility personnel for a threat to commit such a crime, the law enforcement officer may be informed as to the circumstances of the incident, including whether the individual allegedly committing or threatening to commit a crime is or has been a patient in the facility, and the name, address and last known whereabouts of any alleged patient perpetrator.

In connection with any hearing held under the Act, any physician, psychiatrist or psychologist who is treating or has treated the patient may testify about any manner concerning the patient, including testimony about communications which would otherwise be privileged under the psychiatrist-patient or psychologist-patient privileges.<sup>59</sup>

Any disclosure of information from a patient’s clinical record, whether authorized under the exceptions stated above or otherwise, does not destroy the confidential or privileged character of the communication, except for the purpose for which an authorized disclosure is made.<sup>60</sup> Further disclosure would, therefore, require independent compliance with one of the exceptions noted. Any person making a disclosure authorized by the statute shall not be liable for the patient for doing so.<sup>61</sup>

Prior to 1985, a law enforcement officer in the course of a criminal investigation could verify whether or not a person had been treated in a drug or alcohol rehabilitation program and could

obtain that person's most recent address. This provision has been deleted. Any such releases of information must now be made pursuant to a court order.

f. Mentally Ill Persons. Similar Code provisions, entitled "Hospitalization and Treatment Procedures for the Mentally Ill," relate generally to any state-owned hospital or other facility which is used for the diagnosis, care, treatment or hospitalization of persons who are mentally ill, any facility operated or utilized for those purposes by the Veterans Administration or other federal agency, and any other hospital or facility within the State of Georgia approved for those purposes by the Department of Human Resources.<sup>62</sup> Portions of the Act deal specifically with emergency receiving facilities, evaluating facilities and treatment facilities.

Among the rights given to patient's under the Act are those relating to confidentiality.<sup>63</sup> That section requires that a clinical record be maintained for each patient, which shall include data pertaining to admission and such other information as may be required under DHR regulations. The clinical record also includes all medical records, progress notes, charts, admission and discharge data and all other information needed by a facility which pertains to the patient's hospitalization and treatment.<sup>64</sup> That record "shall not be a public record and no part of it shall be released" unless pursuant to one of the exceptions<sup>65</sup> set forth in the Act. A person making an authorized disclosure will not be liable to a patient or other person. The exceptions are:

1. If the chief medical officer of the facility maintaining the record deems release essential for continued treatment, the record or part of it may be released to physicians or licensed psychologists when and as necessary for treatment of the patient.
2. A copy of the record may be released to any person designated in writing by the patient, or if appropriate, his parent or guardian or, if the patient is deceased, to or in response to a valid subpoena of a coroner or medical examiner.
3. When a patient is admitted, his record from another facility or kept by a private practitioner may be released to the admitting facility. The record or information from the record may be released to any facility, community mental health center or private practitioner to whom the patient is transferred.
4. Any part of the record may be disclosed to an employee or staff member of the facility when it is necessary for the proper treatment of the patient.
5. The record shall be released to the patient's attorney if the attorney requests that release and the patient consents to it.
6. If the physician treating the patient determines that a bona fide medical emergency exists, the chief medical officer of the facility may release the patient's record to that physician or to the patient or his attorney.

7. In the event of a hearing held under the Act, the record shall be produced at the request of the patient or his attorney.
8. The record shall be produced in response to a valid subpoena or the order of any court of competent jurisdiction, except for matters privileged under the laws of the State of Georgia.
9. A law enforcement officer in the course of a criminal investigation may be informed whether a person is or has been a patient in a State facility as well as the patient's current address, if known. The statute does not define "State facility," but it would apparently be one either owned or operated by the State. The Act does define "private facility" as including proprietary, non-profit hospitals and hospitals operated by hospital authorities.<sup>66</sup> Presumably, these would not fall within the definition of a State facility.
10. If a law enforcement officer in the course of investigating the commission of a crime on the premises of a health care facility or against the facility personnel for a threat to commit such a crime, the law enforcement officer may be informed as to the circumstances of the incident, including whether the individual allegedly committing or threatening to commit a crime is or has been a patient in the facility, and the name, address and last known whereabouts of any alleged patient perpetrator.

In connection with any hearing held under the Act, any physician, psychiatrist or psychologist who is treating or has treated the patient may testify about any matter concerning the patient, including testimony about communications which would otherwise be privileged under the psychiatrist-patient or psychologist-patient privilege.<sup>67</sup>

When a sheriff transport an adult involuntary patient to a facility, that sheriff may request in writing that a notice of the patient's discharge be given to the sheriff. The notice shall be given if the patient or the patient's guardian consents in writing to the disclosure or if, in its discretion, the court ordering the involuntary treatment provides for the notice in its order for treatment.<sup>68</sup>

Any disclosure of information from a patient's clinical record, whether authorized under the exceptions stated above or otherwise, does not destroy the confidential or privileged character of the communication, except for the purpose for which an authorized disclosure is made.<sup>69</sup> Further disclosure would, therefore, require independent compliance with one of the exceptions noted.

g. Mentally Retarded Persons. The Georgia law regarding Habilitation of Mentally Retarded Persons contains confidentiality provisions virtually identical to those discussed above in connection with facilities treating the mentally ill, alcoholics and drug abusers.<sup>70</sup> The Act defines mental retardation as a state of "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior which originates in the development period."<sup>71</sup> A "facility" is defined as any State-owned or State-operated institution

“utilized 24 hours a day” for the habilitation and residence of persons who are mentally retarded, any facility utilized or operated for such purpose by the Veterans Administration or other federal agency and any other facility within the State of Georgia approved for that purpose by the Department of Human Resources.<sup>72</sup>

The Act requires that a clinical record for each client be maintained.<sup>73</sup> A clinical record contains all habilitation records, progress notes, charts, admission and discharge data and all other information recorded by a facility which pertained to the client’s habilitation.<sup>74</sup> The clinical record shall :not be a public record and no part of it shall be released” unless pursuant to the exceptions<sup>75</sup> set forth in the statute. Any persons making an authorized disclosure shall not be liable to the patient or other persons.<sup>76</sup> The exceptions are as follows:

1. If the superintendent of the facility maintaining the record deems it essential for continued habilitation, any part of the record may be released to persons in charge of the client’s habilitation when and as necessary for that habilitation.
2. A copy of the record may be released to any person designated in writing by the client or, if appropriate, his parent or guardian.
3. If the habilitation plan involves transfer of the client to another facility, or involves the receipt of community services by the client, the record may be released to that facility or to the entity rendering the community service.
4. Any part of the record may be disclosed to employees and staff members of the facility when it is necessary for the proper habilitation of the client.
5. The record shall be released to the client’s attorney if the attorney requests the release and the client consents to it.
6. If a physician treating the client determines that a bona fide medical emergency exists, the superintendent of the facility may release the client’s record to that physician (but not to a psychologist in this case).
7. If a hearing under the Chapter is held, the record may be produced at the request of the client or his attorney.
8. The record shall be produced in response to a valid subpoena of any court or competent jurisdiction, except for matters privileged under the laws of the State of Georgia.
9. A law enforcement officer in the course of a criminal investigation may be informed whether a person is or has been a client in a state facility as well as the client’s current address, if known. The statute does not define “state

facility” or “private facility.” but these terms would likely be interpreted as noted above.

10. If a law enforcement officer in the course of investigating the commission of a crime on the premises of a health care facility or against the facility personnel for a threat to commit such a crime, the law enforcement officer may be informed as to the circumstances of the incident, including whether the individual allegedly committing or threatening to commit a crime is or has been a patient in the facility, and the name, address and last known whereabouts of any alleged patient perpetrator.

In connection with any hearing held under the Act, any physician, psychiatrist or psychologist who is treating or has treated the patient may testify about any matter concerning the patient, including testimony about communications which would otherwise be privileged under the psychiatrist-patient or psychologist-patient privilege.<sup>77</sup>

Any disclosure of information from a patient’s clinical record, whether authorized under the exceptions stated above or otherwise, does not destroy the confidential or privileged character of the communication, except for the purpose for which an authorized disclosure is made.<sup>78</sup> Further disclosure would, therefore, require independent compliance with one of the exceptions noted.

h. Alcoholic and Intoxicated Persons. In 1974, the State enacted legislation regarding the Treatment of Alcoholism and Intoxication, based upon the declared State policy that alcoholics may not be subject to criminal prosecution because of their consumption of alcoholic beverages but rather should be treated in a manner that they may lead normal lives as productive members of society.<sup>79</sup> The effective date of the statute had been postponed on an annual basis since 1975, and the law was ultimately repealed by the legislature in 1994.

If this statute had become effective, it would have provided that the “registration and other records” of treatment facilities shall remain confidential and privileged.<sup>80</sup> With proper consent of the patient or any person authorized to give consent to medical treatment under the Georgia Medical Consent Law, information from patient records may have been made available to researchers or professionals who are treating the patient for the purposes of research into the causes and treatment of alcoholism. Such information shall not, however, be published in a way that discloses a patient’s name or other identifying information.<sup>81</sup>

i. Drug and Alcohol Abusers. Portions of the comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970<sup>82</sup> and the Drug Abuse Office and Treatment of 1972<sup>83</sup> provide confidentiality to records of the identity, diagnosis, prognosis and treatment of any person maintained in connection with the performance of certain alcohol and drug abuse treatment programs conducted or assisted by a department or agency of the United States. Those records may be disclosed only for the purposes and under the circumstances expressly set forth by the respective statutes, or the regulations promulgated pursuant to them.

The statutes contain only general and broad provisions. Each statute, however, contains a comprehensive grant of regulatory authority. Regulations promulgated under the Acts are lengthy, comprehensive and complex.<sup>84</sup> They must be studied closely and in detail before any specific determination can be made about their applicability or whether they permit release of specific information. This discussion can only indicate the content of the regulations in a general manner.

The regulations contain extensive definitions, which are often determinative of an issue. The definitions should never be overlooked in considering questions subject to those regulations. Certain types of communications are excluded from application of the regulations.<sup>85</sup> These include communications within a treatment program between personnel having a need for the information in connection with their duties, communications between a program and a “qualified service organization” (itself a defined term, including outside organizations which render services to a treatment program and which agree to observe patient confidentiality, such as accountants, attorneys for the institutions, computer service bureaus and the like), and communications which include neither patient identifying information nor identifying numbers assigned to the patient.

The regulations apply to the records of the identity, diagnosis, prognosis or treatment of any patient which are maintained in connection with the performance of any alcohol abuse or drug abuse prevention function which is conducted, regulated or directly or indirectly assisted by any department or agency of the United States. Included are programs aided directly or indirectly by government grant or contract, subject to licensure or authorization by a department or agency of the federal government, assisted by state and local governments with federal funds, or assisted by tax laws, whether by allowing tax exemptions for contributions to the institution or granting tax exempt status to the institution.<sup>86</sup>

Effective August 1987, the confidentiality regulations apply only to a program that holds itself out as providing and proves alcohol or drug abuse diagnosis, treatment or referral for treatment.<sup>87</sup> Facilities which do not have specialized alcohol or drug abuse treatment programs, but which provide alcohol and drug abuse care only as an incident to the provision of general medical care, are not subject to the regulations.

Once it has been determined that a facility offers a specialized treatment program and that the program receives federal financial assistance, all records of that program are protected, regardless of the presence or absence of federal financial assistance for an individual patient.<sup>88</sup>

The records subject to the regulations are classified as confidential, and they may be disclosed only as specifically authorized by the regulations. If release of information is not specifically set forth in the regulation, the record cannot be disclosed. “Unconditioned compliance” is required. The rules apply even if the person seeking the record already has the information sought, has other means of obtaining it, enjoys official status, has obtained a subpoena, or asserts any other justification or basis for disclosure not expressly authorized in the regulations.<sup>89</sup> This may be somewhat difficult to explain to an irate sheriff or FBI agent standing at the hospital’s front door, armed with a subpoena and threatening dire consequences. Intimidation, however, is not specifically set forth in the regulations as a basis for release of information. Intimidation, however, is not

specifically set forth in the regulations as a basis for release of information. Hospitals might consider advising local law enforcement and other officials who might seek access to the protected records about these regulations prior to the time that a specific request for the information is made. In many instances this may help avoid misunderstandings and confrontation.

With the patient's consent, confidential information may be released to specific types of recipients, such as (a) the patient's attorney, (b) the patient's family and others with whom he has a personal relationship, (c) third payers and funding sources, (d) employers and employment agencies, (e) certain persons involved in the criminal justice system and (f) to other persons when it is deemed beneficial to the patient and it appears certain that the patient's consent was given freely and voluntarily, and that disclosure of the information will not be harmful to the patient.<sup>90</sup>

Patient consent as contemplated by the regulations is not the standard consent. Moreover, only the consent form which complies with the technical provisions of the regulation is permitted.<sup>91</sup> The consent must be in writing and must contain (1) the name of the program which is to make the disclosure or a general designation of the program, (2) the name or title of the person or organization to which the disclosure is to be made, (3) the name of the patient, (4) the purpose or need for the disclosure, (5) the extent or nature of information to be disclosed, (6) a statement that the consent is subject to revocation at any time except to the extent that action has already been taken in reliance thereon, and a specification of the date, event or condition upon which the consent will expire without express revocation, (7) the date upon which the consent is signed, and (8) the signature of the patient or other person authorized by the regulation to sign for him. If the consent on its face substantially fails to conform to these technical requirements, or if it is known or should be known that the information on the consent is materially false with respect to any item, the consent may not be honored and the information may not be released.<sup>92</sup>

When information is released pursuant to patient consent, the information must be accompanied by a notice stating that the information has been released pursuant to patient consent and cannot be further disclosed without a separate consent of the patient or as otherwise permitted by the regulations.<sup>93</sup> The patient is permitted to consent at the time of the initial disclosure to further disclosure of the information by a recipient.

Confidential information may be disclosed without the patient's consent only under very limited circumstances.<sup>94</sup> Information may be disclosed to medical personnel who need the information in order to treat the patient in a bona fide medical emergency. Immediately following such a disclosure, the program must document in the medical record:

- (1) the name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;
- (2) the name of the individual making the disclosure;
- (3) the date and time of the disclosure; and

- (4) the nature of the medical emergency justifying the disclosure.

Subject to certain specific limitations, the information may also be disclosed for the purposes of conducting scientific research, management audits, financial audits or program evaluations, including those conducted by state and federal governmental agencies. Reports may also be made, without patient consent, of incidents of suspected child abuse and neglect required by law to be reported to state or local authorities. The patient's medical record will, however, still be protected by the regulations and a court order must be obtained prior to its release.

Otherwise, the confidential information may only be disclosed pursuant to court order. A mere subpoena is not sufficient. The regulations provide as an example that "a person holding records subject to these regulations receives a subpoena for those records: a response to the subpoena is not permitted unless an authorized court order is entered" which technically complies with the statute and regulations.<sup>95</sup> The order should be issued only after a hearing is held and the record of that hearing shows that good cause exists for the order. In assessing good cause, the court must weight the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.<sup>96</sup>

At the time of admission, or as soon thereafter as the patient is capable of rational communication, the program must provide the patient with a written summary of these confidentiality requirements. The regulations include a simple notice which may be provided to patients.

j. Abused Children. Georgia law provides that "each and every record concerning reports of child abuse and child controlled substance or marijuana abuse" which may be in the custody of Department of Human Resources or any other state and local agency is confidential and that access to the record is prohibited except to those persons specified in the statute.<sup>97</sup> Any person who permits access to such records by a person or agency not specifically identified shall be guilty of a misdemeanor.<sup>98</sup>

Amendments in 1990 and 1991 greatly expanded the persons who are permitted access to reports of child abuse controlled substance or marijuana abuse which may be in the custody of the Department of Human Resources or other state or local agencies. The following have access to those reports.<sup>99</sup>

1. Any legally mandated, public or private, child protective agency, in any state, which is investigating a report of known or suspected child abuse or treating a child or family which is the subject of a report or record, provided that the agency is subject to similar confidentiality provisions and requirements as provided by Georgia law;
2. A court, by subpoena, when it finds that access to the records may be necessary for determination of an issue before the court;

3. A grand jury, by subpoena, when it determines that access to the records is necessary in the conduct of its official business;
4. Any district attorney or assistant district attorney who seeks access in connection with official duty;
5. Any adult who reports suspected child abuse, provided that access shall be limited to notification requested by the adult of the status of any investigation of the suspected abuse and, if such investigation is completed, whether child abuse was confirmed or unconfirmed;
6. Any adult requesting information regarding an identified deceased child, provided that such information shall be limited to whether there is an ongoing or completed investigation of the death and, if completed, whether child abuse was confirmed or unconfirmed; and
7. The State Personnel Board, by administrative subpoena, upon a finding by the Board's hearing officer that access to the records is necessary for a determination of an issue involving the conduct of departmental personnel in child related employment activities. Those parts of the record which are irrelevant to the employee's child related employment activities, and the name of the complainant or client, may not be disclosed.
8. Police or other state law enforcement officials or any medical examiner or coroner investigating or reporting on known or suspected child abuse.
9. Governor, Attorney General, Lieutenant Governor or the Speaker of the House of Representatives when such officer makes a written request to the Commissioner of the Department which specifies the name of the child for which such access is sought and which describes such officer's need to have access to such records.

Records may also be disclosed for legitimate research for educational, scientific, or public purposes upon application to and hearing before the juvenile court in the county in which the records are located. The names and addresses of persons other than officials, employees, or agents of the agency investigating or treating child abuse must be deleted from any information which is released for purposes of research unless the court determines that having the names and addresses open for review is essential to the research and the child, through his or her representative, gives consent to the release.<sup>100</sup>

In addition, DHR or a county, state or local agency may, when it considers access appropriate, permit access to child abuse records by, or release information from such records to:<sup>101</sup>

1. A physician treating a child he or she suspects may be abused;

2. Police, law enforcement agencies, medical examiners or coroners, in any state, investigating a child abuse report;
3. A person legally authorized to place a child in protective custody when necessary to make certain protective custody decisions;
4. An agency or person, including a parent, having legal custody or responsibility of caring for a child that is the subject of a child abuse report;
5. An agency, facility, or person having responsibility or authorization to assist in making a judicial determination for the child who is the subject of the report;
6. A legally mandated public child protective agency or law enforcement agency of another state, which is subject to similar confidentiality provisions and requirements as provided by Georgia law, when the alleged abuser has left Georgia during or following DHR's investigation of a report of child abuse;
7. A child welfare agency or school, where DHR has investigated allegations of abuse made against any employee and any child remains at risk from exposure to that employee, except that the identity of the person reporting the abuse and any person who may be endangered by disclosure must not be revealed;
8. An employee of any school or child welfare agency against whom allegations of child abuse have been made, when DHR is unable to determine the extent of the employee's involvement in alleged child abuse against any child in the care of that school or agency. In addition, DHR may disclose the information to the employer upon receipt of a signed release by the employee, except that the identify of the person reporting the abuse and any person who may be endangered by disclosure must not be revealed; and
9. Any physician, hospital or medical personnel, dentist, psychologist, podiatrist, nurse, social worker, schoolteacher, guidance counselor, child or day-care personnel, child counseling personnel, child service organization personnel, or law enforcement personnel who has an ongoing relationship with the child named in the record.

Under the amended Georgia law regarding child abuse records and reports, any person who obtains or attempts to obtain records under false pretenses is guilty of a misdemeanor.<sup>102</sup> Information included in any confidential record may not be made a part of any record open to the public except that a district attorney may include the information in the record of any criminal prosecution for child abuse.<sup>103</sup>

Hospitals are required by state law to make reports about suspected child abuse.<sup>104</sup> After the report is made, however, the hospital typically retains information about the report and the patient among its medical records. Even though the statute relating to the confidentiality of such records applies only to records in the custody of DHR and state and local agencies, the fact that violation of the confidentiality provisions is a crime suggests that attitude of the state toward the content of those records. In addition, under the amended statute, material from DHR records may be obtained by hospital personnel for research or treatment purposes. Such materials should retain the full confidentiality protections provided by the child abuse confidentiality provisions.

k. Nursing Home Resident Abuse. O.C.G.A. § 31-8-86 provides for confidentiality of report of nursing home abuse or exploitation of nursing residents. This section was revised by the 1991 Georgia General Assembly to allow disclosure to the public of the name of the facility involved in the report of abuse. However, the name of the resident, the alleged perpetrator, or the person making the report may not be revealed without the written consent of the person whose identity is to be revealed or by a court order. The resident, his representative who is authorized in writing by the resident or who is court appointed, or a family member of a deceased or mentally impaired resident who is unable to grant authorization may obtain copies of the abuse report. The report cannot reveal the names of any other residents or the person making the report.

i. Rape Victims. It is a crime in Georgia for any person to “print and publish, broadcast, televise, or disseminate through any other medium of public dissemination” the name or identity of any female who is the victim of rape or assault with intent to commit rape.<sup>105</sup> While this law cannot prevent broadcast of a rape victim’s name obtained from public records such as court documents,<sup>106</sup> its provisions should apply to hospital records.

m. Medical Review Committee Proceedings. The proceedings and records of a medical review committee are not subject to discovery (that is, release pursuant to subpoena, request for production of documents, or similar process) or introduction into evidence in any civil action against a provider of professional health services arising out of the matters which are the subject of evaluation and review by the medical review committee. Moreover, no person in attendance at a meeting of a medical review committee is permitted or required to testify in any such civil action about any evidence or other matters produced or presented during the proceedings of the medical review committee or about any findings, recommendations, evaluations, opinion or other actions of the committee or any member of the committee.<sup>107</sup>

A medical review committee is defined as a committee of a state or local professional society or of a medical staff or a licensed hospital, nursing home, medical foundation or peer review committee (provided the medical staff operates pursuant to written bylaws that have been approved by the governing board of the hospital or nursing home), which is formed to evaluate and improve the quality of health care rendered by providers of health services or to determine that health services rendered were professionally indicated or were performed in compliance with the applicable standard of care or that the cost of health care rendered was considered reasonable by the providers of professional health services in the area.<sup>108</sup> The statutory definition, although somewhat unclear,

is important, for only those committees that fall within the statutory definition are entitled to the protections in the Act.

To the extent that a medical review committee considers medical records information in its proceedings, the records may not be subject to discovery or introduction into evidence in certain civil trials. The statute providing the protection to the medical review committee proceedings, however, states that information, documents and records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during the proceedings of the committee.<sup>109</sup> The original medical record, therefore, would be subject to discovery from the medical record department of the hospital in normal course. The medical record takes on characteristics of confidentiality under this statute only to the extent it becomes a part of the proceedings of a medical review committee.

n. Peer Review Committee. The proceedings and records of peer review committees are also afforded confidentiality under Georgia law.<sup>110</sup> Except in proceedings alleging violation of the peer review committee statute, the proceedings and records of peer review committees “shall be held in confidence” and are not subject to discovery or introduction into evidence in any civil action against a professional health care provider arising out of the matters which are the subject of evaluation and review by the peer review committee. The statute contains language substantially identical to that relating to medical review committees, and provides that no person in attendance at a meeting of a peer review committee shall be permitted or required to testify in any such civil action about any evidence or other matters produced or presented at the proceedings at such committee or about any findings, recommendations, evaluations, opinions or other actions of a committee or any members of the committee.

The definition sections of this statute are somewhat inconsistent. Although some substantive portions of the statute speak of a “review committee,” only the term “review organization” is defined. Under the statute, a review organization is any panel, organization or committee engaging in “peer review” (which is itself a defined term), which gathers and reviews information relating to the care and treatment of patients by members of the society or association for the purpose of evaluating the quality of health care rendered, reducing morbidity or mortality, or evaluating claims against providers or engaging in underwriting decisions in connection with malpractice coverage.<sup>111</sup>

The statute states that no person providing information to a review organization shall be held, by reason of providing that information, to have violated any criminal law or to be civilly liable under any law unless the person was motivated by malice or unless the person knew such information to be false.<sup>112</sup> No notice to patients is required prior to disclosure to a peer review committee.

Records, reports and recommendations of the Joint Committee on Healthcare Organizations (:JCAHO”) and other national accreditation bodies are now within the definition of peer review records. As a result, these records are not subject to discovery and can not be entered into evidence in any civil action against a health care provider. (One reported case hold that such records may be obtained from the Department of Human Resources through a request made under the Open Records

Act, if the hospital or other institution provided those records to the Department for licensure purposes.<sup>113)</sup>

By including JCAHO within the definition of a “peer review committee,” the statute also authorizes the release of medical records and other confidential material to JCAHO in order to conduct its peer review activities.

o. AIDS Confidential Information. The comprehensive AIDS bill passed in 1988 prohibits the disclosure of AIDS confidential information which is disclosed or discovered within the patient-physician relationship.<sup>114</sup> Redisclosure of confidential information, whether properly or improperly obtained, is also subject to the confidentiality provisions.<sup>115</sup> AIDS confidential information is defined as information which permits identifications of a person and discloses that person:

- (1) has been diagnosed as having AIDS;
- (2) has been or is being treated for AIDS;
- (3) has been determined to be infected with HIV;
- (4) has submitted to an HIV test;
- (5) has had a positive or negative result from an HIV test;
- (6) has been determined to be a person at risk of being infected with AIDS.<sup>116</sup>

Disclosure of AIDS confidential information, except in accordance with the statute, is a misdemeanor<sup>117</sup> and may also subject the disclosing entity to substantial civil damages.

O.C.G.A. § 24-9-47 includes a number of exceptions to the prohibition on disclosure for AIDS confidential information. The exceptions are quite specific with respect to the type of information which may be disclosed, the authorized recipients, and in some cases, the person or organizations permitted to make disclosures. It is, therefore, important that the statutory language be reviewed closely prior to making determinations regarding disclosure of AIDS confidential information.

Several of the exceptions regarding disclosures of AIDS confidential information are comparable to permissible disclosures of other medical information. AIDS confidential information may be disclosed to the person identified by the information, or, if that person is a minor or incompetent, to that person’s parent or legal guardian. Information may also be disclosed to any person or entity designated in writing by the patient, or the patient’s parent or legal guardian, to receive the information. A general disclosure form which does not identify a specific recipient is probably not sufficient to comply with this provision of the Act.

AIDS confidential information may also be disclosed to federal, state or local government agencies, if such disclosure is authorized or required by law. Other laws generally requiring disclosure to private individuals or public employees or entities are sufficient to reach AIDS confidential information only if the clear legislative intent of the law is to disclose such information.<sup>118</sup>

A number of exceptions permitting disclosure of AIDS confidential information relate primarily to access to information for treatment purposes. The results of an HIV test may be disclosed to the physician who ordered the test or to the physician's representative. A physician is authorized to disclose information to another health care provider or facility which has provided, is providing, or will provide care to the patient, and as a result has a legitimate need for the information in order to provide care to the patient. A health care provider who receives such information directly or indirectly from a physician may disclose that information to other providers for the same purposes. Disclosures may be made to designated employees of physicians, health care providers and other entities to receive information and may be disclosed among those employees if reasonably necessary in the ordinary course of business to carry out the purposes for which the disclosure was initially made.

Other authorized disclosures are intended to protect those who may be at risk of infection from the person identified in the AIDS confidential information. The exception discussed earlier about disclosure in health care providers which have provided, are providing, or will provide care authorizes disclosure to the provider if reasonably necessary to protect personnel or patients at risk of becoming infected. A physician may also disclose information about a patient determined to be infected with HIV to the patient's spouse or sexual partner, or to the child of the patient, spouse or sexual partner, if the physician reasonably believes that the other person is at risk of being infected and first attempts to notify the patient that the disclosure will be made.

Hospital administrators and physicians are permitted to disclose to the Department of Human Resources when a patient is determined to be infected and another person is believed to be at risk. Such disclosure should include the name and address of the patient, the fact that the patient has been determined to be infected and the name and address of any other person whom the physician or administrator reasonably believes to be at risk of being infected by that patient. Following such a report, the Department may disclose the information to the county board of health if reasonably necessary to protect that person or other persons at risk of becoming infected. The Department or Board of Health may contact the infected person and any other person believed to be at risk of becoming infected and shall contact the spouse of the infected person.

If a person at risk of infection is a minor or incompetent, any disclosure which could otherwise be made to that individual may be made to the parent or legal guardian. If a person at risk of infection is institutionalized, such as in a prison, group home or long term care facility, the disclosure may be made to the facility's chief administrative officer or designee.

The AIDS statute includes three exceptions applying to release of AIDS confidential information for civil lawsuits and other similar disputes. First, information may in some narrow circumstances be released pursuant to a Request for Production of Documents. Second, a superior court may order release of the information after allowing statutory guidelines for issuing the court order. Third, information may be disclosed if the person identified in the record has waived the confidentiality rights by involvement in the dispute. These three exceptions are discussed in detail in Section V.D. below on Subpoenas and Other Requests-AIDS Confidential Information.

Finally, the AIDS statute provides that AIDS confidential information may be collected, used, and disclosed by an insurer in accordance with the statutes relating to such activities of insurance institutions.<sup>119</sup> Those statutes permit health insurers to obtain a broad general consent at the time a policy is issued to disclosure of all information related to the insured's medical care. Such consents may, however, be withdrawn at any time and therefore might not be effective when presented by an insurer. The hospital will be better protected by establishing a policy requiring the patient's written consent, which acknowledges the existence of AIDS confidential information, immediately prior the release of information to an insurer.

Although the statute includes numerous exceptions authorizing disclosure, it does not impose any duty to disclose such information. A health care provider or other entity which fails to make a permitted disclosure is not liable to the patient or any other person for such failure. In addition, a provider or other entity which does disclose information pursuant to the statute is immune from civil or criminal liability for the disclosure.<sup>120</sup> Finally, if the provider or other entity inadvertently discloses information in violation of the statute, despite the maintenance of procedures reasonably adopted to avoid such disclosure, the provider or entity is immune from civil or criminal liability unless the disclosure was due to gross negligence or wanton and willful misconduct.<sup>121</sup>

### **C. Release of Medical Information.**

Hospitals are routinely requested to release information from patient medical records. The requests may come from various sources -- newspaper reporters, the patient, third party payors, the HMO of which the patient is a member, the Worker's Compensation Board, the PRO, the spouse of a patient involved in divorce litigation, and attorneys of a patient considering malpractice action. The list is virtually endless.

In deciding what response should be made to a request for information, the medical record administrator should first consider the nature of the record and the information contained in it and the identity and authority of the party making the request. For example, a subpoena issued by the local superior court may be sufficient to obtain a copy of a record relating to routine surgical treatment, but would not be sufficient to obtain information about a patient whose record is subject to the federal drug and alcohol abuse regulations. In that instance, it is the nature of the record which largely determines the response that should be made. The request to view a sensitive medical record by a member of the press might be thought to violate the patient's right of privacy. The hospital might, however, freely release the same record to the patient. In making its decision about that record, the identify of the person making the request largely determines the hospital's response.

Release o information from hospital records can be initiated in several ways. First, the release of information can be pursuant to a requirement. A specific statute or regulation may require the release of certain types of information without a request for the release and without the patient's knowledge or consent. Second, the information can be requested. The request might be by the patient or by a third party. The request might be informal or evidenced by the formality of a subpoena or court

order. Third, the release might be voluntary under circumstances in which the institution decides that information should be released. Each of these will be discussed separately.

## 1. Required Release.

a. Child Abuse. Georgia law sets forth specific requirements about child abuse reports.<sup>122</sup> If it is suspected that a child under the age of 18 has been abused, a report of this suspicion must be made if the suspected abuse is encountered by: (1) physicians, interns, and residents; (2) hospitals and medical personnel (3) dentists; (4) licensed psychologists and psychology interns; (5) podiatrists; (6) registered professional nurses and licensed practical nurses; (7) professional counselors, social workers, and marriage and family therapists; (8) school teachers; (9) school administrators; (10) school guidance counselors, visiting teachers, school social workers, and school psychologists; (11) child welfare agency personnel; (12) child-counseling personnel; (13) child service organization personnel; and (14) law enforcement personnel. These classes of persons are required to report suspected child abuse even if the reasonable cause to believe such abuse has occurred or is occurring is based in whole or in part upon any privileged or confidential communication. The report must be made if there is reasonable cause to believe that the child:

- (1) has had physical injury or injuries upon him other than by accidental means by a parent or caretaker, or
- (2) has been neglected or explained by a parent or caretaker, or
- (3) has been sexually assaulted or sexually exploited. A child is considered sexually exploited if a parent or caretaker allows, permits, encourages or requires the child to engage in prostitution or in sexually explicit conduct for the purpose of producing any visual or print medium depicting such conduct. A 1987 Opinion of the Georgia Attorney General<sup>123</sup> held that personnel of public or private schools are “caretakers” within the meaning of the statute, and suspected abuse by such personnel must be reported to and investigated by the Department of Human Resources.

If the person making the report comes in contact with the child through performance of services as a member of the staff of a hospital or similar facility, he must notify the person in charge of the facility or his designed delegate who shall cause the report to be made. The knowing and willful failure to make a required report is a misdemeanor.

An oral report must be made immediately, by telephone or otherwise, to a child welfare agency providing protective services, as designated by the Department of Human Resources or, in the absence of such an agency, to an appropriate police authority or district attorney. If requested, the oral report must be followed by a report in writing. The report shall contain (1) the names and addresses of the child and his parents or caretakers, if known, (2) the child’s age, (3) the nature and extent of the child’s injuries (including any evidence of previous injuries), and (4) any other information that the reporting person believes might be helpful in establishing the cause of injuries

and the identity of the perpetrator. Most of the information which must be included in the report is found in the patient's medical record. Release of that information in connection with a child abuse report can be made without the patient's request, knowledge or consent.

The law permits, but does not require, photographs of the child's injuries to be taken without the permission of the child's parents or guardian. The photographs are to be taken, if at all, to be used as documentation in support of the child abuse allegations made by hospital staff, physicians or others. The photographs must not reveal the identify of the subject if reasonably possible and must be made available as soon as possible to the chief welfare agency providing services and to the appropriate police authority.

b. Nursing Home Resident Abuse. Knowledge of the abuse or exploitation of a resident of any long-term care facility must be reported to DHR.<sup>124</sup> The term "long term care facility" within the meaning of the statute includes any skilled nursing home, intermediate care home, or personal care home regulated by the Department of Human Resources.<sup>125</sup> The list of persons required to make the report is long, and includes physicians, nurses, hospital employees, long-term care facility employees and social workers.<sup>126</sup> The report must be made to DHR immediately by telephone; if immediate report to DHR is not possible, the report must be made to the appropriate law enforcement agency. A written report must be made to DHR within 24 hours after the initial report.<sup>127</sup> Any person with knowledge of abuse may, but is not required to, file a report.<sup>128</sup>

The term "abuse" in this context is defined to mean any intentional or grossly negligent act or omission that causes injury to a resident, including but not limited to assault or battery, failure to provide treatment or care, or sexual harassment of the resident.<sup>129</sup> "Exploitation" within the meaning of this statute is defined more broadly to include "an unjust or improper use of another person or his property for one's own profit or advantage."<sup>130</sup> This clearly encompasses circumstances other than physical injury, neglect or exploitation of a resident.

A report of suspected abuse or exploitation shall include the name and address of the person making the report, the name and address of the abuse or exploited person, the name and address of the long-term care facility, the nature and extent of injuries or condition, the suspected cause of the abuse or exploitation and any other information the reporting person believes might be helpful.<sup>131</sup>

The statute specifically provides for the preservation of the confidentiality of the information reported. The identify of the resident, the alleged perpetrator, and persons making the report or providing information or evidence must not be disclosed to the public unless required to be revealed in court proceedings or upon the written request of the person whose identity is to be revealed, or as otherwise required by law. An allegedly abused or exploited resident may obtain access to information obtained in investigation but that disclosure must be made without revealing the identify of any other resident, the person making the report, or persons providing information by name or inference.<sup>132</sup>

The statute further prohibits any person or long-term care facility from discriminating or retaliating in any matter against any person making a report pursuant to the statute, or against any resident who is the subject of the report.<sup>133</sup>

c. Non-accidental Injuries. Any physician, licensed nurse employed by a medical facility, security personnel employed by a medical facility, or other personnel employed by a medical facility where duties involve the care and treatment of patients who has cause to believe that a patient has had physical injury inflicted other than by accidental means is required to report or cause a report to be made by telephone, followed by a written report if requested, to the person in charge of the medical facility or his delegate.<sup>134</sup> That person must in turn notify the police. The report must contain the name and address of the patient, nature and extent of patient injuries and any other information the reporting person believes might be helpful in establishing the cause of injury and identity of the perpetrator.<sup>135</sup>

Any person, who in good faith makes a report of non-accidental injury or who participates in any resulting legal proceedings, is immune from any civil liability which otherwise might be incurred.<sup>136</sup>

A troubling aspect of this statute is that it appears to require reports to be made of injuries caused by an attempted suicide. While medical judgment may hold that such a report could be harmful to the patient, such injuries appear within the clear wording of the statute. Hospitals that treat injuries of this type should seek legal advice about its legal obligations in such circumstances.

d. Threat to Physical Safety. A celebrated California case, Tarasoff v. Regents of the University of California,<sup>137</sup> established the rule that when a therapist determines (or pursuant to the standards of his profession should determine) that his patient presents a serious threat of violence to another, he has no obligation to use reasonable care to protect the intended victim against the danger. The duty might require the therapist to call the police, warn the victim, or advise others likely to apprise the victim of the danger. In Tarasoff, a patient undergoing psychiatric treatment at the University of California hospital as a voluntary out-patient made numerous threats to kill a particular individual. One of the therapists became sufficiently concerned that he made attempts to have the patient placed in an institution. When the patient did in fact kill the person about whom the threats had been made, the victim's parents brought suit against the therapists and the University. The court held that the therapists had a duty to determine whether the threats were realistic and, if likely to be carried out, warn the potential victim, notwithstanding any doctrines about confidential information.

A case decided by the California Court of Appeals the following year<sup>138</sup> limited the therapists duty to report only potential physical harm to a third party, and refused to apply the rule to require that a therapist report a child's suicidal tendencies to his parents. The court said that the rule established in Tarasoff does not require the therapist to reveal confidential information about the patient's threats of suicide or property damage.

Although this exception to the general confidentiality-privilege rule arose in California, it has recently been favorably by lower courts of other states, including Georgia. In The Bradley Center, Inc. v. Wessner,<sup>139</sup> decided by the Georgia Supreme court in 1982, the court held that where the course of treatment of a mental patient involves an exercise of “control” over him by a physician who knows or should know that the patient is likely to cause bodily harm to others, an independent duty arises from that relationship and falls upon the physician to exercise that control with such reasonable care as to prevent harm to others at the hands of the patient. The Georgia court specifically applied the Tarasoff doctrine to find that a private mental health hospital, treating only voluntary patients, was in sufficient “control” of the patient and should not have released the patient on a short term pass when it knew or should have known the patient might harm another person. In this instance, the patient, on leave from the institution, murdered his wife and her lover.

e. Venereal and Other Reportable Diseases. Any physician or other person who makes a diagnosis of or treats a case of venereal disease, and any superintendent or manager of a hospital in which there is discovered a case of venereal disease, must make a report of that case to the health authorities.<sup>140</sup> The report shall be in the form and manner directed by the Department of Human Resources. The report must provide the name, address, race, age, sex and diagnosis on forms furnished by DHR. Information reported on these forms shall be held confidential by the DHR.<sup>141</sup>

The Department of Human Resources has also been given the authority to declare certain diseases and injuries to be “notifiable diseases” and require that they be reported to the County Board of Health and the Department.<sup>142</sup> A person making such a report may be required to provide essential data deemed necessary and appropriate for the prevention of diseases and accidents. All such reports and data shall be held confidential and shall not be opened to inspection by the public; however, DHR may release the report and data in statistical form or for valid research purposes.<sup>143</sup> Persons acting in good faith in submitting reports or data to DHR or county boards of health in compliance with this statute shall not be liable for any civil damages arising out of that report.<sup>144</sup>

The DHR Rules require each physician and the chief administrative officer (or his designee) of each hospital, nursing home, clinic, health maintenance organization and other named facilities and institutions in the state to report identified diseases by phone or mail.<sup>145</sup> Notifiable diseases are divided into five separate classes with separate reporting deadlines, from immediate to weekly. Notifiable diseases include cholera, botulism, plague, yellow fever, smallpox, anthrax, diphtheria, rabies, typhoid fever, tuberculosis, scarlet fever and typhoid fever. Many others are identified in the regulations.

The comprehensive AIDS statute enacted in 1988 requires health care providers that order HIV tests to report confirmed positive tests to the Department of Human Resources. Such reports are only to include the age, race, sex and county of residence of the person with the confirmed positive test.<sup>146</sup> The Department is permitted, when it determines it to be reasonably necessary, to require mandatory and non-anonymous reporting of confirmed positive HIV test results.<sup>147</sup>

f. Vital Statistics. Reports must be filed in Georgia concerning births occurring in all hospitals in the state, each death occurring in the state, and each fetal death which occurs in the state.<sup>148</sup> The hospital is required to keep a record of “personal particulars and data” concerning each person admitted to the hospital. That record must include the information required by the standard birth, death and fetal death certificate forms. When a dead body is released or disposed of by the hospital, the person in charge is required to keep a record showing the name of the deceased, the date of birth, the name and address of the person to whom the body is released, and the date of removal from the hospital. If final disposition of the body is made by the hospital, the date, place and manner of disposition must be recorded.

g. Spinal-Cord Disable or Head Injured Every public and private health and social agency and every physician authorized to practice medicine in Georgia must report to DHR any person identified as being spinal-cord disabled or head injured.<sup>149</sup> The report must be made for any person suffering from (a) a traumatic or acute onset brain disease which results in temporary or permanent decrease of cognitive, behavioral, social, or physical functioning or (b) any spinal-cord disease, injury or neural tube defect, whether congenital or acquired, which results in partial or total loss of motor or sensory functions and partial or total disability, whether temporary or permanent.<sup>150</sup>

The report must be made within 48 hours after identification of the spinal-cord disabled or head injured person and shall contain the name, address, age, type and extent of disability and such other information as DHR shall require.<sup>151</sup>

h. Unusual or Suspicious Death. Unusual or suspicious deaths must be reported to the coroner or county medical examiner.<sup>152</sup> If any person dies in Georgia as a result of violence, by suicide, by casualty, suddenly when in apparent good health, when unattended by a physician, or in any suspicious or unusual manner, it is the duty of any person having knowledge of the death to notify the coroner or the county medical examiner of the county in which the body is found or the death occurs. This provision does not apply if the unattended death was that of a patient of a licensed hospice.

Persons having knowledge of deaths are encouraged to give particular attention to suspicious deaths of persons 16 years of age and under, and they are required to report all unexpected or unexplained deaths of children under seven years old. The coroner or medical examiner is required to provide a copy of any report of unexpected or unexplained deaths of children to the Department of Family and Children’s Services of the county in which the child resided at the time of death.

Following notification to the coroner, the coroner takes charge of the dead body and summons the medical examiner and any proper peace officers to make inquiries regarding the cause and manner of death. Each of these officials has the authority to take possession of any objects or articles which, in his opinion, may be helpful in establishing the cause of death. Once a report has been made by a hospital, the hospital is not authorized to move the body or take any other action with respect to the dead body without the direction of the coroner.<sup>153</sup>

In connection with the requirement to notify the coroner if a person dies “when unattended by a physician,” an unofficial opinion of the Attorney General indicates that if the deceased was under the care of a physician, it is not essential that the physician be present at the instant of death to avoid the necessity of notifying the coroner.<sup>154</sup>

Failure to report an unusual or suspicious death is a misdemeanor.<sup>155</sup>

i. Notification of Communicable Diseases in Dead Bodies. Georgia law requires notification to persons who handle the disposition of dead bodies of the presence of certain communicable diseases at the time of death.<sup>156</sup> The infectious or communicable diseases which require notification include infectious hepatitis, tuberculosis, venereal disease, and acquire immune deficiency syndrome. Notification must be made by the attending physician if the patient dies in the hospital and by a family member or other person making arrangements for disposition of the body if the death occurs outside the hospital.

Information contained in the notification is privileged and confidential and may be disclosed only if:

- (1) Disclosure is required for reporting of venereal disease;
- (2) Disclosure is required by federal law;
- (3) Disclosure by the physician is authorized by state law;<sup>157</sup>
- (4) Disclosure is required for reporting child abuse;
- (5) Disclosure is for purposes of research and does not reveal the identity of the deceased;
- (6) Disclosure of information regarding a deceased minor is made to the parent;  
or
- (7) Disclosure is made to the person who picks up and dead body or to another person authorized to receive that information in the ordinary course of business.

This Code section provides that information which is privileged and confidential under this section may not be disclosed pursuant to discovery proceedings, subpoena, or court order. This statement is somewhat ambiguous and could be read as prohibiting disclosure of any information, including the medical record, regarding a deceased patient’s communicate disease. The probably intent, however, was to make only the notification itself privileged.

j. Notification of Communicable Diseases in Patients Transported by Law Enforcement Agencies. All correctional facilities and mental health facilities are required to

notify the state of local law enforcement agency when a prisoner or patient transported by the agency has a communicable disease.<sup>158</sup> Among the mental health facilities covered by this equipment are “emergency receiving facilities” for mental health patients, which may include many hospital emergency rooms. The notification must be limited to the fact that the patient has a communicable or infectious disease and whether that disease is airborne or transmissible by blood or other bodily fluids. The specific disease may not be disclosed.

k. Handicapped Newborns. A 1987 Georgia statute which is not yet effective would require all public and private health and social agencies and all physicians to report to the Department of Human Resources all handicapped newborns.<sup>159</sup> A handicapped newborn is defined as a person less than 12 months old who is deaf, blind or has a serious congenital defect as defined by the Department. The reports are to be made within 48 hours of identifying the handicapped newborn and should include the name, age, address, type and extent of handicap, social security number, if any, and other requested information. A person who makes a good faith report pursuant to this section is immune from civil or criminal liability. This statute will become effective six months after the General Assembly appropriate funds for implementation.

I. Access by Licensure Agencies. Mental health programs which are licensed by the Department of Human Resources or which receive public funds are required to provide the agency with access to any records required to be maintained by Georgia statutes or regulations.<sup>160</sup> Access must also be provided upon request to the county board of health. A similar statute authorizes the Department of Human Resources to require the production of records related to the continued licensing of any entity. The Department is permitted to take disciplinary action when a licensee refused to provide the Department with that access.<sup>161</sup>

## **2. Immunity Upon Required Release.**

Under Georgia law, the release of confidential medical information pursuant to “laws requiring disclosure” shall not result in liability to the person making the disclosure.<sup>162</sup> The term “laws requiring disclosure” is broadly defined, and includes laws and statutes of the United States and the State of Georgia, and lawful regulations issued by any department or agency of the United States or the State of Georgia, which require the review, analysis or use of medical information by persons who do not ordinarily have authorized access to that information. The term also includes any authorized practice of disclosure for purpose of evaluating the claim for reimbursement for charges or expenses under any public or private reimbursement or insurance program.<sup>163</sup> Under this statute public and private third party payors may gain access to medical information required to evaluate coverage or payments even though the patient may not have specifically consented to the release.

Any person acting in good faith “shall be immune from liability” for the transmission, receipt or use of medical information disclosed pursuant to laws requiring disclosure.<sup>164</sup> The immunity is, of course, limited to those items of information which must be disclosed. If additional information is gratuitously included, immunity may not be available with respect to that information.

Although child and long-term facility resident abuse reports appear clearly within the definition of “laws requiring disclosure,” the statutes which require those reports contain specific grants of immunity to persons giving reports pursuant to those laws.

### **3. Requested Release.**

a. Request by Patient. A patient may request that his medical records be released to himself or to a third party.<sup>165</sup> (For the purposes of this discussion, a patient’s consent to the release to third parties of information from his medical records may be treated the same as his request for that release.) Because the confidential or privileged nature of a medical record exists primarily for the benefit of the patient, the patient generally may waive that privilege and permit release of the medical information. Release pursuant to such consent may be made without any violation of the patient’s rights.<sup>166</sup> For example, if the patient requests or consents to the release of that information, he cannot later complain that the release of that information violated his right of privacy.<sup>167</sup>

Although the hospital medical record is kept for the benefit of the patient, the hospital and the physicians and other professionals attending the patient, the hospital is the owner of the record.<sup>168</sup> Ownership of the physician record may not, however, be the same as ownership of all of the information contained in that record. Likewise, while the hospital’s ownership of the record may allow it to prevent others from removing the physical record from the hospital’s premises, that does not necessarily mean that the hospital has the right to deny others access to the record or to the information contained in it.

A question frequently raised is whether a hospital must or should allow a patient access to his medical record. The question is often based on the assumption that a patient will request to see his medical record primarily to evaluate it for a possible malpractice claim against the hospital or members of his medical staff. Seeing no reason to cooperate with a potential plaintiff, the hospital may adopt a posture generally resistant to a patient’s request to see his medical record. In the current climate of increased consumer interests, however, it is likely that many patients request to see their medical records without any ulterior motive; they may be genuinely interested in the record simply because it relates to them. To the extent that patient reasons for inspecting records are changing, hospitals might consider whether their response to those inquiries should also be changing. Even if a patient does want to evaluate the record for a possible malpractice claim, the hospital should consider whether permitting the inspection might avoid, rather than cause, litigation. Although the record might show improper treatment, it might just as well show proper and complete treatment. In that case permitting the patient and the patient’s attorney or other experts to review the record could keep the hospital out of court. Refusal of the patient’s request to inspect the record may prompt the patient to suspect that the record shows damaging information. Under these circumstances, the hospital’s posture might produce more litigation rather than avoid it.

Regardless of the policy preferred by the hospital and physicians, a number of Georgia statutes specifically grant patients the right to examine their medical records. Patients subject to the Act regarding Hospitalization and Treatment Procedures for Alcoholics, Drug Dependent

Individuals, and Drug Abusers are granted the right to inspect their medical records.<sup>169</sup> The patient has a right to participate in his care and treatment, and:

Unless the disclosure to the patient is determined by the chief medical officer or the patient's treating physician to be detrimental to the physical or mental health of the patient, and unless a notation to that effect is made a part of the patient's record, the patient shall have the right to reasonable access to review his medical file, to be told his diagnosis, to be consulted on the treatment recommendation and to be fully informed concerning his medication, including its side effects and available treatment alternatives.<sup>170</sup>

Further, except as provided in the section quoted above, "every patient shall have the right to examine all medical records kept in the patient's name by ... the facility where the patient was hospitalized or treated."<sup>171</sup>

Substantially identical provisions are contained in the laws relating to treatment of the mentally ill<sup>172</sup> and the mentally retarded.<sup>173</sup> Patients subject to these parts of the law are entitled to have access to their medical records and to examine those records. Before the patient's rights of access and examination can be denied (1) the chief medical officer of the facility or the patient's treating physician must determine that such access would be detrimental to the physical or mental health of the patient and (2) a notation of that determination must be placed in the patient's medical record.

Georgia law also grants a general right of access to medical records to all patients in the so-called "right of Access Law."<sup>174</sup> The law requires providers to furnish a complete copy of a medical record to the patient or to another designated person upon the patient's written request. The provider may require the person requesting records to pay all reasonable copying and mailing costs prior to release. If the provider determines that disclosure directly to the patient will be harmful to the patient's mental or physical health, the provider may refuse to release the record. Upon such refusal, however, the record must be released to another provider designated by the patient. These provisions do not apply to psychiatric, psychological, or other mental health records.

In dealing with requests by patients to review their medical records, hospitals should not exclude the physician from the decision making process. As suggested by the Georgia statutes, physicians may determine that review of the medical record is not in the best interest of the patient. Moreover, professional courtesy and recognition of the relationship between physician and patient suggests that the physician always be contacted before access to the record is given. Some institutions have adopted policies and procedures by which a medical record is released only through the attending physician, giving him the opportunity to review the record and explain its contents and meaning to the patient. At the physician's request, however, the record is released directly by the hospital.

These right of access provisions raise the issue of potential liability for failure to prevent disclosure of a medical record which proves ultimately harmful to a patient's health. The statutes themselves impose no affirmative duty on providers to evaluate the risks of disclosure. The Right

to Access Law contains permissive language, stating only that a provider “may” refuse to furnish a record.<sup>175</sup> One could argue, however, that providers are obligated to use reasonable care in all matters affecting the physical or mental health of a patient. Where the provider makes a good faith determination that a release is not detrimental to a patient’s health, the provider will in most instances be protected from liability.<sup>176</sup>

In deciding whether and to what extent the patient should be given access to his own medical records, hospitals should consider (a) the rights and interest of the patient, the physician, and the hospital, (b) the purpose for which access is sought, (c) the nature of the information in the medical record and (d) any applicable legal requirement. The hospital is entitled to place reasonable restrictions upon the right of access. The following might constitute a basis for a procedure about access.<sup>177</sup>

- (1) Determine the position which the hospital thinks best satisfies the interest and rights to be recognized, including satisfaction of any applicable legal requirements. This position may depend upon the type of patient seen and the administrative attitude of the hospital generally.
- (2) Seek the support of the medical staff for the institution’s position, particularly if it involves a liberal attitude toward patient access to medical records. In many instances, the physicians will consider the patients to be their patients more than hospital patients and that they have a substantial interest in the access granted. Ideally, the medical staff and the institution evolve toward a common position. The physicians may, for example, want to restrict access to patient records only to persons who have been discharged from the institution, since review of a partial record may give inaccurate information. The Right of Access Law may prevent physicians from restricting access to medical records by current inpatients. That Act, however, defines “patient” as one who “has received” medical treatment;<sup>178</sup> there is no specific provision for access by patients still receiving care.
- (3) If access is to be given, determine that the person requesting access to the patient record is (or was) a patient, has proper authority from the patient to review his records, or stands in such a close relationship (for example, a parent of a minor patient) that he would have the right to inspect the record without the patient’s specific consent.
- (4) Require that the person seeking access has, or represents a person having, a legitimate interest in the record and a legitimate reason for wanting to review the record.

- (5) Require that the request to inspect the record be in writing and be signed by the patient or by his legal representative. The hospital might also consider the requirement that the request be dated and that the date be reasonably contemporaneous to the time of request made to the hospital.
- (6) In every case seek the input of the attending physician in the decision to allow inspection of the record. If the physician recommends that the patient not be permitted to review the record, the hospital should decline the patient's request. The physician should be asked to state whether or not he concurs that the record should be released. The physician may refuse to release medical records to a former patient only after determining that the disclosure would be harmful to that patient's mental or physical health.
- (7) The hospital should be able to restrict the examination of records to reasonable business hours and under circumstances and in a location that will not interfere with the general conduct of the operations of the hospital or compromise the confidentiality of other records.
- (8) The person inspecting the records should not be permitted to remove the original record, or any part of it, from the hospital premises. The record is the property of the hospital and should be maintained by it.
- (9) If a person is given the opportunity to inspect the record, there appears to be no reason not to permit copying of the record. The hospital should be able to make a reasonable charge for the cost of copying and the cost of staff time required to make the copies.

b. Release to Third Parties at Patient Request. In many instances, the same consideration should be given to release of information to a third party pursuant to patient consent as given to release directly to the patient. For example, a patient's consent to the release of information to his attorney can be viewed substantially the same as a request from the patient for direct access. The Right of Access Law provides that when release to a patient is determined to be detrimental to the patient's health, release must be made, upon request, to another provider.<sup>179</sup> The statute is silent as to release under these circumstances to other representatives of the patient. Where the patient requests release to an attorney or other non-provider, the hospital may wish to consider use of a special authorization form which releases the provider from liability for any injury resulting from the disclosure.

A patient's request for release of records to his attorney may also have important implications with respect to the statute of limitations for malpractice suits. Ordinarily, a medical malpractice action must be brought within two years of the incident.<sup>180</sup> There are, however, numerous exceptions and circumstances that will toll the statute of limitations. A Georgia statute<sup>181</sup>

provides that the statute of limitations will be tolled in certain circumstances when an injured person or his attorney requests medical records. In order for the statute to apply, the following standards must be met:

- (1) The request must be made by registered or certified mail, return receipt requested, upon any health care provider for medical records in that provider's custody. The requested records must relate to the injured person's health or medical treatment and must be medical records that the injured person is entitled by law to receive.
- (2) If the request is made by the patient's attorney, an appropriate written authorization to release the records must be enclosed.
- (3) The request must state that the records are needed by the injured person for possible use in medical malpractice action and must request that the records be mailed to the patient or his attorney by certified mail, return receipt requested.
- (4) The person requesting the records must promptly pay all fees associated with copying and mailing the records.

The statute of limitations will stop running on the twenty-second day after the request is received by the health care provider. The statute will not cease running if the provider submits the records, or notifies the patient or attorney that it does not have the requested records within twenty-one days of receiving the request. The statute of limitations begins running again the day after the records, or notice that the provider does not have the records, is received by the patient or the attorney. The maximum period of time that the statute of limitations may be tolled is ninety days, although the attorney may request a court order lengthening that period.

Other patient representatives may have a right to access the medical records through the Right of Access Law. The Georgia Durable Power of Attorney Act.<sup>182</sup> grants a health care agent the same rights as the patient with respect to the examination and copying of the patient's medical records, unless those rights are specifically limited in the power of attorney. This right applies to both mental health and medical records and applies regardless of the type of provider who maintains the records. Any copying of the records shall be at the patient's expense and copying or access shall be subject to any reasonable rules of the provider designed to prevent disruption of patient care.<sup>183</sup>

The Georgia law regarding reporting of abuse of nursing home residents also addresses the right of patient representatives to obtain access to patient medical records. That statute permits family members of deceased or incompetent nursing home residents to act as the patient's "representative" for purposes of obtaining access to reports of abuse. The statute specifically limits the authority of family members to obtain access to other medical records. A family member of a nursing home resident must be designated in writing by the patient or by a court order in order to receive other health care records of the resident.<sup>184</sup>

Release of information from the medical record to insurance companies and other third party payors is a routine part of hospital operations, and obtaining patient's consent to that release is part of the ordinary operation of the hospital. Release of this information rarely causes problems and should be of no substantial concern to hospitals or keepers of their records. If a particular law requires a special form of consent, however, that special consent form must be obtained before the consent is appropriate. For example, the Federal Drug and Alcohol Abuse Regulations discussed above set forth specifically the content for a patient's consent and the precise text for a notice to accompanying the consent. With respect to records subject to those regulations, the normal consent form will not be appropriate and the particular form required by regulation must be followed.

c. Third Party Request. Requests by third parties for medical record information may be with or without the patient's authorization and may be informal (a simple request) or formal (a subpoena or court order). As discussed above, a request accompanied by the patient's consent or authorization is often sufficiently similar to a request by the patient for direct access that responding to the request can be analyzed in the fashion.

The most common form of third party request not authorized by the patient is the subpoena for medical record. Subpoenas and other formal requests for release of medical records are discussed in detail in Section V below.

Release of information to third parties pursuant to a request accompanied by neither patient authorization nor subpoena or court order appears to provide the greatest area of potential liability to hospitals. Those requests are not subject to any statutory immunity attaching to disclosure pursuant to "laws requiring disclosure." Neither has the patient waived any rights which he may have to object to the disclosure. Those statutes which identify the circumstances in which information may be released from medical records do not include simple third party requests as one of those circumstances. Most hospitals routinely decline to respond to requests by third parties for medical record information accompanied by neither patient authorization nor subpoena or court order. This is the proper response.

d. Research Requests. If a request for release of patient information is in connection with a course of study to reduce morbidity or mortality, the release may often be made without patient consent. Georgia law<sup>185</sup> provides generally that:

- (1) The release of information may be made by "any hospital, sanatorium, medical or skilled nursing home or other organization rendering patient care."
- (2) The organization may provide information, interviews, reports, statements, memoranda, or other data relating to the condition or treatment of any person.
- (3) The information may be provided to (a) research groups which have been approved by the medical staff of the institution involved, (b) governmental

health agencies, (c) medical associations and societies, and (d) in-hospital medical staff committees, so long as the information is used in the course of a study for the purpose of reducing morbidity or mortality.

- (4) “No liability of any kind or character for damages or other relief” shall rise or be enforced against any person or organization by reason of (a) having provided the information or material, (b) having released or published the findings and conclusions of such groups to advance medical research, medical education or to achieve the most effective use of health manpower or facilities or (c) having released or published generally a summary of such studies.
- (5) The organization to which the information is provided shall use or publish the material “only for the purpose of advancing medical research, medical education or to achieve the most effective use of health manpower and facilities, in the interest of reducing morbidity or mortality, except that a general summary of such studies may be released by any such group for general publications.”
- (6) The identify of the patient shall be confidential and shall not be revealed under any circumstances.

#### 4. **Voluntary Release.**

In some instances, a hospital may decide to initiate release of medical record information itself without having received a request for that release, without being required by statute or regulation to release the information, and without any legal requirement that the information be released. In general, release of information under such circumstances gives rise to a possible violation of the patient’s right of privacy. Moreover, if release of the information is proscribed by statute or regulation, that release may itself give private rights of action to the patient or may result in penalties imposed by the rule establishing the confidentiality. For example, release of information from record subject to the Federal Drug and Alcohol Regulations might constitute a breach of the patient’s rights of privacy and result in a civil penalty under the regulations, which can range from \$500 to \$5,000 per offense.<sup>186</sup> Before making the decision to release information voluntarily and at its own initiative, therefore, the hospital should consider carefully possible risks of liability which may arise fro such disclosure. Law enforcement officers do not by virtue of serving in that position have any special authority to receive medical information otherwise confidential or privileged. Hospitals should examine the authority of the police officer before releasing information.

a. Child Abuse. Georgia law requires various health professionals to report suspected cases of child abuse.<sup>187</sup> The same statute also provides that “any other person” who has cause to believe that a child under the age of 18 has had physical injury inflicted on him by a parent or caretaker other than by accidental means, or has been neglected or exploited by a parent or caretaker, or has been sexually assaulted, may make the reports to a child welfare agency or an

appropriate police authority as set forth in that statute.<sup>188</sup> Any person who participates in making of such a report “shall in so going be immune from any liability, civil or criminal, that might otherwise be incurred or imposed, provided that such participation is made in good faith.” The immunity inures to any person who makes a report, whether the report is required to be made under the statute or is made voluntarily.<sup>189</sup>

b. Nursing Home Resident Abuse. Similarly, the statute requiring certain persons<sup>190</sup> to report abuse or exploitation of a resident of a long-term care facility provides that “any other person” who has knowledge of such abuse or exploitation may report or cause a report to be made to DHR or an appropriate law enforcement agency.<sup>191</sup> Any person who in good faith makes a report under the statute is immune from liability for such actions.<sup>192</sup>

c. Physician’s Improper Acts. The Georgia Medical Practice Act set forth numerous circumstances under which the Composite State Board of Medical Examiners may refuse to grant a license to practice medicine or may discipline a physician already holding such a license.<sup>193</sup> A portion of the Act states that if a person reports an act or omission of a physician for which a license may be refused or for which the physician may be disciplined, and the report is made “in good faith without fraud or malice,” the person making the report shall be immune from civil or criminal liability for reporting those acts or omissions.<sup>194</sup> Those acts include knowingly making deceptive representations in the practice of medicine; conviction of a felony; commission of a crime of moral turpitude; having a license revoked, suspended or denied by any lawful licensing authority; engaging in unprofessional or unethical conduct; performing or otherwise participating in a criminal abortion; having been adjudicated mentally incompetent or becoming unable to practice medicine with reasonable skill and safety by reason of illness, use of alcohol, drugs or other chemicals, or as a result of any mental or physical condition.<sup>195</sup>

d. Incompetent Drive. A driver’s license advisory board appointed by the Department of Public Safety is authorized by statute to define disabilities affecting a person’s ability to drive safely. The Department may then promulgate regulations making such disabilities disqualifications for obtaining a Georgia driver’s license.<sup>196</sup> All physicians licensed to treat those disabilities may report to the Department the name, date of birth and address of any person with a handicap which would render the person incapable of safely operating a motor vehicle.<sup>197</sup>

e. Juvenile Drug Use. A Georgia statute encourages, but does not require any person exercising in loco parentis control over a minor, to report information regarding suspected habitual use of any controlled substance or marijuana by that child to the child’s parents and a designated child welfare agency.<sup>198</sup> Any person or entity, including a hospital, participating in the making of a report to a child welfare agency pursuant to this statute, or participating in a judicial or other proceeding resulting from the report, is immune from civil or criminal liability if such participation is made in good faith. Further, any person making a report of juvenile drug use, whether required by the statute or not, is immune from liability.<sup>199</sup> A person who is providing counseling or treatment to a child is not required to report any information received from the child.<sup>200</sup>

## V. SUBPOENAS AND OTHER REQUESTS

### A. Subpoenas

The word “subpoena” comes directly from the Latin phrase meaning “under penalty.”<sup>201</sup> In its most simple form, the subpoena is a document issued by a court or governmental agency requiring the recipient to comply with its terms. It may require the recipient to appear at a trial to testify, and may require that certain books and records be brought to the trial. If the recipient does not comply, the law provides a penalty for the refusal. The history and original meanings of the word are reflected in the phrase often seen at the end of a subpoena: “Herein fail not, under penalty of law.”

#### 1. State Court Subpoenas

a. Attendance at Trial or Hearing. At the request of any party to a pending lawsuit, subpoenas requiring a witness’s attendance at a hearing or trial to be held in the suit must be issued by the Clerk of the Court in which the trial is pending. The subpoena is issued by the Clerk under the seal of the Court. The subpoena must state the name of the court which issues it and the title of the action.<sup>202</sup> The typical form of subpoena “commands” the person to whom it is directed to attend the trial or hearing and give testimony at the time and place set forth in the subpoena. Georgia law requires that the court clerk issue a subpoena, signed and sealed by the clerk but otherwise in blank, to any party in a lawsuit who requests it.<sup>203</sup> The party then completes the subpoena before it is served. As a practical matter, this is the procedure most frequently followed by attorneys.

A party may also serve a “subpoena duces tecum,” directing that the person to whom it is directed bring to the trial or hearing the books, papers, documents or other tangible things that are described in the subpoena.<sup>204</sup> If a person receiving a subpoena of this type believes that compliance with the subpoena is unreasonable or improper, a motion may be made promptly (and in any event at or before the time specific in the subpoena for compliance) to the court issuing the subpoena requesting that the court either (1) quash or modify the subpoena if it is found to be unreasonable or oppressive or (2) require as a condition to enforcement of the subpoena that the person seeking it pay the reasonable cost of producing the materials requested.<sup>205</sup>

A subpoena requiring the attendance of a witness at a hearing or trial (including a subpoena which requires that the witness bring books and records to the trial) may be served anywhere within the State of Georgia.<sup>206</sup> A court in Valdosta, for example, could issue a subpoena for medical records from a hospital in Gainesville. The subpoena may be served personally by any sheriff or deputy sheriff in the State or by any other person who is at least 18 years old. It may also be served by registered or certified mail.<sup>207</sup> A subpoena which is served by any of these methods is valid and enforceable.

The witness fee for responding to a subpoena to attend a trial or hearing is \$10.00 per day. If the witness resides in the same county where the testimony is to be given, there is no requirement

that the fees be tendered or paid in advance of the trial. If a witness is asked to attend a trial somewhere within the State other than in the county of the witness' residence, however, service of the subpoena is not valid unless the subpoena is accompanied by tender of one day's witness fee plus mileage at the rate of \$0.20 per mile for traveling expenses for going from the witness' residence to the court and back by the nearest practical route. The tender of fees and mileage can be made by cash or postal money order or by cashier's check or certified check.<sup>208</sup>

If the tender of the fees does not accompany a subpoena requiring a witness to attend a trial or hearing in a county other than the county of residence, then service of the subpoena is not valid and there is no requirement that the witness respond to it. There are three exceptions to this general rule. Witness fees and mileage do not have to be tendered if a subpoena is issued (1) on behalf of the State of Georgia, (2) on behalf of an officer, agency or political subdivision of the State, or (3) by the defendant in a criminal case. Witness and mileage fees are payable in those instances, but advance payment is not required.<sup>209</sup>

A person who fails to comply with proper subpoena validity served may be fined up to \$300.00 and imprisoned for as long as 20 days. In determining the punishment to apply, the judge must consider whether, under the circumstances of each case, the subpoena was served within a reasonable time, but in any event not less than 24 hours prior to the time that appearance pursuant to the subpoena was required.<sup>210</sup>

b. Subpoenas Requiring Attendance at Depositions. Clerks of court also issue subpoenas for taking depositions. The Clerk of the Superior Court of the county where a lawsuit is pending, or the Clerk of any court of record in the county where the deposition is to be taken, can issue subpoenas for taking depositions. The form of the subpoena, the manner in which the subpoena is issued, and the way in which it is served are all governed by the same rules that relate to the issuance of subpoenas for attendance at trial or hearing.<sup>211</sup>

A subpoena for deposition may also require the person to whom it is directed to produce and permit inspection and copying of the books, papers, documents or other tangible matters which are subject to discovery and described in the subpoena.<sup>212</sup> In general, parties to a lawsuit may obtain discovery relating to any matter, not privileged, which is relevant to the subject matter of the lawsuit. Privileged matters are not subject to discovery, and production of them cannot be compelled by subpoena for a deposition.<sup>213</sup>

Because the subpoena requiring attendance at a deposition along with the production of documents is typically used at a time when the parties to a lawsuit are trying to discovery information, this type of subpoena is often very broad and sweeping in its terms. The law, therefore, gives the person upon whom such a subpoena is served several means of protection against burdensome discovery.<sup>214</sup> Although the statutes speak in terms of protection being sought by the person upon whom the subpoena is served, it is the lawyer for that person that generally takes the necessary action.

If a person believes that a subpoena is harmful or excessively overreaching, that person may file a motion with the court seeking protection from the discovery. If sufficient reason is shown, the judge may issue any order which justice requires in order to protect a person from annoyance, embarrassment, oppression, or undue burden or expense. The order may, for example, include any one or more of the following provisions: (1) discovery not be held at all; (2) discovery may be pursued only upon satisfaction of specified terms and conditions, including a designation of the time and place; (3) discovery may be had only by a method other than that selected by the party which originally sought the discovery; (4) certain matters; (5) discovery may be conducted with no one present except the persons designated by the court; (6) the deposition, after it is completed and typed, must be sealed and opened only by order of the court; (7) trade secrets or other confidential research, development or commercial information may not be simultaneously file designated documents or information enclosed in sealed envelopes to be opened as directed by the court.<sup>215</sup>

In addition to those potential remedies, the court may, upon a motion made by a person upon whom a subpoena for production of documents for deposition is served (promptly and in any event at or before the time specified in the subpoena for compliance with it), (1) quash or modify the subpoena if it is unreasonable and oppressive or (2) grant enforcement of the subpoena only if the person seeking production of the documents.<sup>216</sup>

In lieu of filing such a motion, a party receiving a subpoena for production of documents for deposition may file with the attorney initialing the subpoena a written objection to the inspection or copying of any or all of the designated materials. This objection must be made within ten days after service of the subpoena. (If the subpoena requires compliance with its terms in less than ten days, however, the notice must be filed at any time on or before the time specified in the subpoena for compliance). If such an objection is made, the party serving the subpoena will not be entitled to inspect and copy the materials unless he first obtains an order of the court from which the subpoena was issued.<sup>217</sup> If such an order is obtained, however, it is likely that order will simply require compliance with the subpoena. If a hospital receiving a subpoena desires a specific type of protection from compliance with its terms, the hospital should contact its counsel and file its own motion identifying the specific protections sought.

A person who is to give a deposition may be required by the subpoena to appear for the deposition (1) in the county where the person resides, is employed, or transacts business in person; (2) at any place which is not more than 30 miles from the county seat of the county in which the person resides, is employed or transacts business in person; and (3) in any county in which the person is served within the subpoena while the county.<sup>218</sup>

## **2. Federal Court Subpoenas**

Although most subpoenas served upon hospitals for the production of medical records and related materials are issued by state courts, it is not uncommon for federal courts to issue subpoenas requiring the production of medical record information.

a. Attendance of Witnesses. Federal court subpoenas may be issued by the court's clerk or by any attorney issuing the subpoena as an "officer of the court." An attorney may issue the subpoena from the court in which the lawsuit is pending or from the district court for the district where a deposition is to be held or documents are to be produced. The subpoena must state the name of the court and the title of the action and commands each person to whom it is directed to attend and give testimony at a time and place set forth in the subpoena. The clerk will issue a subpoena, or a subpoena for the production of documentary evidence, signed and sealed but otherwise in blank to any party who requests it, who must fill in the subpoena before it is served.<sup>219</sup> The party issuing a subpoena must sign the subpoena and take reasonable steps to avoid undue burdens on the persons subject to the subpoena.<sup>220</sup>

b. Production of Documentary Evidence. The subpoena may also command the person to whom it is directed to produce the books, records, documents or other tangible things described in the subpoena.<sup>221</sup> Under rules revised in 1991, a subpoena may also be issued to a non-party to compel production of evidence independent of a deposition. The recipient of a federal subpoena for production of documents is not required to appear unless the subpoena specifically requires that he or she appear at the trial, hearing or deposition.<sup>222</sup>

A federal court subpoena must contain a statement of the rights of the witnesses.<sup>223</sup> If the person upon whom the subpoena is served believes that the subpoena is improper, that person may object to the subpoena within 14 days after service of the subpoena.<sup>224</sup> If the request fails to allow reasonable time for compliance, it unduly burdensome, relates to privileged material, or requires unreasonable travel in order to respond (except that a court may command travel from any place within the state in which the trial is held), the court may quash or modify the subpoena.<sup>225</sup> If the subpoena requires disclosure of certain trade or other confidential material or of any unretained expert's opinion, or requires unreasonable travel time, the court may likewise quash or modify the subpoena or condition its validity upon assurances that the party to whom the subpoena is directed will be reasonably compensated.<sup>226</sup>

c. Service and Fees. A subpoena may be served by the federal court Marshall or his deputy, or by any other person who is not a party to the pending litigation and is at least eighteen years old. Service of a subpoena upon the person named in it is made by delivering a copy of the subpoena to that person and tendering to him the fees for one day's attendance in court and the appropriate mileage. When the subpoena is issued on behalf of the United States or an officer or agency thereof, however, fees and mileage need not be tendered in order for the subpoena to be enforceable.<sup>227</sup>

d. Subpoenas for Taking Depositions. As is the law in Georgia state courts, a federal court subpoena may also require a person to attend the taking of his deposition. Such a subpoena may also require the person to whom it is directed to produce and permit inspection and copying of books, papers, documents or other tangible things described in the subpoena.<sup>228</sup>

A person to whom a subpoena for the taking of a deposition coupled with a request to produce documents is directed may serve upon the attorney designated in the subpoena written

objection to inspection or copying of any or all of the designated materials as discussed above.<sup>229</sup> If such an objection is made, the party serving the subpoena will not be entitled to inspect and copy the materials except pursuant to an order of the court from which the subpoena was issued.

e. Subpoena for a Hearing or Trial. At the request of any party to a pending lawsuit, subpoenas for the attendance of a witness at a hearing or trial shall be issued by the clerk of the District Court for the district in which the hearing or trial is held.<sup>230</sup> A subpoena requiring a witness's presence at a hearing or trial may be served at any place within the district, or at any place outside of the district that is within 100 miles of the place of the trial or hearing specified in the subpoena, or at a place within the state where a state statute or court rule permits service of a subpoena issued by a state court of general jurisdiction sitting in the place where the district court is held.<sup>231</sup>

### **3. Workers' Compensation Board Subpoenas**

When an employee seeks workers' compensation for a job related injury, the medical record pertaining to the injury and the treatment given for it become highly relevant. Most hospitals, therefore, particularly those located in urban areas, receive subpoenas regularly from the Workers' Compensation Board.

Georgia law requires that the members of the Workers' Compensation Board, or any one of them shall have the power to issue subpoenas.<sup>232</sup> Chapter 10 of Title 24 of the Georgia Code (Subpoenas and Notice to Produce) governs the issuance and enforcement of subpoenas by the Workers' Compensation Board. Therefore, all sheriffs and deputy sheriffs are authorized to serve subpoenas from the Board. Subpoenas may also be served in any other manner authorized by law and they may be served by any person over 18 years of age and by certified or registered mail. Every witness who appears in obedience to a Workers' Compensation Board subpoena is entitled to receive for attendance the regular witness and mileage fees.

The law relating to Workers' Compensation Board subpoenas is not clear in defining the power of the Board to compel the production of medical records. First, the provisions of the law discussed above appear to relate only to subpoenas requiring the attendance of persons to testify about facts known to them. Second, in reciting the authority of the members of the Board, the law states that they may "examine or cause to be examined such part of the books and records of the parties to a proceeding as relate to questions in dispute."<sup>233</sup> Elimination of records does not necessarily include the authority to require production of those records at a particular place. Moreover, the books and records to be examined are those "of the parties to a proceeding."<sup>234</sup> Unless the hospital is the employer involved in the claim for workers' compensation, it is not a party to the proceedings.

Failure to respond to a subpoena of the Workers' Compensation Board may result in fines. The Board, however, does not have legal authority to order imprisonment for failure to respond to a subpoena.<sup>235</sup> However, the statute provides that the Superior Court of the county in which a hearing is to be held shall, upon application of the Board, enforce by proper proceedings the attendance and

testimony of witnesses and “the production and examination of books, papers and records.”<sup>236</sup> It appears, therefore, that failure to respond to Workers’ Compensation Board subpoena will result, if sought by the Board, in an order from a Superior Court requiring production of those records. Failure to comply with such an order would constitute contempt of court.

While hospitals routinely respond to subpoenas for medical records issued by the Workers’ Compensation Board, each hospital should consider specifically its legal position with respect to such subpoenas, particularly subpoenas which attempt to obtain what may appear to be controversial or sensitive records. There is a tendency to assume that the Board best knows its powers and would not issue a subpoena unless it were proper. Because there are obvious legal questions about the subpoenas power of the Board, however, hospitals should seek proper legal counsel in establishing an institutional posture with respect to them.

#### **4. Workers’ Compensation Administrative Law Judge**

After a claim for workers’ compensation is filed, the Board is required to make such investigation as it considers necessary and, either upon its own motion or the application of any interested party, order a hearing with respect to the claim and assign the matter to an administrative law judge.<sup>237</sup> The administrative law judge is specifically given the authority to issue subpoenas.<sup>238</sup> That authority presumably includes the ability to issue subpoenas for the attendance at the hearing as well as for production of documents.

Discovery may proceed with respect to a workers’ compensation hearing the same as in a regular trial.<sup>239</sup> The Workers’ Compensation Act provides that the discovery procedures are the same as those applicable to civil trials. Thus subpoenas for deposition, discussed above, and requests for production of documents, discussed below, both appear to be within the jurisdiction of an administrative law judge in a Workers’ Compensation hearing.

#### **5. Composite State Board of Medical Examiners**

The Composite State Board of Medical Examiners is the body that is given the authority to grant medical licenses to physicians in the State of Georgia.<sup>240</sup> It may refuse to grant those licenses and may discipline physicians for unlawful or unethical conduct.<sup>241</sup> In determining whether a license should be granted or a physician should be disciplined, the Board is authorized to conduct an appropriate investigation. The applicable statute<sup>242</sup> provides that any person properly conducting an investigation of behalf of the Board shall have access to and may examine any writing, document or other material, not privileged, which is deemed by the President of the Board to be related to the fitness of the physician. The Joint Secretary, State Examining Boards, or the President of the Medical Board may issue subpoenas to compel that access. If a subpoena from the Joint Secretary or Medical Board President is disobeyed, the Medical Board may apply to the Superior Court of the county in which the person to whom the subpoena is directed resides for an order requiring obedience with a subpoena. Failure to comply with a court order is punishable as contempt of court.<sup>243</sup>

It is not uncommon for investigational subpoenas from the Medical Board to seek inspection of medical records of patients treated by the physician under investigation. As with subpoena from the Workers' Compensation Board, hospitals should determine in advance their posture on Medical Board subpoenas. The hospital should decide whether it will respond to the subpoena initially or, particularly if the record (or the physician) is controversial or sensitive, the hospital will request the Medical Board to seek the court order described in the statute.

## **6. Coroner's Subpoenas**

A coroner conducting an investigation into an individual's death is authorized to issue subpoenas for the production of any books, records, or papers to the cause of death. Any documents received by the coroner remain confidential and privileged. The county is responsible for the actual costs of copying the subpoenaed records.<sup>244</sup> Coroners of other states may also obtain medical records' papers, or reports concerning the death of a person who was a resident of or is buried in that state.<sup>245</sup>

### **B. Special Rules For Hospital Response to Subpoenas**

Hospitals are served regularly and often frequently with subpoenas requiring the production of medical records, both for use at a hearing or trial and in connection with pretrial discovery. If the regular rules applied, a custodian of the records would be required to attend the deposition or the hearing or trial. There the custodian would identify the records produced as the official hospital medical records keep in the normal course of hospital business and relating to the treatment of a particular patient. This procedure would obviously place a tremendous burden on the hospital. Moreover, the cost of responding to such a burden would be substantial. Medical records would be removed from the hospital and unavailable for hospital use; medical record personnel would be tied up in legal proceedings and absent from the hospital.

Fortunately, hospitals in Georgia are generally relieved of that inconvenience and expense. A statute applicable only to medical records gives hospitals an alternative method of responding to subpoenas for those records.<sup>246</sup> That statute applies to all situations for which subpoenas may issue or for which production may be sought, including, but not limited to, trials, hearings, and discovery.<sup>247</sup>

If it appears that medical records for which a subpoena has been issued should be kept by the hospital as reasonably necessary for the treatment of the patient, the court before which the litigation is pending shall order that a certified copy of the medical record be admitted into evidence in lieu of the original record.<sup>248</sup> Even if it does not appear that the medical record should be kept by the hospital, the hospital may at any time and upon request be permitted to substitute reproductions of medical records, provided that the reproduction is accompanied by a certificate executed by the person responsible for keeping medical records that the reproduction is a true and accurate copy of the medical record.<sup>249</sup>

Under these special rules, a hospital and its personnel shall be deemed to have complied with a subpoena or court order for the production of medical records if it is shown that a certified copy of the record was delivered to the clerk of the court or “other authorized person (by way of illustration, counsel seeking production in discovery proceedings)” by any means, including certified or registered mail.<sup>250</sup> A certificate indicating that the records attached are true and accurate copies of the medical record, signed before a notary public or other officer authorized to administer oaths, shall excuse the personal appearance of any person responsible for keeping the medical records.<sup>251</sup> In general, therefore, a hospital may respond to a subpoena for the production of documentary evidence (subpoena duces tecum) by providing a certified copy of the medical record. A copy of the medical record may be delivered to counsel for the party issuing the subpoena. If there is any question about the record or the circumstances under which it is sought, however, the hospital may send the unified copy of the record directly to the clerk of the court issuing the subpoena.

If a subpoena or order expressly commanded the presence of the individual responsible for the records has been issued, however, and is issued pursuant to authority of the court and “for good cause shown, both appearing of record and on the face of such subpoena or order,” personal presence is required, then the alternative method of responding to the subpoena is not available. The subpoena must state on its fact that “for good cause shown” the court orders the personal appearance of the custodian of the records.<sup>252</sup> If this language does not appear, the hospital may assume that a certified copy of the record may be produced.

If the original medical records are in any case removed from the hospital to the custody of the court pursuant to a subpoena or court order, those records are kept in the custody of the clerk (or the clerk or secretary of the administrative agency issuing the subpoena), and are open to inspection according to the terms of the subpoena or order. After the use for which the records were needed has been satisfied, they must be promptly returned to the hospital by the party who compelled their production in the first instance.<sup>253</sup> If the hospital would be inconvenienced by a lengthy retention of the medical record by the court clerk, a certified copy of the record should be made and kept at the hospital at the time the original record is given up.

If good cause is shown to the court, the court may issue an order that the original medical records be produced in order to determine that the copy delivered to the court is complete and accurate.<sup>254</sup>

If records are produced to determine the accuracy of the reproduction or if a copy of the record is produced after it appears that the original medical record should be kept by the hospital “as reasonably necessary for the treatment of a patient,” the court generally will provide for advance payment to the hospital for the reasonable costs of reproducing the record and reasonable costs incident to the transportation of the record to the court. No hospital may be held in contempt or otherwise penalized for failure to produce the record under those circumstances unless it appears that advance costs have been established and were tendered.<sup>255</sup> If the substitution of the certified copy of the records is made at the request and for the convenience of the institution, however, advance payment of the reproduction costs is not required by statute.<sup>256</sup>

In general, hospitals may respond to routine subpoenas and court orders for the production of medical records by providing a certified copy of the records. The subpoena should always be examined closely to verify that it is routine and does not include a requirement that the custodian of the record appear personally.

### **C. Requests for Production of Documents**

A hospital, whether or not a party to litigation, may be served with a Request For Production of Documents, which requires the hospital to produce, and to permit the party making the request to inspect and copy documents described in the request. Those documents may include writings, charts, photographs, computer records and the like.<sup>257</sup> The request must set forth the items to be inspected, either by individual item or by category, and must describe each item and category with reasonable particularity. The request must specify a reasonable time, place and manner of making the inspection.<sup>258</sup>

A special rule<sup>259</sup> applies to hospital responses to requests for production of documents. A request directed toward a non-party who is a practitioner, hospital, or health care facility, must also be served upon all parties to the action. The hospital must wait 10 days before responding to the request, during which time the hospital or any party may file an objection to the request with the clerk of the court. If no objection has been filed during that period, the hospital must promptly comply with the request.

If the hospital objects to production of the documents the party making the request may seek a court order requiring the inspection, and let the judge decide whether the inspection should be made.<sup>260</sup> If the court does order the production to take place, it may require the hospital to pay the reasonable expenses incurred in obtaining the order, including attorney's fees. The judge cannot make the hospital pay those expenses if he determines that the objection was substantially justified or that other circumstances make an award of expenses unjust. On the other hand, if the order is sought but is not granted (and thus the hospital's objection upheld), the court may require the party insisting upon the production to pay the hospital's expenses, including attorney's fees.<sup>261</sup>

#### **1. Problems for Hospitals**

The submission of requests for production of documents to persons who are not directly involved in the litigation as parties creates several potential problems or areas of concern for hospitals.

First, original medical records are not generally removed from hospital premises. A request for production of documents, however, generally relates to original documents, and anticipates that original documents will be produced for inspection and copying.

Second, the typical request for production of documents requires that they be produced at the office of the attorney initiating the request. The physical production of the documents for inspection and copying at a place other than the hospital is inconvenient and expensive. This is

particularly true in large urban hospitals in which requests for production of documents are received regularly.

Third, the Georgia statute which states that delivery of a certified copy of a medical record constitutes compliance with a subpoena relates only to the production of records pursuant to “subpoena or court order.”<sup>262</sup> That statute makes no mention to requests for production of documents.

Some attorneys initiating requests for production of documents state specifically in the request that sending a certified copy of the medical record to the attorney will be considered by him adequate compliance with the request. While this procedure may be convenient both for the attorney initiating the request and for the hospital, it is not necessarily appropriate. There is no provision in the statute relating to certified copies of medical records which suggests that its provisions apply to requests for production of documents. Moreover, sending the attorney initiating the request a copy of the record may be unfair to the other parties in the litigation. When a request for production of documents is served upon a party to litigation in the normal course, and the documents are physically produced for the attorneys to review, every other party to the action (and in many lawsuits there is more than just one plaintiff and defendant) may also come and review and inspect the records. Sending a copy of the medical record to the attorney initiating the request does not give the other parties an opportunity to review those records. Even if the hospital desired to send every other party a copy of the medical record, the hospital has no way to determine the identify and addresses of all the other parties and their attorneys, and may well not want to incur the expense of multiple copying.

Fourth, request for production of documents do not have the force and formality of subpoenas generally. This concern may be somewhat alleviated under the statute which requires the party seeking production of documents to notify the opposing party. However, in circumstances where the patient is not a party to the litigation, the patient may be unaware of the request and have no opportunity to object to the release of records. The patient may feel that the hospital has some obligation to preserve the confidentiality of the records and desire it to make a routine objection to production of the records on that basis alone.

## **2. Some Suggested Procedures**

For these and other reasons, the attorneys for the Georgia Hospital Association have suggested a procedure for hospitals to follow in response to requests for production of documents.

Under that suggested procedure, the hospital’s attorney contacts the attorney making the request and discusses with him the hospital’s concerns. The attorney is asked to request the medical record by means of subpoena and agree to receiving a certified copy of the record and to pay for it. If the attorney declines those suggestions, the hospital’s counsel then files a routine objection within 10 days after service of the request and takes the position with the court that no production of confidential medical information should be authorize without a subpoena and advance payment of the reproduction costs. The burden is then shifted to the party seeking the documents to apply to the court for an order compelling the production and showing good cause in support of that request.

Some hospitals may desire to establish a procedure for responding to requests for production that does not involve calling the hospital's attorney to handle the matter. The following procedure has been adopted by some hospitals as a procedure to handle request for production of documents.

(a) Immediately upon receipt of the request for production of documents, the hospital determines whether the patient is named as a party.

(1) If it is obvious that the patient is a party, the hospital presumes that his attorney has received a copy of the request that was served upon the hospital lawyer. The patient, through his attorney, may object to the production of records by the hospital and serve the hospital with a copy of the court papers evidencing the objection. If the hospital does not receive a copy of an objection within 10 days, and the request is otherwise proper, the hospital complies with it. One of the reasons that the hospital waits 10 days before responding to the request is to allow the parties to the action, particularly the patient, to interpose an objection if desired.

(2) If it is not obvious that the patient is a party to the action, the hospital sends a letter to the patient stating that it has receive a request for production of the patient's medical records and that the hospital by law must comply with that request if no objection is made. The patient is told that he can make an objection to the hospital's production of the record by contacting his attorney and filing, within 10 days from the hospital's receipt of the request, the appropriate document with the court. (Some hospitals may want to send such a form letter to the patient in every case, particularly if that procedure is administratively easier than having to make individual determination about the patient's being a party to the lawsuit.) If the patient does not act to stop the hospital's production of the record, the hospital complies with the request.

(b) If the request specifies production at a location other than the hospital premises, it may state on its face that delivery of a certified copy of the medical record will be deemed sufficient compliance with the request.

(1) If neither is the case, the hospital should contact its attorney about filing an objection to the request. The hospital's attorney will hopefully resolve the matter informally with the party seeking the request, but because disputes have arisen at this point, the hospital's attorney is contacted to handle the matter.

(2) If both requirements are satisfied, the hospital delivers a certified copy of the patient's medical record to the attorney that made the request (assuming no objection is filed by the patient or another party to the lawsuit).

(3) If the request specifies the hospital as the place for the production of records (and is otherwise proper), the hospital makes the records ready for inspection at the date and time specified.

(4) If the hospital delivers a certified copy of the patient's physical records, a statement for reproduction charges is included.

(c) If the request for production of documents is abnormal in any fashion or presents unusual issues not addressed directly in the procedure statement, the hospital's attorney is contacted for advice.

#### **D. AIDS Confidential Information**

Special rules apply when information sought by a subpoena, court order, or request for production of documents includes AIDS Confidential Information. AIDS Confidential Information may be disclosed pursuant to a subpoena or request for production of documents only if the person identified by it has consented in writing to the disclosure or has been notified of the request at least ten days prior to the time the disclosure is to be made and does not object to the disclosure within the time.<sup>263</sup> All other disclosures of AIDS confidential material pursuant to a subpoena or request for production of documents will require a court order.<sup>264</sup>

Court orders for disclosure are available to prosecutors in connection with a prosecution for reckless conduct, to a public safety agency or the Department of Human Resources if an employee has been exposed to the body fluids of the person identified in the information, and to any party in a civil lawsuit. The court order for disclosure will be issued only if the court finds a compelling need for the information that cannot be met by other means. Public health, safety and welfare needs are weighed against the privacy interest of the patient and the public interest in encouraging voluntary HIV testing.<sup>265</sup>

A petition for a court order to disclose AIDS confidential information is filed under a pseudonym, all hearings on the matter are conducted in private, and the records are sealed. Additional safeguards to prevent further unauthorized disclosure of the information may be imposed by the court.<sup>266</sup>

The protections for AIDS confidential information are waived to the extent that the person identified by the information or the person's representative files a claim for insurance benefits or is involved in a civil lawsuit regarding the claim, places his medical condition at issue in a lawsuit, or is involved in an insurance coverage dispute.<sup>267</sup> A hospital should not rely on the representatives of an attorney, insurance company, or other party to a dispute that confidentiality has been waived.

Pursuant to a 1990 Amendment, AIDS confidential information may also be disclosed as part of an involuntary treatment proceeding for a person alleged to be mentally ill, mentally retarded, or alcoholic or drug dependent.<sup>268</sup> Information may also be disclosed as a part of a guardianship proceeding regarding such a person or that person's estate. This requirement will be applicable to involuntary commitment proceedings undertaken by mental health facilities.<sup>269</sup>

Any person who files or transmits a petition or other document which discloses AIDS confidential information in connection with any such proceeding must provide a cover page which

contains only the type or proceeding or procedure, the court in which the proceeding or procedure is r will be pending, and the words “CONFIDENTIAL INFORMATION.” The cover page may not in any manner disclose the name of any individual nor that such petition or other document contains AIDS confidential information.<sup>270</sup>

AIDS confidential information may only be disclosed with the written consent of the person identified by that information, or that person’s parent or guardian if that person is a minor or has previously been adjudicated as incompetent, or by court order.<sup>271</sup> If a court receives a petition that does not demonstrate consent to release of the information, or court-ordered release, the court will either return the documents to the sender, delete all references to AIDS confidential information, or seek a court order for disclosure from the superior court.<sup>272</sup>

The standards for the court ordering disclosure under these circumstances are generally the same as the standards applied in other situations. the court must determine a compelling need for the information in connection with the particular situation or proceeding at hand. The person identified by the information must be represented by an attorney (even if one must be appointed by the court).<sup>273</sup> The person identified by the information and her attorney must receive personal notice of the petition and notice of the time and place of the superior court hearing regarding the arguments for and against disclosure. Usually the hearing must not be held sooner than 72 hours after service. Certain emergency hearings need not adhere to this time constraint.<sup>274</sup>

In assessing the arguments regarding disclosure, the court will weigh the public health, safety, welfare needs, or any other public or private needs for the disclosure against the privacy interest of the son identified by the information and the public interest which may be disserved by disclosures that may deter voluntary HIV tests.<sup>275</sup>

1. O.C.G.A. § 31-7-2.1(a).
2. Ga. Comp. R. & Regs. r. 290-5-6-.11(a)-(c).
3. Ga. Comp. R. & Regs. r. 290-5-6-.11(d)-(f).
4. Ga. Comp. R. & Regs. r. 290-5-6-.11(i).
5. See *infra* text accompanying notes 125-164.
6. AMH, p. 83 *et seq.*
7. 42 U.S.C. § 1395x(e).
8. See 42 C.F.R. § 482.24.
9. Ga. Comp. R. & Regs. r. 290-5-6.11(h).
10. *Id.*
11. O.C.G.A. § 39-1-1.
12. O.C.G.A. § 9-3-71. An “action for medical malpractice” is defined as any claim for damages resulting from the death of or injury to any person arising out of (1) health, medical, dental or surgical service, diagnosis, prescription, treatment, or care, rendered by a person authorized by law to perform such service or by any lawfully authorized person, or (2) care or service rendered by any public or private hospital, nursing home, clinic, hospital authority, facility or institution, or by any officer, agent or employee thereof acting within the scope of his or her employment. O.C.G.A. § 9-3-70.
13. O.C.G.A. § 9-3-72.
14. O.C.G.A. § 9-3-73.
15. For example, the Internal Revenue Service, the Social Security Administration, and the Department of Labor have promulgated regulations relating to payroll records, each with differing retention periods. Because periods are not uniform, the requirements of each regulation should be monitored.
16. O.C.G.A. § 16-10-94.1.
17. O.C.G.A. § 24-9-21.
18. Confidentiality of Patient Health Information; A Position Paper of the American Medical Record Association. Medical Record News, Journal of the American Medical Record

Association p. 9 (April 1978).

19. Privacy Protection Study Commission, Personal Privacy in an Information Society 283 (1977).
20. American Hospital Association, Hospital Medical Records 5 (1972); Code of Ethics, American College of Hospital Administrators and American Hospital Association (1958).
21. O.C.G.A. § 51-5-1.
22. *Id.*
23. O.C.G.A. § 51-5-4.
24. Southwick, LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 317 (1978).
25. O.C.G.A. §51-5-6; Jones v. Neighborhood Newspaper, Inc., 142 Ga. App. 365, 369 (1977).
26. O.C.G.A. § 51-5-7.
27. O.C.G.A. § 51-5-5.
28. Warren & Brandeis, The Right to Privacy, 4 HARV. L. REV. 192 (1890).
29. American Credit Corp. v. United States Cas. Co., 49 C.F.R. 314 (N.D. Ga. 1969); Prosser and Keeton, TORTS 849-69 (5th ed. 1984).
30. 122 Ga. 190 (1905).
31. Roberson v. Rochester Folding Box Co., 64 N.E. 422 (N.Y. 1902).
32. 171 Ga. 257 (1930).
33. 60 Ga. App. 92 (1939).
34. 138 Ga. App. 425 (1976).
35. Barker v. Time, Inc., 159 S.W. 2d 291, 295 (Mo. 1942).
36. Tanner-Brice Co. v. Sims, 174 Ga. 134 (1931).
37. Waters v. Fleetwood, 212 Ga. 161, 167 (1956).
38. Dennis v. Adcock, *supra* note 34.
39. Horne v. Patton, 287 Ga. 2d 824 (Ala. 1973).

40. Hammonds v. Aetna Cas. & Surety Co., 243 F. Supp. 793, 801 (N.D. Ohio 1965).
41. Principles of Medical Ethics of the American Medical Association § 9 (1957).
42. Bogess v. Aetna Life Insur. Co., 128 Ga. App. 190n(1973).
43. Kimble v. Kimble, 240 Ga. 100 (1977).
44. Christianson v. State, 261 Ga. 80 (1991); Plummer v. State, 299 Ga. 749 (1972); Massey v. State, 226 Ga. 703 (1970);
45. See O.C.G.A. § 24-10-20.
46. O.C.G.A. § 9-11-26(b).
47. 162 Ga. App. 677 (1982).
48. O.C.G.A. § 43-39-16, 24-9-21(6)-(8).
49. O.C.G.A. §§ 24-9-21 and 24.
50. O.C.G.A. § 24-9-24: “Communications to any attorney or to his employee to be transmitted to the attorney pending his employment or in anticipation thereof shall never be heard by the court. The attorney shall not disclose the advice or counsel he may give to his client, nor produce or deliver up title deeds or other papers, except evidence of debt left in his possession by his client. This Code section shall not exclude the attorney as a witness to any facts which may transpire in connection with his employment.”
51. In re R.M., 194 Ga. App. 888 (1990).
52. Cranford v. Cranford, 120 Ga. App. 470 (1969).
53. White v. The State, 180 Ga. App. 185 (1986); Lipsey v. The State, 170 Ga. App. 770 (1984).
54. O.C.G.A. § 26-5-17.
55. O.C.G.A. § 37-7-1 et seq.
56. O.C.G.A. § 37-7-166.
57. O.C.G.A. § 37-7-1(5).
58. O.C.G.A. § 37-7-166(a).
59. O.C.G.A. § 37-7-166(b). DHR has adopted regulations pertaining to patients’ rights which apply to alcoholics and drug users treated pursuant to O.C.G.A. § 37-7. mentally ill persons treated pursuant to O.C.G.A. § 37-3, and mentally retarded persons treated pursuant to

O.C.G.A. § 37-4. The statutory provisions concerning treatment of mentally ill persons and mental retarded persons include provisions regarding disclosure of the patients' clinical records very similar to those set forth in O.C.G.A. § 37-7-166 with respect to alcoholics and drug users. The provisions of the regulations governing confidentiality of such records differ in some respects from the statutory provisions. Ga. Comp. R. & Regs. r. 290-4-7-.05(2)(a)(8) and (9). The statutory provisions would govern to the extent such rules are inconsistent with the statutes.

60. O.C.G.A. § 37-7-177(c).
61. Id.
62. O.C.G.A. § 37-3.
63. O.C.G.A. § 37-3-166.
64. O.C.G.A. § 37-3-1(2).
65. O.C.G.A. § 37-3-166(a).
66. O.C.G.A. § 37-3-1(14).
67. O.C.G.A. § 37-3-166(b).
68. O.C.G.A. § 37-3-166(d).
69. O.C.G.A. § 37-3-166(c).
70. O.C.G.A. § 37-4.
71. O.C.G.A. § 37-4-1(11).
72. O.C.G.A. § 37-4-2(6).
73. O.C.G.A. § 37-4-125.
74. O.C.G.A. § 37-4-2(2).
75. O.C.G.A. § 37-4-125(a).
76. O.C.G.A. § 37-4-125(c).
77. O.C.G.A. § 37-4-125(b).
78. O.C.G.A. § 37-4-125(c).
79. O.C.G.A. § 37-8.

80. O.C.G.A. § 37-8-50(a).
81. O.C.G.A. § 37-8-50(b).
82. 42 U.S.C. § 4582.
83. 21 U.S.C. § 1175.
84. 42 C.F.R. Part 2, “Confidentiality of Alcohol and Drug Abuse Patient Records.”
85. 42 C.F.R. § 2.12(c).
86. 42 C.F.R. § 2.12(b).
87. 42 C.F.R. § 2.12(e).
88. 42 C.F.R. § 2.12(a) and (b).
89. 42 C.F.R. § 2.13(b).
90. 42 C.F.R. Part 2, Subpart C.
91. 42 C.F.R. § 2.31.
92. 42 C.F.R. § 2.31(c).
93. 42 C.F.R. § 2.32.
94. 42 C.F.R. Part 2, Subpart D.
95. 42 C.F.R. § 2.61(b)(1).
96. 42 C.F.R. § 2.64(d).
97. O.C.G.A. § 49-5-40(a).
98. O.C.G.A. § 49-5-44(a).
99. O.C.G.A. § 49-5-41(a).
100. O.C.G.A. § 49-5-41(b).
101. O.C.G.A. § 49-5-41(c).
102. O.C.G.A. § 49-5-44(b).
103. O.C.G.A. § 49-5-44(c).

104. O.C.G.A. § 19-7-5.
105. O.C.G.A. § 16-6-23.
106. Cox Broadcasting Corp. v. Cohn, 420 U.S. 469 (1975).
107. O.C.G.A. § 31-7-143.
108. O.C.G.A. § 31-7-140.
109. O.C.G.A. § 31-7-143.
110. O.C.G.A. § 31-7-133(a).
111. O.C.G.A. § 31-7-131(3).
112. O.C.G.A. § 31-7-132.
113. O.C.G.A. § 31-7-133(b).
114. O.C.G.A. § 24-8-40.1.
115. O.C.G.A. § 24-9-47(b).
116. O.C.G.A. § 31-22-9.1.
117. O.C.G.A. § 24-9-47(o).
118. For example, AIDS confidential information may be disclosed to a funeral director pursuant to O.C.G.A. § 31-21-3.
119. See O.C.G.A. § 33-39.
120. O.C.G.A. § 24-9-47(j).
121. O.C.G.A. § 24-9-47(u).
122. O.C.G.A. § 19-7-5.
123. 1987 Op. Att’y Gen No. 87-29.
124. O.C.G.A. § 31-8-82(a).
125. O.C.G.A. § 31-8-81(3).
126. O.C.G.A. § 31-8-82(a).

127. O.C.G.A. § 31-8-82(a).
128. O.C.G.A. § 31-8-82(b).
129. O.C.G.A. § 31-8-81(1).
130. O.C.G.A. § 31-8-81(2).
131. O.C.G.A. § 31-8-82(c).
132. O.C.G.A. § 31-8-86.
133. O.C.G.A. § 31-8-87.
134. O.C.G.A. § 31-7-9(b).
135. O.C.G.A. § 31-7-9(c).
136. O.C.G.A. § 31-7-9(d).
137. 551 P.2d 334 (Cal. 1976).
138. Bellah v. Greenson, 141 Cal. Rptr. 92 (Cal. App. 1977).
139. 250 Ga. 199 (1982).
140. O.C.G.A. § 31-17-2
141. Ga. Comp. R. & Regs. r. 290-5-17-.01 et seq.
142. O.C.G.A. § 31-12-2(a).
143. Id.
144. O.C.G.A. § 31-12-2(b).
145. Ga. Comp. R. & Regs. R. 290-5-3-.01 et seq.
146. O.C.G.A. § 31-22-9.2(b).
147. O.C.G.A. § 24-9-47(h)(2).
148. O.C.G.A. § 31-10-9, 31-10-15, and 31-10-18.
149. O.C.G.A. § 31-18-3.
150. O.C.G.A. § 31-18-2.

151. O.C.G.A. § 31-18-3.
152. O.C.G.A. § 45-16-24.
153. O.C.G.A. § 45-16-25.
154. 1973 Op. of Att’y Gen. No. U73-65.
155. O.C.G.A. § 16-10-31.
156. O.C.G.A. § 31-21-3.
157. O.C.G.A. § 24-9-40.
158. O.C.G.A. § 42-1-7 (citing O.C.G.A. 37-3-1).
159. O.C.G.A. § 31-1-3.1.
160. O.C.G.A. § 37-2-11.2(a).
161. O.C.G.A. § 31-2-6.
162. O.C.G.A. § 24-9-41 through 45.
163. O.C.G.A. § 24-9-41(4).
164. O.C.G.A. § 24-9-44.
165. O.C.G.A. § 31-33-2.
166. O.C.G.A. § 31-33-5.
167. Orr v. Sievert, 162 Ga. App. 677 (1982); Tanner-Brice Co. v. Sims, 174 Ga. 134 (1931)
168. O.C.G.A. § 31-33-3(b).
169. O.C.G.A. § 37-3-162(b).
170. Id.
171. O.C.G.A. § 37-7-167(a).
172. O.C.G.A. §§ 37-3-162(b) and 37-3-167(a).
173. O.C.G.A. §§ 37-4-122(c) and 37-40126(a).
174. O.C.G.A. § 31-33-1 et seq.

175. O.C.G.A. § 31-33-2(c).
176. O.C.G.A. § 31-33-5.
177. See Horthy, HOSPITAL LAW, Medical Records (1978)
178. O.C.G.A. § 31-33-1(1).
179. O.C.G.A. § 31-33-2(c).
180. O.C.G.A. § 9-3-71.
181. O.C.G.A. § 9-3-97.1.
182. O.C.G.A. § 31-36-1 et seq.
183. O.C.G.A. § 31-33-3(a).
184. O.C.G.A. § 31-8-86.
185. O.C.G.A. § 31-7-6.
186. See supra notes 82-96 and accompanying text.
187. See supra notes 125 and accompanying text
188. O.C.G.A. § 19-7-5(d).
189. O.C.G.A. § 19-7-5(f).
190. See supra note 127 and accompanying text.
191. O.C.G.A. § 31-8-82(b).
192. O.C.G.A. § 31-8-85.
193. O.C.G.A. § 43-34-37(a).
194. O.C.G.A. § 43-34-37(a).
195. O.C.G.A. § 43-34-37(h).
196. O.C.G.A. § 43-34-37(a).
197. O.C.G.A. § 40-5-35(a).
198. O.C.G.A. § 19-7-6(b).

199. O.C.G.A. § 19-7-6(f).
200. O.C.G.A. § 19-7-6(g).
201. The Random House Dictionary of the English Language (2d ed. 1987).
202. O.C.G.A. § 24-10-20(a).
203. O.C.G.A. § 24-10-20(b); 24-10-21.
204. O.C.G.A. § 24-10-22(a).
205. O.C.G.A. § 24-10-22(b).
206. O.C.G.A. § 24-10-21.
207. O.C.G.A. § 24-10-23.
208. O.C.G.A. § 24-10-24.
209. Id.
210. O.C.G.A. § 24-10-25.
211. O.C.G.A. § 9-11-45(a)(1).
212. Id.
213. See O.C.G.A. § 9-11-26.
214. O.C.G.A. § 9-11-26(c).
215. Id.
216. O.C.G.A. § 9-11-45(a)(1).
217. O.C.G.A. § 9-11-45(a)(2).
218. O.C.G.A. § 9-11-45(b).
219. Fed. R. Civ. P. 45(a).
220. Fed. R. Civ P. 45(c)(1).
221. Fed. R. Civ. P. 45(a)((1)(C).
222. Fed. R. Civ. P. 45(a)((2)(A).

223. Fed. R. Civ. P. 45(a)(1)(D).
224. Fed. R. Civ. P. 45(c)(2)(B).
225. Fed. R. Civ. P. 45(c)(3)(A).
226. Fed. R. Civ. P. 45(c)(3)(B).
227. Fed. R. Civ. P. 45(b)(1).
228. Fed. R. Civ. P. 45(a).
229. See supra note 227 and accompany text.
230. Fed. R. Civ. P. 45(a)(2).
231. Fed. R. Civ. P. 45(b)(2). The same rule is applicable to subpoenas for depositions, productions, and inspections, as well as for hearings and trials.
232. O.C.G.A. § 34-9-60.
233. O.C.G.A. § 34-9-60(a).
234. Id.
235. Id.
236. O.C.G.A. § 34-9-60(b).
237. O.C.G.A. § 34-9-100(c).
238. O.C.G.A. § 34-9-69(a).
239. O.C.G.A. § 34-9-102(d).
240. O.C.G.A. § 43-34-27(a).
241. O.C.G.A. § 43-34-37(a).
242. O.C.G.A. § 43-34-37(b).
243. Id.
244. O.C.G.A. § 45-16-27(c).
245. O.C.G.A. § 45-16-10.

246. O.C.G.A. § 24-7-8 and §§ 24-10-70 through 76.
247. O.C.G.A. § 24-10-75.
248. O.C.G.A. § 24-10-71(a).
249. O.C.G.A. § 24-10-71(b).
250. O.C.G.A. § 24-10-72(a).
251. O.C.G.A. § 24-10-72(b).
252. Id.
253. O.C.G.A. § 24-10-74.
254. O.C.G.A. § 24-10-71(c).
255. O.C.G.A. § 24-10-73.
256. Id.
257. O.C.G.A. § 9-11-34(a).
258. O.C.G.A. § 9-11-34(b).
259. O.C.G.A. § 9-11-34(c)(2).
260. Id. (citing O.C.G.A. § 9-11-37(a)).
261. O.C.G.A. § 9-22-37(a)(4).
262. See supra note 253 and accompanying text.
263. O.C.G.A. § 24-9-47(s).
264. O.C.G.A. § 24-9-47(r)-(t).
265. O.C.G.A. § 24-9-47(t).
266. Id.
267. O.C.G.A. § 24-9-47(y).
268. O.C.G.A. § 24-9-47(bb).
269. Id.

- 270. O.C.G.A. § 24-9-47(bb)(1).
- 271. O.C.G.A. § 24-9-47(bb)(2).
- 272. O.C.G.A. § 24-9-47(bb)(3).
- 273. O.C.G.A. § 24-9-47(bb)(3)(C)(i).
- 274. Id.
- 275. O.C.G.A. § 24-9-47(bb)(3)(C)(ii).