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# **Integrating Behavioral and Physical Health Care in New Jersey**

## **Legal Requirements for the Sharing of Patient Health Information among Treatment Providers**

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June 2016



## Table of Contents

Acknowledgments.....	iii
Executive Summary.....	iv
I. Introduction .....	1
II. Review of Federal and New Jersey Law on Sharing of Patient Health Information among Treatment Providers .....	2
A. Federal Law .....	4
1. HIPAA .....	4
a. Permitted uses or disclosures: patient authorization.....	5
b. Permitted uses and disclosures: treatment and operations.....	7
c. Minimum necessary requirement.....	8
d. Psychotherapy notes.....	8
e. Business Associates.....	9
f. Organized Health Care Arrangements .....	10
g. Minors.....	11
2. 42 C.F.R. Part 2 .....	11
a. General provisions .....	12
b. Consent Requirement .....	13
c. “Necessary to carry out the purpose” requirement .....	15
d. Prohibition on redisclosure requirement .....	16
e. Exceptions: internal communications and medical emergencies.....	16
f. Qualified Service Organizations .....	18
g. Part 2 Programs.....	18
h. Minors .....	20
i. Part 2 records and HIOs .....	21
j. Proposed changes to Part 2 regulations .....	21
k. Interaction with other laws.....	22
B. New Jersey Law.....	23
1. Department of Human Services Confidentiality Requirements .....	23
a. Community mental health providers licensed by the New Jersey Department of Human Services or funded by, under contract with, or affiliated with the Division of Mental Health and Addiction Services.....	24

b.	Psychiatric residential treatment facility for individuals under 21 .....	28
c.	Outpatient and residential substance use disorder treatment facilities licensed by DHS .....	29
d.	DHS’s Division of Developmental Disabilities .....	29
e.	Screening and screening outreach services .....	31
2.	Hospitals and other facilities licensed by the New Jersey Department of Health.....	32
3.	Health Care Professionals .....	36
4.	Correctional Facilities.....	42
5.	Sensitive Information.....	42
a.	HIV/AIDS Records.....	43
b.	Venereal Diseases .....	44
c.	Genetic Information.....	45
d.	Treatment of Intoxicated Persons .....	46
III.	Challenges to Health Information Sharing among Treatment Providers .....	46
A.	Misinformation and Fear .....	47
B.	Legal Complexity, Ambiguity, and Gaps.....	47
C.	Operational and Technological Challenges.....	50
IV.	Opportunities to Support Provider Exchange of Treatment Information.....	52
A.	Harmonization of Legal Requirements .....	52
B.	Legal Guidance and Standards.....	53
C.	Technical Guidance and Standards .....	54
D.	Education .....	55
V.	Conclusion.....	55
	Appendix A: Individuals Interviewed or Consulted during Preparation of Report .....	56
	Appendix B: Table - Examples of Treatment Exceptions to Confidentiality Requirements in New Jersey .....	58
	Appendix C: Chart – Examples of Terms Used to Describe Entities Authorized to Receive Patient Health Information Pursuant to Different Treatment Exceptions in New Jersey .....	80
	Appendix D: Table – Examples of New Jersey Authorization, Waiver, Consent, and Approval Requirements to Disclose Protected Health Information.....	82
	Appendix E: Table – Comparing Examples of Specific Requirements for Consent and Authorization in New Jersey .....	106
	Appendix F: Table - Examples of Rules Regarding Minor Consent to Disclosure of Health Information in New Jersey .....	113

## Acknowledgments

This Report was supported by Funding Opportunity Number CMS-1G1-12-001 from the US Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS) under Cooperative Agreement No. 1G1CMS331386-01-07. The contents are solely the responsibility of the Center for Health & Pharmaceutical Law & Policy at Seton Hall Law School and its faculty member, Tara Adams Ragone, and do not necessarily represent the official views of HHS, any of its agencies, or any agency of the State of New Jersey.

The author gratefully acknowledges the insights and expertise shared by a number of individuals, who generously shared their time to help me understand the legal and practical barriers to the exchange of information among physical and behavioral health care providers in New Jersey. Appendix A identifies many of these individuals, and I apologize for any unintentional omissions. I especially would like to thank Helen Oscislowski, Esq. and Krystyna H. Monticello, Esq., who patiently discussed obscure and arcane legal provisions in painstaking detail and generously shared resources to help contextualize my analysis. The New Jersey Hospital Association also graciously shared a comprehensive analysis of HIPAA preemption of New Jersey law, which offered helpful observations. Joel Cantor and Margaret Koller of the Rutgers Center for State Health Policy, the New Jersey State Innovation Model Grant Steering Committee, and John V. Jacobi, Faculty Director of the Center for Health & Pharmaceutical Law & Policy and Dorothea Dix Professor of Health Law & Policy at Seton Hall Law School offered sage input throughout my work.

I further acknowledge Matthew Goss, Timothy McHale, Chelsea Ott, and Lindsay Sheely, a talented group of Seton Hall Law students that provided valuable research assistance and skills to this project. Any errors remain my own.

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## Executive Summary

The chorus in favor of integrating behavioral and physical health services is strong and diverse, both at the federal level and in New Jersey. Providers, payers, regulators, patients, and academics are uniting behind the strong clinical behavioral health literature highlighting integration's positive effects on access and clinical outcomes. But integration requires providers to share health information so they may coordinate care. Health care providers often report experiencing barriers to the exchange of health information with other providers. As care has been siloed, so too have many patient records, and it is not always clear who has the legal authority to access them.

The Center for Health & Pharmaceutical Law & Policy at Seton Hall University School of Law (the Center) was asked to conduct a legal analysis, as part of New Jersey's State Innovation Model Grant, of the barriers related to the sharing of patient health information in connection with the integration of physical and behavioral health care. To inform the legal analysis, the Center conducted a number of interviews with providers, regulators, health information exchanges (HIEs), health information organizations (HIOs), trade and professional associations, consultants, privacy attorneys, advocates, and researchers, to learn more about the specific problems providers face and the questions that need answering.

This Report has three main goals:

1. To summarize the Center's legal analysis of federal and New Jersey laws regarding the sharing of patient health information among treatment providers;
2. To identify challenges to health information sharing among treatment providers that relate to these legal requirements; and
3. To suggest opportunities for the State to support provider exchange of treatment information for integration.

**First, the Report provides an overview of federal and New Jersey statutes and regulations governing when health care providers may exchange patient health records in integrated care settings:**

- Federal privacy law creates a floor. No state may provide less protection to protected patient health information than federal law provides, but states may provide more stringent protection. Thus, it is critical to understand both federal and New Jersey law regarding the sharing of patient health information among treatment providers. Where the requirements of laws differ, generally the law that provides greater protection to patient privacy will govern.
- The approaches of the federal government and New Jersey to regulating confidentiality are quite distinct. There principally are two sources of federal requirements – the Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA, which applies to a broad array of health records; and 42 C.F.R. Part 2, commonly known as Part 2, which creates heightened confidentiality protections for substance use disorder treatment and prevention records. New Jersey, in contrast, has scores of statutes and regulations that establish confidentiality requirements for a variety of

health care facilities, providers, and professionals, as well as for several categories of sensitive, disease- or condition-specific information.

- Generally, federal and New Jersey statutes and regulations do not prohibit providers in integrated settings from sharing patient health information, although several provisions condition disclosure on various requirements. The specific requirements that apply, however, vary depending on a variety of factors, including the custodian of the patient information, the entity that will receive the information, the purpose for which information is being shared, and the type of health information. In some instances, providers may exchange patient information without patient authorization for treatment purposes. But in other situations, patient authorization or consent is required before the information may be disclosed. The Appendix to the Report contains a number of tables that capture the breadth and variety of legal requirements that are in play.

**Second, even though the Center’s analysis generally did not uncover a *per se* legal barrier to exchanging health information, it did reveal challenges to health information sharing among treatment providers:**

- One of the most significant barriers to information sharing is misinformation. A common theme in the Center’s interviews has been that providers are fearful of violating federal or state privacy laws, so they are hesitant to share patient health information. This is particularly true when it comes to behavioral health records because the law treats these records differently in some situations. The Center hopes this Report will dispel some of these myths and fears by clarifying what the law requires and permits with respect to patient health information.
- Beyond misinformation, however, there are a number of legal and operational challenges that are hampering information sharing in integrated settings. For one, the various federal and State laws create a complex web, and that very complexity can be operationally daunting in the context of health care delivery. In addition, there are terms left unclear and undefined in the various laws, which further complicates compliance. Finally, specific categories of privacy protection, including specific diseases and conditions, as well as a patient’s status as a minor, can add a layer of complexity. As a result of these legal and operational challenges, many providers seeking to integrate care are erring on the side of caution and not including behavioral health records in EHRs and HIEs or are not manually sharing those records with collaborating providers.

**Third, there are a number of options available to the State to reduce barriers – both real and perceived -- to information sharing among health care providers.**

- Integration of behavioral and physical health care can improve the lives of patients and help to rationalize a fragmented health care delivery system. The sharing of patient records by coordinating providers is central to integration efforts. Real and perceived legal barriers to the sharing of patient information inhibit integrative efforts. Remedies to many of those barriers are within the authority of the State. Four categories of remedies are described below: statutory and regulatory harmonization; provision of legal guidance; support for technical improvements; and public education.

### ➤ **Harmonization of Legal Requirements**

The Center's review suggests that the State should consider statutory and regulatory reform to simplify, normalize, and make more transparent the State's confidentiality laws. It would be helpful to harmonize, where possible, New Jersey requirements, both with other New Jersey provisions and with federal requirements, which would simplify the task of compliance for health care providers. For example, where consent is required, adoption of uniform elements and definitions, where appropriate, would facilitate standardized consent forms and minimize confusion and unnecessary technicalities. Consideration also should be given to enacting a general exception or exceptions to authorization requirements for treatment purposes, so that members of coordinated care teams directly providing services to a patient share directly relevant information.

The State should consider taking a broad look at its statutory and regulatory scheme to assess the benefits and burdens of the various statutes and regulations that vary from generally applicable health privacy standards like HIPAA. In this regard, it is interesting to note that the New Jersey Department of Human Services' residential and outpatient substance use disorder regulations incorporate the HIPAA and Part 2 requirements, with minor adjustments, rather than a separate set of state-created requirements. The State may have good reason to maintain additional variations that are more protective of confidentiality than federal law. But any variations in legal standards and definitions should be intentional rather than artifactual. Given the 2013 Omnibus amendments to HIPAA and the pending proposed rule changes to Part 2, this is a particularly opportune time for New Jersey to undertake a comprehensive revision of its confidentiality requirements.

### ➤ **Legal Guidance and Standards**

In addition to harmonizing State statutory and regulatory provisions, it would be helpful for New Jersey to issue guidance to clarify agency interpretation of State law, and to articulate State policy with respect to health information exchange in service of integrated care. For example, in addition to clarifying the scope of particular provisions and providing definitions of undefined terms, guidance also could address how population health activities of innovative care organizations fit in to the existing statutory and regulatory framework. Agency guidance offers an opportunity to clarify misinformation and assuage provider fear. Given the number of State bodies responsible for administering the various confidentiality regulations and the desire to avoid inconsistency, a joint statement would best serve the goals of harmonization and clarity.

Publication of model forms also would facilitate adoption of information sharing by simplifying the process, minimizing the burden on providers, and promoting mutual trust. It would be helpful for New Jersey to develop templates, such as for consent forms, that would harmonize federal and State requirements. The State also could consider working with health care providers to develop additional standards that would facilitate health information exchange.

### ➤ **Technical Guidance and Standards**

Health care providers also would benefit from guidance regarding the navigation of the technological options that are available for consent management, data segmentation, interoperability, and the like. The investment in time and money is substantial, and even champions of integration are



hesitant to invest without assurances that the systems comply with existing legal requirements. Establishing standards will lower transaction costs and moderate risk for providers. New Jersey should seek to be involved in federal and interstate projects designed to develop standards and open source technology. By engaging in interstate collaboratives, the State can contribute to the development of best practices and be in a position to promote them within the State.

### ➤ Education

With harmonization, standardization, and guidance, it also will be essential to facilitate education of providers and consumers regarding the benefits of integration, what the law requires to permit the sharing of information among treatment providers, and what resources exist to support integration efforts. Education will address misinformation and fear head-on. Given provider staff turnover and the lack of resources in many health care provider offices to stay abreast of legal developments, it would be helpful for there to be State-specific FAQs, webinars, or training modules that health care practices could use to train new staff and provide ongoing training.



## I. Introduction

Integration of behavioral and physical health care services is increasingly the clinical state of the art, and is a critically important component of health improvement efforts. Providers, payers, regulators, patients, and academics are uniting behind the strong clinical behavioral health literature highlighting integration's positive effects on access and clinical outcomes.<sup>1</sup>

New Jersey is home to a number of integration efforts, including a Behavioral Health Homes pilot that began in Bergen County in 2014.<sup>2</sup> New Jersey also has received a planning grant award from the Substance Abuse and Mental Health Services Administration (SAMHSA) to plan and develop Certified Community Behavioral Health Clinics (CCBHCs).<sup>3</sup> In a sign of its commitment to behavioral health integration, the New Jersey Department of Health issued a "global waiver to permit the sharing of clinical space" to facilitate the integration of behavioral and primary care in some settings.<sup>4</sup> Private foundations like The Nicholson Foundation also have funded behavioral health integration efforts across the State.<sup>5</sup>

Current, complete health records are essential to modern health care, and shared health information is an essential building block of coordinated and integrated care. Despite New Jersey's clear commitment to advancing integration, health care providers often report experiencing barriers to the exchange of health information with other providers. As care has been siloed, so too have many patient records, and it is not always clear who has the legal ability to access them.

The Center for Health & Pharmaceutical Law & Policy at Seton Hall University School of Law (the Center) was asked to conduct a legal analysis, as part of New Jersey's State Innovation Model Grant, of the barriers related to the sharing of patient health information in connection with the integration of physical and behavioral health care. To inform the legal analysis, the Center conducted a number of interviews with providers, regulators, health information exchanges (HIEs), health information

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<sup>1</sup> See generally JOHN V. JACOBI, TARA ADAMS RAGONE, & KATE GREENWOOD, CENTER FOR HEALTH & PHARMACEUTICAL LAW & POLICY, INTEGRATION OF BEHAVIORAL AND PHYSICAL HEALTH CARE: LICENSING AND REIMBURSEMENT BARRIERS AND OPPORTUNITIES IN NEW JERSEY 6-15 (Mar. 31, 2016), available at <http://law.shu.edu/behavioralhealth> (behavioral health integration clinical literature review).

<sup>2</sup> See STATE OF N.J. DEP'T OF HUMAN SERVC., DIV. OF MENTAL HEALTH & ADDICTION SERVC., *Health Homes*, <http://nj.gov/humanservices/dmhas/initiatives/integration/hh.html> (last visited Mar. 30, 2016).

<sup>3</sup> See N.J. DEP'T OF HUMAN SERVC., DIV. OF MENTAL HEALTH & ADDICTION SERVC., *Certified Community Behavioral Health Clinics: CCBHCs Stakeholders*, at 2 (Oct. 2015) (PowerPoint slides on file with author) [hereinafter *CCBHC Webinar*].

<sup>4</sup> See October 19, 2015 Memorandum to FQHCs and Other Department of Health Licensed Primary Care Facilities, Primary Care Association from John A. Calabria, Director of the New Jersey Department of Health, Division of Certificate of Need and Licensing, Re: Waiver to Permit Sharing of Clinical Space, available at [http://www.nj.gov/health/healthfacilities/documents/ac/primary\\_care\\_facilities\\_permitting\\_sharing\\_of\\_clinical\\_space.pdf](http://www.nj.gov/health/healthfacilities/documents/ac/primary_care_facilities_permitting_sharing_of_clinical_space.pdf).

<sup>5</sup> See, e.g., THE NICHOLSON FOUNDATION, INSPIRE (Integrating Networks and Systems to Achieve Patient Healthcare Integration Reform Effectively): Center for Health Education Medicine and Dentistry (CHEMED), <https://thenicholsonfoundation.org/what-we-do/projects/inspire-integrating-networks-and-systems-achieve-patient-healthcare-integration> (last visited Dec. 10, 2015); THE NICHOLSON FOUNDATION, Integrating Care to Reduce Health Disparities in a Medical Home: Trenton Health Team, <https://thenicholsonfoundation.org/what-we-do/projects/integrating-care-reduce-health-disparities-medical-home> (last visited Dec. 10, 2015).

organizations (HIOs), trade and professional associations, consultants, privacy attorneys, advocates, and researchers.

Section II of this Report provides an overview of federal and New Jersey statutes and regulations governing when health care providers may exchange patient health records in integrated settings. The approaches of the federal government and New Jersey to regulating confidentiality are quite distinct: there are principally two sources of federal requirements – the Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA,<sup>6</sup> which applies to a broad array of health records, and 42 C.F.R. Part 2,<sup>7</sup> which creates heightened confidentiality protections for substance use disorder treatment and prevention records. New Jersey, in contrast, has scores of statutes and regulations that establish confidentiality requirements for a variety of health care facilities, licensed professionals, and sensitive information.<sup>8</sup> While generally federal and New Jersey statutes or regulations do not prohibit providers in integrated settings from sharing patient health information, several provisions condition disclosure on a number of requirements.

Section III identifies challenges to information sharing among health care providers. Although the law in many instances permits the sharing of treatment records among health care providers, misinformation and the complexity and variations within New Jersey’s regulatory matrix may be chilling integration. Tables in the Appendix catalogue the dizzying array of provisions and highlight areas of similarity and dissonance that bear on integration’s potential. Operational and technological challenges further complicate integration’s progress.

Section IV identifies four opportunities for the State to support the exchange of patient information among providers. First, the State should look for ways to harmonize New Jersey’s legal requirements, which harmonization would simplify the task of compliance for providers. Second, the State should issue regulatory guidance and standards to clarify ambiguities and increase transparency. Third, the State should support federal and interstate efforts to develop technical guidance and standards that would support the exchange of patient health information. Fourth, the State should develop educational and training materials to combat misinformation and empower providers to integrate care while respecting patient confidentiality.

## II. Review of Federal and New Jersey Law on Sharing of Patient Health Information among Treatment Providers

The Center surveyed federal and New Jersey statutes, regulations, and interpretive guidance that are relevant to the ability of providers to share patient health information in integrated care settings.<sup>9</sup>

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<sup>6</sup> See Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 104th Cong., § 264, available at <https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/Downloads/HIPAALaw.pdf>.

<sup>7</sup> See 42 U.S.C. § 290dd-2 *et seq.*; 42 C.F.R. §§ 2.1 *et seq.*

<sup>8</sup> See Section II.B, *infra*.

<sup>9</sup> Because this Report focuses on the exchange of patient information among treatment providers, such as physicians, clinics, substance use disorder (SUD) treatment programs, and hospitals, its legal overview focuses on federal and New Jersey provisions regarding the ability of treatment providers to exchange patient health information. It does

Generally, federal and New Jersey statutes and regulations do not prohibit providers in integrated settings from sharing patient health information, although several provisions condition disclosure on various requirements. The specific requirements that apply vary depending on a variety of factors, including the custodian of the patient information, the entity that will receive the information, the purpose for which information is being shared, and the type of health information. In some instances, providers may exchange patient information for treatment purposes without patient authorization (Appendices B and C). But in other situations, patient authorization or consent is required before the information may be disclosed, even among treatment providers (Appendices D-F).

What follows is an overview of varying federal and New Jersey legal requirements. Federal privacy law creates a floor.<sup>10</sup> No state may provide less protection to protected patient health information than federal law provides, but states may provide more stringent protection.<sup>11</sup> Thus, it is critical to understand what both federal and New Jersey law provides when it comes to the sharing of patient health information among treatment providers. Where the requirements of laws differ, generally the law that provides greater protection to patient privacy will govern.

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not provide a comprehensive summary of all of the federal and New Jersey laws regarding access to patient health information, such as provisions governing mandatory public health reporting of health information, court orders for the release of health information, mandatory reporting obligations in cases of suspected child abuse, or when health information may be disclosed to family members or personal representatives. It also is beyond the Report's scope to consider the legal barriers to the broader exchange of information that entities such as Accountable Care Organizations (ACOs), Health Homes, and Health Information Organizations (HIOs) are considering, including obtaining data from health plans, public health agencies, and other government agencies to support care management and population health activities.

<sup>10</sup> See U.S. DEP'T OF HEALTH & HUMAN SERVCs., Health Information Privacy, *Does the HIPAA Privacy Rule preempt state laws?*, <http://www.hhs.gov/hipaa/for-professionals/faq/399/does-hipaa-preempt-state-laws/index.html> (last visited Mar. 20, 2016).

<sup>11</sup> See 45 C.F.R. § 160.201 et seq.

## A. Federal Law<sup>12</sup>

### 1. HIPAA

HIPAA, among other things, required the creation of federal standards for privacy of individually identifiable health information.<sup>13</sup> The U.S. Department of Health and Human Services (HHS) then adopted the HIPAA Privacy Rule, which established national standards for the use and disclosure of protected health information (PHI) by entities covered by the law (covered entities or CEs) and their business associates (BAs).<sup>14</sup> The Privacy Rule attempts to strike “a balance that permits important uses of information, while protecting the privacy of people who seek care and healing.”<sup>15</sup> An individual has the right to receive a Notice of Privacy Practices, providing “adequate notice of the uses and disclosures of [PHI] that may be made by the [CE], and of the individual's rights and the [CE]'s legal duties with respect to protected health information.”<sup>16</sup> The Rule specifies what the Notice must contain as well as optional elements.<sup>17</sup>

PHI is any information, whether oral or recorded, that is created or received by entities, including health care providers, that relates to the past, present, or future physical or mental health of an individual.<sup>18</sup> Health care is defined broadly under HIPAA to include, among other things, “preventive,

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<sup>12</sup> The Legal Action Center has produced a number of useful materials that review federal law concerning the sharing of patient health information. See, e.g., LEGAL ACTION CENTER, *Sharing Information Across Physical and Behavioral Health: Debunking Myths, Developing Strategies* (slideshow from National Academy for State Health Policy webinar presented by Karla Lopez, Legal Action Center, on Aug. 6, 2015) (on file with author); LEGAL ACTION CENTER, *Patient Privacy and Confidentiality in the Changing Health Care Environment: HIPAA, 42 C.F.R. Part 2, and Health Care Reform* (webinar presented by Karla Lopez, Esq., Staff Attorney), available at <http://lac.org/resources/substance-use-resources/confidentiality-resources/webinar-patient-privacy-confidentiality-changing-health-care-environment-hipaa-42-c-f-r-part-2-health-care-reform/> [hereinafter *LAC Patient Privacy Webinar*]; LEGAL ACTION CENTER, *Understanding the SAMHSA FAQs: Part 1* (webinar prepared by the Legal Action Center in 2012 under a subcontract from Partners for Recovery; presented by Anita Martin, Esq.), available at [http://lac.org/wp-content/uploads/2014/12/Webinars\\_2012\\_Understanding\\_the\\_SAMHSA\\_FAQs\\_Part\\_1-1.ppt](http://lac.org/wp-content/uploads/2014/12/Webinars_2012_Understanding_the_SAMHSA_FAQs_Part_1-1.ppt) [hereinafter *LAC SAMHSA FAQs Part 1 Webinar*]; LEGAL ACTION CENTER, *Understanding the SAMHSA FAQs: Part 2* (webinar prepared by the Legal Action Center in 2012 under a subcontract from Partners for Recovery; presented by Anita Martin, Esq.), available at <http://lac.org/resources/substance-use-resources/confidentiality-resources/webinar-alcohol-drug-confidentiality-regulations-health-information-technology/> [hereinafter *LAC SAMHSA FAQs Part 2 Webinar*]; LEGAL ACTION CENTER, *Patient Privacy and Confidentiality for SBIRT Providers: HIPAA, 42 C.F.R. Part 2, & Health Care Reform* (webinar presented by Karla Lopez, Esq., Staff Attorney), available at <http://lac.org/wp-content/uploads/2014/07/Final-LAC-Slides-for-JBS-Webinar-09-19-2013.pdf> [hereinafter *LAC SBIRT Webinar*].

<sup>13</sup> See Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 104th Cong., § 264, available at <https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/Downloads/HIPAALaw.pdf>.

<sup>14</sup> See 45 C.F.R. §§ 160.102(a)-(b); 160.103; 164.104(a)(3); 164.500(a), (c).

<sup>15</sup> U.S. DEP'T OF HEALTH & HUMAN SERVCs., Health Information Privacy, *Summary of the HIPAA Privacy Rule*, <http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/> (last visited Mar. 26, 2016).

<sup>16</sup> 45 C.F.R. § 164.520(a).

<sup>17</sup> See *id.* § 164.520(b).

<sup>18</sup> See U.S. DEP'T OF HEALTH & HUMAN SERVCs., Health Information Privacy, *Does the Security Rule apply to written and oral communications?*, <http://www.hhs.gov/hipaa/for-professionals/faq/2010/does-the-security-rule-apply-to->

diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body.”<sup>19</sup>

Most health care providers are CEs subject to HIPAA’s Privacy Rule.<sup>20</sup> A business associate is “a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity.”<sup>21</sup> Generally, CEs and BAs may not use or disclose PHI except as permitted or required by the regulations implementing HIPAA.<sup>22</sup>

#### a. Permitted uses or disclosures: patient authorization

CEs may use and disclose PHI in accordance with a valid, written authorization from the individual<sup>23</sup> or the individual’s personal representative.<sup>24</sup> Generally, CEs may not condition treatment, payment, enrollment, or eligibility on the patient giving authorization, with some exceptions noted in the Rule.<sup>25</sup> Compound authorizations, in which an authorization for use or disclosure of PHI is combined with another document, also generally are not permitted, although the Privacy Rule identifies some exceptions.<sup>26</sup> For example, an authorization under Section 164.508 may be combined with another authorization under the same Section, except when the CE conditioned the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on one of the authorizations.<sup>27</sup>

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[written-and-oral-communications/index.html](#) (last visited Mar. 29, 2016); *LAC Patient Privacy Webinar*, *supra* note 12, at 13, 17; *see also* 45 C.F.R. § 160.103 (defining PHI and individually identifiable information).

<sup>19</sup> *See* 45 C.F.R. § 160.103.

<sup>20</sup> *See id.* §§ 160.102(a)(3); 160.103; 164.104(a)(3); 164.500(a); *see, e.g.*, U.S. DEP’T OF HEALTH & HUMAN SERVS., Health Information Privacy, *Covered Entities and Business Associates* (identifying health care providers, as that term is used in HIPAA, to include providers such as doctors, clinics, psychologists, dentists, chiropractors, nursing homes, and pharmacies), <http://www.hhs.gov/hipaa/for-professionals/covered-entities/index.html> (last visited Mar. 29, 2016). *But see* U.S. DEP’T OF HEALTH & HUMAN SERVS., OFFICE OF THE ASS’T SEC’Y FOR PLANNING & EVALUATION, Standards for Privacy of Individually Identifiable Health Information. Final Privacy Rule Preamble, (Dec. 28, 2000), *available at* <https://aspe.hhs.gov/report/standards-privacy-individually-identifiable-health-information-final-privacy-rule-preamble/covered-entity-0> (“Whether the professionals [such as social workers] . . . are covered by [HIPAA] depends on the activities they undertake, not on their profession or degree. The definitions in this rule are based on activities and functions, not titles. For example, a social service worker whose activities meet this rule’s definition of health care will be a health care provider. If that social service worker also transmits information in a standard HIPAA transaction, he or she will be a covered health entity under this rule. Another social service worker may provide services that do not meet the rule’s definition.”).

<sup>21</sup> U.S. DEP’T OF HEALTH & HUMAN SERVS., Health Information Privacy, *Business Associates*, <http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/business-associates/> (last visited Mar. 20, 2016); *see also* 45 C.F.R. § 160.103.

<sup>22</sup> *See* 45 C.F.R. § 164.502(a).

<sup>23</sup> *See id.* §§ 164.502(a)(1)(4); 164.508(a)(1).

<sup>24</sup> *See id.* § 164.502(g)(1); *see also* U.S. DEP’T OF HEALTH & HUMAN SERVS., Health Information Privacy, *Personal Representatives*, <http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/personal-representatives/index.html> (last visited Mar. 27, 2016) [hereinafter “HHS, *Personal Representatives*”].

<sup>25</sup> *See* 45 C.F.R. § 164.508(b)(4).

<sup>26</sup> *See id.* § 164.508(b)(3).

<sup>27</sup> *See id.* § 164.508(b)(3)(iii). Note that this exception to the general ban on compound authorizations does not apply to psychotherapy notes, which are discussed below. Additional limits to this exception are beyond the scope of this Report. *See id.*

Individuals generally may revoke a revocation in writing at any time, with some limitations set forth in the Rule.<sup>28</sup>

Section 164.508 sets forth the requirements for a valid authorization, which must include, at a minimum, the following core elements:

- (i) A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
- (ii) The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.
- (iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure.
- (iv) A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- (v) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. . . .
- (vi) Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided.<sup>29</sup>

The Privacy Rule also requires the authorization to include "statements adequate to place the individual on notice of" the individual's right to revoke in writing; the ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization; and the potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected.<sup>30</sup> The authorization may include additional elements or information as long as they are consistent with the required elements.<sup>31</sup> Authorizations must be written in plain language,<sup>32</sup> and CEs are required to document and retain signed authorizations as specified in the Rule,<sup>33</sup> with a copy given to the individual.<sup>34</sup>

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<sup>28</sup> See *id.* § 164.508(c)(4).

<sup>29</sup> *Id.* § 164.508(c)(1).

<sup>30</sup> See *id.* § 164.508(c)(2).

<sup>31</sup> See *id.* § 164.508(b)(1)(ii).

<sup>32</sup> See *id.* § 164.508(c)(3).

<sup>33</sup> See *id.* § 164.508(b)(6).

<sup>34</sup> See *id.*



## b. Permitted uses and disclosures: treatment and operations

The Privacy Rule also permits CEs to use and disclose PHI for purposes of treatment and health care operations without getting patient authorization.<sup>35</sup>

“Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.”<sup>36</sup> The treatment exception “was carved out by HIPAA in order to prevent disruption of firmly established workflows and referral activities between providers.”<sup>37</sup> CEs may use or disclose PHI for their own or another health care provider’s treatment activities.<sup>38</sup> The HIPAA treatment exception includes disclosures of PHI in the context of mental health or other specialist therapy in a group setting where other patients and family members are present.<sup>39</sup>

The Privacy Rule defines health care operations as a number of operational activities of the CE, to the extent that the activities are related to covered functions.<sup>40</sup> Of particular relevance to this Report, health care operations, include:

Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 CFR 3.20); population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment[.]<sup>41</sup>

<sup>35</sup> See *id.* §§ 164.502(a)(1)(ii), 164.506. HIPAA permits, but does not require, CEs voluntarily to obtain patient consent for disclosures of PHI for purposes of treatment or health care operations. *What is the difference between “consent” and “authorization” under the HIPAA Privacy Rule?*, <http://www.hhs.gov/hipaa/for-professionals/faq/264/what-is-the-difference-between-consent-and-authorization/index.html> (last visited Mar. 29, 2016). It is important to note that “consent” is not synonymous with “authorization” for purposes of HIPAA. See *id.* Consent is a voluntary choice, and CEs have discretion to determine the form of consent. See *id.* As discussed above, however, the Privacy Rule dictates specific requirements for valid authorizations, when they are required. See *id.*

<sup>36</sup> 45 C.F.R. § 164.501.

<sup>37</sup> Helen Oscislowski, *Health Law Diagnosis: Patient Consent, Sensitive Data and Health Information Exchange*, at 2-3 (Oct. 2011) (on file with author) [hereinafter “Oscislowski, *Patient Consent*”].

<sup>38</sup> See 45 C.F.R. § 164.506(c)(1)-(2).

<sup>39</sup> See U.S. DEP’T OF HEALTH & HUMAN SERVCES., *Health Information Privacy, May mental health practitioners or other specialists provide therapy to patients in a group setting where other patients and family members are present?*, <http://www.hhs.gov/hipaa/for-professionals/faq/203/may-health-care-providers-conduct-group-therapy-sessions/index.html> (last visited Mar. 29, 2016).

<sup>40</sup> See 45 C.F.R. § 164.501.

<sup>41</sup> *Id.*

For a CE to disclose PHI to another CE for the specific health care operations of the receiving entity that are itemized in the Privacy Rule, including population-based activities relating to improving health or reducing health care costs and case management and care coordination, both CEs must have had or have “a relationship with the individual who is the subject of the [PHI] being requested”, and the PHI must pertain to such relationship.<sup>42</sup>

Generally, providers do not need a patient’s authorization to disclose PHI for treatment purposes or for health care operations.<sup>43</sup> As a result, HIPAA generally does not stand as a barrier to the exchange of PHI among health care providers seeking to integrate care because the treatment and health care operations exceptions cover most, if not all, exchanges of PHI in integrated care settings.<sup>44</sup>

### c. Minimum necessary requirement

Generally, CEs and BAs “must make reasonable efforts” to use, disclose, and request only “the minimum necessary [amount of PHI] to accomplish the intended purpose of the use, disclosure, or request.”<sup>45</sup> This requirement, commonly referred to as the minimum necessary requirement, applies to disclosures pursuant to the operations exception, but it does not apply to disclosures pursuant to valid authorizations or the treatment exception, among others.<sup>46</sup>

### d. Psychotherapy notes

As a general matter, HIPAA does not treat behavioral health care information differently than other types of PHI. Psychotherapy notes, however, generally do not fall within the treatment or operations exceptions and require special handling under HIPAA. In most cases, CEs need written authorization from a patient to use or disclose psychotherapy notes.<sup>47</sup>

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<sup>42</sup> See *id.* § 164.506(c)(4)(i).

<sup>43</sup> See generally *id.* § 164.506(a) (“Except with respect to uses or disclosures that require an authorization under § 164.508(a)(2) through (4) or that are prohibited under § 164.502(a)(5)(i), a covered entity may use or disclose protected health information for treatment, payment, or health care operations as set forth in paragraph (c) of this section, provided that such use or disclosure is consistent with other applicable requirements of this subpart”). It is interesting to note that individuals have the right to request CEs to restrict use or disclosure of PHI for treatment or operations purposes, although the CE is not obliged to honor the request. See *id.* § 164.522(a)(1)(i)(A). Even when a CE agrees to a restriction, however, it may use the restricted PHI or disclose it to a health care provider if it is needed to treat the individual’s medical emergency. *Id.* § 164.522(a)(1)(iii). The CE, though, would need to request the receiving health care provider not to further use or redisclose the information. See *id.* § 164.522(a)(1)(iv). CEs may terminate a restriction if the individual requests or agrees to the termination in writing; the individual’s oral agreement to the termination is documented; or the CE informs the individual that it is terminating the restriction, subject to certain requirements in the Privacy Rule. See *id.* § 164.522(a)(2).

<sup>44</sup> As discussed in Section III.B *infra*, there is some question regarding the scope of the treatment and operations exceptions in coordinated care settings that seek to engage in population health activities.

<sup>45</sup> 45 C.F.R. § 164.502(b).

<sup>46</sup> See *id.* § 164.502(b)(i), (iii); see also *id.* § 164.514(d).

<sup>47</sup> See *id.* § 164.508(a)(2). The Privacy Rule recognizes limited exceptions to the psychotherapy authorization requirement, including when the originator of the notes is using them for treatment or a CE is using or disclosing them for its own training programs. See *id.* § 164.508(a)(2)(i)(A)-(B).

It is important to note, however, that psychotherapy notes are defined in a rather narrow fashion:

["]Psychotherapy notes["] means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. ["]Psychotherapy notes["] excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.<sup>48</sup>

Thus, progress notes or other documentation of counseling sessions that are integrated with parts of the record that expressly are excluded from the definition of psychotherapy notes are not deemed psychotherapy notes under HIPAA because they are not kept separate from the rest of the patient's medical record.

The Privacy Rule recognizes an exception to the general prohibition on compound authorizations for psychotherapy notes by permitting authorizations for the use or disclosure of psychotherapy notes to be combined.<sup>49</sup>

#### e. Business Associates

Generally, a CE does not need patient authorization to disclose PHI to a BA, but the CE and BA must execute a valid business associate agreement (BAA), which will set forth how the BA is permitted to use and disclose PHI.<sup>50</sup> The BA may not use or disclose PHI in a manner that would violate the Privacy Rule if done by the CE.<sup>51</sup> The Privacy Rule sets forth a number of requirements for the BAA.<sup>52</sup>

Examples of BAs include a Health Information Organization (HIO), an E-prescribing Gateway, "or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information."<sup>53</sup> An

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<sup>48</sup> *Id.* § 164.501. Note, however, that Section 13424(f) of the HITECH Act requires the Secretary of the U.S. Department of Health and Human Services to consider whether the definition of psychotherapy notes should be "revised to include test data that is related to direct responses, scores, items, forms, protocols, manuals, or other materials that are part of a mental health evaluation, as determined by the mental health professional providing treatment or evaluation." Oscislowski, *Patient Consent*, *supra* note 37, at 3.

<sup>49</sup> 45 C.F.R. § 164.508(c)(ii).

<sup>50</sup> *See id.* §§ 164.502(a)(3); 164.504(e)(2).

<sup>51</sup> *Id.* § 164.502(a)(3).

<sup>52</sup> *See id.* § 164.504(e)(2).

<sup>53</sup> *Id.* § 160.103.

accountable care organization (ACO) may also be a business associate of its covered entity ACO participants.<sup>54</sup>

Thus providers may execute BAAs with HIOs and similar entities to permit the sharing of PHI so the HIO may perform certain services on behalf of the providers. An ACO may collect data for providers and share data regarding shared patients if it has executed a BAA with its providers.

#### f. Organized Health Care Arrangements

Organized Health Care Arrangements (OHCAs), as defined in the Privacy Rule,<sup>55</sup> are five types of arrangements that “involve clinical or operational integration among legally separate covered entities in which it is often necessary to share protected health information for the joint management and operations of the arrangement.”<sup>56</sup> As HHS has described, a key component of OHCAs is that individuals receiving services expect that these arrangements are integrated and jointly manage their operations.<sup>57</sup> OHCAs may include clinically integrated care settings and organized systems of health care, such as independent practice associations.<sup>58</sup>

A CE that participates in an OHCA is permitted to disclose PHI to other participants in the OHCA for any health care operations activities of the arrangement.<sup>59</sup> The Privacy Rule also permits CEs in an OHCA to provide a joint Notice of Privacy Practices.<sup>60</sup> Although a HIO may not participate in an OHCA, it may be a BA of one.<sup>61</sup> Healthcare providers participating in ACOs may satisfy the requirements to be an OHCA.<sup>62</sup>

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<sup>54</sup> See U.S. DEP’T OF HEALTH & HUMAN SERVS., Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, Final Rule, 80 Fed. Reg. 32,692, 32,733 (June 9, 2015), available at <https://www.gpo.gov/fdsys/pkg/FR-2015-06-09/pdf/2015-14005.pdf>.

<sup>55</sup> See 45 C.F.R. § 160.103.

<sup>56</sup> U.S. DEP’T OF HEALTH & HUMAN SERVS., Standards for Privacy of Individually Identifiable Health Information, Final Rule, 65 Fed. Reg. 82,464, 82,494 (Dec. 28, 2000), available at <https://www.gpo.gov/fdsys/pkg/FR-2000-12-28/pdf/00-32678.pdf>.

<sup>57</sup> See *id.*

<sup>58</sup> See *id.* The definition of OHCAs in the Privacy Rule details a number of requirements that entities must satisfy to be deemed an OHCA. See 45 C.F.R. § 160.103.

<sup>59</sup> See 45 C.F.R. § 164.506(c)(5). Generally, as discussed above, CEs may not disclose psychotherapy notes for health care operations absent patient authorization. See *id.* § 164.508(a)(2).

<sup>60</sup> See *id.* § 164.520(d).

<sup>61</sup> See U.S. DEP’T OF HEALTH & HUMAN SERVS., Health Information Privacy, *Can a health information organization (HIO) participate as part of an organized health care arrangement (OHCA)?*, [http://www.hhs.gov/ocr/privacy/hipaa/faq/health\\_information\\_technology/563.html](http://www.hhs.gov/ocr/privacy/hipaa/faq/health_information_technology/563.html) (last visited Mar. 27, 2016).

<sup>62</sup> See Patrick Ouellette, Health IT Security, “How an ACO should maintain health data privacy and security,” (Oct. 4, 2013), available at <http://healthitsecurity.com/news/how-an-aco-should-maintain-data-privacy-and-security>; see generally AKIN GUMP STRAUSS HAUER & FELD HEALTH REFORM ALERT, “Proposed Rule on ACO Shared Savings Program Implicates HIPAA” (Apr. 22, 2011), <https://www.akingump.com/en/news-insights/proposed-rule-on-aco-shared-savings-program-implicates-hipaa.html> (last visited Mar. 27, 2016) (“[I]t seems that the ‘organized health care arrangement’ (OHCA) concept under HIPAA could take on new significance in the ACO context. . . . An OHCA designation would seemingly allow health care professionals and other covered entities participating in an ACO to share PHI with each other and with the ACO for health care operations purposes without entering into a BAA with the ACO.”).

### g. Minors

The Privacy Rule generally looks to state law, including case law, to determine when CEs may disclose PHI concerning unemancipated minors.<sup>63</sup> In most instances, “a parent, guardian, or other person acting *in loco parentis* (collectively, “Parent”) is the personal representative of the minor child and can exercise the minor’s rights with respect to PHI, because the Parent usually has the authority to make health care decisions about his or her minor child.”<sup>64</sup> The Rule, however, identifies three situations in which a Parent is not the personal representative of a minor under HIPAA (but still may be under state law).<sup>65</sup> HHS has issued guidance that offers examples of each of these possible situations:

- When State or other law does not require the consent of a parent or other person before a minor can obtain a particular health care service, and the minor consents to the health care service;

Example: A State law provides an adolescent the right to obtain mental health treatment without the consent of his or her parent, and the adolescent consents to such treatment without the parent’s consent.

- When someone other than the parent is authorized by law to consent to the provision of a particular health service to a minor and provides such consent;

Example: A court may grant authority to make health care decisions for the minor to an adult other than the parent, to the minor, or the court may make the decision(s) itself.

- When a parent agrees to a confidential relationship between the minor and a health care provider.

Example: A physician asks the parent of a 16-year-old if the physician can talk with the child confidentially about a medical condition and the parent agrees.<sup>66</sup>

## 2. 42 C.F.R. Part 2

While HIPAA protects all forms of PHI, federal law also specifically focuses on protecting the confidentiality of alcohol and drug treatment and prevention records.<sup>67</sup> Referred to as Part 2, which is the name for the section of the federal regulations housing these rules,<sup>68</sup> this body of law recognizes the

<sup>63</sup> See 45 C.F.R. § 164.502(g)(3).

<sup>64</sup> See HHS, *Personal Representatives*, *supra* note 24; see also 45 C.F.R. §§ 164.502(g)(3)(i); 164.502(g)(3)(ii)(A).

<sup>65</sup> See 45 C.F.R. § 164.502(g)(3)(i)(A)-(C); U.S. DEP’T OF HEALTH & HUMAN SERVCES., HEALTH INFORMATION PRIVACY, “Does the HIPAA Privacy Rule allow parents the right to see their children’s medical records?” (Dec. 19, 2002), *available at* <http://www.hhs.gov/hipaa/for-professionals/faq/227/can-i-access-medical-record-if-i-have-power-of-attorney/index.html> (last visited April 20, 2016).

<sup>66</sup> HHS, *Personal Representatives*, *supra* note 24.

<sup>67</sup> See 42 U.S.C. § 290dd-2 *et seq.*; 42 C.F.R. §§ 2.1 *et seq.*

<sup>68</sup> See 42 C.F.R. Part 2.

stigma and potential discrimination surrounding addiction.<sup>69</sup> Fear of prosecution or other consequences from disclosure of addiction, such as lost employment or child custody, can deter individuals from seeking appropriate treatment. It is hoped that the heightened privacy protections for substance use treatment and prevention records will encourage patients to seek appropriate treatment without fear of negative consequences.<sup>70</sup> Violations of the Part 2 confidentiality provisions are subject to criminal fines.<sup>71</sup>

a. General provisions

The federal statute authorizing the Part 2 regulations generally requires that the “[r]ecords of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States” be kept confidential and identifies the limited circumstances in which such records may be disclosed.<sup>72</sup>

The Part 2 regulations and regulatory guidance provide more detail about the entities bound by these privacy requirements and the scope of the requirements themselves.<sup>73</sup> Programs that are subject to Part 2,<sup>74</sup> for example, may not disclose information that identifies a patient “directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a Part 2 program,” absent written consent or one of the other enumerated exceptions.<sup>75</sup> The regulations define “patient” to include individuals who have applied for a Part 2 program even if they never received treatment.<sup>76</sup> “Disclose” also is broadly defined to mean the “communication of patient identifying information, the affirmative verification of another person’s communication of patient identifying information, or the communication of any information from the records of a patient who has been identified.”<sup>77</sup>

The Part 2 regulations define “patient identifying information” (PII) to mean the “name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly

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<sup>69</sup> See *id.*; Sarah A. Wattenberg, Prepared by the Legal Action Center for the Substance Abuse and Mental Health Services Administration, U.S. Dep’t of Health & Human Servs., Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE), at 2 (Q1) (undated), available at <http://www.samhsa.gov/sites/default/files/faqs-applying-confidentiality-regulations-to-hie.pdf> [hereinafter SAMHSA 2010 FAQ].

<sup>70</sup> See *LAC SBIRT Webinar*, *supra* note 12, at 10.

<sup>71</sup> See 42 C.F.R. § 2.4.

<sup>72</sup> 42 U.S.C. § 290dd-2. Note that disclosures are permitted in limited circumstances; they are not mandated. See 42 C.F.R. § 2.3(b)(1).

<sup>73</sup> See 42 C.F.R. Part 2; see, e.g., SAMHSA 2010 FAQ, *supra* note 69; U.S. DEP’T OF HEALTH & HUMAN SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., Applying the Substance Abuse Confidentiality Regulations: 42 CFR Part 2 (REVISED) (Dec. 14, 2011, last updated Apr. 28, 2015), available at <http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs> [hereinafter SAMHSA 2011 FAQ].

<sup>74</sup> The definition of a Part 2 Program is discussed in more detail in Section II.A.2.g, *infra*.

<sup>75</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 4 (Q3); see also 42 C.F.R. § 2.12(a)(1).

<sup>76</sup> See 42 C.F.R. § 2.11.

<sup>77</sup> *Id.*

available information.”<sup>78</sup> PII does not include information that an individual is receiving or has received services from a mixed-use facility, such as a general medical facility or community mental health center that provides alcohol or drug treatment in addition to other services, as long as the disclosure does not reveal that the individual is receiving drug or alcohol treatment from the facility.<sup>79</sup> Any disclosure made pursuant to Part 2 “must be limited to that information which is necessary to carry out the purpose of the disclosure.”<sup>80</sup>

These restrictions extend to all records that contain PII, whether they are written, oral, or electronic, even if the party seeking the information already has it, has an alternative means of getting it, has obtained a subpoena or warrant, or is authorized by state law to access it.<sup>81</sup> Records are defined as “any information, whether recorded or not, relating to a patient received or acquired by a federally assisted alcohol or drug program.”<sup>82</sup> Part 2 covers “any record of a diagnosis identifying a patient as an alcohol or drug abuser which is prepared in connection with the treatment or referral for treatment of alcohol or drug abuse,” even if it is not used for that purpose.<sup>83</sup> But a diagnosis of drug overdose or alcohol intoxication that “clearly shows that the individual involved is not an alcohol or drug abuser,” such as an involuntary ingestion of alcohol or drugs or a reaction to a prescribed dosage, is not covered by Part 2.<sup>84</sup>

Part 2 programs must provide patients with a written notice of federal confidentiality requirements.<sup>85</sup> A regulation details what the notice must contain and offers a sample, although programs may devise their own as long as it is consistent with the rule.<sup>86</sup> In fact, the Part 2 regulations expressly provide that “the program may include in the written summary information concerning State law and any program policy not inconsistent with State and Federal law on the subject of confidentiality of alcohol and drug abuse patient records.”<sup>87</sup>

As discussed in more detail in the subsections that follow, Part 2 generally is more restrictive regarding the exchange of health information among treatment providers than HIPAA and many New Jersey laws. But, importantly, its restrictions apply to a limited group of providers.

## b. Consent Requirement

As a general matter, patient consent is necessary for a Part 2 program to disclose its records unless one of the enumerated exceptions applies.<sup>88</sup> When a patient has been adjudicated “as lacking the

<sup>78</sup> *Id.*

<sup>79</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 11 (Q17); SUBSTANCE ABUSE AND MENTAL HEALTH SERVCs. ADMIN., PARTNERS FOR RECOVERY, & LEGAL ACTION CENTER, *Overview of Alcohol/Drug Confidentiality Regulations – 42 C.F.R. Part 2 Webinar*, at 64, available at <http://lac.org/resources/substance-use-resources/confidentiality-resources/webinar-alcohol-drug-confidentiality-regulations-health-information-technology/> [hereinafter *SAMHSA Part 2 Webinar*].

<sup>80</sup> 42 C.F.R. § 2.13(a).

<sup>81</sup> See *id.* § 2.13(b); SAMHSA 2010 FAQ, *supra* note 69, at 3 (Q3); *SAMHSA Part 2 Webinar*, *supra* note 79, at 60; *LAC Patient Privacy Webinar*, *supra* note 12, at 21.

<sup>82</sup> 42 C.F.R. § 2.11.

<sup>83</sup> *Id.* § 2.12(e)(4).

<sup>84</sup> *Id.* § 2.12(e)(4)(ii).

<sup>85</sup> See *id.* § 2.22(a)(2).

<sup>86</sup> See *id.* § 2.22(b)-(d).

<sup>87</sup> *Id.* § 2.22(c).

<sup>88</sup> See 42 U.S.C. § 290dd-2(b)(1); SAMHSA 2010 FAQ, *supra* note 69, at 2 (Q1).



capacity, for any reason other than insufficient age, to manage his or her own affairs,” a guardian or other person authorized under state law may consent to disclosure on the patient’s behalf.<sup>89</sup>

The Part 2 regulations detail the proper form for consent to be effective. Consent must be in writing and contain the following elements:

1. The specific name or general designation of the program or person permitted to make the disclosure.
2. The name or title of the individual or the name of the organization to which disclosure is to be made.
3. The name of the patient.
4. The purpose of the disclosure.
5. How much and what kind of information is to be disclosed.
6. The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under [42 C.F.R.] § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under [42 C.F.R.] § 2.15 in lieu of the patient.
7. The date on which the consent is signed.
8. A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.
9. The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.<sup>90</sup>

The consent form may generally designate the entity disclosing PII.<sup>91</sup> However, the form must more specifically identify the receiving entity.<sup>92</sup> Part 2 requires that the receiving entity be identified either by providing the name of the receiving organization, or the name or title of the receiving entity.<sup>93</sup> While it is permissible to attach a list of the names of all recipients to the consent form, it is not acceptable to refer in the form to a web site, where the names of recipients will be listed.<sup>94</sup>

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<sup>89</sup> 42 C.F.R. § 2.15(a).

<sup>90</sup> *Id.* § 2.31(a); see also SAMHSA 2010 FAQ, *supra* note 69, at 8-9 (Q11).

<sup>91</sup> See 42 C.F.R. § 2.31(a)(1); see also SAMHSA 2011 FAQ, *supra* note 73, at 9 (Q15-16). The Legal Action Center offers this example in a training webinar for a permissible general designation for the disclosing party: “All programs in which the patient has been enrolled as an alcohol or drug abuse patient. See XYZ HIO website for a list of affiliated programs.” See LAC SAMHSA FAQs Part 1 Webinar, *supra* note 12, at 64.

<sup>92</sup> As discussed in Section II.A.2.7 *infra*, SAMHSA has proposed an amendment to Part 2 that would permit general designations for recipients of Part 2 records.

<sup>93</sup> See 42 C.F.R. § 2.31(a)(2); see also SAMHSA 2010 FAQ, *supra* note 69, at 11 (Q18-19); SAMHSA 2011 FAQ, *supra* note 73, at 9 (Q16).

<sup>94</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 11 (Q18); SAMHSA 2011 FAQ, *supra* note 73, at 9 (Q16).



The consent form may not say that consent is effective until revoked.<sup>95</sup> But for purposes of Part 2,<sup>96</sup> it is possible for consent to endure for substantial periods of time, where it is serving a legitimate purpose.<sup>97</sup> It is permissible under Part 2, for example, for a consent to identify that it will expire upon the patient's death, where that duration is necessary to serve the identified purpose.<sup>98</sup>

Given a patient's right to revoke consent at any time,<sup>99</sup> it is critical for Part 2 programs to have policies in place for honoring revocations.<sup>100</sup> Part 2 permits patients to revoke consent orally, although SAMHSA recommends that Part 2 programs get the revocation in writing and/or document it in the patient's record.<sup>101</sup> If a consent form listed multiple receiving parties and the patient revokes consent for only one of them, the revocation is valid, and the consent form remains valid for the remaining providers.<sup>102</sup> These requirements empower patients to more easily manage access to their records, but they also make it more difficult for Part 2 programs to track and implement consent and revocations.

Of particular interest to health care providers seeking to exchange patient health information, "treatment" is a sufficient description of the intended purpose of the disclosure.<sup>103</sup> It is possible to use a single consent form for disclosures to multiple recipients for different purposes as long as the form makes clear what information may be disclosed to which recipients for which purposes.<sup>104</sup> A single consent form also may authorize disclosure as well as redisclosure of Part 2 information to other identified recipients.<sup>105</sup> While the consent must be in writing, the Part 2 program does not need the original copy of the consent form.<sup>106</sup>

The Part 2 regulations include a sample consent form.<sup>107</sup> Importantly, the consent may permit, but may not require, a Part 2 program to disclose PII.<sup>108</sup>

### c. "Necessary to carry out the purpose" requirement

Any disclosure made pursuant to consent must be limited to that "which is necessary to carry out the purpose of the disclosure."<sup>109</sup> The kind and amount of information that satisfies this requirement will vary based on the particular purpose for which information is disclosed.<sup>110</sup>

<sup>95</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 12 (Q22).

<sup>96</sup> LAC cautions, however, that some states limit how long consent may last. See *LAC SAMHSA FAQs Part 1 Webinar*, *supra* note 12, at 76.

<sup>97</sup> See *id.* at 73, 76.

<sup>98</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 12 (Q22).

<sup>99</sup> See 42 C.F.R. § 2.31(a)(8).

<sup>100</sup> See *LAC SAMHSA FAQs Part 1 Webinar*, *supra* note 12, at 78.

<sup>101</sup> SAMHSA 2011 FAQ, *supra* note 73, at 1 (Q1).

<sup>102</sup> See *id.*

<sup>103</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 12 (Q23).

<sup>104</sup> See *id.* at 3 (Q4).

<sup>105</sup> See *id.* at 9 (Q13).

<sup>106</sup> See *id.* at 10 (Q15).

<sup>107</sup> 42 C.F.R. § 2.31(b).

<sup>108</sup> See *LAC SAMHSA FAQs Part 1 Webinar*, *supra* note 12, at 55.

<sup>109</sup> 42 C.F.R. § 2.13(a).

<sup>110</sup> See SAMHSA 2011 FAQ, *supra* note 73, at 3 (Q4).

d. Prohibition on redisclosure requirement

Whenever a Part 2 program discloses information based on written consent, it also must provide a written redisclosure notice to the recipient.<sup>111</sup> The regulation includes specific language that must be used for this notice, which advises the recipient that further disclosure is prohibited unless it is “expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by” Part 2.<sup>112</sup> This requirement applies whether the Part 2 program disclosed information orally, electronically, or in writing.<sup>113</sup> When a Part 2 program discloses PII electronically, the written notice must be sent electronically with the Part 2 records;<sup>114</sup> it is not sufficient to put it on the login page or the introductory or “splash” page of the HIO portal because it needs to be tied to the specific PII that was disclosed.<sup>115</sup>

e. Exceptions: internal communications and medical emergencies

Unlike HIPAA, there is no broad, generally applicable treatment or health care operations exception that permits the sharing of Part 2 records without patient consent.<sup>116</sup> There are a number of exceptions to the Part 2 restrictions,<sup>117</sup> however, including two that apply most directly to integrated care settings, as discussed in this subsection.

For one, the Part 2 restrictions do not apply to disclosures made for purposes of a Part 2 program’s internal communication.<sup>118</sup> Disclosures for purposes of internal communication are only permissible, however, to the extent the recipient needs the information to provide alcohol or drug services.<sup>119</sup> Pursuant to this exception, for example, a Part 2 program may disclose protected information to other program staff within its own program,<sup>120</sup> such as from a drug counselor to his or her supervisor to discuss how to address a patient’s clinical needs.<sup>121</sup> A Part 2 program also may disclose protected information to an entity with administrative control over the program,<sup>122</sup> such as a billing department of the facility so the program can get paid for the services it provides.<sup>123</sup> But a Part 2 detox unit in a hospital may not disclose, without consent, PII to a surgeon in the same hospital who is going to perform hip surgery on an individual: the hip surgeon is not part of the Part 2 program’s staff; the hip surgeon’s unit does not have administrative control over the detox unit; and the hip surgeon does not need the information in

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<sup>111</sup> 42 C.F.R. § 2.32; *see also* SAMHSA 2010 FAQ, *supra* note 69, at 9 (Q12); SAMHSA 2011 FAQ, *supra* note 73, at 4-5 (Q6).

<sup>112</sup> 42 C.F.R. § 2.32; *see also* SAMHSA 2010 FAQ, *supra* note 69, at 9 (Q12); SAMHSA 2011 FAQ, *supra* note 73, at 4 (Q6).

<sup>113</sup> *See SAMHSA Part 2 Webinar*, *supra* note 79, at 78.

<sup>114</sup> *See SAMHSA 2010 FAQ*, *supra* note 69, at 9 (Q12).

<sup>115</sup> *See id.* at 8 (Q13).

<sup>116</sup> *See id.* at 5 (Q5).

<sup>117</sup> 42 U.S.C. § 290dd-2; 42 C.F.R. § 2.12(c). Note that disclosures are permitted in limited circumstances; they are not mandated. *See* 42 C.F.R. § 2.3(b)(1).

<sup>118</sup> *See* 42 C.F.R. § 2.12(c)(3).

<sup>119</sup> *See id.*

<sup>120</sup> *See id.* § 2.12(c)(3)(i).

<sup>121</sup> *See SAMHSA Part 2 Webinar*, *supra* note 79, at 97.

<sup>122</sup> *See* 42 C.F.R. § 2.12(c)(3)(ii).

<sup>123</sup> *See SAMHSA Part 2 Webinar*, *supra* note 79, at 97-98; *LAC SAMHSA FAQs Part 2 Webinar*, *supra* note 12, at 80.

connection with the provision of drug or alcohol treatment services.<sup>124</sup> Therefore, the detox unit will need Part 2-compliant consent to disclose records to the hip surgeon within the same hospital, a requirement that could raise concerns for an integrated facility that wants to coordinate services.

The Part 2 statute also permits programs to disclose PII without patient consent “[t]o medical personnel to the extent necessary to meet a bona fide medical emergency.”<sup>125</sup> The Part 2 regulations employ slightly different language, permitting disclosures “to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.”<sup>126</sup> Either a physical or mental health emergency can trigger the exception.<sup>127</sup>

Although the Part 2 statute and regulations do not define “medical personnel,”<sup>128</sup> SAMHSA guidance provides that any health care provider who is treating a patient for a medical emergency may use professional judgment to determine that a medical emergency exists; the determination need not be made by the Part 2 program itself.<sup>129</sup> Thus, an emergency room physician or HIO affiliated provider who is treating a patient may determine that a medical emergency exists and get access to Part 2 records without patient consent.<sup>130</sup> But a computer system, such as a HIE, cannot be used to automatically make the determination.<sup>131</sup> The medical emergency exception to Part 2 consent applies even if the patient previously withheld consent to disclose PII to the medical professional treating the emergency.<sup>132</sup>

When the medical emergency exception applies, the entire Part 2 record may be released to a treating provider who indicates that s/he needs access to treat the emergency.<sup>133</sup> Interestingly, Part 2 does not prohibit the recipient medical personnel from redisclosing PII for treatment purposes.<sup>134</sup>

When disclosures are made pursuant to the medical emergency exception, the Part 2 program must document in the patient’s record the name of the medical personnel to whom disclosure was made and that person’s affiliation with a health care facility; the name of the individual – and not just an electronic health record -- making the disclosure; the date and time of the disclosure; and the nature of the emergency.<sup>135</sup> The Part 2 program still must comply with the documentation requirements even when a HIO discloses PII in a medical emergency.<sup>136</sup>

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<sup>124</sup> See *LAC SBIRT Webinar*, *supra* note 12, at 40-42; see also SAMHSA 2011 FAQ, *supra* note 73, at 5 (Q5).

<sup>125</sup> 42 U.S.C. § 290dd-2(b)(2)(A).

<sup>126</sup> 42 C.F.R. § 2.51(a).

<sup>127</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 14 (Q29).

<sup>128</sup> See SAMHSA 2011 FAQ, *supra* note 73, at 5 (Q8).

<sup>129</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 13 (Q24).

<sup>130</sup> See *id.* at 13 (Q24); SAMHSA 2011 FAQ, *supra* note 73, at 3 (Q5).

<sup>131</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 13 (Q25).

<sup>132</sup> See *id.* at 16 (Q34).

<sup>133</sup> See *id.* at 13 (Q26).

<sup>134</sup> See *id.* at 13 (Q33); SAMHSA 2011 FAQ, *supra* note 73, at 4 (Q6).

<sup>135</sup> See 42 C.F.R. § 251(c); SAMHSA 2010 FAQ, *supra* note 69, at 14, 15 (Q27, 30, 31); SAMHSA 2011 FAQ, *supra* note 73, at 5 (Q7).

<sup>136</sup> See SAMHSA 2011 FAQ, *supra* note 73, at 5 (Q7).

#### f. Qualified Service Organizations

Similar to BAAs under HIPAA, Part 2 programs may disclose PII without patient consent to Qualified Service Organizations (QSOs),<sup>137</sup> which are independent entities “that provide services to the program or its patients.”<sup>138</sup>

To share PII with a QSO without patient consent, the Part 2 program must execute a written agreement with the QSO, which is referred to as a Qualified Service Organization Agreement (QSOA).<sup>139</sup> The QSOA is similar to a BAA under HIPAA, although HIPAA prescribes more requirements for BAAs than Part 2 does for QSOAs.<sup>140</sup> The QSO must agree in the QSOA that it is fully bound by Part 2 with respect to the PII it receives, stores, processes, or otherwise deals with from the Part 2 program.<sup>141</sup>

The information that the Part 2 program shares with the QSO must be limited to that which is necessary for the QSO to provide the services.<sup>142</sup> Generally the QSO may not redisclose the Part 2 information to others without consent or other authorization permitted by Part 2.<sup>143</sup>

A HIO may serve as a QSO for a Part 2 program by “holding and storing patient data, receiving and reviewing requests for disclosures to third parties, and facilitating the electronic exchange of patients’ information through the HIO network.”<sup>144</sup> Importantly, however, QSOAs are only two-way agreements between the Part 2 program and the QSO, permitting the exchange of PII between the two.<sup>145</sup> As a result, Part 2 patients must provide written consent to permit the HIO to redisclose the Part 2 information to other HIO affiliated members,<sup>146</sup> unless there is a medical emergency or one of the other limited exceptions permitted by Part 2.<sup>147</sup>

One document may be used to satisfy both the BAA and QSOA requirements.<sup>148</sup>

#### g. Part 2 Programs

It is important to note that Part 2 does not apply to all records of SUD treatment, regardless of provider. Rather, they apply to the records of (1) programs that are (2) federally assisted,<sup>149</sup> each of which requirements has detailed descriptions in the regulations and agency guidance.

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<sup>137</sup> See 42 C.F.R. § 2.12(c)(4); SAMHSA 2010 FAQ, *supra* note 69, at 6 (Q6).

<sup>138</sup> LAC Patient Privacy Webinar, *supra* note 12, at 63; see also 42 C.F.R. § 2.11.

<sup>139</sup> See 42 C.F.R. § 2.11; SAMHSA 2011 FAQ, *supra* note 73, at 5 (Q6).

<sup>140</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 6 (Q6); SAMHSA Part 2 Webinar, *supra* note 79169, at 86.

<sup>141</sup> See 42 C.F.R. § 2.11; SAMHSA 2010 FAQ, *supra* note 69, at 5 (Q5).

<sup>142</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 6, 8 (Q6, 10); LAC Patient Privacy Webinar, *supra* note 12, at 87.

<sup>143</sup> See SAMHSA 2011 FAQ, *supra* note 73, at 5-6 (Q6).

<sup>144</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 6 (Q6); LAC SAMHSA FAQs Part 2 Webinar, *supra* note 12, at 22.

<sup>145</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 6 (Q6); LAC SAMHSA FAQs Part 2 Webinar, *supra* note 12, at 20.

<sup>146</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 7 (Q8).

<sup>147</sup> See *id.* at 8 (Q10); SAMHSA 2011 FAQ, *supra* note 73, at 4 (Q6).

<sup>148</sup> See, e.g., LEGAL ACTION CTR., Form 6: Sample Qualified Service Organization/Business Associate Agreement (QSO/BA Agreement), [http://lac.org/wp-content/uploads/2014/12/Sample\\_Form\\_6.pdf](http://lac.org/wp-content/uploads/2014/12/Sample_Form_6.pdf) (last visited Mar. 28, 2016).

<sup>149</sup> See 42 C.F.R. § 2.12(b), (e)(1); SAMHSA 2010 FAQ, *supra* note 69, at 2 (Q2).

A “program” for purposes of Part 2 is defined in three ways:

- (a) An individual or entity (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or
- (b) An identified unit within a general medical facility which holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or
- (c) Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers.<sup>150</sup>

A freestanding drug or alcohol treatment program or a student assistance program in a school, for example, can satisfy the first definition of program.<sup>151</sup> Primary care providers who do not work in general medical care facilities also may fall under the first definition of program “if their principal practice consists of providing alcohol and drug abuse diagnosis, treatment, or referral for treatment, and they hold themselves out as providing the same.”<sup>152</sup> There is no federal guidance defining “principal practice,” however.

The Part 2 regulations also do not define “general medical facility,” but guidance from SAMHSA provides that hospitals, trauma centers, and federally qualified health centers (FQHCs) generally are general medical care facilities for purposes of Part 2.<sup>153</sup> Further, a primary care practice could constitute a general medical facility.<sup>154</sup> Within a general medical facility, a detox unit, an outpatient alcohol or drug treatment program, or an inpatient alcohol or drug treatment program may satisfy the second definition of a program for purposes of Part 2.<sup>155</sup> An addiction specialist who works in a primary care practice may satisfy the third definition of a Part 2 program.<sup>156</sup>

Importantly, an entire general medical facility is not a Part 2 program.<sup>157</sup> A provider working in a general medical facility satisfies the definition of a program under Part 2 only if s/he works in an identified unit of the facility that holds itself out as providing and does provide SUD services, or if the provider

<sup>150</sup> 42 C.F.R. § 2.11; *see also id.* § 2.12(e)(1); SAMHSA 2011 FAQ, *supra* note 73, at 6-7 (Q10).

<sup>151</sup> *See* SAMHSA 2011 FAQ, *supra* note 73, at 7 (Q10); SAMHSA Part 2 Webinar, *supra* note 79, at 42-43; LAC Patient Privacy Webinar, *supra* note 12, at 29.

<sup>152</sup> SAMHSA 2011 FAQ, *supra* note 73, at 7 (Q10) (emphasis in original). Although the Part 2 regulations do not define “holds itself out,” guidance from SAMHSA identifies a number of potential indications that individuals or entities are holding themselves out as providing substance use disorder treatment, including, but not limited to: state licensing procedures; advertising or posting notices in the provider’s office; possessing certifications in addiction medicine; listing themselves in registries of substance use disorder providers; making statements on the internet; providing consultation activities for non-Part 2 programs; providing information to patients or families; any activity that would lead one to reasonably conclude that the providers provide these services. *See id.*

<sup>153</sup> *See id.*

<sup>154</sup> *See id.*

<sup>155</sup> *See* SAMHSA Part 2 Webinar, *supra* note 79, at 46.

<sup>156</sup> *See* LAC Patient Privacy Webinar, *supra* note 12, at 29.

<sup>157</sup> *See* LAC SBIRT Webinar, *supra* note 12, at 28.

consists of personnel or staff whose “primary function” is to provide SUD services.<sup>158</sup> Other units or personnel within the general medical facility are not bound by Part 2’s requirements. Thus, an emergency room doctor in a general medical facility is not a program under Part 2 unless his or her primary function is to provide alcohol or drug-related services.<sup>159</sup>

In individual or entity that satisfies the definition of a “program” for Part 2 purposes also must be “federally assisted” to be subject to Part 2 requirements. The regulations and guidance, again, flesh out what this requirement entails. A program will be deemed to be federally assisted if it is (1) “authorized, licensed, certified, or registered by the federal government;” (2) “receives federal funds in any form, even if the funds do not directly pay for the alcohol or drug abuse services;” (3) has tax exempt status or can take tax deductions for contributions; (4) is authorized by the federal government to conduct business, including that it is certified as a Medicare or Medicaid provider, authorized to conduct methadone maintenance treatment, or is registered with the Drug Enforcement Administration (DEA) to dispense controlled substances used in treating substance use disorders; or (5) is conducted by the federal government.<sup>160</sup>

Guidance from SAMHSA has addressed whether Screening, Brief Intervention, and Referral to Treatment (SBIRT) services provided by primary care providers are bound by Part 2 requirements.<sup>161</sup> If the entity or unit within a general medical facility conducting SBIRT services is a Part 2 program, then the SBIRT patient records are subject to Part 2; but if these services are provided by a non-Part 2 program, the SBIRT records will not be subject to Part 2.<sup>162</sup> Thus, if various providers or units in a FQHC, for example, provide SBIRT services, only the specific providers or units that qualify as Part 2 programs will be bound by Part 2’s privacy requirements.<sup>163</sup>

#### h. Minors

Similar to HIPAA, Part 2 largely leaves to state law the issue of who may consent to the disclosure of the records of minors.<sup>164</sup> The regulations define a minor as a person who has not attained the age of majority under state law, or, if state law is silent, 18.<sup>165</sup> Part 2 programs always must get a minor’s written consent to disclose.<sup>166</sup> If state law requires consent from a parent, guardian, or other person (Parent) to provide substance use treatment to a minor, then the program must get written consent to disclose from

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<sup>158</sup> See 42 C.F.R. § 2.11; *SAMHSA Part 2 Webinar*, *supra* note 79, at 51.

<sup>159</sup> See *SAMHSA Part 2 Webinar*, *supra* note 79, at 49; see also 42 C.F.R. § 2.12(e)(1).

<sup>160</sup> SAMHSA 2010 FAQ, *supra* note 73, at 2-3 (Q2); see also 42 C.F.R. § 2.12(b); *LAC Patient Privacy Webinar*, *supra* note 12, at 32.

<sup>161</sup> SAMHSA 2011 FAQ, *supra* note 73, at 7-8 (Q11). See generally SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS, *SBIRT: Screening, Brief Intervention, and Referral to Treatment* (defining SBIRT as “an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.”), <http://www.integration.samhsa.gov/clinical-practice/SBIRT> (last visited Dec. 4, 2015); *LAC SBIRT Webinar*, *supra* note 12, at 61-83.

<sup>162</sup> See SAMHSA 2011 FAQ, *supra* note 73, at 8 (Q11); *LAC SBIRT Webinar*, *supra* note 12, at 61-90.

<sup>163</sup> See *LAC Patient Privacy Webinar*, *supra* note 12, at 81-82.

<sup>164</sup> See *id.* at 50.

<sup>165</sup> See 42 C.F.R. § 2.14(a).

<sup>166</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 17 (Q37).

both the minor and the Parent.<sup>167</sup> But where a minor has the legal capacity under state law, when acting alone, to seek or obtain alcohol or substance use disorder treatment, consent for disclosure under Part 2 only may be given by the minor.<sup>168</sup> Interestingly, Part 2 does not set a minimum age that a minor must be to give consent.

#### i. Part 2 records and HIOs

Given the heightened protections afforded alcohol and drug treatment and prevention records under federal law, some providers point to Part 2 as a barrier to including these records in integrated treatment records or electronic health record systems.<sup>169</sup> In 2010 and 2011, SAMHSA issued two FAQs attempting to make plain that alcohol and substance use disorder treatment records can be incorporated into electronic HIEs and other methods of exchanging health information without violating Part 2, albeit subject to important requirements.<sup>170</sup>

For example, SAMHSA explained that it is possible to use a single consent form to authorize disclosure of Part 2 information to a HIO and, in the same document, authorize the HIO to redisclose the information to additional identified entities, such as other HIO-affiliated health care providers, as long as both disclosures share the same purpose and the required redisclosure notice accompanies each disclosure.<sup>171</sup>

The FAQs, however, also confirmed SAMHSA's position that consent forms may not generally describe recipients of Part 2 records;<sup>172</sup> rather, "Part 2 consents should identify, by attachment if necessary, all the HIO affiliated members that are potential recipients of the Part 2 data."<sup>173</sup> This means that entities that affiliate with a HIO after the Part 2 consent is signed are not included within that consent.<sup>174</sup>

#### j. Proposed changes to Part 2 regulations

In May 2014, SAMHSA issued a Notice of Public Listening Session, in which it sought input on potential changes to Part 2.<sup>175</sup> In announcing the session, SAMHSA noted the significant changes that have taken place in health care since the Part 2 regulations last were updated in 1987, including new models of integrated care that depend on information sharing to facilitate care coordination.<sup>176</sup> The agency acknowledged that a number of new health care organizations, including HIOs and ACOs, are not including SUD treatment information in their information exchanges because of "the difficulty and

<sup>167</sup> See 42 C.F.R. § 2.14(c); SAMHSA 2010 FAQ, *supra* note 69, at 17 (Q37).

<sup>168</sup> See 42 C.F.R. § 2.14(b); SAMHSA 2010 FAQ, *supra* note 69, at 17 (Q37).

<sup>169</sup> See, e.g., SAMHSA Part 2 Webinar, *supra* note 79, at 24.

<sup>170</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 2 & n. 2 (Q1); SAMHSA 2011 FAQ, *supra* note 73.

<sup>171</sup> See SAMHSA 2010 FAQ, *supra* note 69, at 9 (Q13).

<sup>172</sup> See *id.* at 11 (Q18).

<sup>173</sup> *Id.*; see also SAMHSA 2011 FAQ, *supra* note 73, at 9 (Q16).

<sup>174</sup> See SAMHSA 2011 FAQ, *supra* note 73, at 11 (Q19); LAC SAMHSA FAQs Part 1 Webinar, *supra* note 12, at 66-68.

<sup>175</sup> See DEP'T OF HEALTH & HUMAN SERVCES., SUBSTANCE ABUSE & MENTAL HEALTH SERVCES. ADMIN., 42 CFR Part 2: Confidentiality of Alcohol and Drug Abuse Patient Records, 79 Fed. Reg. 26,929 (May 12, 2014), *available at* <http://www.gpo.gov/fdsys/pkg/FR-2014-05-12/pdf/2014-10913.pdf>.

<sup>176</sup> *Id.* at 26,930.



expense of implementing the functionality and workflow changes necessary to comply” with Part 2’s consent and other requirements, which means that “patients are prevented from fully participating in integrated care efforts even if they are willing to provide consent.”<sup>177</sup> SAMHSA held the listening session in June 2014 and received written comments from a number of entities, including the Legal Action Center.<sup>178</sup>

In February 2016, SAMHSA issued a proposed rule that is intended to “update and modernize” the Part 2 regulations governing substance use disorder prevention and treatment providers because “SAMHSA strives to facilitate information exchange within new health care models while addressing legitimate privacy concerns of patients seeking treatment for [SUD].”<sup>179</sup>

The proposal includes a number of provisions. Several of the proposals are policies that SAMHSA articulated in its 2010 and 2011 FAQs. The proposed rule also includes new policies. In a reversal of policy, for example, the proposed rule would “permit, in certain circumstances, a more general description of the individuals or entities to which a disclosure is made, but only if the individuals or entities have a treating provider relationship with the patient whose information is being disclosed.”<sup>180</sup> It also seeks to narrow the scope of the prohibition on redisclosure<sup>181</sup> and add population health management (but not care coordination) to the list of examples of services that QSOs may perform.<sup>182</sup>

SAMHSA does not propose, however, to change Part 2’s requirement that disclosures of PII generally require patient written consent, expressing the belief that continued confidentiality protection encourages patients to seek treatment.<sup>183</sup> Public comment on the proposed rule closed on April 11, 2016.<sup>184</sup>

#### k. Interaction with other laws

Most alcohol and drug treatment and prevention programs must comply with both HIPAA and Part 2.<sup>185</sup> Programs should follow both laws where possible, and follow the requirements of the more restrictive when they differ. For example, HIPAA permits disclosure without patient consent for treatment, but Part 2 requires consent or one of the other enumerated exceptions, like a medical

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<sup>177</sup> *Id.*

<sup>178</sup> See Comments of the Legal Action Center in Response to U.S. Dept. of Health & Human Services, Substance Abuse & Mental Health Services Administration, Notice of Public Listening Session, 79 Fed. Reg. 26,929 (May 12, 2014), Docket No. FR Doc. 2014-10913 (submitted June 25, 2014), available at [http://lac.org/wp-content/uploads/2014/12/LAC\\_COMMENTS.pdf](http://lac.org/wp-content/uploads/2014/12/LAC_COMMENTS.pdf).

<sup>179</sup> DEP’T OF HEALTH & HUMAN SERVCs., SUBSTANCE ABUSE & MENTAL HEALTH SERVCs. ADMIN., 42 CFR Part 2: Confidentiality of Alcohol and Substance Use Disorder Patient Records; Proposed Rule, 81 Fed. Reg. 6,988, 6,988 (Feb. 9, 2016), available at <https://www.gpo.gov/fdsys/pkg/FR-2016-02-09/pdf/2016-01841.pdf> [hereinafter “Part 2 Proposed Rule”].

<sup>180</sup> See *id.* at 6,994; see also *id.* at 6,997-98, 7,000-01.

<sup>181</sup> See *id.* at 6,990, 7,003.

<sup>182</sup> See *id.* at 6,996.

<sup>183</sup> See *id.* at 6,993; see also *id.* at 6,999-7,000.

<sup>184</sup> See *id.* at 6,988; see, e.g., Legal Action Center Comments on 42 CFR Part 2 - Confidentiality of Substance Use Disorder Patient Records Proposed Rule (SAMHSA 4162-20) (Apr. 11, 2016), available at <http://lac.org/wp-content/uploads/2016/04/Final-LAC-Part-2-Comments-04-11-16.pdf>.

<sup>185</sup> LAC Patient Privacy Webinar, *supra* note 12, at 38.



emergency. Part 2 programs, in short, must follow the requirement that is more protective of patient privacy.<sup>186</sup>

Similarly, with respect to state laws, the Part 2 Regulations recognize that the authorizing statute does not preempt more protective state laws.<sup>187</sup> Thus, the Part 2 regulations will not be construed to authorize violation of a state law that prohibits disclosure.<sup>188</sup> State law also may not authorize or compel a disclosure that Part 2 prohibits.<sup>189</sup>

## B. New Jersey Law

New Jersey does not have an analog to HIPAA that governs the use, disclosure, and general confidentiality of all patient health information. Rather, as discussed in more detail in the subsections that follow and catalogued in the tables in the Appendix, New Jersey has a number of statutes and regulations that address the confidentiality of health information in disparate ways and that apply in different contexts. Several, for example, address the obligations of various health professionals or facilities to maintain the confidentiality of patient records. Others focus on whether the health care provider has a contract with or is licensed by the State Department of Human Services (DHS). Still others focus on the privacy protections due for specific types of sensitive information, such as HIV or AIDS diagnoses, venereal diseases, or genetic information.

Many of New Jersey's laws and regulations incorporate standards sufficiently similar in relevant respects to HIPAA such that treating providers should be able to exchange patient health records for treatment and, in some instances, health care operations if they are in compliance with HIPAA. Others have requirements more akin to Part 2 and thus will require providers to obtain patient consent before sharing protected records. Despite the similarity in many respects to federal requirements, some State laws are more stringent than federal requirements and thus will govern the exchange of protected information in New Jersey.<sup>190</sup> There also are some variations that are less substantively significant but which can further complicate compliance for providers. What follows is a sample of the provisions in New Jersey.<sup>191</sup>

### 1. Department of Human Services Confidentiality Requirements

Title 30 of the New Jersey Statutes governs the "admission and commitment of persons with mental illness, tuberculosis, and developmental disabilities to the several institutions" regulated by DHS.<sup>192</sup> The confidentiality provision for Title 30, N.J.S.A. § 30:4-24.3, provides that "[a]ll certificates, applications, records, and reports made pursuant to the provisions of Title 30 . . . and directly or indirectly

<sup>186</sup> *Id.* at 39.

<sup>187</sup> *See* 42 C.F.R. § 1.20.

<sup>188</sup> *See id.* § 1.20; SAMHSA 2011 FAQ, *supra* note 73, at 8 (Q12).

<sup>189</sup> *See* 42 C.F.R. § 1.20.

<sup>190</sup> *See supra* notes 10-11 & accompanying text; Section II.A.2.k, *supra*. *See generally* LAC Patient Privacy Webinar, *supra* note 12, at 40.

<sup>191</sup> *See also* Dechert, Navigating HIPAA: A Compilation of Health Insurance Portability and Accountability Act Resources – State Law Preemption Analysis (prepared for the New Jersey Hospital Assoc'n 2002) (on file with author).

<sup>192</sup> N.J.S.A. § 30:4-24.

identifying any individual presently or formerly receiving services in a noncorrectional institution under Title 30 . . . , or for whom services in a noncorrectional institution shall be sought under this act shall be kept confidential and shall not be disclosed by any person . . . ,” except as provided by the statute.<sup>193</sup> An exception permits an individual or “his legal guardian, if any, or, if he is a minor, his parent or legal guardian,” to consent to disclosure.<sup>194</sup> The statute does not specify the form the consent must take, such as whether it needs to be in writing or contain any particular information.

The statute also includes a limited treatment exception, expressly providing that it does not “preclude disclosure, upon proper inquiry, of information as to a patient’s current medical condition . . . to the patient’s personal physician . . . if it appears that the information is to be used directly or indirectly for the benefit of the patient.”<sup>195</sup> It also does not “preclude the professional staff of a community agency under contract with the Division of Mental Health Services in the Department of Human Services, or of a screening service, short-term care or psychiatric facility as those facilities are defined in section 2 of P.L.1987, c.116 (C.30:4-27.2) from disclosing information that is relevant to a patient’s current treatment to the staff of another such agency.”<sup>196</sup> Several of these terms are not defined or explained, however. For example, it is not clear whether “personal physician” refers to any physician who has treated the patient or a more narrow class, such as a patient’s current primary care physician. It also is not clear what is meant by “current medical condition” or “another such agency.”

As noted below, this statutory standard is referenced in other DHS regulations, beyond the institutional context.<sup>197</sup>

- a. Community mental health providers licensed by the New Jersey Department of Human Services or funded by, under contract with, or affiliated with the Division of Mental Health and Addiction Services

Similar in some respects to N.J.S.A. § 30:4-24.3, N.J.A.C. § 10:37-6.79 sets forth that community mental health providers licensed by the DHS are required to keep confidential “[c]ertificates, applications, information and records directly or indirectly identifying persons who are receiving mental health services . . . or for whom such services were sought.”<sup>198</sup>

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<sup>193</sup> N.J.S.A. § 30:4-24.3.

<sup>194</sup> *See id.* § 30:4-24.3(a).

<sup>195</sup> *Id.* § 30:4-24.3.

<sup>196</sup> *Id.*

<sup>197</sup> *See generally* New Jersey Privacy and Security Committee’s Dec. 31, 2010 Report to the New Jersey Health Information Technology Coordinator regarding Developing and Implementing a Legal Framework for Private and Secure Health Information Exchange in New Jersey, Exhibit J: Supplemental Research of State Law Completed by/for the Privacy & Security Committee: Additional State Laws Restricting Sharing of Patient Information (Medicaid, DAS, DMH), at 4 (on file with author) (reporting that, “[a]s a matter of policy, the Department of Human Services (DHS) has applied [N.J.S.A. § 30:4-24.3] to all of its institutions and agencies, including the Division of Medical Assistance and Health Services, which administers the Medicaid program and other health care programs.”).

<sup>198</sup> N.J.A.C. § 10:37-6.79(a).

The regulation identifies a number of exceptions to this general confidentiality requirement.<sup>199</sup> Most pertinent for purposes of information sharing to facilitate integrated care, there is a limited treatment exception.<sup>200</sup> Provider agencies may disclose information “to any licensed mental health provider or medical health care provider who has a contract with [the Division of Mental Health and Addiction Services (DMHAS)] or [DHS], or to the consumer’s personal physician if it appears that the information is to be used for the benefit of the consumer.”<sup>201</sup> Although it is not clear, it appears that the “benefit of the consumer” condition only applies to disclosure to a consumer’s personal physician and does not also apply to providers with DHS or DMHAS contracts.

Section 10:37-6.79(b) includes additional provisions for sharing patient health information, “upon presentation of appropriate credentials.”<sup>202</sup> For one, provider agencies may disclose confidential information to employees of the agency involved in the care of the consumer as long as the patient is advised when he or she enters treatment that agency staff will have access.<sup>203</sup> Employees of the agency also may disclose confidential information relevant to current treatment to the staff of another “such agency” as long as the disclosure complies with HIPAA,<sup>204</sup> although the regulation does not define “such agency.”

Disclosures pursuant to Section 10:37-6.79(b), however, are subject to a number of additional conditions.<sup>205</sup> Curiously, for example, the regulation calls for such disclosures to use initials in place of the patient’s name, where possible, which would seem to limit the information’s value for care coordination.<sup>206</sup> In addition, the custodian of the records must provide written notice that redisclosure without patient authorization or as otherwise provided by law is prohibited.<sup>207</sup> The information and records disclosed “shall be limited to that information which is relevant and necessary for the purpose of the disclosure, except as authorized by the consumer or his or her representative or required by law.”<sup>208</sup> But “[w]here the disclosure is between agencies for the purpose of treatment and is not limited by the consumer’s authorization, the agency releasing the information shall rely upon the recipient’s assertion of need for the information.”<sup>209</sup> The request for information and the response thereto must be recorded in the consumer’s clinical record, and consumers are entitled to an accounting for up to six years from the

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<sup>199</sup> *See id.* § 10:37-6.79.

<sup>200</sup> *See id.* § 10:37-6.79(f).

<sup>201</sup> *Id.*

<sup>202</sup> *Id.* § 10:37-6.79(b).

<sup>203</sup> *See id.* § 10:37-6.79(b)(1).

<sup>204</sup> *See id.* § 10:37-6.79(b)(1)(i).

<sup>205</sup> *See id.* § 10:37-6.79(h).

<sup>206</sup> *See id.* § 10:37-6.79(d). This condition may be sensible for other disclosures permitted in Section 10:37-6.79(b), where the purpose for the disclosure does not depend on access to individually identifiable information, such as disclosures for purposes of audit and investigation. *See id.* § 10:37-6.79(b)(2)-(4). But requiring redaction and use of initials seems in tension with disclosures for treatment, where the very purpose of disclosure is to treat an identifiable individual.

<sup>207</sup> *See id.* § 10:37-6.79(h)(1). It is not clear why DHS opted to apply this restriction only to disclosures to treatment personnel and agency staff authorized in Section 10:37-6.79(b) and did not apply a similar redisclosure notice requirement on disclosures to other medical providers pursuant to Section 10:37-6.79(f).

<sup>208</sup> *Id.* § 10:37-6.79(h)(2).

<sup>209</sup> *Id.*

date of any disclosures, upon request.<sup>210</sup> Consumers also must be informed of their right, subject to certain limitations, to inspect material that will be disclosed.<sup>211</sup> Finally, only information generated at the provider agency may be disclosed, although the agency must list the sources of undisclosed information.<sup>212</sup>

Section 10:37-6.79 also provides that provider agencies may disclose their records with authorization from an adult consumer or his or her legally authorized representative.<sup>213</sup> Unlike Section 30:4-24.3, however, Section 10:37-6.79 specifies that the authorization must be written<sup>214</sup> and contain:

- i. The name of the agency disclosing the information;
- ii. The name or title of the person or organization to which disclosure is to be made;
- iii. The name of the consumer;
- iv. The purpose of the disclosure and predictable outcome;
- v. The information to be disclosed;
- vi. The date on which the authorization is signed; and
- vii. The signature of the consumer or of a person authorized by law to sign for the consumer, following a statement that the undersigned understands the nature of the authorization and has been informed that he or she has the right to revoke consent at any time by written communication to the custodian of the records.<sup>215</sup>

A consumer's authorization to release confidential information automatically expires four months from the date it is signed unless the release notes a different time limit or triggering event.<sup>216</sup>

The rule varies somewhat when the patient is a minor.<sup>217</sup> Generally, a minor's "parent or legal guardian may authorize the disclosure of the minor's records, provided that the minor shall be given prior notice and an opportunity to object to the disclosure."<sup>218</sup> But there are special rules when a minor who is fourteen years or older has requested admission and been voluntarily admitted to a psychiatric facility, special psychiatric hospital, or children's crisis intervention service.<sup>219</sup> The regulation recognizes that such a minor may authorize disclosure of confidential records in the same manner as an adult.<sup>220</sup> If that minor

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<sup>210</sup> See *id.* § 10:37-6.79(h)(3). HIPAA also requires an accounting of disclosures of PHI, although it includes a number of exceptions, including disclosures to carry out treatment and health care operations or pursuant to authorizations. See 45 C.F.R. § 164.528(a)(i) & (iv).

<sup>211</sup> See N.J.A.C. § 10:37-6.79(h)(4).

<sup>212</sup> See *id.* § 10:37-6.79(h)(5). If listing the source of undisclosed information would reveal that a consumer has been or is being diagnosed or treated for alcohol or drug abuse, this requirement would seem to violate Part 2. See *id.* § 2.13(c)(2); SAMHSA 2010 FAQ, *supra* note 69, at 14 (Q28).

<sup>213</sup> See N.J.A.C. § 10:37-6.79(a)(1)(i).

<sup>214</sup> See *id.*

<sup>215</sup> *Id.* § 10:37-6.79(i)(1).

<sup>216</sup> See *id.* § 10:37-6.79(i)(2).

<sup>217</sup> See *id.* § 10:37-6.79(a)(1)(ii).

<sup>218</sup> See *id.* § 10:37-6.79(a)(1)(ii)(2).

<sup>219</sup> See *id.* § 10:37-6.79(a)(1)(ii).

<sup>220</sup> See *id.* § 10:37-6.79(a)(1)(ii)(1).

objects to disclosure, his/her parent’s consent is null and void.<sup>221</sup> Disclosure of such a minor’s clinical records requires the minor’s written authorization.<sup>222</sup>

As noted above, Section 10:37-6.79 expressly refers to community mental health providers *licensed by DHS*,<sup>223</sup> such as mental health programs (MHPs).<sup>224</sup> The rules in Chapter 37 also expressly “apply to provider agency programs *funded by* the [DMHAS] governed by the standards at N.J.A.C. 10:37-12 and N.J.A.C. 10:37A through 10:37I.”<sup>225</sup> In addition, DMHAS’s management and governing body standards require that provider agencies that are “contracted with, or funded by, [DMHAS] to provide specific direct mental health services to clients”<sup>226</sup> must have confidentiality policies that comply with N.J.S.A. § 30:4-24.3 and N.J.A.C. § 10:37-6.79.<sup>227</sup> Further, the MHP regulations clarify that references to standards that apply to State-funded programs also apply to non-State funded mental health programs that “have a contract or affiliation agreement with the [DMHAS].”<sup>228</sup> Thus, Section 10:37-6.79 applies to community mental health providers that are licensed by DHS or funded by, under contract with, or affiliated with DMHAS, including: community residences for mentally ill adults;<sup>229</sup> outpatient mental health services;<sup>230</sup> partial care services for adults;<sup>231</sup> short-term care facilities for adults;<sup>232</sup> youth case management services;<sup>233</sup> and family support services.<sup>234</sup>

Some of these programs are subject to State regulations that differ from the provisions in Section 10:37-6.79. Community residences for mentally ill adults, for example, permit disclosure to a patient’s personal physician “if it appears that the information is to be used for the *treatment* of the patient,”<sup>235</sup> whereas Section 10:37-6.79 phrases the condition in terms of whether “it appears that the information is to be used for the *benefit* of the consumer.”<sup>236</sup>

Short-term care facilities for adults also have detailed regulations regarding the confidentiality of health records<sup>237</sup> that differ in some respects from the requirements in Section 10:37-6.79. For example, while Section 10:37-6.79 itemizes the requirements for written authorization to disclose PHI, the short term care facilities for adults regulations require authorizations to “conform to the requirements of the HIPAA privacy rule at 45 CFR 164.508(a).”<sup>238</sup> Section 164.508(a) addresses when authorizations are required. The STCF regulations do not require compliance with Section 164.508(b), which details the

<sup>221</sup> See *id.* § 10:37-6.79(a)(1)(ii)(2).

<sup>222</sup> See *id.* § 10:37-6.79(a)(1)(ii)(3).

<sup>223</sup> See *id.* § 10:37-6.79(a).

<sup>224</sup> See *id.* § 10:190-1.1 *et seq.*

<sup>225</sup> *Id.* § 10:37-1.2 (emphasis added).

<sup>226</sup> *Id.*

<sup>227</sup> *Id.* § 10:37D-2.18(a)(1).

<sup>228</sup> *Id.* § 10:190-1.6.

<sup>229</sup> See *id.* § 10:37A; see also *id.* § 10:37A-3.2.

<sup>230</sup> See *id.* § 10:37E.

<sup>231</sup> See *id.* § 10:37F.

<sup>232</sup> See *id.* § 10:37G; see also *id.* §§ 10:37G-3.1-3.5.

<sup>233</sup> See *id.* § 10:37H; see also *id.* § 10:37H-1.4(a).

<sup>234</sup> See *id.* § 10:37I.

<sup>235</sup> *Id.* § 10:37A-3.2(b) (emphasis added).

<sup>236</sup> *Id.* § 10:37-6.79(f) (emphasis added).

<sup>237</sup> See *id.* §§ 10:37G-3.1-3.5.

<sup>238</sup> *Id.* § 10:37G-3.3(b).

mandatory ingredients of authorizations. In addition, the treatment exception in the short term care facility regulations imposes a “minimum necessary” condition on disclosure of PHI to “staff at a community mental health agency, . . . another screening service or a short-term care or psychiatric facility or special psychiatric hospital . . .” for purposes of treatment.<sup>239</sup> Disclosures made pursuant to Section 10:37-6.79(b) are subject to a “relevant and necessary” limitation, but the limited treatment exception in Section 10:37-6.79(a) requires that the disclosure be used for the benefit of the consumer.

These DHS requirements do not apply to health care facilities such as hospitals that offer mental health services or operate a mental health unit that is licensed by the DOH under the hospital’s main facility license or with a separate DOH license.<sup>240</sup> Instead those entities are governed by DOH licensing requirements that are discussed below.<sup>241</sup> They also do not apply to independent licensed practitioners, including group practices,<sup>242</sup> unless the practitioner or group practice is employed by or otherwise affiliated with a facility that is bound by the DMHAS requirements.<sup>243</sup>

b. Psychiatric residential treatment facility for individuals under 21<sup>244</sup>

The clinical records of psychiatric residential treatment facilities for individuals under 21 are confidential “and shall be disclosed only to authorized persons,” including DHS and its agents.<sup>245</sup> The regulation does not include a general treatment exception, although it does require that a copy of the clinical record, or a summary thereof, accompany the resident if s/he “is transferred to or from another PRTF or program facility.”<sup>246</sup> Curiously, the regulation does not seem to include a consent provision. It would be helpful for DHS to clarify who is authorized to receive these records and what the requirements are, if any, to disclose them.

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<sup>239</sup> N.J.A.C. § 10:37G-3.5(a)(1).

<sup>240</sup> See Helen Oscislawski & Krystyna H. Monticello, *Health Law Diagnosis: Confidentiality of Mental Health Records and Mental Health Related Information in New Jersey*, at 2 (Jan. 2013) (on file with author) [hereinafter “Oscislawski & Monticello, *Confidentiality of Mental Health Records*”]. See N.J.S.A. § 30:1-7. During an interview for this Report, Helen Oscislawski raised the question of whether inpatient psychiatric units at general hospitals, which are licensed by DOH and thus not otherwise subject the DHS regulations, are subject to these DHS privacy requirements *if* they receive state funding or grants (notes of interview on file with author).

<sup>241</sup> See Section II.B.2, *infra*.

<sup>242</sup> See N.J.A.C. § 10:190-1.1(b)(4)(ii); Section II.B.3, *infra*.

<sup>243</sup> See Oscislawski & Monticello, *Confidentiality of Mental Health Records*, *supra* note 240, at 5.

<sup>244</sup> A psychiatric residential treatment facility is not licensed by DOH as a hospital but is “licensed by the New Jersey Division of Youth and Family Services as a residential child care facility in accordance with N.J.A.C. 10:127 or by the Division of Mental Health Services as a psychiatric community residence for youth in accordance with N.J.A.C. 10:37B or by the New Jersey Department of Health and Senior Services or other State agencies with the authority to license such facilities to provide care to children,” N.J.A.C. § 10:75-1.3(c)(1), and it has “a provider agreement with the State Medicaid agency (the Division of Medical Assistance and Health Services),” *id.* § 10:75-1.2.

<sup>245</sup> *Id.* § 10:75-1.5(e).

<sup>246</sup> *Id.* § 10:75-1.5(d).

### c. Outpatient and residential substance use disorder treatment facilities licensed by DHS

DHS's regulations require outpatient<sup>247</sup> and residential<sup>248</sup> substance use disorder treatment facilities to comply with the confidentiality requirements in HIPAA and Part 2, with some exceptions that do not directly affect treatment providers. It is not clear why (or if) DHS determined that the federal standards were adequately protective of patient privacy in these settings but not in others.

The residential regulations apply to “[a]ll substance (alcohol and drug) abuse treatment facilities that provide residential substance use disorders treatment to adults and adolescents including, but not limited to, halfway houses, extended care facilities, long-term residential facilities, short-term residential treatment facilities and non-hospital-based (medical) detoxification or any other similar such organization . . . .”<sup>249</sup> The outpatient regulations establish each client’s “right to be informed if the program has authorized other health care and educational institutions to participate in his or her treatment, the identity and function of these institutions, and to refuse to allow their participation in his or her treatment.”<sup>250</sup>

### d. DHS's Division of Developmental Disabilities

The Developmentally Disabled Rights Act recognizes that persons with developmental disabilities have the right to the “[c]onfidential handling of personal and medical files,” which right is not modified “by reason of admission to or residence at a facility or solely by reason of receipt of any service for persons with developmental disabilities.”<sup>251</sup> Facility is defined broadly to mean “a facility operated by any public or private agency, organization or institution for the provision of services for persons with developmental disabilities.”<sup>252</sup> The regulations adopted by the Division of Developmental Disabilities (DDD) within DHS to implement this statute import the confidentiality standard set forth in N.J.S.A. § 30:4-24.3, requiring that “all certificates, applications, records and reports that directly or indirectly identify an individual currently or formerly receiving services from the Division be kept confidential and are not subject to public disclosure.”<sup>253</sup> In addition to applying to “all records of individuals held by the Division, including applications for services of persons determined ineligible for services and those applications that are initiated but not completed,”<sup>254</sup> the DDD confidentiality provisions also bind “all service components<sup>255</sup> of

<sup>247</sup> *Id.* §§ 10:161B-1.3; 10:161B-16.2(a)(10)(i); 10:161B-18.1(a)(4).

<sup>248</sup> *See id.* § 10:161A-27.1; *see also id.* § 10:161A-19.1(a)(4). Curiously, the definition of confidentiality in the residential regulations refers to HIPAA but not Part 2. *See id.* § 10:161A-1.3.

<sup>249</sup> *See id.* § 10:161A-27.1.

<sup>250</sup> *Id.* § 10:161B-16.2(a)(4). Outpatient SUD treatment facilities that are Part 2 programs would need to obtain patient consent to involve other treatment providers in the patient’s care in the absence of a medical emergency or other exception to Part 2’s consent requirements, discussed in Section II.A.2, *infra*.

<sup>251</sup> N.J.S.A. § 30:6D-(f).

<sup>252</sup> *Id.* § 30:6D-3(c).

<sup>253</sup> N.J.A.C. § 10:41-2.1(a).

<sup>254</sup> *Id.* § 10:41-2.1(b).

<sup>255</sup> Service components are defined in the regulations as “any developmental center, regional office or central office unit.” *Id.* § 10:41-1.3.



the Division and all providers under contract with the Division or licensed by the [DHS].”<sup>256</sup> Thus, for example, community care residences that are licensed by DHS must comply with the DDD confidentiality requirements.<sup>257</sup>

Generally, release of DDD client records requires a written, valid authorization or a court order.<sup>258</sup> The DDD regulations define authorization as requiring compliance with the HIPAA requirements for release of PHI set forth in 45 C.F.R. Parts 160 and 164.<sup>259</sup>

The DDD confidentiality provisions include a number of narrow treatment exceptions to the written authorization requirement, however. Several refer to the exchange of information within programs associated with the Division or Department. For example, if an individual transfers from one provider to another, the client record shall be transferred between the providers on the day of transfer.<sup>260</sup> Relatedly, when a provider assumes “responsibility for an individual from another provider, the receiving provider will have access to the client record of that individual at the time of referral, including copies of the required records.”<sup>261</sup> Importantly, however, provider is defined very narrowly to mean “a person, agency or business that is under contract with the Division or licensed by the Department.”<sup>262</sup> Similarly, the provision permitting release without written authorization “[w]hen an individual is transferred from one component of the Department or Division to another”<sup>263</sup> does not permit release to providers unconnected to DHS. Further, these provisions reference transfers of care rather than a sharing of medical records in an ongoing, bi- or multi-directional collaborative care arrangement.

Two exceptions to the written authorization requirement contemplate disclosure of at least some client records beyond the Division or Department, although both are limited. Medical staff outside of the Department are granted “access to information and records as necessary for the treatment of the individual” only when they “have assumed temporary medical responsibility for the individual.”<sup>264</sup> Individuals or their legal guardians also are required upon admission to provide a list of individuals who may receive information about the individual’s “general medical condition over the telephone,” which list may include a personal physician.<sup>265</sup> The term, “general medical condition,” is not defined in the regulations, although context suggests that it does not involve the level of detail that would facilitate coordinated care.

Although the DDD confidentiality provisions import by reference a number of independent standards, including HIPAA, Part 2, N.J.S.A. § 30:4-24.3, and New Jersey statutory protection for HIV/AIDS records (N.J.S.A. § 26:5C-5 *et seq.*), discussed in Section II.B.5.a below,<sup>266</sup> they also include a number of requirements that are distinct from some of the more common boilerplate language found in many New

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<sup>256</sup> *Id.* § 10:41-1.2.

<sup>257</sup> *See, e.g., id.* § 10:44B-2A.2(c).

<sup>258</sup> *See id.* § 10:41-5.2(a), (c).

<sup>259</sup> *See id.* § 10:41-1.3.

<sup>260</sup> *See id.* § 10:41-4.2(d).

<sup>261</sup> *Id.* § 10:41-4.2(e).

<sup>262</sup> *Id.* § 10:41-1.3.

<sup>263</sup> *Id.* § 10:41-5.2(d)(4).

<sup>264</sup> *Id.* § 10:41-5.2(d)(5).

<sup>265</sup> *Id.* § 10:41-5.2(d)(3).

<sup>266</sup> *See id.* §§ 10:41-2.1(a), (d); 10:41-4.1(b); *see also id.* § 10:41-1.3 (defining authorization in terms of HIPAA requirements).



Jersey regulations. For example, health information regarding family members of an individual must be redacted before those records may be disclosed to a third party, and such information may not be disclosed unless it “is required for treatment and/or services for the individual.”<sup>267</sup> The addresses of community residences also must be redacted from DDD and provider records before they may be disclosed.<sup>268</sup> The regulations also specify that if a patient “is placed with a provider under contract with the Division or licensed by the Department, all records specific to that individual, whether generated or obtained by the provider, belong to the Division and/or Department and shall not be released except by the Division and/or Department.”<sup>269</sup> They also expressly provide that electronic client records are subject to the same confidentiality requirements as paper records.<sup>270</sup> Further, data encryption is required to transmit client-identifying information via electronic mail to persons or agencies external to DHS via electronic mail.<sup>271</sup>

#### e. Screening and screening outreach services

The confidentiality provisions governing screening and screening outreach programs designated by DHS are very similar to the standards for short-term care facilities for adults discussed above.<sup>272</sup> The regulations establish that consumer records held by screening services are protected PHI and require screening service staff and affiliated emergency services staff to comply with all federal and State laws to maintain the confidentiality of consumer PHI, including HIPAA, Part 2, N.J.S.A. § 30:4-24.3, and N.J.S.A. § 26:5C-7 (HIV/AIDS records, discussed in Section II.B.5.a below).<sup>273</sup>

Screening services may disclose consumer PHI “to the extent permitted by a valid, written, unrevoked authorization, signed by the consumer or the consumer’s legal guardian or mental health care representative.”<sup>274</sup> Although the regulation requires that the authorization comply with HIPAA’s authorization requirement in 45 C.F.R. § 164.508(a),<sup>275</sup> it does not similarly require compliance with paragraph (b) of the same Section, which is the paragraph that itemizes the specific content of the authorization. Thus, the regulation does not detail the form or content of the required authorization. Likely given existing confidentiality requirements in other federal and State laws, as discussed elsewhere in this Report, the regulation specifies that “[a]uthorizations for the release of psychotherapy notes,

<sup>267</sup> See *id.* § 10:41-2.1(e); see also *id.* § 10:41-4.3(a) (“When providing client records, all individual identifying information regarding individuals other than the individual who is the subject of the request, must be redacted, including, but not limited to, names, initials, and specific descriptions, from all client and agency records before they are disclosed.”).

<sup>268</sup> See *id.* § 10:41-4.3(b).

<sup>269</sup> See *id.* § 10:41-2.1(f); see also *id.* § 10:41-4.2(a).

<sup>270</sup> See *id.* § 10:41-3.4(a); see also *id.* § 10:41-1.3.

<sup>271</sup> See *id.* §§ 10:41-1.3; 10:41-3.4(c).

<sup>272</sup> Compare *id.* § 10:31-12.1-12.4 (screening and screening outreach programs), with *id.* § 10:37G-3.1-3.5 (short-term care facilities); *supra* notes 237-239 & accompanying text. See generally N.J.S.A. § 30:4-27.2(z) (“‘Screening service’ means a public or private ambulatory care service designated by the commissioner [of DHS], which provides mental health services including assessment, emergency and referral services to persons with mental illness in a specified geographic area.”).

<sup>273</sup> See N.J.A.C. § 10:31-12.1.

<sup>274</sup> *Id.* § 10:31-12.2(a).

<sup>275</sup> See *id.* § 10:31-12.2(b).

HIV/AIDS information and individual drug and alcohol abuse information must specifically identify those records as being subject to release.”<sup>276</sup>

One of the exceptions to the written authorization requirement is for the consumer’s treatment, although the exception includes a number of limitations.<sup>277</sup> Specifically, “professional screening staff may disclose the *minimum necessary* consumer PHI *that is relevant* to a consumer’s treatment and/or referral for treatment . . . to staff at a community mental health agency, as defined in N.J.S.A. 30:9A-2, another screening service or a short-term care or psychiatric facility or special psychiatric hospital, as defined at N.J.S.A. 30:4-27.2.”<sup>278</sup> All disclosures of PHI must be documented in the patient’s record and must be based on individualized determinations.<sup>279</sup>

## 2. Hospitals and other facilities licensed by the New Jersey Department of Health

The statutes and regulations governing hospitals licensed by DOH do not differentiate confidentiality requirements based on the content of patient records.<sup>280</sup> Rather, hospitals must preserve the confidentiality of all hospital records and generally may not release them outside of the hospital without the patient’s approval.<sup>281</sup> A regulation also requires patient consent to contact the patient’s primary care doctor when the patient is admitted to the psychiatric unit of a hospital through the emergency department.<sup>282</sup> None of these provisions specifies what form patient consent or approval must take.

The hospital regulations provide that patient approval is not needed to disclose patient records, however, if the patient is transferred to another health care facility that requires the information.<sup>283</sup>

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<sup>276</sup> *Id.* § 10:31-12.2(c).

<sup>277</sup> *See id.* § 10:31-12.4(a)(1).

<sup>278</sup> *Id.* (emphasis added).

<sup>279</sup> *See id.* § 10:31-12.4(b)-(c).

<sup>280</sup> *See* N.J.S.A. § 26:2H-12.8(g); N.J.A.C. § 8:43G-4.1(a)(21).

<sup>281</sup> *See id.* Patients in a hospital also have a right “[t]o be informed if the hospital has authorized other health care and educational institutions to participate in the patient’s treatment. The patient also shall have a right to know the identity and function of these institutions, and may refuse to allow their participation in the patient’s treatment.” N.J.A.C. § 8:43G-4.1(a)(10). *See generally* N.J.A.C. § 8:43G-15.2(i) (“Original medical records of [sic] components of medical records shall not leave hospital premises unless they are under court order or subpoena or in order to safeguard the record in case of a physical plant emergency or natural disaster.”).

<sup>282</sup> *See* N.J.A.C. § 8:43G-26.7(k); *see also* Oscislowski & Monticello, *Confidentiality of Mental Health Records*, *supra* note 240, at 2. When these conditions are satisfied, however, the regulation requires that the primary care doctor be contacted. *See* N.J.A.C. § 8:43G-26.7(k).

<sup>283</sup> *See id.* § 8:43G-4.1(a)(21). In fact, a general hospital may not transfer a patient to another health care facility unless a complete discharge summary accompanies the patient. *See* N.J.S.A. § 26:2H-12.9c. *See also* N.J.A.C. § 8:43G-12.7(p) (requiring that documentation, including x-ray films and patient’s condition, be sent with patient being transferred from an emergency department to another health care facility); *id.* § 8:43G-15.2(f) (requiring hospital to send a copy of a transfer record to receiving hospital at time of transfer whenever a patient is transferred to another health care facility, including a home health agency, on a nonemergency basis, which record must include diagnosis, physician orders, and other aspects of the patient’s clinical treatment record).

Facility is defined in the hospital regulations as “a general acute care, special or psychiatric hospital licensed pursuant to [Chapter 43G].”<sup>284</sup> “Requires,” however, is not defined in the regulations.

Inter-hospital exchange of information and case reviews with pediatric specialists in other hospitals also are permitted as part of the pediatric intensive care continuous quality improvement program.<sup>285</sup> It is not clear, however, whether these exchanges disclose PHI or deidentified files.

Exchanges of information among treating providers within hospitals, however, generally do not require consent. A DOH regulation specifically requires that medical records will “accompany the patient when he or she leaves the patient care unit for clinical services in other departments of the hospital or shall be retrievable by authorized personnel on a computerized system with a restricted access and entry system.”<sup>286</sup> The HIPAA treatment exception and many of the State’s professional licensing requirements also apply within the hospital, as discussed elsewhere in this overview.<sup>287</sup> If a more protective law applies, however, such as Part 2 (discussed above) or the New Jersey statute protecting the confidentiality of HIV/AIDS records (discussed below), it will restrict exchanges among treating providers even within hospitals.

A number of non-hospital facilities licensed by DOH have similar confidentiality provisions requiring approval or consent to disclose patient records outside of the facility but recognizing an exception when the patient is transferring to another health care facility; they differ, however, regarding whether the consent needs to be in writing and whether the transferee exception includes the qualifier that the transferee facility requires the records.

Long-term care facilities, for example, require “approval” to disclose confidential patient records to anyone outside of the facility but recognize an exception by requiring the release of medical records when a resident transfers to another nursing home or health care facility.<sup>288</sup> The statute and regulations do not define “approval,” and they do not condition the transferee exception on the receiving facility’s need for the records.

Adult day health services facilities similarly recognize a patient’s right to “approve or refuse” – without specifying the form approval or refusal must take -- release of their records except when the patient transfers to another health care facility.<sup>289</sup> This power to approve or refuse, however, extends to the release to *any* individual and is not limited only to individuals outside of the facility.<sup>290</sup>

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<sup>284</sup> *Id.* § 8:43G-1.2(1). “Health care facility” is defined much more expansively in the statute, *see* N.J.S.A. § 26:2H-2(a), but the transferee exception is in the regulations and not the statute.

<sup>285</sup> *See* N.J.A.C. § 8:43G-22.22.

<sup>286</sup> *Id.* § 8:43G-15.3(c).

<sup>287</sup> *See* Section II.A.1.b, *supra* (HIPAA treatment exception); Section II.B.3, *infra* (professional licensing requirements); *see also* N.J.S.A. § 26:2H-12.8(f) (clarifying that the right of a patient admitted to a general hospital to privacy “shall not preclude discussion of a patient’s case or examination of a patient by appropriate health care personnel”).

<sup>288</sup> N.J.S.A. § 30:13-5(g); N.J.A.C. § 8:39-4.1(a)(18).

<sup>289</sup> *See* N.J.A.C. § 8:43F-4.2(a)(9).

<sup>290</sup> *See id.* Interestingly, adult day health services programs for persons with Alzheimer’s or related diseases also are licensed by DHS. *See id.* § 10:164A-1.2. Unlike the DOH regulations, the DHS regulations specify that written consent of the caregiver or authorized agent is required to disclose PII regarding clients. *See id.* § 10:164A-6.2(a). In addition, the DHS regulations do not include a transfer exception to confidentiality.

Pediatric community transitional homes, in contrast, must obtain written consent to disclose records to any individual outside of the facility except in the case of a transfer to another health care facility.<sup>291</sup> In addition to specifying that the consent be written, this regulation also identifies who may give the requisite consent, namely, the “resident (if age appropriate), resident's parent(s), legal guardian, or responsible person.”<sup>292</sup> The transferee exception does not include language regarding the receiving facility's need for the records.

Patients of hospice care programs have the right to approve or refuse in writing the release of their medical records “to any individual outside the hospice,” with limited exceptions that do not include release to transferee facilities.<sup>293</sup>

The regulations governing the confidentiality of patient medical and health records from home health agencies bear a different structure, although the substantive protections are similar. A regulation provides that these records shall be made available to healthcare practitioners involved in a patient's care.<sup>294</sup> This provision does not refer to consent, so it appears that this a form of a treatment exception pursuant to which these records may be disclosed to providers without consent. “Healthcare practitioners involved in the patient's care,” however, is not defined. Although it is not clear from the face of this regulation, it seems from the context of the other home health agency regulations that this treatment exception is limited to providers within the agency. For example, another regulation establishes a patient's right to refuse in writing to the release of home health agency records “to any individual outside the facility . . . .”<sup>295</sup> The home health agency regulations also include a limited transferee exception that requires home health agencies to send a copy of a “transfer record reflecting the patient's immediate needs” when the patient is transferred to “another non acute health care facility.”<sup>296</sup> The regulation itemizes the minimum that this record must contain, including medical information like the patient's diagnosis and medication orders.<sup>297</sup> The implication of this list is that facilities may send less than the complete medical record.<sup>298</sup>

The above discussion highlights differences in the confidentiality requirements of various facilities regulated by DOH. In some instances, variations also exist *within* the regulations governing a particular type of licensed facility. One regulation governing assisted living facilities, for example, generally prohibits release of patient records outside of the facility without approval but does not specify the form that consent must take.<sup>299</sup> A more stringent regulation, however, specifically requires written consent to release records to any individual outside of the facility or program.<sup>300</sup> Both provisions, however, recognize

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<sup>291</sup> See *id.* § 8:43D-12.2.

<sup>292</sup> See *id.* § 8:43D-12.2.

<sup>293</sup> *Id.* § 8:42C-5.1(b)(18).

<sup>294</sup> See *id.* § 8:42-11.1.

<sup>295</sup> *Id.* § 8:42-13.1(b)(14).

<sup>296</sup> *Id.* § 8:42-11.2(d).

<sup>297</sup> *Id.* § 8:42-11.2(d)(1)-(7).

<sup>298</sup> Indeed, the regulation restricts the ability to remove the medical record from the home health agency “except for purposes of providing clinical patient care and treatment.” *Id.* § 8:42-11.2(g)(1).

<sup>299</sup> See *id.* § 8:36-4.1(a)(27).

<sup>300</sup> See *id.* § 8:36-15.3(b).

that consent or approval is not needed when the patient transfers to another health care facility, and neither qualifies the transferee exception on the receiving facility's need for the records.<sup>301</sup>

The regulations governing ambulatory care facilities are internally inconsistent. Like many of the confidentiality regulations for facilities regulated by DOH, one ACF regulation requires patient approval to release patient medical records to anyone outside the facility, "unless another health care facility to which the patient was transferred requires the information."<sup>302</sup> Another provision, however, requires patient written consent for the release of medical record information without distinguishing between releases internal or external to the facility nor recognizing an exception for transfers to other health care facilities.<sup>303</sup>

At least three regulations speak to the confidentiality responsibilities of residential health care facilities, and they differ in some respects. One regulation requires facilities to develop policy and procedure manuals that include, at minimum, "[p]olicies and procedures for maintaining confidentiality of resident records, including policies and procedures . . . for release of the resident's records to any individual outside the facility, as consented to by the resident."<sup>304</sup> This regulation does not reference the transferee exception. The other two regulations, in contrast, specify that written consent is necessary to release patient records. One applies the written consent requirement to a release "to any individual *not associated with* the facility."<sup>305</sup> The other regulation, in subtle but potentially significant contrast, requires residential health care facility resident rights, policies, and procedures to require, at minimum, written consent "for release of his or her records to any individual outside the facility."<sup>306</sup> The two regulations that require written consent both recognize the exception for residents transferred to another health care facility, and neither includes the condition that the transferee facility requires the records.

The transfer exception to consent requirements for disclosure of emergency medical services records stands out from these other DOH regulations. Rather than limiting transfer exceptions to receiving health care *facilities*, emergency medical services records may be disclosed without patient consent when the patient transfers "to another health care *professional* receiving the patient."<sup>307</sup> The exception, however, still is limited to transfers and is not a general treatment exception. This regulation also provides additional guidance regarding consent requirements, requiring policies pursuant to which a "patient, guardian, executor or other legally authorized person" may request patient records in writing, and that the information must be released to a specific person, entity or company."<sup>308</sup>

The DOH also licenses clinical laboratories pursuant to the New Jersey Clinical Laboratory Improvement Act.<sup>309</sup> The statute provides that laboratories may only accept specimens for testing from

<sup>301</sup> See *id.* §§ 8:36-4.1(a)(27), 8:36-15.3(b).

<sup>302</sup> *Id.* § 8:43A-16.2(a)(9)(i); see also *id.* § 8:43A-21.4(b) (discussing transfer of medical records of family planning, prenatal, postpartum, and gynecological services at ambulatory care facilities).

<sup>303</sup> See *id.* § 8:43A-13.5(a)(1). See also *supra* note 290 & accompanying text (regarding inconsistencies between DOH regulations governing adult day health services programs and DHS regulations governing adult day health services programs for persons with Alzheimer's or related diseases).

<sup>304</sup> See *id.* § 8:43-4.6(a)(5) (emphasis added).

<sup>305</sup> *Id.* § 8:43-13.1(b) (emphasis added).

<sup>306</sup> *Id.* § 8:43-14.2(a) (emphasis added).

<sup>307</sup> See *id.* § 8:40-3.5(b)(1)(v) (emphasis added).

<sup>308</sup> See *id.*

<sup>309</sup> N.J.S.A. § 45:9-42.28.

and make reports to persons legally qualified or authorized to do so.<sup>310</sup> The implementing regulation, in turn, specifies that labs may only examine specimens “at the request of a licensed physician, dentist, or other person authorized by law to use the findings of laboratory examinations and shall report only to those authorized by law to receive such results.”<sup>311</sup> Test reports, then, must be sent to “the licensed physician or other authorized person who requested the test,”<sup>312</sup> and the results of laboratory tests and procedures shall be sent to the licensed physician, dentist, or other person authorized by law to use the findings.<sup>313</sup> The statute defines “person” as “any individual, partnership, limited partnership, corporation, or other legal entity,”<sup>314</sup> but it is not clear what other individuals are authorized by law within the meaning of these requirements. Attorneys Helen Oscislawski and Krystyna Nowik Monticello have argued that the State should clarify that authorized persons may contract with a HIE as an agent so the HIE may transmit orders to and receive test results directly from a laboratory.<sup>315</sup>

### 3. Health Care Professionals

Health care professionals also are subject to State statutes and regulations specific to their profession.<sup>316</sup> The State Board of Medical Examiners (BME), for example, is responsible for regulating a number of health care professionals, such as physicians (which includes psychiatrists),<sup>317</sup> physician assistants,<sup>318</sup> podiatrists,<sup>319</sup> certified nurse midwives,<sup>320</sup> acupuncturists,<sup>321</sup> and genetic counselors<sup>322</sup> (BME Regulated Entities). The BME regulations require confidentiality of patient records,<sup>323</sup> but they include a form of treatment exception that permits physicians and other BME Regulated Entities,<sup>324</sup> “in the exercise of professional judgment and in the best interests of the patient (even absent the patient's request), . . .

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<sup>310</sup> See *id.* § 45:9-42.42(c). Federal law defines “authorized person” in terms of who is authorized under state law to order tests, receive results, or both. See 42 C.F.R. §§ 493.2, 493.1241(a).

<sup>311</sup> N.J.A.C. 8:44-2.7(g).

<sup>312</sup> *Id.* 8:44-2.7(i).

<sup>313</sup> *Id.* 8:44-2.7(i)(3).

<sup>314</sup> N.J.S.A. § 45:9-42.27.

<sup>315</sup> See Helen Oscislawski & Krystyna Nowik, Appendix D to the Joint Interim Report of the New Jersey Health Information Technology Commission and the Office of Electronic Health Information Technology Development, Implementation and Deployment, Analysis of Selected New Jersey Confidentiality and Patient Approval Regulations, at 3 (attached as Exhibit C to the New Jersey Privacy and Security Committee’s December 31, 2010 Report to the New Jersey Health Information Technology Coordinator regarding Developing and Implementing a Legal Framework for Private and Secure Health Information Exchange in New Jersey) (on file with author) [hereinafter Oscislawski & Nowik, Appendix D].

<sup>316</sup> As Helen Oscislawski has observed, it is worth noting that the professional licensing statutes and regulations do not apply to individuals with general certifications, but these individuals “will be bound by any licensing regulations that apply to the entity or organization that they are employed by, such as a hospital, psychiatric hospital or psychology practice.” Oscislawski & Monticello, *Confidentiality of Mental Health Records*, *supra* note 240, at 9.

<sup>317</sup> See N.J.S.A. §§ 45:9-5.1, 45:9-6; N.J.A.C. § 13:35.

<sup>318</sup> See N.J.S.A. §§ 45:9-27.11-27.12; N.J.A.C. § 13:35-2B.1 *et seq.*

<sup>319</sup> See N.J.S.A. § 45:5-2; N.J.A.C. § 13:35-2.1 *et seq.*

<sup>320</sup> See N.J.S.A. § 45:10-2; N.J.A.C. § 13:35-2A.1 *et seq.*

<sup>321</sup> See N.J.S.A. § 45:2C-3; N.J.A.C. § 13:35-9.1 *et seq.*

<sup>322</sup> See N.J.S.A. § 45:9-37.114; N.J.A.C. § 13:35-14.1 *et seq.*

<sup>323</sup> See N.J.A.C. § 13:35-6.5(d).

<sup>324</sup> See *id.* § 13:35-6.5(a) (defining “licensee” to mean “any person licensed or authorized to engage in a health care profession regulated by the Board of Medical Examiners”).



[to] release pertinent information about the patient's treatment to another licensed health care professional who is providing or has been asked to provide treatment to the patient, or whose expertise may assist the licensee in his or her rendition of professional services.”<sup>325</sup> A similar treatment exception applies to dentists<sup>326</sup> and chiropractors.<sup>327</sup>

BME Regulated Entities who have “a good faith belief that the patient because of a mental or physical condition may pose an imminent danger to himself or herself or to others” also may exercise professional judgment to release pertinent information to other health care professionals “to minimize the threat of danger.”<sup>328</sup>

Psychologists<sup>329</sup> and psychoanalysts<sup>330</sup> regulated by the State Board of Psychological Examiners, and rehabilitation counselors, professional counselors, and associate counselors,<sup>331</sup> regulated by the State Board of Marriage and Family Therapy Examiners, are subject to more narrow treatment exceptions.

Generally, a licensed psychologist needs to “preserve the confidentiality of information obtained from a client in the course of the licensee's teaching, practice or investigation.”<sup>332</sup> N.J.A.C. § 42-8.3(f)(4), however, requires release “[i]n order to contribute appropriate client information to the client record maintained by a hospital, nursing home or similar licensed institution which is providing or has been asked to provide treatment to the client.”<sup>333</sup> Another regulation requires a licensee “to *reveal* the information [obtained from a client in the course of the licensee's teaching, practice or investigation] . . . to appropriate professional workers” and others “if in the licensee's judgment, exercised in accordance with the standards of the profession,” there is a clear and imminent danger to the individual or the public and related circumstances itemized in the regulation.<sup>334</sup> “Reveal” is not defined in the regulation, and it is not clear if this authorizes the exchange of patient records or just the revelation of facts or summaries. A third regulation plainly permits, but does not require, only the *discussion* of “the information obtained in clinical or consulting relationships, or in evaluating data concerning children, students, employees and others, only for professional purposes and only with persons *clearly connected* with the case.”<sup>335</sup> “Clearly

<sup>325</sup> *Id.* § 13:35-6.5(d)(3); *see also id.* § 13:35-9.16(d)(3) (acupuncturists regulations); *but see* N.J.S.A. § 45:9-37.120 (establishing confidentiality of records of genetic counselor without reference to a treatment exception); N.J.A.C. § 13:35-14.17 (same); *see generally* N.J.A.C. § 13:35-6.5(b)(3)(vii)(1) (requiring that each day's entry into patient records “prepared and maintained on a personal or other computer” promptly be made available to “a physician responsible for the patient's care”); N.J.A.C. § 13:35-9.16(b)(3)(vii) (requiring copy of each day's entry in computerized acupuncturist treatment records be made available to a physician responsible for the patient's care no later than 10 days after a request for the records).

<sup>326</sup> *See* N.J.A.C. § 13:30-8.7(f)(2).

<sup>327</sup> *See id.* § 13:44E-2.2(e)(2).

<sup>328</sup> *Id.* § 13:35-6.5(d)(4). This discretion does not extend to the release of information in the medical record “containing identifying information about a person who has AIDS or an HIV infection,” disclosure of which is governed by N.J.S.A. 26:5C-8, *see* N.J.A.C. § 13:35-6.5(d)(4). New Jersey's law governing the confidentiality of HIV/AIDS records is discussed in Section II.B.5.a, *infra*. The confidentiality regulations for chiropractors and dentists do not include language similar to the BME “danger” exception. *See* N.J.A.C. §§ 13:30-8.7; 13:44E-2.2.

<sup>329</sup> *See* N.J.A.C. §§ 13:42-8.3(f)(4); § 13:42-8.5(a), (c).

<sup>330</sup> *See* §§ 13:35-6.5(d)(4); 13:42A-6.2(3)-(4), 13:42A-6.3(a), (c), (g).

<sup>331</sup> *See* §§ 13:35-6.5(d)(4); 13:34-27.5(a)(4), (e); § 13:34-18.5(a)(4), (e); *see generally* N.J.S.A. § 45:8B-49.

<sup>332</sup> N.J.A.C. § 13:42-8.5(a); *see also* N.J.S.A. § 45:14B-28.

<sup>333</sup> N.J.A.C. § 13:42-8.3(f)(4).

<sup>334</sup> *Id.* § 13:42-8.5(a) (emphasis added).

<sup>335</sup> *Id.* § 13:42-8.5(c) (emphasis added). *See generally id.* § 13:42-8.5(g).

connected” also is not defined in the regulation. Certified psychoanalysts are bound by nearly identical requirements.<sup>336</sup>

The regulations governing rehabilitation counselors, professional counselors, and associate counselors are similar in some respects to those regulating psychologists and psychoanalysts. They contain, for example, the permissive “discuss” provision as well a similar mandatory requirement to release confidential client records “if the licensee has information that the client presents a clear and present danger to the health or safety of an individual.”<sup>337</sup> There is no comparable requirement to release client information to ensure institutional records are complete, which, though limited, is more akin to a treatment exception than the other more qualified provisions. Rather, where “a client is receiving counseling services from another mental health professional,” a rehabilitation, professional, or associate counselor requires client consent to “inform the other mental health professional already involved and develop clear agreements to avoid confusion and conflict for the client.”<sup>338</sup>

Respiratory care practitioners,<sup>339</sup> regulated by the State Board of Respiratory Therapy, may also be subject to a variation of a treatment exception, although the regulation is not clear. Paragraph (d)(3) of N.J.S.A. § 13:44F-8.2 provides that licensees, in outpatient settings,<sup>340</sup> “shall provide copies of records in a timely manner to a patient or another designated health care provider where the patient's continued care is contingent upon their receipt.”<sup>341</sup> This provision, standing alone, suggests that releases to designated health care providers – an undefined term – where needed for continued care, are mandatory and do not need consent. Paragraph (d)(1) of the same regulation, however, provides that “[r]eports of all care and/or tests performed by respiratory care practitioners shall be provided no later than 30 days from the receipt of a written request from the patient or authorized representative.”<sup>342</sup> The regulation does not expressly provide that the written request requirement in (d)(1) applies to (d)(3), so it is possible that (d)(3) creates an exception to the written request requirement. But it also is possible that (d)(1) establishes the baseline written request requirement to access patient records, and (d)(3) merely requires a more time-sensitive response when care depends on it, without affecting the written request requirement. It would be helpful for the agency to clarify these provisions.

The closest licensed or certified social workers and marriage and family therapists come to a treatment exception to consent or waiver requirements is a provision permitting disclosure when failure

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<sup>336</sup> See *id.* §§ 13:42A-6.2(f)(4), 13:42A-6.3(a), (c), (g).

<sup>337</sup> See *id.* §§ 13:34-27.5(a)(4), (e); *id.* § 13:34-18.5(a)(4), (e); see generally N.J.S.A. § 45:8B-49.

<sup>338</sup> N.J.A.C. § 13:34-30.2.

<sup>339</sup> See *id.* § 13:44F-8.2(d)(3).

<sup>340</sup> This respiratory care therapist regulations are an example of the interplay of New Jersey’s varying confidentiality regulations. What rules apply to respiratory care practitioners depends on where they work. Respiratory care practitioners who are “employed in a setting regulated by the Department of Health [] shall comply with all applicable [DOH] rules.” *Id.* § 13:44F-8.2(c). See also *id.* § 13:44G-12.4(h) (“This section [regarding release of client records] shall not apply to a social worker in an agency setting who does not, by agency policy, have control over or authority to release client records.”); Oscislawski & Monticello, *Confidentiality of Mental Health Records*, *supra* note 240, at 6 (stating that “any records relating to clients treated by a psychologist, which may be maintained by a hospital or other facility will remain subject to the rules and regulations governing disclosure of medical records from such facility”).

<sup>341</sup> N.J.A.C. § 13:44F-8.2(d)(3) (emphasis added).

<sup>342</sup> *Id.* § 13:44F-8.2(d)(1).



to disclose would present a clear and present danger to the health or safety of an individual.<sup>343</sup> Depending on the facts, this could permit disclosure to another health care professional for purposes of treatment to address a clear and present danger to the patient. But the design of this exception is not specifically to facilitate treatment. In fact, the social worker regulations expressly contemplate that disclosure of client records to “[a]nother licensed health care professional, hospital, nursing home or similar licensed institution which is providing or has been asked to provide treatment to the client” will require a “written request of the client or authorized representative.”<sup>344</sup>

Because the State Board of Marriage and Family Therapy Examiners’ statutes and regulations require licensed clinical alcohol and drug counselors and certified alcohol and drug counselors to comply with Part 2,<sup>345</sup> there is no treatment exception for these health care professionals other than Part 2’s limited medical emergency and internal communications exceptions. The massage and bodywork therapist<sup>346</sup> and physical therapist<sup>347</sup> regulations also do not include a treatment exception.<sup>348</sup>

The regulations governing pharmacists are surprisingly vague. Although patient records are confidential, they “shall be made available to persons authorized to inspect them under State and Federal statutes and regulations.”<sup>349</sup> Although these terms are not defined in the statute, “inspect” suggests that this language is directed at health oversight functions of government rather than treatment providers.

To the extent health care professionals do not satisfy, choose not to exercise their discretion regarding, or are not eligible for one of the treatment exceptions discussed above, they will need a waiver from the client, or authorized representative, where authorized, to release client records to other health care providers for purposes of treatment. There is substantial variety when it comes to what specifically will satisfy waiver requirements for different professions.

Psychologists and psychoanalysts, for example, shall release confidential information with a waiver from the client or authorized representative, which need not be written, unless the licensee requires it.<sup>350</sup> In contrast, clients of marriage and family therapists,<sup>351</sup> rehabilitation counselors,<sup>352</sup> professional counselors, and associate counselors<sup>353</sup> must agree in writing to waive confidentiality. As

<sup>343</sup> See N.J.S.A. § 45:15BB-13; N.J.A.C. § 13:34-8.3(a)(4); see also N.J.A.C. § 13:44G-12.3(a)(4); see generally N.J.S.A. § 45:8B-29.

<sup>344</sup> N.J.A.C. § 13:44G-12.4(b)(3); cf. N.J.S.A. § 45:15BB-13(e) (permitting social worker to disclose confidential patient information if a “patient or client agrees to waive the privilege”); N.J.A.C. § 13:44G-12.3(a)(7) (same).

<sup>345</sup> See N.J.S.A. § 45:2D-11; N.J.A.C. § 13:34C-4.5(b).

<sup>346</sup> See N.J.A.C. § 13:37A-5.3(c).

<sup>347</sup> See *id.* § 13:39A-3.3(a), (d).

<sup>348</sup> See Section II.2.e, *supra*.

<sup>349</sup> See N.J.A.C. §§ 13:39-7.6(d); 13:39-7.19(e).

<sup>350</sup> See *id.* §§ 13:42-8.3(b), (f)(3); 13:42A-6.2(b), (f)(3). N.J.S.A. 45:14B-36 establishes a number of requirements for an “authorization for the purpose of .P.L. 1985, c.256 (C.45:14B-30 et seq.),” including that the authorization be in writing. Although the internal statutory reference could be made more clear, these requirements seem to apply specifically to authorizations for a licensed psychologist to disclose limited confidential treatment information “to a third-party payor for the purpose of obtaining benefits from the third-party payor for psychological services . . .,” 45 N.J.S.A. § 45:14B-32, and not generally to all disclosures of confidential treatment information by psychologists.

<sup>351</sup> See N.J.A.C. § 13:34-8.3(a)(6).

<sup>352</sup> See *id.* § 13:34-27.5(a)(6).

<sup>353</sup> See *id.* § 13:34-18.5(a)(6).

discussed above, respiratory care practitioners must provide reports of care and/or tests that they performed in response to a written request from the patient or authorized representative.<sup>354</sup>

With a written request from a client or authorized representative, social workers must provide a copy or summary of the client record to “[a]nother licensed health care professional, hospital, nursing home or similar licensed institution which is providing or has been asked to provide treatment to the client.”<sup>355</sup> Dentists who cannot or choose not to rely on the treatment exception discussed above also will need a written request from a patient or the patient’s authorized representative to provide a copy of the patient record “to . . . a dentist of the patient’s choosing.”<sup>356</sup> Chiropractors have a similar provision regarding release to “another designated health care provider.”<sup>357</sup> These regulations do not provide additional guidance regarding the contents of the required writing.

BME Regulated Entities that cannot or choose not to rely on the treatment exception discussed above must satisfy three requirements to disclose confidential records to a specified individual or entity, such as a health care professional: “1. Secure and maintain a current written authorization, bearing the signature of the patient or an authorized representative; 2. Assure that the scope of the release is consistent with the request; and 3. Forward the records to the attention of the specific individual identified or mark the material ‘Confidential.’”<sup>358</sup>

Similar language exists in the massage and bodywork therapist<sup>359</sup> and physical therapist<sup>360</sup> regulations, with the exception that these regulations have an “and” instead of an “or” before the requirement to “mark the material ‘Confidential.’”

Licensed clinical alcohol and drug counselors and certified alcohol and drug counselors must comply with Part 2’s written consent requirements, as discussed above.<sup>361</sup>

Health care professionals also must keep track of who is authorized to give consent. While authorized representatives of patients or clients often are empowered to waive confidentiality, this term does not have a uniform definition. The Board of Social Work Examiners, for example, adopts a fairly common definition of “authorized representative” that recognizes, among other examples not pertinent to this Report, “a person designated by the client or a court to exercise rights under this section,” such as the client’s attorney, as an authorized representative.<sup>362</sup> But the regulation states that the meaning of authorized representative is not limited to this definition,<sup>363</sup> making it unclear how health care professionals can know who might qualify as an authorized representative. In addition, the regulations

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<sup>354</sup> *Id.* § 13:44F-8.2(d)(1).

<sup>355</sup> *Id.* § 13:44G-12.4(b).

<sup>356</sup> *Id.* § 13:30-8.7(e)(1) (emphasis added).

<sup>357</sup> *Id.* § 13:44E-2.2(e)(1).

<sup>358</sup> *Id.* § 13:35-6.5(e); *see also id.* § 13:35-9.16(a)(1) (acupuncturists); *cf. id.* § 13:35-10.10(d) (even though athletic trainers are one of the BME Regulated Entities, their regulations include an “and” instead of an “or” before “mark the material ‘Confidential.’”).

<sup>359</sup> *See id.* § 13:37A-5.3(c).

<sup>360</sup> *See id.* § 13:39A-3.3(a), (d).

<sup>361</sup> *See* N.J.S.A. § 45:2D-11 (requiring compliance with 42 C.F.R. § 2.1 *et seq.*); N.J.A.C. § 13:34C-4.5(b). *See* Section II.A.2.b, *infra* (Part 2 consent requirement).

<sup>362</sup> N.J.A.C. § 13:44G-12.4(a).

<sup>363</sup> *See id.*

governing Marriage and Family Therapists,<sup>364</sup> Rehabilitation Counselors,<sup>365</sup> Professional Counselors, and Associate Counselors<sup>366</sup> refer only to waiver by the client or patient and do not refer to authorized representatives when discussing waiver of confidentiality.<sup>367</sup>

The rules also differ regarding when parents or legal representatives of minors are authorized representatives who may waive confidentiality for their children and when effective waiver requires the minor's agreement as well. The Dental Board deems the parent or guardian who has custody (whether sole or joint) to be an authorized representative of a minor patient.<sup>368</sup> The same is true for the BME, "except where the condition being treated relates to pregnancy, sexually transmitted disease or substance abuse."<sup>369</sup> When a client is 14 years or older but not yet the age of majority, however, the regulations for social workers,<sup>370</sup> psychologists,<sup>371</sup> and professional and associate counselors<sup>372</sup> require that authorizations be signed by the client *and* by the client's parent or legal guardian, unless otherwise ordered by a court.

In some instances, patient consent requires health care professionals to obtain a waiver from more than just the individual patient in question. When a marriage and family therapist,<sup>373</sup> rehabilitation counselor,<sup>374</sup> professional counselor, or associate counselor,<sup>375</sup> for example, is providing services to more than one person in a family, each family member who is at least 18 years of age (unless federal or State law requires persons under the age of 18 years to agree to the waiver as well) must agree to waive their right to confidentiality in order for the professional to disclose any information received from any family member. Social workers have a similar provision, although it requires agreement from anyone in the family who is at least 14 years old.<sup>376</sup> These provisions do not specify whether the family members must agree in writing to the waiver or just the client. The alcohol and drug counselor regulations are more exacting, requiring a signed release from all persons who are referred to in family counseling notes before the notes may be released to a third party.<sup>377</sup>

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<sup>364</sup> See *id.* § 13:34-8.3(a)(6).

<sup>365</sup> See *id.* § 13:34-27.5(a)(6).

<sup>366</sup> See *id.* § 13:34-18.5(a)(6).

<sup>367</sup> Although the regulations for Rehabilitation, Professional, and Associate Counselors reference authorized representatives in the context of accessing patient or client records, these references seem to be limited to patients/clients requesting and accessing a copy of their own records rather than waivers to share these records with third parties. See *id.* § 13:34-27.3(b) (rehabilitation counselors); *id.* § 13:34-18.3(b) (professional counselors and associate counselors).

<sup>368</sup> See *id.* § 13:30-8.7(e)(1).

<sup>369</sup> *Id.* § 13:35-6.5(a).

<sup>370</sup> See *id.* § 13:44G-12.4(a)(2).

<sup>371</sup> See *id.* § 13:42-8.6(a).

<sup>372</sup> See *id.* § 13:34-18.6(a).

<sup>373</sup> *Id.* § 13:34-8.3(a)(6).

<sup>374</sup> See *id.* § 13:34-27.5(a)(6).

<sup>375</sup> See *id.* § 13:34-18.5(a)(6).

<sup>376</sup> See N.J.S.A. § 45:15BB-13(e); N.J.A.C. § 13:44G-12.3(a)(7).

<sup>377</sup> See N.J.A.C. § 13:34C-4.5(e).

#### 4. Correctional Facilities

New Jersey Department of Corrections (DOC) records “relating to medical, psychiatric or psychological history, diagnosis, treatment or evaluation” or consisting “of any alcohol, drug or other substance abuse information, testing, assessment, evaluation, report, summary, history, recommendation or treatment, including any assessment instruments,” are confidential.<sup>378</sup> The Administrator or designee of any State correctional facility determines whether to provide inmate medical records to medical or mental health doctors outside of DOC.<sup>379</sup> Thus, the Administrator or designee determines whether a treatment exception to confidentiality exists beyond the facility. Adult county correctional facilities have a similar provision that looks for guidance to the County Attorney regarding whether and to what extent to disclose inmate medical records to medical professionals outside of the county jails.<sup>380</sup> The regulations governing municipal detention facilities similarly designate medical, psychiatric, psychological, and substance use disorder records as confidential and not subject to public access.<sup>381</sup> But they do not address disclosure of these records to health care providers external to the detention facilities.

#### 5. Sensitive Information

As discussed below, New Jersey law also provides protections to certain types of health information that are considered particularly sensitive and thus in need of focused protection. These requirements apply to the categories of information regardless if they are held by individual practitioners or facilities.<sup>382</sup>

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<sup>378</sup> *Id.* § 10A:22-2.3(a)(3)-(4); *see also id.* §§ 10A:16-2.18; 10A:16-4.4.

<sup>379</sup> *See id.* § 10A:22-2.3(c)(5). Upon discharge, inmates may request a copy of their full medical record, disclosure of which is to be in compliance with the BME’s confidentiality requirements discussed above. *See id.* § 10A:22-2.8(c).

<sup>380</sup> *See id.* §§ 10A:31-6.8(c)(5); 10A:31-6.10(a)(3)-(4). The regulations do not provide a process for an inmate to request a copy of his/her complete medical record upon discharge. *See also id.* § 10A:71-2.2(a)(1)-(2), (b), (d).

<sup>381</sup> *See id.* § 10A:34-1.6(a)(3)-(4).

<sup>382</sup> It is notable that the National Committee on Vital and Health Statistics in 2010 suggested additional categories of information that HHS should recognize as sensitive, including mental health information (such as psychiatric diagnoses, descriptions by patients of traumatic events, descriptions or analyses of reports by the patients of emotional, perceptual, behavioral, or cognitive states; but not related critical health information, such as medication lists, allergies and non-allergic drug reactions, dangerous behavior within medical settings, information from medical notes, tests, procedures, imaging or laboratory, studies performed in a mental health facility that is not related to the mental health treatment but that would otherwise be considered medical information, such as cardiac studies to diagnose reported chest pain); sexuality and reproductive health information (such as sexual activity, sexual orientation, gender dysphoria and sexual reassignment, abortion, miscarriage, or past pregnancy, infertility and use of assisted reproduction technologies, sexual dysfunction, the fact of having adopted children. *See Nov. 10, 2010 Letter from Justine M. Carr, M.D., Chairperson, National Committee on Vital and Health Statistics, to The Honorable Kathleen Sebelius, Secretary, Dep’t of Health & Human Servs., Re: Recommendations Regarding Sensitive Health Information, available at <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/05/101110lt.pdf>.*

### a. HIV/AIDS Records

HIV/AIDS records are singled out for confidentiality protection by New Jersey’s AIDS Assistance Act (AAA).<sup>383</sup> The statutory protection is broad: records maintained by a number of entities, including health care providers; health care facilities; laboratories; an organization pursuant to a contract with, grant from, or regulation by the [DOH] in connection with this statute; and *any other* institution or person, that contain “identifying information about a person who has or is suspected of having AIDS or HIV infection are confidential and shall be disclosed only for the purposes authorized by” the AAA.<sup>384</sup> The statute defines identifying information as “the name, address, Social Security number, or similar information by which the identity of a person who has or is suspected of having AIDS or HIV infection may be determined with reasonable accuracy either directly or by reference to other publicly available information.”<sup>385</sup>

Generally, the content of a record that is subject to the AAA may be disclosed with the prior written informed consent of the person who is the subject of the record.<sup>386</sup> The AAA defines informed consent to be what is required by Section 2.31 of the federal Part 2 regulations, as discussed in Section II.A.2.b above.<sup>387</sup> It further specifies that when consent is required for disclosure of a record of a minor, defined as someone under 12 years of age,<sup>388</sup> “who has or is suspected of having AIDS or HIV infection, consent shall be obtained from the parent, guardian, or other individual authorized under State law to act in the minor’s behalf.”<sup>389</sup>

The AAA permits limited exceptions to the written informed consent requirements. The exception most pertinent to treatment providers is a version of a treatment exception permitting health care providers and facilities to disclose HIV/AIDS records without prior informed written consent to “qualified personnel involved in medical education or in the diagnosis and treatment of the person who is the subject of the record. Disclosure is limited to only personnel directly involved in medical education or in the diagnosis and treatment of the person.”<sup>390</sup> The AAA defines “diagnosis and treatment” as “services or activities carried out for the purpose of, or as an incident to, diagnosis, prevention and treatment of AIDS

<sup>383</sup> See N.J.S.A. § 26:5C-7 *et seq.* See also *Estate of Behringer v. Medical Ctr. at Princeton*, 249 N.J. Super. 597, 606 (Law. Div. 1991) (holding that a hospital breached its duty of confidentiality to the plaintiff “when it failed to take reasonable precautions regarding plaintiff’s medical records to prevent plaintiff’s AIDS diagnosis from becoming a matter of public knowledge”).

<sup>384</sup> N.J.S.A. § 26:5C-7.

<sup>385</sup> *Id.* § 26:5C-5.

<sup>386</sup> See *id.* § 26:5C-8(a).

<sup>387</sup> See *id.* § 26:5C-5 (citing 42 C.F.R. § 2.31); Section II.A.2.b, *supra*.

<sup>388</sup> See N.J.S.A. § 26:5C-5.

<sup>389</sup> *Id.* § 26:5C-13. *But cf. id.* § 9:17A-4(a)(1) (establishing that a minor “who is at least 13 years of age and is or believes that he or she may be infected with the human immunodeficiency virus or have acquired immune deficiency syndrome” may consent to treatment as if s/he had attained the age of majority).

<sup>390</sup> *Id.* § 26:5C-8(b)(3). The statute also permits records to be disclosed without written informed consent “[i]n all other instances *authorized* by State or federal law.” *Id.* § 26:5C-8(b)(6) (emphasis added). It does not define, however, what it means for disclosure to be “authorized.” HIPAA *permits* disclosures of PHI for a number of purposes, including treatment and healthcare operations. See 45 C.F.R. § 164.502(a)(1)(ii). It would be helpful for the DOH to clarify whether “authorized” reaches HIPAA’s permitted disclosures. Given the existence of the specific exception for treatment in N.J.S.A. § 26:5C-8(b)(3), it is unnecessary to resolve the meaning of “authorized” for purposes of this Report.

and HIV infection and includes interviewing and counseling.”<sup>391</sup> The terms, “qualified personnel” and “directly involved,” however, are not defined in the statute. It thus is not clear, for example, whether health care personnel, such as nurses or care managers, are “qualified personnel” who may qualify for the exception. In this regard, it is interesting to note that a DOH regulation permits a “clinical practitioner or birth birthing [*sic*] facility” to provide a woman’s positive HIV test result to the clinical practitioner who is caring for the woman’s infant “[f]or purposes of disease prevention and control.”<sup>392</sup> Clinical practitioner, for purposes of this regulation, includes “a physician currently licensed to practice in New Jersey; an advanced practice nurse currently certified under the New Jersey Advanced Practice Nurse Certification Act; or a physician assistant licensed under the Physician Assistant Licensing Act, acting within the rules governing those professions.”<sup>393</sup>

Similar to Part 2, the AAA contains a limitation on redisclosure such that any record disclosed pursuant to the AAA may not be redisclosed by the recipient except as provided by the statute.<sup>394</sup> Individuals aggrieved by a violation of this act may bring a civil action seeking “appropriate relief, including actual damages, equitable relief and reasonable attorney’s fees and court costs. Punitive damages may be awarded when the violation evidences wantonly reckless or intentionally malicious conduct by the person or institution who committed the violation.”<sup>395</sup>

#### b. Venereal Diseases

New Jersey law provides protection for the confidentiality of records regarding venereal diseases, which include syphilis, gonorrhea, chancroid, lymphogranuloma venereum, and granuloma inguinale.<sup>396</sup> The statute broadly prohibits any person from disclosing “the name or address or the identity of any person known or suspected to have a venereal disease,” with limited exceptions.<sup>397</sup>

One of the exceptions permits disclosure “to the person’s physician.”<sup>398</sup> The statute also permits the person’s physician to disclose “the name, address or identity of such person when and only when the physician . . . shall deem such disclosure necessary in order to protect the health or welfare of the person or of his family or of the public.”<sup>399</sup> It further permits a licensed physician to inspect “[d]ocuments, records or reports which contain or would reveal the name, address or identity of a person known or suspected to have a venereal disease or treated for such a disease” when the records custodian deems “the inspection necessary in order to protect the health or welfare of the person or of his family or of the public.”<sup>400</sup>

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<sup>391</sup> N.J.S.A. § 26:5C-5.

<sup>392</sup> N.J.A.C. § 8:61-4.7(b)(1). The regulations define “birthing facility” as “a hospital or ambulatory care facility birth center licensed by the Department of Health and Senior Services [*sic*] that provide[s] birthing and newborn care services.” *Id.* § 8:61-4.3.

<sup>393</sup> *Id.* § 8:8-1.2.

<sup>394</sup> N.J.S.A. § 26:5C-11.

<sup>395</sup> *Id.* § 26:5C-14.

<sup>396</sup> *See id.* § 26:4-27.

<sup>397</sup> *See id.* § 26:4-41.

<sup>398</sup> *See id.*

<sup>399</sup> *See id.*

<sup>400</sup> *See id.*

The intended meaning and scope of “necessary to protect the health of welfare” is not clear from the statute. Helen Oscislowski, Esq. has raised concerns that this statute may be preempted by HIPAA to the extent it permits disclosures of PHI without authorization for the treatment of an individual’s family members, whereas HIPAA’s treatment exception is limited to the specific individual whose PHI is disclosed.<sup>401</sup> The venereal disease statute also does not address whether patients may waive their right to confidentiality and, if so, the form that waiver must take.

### c. Genetic Information

The New Jersey Genetic Privacy Act (GPA) protects the confidentiality of genetic information as “personal information that should not be collected, retained or disclosed without the individual’s authorization.”<sup>402</sup> No matter how a person – which is defined broadly to include one or more individuals, partnerships, associations, organizations, corporations, legal representatives, among others<sup>403</sup> – comes to be in possession of genetic information, s/he/it is prohibited from disclosing “the identity of an individual upon whom a genetic test has been performed or to disclose genetic information about the individual in a manner that permits identification of the individual.”<sup>404</sup>

The GPA does not include a treatment exception that permits disclosure without patient consent for the purposes of treatment. But there are a number of exceptions to its disclosure prohibitions, including an exception when a tested individual or his/her representative signs a written consent that “complies with the requirements of the Department of Health . . . .”<sup>405</sup> It does not appear, however, that DOH has promulgated regulations to implement this statute. The disclosure provisions include a redisclosure limitation, which applies the statutory protections “to any subsequent disclosure by any person after another person has disclosed genetic information or the identity of an individual upon whom a genetic test has been performed.”<sup>406</sup> But the statute does not require that recipients of protected genetic information receive a written notice of the redisclosure limitations. A person who requires or requests genetic testing or receives records, results, or findings of genetic testing, however, must provide the person tested with a notice that provides, among other things, that the information may not be

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<sup>401</sup> See Attorneys at Oscislowski LLC, Snapshot of New Jersey Consent Standards (Sept. 20, 2012) (on file with author).

<sup>402</sup> See N.J.S.A. § 10:5-44(b). See also *id.* § 10:5-5 (defining genetic information). The GPA applies to the collection, retention, and disclosure of genetic information. This Report focuses on the disclosure of protected information among treatment professionals, and thus the text focuses on the GPA’s disclosure restrictions. But it is possible treatment providers will seek to exchange information with laboratories, for example, that collect and retain genetic information. As a general matter, informed consent from an individual or an individual’s representative is needed to obtain genetic information from an individual or to obtain an individual’s DNA sample, see *id.* § 10:5-45, or to retain that information, see *id.* § 10:5-46. The federal Genetic Information Nondiscrimination Act of 2008 focuses on restricting the use of genetic information by employers and limits disclosure to insurers; it does not limit the exchange of genetic information among health care providers for treatment purposes. See 42 U.S.C. § 2000ff-5.

<sup>403</sup> See N.J.S.A. § 10:5-5.

<sup>404</sup> *Id.* § 10:5-47(a).

<sup>405</sup> See *id.* § 10:5-47(a)(5).

<sup>406</sup> See *id.* § 10:5-47(b).



disclosed without written consent unless another exception in the statute applies.<sup>407</sup> The GPA establishes criminal and civil penalties for violations.<sup>408</sup>

#### d. Treatment of Intoxicated Persons

The records of the treatment of intoxicated persons also are afforded special treatment under New Jersey law – at least on paper. Records of the treatment provided at “any public, private place, or portion thereof providing services especially designed for the treatment of intoxicated persons or alcoholics; including, but not limited to intoxication treatment centers, inpatient treatment facilities, outpatient facilities, and residential aftercare facilities,”<sup>409</sup> “shall be confidential and shall be made available only upon proper judicial order, whether in connection with pending judicial proceedings or otherwise.”<sup>410</sup> The statute does not seem to include a treatment exception or any provision permitting patients to authorize the release of their records. If in fact a court order is required to obtain these records, this would make it much more difficult for providers to exchange these records in an integrated care setting. When the Center asked about this statute in interviews for this Report, individuals repeatedly expressed the belief that patients always may consent to the release of their records and that a court order is not necessary, despite the statute’s language.<sup>411</sup> As discussed above, New Jersey law permits disclosure with consent for the records of residential and outpatient substance use disorder treatment by requiring compliance with Part 2.<sup>412</sup> It would be helpful for the State to clarify the scope and intent of the intoxicated persons treatment statute.

### III. Challenges to Health Information Sharing among Treatment Providers

Through both legal research and qualitative interviews, the Center identified three primary barriers to information sharing among treatment providers in New Jersey. As discussed below, there is considerable misinformation in the provider community regarding what the law prohibits and permits. Second, as preceding Section II and the corresponding tables in the Appendix bring home, although federal and New Jersey statutes and regulations generally do not flatly prohibit the exchange of PHI among treatment providers, the laws are complex and in some respects unclear and incomplete. Third, it is operationally and technologically difficult to comply with the myriad legal requirements. Both small and large providers agreed that these challenges, independently and in tandem, serve as barriers to integrated care.

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<sup>407</sup> See *id.* § 10:5-48(a).

<sup>408</sup> See *id.* § 10:5-49.

<sup>409</sup> *Id.* § 26:2B-8.

<sup>410</sup> *Id.* § 26:2B-20(a).

<sup>411</sup> But see Dechert, *supra* note 191, at 45 (concluding that this statute is more stringent than HIPAA because it does not permit disclosures for treatment, payment, or healthcare operations and recommending that covered facilities require a proper judicial order before disclosing patient records).

<sup>412</sup> See Section II.B.1.c, *supra*.



## A. Misinformation and Fear

One of the most significant and pervasive barriers to health information sharing is misinformation. Often, health care providers blame HIPAA for their refusal to exchange records when HIPAA generally is not a barrier to the exchange of PHI among providers for treatment purposes. Some know about Part 2, but few know its fine details. And even fewer are well-versed in the matrix of State-specific laws that govern in New Jersey. There simply is too little knowledge of what the law requires.

A common theme in the Center’s interviews was that providers are reluctant to share patient health information because they are fearful of violating federal or State privacy laws. Misinformation, coupled with fear of liability for violating federal or State legal requirements, has led to overly cautious behavior.<sup>413</sup> This is particularly true when it comes to substance use disorder records because of the special protections they receive under the law. Rather than simply affording these records the protections they are due, such as securing written consent for their disclosure when required, health care providers not infrequently err on the side of caution and withhold records that they legally may share with other treatment providers.

The danger of misinformation and fear affects small and large providers alike. Repeatedly, the Center spoke with or learned of integration innovators who were implementing shared medical records – but not in both directions, at least not yet. Some of this is due to legal and operational challenges, as discussed below. But some explained that they were “starting small and safe,” and “steering clear” of sensitive information that gets heightened protection. This could result in information that is important for coordinated care being withheld from treatment providers.

Misinformation about what the law requires also can lead to violations of individuals’ privacy rights. For example, the Center heard reports that some State agencies may be using outdated global release forms that do not comply with HIPAA or Part 2 to seek disclosure of patient-specific confidential behavioral health treatment records.

The Center hopes this Report will help dispel myths and fears by clarifying what the law requires and permits with respect to the exchange of patient health information among health care providers.

## B. Legal Complexity, Ambiguity, and Gaps

In addition to misinformation and fear, there remain a number of legal complexities, ambiguities, and gaps that hamper information sharing in integrated settings.

For one, the various federal and State laws create a complex web for health care providers to navigate. It can be difficult for providers to keep track of the different rules that apply depending on, for

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<sup>413</sup> See, e.g., Robert Belfort, William Bernstein, & Susan Ingargiola, Manatt, Phelps & Phillips, *Integrating Physical and Behavioral Health Strategies for Overcoming Legal Barriers to Health Information Exchange*, at 4 (Jan. 2014), (“Provider misconceptions about the restrictions imposed under state and federal laws may stifle data exchange that is legally permissible.”), available at [https://www.manatt.com/uploadedFiles/Content/4\\_News\\_and\\_Events/Newsletters/IntegratingPhysicalandBehavioralHealth.pdf](https://www.manatt.com/uploadedFiles/Content/4_News_and_Events/Newsletters/IntegratingPhysicalandBehavioralHealth.pdf).

example, who the custodian is, how the custodian is licensed, who may receive protected information and for what purposes, the subject matter of the records, and the nature of the relationship between the custodian and the State.

The lack of standardization of legal requirements can “fuel[] uncertainty and mistrust.”<sup>414</sup> For example, as reflected in the tables in Appendices D-F, the varying standards for what constitutes valid consent, authorization, or waiver of confidentiality, where it is required, can make compliance seem daunting. Providers may reject another provider’s consent form, for example, fearing that it is deficient in some respect. This can slow down, if not preclude, information exchange because the other provider may face difficulty re-securing consent from the patient on the new form.

The chart in Appendix C further illustrates this point. It lists nearly twenty different formulations found in the surveyed laws to describe the entities eligible to receive patient health data pursuant to treatment exceptions. In addition to the variety, there are a number of terms left unclear and undefined in the various laws, which further complicates compliance.

The limited treatment exception under New Jersey law for DHS mental health facilities, for example, only permits disclosure to personal physicians.<sup>415</sup> The regulation does not define this term, however, leaving it unclear whether it applies only to primary care physicians or to all physicians who are treating an individual. Similarly, it is not clear if it applies only to individual physicians or also to clinics such as FQHCs that provide primary services to significant populations in New Jersey. On its face, this term does not seem to apply to physician-extenders, like nurse practitioners, advanced practice nurses, or physician assistants, or to social workers, all of whom increasingly play vital roles in coordinated care models. The New Jersey statute protecting the confidentiality of venereal disease records includes similar undefined language.<sup>416</sup> In a similar vein, New Jersey’s AIDS Assistance Act does not define the scope of the term, “qualified personnel.”<sup>417</sup>

Relatedly, an exhibit to the 2010 Report of the State’s Privacy and Security Committee requested clarification whether New Jersey’s HIV/AIDS confidentiality statute<sup>418</sup> or the State law governing confidentiality of venereal disease records<sup>419</sup> requires prior informed consent to disclose to other treating professionals certain HIV/AIDS or venereal disease pharmaceutical drugs recorded in a patient’s medical record to other treating professionals.<sup>420</sup> This document similarly raised concerns that there is a gap in New Jersey law that needs to be filled to clarify that HIOs are permitted to send and receive laboratory orders and test results.<sup>421</sup>

Beyond gaps, there are inconsistencies and tensions between these varying bodies of law – and sometimes within the same regulatory scheme – that need to be resolved. As noted in Section II.B, for example, there also are a few outlier provisions that do not include patient consent or treatment

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<sup>414</sup> *Id.* at 4.

<sup>415</sup> See N.J.A.C. § 10:37-6.79(f).

<sup>416</sup> See N.J.S.A. § 26:4-41.

<sup>417</sup> See *id.* § 26:5C-8(b)(1).

<sup>418</sup> See *id.* § 26:5C-5 *et seq.*

<sup>419</sup> See *id.* § 26:4-41.

<sup>420</sup> See Oscislowski & Nowik, Appendix D, *supra* note 315.

<sup>421</sup> See *id.*

exception language. In addition, there are provisions that seem to be inconsistent with corollary provisions, such as the ACF, BME regulated entities, residential substance use disorder, and the DOH and DHS adult day services regulations. Some provisions also may be preempted.

Another area of confusion that several interviewees raised surrounds a coordinated care entity's ability to exchange information for population health purposes. The definitions for both the "treatment" and "health care operations" exceptions in HIPAA include elements of the management of health care and care coordination. "Treatment" is defined as "the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another."<sup>422</sup> Health care operations include "[c]onducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines . . . ; patient safety activities . . . ; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment."<sup>423</sup> The treatment exception does not require an existing treatment relationship but the healthcare operations exception does.<sup>424</sup> Providers with whom the Center spoke suggested that population health efforts constitute treatment, even if the initial exchange of information does not itself involve treatment and instead may lead to treatment through targeted case management. As a result, they contend, there is no requirement for an existing treatment relationship. It is not clear, however, that these activities fall within the treatment exception.<sup>425</sup> It also is not clear how the exchange of targeted population health data fits with State law. Notably, New Jersey does not have a single definition of treatment or an operations exception. This lack of clarity is serving as a barrier to integration efforts.

Tracking who is authorized to consent to the disclosure of patient health information also can be challenging and complicated. In many instances, parents or guardians may consent to the release of a minor's health record. In certain instances under New Jersey law, however, as highlighted in the table in Appendix F, unemancipated minors have the right to consent to disclosure. For example, a patient who is at least 12 years old must provide informed written consent to disclose records containing HIV/AIDS

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<sup>422</sup> 45 C.F.R. § 164.501.

<sup>423</sup> *Id.* § 164.501(2)(1).

<sup>424</sup> *See id.* § 164.506(c)(4).

<sup>425</sup> *See, e.g.*, U.S. DEP'T OF HEALTH & HUMAN SERVCES., CENTERS FOR MEDICARE & MEDICAID SERVS., Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Saving, 76 Fed. Reg. 19,528, 19,558 (Apr. 7, 2011) ("ACOs are tasked with working with ACO participants and ACO providers/suppliers to evaluate their performance, conduct quality assessment and improvement activities, and conduct population-based activities relating to improved health for their assigned beneficiary population. When done by or on behalf of a covered entity, these are covered functions and activities that would qualify as "health care operations" under the first and second paragraphs of the definition of health care operations at 45 CFR 164.501."); Tom Liu, The Advisory Board Co., Care Transformation Center Blog, "HOW TO: Share data without breaking HIPAA" (1:37 PM May 6, 2014), <https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2014/05/how-to-share-compliant-data> (last visited Mar. 30, 2016) ("In most cases, care management functions will fall under "treatment" if they apply to care for individuals or "health care operations" if they are done at a population level.). *See generally* Part 2 Proposed Rule, *supra* note 179, 81 Fed. Reg. at 6,996 ("SAMHSA proposes to revise the definition of QSO to include population health management in the list of examples of services a QSO may provide.").

information.<sup>426</sup> A minor who is fourteen years or older and has requested admission and been voluntarily admitted to a psychiatric facility, special psychiatric hospital, or children's crisis intervention service may authorize disclosure of confidential records in the same manner as an adult.<sup>427</sup> If that minor objects to disclosure, his/her parent's consent is null and void.<sup>428</sup> A minor of any age must consent to the disclosure of Part 2 records.<sup>429</sup> Although there are versions of treatment exceptions in some of these provisions that may alleviate a provider's need to obtain consent or authorization to disclose PHI, the qualified, limited, and varied nature of these exceptions further complicates the analysis for health care providers.<sup>430</sup>

The New Jersey confidentiality requirements also have been criticized as outdated and inconsistent with modern practice. As discussed above, hospitals and several other health care facilities are only permitted to release medical records to other facilities to which a patient is transferred. It is not clear what the original rationale was for adopting such a narrow treatment exception. But given the increasing role of hospitalists to provide care in facilities and then have follow-up care provided in the community, the rules are out of date. Continuity of care demands that hospitalists provide records to treating providers who are outside of facilities.

As a general matter, several New Jersey confidentiality provisions seem to assume the use of paper records and have not been updated to reflect the use of electronic health records. For example, it is not clear if requirements in many of the professional licensing regulations to mark disclosed records as confidential apply to electronic records or only paper.<sup>431</sup>

Because "multiprovider collaborations tend to devolve to the lowest common denominator, where the most restrictive interpretation of the law becomes the standard for sharing, or not sharing, data,"<sup>432</sup> complexity and confusion erect barriers to information exchange.

### C. Operational and Technological Challenges

Adding to the informational and legal issues are a host of operational and technological challenges that further impede the exchange of patient health information among treatment providers.

It is difficult at an operational level for providers to ensure compliance with the various requirements imposed by federal and State confidentiality laws. As the legal overview in Section II reveals, and as reflected in the summary tables in the Appendix, depending on what information is being shared, by whom, to whom, and for what purposes, different legal requirements apply, including: specific and

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<sup>426</sup> See N.J.S.A. §§ 26:5C-5, 26:5C-8(a). Note, however, that a patient must be at least 13 to consent to HIV/AIDS treatment in New Jersey. See N.J.S.A. § 9:17A-4(a)(1).

<sup>427</sup> See N.J.A.C. § 10:37-6.79(a)(1)(ii)(1).

<sup>428</sup> See *id.* § 10:37-6.79(a)(1)(ii)(2).

<sup>429</sup> See 42 C.F.R. § 2.14(a), (b); N.J.S.A. § 9:17A-4(b).

<sup>430</sup> See generally Attorneys at Oscislawski LLC, *White Paper: Minors and Emancipated Medical Treatment in New Jersey*, at 1 (Revised July 2015 v. 3) (on file with author).

<sup>431</sup> As noted above, the DDD confidentiality rules avoid this ambiguity by specifically providing that electronic client records are subject to the same confidentiality requirements as paper records. See *id.* § 10:41-3.4(a); see also *id.* § 10:41-1.3. There may be reasons to treat electronic records differently than paper, in some cases. The key is to ensure the governing law is clear.

<sup>432</sup> Belfort *et al.*, *supra* note 413, at 4.

varying consent requirements; written redisclosure notices; minimum necessary requirements; and specific information to document disclosures of Part 2 information in medical emergencies.

Providers also must be able to track consents, including their expirations and revocations, ensure that disclosures are of the type and extent and for the purpose(s) authorized by consumers; and verify that an authorized person executed the authorization. Part 2 programs need to update patient consents each time a new provider joins a practice or becomes an affiliated member of a HIO, which changes can be frequent. Ensuring compliance with New Jersey's laws on whether minors may consent to disclosure rather than or in addition to parents or guardians adds an additional level of complexity to consent tracking because custodians must keep track of whose consent is needed for different parts of patient records and at different points in time, as children reach trigger years.

Some of these issues are highly sophisticated, including assessing whether a disclosure qualifies for an exception or triggers a consent or authorization requirement. Others are more administrative or ministerial, like documenting and following up on revocations. Not all providers, whether small or large health systems, have the administrative or technological capacity to comply with these requirements. In all settings, compliance with these provisions adds costs.

Several of the individuals the Center interviewed explained that legacy systems cannot account for the consent requirements and the level of granularity that federal and State law demand. Unfortunately, many behavioral health providers were not eligible to receive meaningful use incentive grants that could have funded technological development.<sup>433</sup>

Certain requirements are challenging even with the most sophisticated and interoperable of systems. Sensitive data pose a particular challenge. Unlike protections for entire records from certain providers or facilities, which are easy to identify and can be kept separate with relative ease, sensitive data can be embedded in general medical records that otherwise may be disclosed, such as within discharge summaries or narrative treatment notes. Providers and HIE technologists reported that it is difficult to segregate unstructured data like treatment narratives. If providers use catch-all consents, patients have an all-or-nothing choice to either authorize or deny disclosure of the entire record, which can lead to too much or too little information being shared. To avoid the all-or-nothing approach, providers using paper records need to redact specific portions of records, which is time-consuming.

The technological capacity to tag and segregate sensitive data elements – known as data segmentation<sup>434</sup> -- is improving, although it is not universally adopted, and it can be cost-prohibitive.

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<sup>433</sup> See CENTERS FOR MEDICARE & MEDICAID SERVICES, EHR Incentive Programs, Eligibility, <https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/eligibility.html> (last visited Mar. 30, 2016); see also NueMD, Meaningful Use Info Ctr., Meaningful Use: Qualify for EHR Incentive Programs, <http://www.nuemd.com/white-papers/qualify-ehr-incentive-programs> (last visited Mar. 30, 2016) (“Both the Medicare and Medicaid EHR Incentive Programs currently exclude clinical psychologists, clinical social workers, physical therapists, occupational therapists, dietitians, diabetes nurse educators and “hospital-based” physicians. The Centers for Medicare & Medicaid Services (CMS) defines hospital-based physicians as those who provide 90 percent or more of their services in a hospital inpatient or outpatient setting.”).

<sup>434</sup> See HealthIT.gov, Data Segmentation Overview (“‘Data segmentation’ is the term often used to describe the electronic labeling or tagging of a patient’s health information in a way that allows patients or providers to electronically share parts, but not all, of a patient record. Data segmentation helps providers comply with specific state and federal laws, helping to keep the ‘sensitive’ portions of a patient’s electronic record private. For example, mental health counseling, Human Immunodeficiency Virus (HIV) status, substance abuse treatment, and other types

Some also worry that it diminishes the value of disclosed health records to exclude pieces of care. Health care providers may be reluctant to rely on partial records.

There also are interoperability concerns when providers have adopted different electronic systems that have varying capacities. Greg Allen, Policy Director of the Office of Health Insurance Programs in the New York State Department of Health, identified the lack of “[c]onsistent [d]ata standards and data governance . . . across providers in the system” as a challenge to sharing data across systems.<sup>435</sup>

Adding to these operational and technological challenges is the fact that many health care providers have reported high staff turnover rates. High staff turnover further complicates a practice’s ability to develop expertise to handle these challenges.

## IV. Opportunities to Support Provider Exchange of Treatment Information for Integration

Integration of behavioral and physical health care can improve the lives of patients and help to rationalize a fragmented health care delivery system.<sup>436</sup> Sharing of patient records by coordinating providers is central to integration efforts. Real and perceived legal barriers to the sharing of patient information inhibit integrative efforts. Remedies to many of those barriers are within the authority of the State. Four categories of remedies are described below: statutory and regulatory harmonization; provision of legal guidance; support for technical improvements; and public education.<sup>437</sup>

### A. Harmonization of Legal Requirements

The Center’s review suggests that the State should consider statutory and regulatory reform to simplify, normalize, and make more transparent the State’s confidentiality laws. It would be helpful to harmonize, where possible, New Jersey requirements, both with other New Jersey provisions and with federal requirements, which would simplify the task of compliance for health care providers. For example, where consent is required, adoption of uniform elements and definitions of key terms, where appropriate, would facilitate standardized consent forms and minimize confusion and unnecessary technicalities. Consideration also should be given to enacting a general exception or exceptions to authorization requirements for treatment purposes, so that members of coordinated care teams directly providing services to a patient may share information that is directly relevant.

Throughout this process, the State should consider taking a broad look at its statutory and regulatory scheme to assess the benefits and burdens of the various statutes and regulations that vary

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of sensitive topics may need to be treated differently than other parts of a patient’s record depending on the applicable laws.”), <https://www.healthit.gov/providers-professionals/data-segmentation-overview> (last visited Mar. 30, 2016).

<sup>435</sup> See Greg Allen, Policy Director of the Office of Health Insurance Programs in the New York State Department of Health, *Sharing Health Information Across Systems* (slideshow from National Academy for State Health Policy webinar on Aug. 6, 2015) (on file with author).

<sup>436</sup> See generally JACOBI ET AL., *supra* note 1.

<sup>437</sup> Cf. Belfort *et al.*, *supra* note 413, at 2.



from privacy standards like HIPAA that apply generally to patient health information. In this regard, it is interesting to note that DHS's residential and outpatient substance use disorder regulations incorporate the HIPAA and Part 2 requirements, with minor adjustments. The State may have good reason to maintain additional variations that are more protective of confidentiality than federal law, but any variations in legal standards and definitions should be intentional rather than artifactual. One interviewee opined that several of New Jersey's confidentiality provisions predate passage of and subsequent amendments to HIPAA and Part 2, and they have not been systematically reviewed.

Given the 2013 Omnibus amendments to HIPAA<sup>438</sup> and the pending proposed rule changes to Part 2, this is a particularly opportune time for New Jersey to undertake a comprehensive revision of its confidentiality requirements.

## B. Legal Guidance and Standards

In addition to harmonizing State statutory and regulatory provisions, it would be helpful for New Jersey to issue guidance to clarify agency interpretation of State law and to articulate State policy with respect to health information exchange in service of integrated care.<sup>439</sup> For example, in addition to clarifying the scope of particular provisions and providing definitions of undefined terms, guidance also could address how innovative care organizations fit in to the existing statutory and regulatory framework. Agency guidance offers an opportunity to clarify misinformation and assuage provider fear. As Robert Belfort, William Bernstein, and Susan Ingargiola have observed, the SAMHSA FAQs discussed above are a useful model:

While SAMHSA may have offered informal advice to Part 2 providers on some of these issues previously, the issuance of a formal, written guidance document to the public gave far greater comfort to the industry and allowed collaborating clinicians to operate under a universally agreed upon set of principles. State agencies may be in a similar position to correct misconceptions or eliminate ambiguities regarding the meaning of state mental health or other privacy laws, clearing the way for providers to exchange data without fear of regulatory enforcement.<sup>440</sup>

Given the number of State bodies responsible for administering the various confidentiality regulations and the desire to avoid inconsistency, a joint statement would best serve the goals of harmonization and clarity.

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<sup>438</sup> See U.S. DEP'T OF HEALTH & HUMAN SERVCs., Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules; Final Rule (Jan. 25, 2013), *available at* [https://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf?utm\\_source=buffer&utm\\_campaign=Buffer&utm\\_content=buffer5bc4f&utm\\_medium=twitter](https://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf?utm_source=buffer&utm_campaign=Buffer&utm_content=buffer5bc4f&utm_medium=twitter).

<sup>439</sup> Health care providers also would benefit from clear guidance from the federal government regarding federal requirements. Questions about population health activities, in particular, repeatedly surfaced during the Center's interviews and implicate the scope of HIPAA's treatment and operations exceptions.

<sup>440</sup> Belfort *et al.*, *supra* note 413, at 7.

Publication of model forms also would facilitate adoption of information sharing by simplifying the process, minimizing the burden on providers, and promoting mutual trust.<sup>441</sup> There are model consent forms and BAAs/QSOAs available that address both HIPAA and Part 2 requirements.<sup>442</sup> It would be helpful for New Jersey to develop comparable templates that would harmonize federal and State requirements in a similar vein. The Statewide Health Information Network of New York developed a standard consent form that complies with HIPAA, Part 2, and state laws concerning mental health, substance use disorder, and HIV records and that has been approved by state regulatory agencies.<sup>443</sup> The State also could consider working with health care providers to develop additional standards that would facilitate health information exchange.

### C. Technical Guidance and Standards

Health care providers also would benefit from guidance regarding the navigation of the technological options that are available for consent management, data segmentation, interoperability, and the like. The investment in time and money is substantial, and even champions of integration are hesitant to invest without assurances that systems comply with existing legal requirements. Establishing standards will lower transaction costs and moderate risk for providers.

SAMHSA has been involved with and has funded a number of projects supporting health information exchange among behavioral and physical health care providers. In 2012, for example, it funded a one-year project with five HIEs to develop the infrastructure needed to support the exchange of sensitive health information.<sup>444</sup> It also worked with the Office for the National Coordinator for Health Information Technology (ONC)'s Standards and Interoperability (S&I) Framework on the Data Segmentation for Privacy (DS4P) initiative, which "facilitated the development of standards to improve the interoperability of EHRs containing sensitive information that must be protected to a greater degree than other health information due to 42 CFR part 2 and similar state laws."<sup>445</sup> The DS4P initiative involved 344 volunteers from federal and state agencies, behavioral health providers, HIEs, EHR and other IT companies, patient advocacy groups, and professional societies.<sup>446</sup> One of the goals of the S&I Framework is to develop open source technology for consent management and data segmentation.<sup>447</sup>

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<sup>441</sup> *Id.* at 8.

<sup>442</sup> See, e.g., Legal Action Center, Sample Forms – Confidentiality, <http://lac.org/resources/substance-use-resources/confidentiality-resources/sample-forms-confidentiality/> (last visited Mar. 30, 2016).

<sup>443</sup> See Belfort *et al.*, *supra* note 413, at 8.

<sup>444</sup> See Part 2 Proposed Rule, *supra* note 179, at 81 Fed. Reg. at 6,992; SAMHSA-HRSA Center for Integrated Health Solutions, The Current State of Sharing Behavioral Health Information in Health Information Exchanges, at 15 (Sept. 2014), available at [http://www.integration.samhsa.gov/operations-administration/HIE\\_paper\\_FINAL.pdf](http://www.integration.samhsa.gov/operations-administration/HIE_paper_FINAL.pdf).

<sup>445</sup> Part 2 Proposed Rule, *supra* note 179, at 81 Fed. Reg. at 6,992.

<sup>446</sup> *Id.*

<sup>447</sup> See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., Confidentiality, Substance Use Treatment, and Health Information Technology Webinar, at 29 (May 25, 2012), available at <http://lac.org/resources/substance-use-resources/confidentiality-resources/webinar-alcohol-drug-confidentiality-regulations-health-information-technology/>.



New Jersey should be involved in these and other federal and interstate projects designed to develop standards and open source technology. By engaging in interstate collaboratives, the State can contribute to the development of best practices and be in a position to promote them within the State.

#### D. Education

With harmonization, standardization, and guidance, it also will be essential to facilitate education of providers and consumers regarding the benefits of integration, what the law requires to permit the sharing of information among treatment providers, and what resources exist to support integration efforts. Education will address misinformation and fear head-on. Given staff turnover and the lack of resources in many health care provider offices to stay current, it would be helpful for there to be FAQs, webinars, or training modules that practices could use to train new staff and provide ongoing training. The Legal Action Center has developed a useful series of webinars that provide a comprehensive overview of federal law. Given the complexity of New Jersey law, it would be valuable to develop New Jersey-specific modules.

#### V. Conclusion

There is strong support for integrating primary and behavioral health care. Integration requires providers to exchange patient health information in service of coordinated, holistic care. New Jersey's complex web of confidentiality provisions often is cited as a barrier to integration. Through a combination of legal and regulatory harmonization, agency guidance, technical standardization, and training and outreach, New Jersey can dispel misperceptions, improve transparency, and advance the common mission of improved access to quality, coordinated behavioral and physical health care in the State.

## Appendix A

### **Individuals Interviewed or Consulted during Preparation of Report**

Karen Ali, New Jersey Hospital Association

Alexa Rae Agudo, New Jersey Innovation Institute

Kathy Bianco, Care Plus NJ, Inc.

Mary A. Ditri, New Jersey Hospital Association

Michael Fay, Care Plus NJ, Inc.

Vicki Fresolone, New Jersey Division of Mental Health & Addiction Services

Jillian Hudspeth, New Jersey Primary Care Association

Mark Humowiecki, Camden Coalition of Healthcare Providers

Dr. Norma Jean-Francois, New Jersey Innovation Institute

Joseph Masciandaro, Care Plus NJ, Inc.

William Maslak, Care Plus NJ, Inc.

Deborah Mitchell, Virtua

Juan Montanez, Health Management Associates

Krystyna H. Monticello, Attorneys at Oscislawski LLC

June Noto, New Jersey Association of Mental Health and Addiction Agencies, Inc.

Jesus Novoa, NJ-HITEC

John O'Brien, Centers for Medicare & Medicaid Services

William O'Byrne, NJ-HITEC

Helen Oscislawski, Attorneys at Oscislawski LLC

Jill T. Ojserkis, Cooper Levenson, P.A.

Gregory Paulson, Trenton Health Team

Harry Postel, Catholic Charities Diocese of Trenton

Mike Relli, Knight Consulting

Tracy Samuelson, SERV Behavioral Health System, Inc.

Dr. Terry Shlimbaum

Julia Staas, Virtua

Colleen Woods, CMH Executive Consulting

Van Zimmerman, Jersey Health Connect

## Appendix B

### **Table - Examples of Treatment Exceptions to Confidentiality Requirements in New Jersey**

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
HIPAA <sup>1</sup>	Permits covered entities (CEs) to use and disclose PHI for purposes of <b>treatment</b> without getting patient authorization.	<ul style="list-style-type: none"> <li>Health care providers</li> <li>Business Associates (BAs)</li> </ul>	<ul style="list-style-type: none"> <li>Protected Health Information (PHI)                             <ul style="list-style-type: none"> <li>Exception for psychotherapy notes (generally require authorization to disclose)</li> </ul> </li> </ul>	<p><b>Treatment:</b> the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another</p>
	Permits CEs to use and disclose PHI for purposes of enumerated <b>healthcare operations</b> without getting patient authorization.	<ul style="list-style-type: none"> <li>Health care providers</li> <li>Business Associates</li> </ul>	<ul style="list-style-type: none"> <li>Protected Health Information (PHI)                             <ul style="list-style-type: none"> <li>Exception for psychotherapy notes (require authorization to disclose)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>HIPAA regulations itemize a number of healthcare operations, including population-based activities relating to improving health or reducing health care costs and case management and care coordination.</li> <li>Both the disclosing CE/BA and the receiving CE/BA must have had or have “a relationship with the individual who is the subject of the [PHI] being requested”, and the PHI must pertain to that relationship.</li> <li>Generally, CEs and BAs “must make reasonable efforts” to use, disclose, and request only “the minimum necessary [amount of PHI] to accomplish the intended purpose of the use, disclosure, or request.”</li> </ul>

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
Part 2 <sup>2</sup>	<b>Internal Communications Exception:</b> Part 2 restrictions do not apply to disclosures made for purposes of a Part 2 program’s internal communication.	<ul style="list-style-type: none"> <li>Other Part 2 program staff/personnel within the same program.</li> <li>Personnel part of an entity that has direct administrative control over the program.</li> </ul>	<ul style="list-style-type: none"> <li>Information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse</li> </ul>	Disclosures for purposes of internal communication are only permissible to the extent the recipient needs the information to provide alcohol or drug services.
	<b>Bona Fide Medical Emergency Exception:</b> Part 2 statute permits programs to disclose PII without patient consent “[t]o medical personnel to the extent necessary to meet a bona fide medical emergency.”	Medical Personnel	<ul style="list-style-type: none"> <li>Information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.</li> <li>The entire Part 2 record may be released to a treating provider who indicates that s/he needs access to treat the emergency.</li> </ul>	<ul style="list-style-type: none"> <li>Part 2 regulation describes the exception as permitting disclosures “to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.”</li> <li>“Medical Personnel” is undefined, but SAMHSA guidance provides that any health care provider who is treating a patient for a medical emergency may use professional judgment to determine that a medical emergency exists.</li> <li>Part 2 does not prohibit the recipient medical personnel from redisclosing PII for treatment purposes.</li> <li>Regulations require Part 2 Program to document specific information when</li> </ul>

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
				disclosures are made pursuant to this exception.
New Jersey Department of Human Services Confidentiality Requirements				
DHS Confidentiality provision, N.J.S.A. § 30:4-24.3 <sup>3</sup>	Treatment exception: does not preclude disclosure if it appears that the information is to be used directly or indirectly <b>for the benefit of the patient</b>	Patient's <b>Personal Physician</b>	Patient's <b>current medical condition</b>	<ul style="list-style-type: none"> <li>• "For the benefit of" is not defined</li> <li>• "Personal Physician" is undefined</li> <li>• "Current Medical Condition" is undefined</li> </ul>
	Does not preclude disclosure by the professional staff of a community agency <b>under contract</b> with the Division of Mental Health Services in the Department of Human Services, or of a screening service, short-term care or psychiatric facility	to the staff of <b>another such agency</b>	<ul style="list-style-type: none"> <li>• Information that is <b>relevant to a patient's current treatment</b></li> </ul>	<ul style="list-style-type: none"> <li>• "another such agency" is not defined</li> <li>• "relevant to a patient's current treatment" is not defined</li> </ul>

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
Community Mental Health Providers Licensed by DHS or Funded by, under Contract with, or Affiliated with DMHAS <sup>4</sup>	<p><b>§ 10:37-6.79(f):</b>                      Provider agencies may disclose if it appears that the information is to be used <b>for the benefit of the consumer</b></p>	<ul style="list-style-type: none"> <li>Any licensed mental health provider or medical health care provider who has a <b>contract with</b> the Division of Mental Health and Addiction Services (DMHAS) or the Department of Human Services (DHS)</li> <li>Consumer’s <b>personal physician</b></li> </ul>		<ul style="list-style-type: none"> <li>“For the benefit of the consumer” is not defined</li> <li>Unclear if “for the benefit of the consumer” requirement applies to disclosures to providers with DMHAS or DHS contracts or only personal physicians</li> </ul>
	<p><b>§ 10:37-6.79(b):</b> Upon presentation of appropriate credentials, provider agencies may disclose confidential information</p>	Employees of the agency <b>involved in the care</b> of the consumer as long (as the patient is advised when he or she enters treatment that agency staff will have access)		<ul style="list-style-type: none"> <li><b>Additional requirements for disclosures pursuant to § 10:37-6.79(b),</b> including:                             <ul style="list-style-type: none"> <li>Must use <b>initials</b> in place of the patient’s name, where possible</li> <li>Must provide <b>written notice that redisclosure</b> without patient authorization or as otherwise provided by law is prohibited</li> <li>Limited to information <b>relevant and necessary for the purpose of the disclosure</b>, except as authorized by the consumer or his or her representative or required by law</li> </ul> </li> </ul>
	<p><b>§ 10:37-6.79(b):</b> Upon presentation of appropriate credentials, employees of the agency may disclose confidential information</p>	Staff of “ <b>another such agency</b> ”	<b>relevant to current treatment</b>	



EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
	as long as the disclosure complies with HIPAA			<ul style="list-style-type: none"> <li>○ Limited to <b>information generated at the provider agency</b>, although must list the sources of undisclosed materials</li> <li>○ <b>Recording, accounting, and inspection provisions</b></li> <li>● “Another such agency” is not defined</li> </ul>
<b>NJ Community Residences for Mentally Ill Adults<sup>5</sup></b>	Permits disclosure to a patient’s <b>personal physician</b> if it appears that the information is to be used <b>for the treatment</b> of the patient	Patient’s <b>personal physician</b>	Information to be used for the <b>treatment</b> of the patient	Note that community residences for mentally ill adults also are subject to Section 10:37-6.79(f), which phrases the condition in terms of whether “it appears that the information is to be used for the <i>benefit</i> of the consumer.” (see above)
<b>Short Term Care Facilities<sup>6</sup></b>	Disclosure of PHI for purposes of treatment	<b>Staff at a community mental health agency, another screening service or a short-term care or psychiatric facility or special psychiatric hospital</b>	<b>minimum necessary requirement</b>	Short term care facilities are bound by Section 10:37-6.79(b), which includes a “relevant and necessary” limitation.
<b>Psychiatric residential treatment facility for individuals under 21<sup>7</sup></b>	Must accompany the resident if s/he is <b>transferred</b>	To or from another PRTF or program facility	<b>copy of the clinical record</b> , or a summary thereof	

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
Outpatient <sup>8</sup> and Residential <sup>9</sup> Substance Use Disorder Treatment Facilities				<ul style="list-style-type: none"> <li>• Must <b>comply with HIPAA and Part 2</b> (see above)</li> <li>• The outpatient regulations establish each client’s “right to be informed if the program has authorized other health care and educational institutions to participate in his or her treatment, the identity and function of these institutions, and to refuse to allow their participation in his or her treatment.”<sup>10</sup></li> </ul>
NJ Division of Developmental Disabilities (DDD) <sup>11</sup>	When provider <b>assumes responsibility</b> for an individual from another provider	Receiving provider	Access to the client record at time of referral, including copies of required records	<ul style="list-style-type: none"> <li>• <b>Provider</b> is defined as a person, agency, or business that is <b>under contract</b> with the DDD or licensed by DHS.</li> <li>• <b>Health information regarding family members</b> of an individual may not be disclosed unless it “is required for treatment and/or services for the individual.”</li> </ul>
	If individual <b>transfers from one provider to another</b>	Transferee provider on day of transfer	Client record	
	When an individual is <b>transferred from one component</b> of the Department or Division to another	Transferee component of DHS or the DDD	Client record	
	When <b>medical staff outside of department/division have assumed temporary medical</b>	Medical staff outside of department/division who have assumed temporary medical responsibility for the individual	Access to information and records as <b>necessary</b> for treatment	

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
	responsibility for the individual			
	Upon admission, individuals or their legal guardians must provide a <b>list of individuals</b> who may receive information, which list may include a <b>personal physician</b> , among others	<b>Personal physician</b> , if identified on list by individual or legal guardian	Information regarding the individual's <b>general medical condition</b> over the telephone	“General Medical Condition” is undefined
<b>Screening and Screening Outreach Services<sup>12</sup></b>	Professional screening staff may disclose	<b>Staff at:</b> <ul style="list-style-type: none"> <li>• A community mental health agency;</li> <li>• Another screening service;</li> <li>• A short-term care or psychiatric facility; or</li> <li>• A special psychiatric hospital</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Minimum necessary</b> consumer PHI that is <b>relevant</b> to a consumer's treatment and/or referral for treatment</li> </ul>	All disclosures of PHI must be <b>documented</b> in the patient’s record and must be based on individualized determinations
<b>Hospitals and Other Facilities Regulated by NJ Department of Health</b>				
<b>Hospitals<sup>13</sup></b>	If the patient is <b>transferred to another health care facility</b> that <b>requires</b> the information	Transferee health care facility		<ul style="list-style-type: none"> <li>• <b>“Facility”</b> is defined as “a general acute care, special or psychiatric hospital licensed pursuant to [Chapter 43G].”</li> <li>• <b>“Requires”</b> is not defined, but there are situations in which the statute or rules seem</li> </ul>

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
				<p>to presume the transferee facility’s need for at least some records. For example:</p> <ul style="list-style-type: none"> <li>○ When a general hospital transfers a patient to another health care facility, a complete discharge summary must accompany the patient.</li> <li>○ Certain documentation, including x-ray films and patient’s condition, must be sent with patient being transferred from an emergency department to another health care facility.</li> <li>○ Hospital must send copy of transfer record to receiving hospital at time of transfer whenever a patient is transferred to another health care facility, including a home health agency, on a nonemergency basis, which record must include diagnosis, physician orders, and other aspects of the patient’s clinical treatment record.</li> </ul> <ul style="list-style-type: none"> <li>● Patients in a hospital also have a right “[t]o be informed if the hospital has authorized other health care and educational institutions to participate in the patient’s</li> </ul>

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
				treatment. The patient also shall have a right to know the identity and function of these institutions, and may refuse to allow their participation in the patient's treatment."
	<b>Pediatric intensive care continuous quality improvement program</b>	Inter-hospital exchange with pediatric specialists in other hospitals	information and case reviews	Unclear whether these exchanges disclose PHI or deidentified files.
	<b>Exchanges of information among treating providers within hospitals,</b> however, generally do not require consent.	Treating providers within the same facility		For example, medical records will "accompany the patient when he or she leaves the patient care unit for clinical services in other departments of the hospital or shall be retrievable by authorized personnel on a computerized system with a restricted access and entry system."
<b>Long Term Care Facilities<sup>14</sup></b>	Permits disclosure on <b>transfer to another nursing home or health care facility</b>	Transferee nursing home or health care facility	Records concerning medical condition and treatment	"Health care facility" is defined as "a facility so defined in N.J.S.A. 26:2H-1 <i>et seq.</i> , and amendments thereto."
<b>Adult day health services facilities<sup>15</sup></b>	Permits disclosure on <b>transfer to another health care facility</b>	Another health care facility to which the patient was transferred	Participant's records and disclosures	<ul style="list-style-type: none"> <li>"Health care facility" is defined as "a facility so defined in N.J.S.A. 26:2H-1 <i>et seq.</i>".</li> <li><b>But note</b> that DHS licenses Adult Day Health Services Programs for Persons with Alzheimer's or Related Diseases, and its regulations do not include a transferee exception.<sup>16</sup></li> </ul>

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
Pediatric Community Transitional Homes <sup>17</sup>	Permits disclosure on transfer to another health care facility	Another health care facility to which the patient was transferred	Records and information regarding the individual resident	"Health care facility" is defined as "facility as defined within N.J.S.A. 26.2H-2, as amended."
Home Health Agencies <sup>18</sup>	Shall be made available to->	<b>Health care practitioners involved in the patient's care</b>	Patient's medical/health record	<ul style="list-style-type: none"> <li>• "Health care practitioners" is not defined</li> <li>• "involved in the patient's care" is not defined</li> <li>• Unclear, but likely only applies to disclosures within the agency.</li> </ul>
	Limited transferee exception when patient is transferred to "another non acute health care facility"	Transferee non acute health care facility at time of transfer	Copy of <b>transfer record</b> reflecting the patient's immediate needs	<ul style="list-style-type: none"> <li>• Transfer order must contain at least:                             <ul style="list-style-type: none"> <li>○ Diagnosis, including history of any serious conditions unrelated to the proposed treatment which might require special attention to keep the patient safe</li> <li>○ Physician orders in effect at the time of transfer and the last time each medication was administered</li> <li>○ The patient's plan of care</li> <li>○ Hazardous behavioral problems</li> <li>○ Drug and other allergies</li> <li>○ Reason for transfer</li> <li>○ A notice of the existence of an advance directive and/or Do Not Resuscitate (DNR) order</li> </ul> </li> </ul>

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
				<ul style="list-style-type: none"> <li>“Non acute health care facility” is not defined</li> </ul>
<b>Assisted Living Facilities</b> <sup>19</sup>	When resident is transferred to another health care facility	Transferee health care facility	Information in the resident’s records	“Health care facility” is defined as “a facility defined in N.J.S.A. 26:2H-1 <i>et seq.</i> , and amendments thereto.”
<b>Ambulatory Care Facilities</b> <sup>20</sup>	When patient is transferred to another health care facility that requires the information	Transferee health care facility that requires the information	Information in the patient’s medical record	<ul style="list-style-type: none"> <li>“Health care facility” is defined as “a facility so defined in N.J.S.A. 26:2H-1 <i>et seq.</i>”</li> <li>“Requires” is not defined</li> <li><b>But see conflicting state regulation</b> at N.J.A.C. § 8:43A-13.5(a)(1) that requires written consent for release of medical record information and does not include expressly include an exception from this requirement for transfers to other facilities</li> </ul>
<b>Residential Health Care Facilities</b> <sup>21</sup>	When resident is transferred to another health care facility	Transferee health care facility	Records and information about an individual resident	<ul style="list-style-type: none"> <li>“Health care facility” is defined as “a facility so defined in N.J.S.A. 26:2H-1 <i>et seq.</i>, and amendments thereto.”</li> <li><b>Note</b> that N.J.A.C. § 8:43-4.6(a)(5), which requires RHCs to develop policy and procedure manuals that include, at minimum, “[p]olicies and procedures for maintaining confidentiality of resident records, including policies and procedures . . . for release of the resident's records to any individual outside the facility, as consented</li> </ul>



EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
				to by the resident,” does not reference a transferee exception.
<b>Emergency Medical Services</b> <sup>22</sup>	When patient <b>transfers to another health care professional</b>	Health care professional receiving the patient	Patient Information	<ul style="list-style-type: none"> <li>• “Health care professional” and “receiving health care professional” are not defined.</li> <li>• But "Receiving health care facility" is defined as “a general hospital, nursing home, physician's office, outpatient facility or rehabilitation facility to which a patient is transferred following evaluation and/or treatment.”</li> </ul>
<b>Health Care Professionals</b>				
<b>BME Regulated Entities</b> <sup>23</sup> (e.g., physicians, including psychiatrists; <sup>24</sup> physician assistants; <sup>25</sup> podiatrists; <sup>26</sup> certified nurse midwives; <sup>27</sup> acupuncturists; <sup>28</sup> and genetic counselors <sup>29</sup> )	<b>General treatment exception:</b> May release in the exercise of <b>professional judgment and in the best interests</b> of the patient (even absent the patient's request)	To <b>another licensed health care professional who is providing or has been asked to provide</b> treatment to the patient, or whose <b>expertise may assist</b> the licensee in his or her rendition of professional services	Pertinent information about the patient's treatment	
	<b>Imminent danger exception:</b> May exercise <b>professional judgment</b> if has “a <b>good faith belief that the patient</b>	To other <b>health care professionals</b>	Pertinent information “to <b>minimize the threat of danger</b> ”	<b>Does not authorize</b> release of records containing identifying information about a person who has AIDS or an HIV infection, without patient consent, unless authorized by N.J.S.A. 26:5C-8.

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
	because of a mental or physical condition may pose an imminent danger to himself or herself or to others”			
	<b>Computerized patient records:</b> Must make available promptly (specified as within 10 days in acupuncturist regulations)	To a <b>physician responsible for the patient's care</b>	Copy of each day's entry, identified as preliminary or final as applicable	
<b>Dentists<sup>30</sup></b>	May release in the exercise of <b>professional judgment and in the best interests</b> of the patient (even absent the patient's request)	To <b>another licensed health care professional who is providing or who has been asked to provide</b> treatment to the patient, or <b>whose expertise</b> may assist the licensee in his or her rendition of professional services	<b>Pertinent information</b> about the patient's treatment	
<b>Chiropractors</b>	May release in the exercise of <b>professional judgment and in the best interests</b> of the patient (even absent the patient's request)	To <b>another licensed health care professional who is providing or who has been asked to provide</b> care to the patient, or whose <b>expertise may assist the</b>	<b>Pertinent information</b> about the patient's care	

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
		licensee in his or her rendition of professional services		
Psychologists <sup>31</sup>	Requires licensee to release ->	A <b>hospital, nursing home or similar licensed institution which is providing or has been asked to provide</b> treatment to the client	<b>Appropriate</b> client information	“Appropriate” is not defined
	Requires licensee to “ <b>reveal</b> ” if in the licensee's <b>judgment</b> , exercised in accordance with the standards of the profession, there is a <b>clear and imminent danger</b> to the individual or the public and related circumstances itemized in the regulation	To <b>appropriate professional workers</b> and others	Information obtained from a client in the course of the licensee's teaching, practice, or investigation	<ul style="list-style-type: none"> <li>• “Reveal” is not defined; unclear if this authorizes exchange of patient records or just revelation of facts or summaries</li> <li>• “appropriate professional workers” also is not defined</li> </ul>
	Permits, but does not require, licensee to <b>discuss</b>	Only for <b>professional purposes</b> and only with persons <b>clearly connected</b> with the case	The information obtained in clinical or consulting relationships, or in evaluating data concerning children, students, employees and others	“Clearly connected” is not defined

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
Certified Psychoanalysts <sup>32</sup>	Nearly identical to psychologists			
Rehabilitation Counselors, <sup>33</sup> Professional Counselors, and Associate Counselors <sup>34</sup>	The licensee has information that the client presents a <b>clear and present danger</b> to the health or safety of an individual	Not specified	Information obtained from a client in the course of performing counseling services for the client	
	Permits, but does not require, licensee to <b>discuss</b>	only for <b>professional purposes</b> and only with persons <b>clearly connected</b> with the case, as provided under applicable State and Federal laws and regulations	Information obtained in clinical or consulting relationships, or in evaluating data concerning children, students, employees and others	“Clearly connected” is not defined
	If: <ul style="list-style-type: none"> <li>client is receiving <b>counseling services from another mental health professional</b>; and</li> <li><b>client consents</b></li> </ul>	Other <b>mental health professional already involved in treatment</b> of client	Inform of treatment being provided and develop clear agreements to avoid confusion and conflict for the client	<ul style="list-style-type: none"> <li>Does not specify if client consent needs to be in writing</li> <li>Does not define mental health professional</li> </ul>
Licensed and Certified Social Workers <sup>35</sup>	Failure to disclose presents <b>clear and present danger</b> to	Not specified	Confidential information acquired from client or patient while performing social work	

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
	health or safety of an individual		services for that client or patient	
	At the <b>written request</b> of the client or personal representative, licensee shall provide ->	<b>Another licensed health care professional, hospital, nursing home or similar licensed institution that is providing or has been asked to provide treatment to the client.</b>	Client record or summary thereof within 30 days of request	Provision <b>does not apply to social worker in agency setting</b> who does not, by agency policy, have control over or authority to release client records. <sup>36</sup>
<b>Marriage and Family Therapists<sup>37</sup></b>	Licensee has information that client <b>presents clear and present danger</b> to health or safety of self and/or others	Not specified	Information obtained from client in course of performing marriage and family therapy services for the client	
<b>Respiratory Care Practitioners<sup>38</sup></b>	Licensee shall provide in a timely manner where the patient's <b>continued care is contingent</b> upon their receipt	A patient <b>or another designated health care provider</b>	copies of records	<ul style="list-style-type: none"> <li>• <b>Unclear</b> if paragraph (d)(1) of the same regulation, requiring written request from patient or authorized representative, applies<sup>39</sup></li> <li>• “Designated health care providers” is not defined</li> <li>• <b>Applies in outpatient settings;</b><sup>40</sup> Respiratory care practitioners “employed in a setting regulated by the Department of Health [] shall comply with all applicable [DOH] rules.”<sup>41</sup></li> </ul>

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
Licensed Clinical Alcohol and Drug Counselors and Certified Alcohol and Drug Counselors <sup>42</sup>	Must <b>comply with Part 2</b> requirements, 42 C.F.R. § 2.1 <i>et seq.</i> <ul style="list-style-type: none"> <li>• <b>Medical emergencies exception</b></li> <li>• <b>Internal communications exception</b></li> </ul>	Must comply with Part 2 requirements, 42 C.F.R. § 2.1 <i>et seq.</i>	Must comply with Part 2 requirements, 42 C.F.R. § 2.1 <i>et seq.</i>	
Pharmacists <sup>43</sup>	Shall make available ->	to <b>persons authorized to inspect</b> them under State and Federal statutes and regulations	confidential records	<b>Unclear</b> , but likely “persons authorized” refers to entities charged with health oversight functions rather than integrated care providers
Massage and Bodywork Therapist <sup>44</sup> and Physical Therapist <sup>45</sup>				<b>No treatment exception</b> in statute or regulations
<b>Correctional Facilities</b>				
State Correctional Facilities <sup>46</sup>	The <b>Administrator or designee</b> of any State correctional facility <b>determines whether</b> to provide records to <b>medical or mental health doctors outside</b>		Inmate medical records	The Administrator or designee of any State correctional facility determines whether to provide inmate medical records to medical or mental health doctors outside of DOC.

EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
	of the Department of Corrections.			
<b>Adult County Correctional Facilities</b> <sup>47</sup>	Upon advice of the <b>County Counsel</b> , select records of adult inmates shall be made available to medical and psychiatric doctors.	Medical or psychiatric doctors	Select records of adult inmates	
<b>Sensitive Information</b>				
<b>AIDS Assistance Act</b> <sup>48</sup>	Permits health care providers and facilities to disclose HIV/AIDS records without prior informed written consent.	<b>Qualified personnel directly involved</b> in medical education or in the <b>diagnosis and treatment</b> of the person who is subject of the record.	HIV/AIDS records	<ul style="list-style-type: none"> <li>• Qualified personnel” is undefined.</li> <li>• “Directly involved” is undefined.</li> <li>• <b>Diagnosis and Treatment:</b> services or activities carried out for the purpose of, or as an incident to, diagnosis, prevention and treatment of AIDS and HIV infection and includes interviewing and counseling</li> </ul>
<b>DOH Regulation – Birthing Facility</b> <sup>49</sup>	Permits a <b>clinical practitioner or birthing facility to disclose HIV positive test results for purposes of disease prevention and control.</b>	<b>Clinical practitioner</b> caring for the woman’s infant.	Woman’s positive HIV test results	<b>“Clinical practitioner”</b> is defined as “a <b>physician</b> currently licensed to practice in New Jersey; an <b>advanced practice nurse</b> currently certified under the New Jersey Advanced Practice Nurse Certification Act; or a <b>physician assistant</b> licensed under the Physician Assistant Licensing Act, acting within the rules governing those professions.”



EXAMPLES OF TREATMENT EXCEPTIONS TO CONFIDENTIALITY REQUIREMENTS IN NEW JERSEY				
Legal Authority/ Health Care Entity	Exception to Confidentiality	To Whom Information May Be Disclosed	Information that May Be Disclosed	Notes
Venereal Disease <sup>50</sup>	May disclose to person's physician	Person's physician	Name, address, and identity of person known or suspected to have a venereal disease	<ul style="list-style-type: none"> <li>• "Person's physician" is not defined.</li> <li>• Person's physician may disclose name, address, or identity of such person when and only when the physician deems the disclosure <b>necessary to protect</b> the health or welfare of the person or of his family or of the public.</li> <li>• Custodian of records also may permit licensed physician to <b>inspect records</b> protected by this statute if deemed <b>necessary to protect</b> the health or welfare of the person or of his family or of the public.</li> <li>• <b>Query</b> whether this provision is <b>preempted</b> to the extent it authorizes disclosure of PHI without authorization for the treatment of family members</li> </ul>
Genetic Information <sup>51</sup>				<b>No treatment exception.</b>
Treatment of Intoxicated Persons <sup>52</sup>				<b>No treatment exception in statute.</b>

<sup>1</sup> See 45 C.F.R. §§ 164.501, 164.502, 164.506.

<sup>2</sup> See 42 U.S.C. § 290dd-2(b)(2)(A); 42 C.F.R. §§ 2.12.

<sup>3</sup> See N.J.S.A. § 30:4-24.3.

<sup>4</sup> See N.J.A.C. § 10:37-6.79. This includes mental health programs; community residences for mentally ill adults; outpatient mental health services; partial care services for adults; short-term care facilities for adults; youth case management services; and family support services.

<sup>5</sup> See *id.* § 10:37A-3.2(b).

<sup>6</sup> *Id.* § 10:37G-3.5(a)(1).

<sup>7</sup> See *id.* § 10:75-1.5.

<sup>8</sup> *Id.* §§ 10:161B-1.3; 10:161B-16.2(a)(10)(i); 10:161B-18.1(a)(4).

<sup>9</sup> See *id.* § 10:161A-27.1; see also *id.* § 10:161A-19.1(a)(4). Curiously, the definition of confidentiality in the residential regulations refers to HIPAA but not Part 2. See *id.* § 10:161A-1.3. The residential regulations apply to “[a]ll substance (alcohol and drug) abuse treatment facilities that provide residential substance use disorders treatment to adults and adolescents including, but not limited to, halfway houses, extended care facilities, long-term residential facilities, short-term residential treatment facilities and non-hospital-based (medical) detoxification or any other similar such organization . . . .” See *id.* § 10:161A-27.1.

<sup>10</sup> *Id.* § 10:161B-16.2(a)(4). Outpatient SUD treatment facilities that are Part 2 programs would need to obtain patient consent to involve other treatment providers in the patient’s care in the absence of a medical emergency or other exception to Part 2’s consent requirements, discussed in Section II.A.2, *infra*.

<sup>11</sup> See *id.* §§ 10:41-1.3; 10:41-2.1(e); 10:41 4.2(d), (e); 10:41-5.2(d)(3)-(5). In addition to applying to “all records of individuals held by the Division, including applications for services of persons determined ineligible for services and those applications that are initiated but not completed,” *id.* § 10:41-2.1(b), the DDD confidentiality provisions also bind “all service components of the Division and all providers under contract with the Division or licensed by the [DHS].” *Id.* § 10:41-1.2; see also *id.* § 10:41-1.3 (defining service components as “any developmental center, regional office or central office unit”). Thus, for example, community care residences that are licensed by DHS must comply with the DDD confidentiality requirements. See, e.g., *id.* § 10:44B-2A.2(c).

<sup>12</sup> *Id.* § 10:31-12.4.

<sup>13</sup> See N.J.S.A. § 26:2H-12.9c; N.J.A.C. §§ 8:43G-4.1, 12.7(p), 15.2(f), 15.3(c), 22.22.

<sup>14</sup> N.J.S.A. § 30:13-5(g); N.J.A.C. § 8:39-4.1(a)(18).

<sup>15</sup> See N.J.A.C. § 8:43F-4.2(a)(9).

<sup>16</sup> See *id.* §§ 10:164A-1.2, 6.2(a).

<sup>17</sup> See *id.* §§ 8:43D-1.3, 12.2.

<sup>18</sup> See *id.* §§ 8:42-11.1-11.2.

<sup>19</sup> See *id.* §§ 8:36-1.3, 4.1(a)(2&, 15.3(b).

<sup>20</sup> *Id.* § 8:43A-16.2(a)(9)(i); see also *id.* § 8:43A-21.4(b) (discussing transfer of medical records of family planning, prenatal, postpartum, and gynecological services at ambulatory care facilities).

<sup>21</sup> *Id.* §§ 8:43-1.3, 13.1(b), 14.2(a).

<sup>22</sup> See *id.* §§ 8:40-1.3, 3.5(b)(1)(v).

<sup>23</sup> See *id.* § 13:35-6.5(a) (defining “licensee” for purposes of the regulations governing patient records, which includes the treatment exception, to mean “any person licensed or authorized to engage in a health care profession regulated by the Board of Medical Examiners”).

<sup>24</sup> See N.J.S.A. §§ 45:9-5.1, 45:9-6; N.J.A.C. §13:35.

<sup>25</sup> See N.J.S.A. §§ 45:9-27.11-27.12; N.J.A.C. §13:35-2B.1 *et seq.*

<sup>26</sup> See N.J.S.A. § 45:5-2; N.J.A.C. §13:35-2.1 *et seq.*

<sup>27</sup> See N.J.S.A. § 45:10-2; N.J.A.C. §13:35-2A.1 *et seq.*

<sup>28</sup> See N.J.S.A. § 45:2C-3; N.J.A.C. §13:35-9.1 *et seq.*; see also N.J.A.C. § 13:35-9.16 (acupuncturist regulations).

- <sup>29</sup> See N.J.S.A. § 45:9-37.114; N.J.A.C. §13:35-14.1 *et seq.*; *but see* N.J.S.A. § 45:9-37.120 (establishing confidentiality of records of genetic counselor without reference to a treatment exception); N.J.A.C. § 13:35-14.17 (same).
- <sup>30</sup> See N.J.A.C. § 13:30-8.7(f)(2).
- <sup>31</sup> See *id.* § 13:42-8.3(f)(4); *id.* § 13:42-8.5(a) & (c). See generally *id.* § 13:42-8.5(g).
- <sup>32</sup> See *id.* §§ 13:42A-6.2(f) (4), 13:42A-6.3(a), (c), (g).
- <sup>33</sup> See *id.* § 13:34-27.5.
- <sup>34</sup> See *id.* §§ 13:34-27.5(a)(4), (e); *id.* § 13:34-18.5(a)(4); *id.* § 13:34-30.2, (e); see generally N.J.S.A. § 45:8B-49.
- <sup>35</sup> See N.J.S.A. § 45:15BB-13; N.J.A.C. §§ 13:44G-12.3(a)(4), 13:44G-12.4(b)(3).
- <sup>36</sup> See N.J.A.C. § 13:44G-12.4(h).
- <sup>37</sup> See *id.* § 13:34-8.3(a)(4) ; see generally N.J.S.A. § 45:8B-29.
- <sup>38</sup> N.J.A.C. § 13:44F-8.2(d)(3).
- <sup>39</sup> *Id.* § 13:44F-8.2(d)(1).
- <sup>40</sup> See *id.* § 13:44F-8.2(c).
- <sup>41</sup> *Id.* § 13:44F-8.2(c).
- <sup>42</sup> See N.J.S.A. § 45:2D-11; N.J.A.C. § 13:34C-4.5(b).
- <sup>43</sup> See N.J.A.C. §§ 13:39-7.6(d); 13:39-7.19(e).
- <sup>44</sup> See *id.* § 13:37A-5.3(c).
- <sup>45</sup> See *id.* §13:39A-3.3(a), (d).
- <sup>46</sup> See *id.* § 10A:22-2.3(c)(5). Upon discharge, inmates may request a copy of their full medical record, disclosure of which is to be in compliance with the BME's confidentiality requirements discussed above. See *id.* § 10A:22-2.8(c).
- <sup>47</sup> See *id.* §§ 10A:31-6.8(c)(5); see generally § 10A:31-6.10(a)(3)-(4). Note that the regulations do not provide a process for an inmate to request a copy of his/her complete medical record upon discharge. See also *id.* § 10A:71-2.2(a)(1)-(2), (b), (d).
- <sup>48</sup> See N.J.S.A. §§ 26:5C-5, 8(b)(3).
- <sup>49</sup> N.J.A.C. § 8:61-4.7(b)(1).
- <sup>50</sup> See N.J.S.A. § 26:4-41.
- <sup>51</sup> See N.J.A.C. § 10:5-47-48.
- <sup>52</sup> N.J.S.A. § 26:2B-8.

## Appendix C

### **Chart – Examples of Terms Used to Describe Entities Authorized to Receive Patient Health Information Pursuant to Different Treatment Exceptions in New Jersey**

Health Care Providers

**physician responsible** for patient's care

patient's **personal physician** if it appears that the information is to be used directly or indirectly *for the benefit of the patient*

patient's **personal physician** "if it appears that the information is to be used for the *treatment* of the patient"

**Health care practitioners** *involved in the patient's care*

**Health care professional** *receiving the patient*

**qualified personnel** *directly involved in the diagnosis and treatment of the person who is the subject of the record-*

**designated health care practitioners** where patient's *continued care is contingent* upon their receipt

**licensed health care professional** who is providing or who has been asked to provide *treatment* to the patient, or whose *expertise may assist* the licensee in rendition of professional services

*appropriate* **professional workers**

**medical personnel** to the extent *necessary to meet a bona fide medical emergency*

persons **clearly connected** with the case

**mental health professional** *already involved in treatment* of client

**Medical staff** outside department/division who have assumed *temporary medical responsibility* for the individual

Health Care Facilities

information that is *relevant* to a patient's *current treatment* to the **staff of another such agency**

**hospital, nursing home, or similar licensed institution** that is providing or has been asked to provide *treatment* to the client

transferee **health care facility** that *requires* the information

transferee **health care facility**

## Appendix D

### **Table – Examples of New Jersey Authorization, Waiver, Consent, and Approval Requirements to Disclose Protected Health Information**

**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
HIPAA <sup>1</sup>	Yes	<ol style="list-style-type: none"> <li>1. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.</li> <li>2. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.</li> <li>3. The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure. . . .</li> <li>4. A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does</li> </ol>	<p>Yes</p> <p>Individuals generally may revoke a revocation in writing at any time, with some limitations set forth in the Rule.</p>	No	Yes – see required authorization element 5.	<ul style="list-style-type: none"> <li>• Generally, CEs may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signed the authorization.</li> <li>• Authorization must be written in plain language.</li> <li>• Covered entities must document and retain signed authorizations.</li> <li>• Covered entities must provide the individual with a copy of the authorization.</li> <li>• Compound authorizations, in which an authorization for use or disclosure of PHI is combined with another document, also generally are not permitted, although the Privacy Rule identifies some exceptions.</li> <li>• Generally looks to state law, including case law, to determine when CEs may disclose PHI concerning unemancipated minors.</li> <li>• (See Report and sources cited therein for more details about HIPAA.)</li> </ul>



EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT, AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION						
Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
		not, or elects not to, provide a statement of the purpose. 5. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. 6. Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided 7. Statements adequate to place the individual on notice: <ul style="list-style-type: none"> <li>a. Of the individual's right to revoke in writing, including information regarding</li> </ul>				

**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
		exceptions, as detailed in the rule. b. Of the potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected. c. Whether CEs may condition treatment, payment, enrollment, or eligibility for benefits on whether individual signs authorization.				
<b>Part 2<sup>2</sup></b>	Yes	1. The specific name or general designation of the program or person permitted to make the disclosure. 2. The name or title of the individual or the name of the organization to which disclosure is to be made.	Yes - see required authorization element 8. <ul style="list-style-type: none"> <li>May revoke orally, but SAMHSA</li> </ul>	Yes <ul style="list-style-type: none"> <li>Must provide a written redisclosure notice to</li> </ul>	<ul style="list-style-type: none"> <li>Consent may not last longer than reasonably necessary to serve</li> </ul>	<ul style="list-style-type: none"> <li>“Treatment” is a sufficient description of the intended purpose of the disclosure.</li> <li>Any disclosure made pursuant to consent must be limited to that “which is necessary to carry out the purpose of the disclosure.”</li> </ul>

**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
 AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
		3. The name of the patient. 4. The purpose of the disclosure. 5. How much and what kind of information is to be disclosed. 6. The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient. 7. The date on which the consent is signed. 8. A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the	recommends in writing.	the recipient. • Regulations provide specific language that must be used.	the purpose for which it is granted. • May not say effective until revoked.	• Largely leaves to state law the issue of who may consent to the disclosure of the records of minors. • Part 2 programs always must get a minor’s written consent to disclose. • (See Report and sources cited therein for more details about HIPAA.)

**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
		<p>disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.</p> <p>9. The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.</p>				
<b>New Jersey Department of Human Services Confidentiality Requirements</b>						
<b>DHS Confidentiality Provision, N.J.S.A. § 30:4-24.3<sup>3</sup></b>	Not specified	Not specified	Not specified	Not specified	Not specified	An exception permits an individual or “his legal guardian, if any, or, if he is a minor, his parent or legal guardian,” to consent to disclosure.

**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
 AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
<b>Community Mental Health Providers Licensed by DHS or Funded by, under Contract with, or Affiliated with DMHAS<sup>4</sup></b>	Yes	1. The name of the agency disclosing the information; 2. The name or title of the person or organization to which disclosure is to be made; 3. The name of the consumer; 4. The purpose of the disclosure and predictable outcome; 5. The information to be disclosed; 6. The date on which the authorization is signed; and 7. The signature of the consumer or of a person authorized by law to sign for the consumer, following a statement that the undersigned understands the nature of the authorization and has been informed that he or she has the right to revoke consent at any time by written communication to the custodian of the records.	Yes, see required authorization element 7.	Not specified	4 months from the date it is signed unless the release notes a different time limit or triggering event.	<ul style="list-style-type: none"> <li>• Provider agencies may disclose their records with authorization from an adult consumer or his or her legally authorized representative.</li> <li>• Generally, a minor’s “parent or legal guardian may authorize the disclosure of the minor’s records, provided that the minor shall be given prior notice and an opportunity to object to the disclosure.”</li> <li>• Disclosure of clinical record of minor, who is <math>\geq 14</math> and requested admission and been voluntarily admitted to a psychiatric facility, special psychiatric hospital, or children’s crisis intervention service, requires the minor’s written authorization.</li> </ul>

**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
Psychiatric residential treatment facility for individuals under 21 <sup>5</sup>						Does not seem to include a provision permitting patients to consent to disclosure of confidential information.
Short-term care facilities for adults <sup>6</sup>	Yes	<p>Authorizations must “conform to the HIPAA privacy rule at 45 CFR 164.508(a),” which addresses when written authorization is required.</p> <ul style="list-style-type: none"> <li>Note that STCFs for Adults also must comply with Section 10:37-6.79, which identifies specific requirements for what written authorizations to disclose PHI must include. (see above).</li> </ul>	Not specified.	Not specified.	Not specified.	<ul style="list-style-type: none"> <li>Patient PHI may be disclosed to the extent permitted by a valid, written, unrevoked authorization, signed by the patient or the patient's legal guardian or mental health care representative.</li> <li>STCF staff must comply with all State and Federal confidentiality laws to maintain the confidentiality of patient PHI, including, but not limited to, the protections mandated by N.J.S.A. 30:4-24.3 and 26:5C-7 (HIV/AIDS records); HIPAA's Federal privacy rules, as they apply to the release of and access to patient PHI; 42 CFR Part 2; 34 CFR 361.38, Vocational Rehabilitation</li> </ul>

**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
 AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
						Protection, Use and Release of Patient Information; and the Federal Fair Housing Amendments of 1988, 42 U.S.C. §§ 3601 <i>et seq.</i> <ul style="list-style-type: none"> <li>• Authorizations for the release of psychotherapy notes, HIV/AIDS information, and individual drug and alcohol abuse information must specifically identify those records as being subject to release.</li> </ul>
<b>Outpatient<sup>7</sup> and Residential<sup>8</sup> Substance Use Disorder Treatment Facilities</b>	Must comply with HIPAA and Part 2 (see above).	Must comply with HIPAA and Part 2 (see above).	Must comply with HIPAA and Part 2 (see above).	Must comply with HIPAA and Part 2 (see above).	Must comply with HIPAA and Part 2 (see above).	
<b>NJ Division of Developmental Disabilities (DDD)<sup>9</sup></b>	Yes	Must comply with HIPAA requirements for release of PHI set forth in 45 C.F.R. Parts 160 and 164 (see above).	Must comply with HIPAA requirements for release of PHI set forth in 45 C.F.R.	Must comply with HIPAA requirements for release of PHI set forth in	Must comply with HIPAA requirements for release of PHI set forth	<ul style="list-style-type: none"> <li>• Generally redact health information regarding family members before disclosing to third party.</li> </ul>



**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
			Parts 160 and 164 (see above).	45 C.F.R. Parts 160 and 164 (see above).	in 45 C.F.R. Parts 160 and 164 (see above).	<ul style="list-style-type: none"> <li>• Redact addresses of community residences before disclosing.</li> <li>• If patient “is placed with a provider under contract with the Division or licensed by the Department, all records specific to that individual, whether generated or obtained by the provider, belong to the Division and/or Department and shall not be released except by the Division and/or Department.”</li> <li>• Electronic client records are subject to the same confidentiality requirements as paper records.</li> </ul>
<b>Screening and Screening Outreach Services<sup>10</sup></b>	Yes	Requires authorization to comply with HIPAA’s authorization requirement in 45 C.F.R. § 164.508(a), which addresses when authorizations are required, but does not expressly require compliance with paragraph (b) of the same Section in HIPAA, which itemizes the specific content of the authorization.	Not specified	Not specified	Not specified	<ul style="list-style-type: none"> <li>• Screening services may disclose consumer PHI “to the extent permitted by a valid, written, unrevoked authorization, signed by the consumer or the consumer’s legal guardian or mental health care representative.”</li> <li>• Must comply with all federal and State laws to maintain the confidentiality of consumer PHI, including HIPAA, Part 2, N.J.S.A. §</li> </ul>

EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT, AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION						
Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
						30:4-24.3, and N.J.S.A. § 26:5C-7 (HIV/AIDS). <ul style="list-style-type: none"> <li>“Authorizations for the release of psychotherapy notes, HIV/AIDS information and individual drug and alcohol abuse information must specifically identify those records as being subject to release.”</li> </ul>
<b>Adult Day Health Services Programs for Persons with Alzheimer’s or Related Diseases<sup>11</sup></b>	Yes	Not specified	Not specified	Not specified	Not specified	<ul style="list-style-type: none"> <li>Licensed by DHS.</li> <li>Unlike the DOH regulations of adult day health services facilities, discussed below, the DHS regulations specify that written consent of the caregiver or authorized agent is required to disclose PII regarding clients (and they do not include a transfer exception to confidentiality).</li> </ul>

**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

<b>Legal Authority/ Health Care Entity</b>	<b>Required to be in writing?</b>	<b>Specific Elements or Statements Required?</b>	<b>Right to Revoke?</b>	<b>Redisclosure limitation?</b>	<b>Expiration?</b>	<b>Other</b>
<b>Hospitals and Other Facilities Regulated by NJ Department of Health</b>						
<b>Hospitals<sup>12</sup></b>	Not specified	Not specified	Not specified	Not specified	Not specified	Generally may not release patient records outside of the hospital without the patient’s approval (with transferee exception).
	Not specified	Not specified	Not specified	Not specified	Not specified	Patient consent is required to contact the patient’s primary care doctor when the patient is admitted to the psychiatric unit of a hospital through the emergency department.
<b>Long Term Care Facilities<sup>13</sup></b>	Not specified	Not specified	Not specified	Not specified	Not specified	<ul style="list-style-type: none"> <li>Require “approval” to disclose confidential patient records to anyone outside of the facility (with transferee exception).</li> <li>“Approval” is not defined.</li> <li>"Health care facility" is defined as “a facility so defined in N.J.S.A. 26:2H-1 <i>et seq.</i>, and amendments thereto.”</li> </ul>
<b>Adult day health services facilities<sup>14</sup></b>	Not specified.	Not specified	Not specified	Not specified	Not specified	<ul style="list-style-type: none"> <li>DOH regulations establish patient’s right to “approve or refuse” release of their records to <i>any</i> individual (with transferee exception), but do not specify. the form approval or refusal must take.</li> </ul>

**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
 AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

<b>Legal Authority/ Health Care Entity</b>	<b>Required to be in writing?</b>	<b>Specific Elements or Statements Required?</b>	<b>Right to Revoke?</b>	<b>Redisclosure limitation?</b>	<b>Expiration?</b>	<b>Other</b>
						<ul style="list-style-type: none"> <li>• But see DHS regulation of adult day health services programs for persons with Alzheimer’s or related diseases, which are licensed by DHS, discussed above.</li> </ul>
<b>Pediatric Community Transitional Homes<sup>15</sup></b>	Yes	Not specified	Not specified	Not specified	Not specified	<ul style="list-style-type: none"> <li>• To disclose records to any individual outside of the facility (with transferee exception).</li> <li>• Regulation also identifies who may give the requisite consent, namely, the “resident (if age appropriate), resident’s parent(s), legal guardian, or responsible person.”</li> </ul>
<b>Hospice Care Programs<sup>16</sup></b>	Yes – right to approve or refuse in writing	Not specified	Not specified	Not specified	Not specified	Regarding release of medical record “to any individual outside the hospice” with limited exceptions that do not include release to transferee facilities.
<b>Home Health Agencies<sup>17</sup></b>	Yes - right to refuse in writing	Not specified	Not specified	Not specified	Not specified	Regarding release of home health agency records “to any individual outside the facility . . .”
<b>Assisted Living Facilities<sup>18</sup></b>	Yes	Not specified	Not specified	Not specified	Not specified	<ul style="list-style-type: none"> <li>• Specifically requires written consent to release records to any individual outside of the facility or program (with transferee exception).</li> </ul>

**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

<b>Legal Authority/ Health Care Entity</b>	<b>Required to be in writing?</b>	<b>Specific Elements or Statements Required?</b>	<b>Right to Revoke?</b>	<b>Redisclosure limitation?</b>	<b>Expiration?</b>	<b>Other</b>
						<ul style="list-style-type: none"> <li>Note that another regulation generally prohibits release of patient records outside of the facility without approval but does not specify the form that approval must take.<sup>19</sup></li> </ul>
<b>Ambulatory Care Facilities<sup>20</sup></b>	Not specified	Not specified	Not specified	Not specified	Not specified	<p>Note internal inconsistency between regulations governing ACFs in New Jersey:</p> <ul style="list-style-type: none"> <li>One ACF regulation requires patient approval to release patient medical records to anyone outside the facility (with a transferee exception).</li> <li>Another provision requires patient written consent for the release of medical record information without distinguishing between releases internal or external to the facility (with no exception for transfers to other health care facilities).</li> </ul>
	Yes	Not specified	Not specified	Not specified	Not specified	
<b>Residential Health Care Facilities<sup>21</sup></b>	Yes	Not specified	Not specified	Not specified	Not specified	<ul style="list-style-type: none"> <li>One RHCF regulation requires written consent to release medical records “to any individual <i>not associated with</i> the facility.”</li> </ul>
	Yes	Not specified	Not specified	Not specified	Not specified	

EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT, AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION						
Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
						<ul style="list-style-type: none"> <li>○ “Associated with” is not defined</li> <li>● Another requires RHCF resident rights, policies, and procedures to require, at minimum, written consent “for release of his or her records to any individual outside the facility.”<sup>22</sup></li> </ul>
<b>Emergency Medical Services<sup>23</sup></b>	Yes	Not specified	Not specified	Not specified	Not specified	Provides additional guidance regarding consent requirements, requiring policies pursuant to which a “patient, guardian, executor or other legally authorized person” may request patient records in writing, and that the information must be released to a specific person, entity or company.”
<b>Health Care Professionals</b>						
<b>Psychologists<sup>24</sup></b>	Not unless licensee requires it	Not specified	Not specified	Not specified	Not specified	<ul style="list-style-type: none"> <li>● Client or authorized representative may authorize disclosure.</li> </ul>

EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT, AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION						
Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
						<ul style="list-style-type: none"> <li>If client is &gt; 14 but &lt; age of majority, authorization must be signed by client and client's parent or legal guardian.</li> </ul>
<b>Psychoanalysts</b> <sup>25</sup>	Not unless licensee requires it	Not specified	Not specified	Not specified	Not specified	Client or authorized representative may authorize disclosure.
<b>Marriage and Family Therapists,</b> <sup>26</sup> <b>Rehabilitation Counselors,</b> <sup>27</sup> <b>Professional Counselors, and Associate Counselors</b> <sup>28</sup>	Yes (does not specify if family consent must be in writing)	Not specified	Not specified	Not specified	Not specified	<ul style="list-style-type: none"> <li>Client or authorized representative may authorize disclosure.</li> <li>Professional and associate counselors: if client is &gt; 14 but &lt; age of majority, authorization must be signed by client and client's parent or legal guardian.</li> <li>Need agreement from each family member ≥ 18 years (unless federal or State law requires consent from &lt; 18) who is receiving services.                             <ul style="list-style-type: none"> <li>Does not specify if family consent must be in writing.</li> </ul> </li> </ul>
<b>Respiratory Care Practitioners</b> <sup>29</sup>	Yes	Not specified	Not specified	Not specified	Not specified	<ul style="list-style-type: none"> <li>Applies to respiratory care practitioners in outpatient settings.</li> <li>Client or authorized representative may authorize disclosure.</li> <li>Patient, duly authorized representative, or another</li> </ul>

EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT, AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION						
Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
						designated health care provider may receive disclosed information.
<b>Social Workers<sup>30</sup></b>	Yes (does not specify if family consent must be in writing)	Not specified	Not specified	Not specified	Not specified	<ul style="list-style-type: none"> <li>• Client or authorized representative may authorize disclosure.</li> <li>• Unless otherwise ordered by a court, when the client is <math>\geq 14</math> but has not yet reached the age of majority, an authorization shall be signed by the client and by the client's parent or legal guardian.</li> <li>• Need agreement from anyone in family <math>\geq 14</math> years</li> <li>• "Another licensed health care professional, hospital, nursing home or similar licensed institution which is providing or has been asked to provide treatment to the client" may receive disclosed information.                             <ul style="list-style-type: none"> <li>○ Does not specify if family member agreement needs to be in writing.</li> </ul> </li> <li>• Does not apply to social worker in agency setting who does not, by</li> </ul>



**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

<b>Legal Authority/ Health Care Entity</b>	<b>Required to be in writing?</b>	<b>Specific Elements or Statements Required?</b>	<b>Right to Revoke?</b>	<b>Redisclosure limitation?</b>	<b>Expiration?</b>	<b>Other</b>
						agency policy, have control over or authority to release client records.
<b>Dentists<sup>31</sup></b>	Yes	Not specified	Not specified	Not specified	Not specified	<ul style="list-style-type: none"> <li>• Client or authorized representative may authorize disclosure.</li> <li>• Patient, authorized representative, or dentist of patient's choosing may receive disclosed information.</li> </ul>
<b>Chiropractors<sup>32</sup></b>	Yes	Not specified	Not specified	Not specified	Not specified	<ul style="list-style-type: none"> <li>• Client or authorized representative may authorize disclosure.</li> <li>• Patient, authorized representative, or another designated health care provider may receive disclosed information.</li> </ul>
<b>BME Regulated Entities (e.g., physicians, including psychiatrists;<sup>33</sup> physician assistants;<sup>34</sup> podiatrists;<sup>35</sup> certified nurse midwives;<sup>36</sup> acupuncturists;</b>	Yes	Not specified	Not specified	Not specified	Not specified	3 requirements: <ol style="list-style-type: none"> <li>1. Secure and maintain a current written authorization, bearing the signature of the patient or an authorized representative;</li> <li>2. Assure scope of release is consistent with request; and</li> <li>3. Forward records to attention of specific individual identified <b>or</b> mark the material "Confidential"<sup>39</sup></li> </ol> <ul style="list-style-type: none"> <li>• Client or authorized representative may authorize disclosure.</li> </ul>

EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT, AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION						
Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
<sup>37</sup> and genetic counselors <sup>38)</sup>						<ul style="list-style-type: none"> <li>Applies to records from other licensees or health care providers that are part of patient’s record.</li> </ul>
Massage and Bodywork Therapist <sup>40</sup> and Physical Therapist <sup>41</sup>	Yes	Not specified	Not specified	Not specified	Not specified	Requirements: <ol style="list-style-type: none"> <li>Secure and maintain a current written authorization, bearing the signature of the client or an authorized representative;</li> <li>Assure scope of <u>release</u> is consistent with request;</li> <li>Forward records to attention of specific individual identified; <b>and</b></li> <li>Mark the material “Confidential”</li> </ol> <ul style="list-style-type: none"> <li>Client or authorized representative may authorize disclosure.</li> </ul>
Licensed Clinical Alcohol and Drug Counselors and Certified Alcohol and Drug Counselors <sup>42</sup>	Yes (including family release)	Must comply with Part 2 requirements (see above)	Must comply with Part 2 requirements (see above)	Must comply with Part 2 requirements (see above)	Must comply with Part 2 requirements (see above)	<ul style="list-style-type: none"> <li>Largely leaves to state law the issue of who may consent to the disclosure of the records of minors.</li> <li>Part 2 programs always must get a minor’s written consent to disclose.</li> <li>All persons referred to in family counseling notes must sign release.</li> </ul>

**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
<b>Sensitive Information</b>						
<b>AIDS Assistance Act<sup>43</sup></b>	Yes – prior written informed consent	Must comply with Section 2.31 of the federal Part 2 regulations (see above)	Must comply with Section 2.31 of the federal Part 2 regulations (see above)	Yes	Must comply with Section 2.31 of the federal Part 2 regulations (see above)	The statute also permits records to be disclosed without written informed consent “[i]n all other instances <i>authorized</i> by State or federal law.” <i>Id.</i> § 26:5C-8(b)(6) (emphasis added). It is unclear whether this reaches HIPAA’s permitted disclosures of PHI for a number of purposes, including treatment and healthcare operations. See 45 C.F.R. § 164.502(a)(1)(ii).
<b>Genetic Information<sup>44</sup></b>	Yes	Must comply with the requirements of the Department of Health (although it does not appear that DOH has promulgated regulations to implement this statute).	Not specified.	Yes. <ul style="list-style-type: none"> <li>Does not require that recipient of protected genetic information receive written notice of redisclosure limitations.</li> </ul>	Not specified.	Exception to disclosure prohibition when a tested individual or his/her representative signs a written consent that “complies with the requirements of the Department of Health.”

EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT, AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION						
Legal Authority/ Health Care Entity	Required to be in writing?	Specific Elements or Statements Required?	Right to Revoke?	Redisclosure limitation?	Expiration?	Other
				<ul style="list-style-type: none"> <li>Rather, person who requires or requests genetic testing or receives records, results, or findings must provide notice to person tested that provides, among other things, that the information may not be disclosed without written consent unless</li> </ul>		

**EXAMPLES OF NEW JERSEY AUTHORIZATION, WAIVER, CONSENT,  
AND APPROVAL REQUIREMENTS TO DISCLOSE PROTECTED HEALTH INFORMATION**

<b>Legal Authority/ Health Care Entity</b>	<b>Required to be in writing?</b>	<b>Specific Elements or Statements Required?</b>	<b>Right to Revoke?</b>	<b>Redisclosure limitation?</b>	<b>Expira- tion?</b>	<b>Other</b>
				another exception in the statute applies.		
<b>Venereal Disease<sup>45</sup></b>						No provision for patient consent to disclosure.
<b>Treatment of Intoxicated Persons<sup>46</sup></b>						No provision for patient/client consent to disclosure.

<sup>1</sup> See 45 C.F.R. §§ 164.502, 508.

<sup>2</sup> See 42 U.S.C. § 290dd-2(b)(1); 42 C.F.R. §§ 2.12(a)(1), 2.13, 2.14, 2.31, 2.32.

<sup>3</sup> See N.J.S.A. § 30:4-24.3(a).

<sup>4</sup> See N.J.A.C. § 10:37-6.79. This includes mental health programs; community residences for mentally ill adults; outpatient mental health services; partial care services for adults; short-term care facilities for adults; youth case management services; and family support services.

<sup>5</sup> See *id.* § 10:75-1.5.

<sup>6</sup> See *id.* § 10:37G; see also *id.* §§ 10:37G-3.1-3.5.

<sup>7</sup> *Id.* §§ 10:161B-1.3; 10:161B-16.2(a)(10)(i); 10:161B-18.1(a)(4).

<sup>8</sup> See *id.* § 10:161A-27.1; see also *id.* § 10:161A-19.1(a)(4). Curiously, the definition of confidentiality in the residential regulations refers to HIPAA but not Part 2. See *id.* § 10:161A-1.3. The residential regulations apply to “[a]ll substance (alcohol and drug) abuse treatment facilities that provide residential substance use disorders treatment to adults and adolescents including, but not limited to, halfway houses, extended care facilities, long-term residential facilities, short-term residential treatment facilities and non-hospital-based (medical) detoxification or any other similar such organization . . . .” See *id.* § 10:161A-27.1.

<sup>9</sup> See *id.* §§ 10:41-1.3; 10:41-2.1(e)-(f); 10:41-3.4(a); 10:41-4.2(a); 10:41-4.3(a)-(b); 10:41-5.2(a), (c). In addition to applying to “all records of individuals held by the Division, including applications for services of persons determined ineligible for services and those applications that are initiated but not completed,” *id.* §

10:41-2.1(b), the DDD confidentiality provisions also bind “all service components of the Division and all providers under contract with the Division or licensed by the [DHS].” *Id.* § 10:41-1.2; *see also id.* § 10:41-1.3 (defining service components as “any developmental center, regional office or central office unit”). Thus, for example, community care residences that are licensed by DHS must comply with the DDD confidentiality requirements. *See, e.g., id.* § 10:44B-2A.2(c).

<sup>10</sup> *Id.* §§ 10:31-12.1; 10:31-12.2(a)-(b).

<sup>11</sup> *See id.* §§ 10:164A-1.2, 6.2(a).

<sup>12</sup> *See* N.J.S.A. § 26:2H-12.8(g); N.J.A.C. § 8:43G-4.1(a)(21). Patients in a hospital also have a right “[t]o be informed if the hospital has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and may refuse to allow their participation in the patient's treatment.” N.J.A.C. § 8:43G-4.1(a)(10). *See generally* N.J.A.C. § 8:43G-15.2(i) (“Original medical records of [sic] components of medical records shall not leave hospital premises unless they are under court order or subpoena or in order to safeguard the record in case of a physical plant emergency or natural disaster.”).

<sup>13</sup> N.J.S.A. § 30:13-5(g); N.J.A.C. § 8:39-4.1(a)(18).

<sup>14</sup> *See* N.J.A.C. § 8:43F-4.2(a)(9).

<sup>15</sup> *See id.* §§ 8:43D-1.3, 12.2.

<sup>16</sup> *Id.* § 8:42C-5.1(b)(18).

<sup>17</sup> *Id.* § 8:42-13.1(b)(14).

<sup>18</sup> *See id.* § 8:36-15.3(b).

<sup>19</sup> *See id.* § 8:36-4.1(a)(27).

<sup>20</sup> *Id.* §§ 8:43A-13.5(a)(1), 16.2(a)(9)(i); *see also id.* § 8:43A-21.4(b) (discussing transfer of medical records of family planning, prenatal, postpartum, and gynecological services at ambulatory care facilities).

<sup>21</sup> *Id.* §§ 8:43-13.1(b), 14.2(a).

<sup>22</sup> *See also id.* § 8:43-4.6(a)(5). (requiring facilities to develop policy and procedure manuals that include, at minimum, “[p]olicies and procedures for maintaining confidentiality of resident records, including policies and procedures . . . for release of the resident's records to any individual outside the facility, as consented to by the resident”).

<sup>23</sup> *See id.* § 8:40-3.5(b)(1)(i).

<sup>24</sup> *See id.* §§ 13:42-8.3, 8.6, 8.6.

<sup>25</sup> *See id.* § 13:42A-6.2.

<sup>26</sup> *See id.* § 13:34-8.3.

<sup>27</sup> *See id.* § 13:34-27.5.

<sup>28</sup> *See id.* §§ 13:34-18.5(a)(6), 18.6(a).

<sup>29</sup> *See id.* § 13:44F-8.2(d)(1), (3).

<sup>30</sup> *See* N.J.S.A. § 45:15BB-13(e); N.J.A.C. §§ 13:44G-12.3(a)(7), 12.4.

<sup>31</sup> *See* N.J.A.C. § 13:30-8.7(e)(1).

<sup>32</sup> *Id.* § 13:44E-2.2(e)(1).

<sup>33</sup> *See* N.J.S.A. §§ 45:9-5.1, 45:9-6; N.J.A.C. § 13:35-6.5(e).

<sup>34</sup> *See* N.J.S.A. §§ 45:9-27.11-27.12; N.J.A.C. § 13:35-2B.1 *et seq.*

<sup>35</sup> *See* N.J.S.A. § 45:5-2; N.J.A.C. § 13:35-2.1 *et seq.*

<sup>36</sup> See N.J.S.A. § 45:10-2; N.J.A.C. § 13:35-2A.1 *et seq.*

<sup>37</sup> See N.J.S.A. § 45:2C-3; N.J.A.C. § 13:35-9.16.

<sup>38</sup> See N.J.S.A. § 45:9-37.114; N.J.A.C. § 13:35-14.1 *et seq.*

<sup>39</sup> Interestingly, although the State Board of Medical Examiners (BME) promulgated the regulations for athletic trainers and receives applications for licensure for athletic trainers, *see* N.J.A.C. § 13:35-10.1, the athletic trainers regulation includes “and” rather than “or” when describing this obligation, dissimilar to the BME requirement but similar to the standard applicable to Massage and Bodywork Therapists and Physical Therapists, *see id.* § 10.10(d)(3).

<sup>40</sup> See *id.* § 13:37A-5.3(c).

<sup>41</sup> See *id.* § 13:39A-3.3(a), (d).

<sup>42</sup> See N.J.S.A. § 45:2D-11 (requiring compliance with 42 C.F.R. § 2.1 *et seq.*); N.J.A.C. § 13:34C-4.5(b), (e).

<sup>43</sup> See N.J.S.A. §§ 26:5C-5, 8(a), 11.

<sup>44</sup> See N.J.A.C. § 10:5-47(a)(5), (b), -48.

<sup>45</sup> See N.J.S.A. § 26:4-41.

<sup>46</sup> *Id.* § 26:2B-8.

## Appendix E

### **Table – Comparing Examples of Specific Requirements for Consent and Authorization in New Jersey**



<b>COMPARING EXAMPLES OF SPECIFIC REQUIREMENTS FOR CONSENT AND AUTHORIZATION IN NEW JERSEY</b>				
	<b>HIPAA, 45 CFR 164.508 (Authorization)</b>	<b>42 C.F.R. Part 2 (Consent)</b>	<b>N.J.A.C. § 10:37-6.79 (Authorization)</b>	<b>N.J.S.A. § 30:4-24.3 (Consent)</b>
<b>No specifics provided</b>				X
<b>Must be written</b>	X	X	X	
<b>Information to be disclosed</b>	A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.	How much and what kind of information is to be disclosed.	The information to be disclosed.	
<b>Identity of disclosing party</b>	The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.	The specific name or general designation of the program or person permitted to make the disclosure.	The name of the agency disclosing the information.	
<b>Identity of receiving party</b>	The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure.	The name or title of the individual or the name of the organization to which disclosure is to be made.	The name or title of the person or organization to which disclosure is to be made.	
<b>Purpose of disclosure</b>	A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual	The purpose of the disclosure.	The purpose of the disclosure and predictable outcome.	

COMPARING EXAMPLES OF SPECIFIC REQUIREMENTS FOR CONSENT AND AUTHORIZATION IN NEW JERSEY				
	HIPAA, 45 CFR 164.508 (Authorization)	42 C.F.R. Part 2 (Consent)	N.J.A.C. § 10:37-6.79 (Authorization)	N.J.S.A. § 30:4-24.3 (Consent)
	initiates the authorization and does not, or elects not to, provide a statement of the purpose.			
<b>Expiration</b>	An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure.	The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.	4 months from the date it is signed unless the release notes a different time limit or triggering event.	
<b>Signature Requirement</b>	Signature of the individual. If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided	The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient.	The signature of the consumer or of a person authorized by law to sign for the consumer, following a statement that the undersigned understands the nature of the authorization and has been informed that he or she has the right to revoke consent at any time by written communication to the custodian of the records.	

<b>COMPARING EXAMPLES OF SPECIFIC REQUIREMENTS FOR CONSENT AND AUTHORIZATION IN NEW JERSEY</b>				
	<b>HIPAA, 45 CFR 164.508 (Authorization)</b>	<b>42 C.F.R. Part 2 (Consent)</b>	<b>N.J.A.C. § 10:37-6.79 (Authorization)</b>	<b>N.J.S.A. § 30:4-24.3 (Consent)</b>
<b>Date Requirement</b>	X	The date on which the consent is signed.	The date on which the authorization is signed.	
<b>Name of patient or consumer</b>		The name of the patient.	The name of the consumer.	
<b>Revocation</b>	Statement adequate to place the individual on notice of the individual's right to revoke in writing, including information regarding exceptions, as detailed in the rule.	<ul style="list-style-type: none"> <li>• A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.</li> <li>• Permits patient to revoke consent orally (but SAMHSA recommends in writing).</li> </ul>	Right to revoke consent at any time by written communication to the custodian of the records.	
<b>Ability to Condition Treatment</b>	Statement adequate to place the individual on notice of whether CEs may condition treatment, payment, enrollment, or			

COMPARING EXAMPLES OF SPECIFIC REQUIREMENTS FOR CONSENT AND AUTHORIZATION IN NEW JERSEY				
	HIPAA, 45 CFR 164.508 (Authorization)	42 C.F.R. Part 2 (Consent)	N.J.A.C. § 10:37-6.79 (Authorization)	N.J.S.A. § 30:4-24.3 (Consent)
	eligibility for benefits on whether individual signs authorization.			
<b>Redisclosure</b>	Statement adequate to place the individual on notice of the potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected	Must include a written statement that the information disclosed pursuant to consent may not be redisclosed. Rule provides specific language for this notice.		
<b>Plain Language Requirement</b>	X			
<b>Copy of Authorization to Individual</b>	X			
<b>Documentation</b>	A CE must document and retain any signed authorization as required by the rule.			
<b>Expressly Permitted to Contain Additional Elements</b>	A valid authorization may contain elements or information in addition to the elements required by this section, provided that			

COMPARING EXAMPLES OF SPECIFIC REQUIREMENTS FOR CONSENT AND AUTHORIZATION IN NEW JERSEY				
	HIPAA, 45 CFR 164.508 (Authorization)	42 C.F.R. Part 2 (Consent)	N.J.A.C. § 10:37-6.79 (Authorization)	N.J.S.A. § 30:4-24.3 (Consent)
	such additional elements or information are not inconsistent with the elements required by this section.			
<b>Compound Authorizations</b>	An authorization for use or disclosure of protected health information may not be combined with any other document to create a compound authorization, except as provided in the rule.			
<b>Minors</b>	<ul style="list-style-type: none"> <li>• Generally looks to state law to determine when CEs may disclose PHI concerning unemancipated minors.</li> <li>• Identifies three situations in which a parent, guardian, or other person acting in <i>loco parentis</i> is not the personal representative of a minor under HIPAA</li> </ul>	<ul style="list-style-type: none"> <li>• Largely leaves to state law the issue of who may consent to the disclosure of the records of minors.</li> <li>• Always requires minor’s written consent to disclose. Whether also need parent or guardian’s consent depends on state law.</li> <li>• Where a minor has the legal capacity under state law, when acting alone, to seek or obtain</li> </ul>	<ul style="list-style-type: none"> <li>• A minor <math>\geq 14</math>, who has requested admission and been admitted voluntarily to a psychiatric facility, special psychiatric hospital, or children's crisis intervention service may authorize the disclosure of his or her records in the same manner as an adult.</li> <li>• The minor's parent or legal guardian may authorize the disclosure of the minor's records,</li> </ul>	An individual or “his legal guardian, if any, or, if he is a minor, his parent or legal guardian,” may consent to disclosure.

COMPARING EXAMPLES OF SPECIFIC REQUIREMENTS FOR CONSENT AND AUTHORIZATION IN NEW JERSEY				
	<b>HIPAA, 45 CFR 164.508 (Authorization)</b>	<b>42 C.F.R. Part 2 (Consent)</b>	<b>N.J.A.C. § 10:37-6.79 (Authorization)</b>	<b>N.J.S.A. § 30:4-24.3 (Consent)</b>
	(but may be under state law).	alcohol or substance use disorder treatment, consent for disclosure under Part 2 only may be given by the minor. <ul style="list-style-type: none"> <li>Does not set a minimum age that a minor must be to give consent.</li> </ul>	provided that the minor shall be given prior notice and an opportunity to object to the disclosure. <ul style="list-style-type: none"> <li>Disclosure of clinical record of minor, who is <math>\geq 14</math> and requested admission and been voluntarily admitted to a psychiatric facility, special psychiatric hospital, or children’s crisis intervention service, requires the minor’s written authorization.</li> </ul>	

## Appendix F

### **Table - Examples of Rules Regarding Minor Consent to Disclosure of Health Information in New Jersey**

<b>EXAMPLES OF RULES REGARDING MINOR CONSENT TO DISCLOSURE OF HEALTH INFORMATION IN NEW JERSEY</b>	
<b>Law</b>	<b>Rules</b>
<b>HIPAA<sup>1</sup></b>	<ul style="list-style-type: none"> <li>• Generally looks to state law to determine when CEs may disclose PHI concerning unemancipated minors.</li> <li>• Guidance identifies three situations in which a parent, guardian, or other person acting <i>in loco parentis</i> is not the personal representative of a minor under HIPAA*:                             <ul style="list-style-type: none"> <li>○ When State or other law does not require the consent of a parent or other person before a minor can obtain a particular health care service, and the minor consents to the health care service;</li> <li>○ When someone other than the parent is authorized by law to consent to the provision of a particular health service to a minor and provides such consent;</li> <li>○ When a parent agrees to a confidential relationship between the minor and a health care provider.</li> </ul> </li> </ul> <p>*Note that state or other laws may grant the parent access to the minor’s medical records.</p>
<b>42 C.F.R. Part 2<sup>2</sup></b>	<ul style="list-style-type: none"> <li>• Largely leaves to state law the issue of who may consent to the disclosure of the records of minors.</li> <li>• Defines a minor as a person who has not attained the age of majority under state law, or, if state law is silent, 18.</li> <li>• Part 2 Programs always must get a minor’s written consent to disclose.                             <ul style="list-style-type: none"> <li>○ If state law requires consent from a parent, guardian, or other person (Parent) to provide substance use treatment to a minor, then the program must get written consent to disclose from both the minor and the Parent.</li> <li>○ But where a minor has the legal capacity under state law, when acting alone, to seek or obtain alcohol or substance use disorder treatment, consent for disclosure under Part 2 only may be given by the minor.</li> </ul> </li> <li>• Part 2 does not set a minimum age that a minor must be to give consent.</li> </ul>
<b>Title 30 Confidentiality Provision<sup>3</sup></b>	Permits an individual or “his legal guardian, if any, or, if he is a minor, his parent or legal guardian,” to consent to disclosure.
<b>Community Mental Health Providers Licensed by or Funded by, under Contract with, or Affiliated with the New Jersey</b>	<ul style="list-style-type: none"> <li>• Generally, a minor’s “parent or legal guardian may authorize the disclosure of the minor’s records, provided that the minor shall be given prior notice and an opportunity to object to the disclosure.”</li> <li>• When a minor <math>\geq 14</math> has requested admission and been voluntarily admitted to a psychiatric facility, special psychiatric hospital, or children’s crisis intervention service:                             <ul style="list-style-type: none"> <li>○ The minor may authorize disclosure of confidential records in the same manner as an adult.</li> <li>○ If that minor objects to disclosure, his/her parent’s consent is null and void.</li> <li>○ Disclosure of such a minor’s clinical records requires the minor’s written authorization.</li> </ul> </li> </ul>



EXAMPLES OF RULES REGARDING MINOR CONSENT TO DISCLOSURE OF HEALTH INFORMATION IN NEW JERSEY	
Law	Rules
Department of Human Services <sup>4</sup>	
Dentists <sup>5</sup>	The parent or guardian who has custody (whether sole or joint) is an authorized representative of a minor patient.
BME Regulated Entities (e.g., physicians, including psychiatrists; <sup>6</sup> physician assistants; <sup>7</sup> podiatrists; <sup>8</sup> certified nurse midwives; <sup>9</sup> acupuncturists, <sup>10</sup> and genetic counselors <sup>11</sup> )	<ul style="list-style-type: none"> <li>• Generally, the parent or guardian who has custody (whether sole or joint) is an authorized representative of a minor patient.</li> <li>• A parent or guardian will not be considered an authorized representative, however, where the minor’s condition being treated relates to pregnancy, sexually transmitted disease or substance abuse.</li> </ul>
Social Workers, <sup>12</sup> Psychologists, <sup>13</sup> Professional Counselors, and Associate Counselors <sup>14</sup>	<p>Generally:</p> <ul style="list-style-type: none"> <li>• If the client is a minor, a parent or legal guardian will be deemed to be an authorized representative.</li> <li>• When the client is <math>\geq 14</math>, but has not yet reached the age of majority, an authorization must be signed by the client <u>and</u> by the client's parent or legal guardian.</li> </ul>
Social Workers <sup>15</sup>	When a social worker provides services to more than one person in a family, each family member who is at least 14 must agree to waive their right to confidentiality in order for the professional to disclose any information received from any family member.
Alcohol and Drug Counselors <sup>16</sup>	<ul style="list-style-type: none"> <li>• “Confidentiality is applicable to both adults and minors in conformance with Federal and State law.”</li> <li>• A licensee or certificate holder must get “a signed release from all persons who are referred to in family counseling notes prior to release of such notes to a third party.”</li> </ul>
AIDS Assistance Act <sup>17</sup>	<ul style="list-style-type: none"> <li>• When consent is required for disclosure of the record of a minor “who has or is suspected of having AIDS or HIV infection, consent shall be obtained from the parent, guardian, or other individual authorized under State law to act in the minor’s behalf.” <ul style="list-style-type: none"> <li>○ Minor is defined as a person under the age of 12.<sup>18</sup></li> </ul> </li> </ul>

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<sup>1</sup> See 45 C.F.R. § 164.502.

<sup>2</sup> See 42 C.F.R. § 2.14.

<sup>3</sup> N.J.S.A. § 30:4-24.

<sup>4</sup> See N.J.A.C. § 10:37-6.79.

<sup>5</sup> See *id.* § 13:30-8.7(e)(1).

<sup>6</sup> See N.J.S.A. §§ 45:9-5.1, 45:9-6; N.J.A.C. § 13:35-6.5(e).

<sup>7</sup> See N.J.S.A. §§ 45:9-27.11-27.12; N.J.A.C. § 13:35-2B.1 *et seq.*

<sup>8</sup> See N.J.S.A. § 45:5-2; N.J.A.C. § 13:35-2.1 *et seq.*

<sup>9</sup> See N.J.S.A. § 45:10-2; N.J.A.C. § 13:35-2A.1 *et seq.*

<sup>10</sup> See N.J.S.A. § 45:2C-3; N.J.A.C. §§ 13:35-9.16.

<sup>11</sup> See N.J.S.A. § 45:9-37.114; N.J.A.C. § 13:35-14.1 *et seq.*

<sup>12</sup> See *id.* § 13:44G-12.4(a).

<sup>13</sup> See *id.* § 13:42-8.6(a).

<sup>14</sup> See *id.* § 13:34-18.6(a).

<sup>15</sup> See N.J.S.A. § 45:15BB-13(e); N.J.A.C. § 13:44G-12.3(a)(7).

<sup>16</sup> N.J.A.C. § 13:34C-4.5(d), (e).

<sup>17</sup> See N.J.S.A. §§ 26:5C-5, -13.

<sup>18</sup> Note that N.J.S.A. § 9:17A-4(a)(1) establishes 13 as the minimum age to be able to consent to HIV/AIDS treatment.



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