

WHITING FORENSIC HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 9:	Management of Information
PROCEDURE 9.38:	Confidentiality of Patient Information / Processing of Requests for Patient Information
Governing Body Approval:	June 7, 2018
REVISED:	

PURPOSE: To inform all Whiting Forensic Hospital (WFH) employees that all patient information is confidential and to provide Health Information Management (HIM), and Unit Clerks as directed by HIM, instruction regarding processing of requests for patient information.

SCOPE: All Clinical Staff, HIM, and Unit Clerk Staff

POLICY:

All information obtained and records prepared in the course of providing services to patients shall be confidential. Confidentiality of health information is protected under the following state and federal regulations:

Medical Information	<i>Section 4-104 of the Connecticut General Statutes</i>
Psychiatric Records	<i>Chapter 899 of the Connecticut General Statutes</i>
Substance Abuse Records	<i>42 CFR Part 2 of the Federal Regulations</i>
AIDS and/or HIV Related Information	<i>Chapter 368x of the C.G.S.</i>

In general, the above Statutes and Regulations state that medical, psychiatric, substance abuse or AIDS/HIV related information may not be released from patients' medical records without the informed written authorization of the patient.

Requests for copies of patient information are processed by HIM. The Unit Clerks under the direction of HIM may send copies of patient information as requested by the Social Worker for Discharge Planning purposes.

PROCEDURE:

1. Confidentiality of Patient Information:

- A. Each patient has the right to privacy and confidentiality, and this right extends to the fact of hospitalization, except when hospitalization is ordered by a court or other judicial body and is a matter of public record.
- B. Confidentiality applies to the involuntary, as well as to the voluntary patient. Patient information may only be released in compliance with this policy and Connecticut General Statutes regarding court-committed or PSRB-committed patients.
- C. Any staff member who violates the confidentiality of a patient may be liable to a lawsuit for monetary damages and the breach of confidentiality could lead to termination of employment.

2. Documents Defined as Part of the Medical Record:

The Public Health Code for the State of Connecticut defines the parts of the Medical Records as, "*the clinical record of the care and treatment of the patient, and his response to same.*" Other records distinguished: Medical records are maintained separately from business and other administrative records:

- A. *Incident reports* are not filed in the patient's medical record and are NOT considered part of the medical record. Subpoenas received by HIM which include incident reports are to be referred to the Chief Executive Officer (CEO), Chief Medical Officer (CMO) or designee.
- B. *Documentation received from other providers of care* is considered part of the medical record, as they are relied upon in the diagnosis, treatment and/or care of the patient. This information is not released unless it is specified on the authorization form per re-disclosure policies outlined in Connecticut General Statute 52-146i and Federal Regulations 42 CFR Part 2.
- C. Information received at Whiting Forensic Hospital (WFH) *pertaining to treatment at another hospital during Hospital Leave Status*, are not released unless it is specified on the authorization form per re-disclosure policies outlined in Connecticut General Statute 52-146i and Federal Regulations 42 CFR Part 2.
- D. Other information received at WFH, which does *not involve the diagnosis, treatment and/or care of the patient*, are not released. Persons requesting such information are referred to such other agencies.
- E. *HIV/AIDS Testing* is not part of the medical record if testing was resulting from a "significant exposure." When a physician obtains voluntary consent to testing after an

occupational exposure, or when involuntary testing is authorized, as provided in section 19a-582(e)(5) of the C.G.S., no record of the existence or results of the HIV-related test will appear in the person's medical record or other records unless the test result is relevant to the medical care the person is receiving at that time, or the person makes a specific written request that the test result be recorded. Access to these records shall be limited to the physician or to persons designated by the CEO or COPS of WFH.

- F. *Legal documents* pertaining to the patient's legal status, to include Court Reports, may be released if specified on the authorization to release information form, per re-disclosure policies.
- G. *A WFH patient's writings that are disclosed to the treatment team, such as journal entries or letters*, are considered part of the medical record but will not be released to third parties unless authorized by the patient or his/her representative.
- H.

3. Written Authorization to Release Patient Information:

- A. No information shall be released or shared without a proper authorization to release or share information.
 - 1. The signature of the person authorizing a release of information must be legible, must be signed in ink and dated. If a signature is in doubt or is not verifiable, the requestor may be notified to furnish a notarization with the signature before information may be released. No photocopied signatures are accepted. Signatures recorded as "X" require a witness signature.
 - 2. Authorizations received by fax will be honored, and the signature will be considered an original signature.
 - 3. Authorizations to release or share information must be a permanent part of the patient's medical record.
 - 4. Form WFH-184 is used for securing or releasing information to/from other hospitals/clinics/agencies/individuals regarding medical, psychiatric, alcohol and/or drug diagnoses and treatment and confidential HIV related information.

4. Persons Who May Authorize the Use and Disclosure of Patient Health Information (PHI):

- A. The patient:
 - 1. An involuntary patient, as well as a voluntary patient, may give or refuse to give an authorization. Court-committed patients may also give or refuse authorization, except to the Superior Court and/or PSRB as required by statute.
 - 2. Any competent patient 18 years of age or over may give WFH the authority to seek, release, or share information.
 - 3. If WFH seeks the patient's authorization, care must be taken to ensure that the patient is competent and arrived at an informed consent at the time the authorization is given.

B. Legal Guardian/Conservator/Executor or Administrator of Estate/Next-of-Kin:

1. The duly appointed legal guardian or conservator of an incapacitated patient may authorize WFH to seek, release, or share information. Documentation attesting their authority must accompany any such authorization.
 - a. Patients who have a conservator of person may authorize the use and disclosure of PHI without the written authorization of the conservator when it is necessary to facilitate the obtaining of PHI or the disclosure of PHI. The patient must have a basic understanding of hospital's need to seek or disclose his/her PHI.
2. The duly appointed Executor or Administrator of an estate or next-of-kin, of a deceased patient may authorize WFH to release information. The patient's death certificate, next-of-kin birth certificate, and documentation attesting their authority must accompany any such authorization.

C. Whiting Forensic Hospital:

1. WFH may release information without an authorization from the patient who is incapacitated in the opinion of a qualified psychiatrist and for whom a legal guardian has not been appointed and there is no known next of kin. The release of information must be in the best interest of the patient. Such verbal or written information may be disclosed only:
 - a. in communication between qualified physicians in provision of services or appropriate referrals, or,
 - b. to the extent necessary to make claims on behalf of a patient for aid, insurance, or medical assistance to which he/she may be entitled.

5. Disclosure of Patient Information – General Statement of Policy:

- A. All written requests to WFH to release information shall be referred to HIM for processing to ensure that all requests are processed according to existing regulations/policies.
- B. If a request is defective in any way, HIM shall return it to the requestor with an explanation and request for correction.
- C. All requests of an unusual nature shall be referred to the CEO or CMO of WFH.
- D. HIM shall determine whether it or a more appropriate unit (e.g., a treatment team, Patient's Accounts) shall respond to the request.
- E. HIM shall have final responsibility for reviewing all information to be released, to protect confidentiality, and to guard against releasing information about other patients, family members, relatives, etc., or records from other agencies.

6. Confidentiality of Specific Health Information:

A. Psychiatric Health Records:

Psychiatric health records are considered privileged communications and are thus

protected under Chapter 899 of the Connecticut General Statutes. C.G.S. 52-146d et seq. states that the protected communications include all "oral and written communications and records thereof relating to diagnosis and treatment of a patient's mental condition between the patient and a psychiatrist, or between a member of the patient's family and a psychiatrist, or between any such persons and a person participating under the supervision of a psychiatrist in the accomplishment of the objectives of diagnoses and treatment, wherever made." This privilege applies to civil and criminal actions, juvenile, probate, commitment and arbitration proceedings, proceedings preliminary to such actions or proceedings, and legislative and administrative proceedings.

B. Drug and Alcohol Abuse Treatment Records:

Substance abuse records are governed by federal and state statutes and regulations.

7. Confidentiality Statements:

A. All written communications or records regarding a patient (current/former) in this facility, which are disclosed to another person or agency, shall bear the following statement(s):

"NOTE: Confidentiality of psychiatric, drug and/or alcohol abuse and HIV records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization as provided under Connecticut General Statutes, Chapter 899c and sections 19a-581 through 590, and Federal Regulations 42 CFR 2. These laws prohibit you from making any further disclosure without specific written consent of the person to whom it pertains. A general authorization for the release of information is NOT sufficient for this purpose."

B. The following statement is added to the cover-letter for releases of information to attorneys:

“We are disclosing this information to you under Connecticut General Statutes. Under these statutes, you may not re-disclose the information contained therein to the patient without express authorization from this hospital or the patient's physician as provided in Section 4-194 of the Connecticut General Statutes.”

8. Required Elements for an Authorization to Release Patient Information:

- A. The purpose of the request.
- B. The specific information being requested.
- C. The name and address of the organization or individual requesting the information.
- D. The date the authorization was signed.
- E. A notice that authorization is valid only for a specified period of time.
- F. See also Operational Procedure Manual – Policy 9/HIPAA

9. Copying of Medical Record Documentation:

- A. If a patient or WFH Staff request that copies from the patient's record be sent to outside agencies, hospitals, or individuals, a team member is responsible for obtaining the patient's authorization (WFH-184). The request is processed by the Unit Clerk under the direction of HIM or the authorization form is sent to HIM for processing. HIM staff and the Unit Clerks as instructed by HIM, are the only WFH employees to reproduce any portion of the medical record for correspondence purposes.
- B. Whenever information is released, the authorization to release information shall be placed in the patient's record. This shall include a statement on:
 - a. The information released.
 - b. The date released.
 - c. The initials(s) of the HIM staff or Unit Clerk who released the information.
- C. Information regarding the release of patient information which includes where the information was sent, itemization of information sent, date request received and date processed is documented and maintained by HIM staff.
- D. For court-committed patients, Social Workers or other treatment staff may fax patient information as required by the court (letter to court) or information for referrals to other treatment facilities in the absence of the unit clerk assigned to the unit to expedite the delivery of the required information. During regular business hours all records faxing should be completed by a unit clerk.
 - a. The Social Worker or other treatment staff insures an Authorization for the Use and Disclosure of Protected Health Information form has been signed by the patient. If the purpose for the request or specific information required falls within the "other" categories on the release form, the information cannot not be sent without prior approval by the Director of HIM. The release form must contain the required elements to include:
 - 1. The purpose of the request.
 - 2. The specific information being released.
 - 3. The name, address and fax number of the organization and/or individual to receive the information.
 - b. The Social Worker or other treatment staff faxing patient information completes a cover letter (WFH-269) that lists:
 - 1. The information being faxed.
 - 2. Method of verification of identity/determination of authority.
 - 3. Documentation of a "Time Out" review of the information being sent.

10. Review of Medical Records by Non-WFH Employees – *No Copies Furnished:*

- A. When a request to review (no copies requested) a patient record is received, which has been authorized by the patient, the requestor may review the record on the unit or may review the record in HIM of the unit in which the patient resides.
- B. In the event that the record is of a patient who has been discharged (or expired), the record is reviewed by the requestor in HIM.
- C. Record reviews of active patients in the Whiting Forensic Hospital takes place in the CEO's office or other designated location.
- D. It is requested of all persons reviewing records that this review be conducted between the hours of 8:30 a.m. and 4:00 p.m. If the requestor wishes to review the record after 4:00 p.m., the record is reviewed on the unit in which the patient resides. The Nursing Department insures that a WFH employee is present during the review.

11. Oral Disclosures of Information:

Section 52-146(l) of the Connecticut General Statutes states that in cases where the disclosure of psychiatric information is made orally, the recipient of the information must be informed that such information is governed by the provisions of Chapter 899 of the Connecticut General Statutes.

12. Release of Information to Courts:

A. Subpoena Duces Tecum:

- 1. The subpoena provision in the Connecticut General Statutes 4-104 does NOT apply to psychiatric or substance abuse records.
- 2. It is required that an authorization be obtained from a patient whose records have been subpoenaed before disclosure whether the patient is named as a part to the lawsuit or not. If the patient or his/her attorney refuses to authorize the disclosure of the health record, the information may not be released. No information may be produced pursuant to a subpoena without valid written authorization from the patient (or legal guardian, conservator or executor of their estate). See Also Operational Manual Chapter 9; Procedure 9.4 Subpoena of Medical Records.

B. Commitment Proceedings and Appointment of a Conservator - Probate Court:

- a. In the instances where a patient is in our hospital and the court hearing is related to their legal status with WFH, a court order will not be required in order to have our staff or medical record present in court.

- b. For Probate Court proceedings for appointment of a conservator, authorization from the patient or a court order will not be required in order to have our staff or the medical record present in court as outlined in C.G.S. 152-146f(4).

13. Telephone Inquiries:

- A. The fact of hospitalization is confidential and shall not be revealed, nor shall any information be released over the phone.
- B. When a caller wishes to talk with a patient, the caller shall not be informed whether or not the person is a patient. The caller shall be informed that if the person is a patient, he/she will be notified and may return their call.

14. Visitors:

The fact of hospitalization is confidential and shall not be revealed, nor shall any information be released to a visitor requesting to see a patient. The visitor is to be referred to the Nursing Supervisor.

15. Family Members of Patients:

No information on current patients is to be released by anyone, except the appropriate treating staff, without the written authorization of the patient. The patient must be informed that information appropriate to the treatment needs of the patient will be sought from and/or shared with family members. If the patient requests that the family members not be informed of the hospitalization, and it is essential that family members be informed or information be sought from them, the patient must be informed of the essential nature of the need and his/her cooperation solicited. If the patient absolutely refuses, his/her wish must be honored.

16. News Media:

All requests by News Media for patient-specific information is referred to the CEO or CMO of WFH.

17. WFH Staff:

- A. No staff member may have access to patients' records unless the staff member has a bona fide treatment responsibility, interest in the furtherance of the patients' treatment goals, or as directed by the CEO or CMO.
- B. Treatment staff or HIM has the right to deny access to a patient's record if not satisfied with the staff member's responsibility or interest in the matter. The staff member is referred to the CEO or CMO.

18. State Collection Services and the Department of Income Maintenance:

The patient's name, address, and fees for service may be disclosed, under the provisions of Connecticut General Statutes, Section 17b-225 to the State Collection Services, as well as treatment information (e.g., diagnoses, dates and duration of treatment, discharge summary). This statute also covers matters concerning financial assistance to patients by the State Department of Income Maintenance.

19. Disability Rights Connecticut (DRCT):

- A. DRCT may review medical records when the patient or their conservator has signed a release of information or when the DRCT determines there is probable cause to believe that the patient is being abused or neglected, or DRCT has received a complaint of abuse or neglect.
- B.

20. Case Managers:

The authorization for Mental Health Case Managers to review the patient's medical record is obtained when the patient signs the Consent for Treatment form upon admission to WFH. Requests for copies of medical record documentation are process by HIM with the patient's written authorization (WFH-184).

21. Medical Examiner:

Information requested by a properly identified medical examiner, in the case of a patient's death, may be released without written authorization.

22. Release of Information – Legal Issues:

A. Law Enforcement Agencies:

- 1 Information regarding treatment rendered at WFH may be given to clinical staff engaged in diagnosis or treatment of the patient without the patient's authorization (as per CGS 52-146f(1)) when the patient is in the custody of Law Enforcement Agencies (i.e., jail, prison, police lockup, or other detention facility). HIM returns the call from the Law Enforcement Agency to verify their identification.
- 2 Medical records or other patient information will not be released to law enforcement personnel without the patient's written authorization. In the absence of statutory authority, court order, search warrant, etc., a police agency has no authority to examine a medical record.
- 3. Crimes committed on the WFH premises or against WFH employees may be reported to law enforcement personnel. The circumstances of the incident, the patient's name, address, and the patient's last known whereabouts are the ONLY information to be

released. Information from the patient's medical record may NOT be released.

4. Suspected child abuse and neglect may be reported, but only the minimum necessary information to complete the report shall be released. (See Procedure 9.23 Use and Disclosure of Protected Health Information Without Patient/Conservator Authorization.)
- B. Attorneys Appointed to Represent Involuntary Patients - Commitment Proceedings by the Probate Court:
- a. As a patient's representative, an attorney has the right to communicate with staff and to review the patient's record as outlined in C.G.S. 52-146f.
 - b. The attorney must furnish the court order or written authorization from the patient to the Nursing Supervisor.
- C. Psychiatrist or Other Professional Person Appointed to Evaluate Patients:
- a. Per C.G.S. 52-146f(4), an outside psychiatrist or other professional person appointed by the court to evaluate a patient has the right to review the patient's record.
 - b. The outside psychiatrist or other professional person must furnish the court order to the Nursing Supervisor.
 - c. The patient's record is reviewed in the CEO's Office or other designated area, in the presence of treatment or administrative staff.
 - d. Copies of the medical record must be furnished upon request. After the court order has been verified by Health Information Management, copies are provided as requested.

23. Treatment Facilities:

Other Department of Mental Health Facilities/Crisis Intervention Programs Funded by DMHAS:

C.G.S. 17a-451(t) states the commissioner of mental health may direct "clinical staff at department of mental health facilities or in crisis intervention programs funded by the department who are providing treatment to a patient to request disclosure of the patient's record of previous treatment in order to accomplish the objectives of diagnosis or treatment of the patient. If the clinical staff in possession of the requested record determines that disclosure would assist the accomplishment of the objectives of diagnosis or treatment, the record may be disclosed to the requesting clinical staff without patient authorization. Records disclosed shall be limited to records maintained at department facilities or crisis intervention programs funded by the department."

24. Social Agencies Other Treatment Facilities:

- A. Current Patients - *See # 25 below*
- B. Discharged Patients - No information is to be released except upon the receipt of a written, duly executed authorization to release information.

25. Sharing/Releasing Information – Current Inpatient:

A. Mental Health Centers or Clinics:

- a. Sharing information is by treatment teams or other appropriate professional staff only and applies only to current patients on whom there is joint activity; admission to WFH through a Center or Clinic; patient referral by WFH to a Center or Clinic for continuing or follow-up care or treatment; etc. The treating teams honors the request.
- b. The call is transferred to the team, and verbal information is given by only a qualified staff person. A qualified staff person may include the attending psychiatrist, psychologist, social worker, unit director, or other staff involved with treatment of the patient and development of the treatment plan. Requests for written information are processed with the patient's authorization (WFH-184) by the Unit Clerk or HIM Staff.
- c. The patient must be informed that there will be sharing of information between the two facilities.
- d. Information disclosed must be documented in the medical record.

B. Agencies or Individuals Involved with Current Patients:

- a. The treatment teams or other appropriate professional staff may share verbal information with agencies (welfare departments, courts, etc.) or individuals (physicians, attorneys, probation officers, etc.) involved with current patients. Requests for written information are processed with the patient's authorization (WFH-184) by HIM.
- b. The information must be pertinent and specific, and its purpose must be the furtherance of the patient's treatment goals.
- c. The patient must be informed that there will be a sharing of information.
- d. Any sharing of information must be documented in the patient's record.

26. Facilities Where Patients Are Placed:

- A. The treatment teams or other appropriate professional staff, only, may share verbal information with facilities (e.g., group homes and other supervised residential settings) where patients may be placed for follow-up care and/or treatment. Requests for written information are processed with the patients' authorization (WFH-184) by the Unit Clerk or HIM Staff.
 - a. The information must be pertinent and specific, and its purpose must be the furtherance of the patient's treatment goals.
 - b. The patient must be informed that there will be a sharing of information.
- B. Nursing Homes, Acute Care Hospitals, or Other Hospitals (Direct Transfer or Medical Discharge Acute Care MD/AC Status):
 - a. Per Federal and State regulations, pertinent medical/psychiatric information is sent with the patient (or sent as soon as possible) upon direct transfer to a nursing home, an acute care hospital, or other medical or psychiatric (inpatient) hospital without written authorization from the patient. The discharge summary is sent as soon as it is completed.

27. Requests from Patients (former or Active) to Inspect or Receive Copies of their Medical Record:

A. Active Patients: - Treatment Plans:

Treatment Plan - In compliance with The Joint Commission (TJC) and Medicare Regulations and Standards, the patient is to participate in the development of their treatment plan, and such participation is to be documented in the medical record. As appropriate, the patient reviews and signs the treatment plan with a member of the Treatment Team to indicate their participation. The patient may receive a copy of the Treatment Plan. No written authorization is required.

B. Discharged Patients:

- a. The Director of HIM is responsible for responding to all requests for patient access to records for discharged patients. Requests made elsewhere are referred directly to HIM, Merritt Hall.
- b. All requests for copies of medical records MUST be in writing (WFH-184)

c. Except for requests from Active Patients for copies of current Treatment Plans, the Director of HIM asks the patient the purpose of the request. HIM offers to send the record directly to the individual/agency the copy is needed for.

1. If the patient still requests a copy, their request is referred to a psychiatrist for approval/denial of their request.

28. Exceptions for Releasing Information Without Written Authorization:

A. Psychiatric or Medical Emergencies:

a. Phone requests for information are honored in the case of psychiatric or medical emergencies to facilitate immediate and effective treatment of the patient.

b. Such release of information is only to a professional person or another hospital and only in cases where a patient under their immediate care is in an emergency situation. Verification must be made of the professional person or hospital by returning the telephone call.

c. Information is released when a psychiatrist determines that there is imminent risk of danger to self/others or when it is necessary to disclose for the purpose of admitting the patient to a mental health facility.

d. Per C.G.S. 52-146f(2), this disclosure is permissible only in order to effect immediate hospitalization of the patient, and not for any other purpose (e.g., informing police of possible criminal actions of the patient, etc.).

e. For current patients, the treating teams honors the request. The call is transferred to the team, and information is given by only a qualified staff person. A qualified staff person may include the attending psychiatrist, psychologist, social worker, unit director, or other staff involved with treatment of the patient and development of the treatment plan.

f. For discharged patients, HIM honors the request or may call upon the treatment team to respond to the request as above.

B. Information Exchange Between Mental Health Centers/Clinics, Medical or Psychiatric Hospitals and WFH for Discharged Patients:

a. Information may be shared between Mental Health Centers/Clinics, Medical or Psychiatric Hospitals, and WFH when a patient is being transferred from one of these Mental Health facilities to another for continued care.

b. In order to exchange written information, the signature of the patient must be obtained (WFH-184), and the request is processed by HIM. The Discharge Summary is copied and sent as soon as it is completed.

c. Qualified Services Organization Agreements:

A qualified services organization agreement means a person who provides services such as bill collecting, laboratory analysis, or medical or other professional services for which they have entered into a written agreement with WFH.

29. Regulatory Agencies, Research Facilities, DMHAS, and WFH Administration:

A. Conduct of Research, Gathering Statistical Data, Education (C.G.S. 52-146g):

For research requests, see Procedure 9.26 Use and Disclosure of Protected Health Information for Research. Members of the Utilization Review Committee, Quality Assurance/Improvement Committees, Medical Record Committee or professional staff performing medical evaluation studies (to include Infection Control Studies, Death Review etc.) may review medical records which are determined to be necessary for these individuals to perform their duties as part of the peer review process. Written authorization is not necessary.

B.

C. TJC and Department of Public Health:

- a. Surveyors of TJC and DPH may review medical records for accreditation or certification purposes without the authorization of the patient. These surveyors abide by our WFH/DMHAS confidentiality policies.

D. Exposure Evaluation Group:

Disclosure of confidential HIV-related information may be revealed to WFH health care or other workers who in the course of their occupational duties have had a significant exposure to HIV infection, provided the criteria outlined in Connecticut General Statutes 19a-581 through 590 are met. All such disclosures are made by the Chairman of the "Exposure Evaluation Group" or his designee.

30. Confidentiality of Substance Abuse Information

A. Confidentiality of Alcohol and Drug Abuse patient records is defined in 42 CFR Part 2 of the Federal Regulations. The regulations permit disclosure without patient authorization if the disclosure is:

- a. to medical personnel to meet any individual's bona fide medical emergency;
- b. authorization to qualified personnel for research, audit, or program evaluation. Qualified personnel may not include patient identifying information in any report or otherwise disclose patient identities except back to the program which was the source of the information;
- c. pursuant to a court order after the court has made a finding that "good cause" exists.

d. required to fulfill reporting obligations to the PSRB and/or Superior Court as mandated by Connecticut General Statutes.

- B. Information may be released with the written authorization of the patient (WFH-184) which specifies that drug/alcohol information is being released. If the form received, for WFH to release substance abuse information, does not specify that drug/alcohol abuse information may be disclosed, the authorization form is returned to the sender with a copy of the confidentiality statement as outlined in 42 CFR Part 2 of the Federal Regulations.

31. Disclosure of AIDS and/or HIV Related Information:

- A. The confidentiality of AIDS and/or HIV related information is protected under C.G.S. Chapter 368x. Information may not be released without the patient's written authorization (WFH-184) for disclosure of confidential HIV related information which is signed by the protected individual or a person authorized to authorization to health care for the individual which is dated and specifies to whom disclosure is authorized, the purpose for such disclosure and the time period during which the release is to be effective. A general authorization for the release of medical or other information is NOT a release of confidential HIV related information.
- B. Conditions under Which HIV Related Information May Be Disclosed:**
- a. No person who obtains confidential HIV related information may disclose or be compelled to disclose such information except for the following:
 1. the protected individual or his legal guardian
 2. any person who secures a release of confidential HIV related information
 3. a federal, state or local health officer when such disclosure is mandated or authorized by federal or state law
 4. a health care provider or health facility when knowledge of the HIV related information is necessary to provide appropriate care or treatment to the protected individual or a child of the individual and when confidential HIV related information is already recorded in a medical chart or record and a health care provider has access to such record for the purpose of providing medical care to the protected individual
 5. a medical examiner to assist in determining the cause or circumstances of death
 6. health facility staff committees or accreditation or oversight review organizations which are conducting program monitoring, program evaluation or service reviews

7. a health care provider or other person in cases where such provider or person in the course of his occupational duties has had a significant exposure to HIV infection, provided the criteria outlined in C.G.S. 19a-583 are met
8. employees of hospitals for mental illness operated by the department of mental health if the infection control committee of the hospital determines that the behavior of the patient poses a significant risk of transmission to another patient of the hospital
9. any person allowed access to such information by a court order which is issued in compliance with provisions outlined in C.G.S. 19a-582
10. life and health insurers, government payers and health care centers and their affiliates, reinsurer, and contractors, except agents and brokers, in connection with underwriting and claim activity for life, health, and disability benefits
11. any health care provider specifically designated by the protected individual to receive such information received by a life or health insurer or health care center pursuant to an application for life, health or disability insurance.

B. Disclosures to Known Partner(s):

- a. A physician may disclose confidential HIV-related information to a known partner of a protected individual if both the partner and the protected individual are under the physician's care or to a public health officer for the purpose of informing or warning partners of the protected individual that they may have been exposed to the HIV virus under conditions outlined in C.G.S. 19a-584. The physician may also warn or inform a partner at the request of the protected individual as outlined in Chapter 368x of the Connecticut General Statutes.
- b. The physician or public health officer shall have no obligation to warn or inform, identify, or locate any partner.

C. Notation of Disclosures:

- a. Disclosures made to the below-listed persons/agencies do not need to be noted in the medical record:
 1. a federal, state, or local health officer when such disclosure is mandated or authorized by federal or state law
 2. persons reviewing information or records in the ordinary course of ensuring that a health facility is in compliance with applicable quality care standards or any other authorized program evaluation
 3. program monitoring or service review
- b. ALL other disclosures, oral and written, must be noted in the medical record or with any record of an HIV-related test result of a protected individual, who shall be informed of such disclosures upon request; provided for disclosures made to governmental agents requiring information necessary for payments to be made on

behalf of patients or clients pursuant to contract law, such notation need only be entered at the time the disclosure is first made.

D. Disclosure of Confidential HIV-Related Information to a Health Care or Other Worker Pursuant to a "Significant Exposure"

Disclosure of confidential HIV related information may be revealed to WFH health care or other workers who in the course of their occupational duties have had a significant exposure to HIV infection, provided the criteria outlined in C.G.S. 19a-583 are met. All such disclosures are made by the Chair of the exposure evaluation group or his/her designee. The exposure evaluation group shall be an ad hoc group assigned by the CMO.

E. Disclosures to Mental Health Centers, Clinics, Medical/Psychiatric Hospitals, Nursing Homes, Group Homes, Boarding Homes, Family Care Homes, or Other Treatment Facilities

- a. Confidential HIV-related information may only be disclosed to a health care provider or health facility without the patient's authorization when knowledge of the HIV - related information is necessary to provide appropriate care or treatment to the protected individual. This may only be determined by a physician.
- b. A notation of the disclosure is made by the physician in the patient's medical record.

F. To Courts, Administrative Agencies via Subpoena Duces Tecum

The subpoena provision in the Connecticut General Statutes 4-104 does NOT apply to confidential HIV-related information. When a record is subpoenaed that contains confidential HIV-related information, the facility must request either a court order or authorization of the patient prior to release of the record, or certified true copy thereof.