CONFIDENTIALITY

written by Richard Leslie | November 1, 2021

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NOTE: The following article was first published on the CPH Insurance's website in October 2014. It appears below with minor additions and changes. The important exception to confidentiality discussed in this article should be well understood by patients and practitioner from the outset of treatment. Such an understanding can help to avoid problems for the practitioner.

Confidentiality is the cornerstone of psychotherapy and most patients expect it. Many patients, however, perhaps most, are not aware of the many exceptions to confidentiality (e.g., over 25 under California law). In many states, and in HIPAA regulations (federal), there is no requirement to inform patients of all of the exceptions to confidentiality. Some practitioners routinely tell patients of their child abuse reporting duties or the dangerous patient exception to confidentiality, although in some states, such disclosures may not be required. One exception to confidentiality that should be disclosed is the one that allows practitioners to communicate with other licensed practitioners or health care facilities and to share personally identifiable "medical information" for purposes of diagnosis or treatment of the patient.

The reality is that some licensed mental health professionals remain unaware of the basic and important proposition that a written and signed authorization from the patient is not required in order to communicate with, or exchange treatment records or information with another health care professional or health facility, if done for purposes of diagnosis or treatment of the patient. The importance of this basic legal principle cannot be over-emphasized, and its usefulness should not be under-estimated. The specific language used in a particular state law will determine the breadth of, or limitations to, this general principle. For those practitioners who are "covered entities" under HIPAA regulations, the required Notice of Privacy Practices informs patients, among other things, of the fact that their personal health information can be used and disclosed, without their written authorization, with other health professionals or facilities for purposes of diagnosis or treatment.

I was reminded of this principle of law by my consultation with a practitioner who was being manipulated by a patient. The patient was being treated for an eating disorder and was telling the therapist that she would not sign an authorization for the therapist to speak with her physician, even though the therapist thought that such communication was appropriate and necessary. (I also recall several cases where a patient with an eating disorder tried to limit the ability of the therapist to communicate with other health care providers or with family members, even in cases of suspected imminent self-harm.) What the patient did not know is that the therapist was free to talk with or otherwise communicate with the doctor without the written and signed authorization of the patient.

Unfortunately, the therapist was also not aware of this information. If the therapist would have been aware, this principle of law could have been disclosed in any required or voluntary disclosure form or information statement given to the patient at the outset of treatment.

Patients should understand that they cannot tie the hands of their therapists by limiting their communications with other health care professionals for purposes of diagnosis or treatment, which would expose them to potential liability for negligence. Therapists generally do not, and should not, treat patients in such a vacuum. Communication with other health care providers or facilities, whether former or current, is often necessary or desirable for the provision of prudent and reasonable care. If patients are not comfortable with this, they can search for a practitioner who may be willing to let the patient set such rules, rather than abiding by the public policy determinations made by the state legislature or by federal regulators. The practitioner is not in a power struggle with the patient, but rather, the public policy regarding these kinds of permitted disclosures has been long established. Disclosures to other health care professionals for purposes of diagnosis or treatment of the patient are not typically mandated by law, but rather, are expressly permitted by law. If practitioners want to agree to restrictions on, or exceptions to, this basic principle they may do so – but there is risk in doing so.

There are many questions that arise involving this widely accepted principle of law, and they arise in a variety of scenarios. For example, suppose that a patient asks that a former therapist not provide information to a requesting/treating psychiatrist. Would or should the therapist comply with such a request from the patient? Should any request be made in writing? How should that request from the patient be handled? How much information is desired by the psychiatrist? Is it wanted for diagnosis or treatment purposes, or for some other purpose? Does the psychiatrist need to see the written records, or might a conversation with the former therapist suffice? Would the therapist be obligated to share only the minimum necessary to satisfy the request, or must the therapist share as much information as possible in order to help the psychiatrist better treat the patient? Might therapists have liability if they comply with the patient's request and refuse to share the information desired by the psychiatrist?

A final comment about this principle of law involves HIPAA in its earlier iterations. There were federal regulations requiring that the patient sign an informed consent form containing specified content regarding the practitioner's right to release personal health information without the signed authorization of the patient, for purposes of treatment, payment, or health care operations. While these regulations contained no requirement to include a provision disclosing that the practitioner had the right to refuse treatment if the patient did not sign the informed consent form, such a provision was not prohibited. Thereafter, federal regulators (U.S. Department of Health and Human Services) recognized the importance for the practitioner to be able to share otherwise confidential information with other health care practitioners and facilities for diagnosis or treatment purposes. The once required informed consent regulation was then repealed, thereby allowing practitioners who choose to have a consent process complete discretion in designing that process. The federal regulators had decided that this important principle of confidentiality need only be disclosed in the Notice of Privacy Practices.