# Confidentiality – Some Basics Revisited

written by Richard Leslie | September 5, 2023

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***NOTE*: The importance of the duty of confidentiality between patient and practitioner is at the core of that professional relationship. There are various aspects of the duty of confidentiality that are sometimes misunderstood – either by the mental health practitioner or the patient. The following article addresses just a few of those aspects. It was first published on the CPH and Associates' website in October 2015. It appears below with minor changes.**

I once again focus upon the importance of confidentiality and some of its basics. For those who care about their profession as a psychotherapist, marriage and family therapist, mental health or professional counselor (whatever the description), they too should focus upon confidentiality and its critical importance to patients, to society, and to their chosen profession. State law (including regulations and case law) addressing confidentiality governs practitioners who are not subject to HIPAA. HIPAA's "Privacy Rule" (federal regulations) applies to those who are "covered entities," even if the "entity" is a sole practitioner (state law may also apply). State legislatures pass laws that either protect or encroach upon the confidentiality rights of patients, as does the U.S. Department of Health and Human Services in the form of federal regulations.

Confidentiality is, in essence, a restriction upon the volunteering of information outside of the courtroom setting. The concept of privilege (and privileged communications) involves the right and duty to withhold testimony and records in a legal proceeding. Confidentiality is considered by many to be the cornerstone of psychotherapy. This reality was recognized in the famous Tarasoff vs. Regents, University of California decision of the California Supreme Court decades ago (1976 to be precise – thus the word "he" in the following quote from the decision to describe the therapist). In one of my favorite passages from the decision, the Court made abundantly clear that it understood the importance of confidentiality. To quote the Court:

"We realize that the open and confidential character of psychotherapeutic dialogue encourages patients to express threats of violence, few of which are ever executed. Certainly a therapist should not be encouraged routinely to reveal such threats; such disclosures could seriously disrupt the patient's relationship with his therapist and with the persons threatened. To the contrary, the therapist's obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others, and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger."

What I have always admired about the Court's opinion in Tarasoff, especially the quoted passage, is the

respect and deference the court gives to confidentiality. The Court protects confidentiality even in the face of articulated threats of violence. It properly views confidentiality as the necessary ingredient to the therapist-patient relationship. It would be relatively easy to convince the uninformed or poorly informed public, and some lawmakers, that there should be increased exceptions to confidentiality by making arguments based upon a generalized or misplaced focus on crime prevention or crime detection. This can be a slippery and very dangerous slope. By use of the phrase "uninformed or poorly informed," I refer to a lack of knowledge about mental health treatment and the need to protect patient privacy and confidentiality, and the resultant benefits to the patient, to society, and to the profession. Therapists treat, and hopefully, heal. Patients must reveal the very personal details of their lives in order to get meaningful and effective help; and criminal activity or involvement (both minor and major) is often revealed. Others, however, are charged with the responsibility to prevent, detect, and prosecute crime.

Suppose that a police officer, deputy sheriff, detective, or welfare fraud investigator comes to your office asking questions about a particular suspect and asking whether you are treating such person. I have spoken to therapists whose first instincts were to be cooperative with governmental agents and to want to help. I quickly convince most therapists that they should have a different attitude – that is, an attitude of non-cooperation (pleasantly delivered – unlike the following). "None of your business officer – I do not reveal the identity of my patients to anyone and I am unwilling to acknowledge the fact that I may not be treating a particular person. I wish you well." The above scenario addresses confidentiality as to the "fact of the therapist-patient relationship" rather than as to the content of the confidential communications.

Signed authorizations from patients enable mental health practitioners to share confidential information with others, within the confines of the authorization (time period and content). Otherwise, confidentiality can only be broken when certain disclosures/reports are required by law or when they are authorized or permitted by law. If simply permitted but not mandated, practitioners must use their best judgment as to whether a disclosure could disrupt or harm the therapeutic relationship. Perhaps the most important and useful exception to confidentiality, where a signed authorization from the patient is not necessary, is where the information is released to another health care provider or health care facility for purposes of the diagnosis or treatment of the patient. This is the law in California, and I suspect in most other states. The U.S. Department of Health and Human Services recognized this basic principle when promulgating the Privacy Rule implementing HIPAA. Usually, the past crimes (felonies and misdemeanors) of the patient will be treated as confidential, but state law will of course determine the exceptions to this general principle. Most states have mandatory reporting laws for suspected child abuse or neglect, elder abuse, and dependent adult abuse.

The duty of confidentiality typically survives the death of the patient, so care must be taken after the death of a patient, which may occur suddenly or unexpectedly. In cases of suspected wrongdoing against or suicide of the patient, the county coroner or medical examiner will typically have access to mental health records (to determine the cause of death, for example) under state law. A family member or surviving spouse may pressure the treating therapist to release information about the deceased. A

fine line must often be walked between being supportive or understanding of the aggrieved survivors and maintaining confidentiality. Is there a signed authorization from the personal representative or beneficiary of the deceased (or someone else who is authorized under state law) to allow release of the information to a third party?  Does the requesting person have a right to inspect the records? The determination as to who is entitled to authorize the release of information or to have access to the information may take some time, and it is important for therapists to maintain confidentiality until they are clear about the authority of the requesting person (being careful to comply with any time requirement).