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STATE OF MICHIGAN

FRANK J. KELLEY, ATTORNEY GENERAL

Opinion No. 5709

May 20, 1980

MENTAL HEALTH:

Community mental health boards

Patient rights

A county community mental health board may obtain information concerning specific recipients of mental health services from private or public agencies with which it has contracted to provide mental health services to such recipients without necessity for securing the recipient's approval. Such information may be shared within the units of the community mental health program.

Honorable Claude A. Trim
State Representative
The Capitol
Lansing, Michigan 48909

You have requested my opinion on the following questions:

> (1) May a county community mental health board, which is legally defined as the 'Governing Body' and 'the Provider' of mental health services--require information about specific clients from the service provider agencies with which it contracts without the express agreement of the client?
>
> (2) May such a county community mental health board require its contracting service providers to share information about clients with each other, inasmuch as they are both part of the same single county mental health system?

1974 PA 258; MCLA 330.1001 et seq; MSA 14.800(1) et seq, 1974 PA 258, supra, MCLA 330.1200 et seq, is known as the Mental Health Code. 1974 PA 258, supra, ch 2, Sec. 200, et seq provides for county community mental health programs. 1974 PA 258, supra, Sec. 206 states that '[t]he purpose of a county community mental health program shall be to provide a range of mental health services for persons who are located within that county.' 1974 PA 258, supra, Sec. 208, as last amended by 1978 PA 166, requires that a minimum level of services be furnished through the county program. Upon establishment of a county mental health program, a twelve (12) member county community health board is established pursuant to 1974 PA 258, supra, Secs. 212 and 222.

1974 PA 258, supra, Sec. 226 sets forth the powers and duties of the county community mental health board and under subsection (g), the county community mental health board is empowered to approve and authorize all contracts for the providing of mental health services. Consideration must also be given to 1974 PA 258, supra, Sec. 226(h), which directs the county community health board to review and evaluate the quality, effectiveness and efficiency of services provided through the county program. Further, 1974 PA 258, supra, Sec. 226(j) permits the board to establish general policy guidelines within which the county program shall be executed by the director of the program. Also pertinent is 1974 PA 258, supra, Sec. 228, which states

'Subject to the provisions of this chapter, a board is authorized to enter into contracts for the purchase of mental health services with private or public agencies. . . .'

1974 PA 258, supra, ch 7, Sec. 700, et seq, sets forth the rights of recipients of mental health services. OAG, 1979-1980, No 5502, p ___ (July 2, 1979). 1974 PA 258, supra, Sec. 702(a) specifies that the receipt of mental health services '[s]hall not operate to deprive any person of his rights, benefits, or privileges.'

1974 PA 258, supra, Sec. 746, which concerns the records of recipients, states:

'(1) A complete record shall be kept current for each recipient of mental health services. The record shall at least include information pertinent to the services provided to the recipient, pertinent to the legal status of the recipient, required by this chapter or other provision of law, and required by rules or policies.

(2) The material in the record shall be confidential to the extent it is made confidential by section 748.'

In 1974 PA 258, supra, Sec. 748, the legislature has provided:

'(1) Information in the record of a recipient, and other information acquired in the course of providing mental health services to a recipient, shall be kept confidential and shall not be open to public inspection. The information may be disclosed outside the department, county community mental health program, or licensed private facility, [(1)] whichever is the holder of the record, only in the circumstances and under the conditions set forth in this section.

(2) When information is disclosed, the identity of the individual to whom it pertains shall be protected and shall not be disclosed unless it is germane to the authorized purpose for which disclosure was sought; and, when practicable, no other information shall be disclosed unless it is germane to the authorized purpose for which disclosure was sought.

(3) Any person receiving information made confidential by this section shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained.

. . .

(5) Information may be disclosed if the holder of the record and the recipient, his parents if he is a minor, or his legally appointed guardian consent:

(a) To providers of mental health services to the recipient.

(b) To the recipient or any other person or agency, provided that in the judgment of the holder the disclosure would not be detrimental to the recipient or others.

(6) Information may be disclosed in the discretion of the holder of the record:

(a) As necessary in order for the recipient to apply for or receive benefits.

(b) As necessary for the purpose of outside research, evaluation, accreditation, or statistical compilation, provided that the person who is the subject [sic, 'subject'] of the information can be identified from the disclosed information only when such identification is essential in order to achieve the purpose for which the information is sought or when preventing such identification would clearly be impractical, but in no event when the subject of the information is likely to be harmed by such identification.

(c) To providers of mental or other health services or a public agency when there is a compelling need for disclosure based upon a substantial probability of harm to the recipient or other persons.' [Emphasis supplied.]

Further, 1974 PA 258, supra, Sec. 750, specifies that communications between a mental health recipient and a psychiatrist or psychologist are privileged. See also RJA, 1961, Sec. 2157; MCLA 600.2157; MSA 27A.2157; People v Lapsley, 26 Mich App 424; 182 NW2d 601 (1970), lv app den 384 Mich 825 (1971); the freedom of information act, 1976 PA 442, as amended; Sec. 13(1)(i); MCLA 15.243(1)(i); MSA 4.1801(13)(1)(i).

(1) May a county community mental health board, which is legally defined as the 'Governing Body' and 'the Provider' of mental health services--require information about specific clients from the service provider agencies with which it contracts without the express agreement of the client?

1974 PA 258, Sec. 748(1), supra, provides that information concerning a recipient may be disclosed 'outside' the county community mental health program only as provided in section 748. This provision is designed to protect against the dissemination of information to facilities or persons outside the community mental health program. Where a recipient receives mental health services pursuant to a county community health program, the county program is the 'holder' of the record under 1974 PA 258, Sec. 748(1), supra. Thus, information concerning recipients may be circulated within units of the community mental health program, which includes those private or public agencies with which the county mental health board has contracted for mental health services, pursuant to 1974 PA 258, Sec. 228, supra.

A review of mental health recipients' privacy rights prior to the enactment of 1974 PA 258, Sec. 748, supra, is instructive.

Community mental health service programs were initially established pursuant to 1963 PA 54. [(2)] Thereafter, 1973 PA 85 added Sec. 15 to 1963 PA 54, supra, to provide:

'The department of mental health in developing and operating its community services data system shall insure that a patient's right of privacy is held inviolate and to this end the department will not collect and store community services data which would make it possible to identify a patient by name. Further, no such information in the possession of the department prior to the effective date of this section [August 5, 1973] may be disclosed.' [(3)]

1974 PA 107 [(4)] was enacted to provide for the licensing and regulation of mental hospitals, psychiatric hospitals and psychiatric units. 1974 PA 107, supra, Sec. 9, stated:

'The director [of the department of mental health] shall make inspections, require reports, have access to information to the extent necessary to carry out the purposes of this act and the rules promulgated by him. A licensee shall include on a patient's medical chart a complete record of the purpose of hospitalization, of tests and examinations performed, and of observations made and treatments provided. Representatives of the department of mental health shall respect the confidentiality of records pertaining to patient care, and shall not disclose the contents of the records or the identity of the patient, except upon court order.'

Thus, under the former provisions of 1963 PA 54, Sec. 15, supra, the privacy of patients who received community mental health services was to be held inviolate, and patient data may not be maintained in any manner whereby a patient may be identified by name. Further, under 1974 PA 107, Sec. 9, supra, patients' privacy rights were further safeguarded as patient records were to be held confidential by the department of mental health, and neither the contents of a record nor the name of a patient may be disclosed without court order. However, no provision of 1963 PA 53, supra, or 1974 PA 107, supra, in safeguarding the privacy rights of recipients of mental health services prohibited the dissemination of a patient's record information within the framework of the mental health system, in furtherance of the furnishing of mental health services.

When enacting a comprehensive statute, such as 1974 PA 258, supra, the legislature is presumed to have knowledge of existing statutes. Skidmore v Czapiga, 82 Mich App 689; 267 NW2d 150, lv den 403 Mich 810 (1978). Therefore, it must be presumed the legislature in enacting 1974 PA 258, Sec. 748, supra, was cognizant of the provisions of 1963 PA 54, Sec. 15, supra, and 1974 PA 107, Sec. 9, supra.

Thus, information concerning a recipient which is circulated within the community mental health program must be held as confidential information and not open to public inspection; 1974 PA 258, Sec. 748(1), supra. Further, 1974 PA 258, Sec. 748(5)(a), supra, provides that information may be disclosed to others who provide mental health services to the recipient, where the holder of the record and the recipient (or the minor recipient's parents, or guardian) consent; this provision is applicable to dissemination of information to a facility which is not part of the community mental health program. However, it must be emphasized that information concerning a recipient which is utilized within the framework of the county mental health program must not disclose the identity of the recipient, unless germane to the authorized purpose for which the information was sought, and no other information shall be disclosed unless germane to such authorized purpose. 1974 PA 258, Sec. 748(2), supra. The mode of proceding mental health services must 'protect and promote the basic human dignity to which a recipient of services is entitled.' 1974 PA 258, supra, Sec. 704(3).

Therefore, it is my opinion that a county community mental health board may obtain information concerning specific recipients from private or public agencies with which it has contracted to provide mental health services to recipients, where such information is sought for a purpose germane to the county mental health program, without procuring the consent of the recipient.

(2) May such a county community mental health board require its contracting service providers to share, information about clients with each other, inasmuch as they are both of the same single county mental health system?

In accordance with my response to your first question, and in light of the powers and duties of county community mental health boards set out in 1974 PA 258, Sec. 226, supra, it is also my opinion that a county community mental health board may require the service providers with which it contracts to share information concerning recipients, so long as such information is germane to the provision of mental health services, subject to the provisions of 1974 PA 258, Sec. 748, supra, provided that such information is not disseminated outside the county mental health program.

Frank J. Kelley

Attorney General

(1) 'Facility' is defined in 1974 PA 258, supra, Sec. 700(c) as 'a residential facility which provides mental health services, which is licensed by the state or is operated by or under contract with a public agency.'

(2) Repealed by 1974 PA 258, supra, Sec. 1106(a).

(3) This provision appears in substantially the same language in 1974 PA 258, supra, Sec. 244(b)(ii).

(4) Repealed by 1974 PA 258, Sec. 1106(a), supra fn 1.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

JAMES K. HAVEMAN
DIRECTOR

February 19, 2013

TO: CMHSP Executive Directors
DHS County Offices

FROM: Lynda Zeller, Deputy Director
Behavioral Health and Developmental Disabilities Administration
Department of Community Health

Steve Yager, Director
Children's Services Administration
Department of Human Services

SUBJECT: INTER-AGENCY AGREEMENT FOR THE PROVISION OF ADULT PROTECTIVE SERVICES

Section 6.3.2 of the contract between the Michigan Department of Community Health (MDCH) and the Community Mental Health Services Programs (CMHSPs) requires each CMHSP to make reasonable efforts to obtain a signed agreement between the CMHSP Office of Recipient Rights, the Michigan Department of Human Services (MDHS) Bureau of Children and Adult Licensing (BCAL), and MDHS Adult Protective Services (APS). The agreement addresses the reporting and investigation of suspected abuse, neglect, and exploitation in programs operated or contracted with the CMHSP.

Staff members from the MDHS and the MDCH have worked together to update a model agreement that meets this requirement. A copy of the model agreement is attached.

In addition to updating the agreement, MDHS and MDCH staff members identified processes for reviewing and obtaining signatures on these agreements that will help ensure its effective implementation. The expectation is that staff from the CMHSP and DHS local office will meet face-to-face to review the agreement before signing. After the agreement has been signed by the CMHSP Executive Director and the DHS County Director, it will be forwarded by the MDHS Bureau of Children and Adult Licensing (BCAL) Area Manager to Luttrell Levingston, the BCAL manager for review. Mr. Levingston will then forward the agreement to Jim Gale, Director of BCAL for signature.

Minor changes may be made to the model agreement to reflect local processes. However, the overall agreement should remain substantially intact as issued. As identified above, any modifications made to the model agreement will be reviewed by Tom Renwick and Luttrell Levingston prior to MDHS signature.

Finally, MDHS and MDCH will require that the CMHSP and local MDHS entities meet at least annually to review the agreement and evaluate its effectiveness. Please feel free to contact Luttrell Levingston at 248-975-5072 or Thomas Renwick at 517-373-2568 if you have any questions.

Cc: Jim Gale, MDHS
Luttrell Levingston, MDHS
Cynthia Farrell, MDHS

INTER-AGENCY AGREEMENT FOR THE PROVISION OF ADULT PROTECTIVE SERVICES

MICHIGAN DEPARTMENT OF HUMAN SERVICES
< > COUNTY
ADULT PROTECTIVE SERVICES

AND

MICHIGAN DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILDREN AND ADULT LICENSING

AND

< COMMUNITY MENTAL HEALTH SERVICES PROGRAM>

Introduction

Following is an Inter-Agency Agreement between the Michigan Department of Human Services Adult Protective Services (DHS-APS), the Michigan Department of Human Services Bureau of Children and Adult Licensing (DHS-BCAL) and the <Community Mental Health Services Program> regarding responsibilities for the provision of adult protective services required under Act 519 of the Public Acts of 1982 as amended (Act 519, MCL 400.1 *et. seq.*); Act 258 of the Public Acts of 1974 as amended (Act 258, MCL 330.1755 *et. seq.*); Act 218 of the Public Acts of 1979 as amended (Act 218, MCL 400.701 *et. seq.*); and Act 368 of the Public Acts of 1978 as amended (Act 368, MCL 333.20101 *et. seq.*.

Adults receiving mental health services, either directly under contract with the <Community Mental Health Services Program> or its subcontractors are entitled to protection from abuse and neglect pursuant to Act 258. DHS-APS is mandated by Act 519 to provide protective services to vulnerable adults as determined necessary by DHS after investigation of reports of abuse, neglect or exploitation. DHS-BCAL is mandated by Act 218 and Act 368 to investigate allegations of abuse, neglect or exploitation of individuals in licensed Adult Foster Care Homes and Homes for the Aged. The <Community Mental Health Services Program> Office of Recipient Rights <CMHSP>-ORR has the statutory responsibility to investigate allegations of abuse, neglect or exploitation of consumers of CMHSP services under Act 258. Recognizing that DHS-APS, DHS-BCAL and the <CMHSP>-ORR each have statutory responsibilities for the provision of their respective services to adults, the parties have agreed to develop a coordinated approach to the reporting and investigation of complaints.

PURPOSE:

To enter into an agreement between DHS-APS, DHS-BCAL and <CMHSP>-ORR to more effectively and cooperatively protect the rights of consumers through each entity's statutorily prescribed role in the reporting and investigation of alleged or suspected abuse, neglect or exploitation of adults participating in programs under the auspices of <CMHSP>, including contracted or subcontracted residential service providers.

1:00 RESPONSIBILITY TO REPORT SUSPECTED ABUSE, NEGLECT, AND EXPLOITATION OF ADULTS IN MENTAL HEALTH SERVICE PROGRAMS:

1.01 Any employee of a mental health program under the auspices of <CMHSP>, under contract with <CMHSP> or any subcontractor employee, who has knowledge of, suspects or has reasonable cause to believe an adult in a home, facility, or a program has been abused, neglected, or exploited, shall report the information as soon

as possible but not later than 24 hours after becoming aware of the information to DHS -APS. A report shall also be made to the <CMHSP>-ORR and, when the harm is alleged to have occurred in a licensed home or facility, and to the appropriate DHS-BCAL office.

The reporting responsibility requires notification to all the following agencies:

- DHS-APS
- <CMHSP>-ORR
- DHS-BCAL, when it occurs in a licensed home or facility

1.02 Any DHS Services Specialist who has knowledge of, suspects or has reasonable cause to believe an adult in a licensed home, facility, or program of the <CMHSP> has been abused, neglected, or exploited, shall report the information as soon as possible, but not later than 24 hours after becoming aware of the information, to the <CMHSP>-ORR and, when the harm is alleged to have occurred in a licensed home or facility, to the appropriate DHS-BCAL office. This report shall be verbal with a written notification to follow within 72 hours.

1.03 Any DHS-BCAL Licensing staff who has knowledge of, suspects or has reasonable cause to believe an adult receiving mental health services in a licensed home or facility or in an unlicensed home has been abused, neglected, or exploited shall report the information as soon as possible, but not later than 24 hours of becoming aware of the information, to the <CMHSP>-ORR and DHS-APS. The initial report shall be verbal with a written notification to follow within 72 hours.

2.00 RESPONSIBILITY TO INVESTIGATE REPORTS OF SUSPECTED ABUSE, NEGLECT, OR EXPLOITATION OF ADULTS IN MENTAL HEALTH SERVICE PROGRAMS

2.01 DHS-APS shall have responsibility for the investigation of reports of suspected abuse, neglect or exploitation of all vulnerable adults, including those adults in community mental health programs, and licensed and unlicensed settings.

2.02 Concurrently, <CMHSP>-ORR shall have responsibility to begin an investigation in accordance with Act 258and <CMHSP> policy.

2.03 Concurrently, DHS-BCAL shall conduct an investigation in accordance with Act 218, Act 368 and BCAL policy.

In the interest of efficiency and to avoid unnecessary duplication, DHS-APS, DHS-BCAL and <CMHSP>-ORR shall develop procedures for coordination of investigations. Local procedures must assure adherence to the respective program's investigative procedures. Primary consideration must be given to protective measures as appropriate.

3.00 **RESPONSIBILITY TO SHARE INFORMATION AND COORDINATE INVESTIGATIONS OF SUSPECTED ABUSE NEGLECT OR EXPLOITATION OF ADULTS IN MENTAL HEALTH SERVICE PROGRAMS:**

3.01 In accordance with the statutory requirements of P.A. 519, P.A. 258, P.A. 368, P.A. 218 and 45 CFR 164.512(d) (HIPAA) and to fulfill each agency responsibility to investigate and provide their respective services to vulnerable persons, case records and other information pertinent to the investigation may be mutually shared. Nothing in this agreement shall be construed to obligate DHS to release reporting source or complainant information in violation of MCL 400.11c, MCL 400.724(7), or MCL § 333.20180 or to obligate a CMHSP to release reporting source or complainant information in violation of MCL 330.1723.

3.02 Coordination between respective investigative agencies shall be maintained during the course of each investigation, including sharing of investigative findings and coordinating referrals to other agencies, such as law enforcement.

4.00 **RESPONSIBILITY TO SHARE INVESTIGATION REPORTS OF SUSPECTED ABUSE, NEGLECT AND EXPLOITATION OF ADULTS IN MENTAL HEALTH SERVICE PROGRAMS;**

4.01 The DHS-APS shall, consistent with law, share reports of all investigations of abuse, neglect or exploitation involving mental health consumers within five (5) days of completion of the reports. The reports shall be provided to the following as appropriate:

- <CMHSP>-ORR
- The DHS-BCAL Licensing staff when the investigation involves a facility licensed under Act 218 or Act 368.

4.02 DHS-BCAL shall share a copy of their reports on investigations of abuse, neglect or exploitation within five (5) days of completion of the reports. The reports shall be provided to the following as appropriate:

- The <CMHSP>-ORR
- The DHS-APS Services Program Manager

4.03 <CMHSP>-ORR shall share a copy of the reports for all investigations of abuse, neglect, or exploitation of <CMHSP> consumers within five (5) days of completion of the report. The reports shall be provided to the following, as appropriate:

- The DHS-APS Services Program Manager
- The DHS-BCAL staff when the investigation involves a facility licensed under Act 218 or Act 368.

5.00 ADMINISTRATION

5.01 The <CMHSP>-ORR shall provide to DHS-APS and DHS-BCAL a list, including phone numbers, of all agencies under contract to <CMHSP> within 30 days of the effective date of this agreement and at least semi-annually thereafter.

5.02 The <CMHSP>-ORR shall provide to DHS-APS and DHS-BCAL the names, addresses, and phone numbers of the <CMHSP> management staff on a quarterly basis.

5.03 The DHS-APS shall provide to the <CMHSP>-ORR and to DHS-BCAL the names, addresses, and phone numbers of the DHS-APS Services Program Manager(s) on a quarterly basis.

5.04 The DHS-BCAL shall provide to the<CMHSP>-ORR and DHS-APS Services Program Manager the names, addresses, and phone number of Area Managers on a quarterly basis.

5.05 DHS-APS, <CMHSP>-ORR and DHS-BCAL shall assure that training concerning this agreement is provided to their respective designated staff.

6.00 DISPUTE RESOLUTION

6.01 Resolution of disputes regarding compliance with this agreement shall first be attempted by frontline staff in each organization involved. If unsuccessful, the issue shall be referred to the next level of management within each organization.

This agreement shall be effective once all parties have signed. The organizations shall meet at least annually to address any concerns related to this agreement.

Signed: _____ Date_____

<NAME>, Director
<County> Department of Human Services

Signed: _____ Date_____

<NAME>, Executive Director
<CMHSP>

Signed: _____ Date_____

James Gale, Director
Michigan Department of Human Services
Bureau of Children and Adult Licensing

STATE OF MICHIGAN

FRANK J. KELLEY, ATTORNEY GENERAL

Opinion No. 6700

September 18, 1991

DEPARTMENT OF SOCIAL SERVICES:

Access to community mental health recipient information in the course of adult protective services investigation.

A Michigan Department of Social Services adult protective services worker may, in the course of carrying out an adult protective services investigation, obtain access to community mental health recipient information regardless of the source of a report or information concerning suspected abuse, neglect, exploitation or endangerment that led to the investigation.

Gerald H. Miller

Director

Michigan Department of Social Services

235 S. Grand Avenue

Lansing, Michigan 48909

You have requested my opinion on whether the Michigan Department of Social Services may obtain access to community mental health recipient information in the course of an adult protective services investigation.

The adult protective services law, MCL 400.11 et seq; MSA 16.411 et seq, amended the Social Welfare Act, MCL 400.1 et seq; MSA 16.401 et seq, adding various provisions for the reporting and investigation of suspected instances of abuse, neglect, exploitation or endangerment of adults and the provision of services for preventing, identifying and treating such cases. The Social Welfare Act imposes upon the Michigan Department of Social Services the duty to investigate reports made pursuant to the Act, and adult protective services workers employed by that agency must determine whether an adult is in need of protective services.

Section 11b of the Social Welfare Act provides, in pertinent part:

> (1) Within 24 hours after receiving a report made or information obtained pursuant to section 11a, the county department of social services shall commence an investigation to determine whether the person suspected of being abused, neglected, exploited, or endangered is an adult in need of protective services. A reasonable belief on the part of the county department that the person is an adult in need of protective services is a sufficient basis for investigation....

As is observed above, the Social Welfare Act mandates that the Michigan Department of Social Services investigate suspected instances of abuse, neglect, exploitation or endangerment of adults and determine the cause and manner in which it is occurring. Section 11b(5) of that Act explicitly authorizes the Department of Social Services to include in its investigation a medical and psychological evaluation and review. In order to effectively carry out this statutorily mandated investigation, adult protective services workers employed by the Michigan Department of Social Services must be permitted access to information, including information contained in community mental health records, which will assist in the goal of protecting vulnerable adults. Disclosure of such community mental health records to adult protective services workers is, therefore, "necessary in order to comply with another provision of law" within the meaning of section 748(4)(d) of the Mental Health Code, supra, and is, moreover, an appropriate disclosure to a "public agency" since there is a "compelling need for disclosure based upon a substantial probability of harm to the recipient or other persons" within the meaning of section 748(6)(c) of the Mental Health Code.

If the right of the Michigan Department of Social Services, through its adult protective services workers, to gain access to information or records pertaining to a recipient of community mental health services suspected of being abused were conditioned on whether a report of mistreatment is made by community mental health staff, the result would be that the community mental health agency and not the Michigan Department of Social Services would make the determination of whether a vulnerable adult is in need of protective services. As previously noted, the Social Welfare Act mandates that the Michigan Department of Social Services make this determination.

It is a well settled principle of statutory construction that statutes must be construed so as to avoid, not produce, absurd results or consequences. Hiltz v. Phil's Quality Market, 417 Mich 335; 337 NW2d 237 (1983); In the Matter of Karen Marable, 90 MichApp 7; 282 NW2d 221 (1979), lv den 407 Mich 871 (1979).

Thus, if there exists information held by a community mental health agency regarding an adult who is suspected of being abused, adult protective services workers are authorized to review such information in the course of an adult protective services investigation. A community mental health agency is required to disclose such information or records in order to comply with another provision of law, namely, section 11b of the Social Welfare Act. The disclosure requirement exists irrespective of the source of the report to the Michigan Department of Social Services that the adult's safety or welfare may be in jeopardy.

It is my opinion, therefore, that a Michigan Department of Social Services adult protective services worker may, in the course of carrying out an adult protective services investigation, obtain access to community mental health recipient information regardless of the source of a report or information concerning suspected abuse, neglect, exploitation or endangerment that led to the investigation.

Frank J. Kelley

Attorney General

STATE OF MICHIGAN

MIKE COX, ATTORNEY GENERAL

CHILDREN AND MINORS: Parent's access to minor's mental health records

MENTAL HEALTH:

A parent to whom a court has granted joint legal custody, but not physical custody, of a minor child may consent to the release of, and have access to, the minor child's mental health records under section 748(6) of the Mental Health Code, unless in the written judgment of the holder of the records the disclosure would be detrimental to the minor child or others.

Opinion No. 7149

February 20, 2004

Honorable Stephen Adamini
State Representative
The Capitol
Lansing, MI 48913

You have asked whether a parent to whom a court has granted joint legal custody, but not physical custody, of a minor child, may consent to the release of, and have access to, the minor child's mental health records under section 748(6) of the Mental Health Code.

Your question seeks clarification of OAG, 2001-2002, No 7092, p 58 (October 16, 2001), which addressed whether section 10 of the Child Custody Act of 1970[1] requires disclosure of a minor's mental health records to the child's noncustodial parent without the consent of the custodial parent required by section 748(6) of the Mental Health Code. That opinion, however, did not consider any distinctions between physical and legal custody in concluding that section 10 of the Child Custody Act does not require disclosure of a minor's mental health services records to the child's noncustodial parent without the consent of the custodial parent required by section 748(6) of the Mental Health Code. You advise that mental health treatment providers seek further guidance in situations where parents share joint legal custody, but not physical custody.

The Mental Health Code requires that records be maintained for recipients of mental health services and that the material in those records "shall be confidential to the extent it is made confidential by section 748." MCL 330.1746(1). Section 748(1) reiterates this confidentiality requirement and provides that the information may be disclosed "only in the circumstances and under the conditions set forth in this section or section 748a."[2] MCL 330.1748(1). Section 748(6) of the Mental Health Code, which describes circumstances where confidential information may be disclosed, is the focus of your inquiry. Section 748(6) states:

Except as otherwise provided in subsection (4),[3] if consent is obtained from the recipient, the recipient's guardian with authority to consent, *the parent with legal custody of a minor recipient,* or the court-appointed personal representative or executor of the estate of a deceased recipient, information made confidential by this section may be disclosed to all of the following:

(a) A provider of mental health services to the recipient.

(b) The recipient or his or her guardian or *the parent of a minor recipient* or another individual or agency unless in the written judgment of the holder the disclosure would be detrimental to the recipient or others. [MCL 330.1748(6); emphasis added.]

Thus, unless the holder of the record determines in writing that the disclosure would be detrimental to the recipient or others, section 748(6) authorizes disclosure of confidential information regarding a minor recipient if the parent with "legal custody" of the minor consents.

A cardinal rule of statutory construction is to ascertain and give effect to the intent of the Legislature. *Browder v Int'l Fidelity Ins Co*, 413 Mich 603, 611; 321 NW2d 668 (1982). Meaning and effect must be given to every word and sentence of a statute, *Robinson v Detroit*, 462 Mich 439, 459; 613 NW2d 307 (2000), so as to produce, if possible, a harmonious result. *Weems v Chrysler Corp*, 448 Mich 679, 699-700; 533 NW2d 287 (1995). Thus, it becomes necessary to determine the meaning of "legal custody" by giving effect to both words used together.

Although the Mental Health Code does not define the term "legal custody," guidance as to its meaning is found in the Child Custody Act. "Joint custody" is provided for and defined in subsections (1) and (7) respectively of section 6a of the Child Custody Act, which state in pertinent part:

(1) In custody disputes between parents, the parents shall be advised of joint custody. At the request of either parent, the court shall consider an award of joint custody . . . . In other cases joint custody may be considered by the court. The court shall determine whether joint custody is in the best interest of the child . . . .

* * *

(7) As used in this section, "joint custody" means an order of the court in which 1 or both of the following is specified:

(a) That the child shall reside alternately for specific periods with each of the parents.

(b) That the parents shall share decision-making authority as to the important decisions affecting the welfare of the child. [MCL 722.26a(1) and (7).]

In *Wellman v Wellman*, 203 Mich App 277, 279 (1994), the Court of Appeals analyzed this provision:

In substance, custody disputes between parents are governed by MCL 722.26a; MSA 25.312(6a). In particular, at the request of either parent, as here, the trial court "shall consider an award of joint custody, and shall state on the record the reasons for granting or denying a request." MCL 722.26a(1); MSA 25.312(6a)(1). As used in that section, the term "joint custody" means an order that specifies either that "the child shall reside alternately for specific periods with each of the parents," or that "the parents shall share decision-making authority as to the important decisions affecting the welfare of the child," or both. MCL 722.26a(7); MSA 25.312(6a)(7). The trial court must determine whether joint custody is in the best interest of the child by considering the factors enumerated in MCL 722.23; MSA 25.312(3), and by considering whether "the parents will be able to cooperate and generally agree concerning important decisions affecting the welfare of the child." MCL 722.26a(1)(a) and (b); MSA 25.312(6a)(1)(a) and (b).

The Court of Appeals went on to make a distinction between a grant of joint legal custody and a grant of physical custody under section 6a of the Child Custody Act:

Further, we are not convinced that it was inconsistent for the trial court to grant joint legal custody while denying joint physical custody. While the parties may have had prior disagreements over visitation, there was also evidence that it was in the children's best interests to maintain more contact with their father than one would normally expect if the mother had sole custody and the father had nothing more than visitation rights. [203 Mich App at 280.]

Thus, the type of joint custody defined in section 6a(7)(a) of the Child Custody Act, MCL 722.26a(7)(a), is generally referred to as joint *physical* custody. The type of joint custody defined in section 6a(7)(b) of the Child Custody Act is generally referred to as joint *legal* custody. Under the Child Custody Act, however, both types are referred to as "joint custody."[4]

Indeed, the Legislature has recognized the distinction between legal and physical custody in several other provisions of the Mental Health Code. See, e.g., MCL 330.748(5) (a parent "with legal and physical custody" of a minor recipient may consent to release of confidential records to an attorney for the recipient); MCL 330.1716(1)(c) (only a parent with "legal and physical custody" can consent to surgery); MCL 330.1717(1)(b) (only a parent with "legal and physical custody" can consent to electroconvulsive therapy).

Section 748(6) of the Mental Health Code authorizes disclosure of confidential information in a minor recipient's mental health records to a parent of the minor if the parent with "legal custody" of a minor gives consent and the disclosure would not be detrimental to the recipient or others according to the holder of the records. Significantly, in contrast to other sections of the Mental Health Code in which the Legislature has required both "legal and physical" custody, section 748(6) requires only "legal custody." Under the doctrine of statutory construction holding that the express mention in a statute of one thing implies the exclusion of other similar things,[5] the Legislature's choice to require "legal" but not "physical" custody in section 748(6) must be given effect. Thus, a parent who has "legal" custody is authorized to consent to the release of his or her minor child's mental health records, regardless of whether he or she has physical custody.

This conclusion is also supported by sound public policy. A parent who is granted legal custody of a child "share[s] decision making authority as to the important decisions affecting the welfare of the child." MCL 722.26a(7)(b). Access to a minor child's mental health records may be critical in assuring that this decision-making authority is exercised knowledgably and in accordance with the best interests of the child.

It is my opinion, therefore, that a parent to whom a court has granted joint legal custody, but not physical custody, of a minor child may consent to the release of, and have access to, the minor child's mental health records under section 748(6) of the Mental Health Code, unless in the written judgment of the holder of the records the disclosure would be detrimental to the minor child or others.

MIKE COX
Attorney General

[1]Section 10 of the Child Custody Act, MCL 722.30, provides: "Notwithstanding any other provision of law, a parent shall not be denied access to records or information concerning his or her child because the parent is not the child's custodial parent, unless the parent is prohibited from having access to the records or information by a protective order. . . ."

[2]Section 748a, MCL 330.1748a, deals with neglected and abused children and is not relevant to your question.

[3]Subsection 4 deals with adult recipients and is not relevant to your question.

[4]The legal forms approved by the State Court Administrative Office for use in matters involving the Friend of the Court also recognize a distinction between legal custody and physical custody. Form FOC 89, "ORDER REGARDING CUSTODY AND PARENTING TIME," identifies four different types of custody: 1) joint physical custody; 2) joint legal custody; 3) sole legal custody; or 4) sole physical custody. Form FOC 89 can be found at http://courts.michigan.gov/scao/courtforms/domesticrelations/custody-parentingtime/foc89.pdf.

[5]Michigan recognizes the principle of *expressio unius est exclusio alterius. Stowers v Wolodzko,* 386 Mich 119, 133; 191 NW2d 355 (1971).

CHILD PROTECTION LAW (EXCERPT)
Act 238 of 1975

722.623 Individual required to report child abuse or neglect; written report; transmitting report to county department; copies to prosecuting attorney and probate court; conditions requiring transmission of report to law enforcement agency; pregnancy of or venereal disease in child less than 12 years of age; exposure to or contact with methamphetamine production.

Sec. 3.

(1) An individual is required to report under this act as follows:

(a) A physician, dentist, physician's assistant, registered dental hygienist, medical examiner, nurse, person licensed to provide emergency medical care, audiologist, psychologist, marriage and family therapist, licensed professional counselor, social worker, licensed master's social worker, licensed bachelor's social worker, registered social service technician, social service technician, a person employed in a professional capacity in any office of the friend of the court, school administrator, school counselor or teacher, law enforcement officer, member of the clergy, or regulated child care provider who has reasonable cause to suspect child abuse or neglect shall make immediately, by telephone or otherwise, an oral report, or cause an oral report to be made, of the suspected child abuse or neglect to the department. Within 72 hours after making the oral report, the reporting person shall file a written report as required in this act. If the reporting person is a member of the staff of a hospital, agency, or school, the reporting person shall notify the person in charge of the hospital, agency, or school of his or her finding and that the report has been made, and shall make a copy of the written report available to the person in charge. A notification to the person in charge of a hospital, agency, or school does not relieve the member of the staff of the hospital, agency, or school of the obligation of reporting to the department as required by this section. One report from a hospital, agency, or school is adequate to meet the reporting requirement. A member of the staff of a hospital, agency, or school shall not be dismissed or otherwise penalized for making a report required by this act or for cooperating in an investigation.

(b) A department employee who is 1 of the following and has reasonable cause to suspect child abuse or neglect shall make a report of suspected child abuse or neglect to the department in the same manner as required under subdivision (a):

(i) Eligibility specialist.

(ii) Family independence manager.

(iii) Family independence specialist.

(iv) Social services specialist.

(v) Social work specialist.

(vi) Social work specialist manager.

(vii) Welfare services specialist.

(c) Any employee of an organization or entity that, as a result of federal funding statutes, regulations, or contracts, would be prohibited from reporting in the absence of a state mandate or court order. A person required to report under this subdivision shall report in the same manner as required under subdivision (a).

(2) The written report shall contain the name of the child and a description of the abuse or neglect. If possible, the report shall contain the names and addresses of the child's parents, the child's guardian, the persons with whom the child resides, and the child's age. The report shall contain other information available to the reporting person that might establish the cause of the abuse or neglect, and the manner in which the abuse or neglect occurred.

(3) The department shall inform the reporting person of the required contents of the written report at the time the oral report is made by the reporting person.

(4) The written report required in this section shall be mailed or otherwise transmitted to the county department of the county in which the child suspected of being abused or neglected is found.

(5) Upon receipt of a written report of suspected child abuse or neglect, the department may provide copies to the prosecuting attorney and the probate court of the counties in which the child suspected of being abused or neglected resides and is found.
(6) If an allegation, written report, or subsequent investigation of suspected child abuse or child neglect indicates a violation of sections 136b and 145c, sections 520b to 520g of the Michigan penal code, 1931 PA 328, MCL 750.136b, 750.145c, and 750.520b to 750.520g, or section 7401c of the public health code, 1978 PA 368, MCL 333.7401c, involving methamphetamine has occurred, or if the allegation, written report, or subsequent investigation indicates that the suspected child abuse or child neglect was committed by an individual who is not a person responsible for the child's health or welfare, including, but not limited to, a member of the clergy, a teacher, or a teacher's aide, the department shall transmit a copy of the allegation or written report and the results of any investigation to a law enforcement agency in the county in which the incident occurred. If an allegation, written report, or subsequent investigation indicates that the individual who committed the suspected abuse or neglect is a child care provider and the department believes that the report has basis in fact, the department shall, within 24 hours of completion, transmit a copy of the written report or the results of the investigation to the child care regulatory agency with authority over the child care provider's child care organization or adult foster care location authorized to care for a child.
(7) If a local law enforcement agency receives an allegation or written report of suspected child abuse or child neglect or discovers evidence of or receives a report of an individual allowing a child to be exposed to or to have contact with methamphetamine production, and the allegation, written report, or subsequent investigation indicates that the child abuse or child neglect or allowing a child to be exposed to or to have contact with methamphetamine production, was committed by a person responsible for the child's health or welfare, the local law enforcement agency shall refer the allegation or provide a copy of the written report and the results of any investigation to the county department of the county in which the abused or neglected child is found, as required by subsection (1)(a). If an allegation, written report, or subsequent investigation indicates that the individual who committed the suspected abuse or neglect or allowed a child to be exposed to or to have contact with methamphetamine production, is a child care provider and the local law enforcement agency believes that the report has basis in fact, the local law enforcement agency shall transmit a copy of the written report or the results of the investigation to the child care regulatory agency with authority over the child care provider's child care organization or adult foster care location authorized to care for a child. Nothing in this subsection or subsection (1) shall be construed to relieve the department of its responsibilities to investigate reports of suspected child abuse or child neglect under this act.
(8) For purposes of this act, the pregnancy of a child less than 12 years of age or the presence of a venereal disease in a child who is over 1 month of age but less than 12 years of age is reasonable cause to suspect child abuse and neglect have occurred.
(9) In conducting an investigation of child abuse or child neglect, if the department suspects that a child has been exposed to or has had contact with methamphetamine production, the department shall immediately contact the law enforcement agency in the county in which the incident occurred.

History: 1975, Act 238, Eff. Oct. 1, 1975 ;-- Am. 1978, Act 252, Eff. Mar. 30, 1979 ;-- Am. 1978, Act 573, Eff. Mar. 30, 1979 ;-- Am. 1980, Act 511, Imd. Eff. Jan. 26, 1981 ;-- Am. 1984, Act 418, Eff. Mar. 29, 1985 ;-- Am. 1988, Act 372, Eff. Mar. 30, 1989 ;-- Am. 1994, Act 177, Imd. Eff. June 20, 1994 ;-- Am. 2002, Act 10, Imd. Eff. Feb. 14, 2002 ;-- Am. 2002, Act 661, Imd. Eff. Dec. 23, 2002 ;-- Am. 2002, Act 693, Eff. Mar. 1, 2003 ;-- Am. 2006, Act 264, Imd. Eff. July 6, 2006 ;-- Am. 2006, Act 583, Imd. Eff. Jan. 3, 2007 ;-- Am. 2008, Act 300, Imd. Eff. Oct. 8, 2008 ;-- Am. 2008, Act 510, Imd. Eff. Jan. 13, 2009

STATE OF MICHIGAN

BILL SCHUETTE, ATTORNEY GENERAL

CHILD PROTECTION LAW: Duty of community mental health professional to report child abuse or neglect

MENTAL HEALTH CODE:

The definition of "child abuse" in the Child Protection Law, MCL 722.622(f), includes choking, regardless of whether it results in death or only some other physical injury to a child, if the choking is nonaccidental and perpetrated by a person identified in the statute.

Section 3(1)(a) of the Child Protection Law, MCL 722.623(1)(a), imposes a duty on a community mental health professional to report suspected child abuse that may have resulted in the death of a child, regardless of when the abuse and death occurred.

A mental health professional would have a duty to report suspected child abuse about which the professional received knowledge during the provision of mental health services. Although section 748(1) of the Mental Health Code, MCL 330.1748(1), generally protects from disclosure records or information acquired by a mental health professional during the course of providing mental health services, that provision does not protect records or information revealing suspected child abuse or neglect that a mental health professional would have a duty to report under section 3(1)(a) of the CPL, MCL 722.623(1)(a).

Opinion No. 7264 April 24, 2012

Honorable Richard E. Hammel
State Representative
The Capitol
Lansing, MI 48909

You have asked several questions concerning the reporting or disclosing of child abuse under the Child Protection Law (CPL), 1975 PA 238, MCL 722.621 *et seq*., and the Mental Health Code, MCL 330.1001 *et seq*.

The broad purpose of the CPL is to prevent child abuse and neglect. *Becker-Witt v Bd of Examiners of Social Workers*, 256 Mich App 359, 364; 663 NW2d 514 (2003), citing *Williams v Coleman*, 194 Mich App 606, 614-615; 488 NW2d 464 (1992). To effectuate that purpose, the act defines conduct that is abusive or neglectful, and establishes methods for the reporting to, and the investigation of, instances of abuse and neglect by the Department of Human Services. See, e.g., *Michigan Ass'n of Intermediate Special Educ Administrators v Dep't of Social Services*, 207 Mich App 491; 526 NW2d 36 (1994). The reporting requirement is a crucial component of the CPL. After reviewing various amendments expanding the CPL's reporting provision, one court stated, "[t]hrough this evolutionary process, the Legislature made clear its intent to have a strong reporting system." *Williams*, 194 Mich App at 615. And as explained in *People v Beardsley*, 263 Mich App 408, 413-414;

688 NW2d 304 (2004), the purpose of the reporting requirement is to protect children from abuse perpetrated by those who would normally act as protectors of children:

> The preamble to the CPL states that the purpose of the CPL is, in part, "to require the reporting of child abuse and neglect by certain persons." The statute's definition of "child abuse," which identifies parents and others responsible for a child's health and welfare, reflects the statute's purpose of protecting children in situations where abuse and neglect frequently go unreported, i.e., when perpetrated by family members or others with control over the child. Hence, reports are required to be made to the [the Department] rather than to the police, which would be the appropriate agency to contact in the case of . . . abuse involving a person without any familial contacts or other authority over the child. Typically, parents, teachers, and others who are responsible for the health and welfare of a child will be the first to report instances of child abuse by unrelated third parties. *This act is designed to protect children when the persons who normally do the reporting are actually the persons responsible for the abuse, and thus unlikely to report it*. [Emphasis added.]

"In other words, the imposition of a duty to report suspected child abuse . . . is based, not on the occurrence of such abuse, but on the type of relationship the alleged perpetrator has with the minor child." *Doe v Doe*, 289 Mich App 211, 216; ___ NW2d ___ (2010). As a remedial statute that protects the public health and general welfare, the CPL should be liberally construed. *Williams*, 194 Mich App at 612, citing *Soap & Detergent Ass'n v Natural Resources Comm*, 415 Mich 728, 740; 330 NW2d 346 (1982), citing 3 Sands, Sutherland Statutory Construction (4th ed.), § 65.03, p 163.

You first ask whether the death of a child as a result of abuse, specifically choking, constitutes "child abuse" as defined in section 2(f), MCL 722.622(f), of the CPL.

The primary goal of interpreting statutes is to ascertain and give effect to the Legislature's intent. *Frankenmuth Mut Ins Co v Marlette Homes, Inc*, 456 Mich 511, 515; 573 NW2d 611 (1998). Effect must be given to the interpretation that accomplishes the statute's purpose. *People v Adair*, 452 Mich 473, 479-480; 550 NW2d 505 (1996). Statutes are construed in their entirety, and provisions must be read in the context of the entire statute so as to produce a harmonious whole. *Macomb County Prosecutor v Murphy*, 464 Mich 149, 159; 627 NW2d 247 (2001). Furthermore, in interpreting a statute, both the plain meaning of the critical word or phrase as well as its placement and purpose in the statutory scheme must be considered. *Sun Valley Foods Co v Ward*, 460 Mich 230, 237; 596 NW2d 119 (1999).

The CPL defines "child" as "a person under 18 years of age," MCL 722.622(e), and defines "child abuse," in relevant part, as:

> [*H*]*arm . . . to a child's health . . . that occurs through nonaccidental physical . . . injury* . . . or maltreatment, by a parent, a legal guardian, or any other person responsible for the child's health or welfare or by a teacher, a teacher's aide, or a member of the clergy. [MCL 722.622(f); emphasis added.]

The statute does not expressly reference "death" within the definition of child abuse. But it was not necessary to do so. The death of a child is certainly "harm . . . to a child's health" of the worst kind.[1] Thus, with respect to the choking referred to in your request, if the act was "nonaccidental" and

perpetrated by a person listed in the definition, it was "child abuse," regardless of whether the incident resulted in the child's death or only physical injury. In other words, an act involving the death of a child constitutes "child abuse" under the CPL if the facts reveal that the death resulted from nonaccidental physical injury perpetrated by a listed individual.

It is my opinion, therefore, that the definition of "child abuse" in the CPL, MCL 722.622(f), includes choking, regardless of whether it results in death or only physical injury to a child, if the choking is nonaccidental and perpetrated by a person identified in the statute.

You next ask whether section 3(1)(a) of the CPL, MCL 722.623(1)(a), imposes a duty on a community mental health professional to report suspected child abuse that results in the death of the child where the abuse and death occur several years before the mental health professional learns of the suspected abuse.

Although your request does not identify a particular category of community mental health professional,[2] the Mental Health Code defines the term "mental health professional" to include six categories of licensed professionals. See MCL 330.1100b(14)(a) through (f). Under section 3(1)(a) of the CPL, all of these "mental health professional[s]" are required to report[3] "suspected child abuse":

> A physician, . . . nurse, . . . psychologist, marriage and family therapist, licensed professional counselor, . . . [and] licensed master's social worker, . . . *who has reasonable cause to suspect child abuse . . . shall make immediately . . . an oral report, or cause an oral report to be made, of the suspected child abuse* . . . to the [Department of Human Services]. [MCL 722.623(1)(a); emphasis added.][4]

Again, the term "child abuse," in relevant part, "means harm or threatened harm to a child's health or welfare that occurs through nonaccidental physical . . . injury . . . or maltreatment," by one of the persons listed in the statute. MCL 722.622(f).

The phrase "harm or threatened harm" in section 2(f) plainly includes both harm to a child that has already occurred, and present or future harm to a child. In the situation you describe, the deceased child suffered a past incident of harm. Consistent with the discussion above, if the death or injury stems from a nonaccidental physical injury perpetrated by an individual listed in section 2(f), then the past incident constitutes "child abuse." Nothing in section 2(f) suggests that an act of child abuse is no longer abuse if the child is deceased at the time of disclosure, nor may such a limitation be read into the statute. See, e.g., *Roberts v Mecosta County Gen Hosp*, 466 Mich 57, 63; 642 NW2d 663 (2002), citing *Omne Financial, Inc v Shacks, Inc*, 460 Mich 305, 311; 596 NW2d 591 (1999) ("[n]othing may be read into a statute that is not within the manifest intent of the Legislature as derived from the language of the statute itself."). Similarly, section 3(1)(a) does not condition reporting on whether the child is still alive at the time an individual required to report child abuse is assessing his or her duty under the statute. Rather, a mandatory reporter, such as a mental health professional, must immediately report child abuse if the professional has reasonable cause to suspect that an act of child abuse occurred. The statute does not expressly require that the child survive the abuse in order for the act to qualify as a reportable event, and, as above, no such requirement may be read into the statute. *Roberts*, 466 Mich at 63.[5]

This analysis is supported by the fact that under section 8, MCL 722.628, the Department of Human

Services must contact law enforcement officials if the cause of a child's death is suspected to be from abuse or neglect, and continue its own investigation. Section 8(3)(a) states, in relevant part:

(3) In conducting its investigation, the department shall seek the assistance of and cooperate with law enforcement officials within 24 hours after becoming aware that 1 or more of the following conditions exist:

(a) Abuse or neglect is the suspected cause of a child's death. [MCL 722.628(3)(a).]

Section 8(5) provides that the involvement of law enforcement officials "does not relieve or prevent the department from proceeding with its investigation . . . if there is reasonable cause to suspect that the child abuse or neglect was committed by a person responsible for the child's health or welfare." MCL 722.628(5). Thus, the death of a child does not preclude or excuse an investigation of suspected child abuse or neglect reported to the Department of Human Services.[6]

This determination is also consistent with the inclusion of medical examiners as persons required to report suspected child abuse under section 3(1)(a). MCL 722.623(1)(a). The duty of a medical examiner includes investigating deaths that occur by violence, are unexpected, or occur outside the presence of a physician. MCL 52.202. A medical examiner would generally discover an act of suspected child abuse only after the child's death and during the examiner's investigation. Accordingly, the inclusion of medical examiners as mandatory reporters further demonstrates that the Legislature intended to require the reporting of suspected child abuse, even if the child dies before any report can be made.

Thus, with respect to your question, the lapse of several years between the child's death and the revelation of the suspected child abuse does not negate the mental health professional's duty to report. Whether a report under such circumstances will prove productive is not a determination a mental health professional is free to make under section 3(1)(a) of the CPL. See *People v Cavaiani*, 172 Mich App 706, 715; 432 NW2d 409 (1988). Rather, that determination belongs to the Department of Human Services and other investigative agencies. *Id*.[7] As the Court of Appeals explained in *Cavaiani*, a mandatory reporter "is not free to arrogate to himself the right to foreclose the possibility of a legal investigation by the state. The state has different interests, and its sovereignty is offended by child abuse." *Id*.[8]

It is my opinion, therefore, that section 3(1)(a) of the CPL, MCL 722.623(1)(a), imposes a duty on a community mental health professional to report suspected child abuse that may have resulted in the death of a child, regardless of when the abuse and death occurred.

You next ask whether an incident of suspected child abuse disclosed by a recipient of mental health services to a community mental health professional during the course of providing mental health services is confidential information under section 748(1) of the Mental Health Code, MCL 330.1748.

With respect to such information, MCL 330.1748(1) provides:

> Information in the record of a recipient, *and other information acquired in the course of providing mental health services to a recipient, shall be kept confidential* and shall not be open to public inspection. The information may be disclosed outside the department, community mental health services program, licensed facility, or

> contract provider, whichever is the holder of the record, *only in the circumstances and under the conditions set forth in this section or section 748a*. [Emphasis added.]

Information regarding an act of child abuse, if disclosed to a mental health professional during the course of treatment, would be "information acquired in the course of providing mental health services," and would initially be considered "confidential" under section 748(1).

However, as discussed above, a community mental health professional is "required" to report "suspected child abuse" to the Department of Human Services under section 3(1)(a) of the CPL, MCL 722.623(1)(a), to the extent the incident falls within the definition of such abuse. See MCL 722.622(f). While section 748 does not expressly acknowledge or incorporate the CPL's reporting requirement, MCL 330.1748a, which concerns requests for information regarding child abuse and neglect, does. That statute provides that "[a] duty under this act [the Mental Health Code] relating to child abuse and neglect *does not alter a duty imposed under another statute, including the child protection law regarding the reporting or investigation of child abuse or neglect*." (Citation omitted; emphasis added.) This statute effectively incorporates into the Mental Health Code, including section 748's confidentiality provision, the mandatory reporting requirement set forth in section 3(1)(a) of the CPL. See also *Becker-Witt*, 256 Mich App at 364 ("[W]e believe that the Child Protection Law . . . imposed a legal duty on petitioner [a licensed social worker], on behalf of her client's children, to report her client's suspected child abuse").

Indeed, the Mental Health Code recognizes elsewhere a mental health professional's duty to report child abuse or neglect. MCL 330.1707(5), which concerns the provisions of services to minors, specifically provides that nothing in that section "relieve[s] a mental health professional from his or her duty to report suspected child abuse or neglect under section 3 of the child protection law."[9] Thus, while section 748 of the Mental Health Code generally protects from disclosure records or information acquired by a mental health professional during the course of providing mental health services, that statute does not protect information that a mental health professional otherwise has a duty to disclose or report under section 3(1)(a) of the CPL.[10]

This determination is consistent with the substance of section 748a, which requires a mental health professional to produce records when requested in a child abuse or neglect investigation. MCL 330.1748a(1) provides, in part:

> If there is a compelling need for mental health records or information to determine whether child abuse or child neglect has occurred or to take action to protect a minor where there may be a substantial risk of harm, a [Department of Human Services] caseworker or administrator directly involved in the child abuse or neglect investigation shall notify a mental health professional that a child abuse or neglect investigation has been initiated involving a person who has received services from the mental health professional and shall request in writing mental health records and information that are pertinent to that investigation.

After receiving the request, the mental health professional must review all mental health records and information in the mental health professional's possession to determine if there is information pertinent to the investigation. MCL 330.1748a(1). The mental health professional must then release the relevant records or information to the Department of Human Services within fourteen days of the request. *Id*. Concluding that section 748(1) does not prohibit a mental health professional from

disclosing confidential records or information in order to comply with the duty to report suspected child abuse under section 3(1)(a) of the CPL is consistent with the mental health professional's duty to disclose the same information upon request under section 748a.

It is my opinion, therefore, that a mental health professional would have a duty to report suspected child abuse about which the professional received knowledge during the provision of mental health services. Although section 748(1) of the Mental Health Code, MCL 330.1748(1), generally protects from disclosure records or information acquired by a mental health professional during the course of providing mental health services, that provision does not protect records or information revealing suspected child abuse or neglect that a mental health professional would have a duty to report under section 3(1)(a) of the CPL, MCL 722.623(1)(a).[11]

BILL SCHUETTE
Attorney General

[1] Notably, the Department of Human Service's Children Protective Services Manual lists "death" as an "injury" to a child for purposes of conducting an investigation. (Children Protective Services Manual, CPS Investigation – General Instructions and Checklist, PSM 713-1 (June 1, 2010).)

[2] Chapter 2 of the Mental Health Code, MCL 330.1200a *et seq*., establishes community mental health agencies to provide mental health services to individuals within their geographic areas.

[3] Notably, section 3(1)(a) imposes a similar duty to report with respect to child "neglect," which is defined at MCL 722.622(j). But because your question specifically refers to "child abuse," this opinion limits its discussion to that circumstance.

[4] The CPL also provides, in part, that "any person . . . who has reasonable cause to suspect child abuse . . . may report the matter to the [Department of Human Services] or a law enforcement agency." MCL 722.624.

[5] In OAG, 1997-1998, No 6934, p 15 (March 19, 1997), this office determined that because the definition of "child" under the CPL is limited to persons under the age of eighteen, section 3(1)(a) did not impose a duty on a mental health professional to report child abuse when an adult recipient of mental health services discloses that he or she was abused as a child or when an adult recipient discloses having abused a child, who is now an adult, unless there is reasonable cause to suspect that the abuser presents a threat of harm to another child. The question raised here does not present the same concern because the victim here was a child at the time of the suspected abuse and resulting death, and never reached the age of majority.

[6] This determination is supported by other provisions of the CPL that require the investigation or reporting to certain agencies of the death of a child from child abuse or neglect. See, e.g., MCL 722.627b, 722.627c, 722.627d, 722.627k, and 722.628b. The Department of Human Services has a general duty to report suspected child abuse or neglect to law enforcement. See MCL 722.623(6), 722.628(1), (2), and (3).

[7] In fact, the department's Children Protective Services Manual provides that "[a] CPS investigation must occur if there are allegations that the death was due to child abuse/neglect or if it is a sudden

and unexplained infant death . . . .” (Children Protective Services Manual, CPS Intake – Special Cases, PSM 712-6, p 9 (June 1, 2010).) The manual further provides that the “fact that a deceased child has no siblings is not a sufficient reason to reject an otherwise appropriate CPS complaint. As long as there is reasonable cause for an investigation, it is to be conducted in full, with cooperation and collaboration with law enforcement.” *Id*.

[8] Notably, under section 5 of the CPL, “[a] person acting in good faith who makes a report, cooperates in an investigation, or assists in any other requirement of [the CPL] is immune from civil or criminal liability that might otherwise be incurred by that action.” MCL 722.625. But a person required to report suspected child abuse or neglect, who fails to do so, may be held civilly liable for any damages proximately caused by the failure to report, MCL 722.733(1), and may be charged with a misdemeanor, MCL 722.733(2).

[9] The Mental Health Code requires mental health professionals to report the suspected “criminal abuse” of a recipient of mental health services. See MCL 330.1723(1) and (2). Children may be the recipients of mental health services, MCL 330.1100c(12), and “criminal abuse” includes the commission or attempt to commit first-degree child abuse. See MCL 330.1700(a)(v) and MCL 750.136b. Thus, under the Mental Health Code, a mental health professional has a similar obligation to report child abuse with respect to a child recipient of mental health services.

[10] The CPL itself abrogates any privilege that would normally attach to communications between a mental health professional and a person receiving services with respect to the duty to report child abuse or neglect. See MCL 722.631 (“[a]ny legally recognized privileged communication except that between attorney and client or that made to a member of the clergy . . . is abrogated and shall not constitute grounds for excusing a report otherwise required to be made . . . .”). See also OAG, 1979-1980, No 5440, p 43 (February 8, 1979).

[11] While you raised an additional question regarding whether a community mental health professional may report suspected child abuse to law enforcement under section 12 of the CPL, MCL 722.632, the Mental Health Code itself includes a provision permitting disclosure to public agencies such as a law enforcement agency. See MCL 330.1748(7)(c). See also MCL 330.1946(1) and (2)(b)-(c).

REVISED JUDICATURE ACT OF 1961 (EXCERPT)
Act 236 of 1961

600.2157a Definitions; consultation between victim and sexual assault or domestic violence counselor; admissibility.

Sec. 2157a. (1) For purposes of this section:

(a) "Confidential communication" means information transmitted between a victim and a sexual assault or domestic violence counselor, or between a victim or sexual assault or domestic violence counselor and any other person to whom disclosure is reasonably necessary to further the interests of the victim, in connection with the rendering of advice, counseling, or other assistance by the sexual assault or domestic violence counselor to the victim.

(b) "Domestic violence" means that term as defined in section 1501 of Act No. 389 of the Public Acts of 1978, being section 400.1501 of the Michigan Compiled Laws.

(c) "Sexual assault" means assault with intent to commit criminal sexual conduct.

(d) "Sexual assault or domestic violence counselor" means a person who is employed at or who volunteers service at a sexual assault or domestic violence crisis center, and who in that capacity provides advice, counseling, or other assistance to victims of sexual assault or domestic violence and their families.

(e) "Sexual assault or domestic violence crisis center" means an office, institution, agency, or center which offers assistance to victims of sexual assault or domestic violence and their families through crisis intervention and counseling.

(f) "Victim" means a person who was or who alleges to have been the subject of a sexual assault or of domestic violence.

(2) Except as provided by section 11 of the child protection law, Act No. 238 of the Public Acts of 1975, being section 722.631 of the Michigan Compiled Laws, a confidential communication, or any report, working paper, or statement contained in a report or working paper, given or made in connection with a consultation between a victim and a sexual assault or domestic violence counselor, shall not be admissible as evidence in any civil or criminal proceeding without the prior written consent of the victim.

History: Add. 1984, Act 340, Eff. Mar. 29, 1985

REVISED JUDICATURE ACT OF 1961 (EXCERPT) Act 236 of 1961
600.2157 Physician-patient privilege; waiver.
Sec. 2157. Except as otherwise provided by law, a person duly authorized to practice medicine or surgery shall not disclose any information that the person has acquired in attending a patient in a professional character, if the information was necessary to enable the person to prescribe for the patient as a physician, or to do any act for the patient as a surgeon. If the patient brings an action against any defendant to recover for any personal injuries, or for any malpractice, and the patient produces a physician as a witness in the patient's own behalf who has treated the patient for the injury or for any disease or condition for which the malpractice is alleged, the patient shall be considered to have waived the privilege provided in this section as to another physician who has treated the patient for the injuries, disease, or condition. If a patient has died, the heirs at law of the patient, whether proponents or contestants of the patient's will, shall be considered to be personal representatives of the deceased patient for the purpose of waiving the privilege under this section in a contest upon the question of admitting the patient's will to probate. If a patient has died, the beneficiary of a life insurance policy insuring the life of the patient, or the patient's heirs at law, may waive the privilege under this section for the purpose of providing the necessary documentation to a life insurer in examining a claim for benefits.
History: 1961, Act 236, Eff. Jan. 1, 1963 ;- Am. 1989, Act 102, Eff. Sept. 1, 1989 ;- Am. 1995, Act 205, Imd. Eff. Nov. 29, 1995
http://law.justia.com/michigan/codes/2006/mcl-chap600/mcl-600-2157.html

PUBLIC HEALTH CODE (EXCERPT) Act 368 of 1978
333.18237 Confidential information; disclosure; waiver.
Sec. 18237 A psychologist licensed or allowed to use that title under this part or an individual under his or her supervision cannot be compelled to disclose confidential information acquired from an individual consulting the psychologist in his or her professional capacity if the information is necessary to enable the psychologist to render services. Information may be disclosed with the consent of the individual consulting the psychologist, or if the individual consulting the psychologist is a minor, with the consent of the minor's guardian, pursuant to section 16222 if the psychologist reasonably believes it is necessary to disclose the information to comply with section 16222, or under section 16281. In a contest on the admission of a deceased individual's will to probate, an heir at law of the decedent, whether a proponent or contestant of the will, and the personal representative of the decedent may waive the privilege created by this section.
History: 1978, Act 368, Eff. Sept. 30, 1978 ;-- Am. 1993, Act 79, Eff. Apr. 1, 1994 ;- Am. 1998, Act 496, Eff. Mar. 1, 1999
http://www.legislarure.mi.gov

333.18117 Privileged communications; disclosure of confidential information.
Sec. 18117 For the purposes of this part, the confidential relations and communications between a licensed professional counselor or a limited licensed counselor and a client of the licensed professional counselor or a limited licensed counselor are privileged communications, and this part does not require a privileged communication to be disclosed, except as otherwise provided by law. Confidential information may be disclosed only upon consent of the client, pursuant to section 16222 if the licensee reasonably believes it is necessary to disclose the information to comply with section 16222, or under section 16281.
History: Add. 1988, Act 421, EfF. Mar. 30, 1989 ;-- Am. 1993, Act 79, EfF. Apr. 1, 1994 ;-- Am. 1998, Act 496, EfF. Mar. 1, 1999
http://www.legislature.mi.gov

PUBLIC HEALTH CODE (EXCERPT)
Act 368 of 1978

333.5131 Serious communicable diseases or infections of HIV infection and acquired immunodeficiency syndrome; confidentiality of reports, records, data, and information; test results; limitations and restrictions on disclosures in response to court order and subpoena; information released to legislative body; applicability of subsection (1); immunity; identification of individual; violation as misdemeanor; penalty.

Sec. 5131.

(1) All reports, records, and data pertaining to testing, care, treatment, reporting, and research, and information pertaining to partner notification under section 5114a, that are associated with the serious communicable diseases or infections of HIV infection and acquired immunodeficiency syndrome are confidential. A person shall release reports, records, data, and information described in this subsection only pursuant to this section.

(2) Except as otherwise provided by law, the test results of a test for HIV infection or acquired immunodeficiency syndrome and the fact that such a test was ordered is information that is subject to section 2157 of the revised judicature act of 1961, 1961 PA 236, MCL 600.2157.

(3) The disclosure of information pertaining to HIV infection or acquired immunodeficiency syndrome in response to a court order and subpoena is limited to only the following cases and is subject to all of the following restrictions:

(a) A court that is petitioned for an order to disclose the information shall determine both of the following:

(i) That other ways of obtaining the information are not available or would not be effective.

(ii) That the public interest and need for the disclosure outweigh the potential for injury to the patient.

(b) If a court issues an order for the disclosure of the information, the order shall do all of the following:

(i) Limit disclosure to those parts of the patient's record that are determined by the court to be essential to fulfill the objective of the order.

(ii) Limit disclosure to those persons whose need for the information is the basis for the order.

(iii) Include such other measures as considered necessary by the court to limit disclosure for the protection of the patient.

(4) A person who releases information pertaining to HIV infection or acquired immunodeficiency syndrome to a legislative body shall not identify in the information a specific individual who was tested or is being treated for HIV infection or acquired immunodeficiency syndrome.

(5) Subject to subsection (7), subsection (1) does not apply to the following:

(a) Information pertaining to an individual who is HIV infected or has been diagnosed as having acquired immunodeficiency syndrome, if the information is disclosed to the department, a local health department, or other health care provider for 1 or more of the following purposes:

(i) To protect the health of an individual.

(ii) To prevent further transmission of HIV.

(iii) To diagnose and care for a patient.

(b) Information pertaining to an individual who is HIV infected or has been diagnosed as having acquired immunodeficiency syndrome, if the information is disclosed by a physician or local health officer to an individual who is known by the physician or local health officer to be a contact of the individual who is HIV infected or has been diagnosed as having acquired immunodeficiency syndrome, if the physician or local health officer determines that the disclosure of the information is necessary to prevent a reasonably foreseeable risk of further transmission of HIV. This subdivision imposes an affirmative duty upon a physician or local health officer to disclose information pertaining to an individual who is HIV infected or has been diagnosed as having acquired immunodeficiency syndrome to an individual who is known by the physician or local health officer to be a contact of the individual who is HIV infected or has been diagnosed

as having acquired immunodeficiency syndrome. A physician or local health officer may discharge the affirmative duty imposed under this subdivision by referring the individual who is HIV infected or has been diagnosed as having acquired immunodeficiency syndrome to the appropriate local health department for assistance with partner notification under section 5114a. The physician or local health officer shall include as part of the referral the name and, if available, address and telephone number of each individual known by the physician or local health officer to be a contact of the individual who is HIV infected or has been diagnosed as having acquired immunodeficiency syndrome.

(c) Information pertaining to an individual who is HIV infected or has been diagnosed as having acquired immunodeficiency syndrome, if the information is disclosed by an authorized representative of the department or by a local health officer to an employee of a school district, and if the department representative or local health officer determines that the disclosure is necessary to prevent a reasonably foreseeable risk of transmission of HIV to pupils in the school district. An employee of a school district to whom information is disclosed under this subdivision is subject to subsection (1).

(d) Information pertaining to an individual who is HIV infected or has been diagnosed as having acquired immunodeficiency syndrome, if the disclosure is expressly authorized in writing by the individual. This subdivision applies only if the written authorization is specific to HIV infection or acquired immunodeficiency syndrome. If the individual is a minor or incapacitated, the written authorization may be executed by the parent or legal guardian of the individual.

(e) Information disclosed under section 5114, 5114a, 5119(3), 5129, 5204, or 20191 or information disclosed as required by rule promulgated under section 5111.

(f) Information pertaining to an individual who is HIV infected or has been diagnosed as having acquired immunodeficiency syndrome, if the information is part of a report required under the child protection law, 1975 PA 238, MCL 722.621 to 722.638.

(g) Information pertaining to an individual who is HIV infected or has been diagnosed as having acquired immunodeficiency syndrome, if the information is disclosed by the department of human services, the probate court, or a child placing agency in order to care for a minor and to place the minor with a child care organization licensed under 1973 PA 116, MCL 722.111 to 722.128. The person disclosing the information shall disclose it only to the director of the child care organization or, if the child care organization is a private home, to the individual who holds the license for the child care organization. An individual to whom information is disclosed under this subdivision is subject to subsection (1). As used in this subdivision, "child care organization" and "child placing agency" mean those terms as defined in section 1 of 1973 PA 116, MCL 722.111.

(6) A person who releases the results of an HIV test or other information described in subsection (1) in compliance with subsection (5) is immune from civil or criminal liability and administrative penalties including, but not limited to, licensure sanctions, for the release of that information.

(7) A person who discloses information under subsection (5) shall not include in the disclosure information that identifies the individual to whom the information pertains, unless the identifying information is determined by the person making the disclosure to be reasonably necessary to prevent a foreseeable risk of transmission of HIV. This subsection does not apply to information disclosed under subsection (5)(d), (f), or (g).

(8) A person who violates this section is guilty of a misdemeanor, punishable by imprisonment for not more than 1 year or a fine of not more than $5,000.00, or both, and is liable in a civil action for actual damages or $1,000.00, whichever is greater, and costs and reasonable attorney fees. This subsection also applies to the employer of a person who violates this section, unless the employer had in effect at the time of the violation reasonable precautions designed to prevent the violation.

History: Add. 1988, Act 488, Eff. Mar. 30, 1989 ;-- Am. 1989, Act 174, Imd. Eff. Aug. 22, 1989 ;-- Am. 1989, Act 271, Imd. Eff. Dec. 26, 1989 ;-- Am. 1992, Act 86, Eff. Mar. 31, 1993 ;-- Am. 1994, Act 200, Imd. Eff. June 21, 1994 ;-- Am. 1997, Act 57, Eff. Jan. 1, 1998 ;-- Am. 2010, Act 119, Imd. Eff. July 13, 2010 **Admin Rule:** R 325.9001 et seq. of the Michigan Administrative Code

Your HIV Status is Your Private Business

Kendra S. Kleber
Attorney at Law
Director of Legal Services
Michigan Advocates Exchange, Inc.

Generally, Michigan law protects the confidentiality of every person's HIV status. With a few exceptions, it is against the law to talk about HIV or AIDS status. It doesn't matter if the disclosure happens by accident or purposefully, and it doesn't matter if the person being, talked about is HIV-positive or HIV-negative. There are some situations when t is not against the law to talk about someone's HIV status, but there are not many and they are very specific For example, anyone can disclose someone's identity and their HIV status to the local health department, if they believe that there is a real risk of HIV transmission.

Michigan law says that if you are HIV-positive then you must disclose your status to a sex partner before you become intimate, or else you have committed a felony. Because this felony exposure law forces you to disclose your status, you can't keep it a perfect secret. That means you may have problems with your confidential information being repeated without your permission.

If you, your family or your property are in physical danger because of harassment or bullying related to your HIV status, you need to call for help. Start with the police. (You might also call the local prosecutor's office, the sheriff s office, the State, Police, an HIVcase management agency, or a lawyer.) Say that you are in danger, that you have a disability, and that you are afraid for your safety. And then listen to what they have to say. You may want to call more than one agency so you can choose whose advice you want to follow. <u>You do not have to reveal your HIV status to be protected from a real threat of physical danger.</u>

If you have a feeling that someone is talking about your HIV status, start taking notes. Keep a record of what you find out, when you learn it, who you think is doing the talking, who told you it was happening, and what reasons someone may have for revealing your HIV status. You need as much information as possible to explain why you think that someone is talking about you in case you end up calling the police.

If someone does reveal your HIV status without your permission, it may be a misdemeanor. You can file a police report and perhaps have them arrested. If you call the police and they do not know about the HIV confidentiality law, ask them (nicely) to look it up in their warrant book (the number of the law is MI Compiled Law section 333.5131).

You may also be able to sue the person who revealed your status. You have the, right to file a lawsuit for $1,000 per actual disclosure, which means that you might be able to sue in Small Claims Court (where you can tell your story to the judge yourself, without a lawyer). If the person who talked about your status learned it while doing their job, you May be able to sue their employer.

If you don't want to get the police involved, and you don't want to file a lawsuit, you can still inform the person that he or she is breaking the law. The attached letter could be used to ask the person to stop talking about your status. The letter explains the law and the penalties for breaking it, and is designed to get our phone number to people who need more information. You can also use the "shut up cards" that we've printed, to help give people information about HIV and confidentiality. *(contact Michigan Advocates for the actual letter and cards)*

Every person in Michigan has the right to insist that their HIV status be kept confidential. Just like you have the right to confidentiality, you also have the obligation not to reveal someone else's HIV status. Be careful to protect the HIV/AIDS status of any friends, acquaintances or people you meet at HIV-specific service providers like your doctor or an AIDS service organization. No matter how public someone may be about their HIV status, if they haven't given <u>you</u> permission to talk about it, then don't.

The best way to protect your HIV status is to be really careful about who you tell. Deciding who and how to tell are big decisions, and you may be able to prevent a lot of problems by talking with a counselor, a social worker, a case manager or a lawyer before you disclose your status to anyone other than your sex partner.

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DCH-3927: BEHAVIORAL HEALTH CONSENT FORM
BACKGROUND INFORMATION

Health information sharing is an important part of delivering quality health care to individuals. Individuals and their health care providers share information with each other to diagnose health issues, make decisions about treatments, and coordinate care.

Under the Health Insurance Portability and Accountability Act (HIPAA), health care providers may share many kinds of health information with other providers for the purposes of payment, treatment, and health care operations. However, providers must receive specific consent to share an individual's health records containing certain types of information. In Michigan, federal and state laws require providers to receive consent to share the following types of information:

- Behavioral health or mental health services that are provided by the Michigan Department of Health and Human Services (MDHHS), a Community Mental Health Service Provider, or an entity under contract with the MDHHS or a Community Mental Health Service Provider
- Referrals and /or treatment for a substance use disorder

In the past, each provider has developed his or her own form to receive the individual's consent to share the above types of information. The differences between forms made sharing information across the health care system difficult for individuals and providers.

To address this problem, the Michigan legislature passed a law (Public Act 129 of 2014), which directed MDHHS to create a standard consent form for sharing the types of information listed above. The goal of the law is to make the consent process simpler for individuals and providers in Michigan.

MDHHS recognizes that multiple laws, statutes, and regulations govern the sharing of health information. The Department designed the consent form to align with the requirements contained in HIPAA, 42 Code of Federal Regulations Part 2, and the Michigan Mental Health Code, and the Michigan Public Health Code.

Public Act 129 requires "all public and private agencies, departments, corporations, or individuals that are involved with treatment of an individual experiencing serious mental illness, serious emotional disturbance, developmental disability, or substance use disorder" to accept and honor the standard form (DCH-3927) unless the entity is held to more stringent requirements under federal law. The following entities are held to more stringent requirements and are not required to accept DCH-3927:

> Individuals and agencies that provide services under the Violence Against Women Act or Family Violence Prevention and Services Act. These individuals and agencies should not use the standard form and must complete a separate release for sharing health information. These entities can refer to the "Provider Specific Frequently Asked Questions" document or www.michigan.gov/domesticviolence for more information.

For additional information about DCH-3927, contact the Department by phone at 844-275-6324 or by email at MDHHS-BHConsent@michigan.gov.

This document is for informational purposes only.
It is not intended to provide legal advice or to address all circumstances that might arise.
Individuals and entities using this document are encouraged to consult their own legal counsel.

THINGS TO CONSIDER WHEN GIVING CONSENT TO SHARE HEALTH INFORMATION

YOUR INFORMATION. YOUR RIGHTS. YOUR CHOICES.

YOUR INFORMATION

When you receive health care, your health care provider keeps records about your health and the services you receive:

- These records (which include any information about the services, tests, diagnoses, treatment, etc. that you receive) become a part of your medical record.
- Under the Health Insurance Portability and Accountability Act (HIPAA), your health care provider does not need your consent to share most types of your health information for purposes of payment, treatment, and health care operations.
- Other federal and state laws require your health care provider to get your consent to share certain types of health information such as:
    - Behavioral health and mental health services[1]
    - Referrals and /or treatment for a substance use disorder[2]

YOUR RIGHTS AND CHOICES

Concerning the types of information described above, you have the right to:

- Talk with your provider about the benefits and risks of sharing your health information
- Choose whether to sign the form and provide your consent
- Choose what information is shared
- Choose who should receive your health information
- Choose the time period for sharing your information (for example, one month, six months, one year, etc.)
- Withdraw your consent to share your information
- Receive a copy of your medical records
- File a complaint if you believe information has been shared against your wishes

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

[1] P.A. 258 of 1974 and MCL 330.1748
[2] 42 CFR Part 2

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CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION FOR CARE COORDINATION PURPOSES

Michigan Department of Health and Human Services

This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault or stalking. A separate consent form must be completed with the person or agency that provided those services. (See FAQ at www.michigan.gov/bhconsent to determine if this restriction applies to you or your agency.)

Individual's Name	Date of Birth	Individual's ID Number (Medicaid ID, Last 4 digits of SSN, other)

Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or agency can use and share most of your health information in order to provide you with treatment, receive payment for your care, and manage and coordinate your care. However, your consent is needed to share certain types of health information. This form allows you to provide consent to share the following types of information.

- Behavioral and mental health services
- Referrals and treatment for an alcohol or substance abuse disorder

This information will be shared to help diagnose, treat, manage and get payment for your health needs. You can consent to share all of this information or just some information. (See FAQ at www.michigan.gov/bhconsent)

I. I consent to share my information among:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

II. I consent to share:

☐ All of my behavioral health and substance use disorder information

☐ All of my behavioral health and substance use disorder information except: (List types of health information you do not want to share below)

_____

I understand that HIPAA allows providers and other agencies to use and share much of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.

III. By signing this form I understand:

- I am giving consent to share my behavioral health and substance use disorder information. Behavioral health and substance use disorder information includes, but is not limited to, referrals and services for alcohol and substance use disorders.
- My information may be shared among each agency and person listed above.
- My information will be shared to help diagnose, treat, manage and pay for my health needs.
- My consent is voluntary and will not affect my ability to obtain mental health or medical treatment, payment for medical treatment, health insurance or benefits.
- My health information may be shared electronically.
- Other types of my information may be shared with my behavioral health and substance use disorder information. HIPPA allows my providers and other agencies to use and share most of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.
- The sharing of my health information will follow state and federal laws and regulations.
- This form does not give my consent to share psychotherapy notes as defined by federal law.
- I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back.
- I should tell all agencies and people listed on this form when I withdraw my consent.
- I can have a copy of this form.
- My consent will expire on the following date, event or condition unless I withdraw my consent. (If expiration date is left blank or is longer than one year, the consent will expire 1 year from the signature date.)

_____

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

Signature of person giving consent or legal representative	Date

Relationship to individual

☐ Self ☐ Parent ☐ Guardian ☐ Authorized Representative

WITHDRAW OF CONSENT

I understand that any information already shared with or in reliance upon my consent cannot be taken back.

I withdraw my consent to the sharing of my health information:

☐ Between any of the following persons or agencies:

_____ _____

_____ _____

_____ _____

OR

☐ For all persons and agencies:

_____ _____

Signature of person giving consent or legal representative Date

Relationship to individual

☐ Self ☐ Parent ☐ Guardian ☐ Authorized Representative

Verbal Withdraw of Consent:

This consent was verbally withdrawn.

_____ _____

Signature of person giving consent or legal representative Date

☐ Individual provided copy ☐ Individual declined copy

AUTHORITY:	This form is acceptable to the Michigan Department of Health and Human Services as compliant with HIPAA privacy regulations, 45CFR Parts 160 and 164 as modified August 14, 2002, 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq and PA 129 of 2014, MCL 330.1141a.
COMPLETION:	Is Voluntary, but required if disclosure is requested.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

Frequently Asked Questions for Providers and Organizations About the DCH-3927, Consent to Share Behavioral Health Information for Care Coordination Purposes

If you provided services to someone who has experienced domestic violence, sexual assault and/or stalking, and would like to release information about the individual, you should refer to Questions 3 and 4.

You may also visit www.michigan.gov/domesticviolence for more information.

1. What is the purpose of this form?

The purpose of the form is to enable providers and organizations to share certain types of behavioral health information that have special privacy protections under federal and state law. The Michigan Department of Health and Human Services created this form in compliance with Public Act 129 of 2014, which directs the department to:

"…develop a standard release form for exchanging confidential mental health and substance use disorder information for use by all public and private agencies, departments, corporations or individuals that are involved with treatment of an individual experiencing serious mental illness, serious emotional disturbance, developmental disability or substance use disorder."

2. What are my responsibilities under this form and Public Act 129 of 2014?

All public and private agencies, departments, corporations, or individuals involved with the treatment of an individual experiencing serious mental illness, serious emotional disturbance, developmental disability or substance use disorder are required to honor and accept this form as a valid consent to share certain types of health information. Individuals and organizations that provide services under the Violence Against Women Act or Family Violence Prevention and Services Act are not required to accept and honor the form.

3. Why is there an exception for individuals or organizations that have provided services for domestic violence, sexual assault and/or stalking? What should I do if my client would like to release information about services for domestic violence, sexual assault or stalking?

Providers receiving federal funding under the Violence Against Women Act and/or Family Violence Prevention and Services Act are held to more stringent consent requirements under federal law and are therefore exempt from the requirements of Public Act 129 of 2014. Additional safeguards may need to be in place before health information is shared for individuals who have experienced domestic violence, sexual assault and stalking. You may want to speak with the individual to see if additional safeguards are necessary.

For guidance on addressing issues related to consent and the provision of services for domestic violence, sexual assault and/or stalking, please refer to www.michigan.gov/domesticviolence through the Michigan Department of Health and Human Services.

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4. Some of the individuals that I serve have experienced domestic violence, sexual assault and/or stalking. May I still use the behavioral health consent form?

If you are an individual or organization that receives federal funding under the Violence Against Women Act and/or Family Violence Prevention and Services Act, you should not use the Behavioral Health consent form. Individuals and organizations that receive funding under these programs are held to more stringent consent requirements.

If you provide services to individuals who have experienced domestic violence, sexual assault and/or stalking but you do not receive federal funding under these programs, you should evaluate whether additional safeguards may need to be in place before information is shared. You may want to speak with the individual to see if additional safeguards are necessary. You may visit www.michigan.gov/domesticviolence for more information.

5. Do I have to use this form? Can I still use my own form? Can I still accept other release forms besides the behavioral health consent form?

You are required to honor this form when presented with it unless you are held to more stringent requirements under federal law. However, you may still use your own consent form or accept other consent forms that are in compliance with federal and state confidentiality laws.

6. Why does the department encourage entities to use the behavioral health consent form?

The behavioral health consent form allows individuals, providers and other organizations to use a common consent form to comply with relevant federal and state confidentiality laws. The use of the behavioral health consent form will reduce confusion, simplify the process and enable more meaningful use of an individual's health information.

7. What constitutes "accepting" the form?

A provider or entity that receives the form must accept the form and disclose the information to the parties listed on the form as authorized.

8. Is the behavioral health consent form compliant with the Health Insurance Portability and Accountability Act (HIPAA) as well as other federal and state privacy laws and regulations?

The Michigan Department of Health and Human Services has designed the behavioral health consent form to be compliant with the following federal and state laws:

- 42 Code of Federal Regulations Part 2
- Michigan Mental Health Code
- Health Insurance Portability and Accountability Act

HIPAA does not require an authorization or consent in order to use or disclose an individual's protected health information for treatment, payment or health care operations purposes. The disclosures made under the behavioral health consent form are to diagnose, treat, manage, and receive payment for an individual's health care needs. These purposes fit within HIPAA's permissible disclosures without consent or authorization. Therefore, a separate HIPAA-compliant authorization is not required. However, health care providers and other organizations may

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choose to have individuals complete a HIPAA-compliant authorization in conjunction with the form in order to share information for other purposes. Providers and other organizations should consult with their legal counsel on whether individuals should complete a separate HIPAA authorization for other purposes.

9. Why does the form not contain all of the elements required for an authorization under HIPAA?

HIPAA does not require an authorization in order to use or disclose an individual's protected health information for treatment, payment or health care operations purposes. A HIPAA authorization may need to be completed if information is to be disclosed outside of the treatment, payment and health care operations exceptions under HIPAA. For example, a HIPAA authorization is required to share information for marketing purposes and to share psychotherapy notes. Health care providers and other organizations should consult with their legal counsel on whether individuals should complete a separate HIPAA authorization for other purposes.

10. What kind of information can be disclosed under the behavioral health consent form?

Under HIPAA, covered entities may share most types of health information for the purposes of payment, treatment, and health care operations. Public Act 129 of 2014 does not require entities to use the behavioral health consent form to share information that could be shared exclusively under the requirements of HIPAA, as described in the previous question.

Under federal and state law, entities must receive specialized consent to share health information in an individual's record related to:

- Behavioral health or mental health services that are provided by the Michigan Department of Health and Human Services, a Community Mental Health Service Provider, or an entity under contract with the Michigan Department of Health and Human Services or a Community Mental Health Service Provider[1].
- Referrals and /or treatment for a substance use disorder[2].

The Michigan Department of Health and Human Services designed the behavioral health consent form to allow for the release of these types of information consistent with HIPAA and other federal and state confidentiality laws. The behavioral health consent form cannot be used to consent to the sharing of psychotherapy notes.

11. When do I need consent to share health records related to communicable diseases?

DCH-3927 is a behavioral health consent form that individuals can use to authorize the sharing of behavioral health information. Individuals may use this form to consent to sharing of mental health records and substance use disorder records.

Most types of communicable diseases information can be shared under HIPAA without consent. Additionally, the Michigan Public Health Code requires the reporting of communicable diseases to public health officials. Health care providers and other organizations should review the Michigan Public Health Code and other applicable statutes to determine the requirements for sharing communicable disease information and reporting information to public health officials[3].

1 PA 258 of 1974 and MCL 330.1748
2 42 CFR Part 2
3 PA 368 of 1978, MCL 333.1101 et seq

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It is not intended to provide legal advice or to address all circumstances that might arise.
Individuals and entities using this document are encouraged to consult their own legal counsel.

12. Can I re-disclose information shared with me under the behavioral health consent form?

Federal law generally prohibits the re-disclosure of substance use disorder information unless the re-disclosure is expressly permitted by the written consent. The behavioral health consent form allows an individual to designate providers and organizations that may share information among each other, as specified in the form. Federal law requires that a specific notice regarding re-disclosure accompany any disclosure of substance use disorder information that is shared with the individual's written consent[4].

13. How should the individuals that I serve list the entities with which they would like to share their health information?

Under Section 1, the individual should include (1) the name of the provider or organization for whom the form is being completed and (2) any other providers or organizations with whom he or she would like his or her health information shared. The individual should include the specific name of the individual or organization that is given permission to share and receive information as opposed to a general designation. *Please note that a provider or organization who is listed on the form may share information with any other individual or organization that is also listed on the form.*

14. When I send a completed DCH-3927 form to another provider or organization, can I include a cover letter to help explain the request to share health information?

Yes, health care providers and other organizations may use a cover letter in conjunction with a completed DCH-3927 form in order to provide further details about the request to share health information. The Michigan Department of Health and Human Services does not have a standard template for a cover letter that could be used with a completed DCH-3927 form. Health care providers and other organizations are encouraged to design their own cover letters to meet their needs.

Health care providers or organizations that are designing their own cover letter templates could consider including the following elements as part of that document:

- An area where the name of the requesting organization can be listed.
- An area where the contact information for the requesting organization can be listed.
- A section where the types of records being requested can be described in further detail.
    - Specific records or pieces of information that are being requested.
    - Specific time period of records that are being requested.

15. If I receive a completed DCH-3927 form from another health care provider or organization, is there any information that I should include with any records that I send to the requesting organization?

Yes, if you will be sharing any substance use disorder information that is covered under 42 CFR Part 2, you should include a re-disclosure notice with any records that you share with the requesting organization. A re-disclosure notice should include the following language:

4 See 42 CFR 2.32

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This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

16. Do I need to have the individual sign the behavioral health consent form every year?

The form is designed so that an individual may consent to the sharing of his or her health information for up to one year. An individual must renew his or her consent form each year.

17. What methods of communication can I use to share health information once the individual has provided consent?

Providers and organizations may share health information verbally or through mail, fax or electronically. Providers should consider how to comply with an individual's wishes when determining how to send information. For example, a provider should not disclose information electronically if there is no way to electronically separate health information that cannot be disclosed from the other health information that may be disclosed.

18. What resources can I share with individuals to assist them with the consent process?

The Michigan Department of Health and Human Services developed the following resource documents that may be shared with individuals: "Frequently Asked Questions from Individuals about the Behavioral Health Consent Form" and "Consent Process Brochure." The most recent versions of these documents are available on the Michigan Department of Health and Human Services website at www.michigan.gov/bhconsent.

19. How should my organization handle the withdrawal of consent by an individual?

Individuals may withdraw their consent verbally or in writing.

A provider should retain a copy of the withdrawal and provide a copy to the individual if the individual withdraws consent in writing. The entity should inform the individual that he or she should notify all providers and organizations listed on the form that consent has been withdrawn. The entity may also choose to assist the individual with sending a copy of withdrawal to other providers or organizations on the form.

If the individual withdraws consent verbally, the entity should document the time, place and manner of the withdrawal for their records. The entity should also share a copy of the withdrawal with the individual. The entity should inform the individual that he or she should notify all providers and organizations listed on the form that consent has been withdrawn. The entity may choose to assist the individual with sending a copy of revocation to other providers or organizations on the form.

20. If I have questions about the form or Public Act 129 of 2014, who should I contact?

For questions about the Behavioral Health Consent form or Public Act 129 of 2014, please contact the Michigan Department of Health and Human Services by phone at 844-275-6324, online at www.michigan.gov/bhconsent, or by email at MDHHS-BHConsent@michigan.gov.

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Frequently Asked Questions for Michigan Residents About the DCH-3927, Consent to Share Behavioral Health Information for Care Coordination Purposes

If you have experienced domestic violence, sexual assault, and/or stalking and would like to release information on services that you received, you should refer to Question 11.

You may also visit www.michigan.gov/domesticviolence for more information.

1. Why am I being asked to share my behavioral health information?

You may be receiving health care from several providers or organizations. Each provider has a record about your care. Your provider may ask to share your record with another provider or organization. Here are some reasons that your provider may be asking to share your record:

- Make sure that all of your health needs have been addressed.
- Ensure that any treatments that you have been prescribed are safe and appropriate.
- Coordinate services with other providers or organizations.

2. Is my consent required to share my all health information?

Your health care provider may share most types of health information for the purposes of payment, treatment or health care operations under the Health Insurance Portability and Accountability Act (HIPAA). However, other federal laws and state laws require your provider to get your consent to share certain types of health information. In Michigan, providers must receive your consent to share the following types of information:

- Behavioral health or mental health services that are provided by the Michigan Department of Health and Human Services, a Community Mental Health Service Provider, or an entity under contract with the Michigan Department of Health and Human Services or a Community Mental Health Service Provider[1].
- Referrals and/or treatment for a substance use disorder[2].

Behavioral Health Consent form, also known as DCH-3927, can be used to consent to share these types of information. DCH-3927 cannot be used to share psychotherapy notes as defined under federal law.

3. What is behavioral health information?

Behavioral health services may address mental health needs and substance use disorders. Providers keep records on the behavioral health services that individuals receive. These records are known as “behavioral health information.” Federal and state law require your provider to receive consent to share your behavioral health information with other providers.

1 PA 258 of 1974 and MCL 330.1748
2 42 CFR Part 2

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4. I have a communicable disease. Do I need to provide consent for this information to be shared?

DCH-3927 is a consent form for the sharing of behavioral health information. You can use the form to consent to share mental health records and substance use disorder records.

Under HIPAA, your provider can share most communicable disease information with other health care providers. Additionally, your provider must report certain communicable disease information to public health officials. You can ask your provider about what types of communicable disease information may be shared or reported under state and federal laws.

5. Can I limit what information will be shared?

Under Section II on the form, you have two options for deciding what information you want to have shared. You may choose to share all of your information or only some of it. If you choose to only share some of your information, you must list under Section II what information you do not want shared. You should speak with your provider or his or her staff about the benefits and risks of sharing only part of your health information.

6. Why will my health care provider share my health information?

Your provider can share your health information listed in Section II to help diagnose, treat, manage and get payment for your health needs. Ask your provider or organization if you have questions as to why or how your health information will be shared.

7. With whom will my provider share this information?

You can list any provider, agency, organization that you want to share your health information. You must write the name of the individual, agency or organization that you want to share and receive your information under Section I. Please note that any individual, agency or organization that you list on the form can share information with other individuals, agencies and organizations listed on the form. If you have any questions, you can ask your health care provider or his or her staff to explain the process to you.

8. What if I do not consent to share my health information?

Your consent is voluntary, and your decision not to consent will not affect your ability to get mental health or medical treatment, health insurance, or benefits. However, if you do not provide consent, your provider may not be able to share your health information such as your behavioral health records or substance use disorder treatment records. If you do not provide consent, your substance use disorder provider or organization may not be able to bill your insurance and may require that you pay out-of-pocket for substance use disorder treatment. You should discuss this issue with your substance use disorder provider or organization.

Your provider may still share information under HIPAA that does not need additional consent under state or federal laws. HIPAA allows providers to share this information without your consent for purposes such as payment, treatment and health care operations.

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9. How will my information be shared?

Your provider may share your information verbally, through mail or fax, or by using another electronic method. You may talk with your provider about how he or she will share your information.

10. If I provide my consent now, can I withdraw it at a later time?

Yes, you may withdraw your consent at any time. To withdraw your consent, fill out the Withdraw of Consent section or tell your provider that you wish to withdraw your consent. You must notify all providers and organizations listed on your form that you no longer consent to share your information. If you are withdrawing consent to share information for only some of the providers and organizations on the form, you must notify all providers and organizations listed on the form of this change.

You should keep a copy of the form that you used to withdraw consent. Information that has already been shared based on your consent cannot be taken back. Your provider may still share information under HIPAA that does not need additional consent under state or federal laws. HIPAA allows providers to share most kinds of health information with other providers or organizations for purposes such as payment, treatment and health care operations.

11. Will my health care provider keep my information confidential?

HIPAA and certain other federal and state laws require your provider to protect your health information. Your provider must meet privacy and security requirements under these laws. You may ask your provider about how he or she protects your health information.

12. I have experienced domestic violence, sexual assault and/or stalking. This document says that I must complete a separate consent to share health information. Why is this? What should I do?

Additional safeguards may need to be in place before your health information can be shared. Talk to your provider if you have concerns about sharing your health information. You may also visit the Michigan Department of Health and Human Services website at: www.michigan.gov/domesticviolence for additional information.

13. If I have questions about the form, who can I ask?

You can ask your health care provider, his or her staff or your patient advocate. You can also contact the Michigan Department of Health and Human Services by phone at 844-275-6324, online at www.michigan.gov/bhconsent, or by email at MDHHS-BHConsent@michigan.gov.

MDHHS
Michigan Department of Health & Human Services

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

Hospital Name/Logo
Mental Health Services

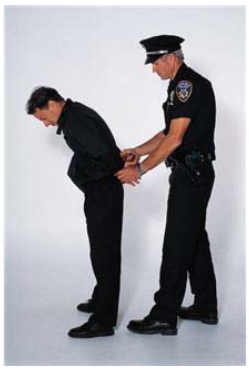
Important Information for Visitors:

Your Hospital Name's Mental Health Services is committed to providing quality, compassionate care to your loved one.

Please understand that there are State and Federal laws in place to protect the privacy and confidentiality of your adult loved one. Because of this, we are unable to release any type of information to you without written permission from our patient. We are, however, able to take information from you about your loved one that you feel is important for us to know in order to better care for him/her.

If you have information that you feel is imperative for our treatment team to be aware of, please contact us by calling XXX-XXX-XXXX.
You may ask to speak with the social worker or nurse on duty, and we will be happy to communicate your concerns with your loved one's physician and the rest of the treatment team.

LARA licensing states that the hospital could also solicit information when a family member calls. Asking to please tell about the psychiatric history & was the family member on medications etc., and give some idea of what worked & how things were going. It's OK to ask about social history & solicit info without transmitting what's happening at the hospital.



There have been many questions recently regarding incidents that involve activity, including that of a sexual nature between recipients. Criminal sexual conduct is required to be reported to law enforcement. It does not matter if it is an employee to patient or patient to patient incident. This means information about the incident must be provided to the police, including the patients' names and addresses. The agency is required to cooperate with the law enforcement investigation. Staff would not copy any information from the chart and staff would only provide verbal information related to the incident that occurred. Staff must contact the police as soon as possible and the reporting individual must also complete the Report on Suspected Criminal Abuse form (located _____ _____). This form must be sent to the police within 72 hours of making the oral report/phone call. This report also contains the patients' names and a detailed description of the criminal abuse incident.

Please review the Patient Abuse/Neglect Policy for definitions and information on the reporting procedure and requirements.

The MI Penal Code states that criminal abuse does not include an assault or an assault and battery committed by a patient against another patient (for example, slapping, bumping, hitting, jostling.) Since this is not a mandatory required report, staff may not report an assault or an assault and battery between patients to law enforcement The patient who is the victim always has the right to also file a police report in any situation.

Please note that staff is only required to provide confidential information to police if the case was reported as and is being investigated as a criminal abuse case. If the police show up to take a report for an incident called in by a patient and the incident is not being reported as a criminal abuse case staff are not allowed to provide information to the police and should inform the police, after neither confirming nor denying the presence of the individual, that the only way staff can do so is with a court order directing them to disclose the requested information. The patients allegedly involved in these cases may agree/consent to talk to the police and provide their own information. Staff is required to report and provide information in all criminal abuse cases which are being prosecuted!

(if your hospital requires security to be notified:) Please make sure _____ security is notified for all suspected criminal abuse cases ASAP. _____ security must also be present anytime the police are contacted and arrive to the unit to meet with staff and patients and complete their report.

If you have any additional questions - please do not hesitate to contact me.

Your name, Recipient Rights Advisor, phone #:

Questions regarding Confidentiality

1. Law Enforcement

From: Dianne L. Baker
Subject: Re: Suggested Language: Court Order Allowing Disclosure of Information to Law Enforcement

When working with law enforcement, it is not inappropriate to provide tools for better inter-agency interaction. Officers coming to your LPH/U or CMH Group Home may wish to use this language for obtaining orders from the Judge:

Order for Disclosure of Patient Information And Authority to Conduct an On-Site Interview
An application for disclosure of patient information and the authority to enter (Mental Health Service Provider. Address) to (e.g. conduct an interview with, arrest, search) (named patient) who is believed to be under care at the above location having been filed

IT IS HEREBY ORDERED and in compliance with MCL 330.1748(5) that any mental health care provider at the above mental health service provider location where the named person is treated and/or detained is hereby ordered to provide access to the patient and to disclose to law enforcement authorities admission and discharge information regarding the person.
DCH-ORR February 2009

2. Serving Papers

From: Dianne L. Baker
Subject: Serving Papers on Mental Health Patient

In my opinion, a practical process would be this:

When a process server shows up with papers for a person thought to be on the mental health unit, staff response should be IN ALL CASES; "I'm sorry but based on state and federal confidentiality laws, I cannot confirm or deny that the named individual is here. If that person is here, however, I will let them know that you wish to see them. You may want to check back with us later."

The staff person then lets the patient know that there was an attempt to serve papers and ask them if they wish to be served. If they consent, when the process server checks back, you can let them know that the patient will see them at such and such a time. Make sure you get written authorization to identify the patient and their location to the process server. Make sure you say this to every process server. If the patient does not want to receive the papers, when the server calls or shows up again, repeat the same thing.

I would warn staff not to accept the papers, touch them or be touched by them at any time as this may be considered personal service anyway. As always, PLEASE CONSULT WITH LEGAL COUNSEL ON HOW THEY WISH YOU TO PROCEED.
DCH-ORR November 2001

HIPAA Privacy Rule and Sharing Information Related to Mental Health

Background

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. Ensuring strong privacy protections is critical to maintaining individuals' trust in their health care providers and willingness to obtain needed health care services, and these protections are especially important where very sensitive information is concerned, such as mental health information. At the same time, the Privacy Rule recognizes circumstances arise where health information may need to be shared to ensure the patient receives the best treatment and for other important purposes, such as for the health and safety of the patient or others. The Rule is carefully balanced to allow uses and disclosures of information—including mental health information—for treatment and these other purposes with appropriate protections.

In this guidance, we address some of the more frequently asked questions about when it is appropriate under the Privacy Rule for a health care provider to share the protected health information of a patient who is being treated for a mental health condition. We clarify when HIPAA permits health care providers to:

- Communicate with a patient's family members, friends, or others involved in the patient's care;
- Communicate with family members when the patient is an adult;
- Communicate with the parent of a patient who is a minor;
- Consider the patient's capacity to agree or object to the sharing of their information;
- Involve a patient's family members, friends, or others in dealing with patient failures to adhere to medication or other therapy;
- Listen to family members about their loved ones receiving mental health treatment;
- Communicate with family members, law enforcement, or others when the patient presents a serious and imminent threat of harm to self or others; and
- Communicate to law enforcement about the release of a patient brought in for an emergency psychiatric hold.

In addition, the guidance provides relevant reminders about related issues, such as the heightened protections afforded to psychotherapy notes by the Privacy Rule, a parent's right to access the protected health information of a minor child as the child's personal representative, the potential applicability of Federal alcohol and drug abuse confidentiality regulations or state laws that may provide more stringent protections for the information than HIPAA, and the intersection of HIPAA and FERPA in a school setting.

Questions and Answers about HIPAA and Mental Health

Does HIPAA allow a health care provider to communicate with a patient's family, friends, or other persons who are involved in the patient's care?

Yes. In recognition of the integral role that family and friends play in a patient's health care, the HIPAA Privacy Rule allows these routine – and often critical – communications between health care providers and these persons. Where a patient is present and has the capacity to make health care decisions, health care providers may communicate with a patient's family members, friends, or other persons the patient has involved in his or her health care or payment for care, so long as the patient does not object. See 45 CFR 164.510(b). The provider may ask the patient's permission to share relevant information with family members or others, may tell the patient he or she plans to discuss the information and give them an opportunity to agree or object, or may infer from the circumstances, using professional judgment, that the patient does not object. A common example of the latter would be situations in which a family member or friend is invited by the patient and present in the treatment room with the patient and the provider when a disclosure is made.

Where a patient is not present or is incapacitated, a health care provider may share the patient's information with family, friends, or others involved in the patient's care or payment for care, as long as the health care provider determines, based on professional judgment, that doing so is in the best interests of the patient. Note that, when someone other than a friend or family member is involved, the health care provider must be reasonably sure that the patient asked the person to be involved in his or her care or payment for care.

In all cases, disclosures to family members, friends, or other persons involved in the patient's care or payment for care are to be limited to only the protected health information directly relevant to the person's involvement in the patient's care or payment for care.

OCR's website contains additional information about disclosures to family members and friends in fact sheets developed for consumers - PDF and providers - PDF.

Does HIPAA provide extra protections for mental health information compared with other health information?

Generally, the Privacy Rule applies uniformly to all protected health information, without regard to the type of information. One exception to this general rule is for psychotherapy notes, which receive special protections. The Privacy Rule defines psychotherapy notes as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record. Psychotherapy notes do not include any information about medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, or results of clinical tests; nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Psychotherapy notes also do not include any information that is maintained in a patient's medical record. See 45 CFR 164.501.

Psychotherapy notes are treated differently from other mental health information both because they contain particularly sensitive information and because they are the personal notes of the therapist that typically are not required or useful for treatment, payment, or health care operations purposes, other than by the mental health professional who created the notes. Therefore, with few exceptions, the Privacy Rule requires a covered entity to obtain a patient's authorization prior to a disclosure of psychotherapy notes for any reason, including a disclosure for treatment purposes to a health care provider other than the originator of the notes. See 45 CFR 164.508(a)(2). A notable exception exists for disclosures required by other law, such as for mandatory reporting of abuse, and mandatory "duty to warn" situations regarding threats of serious and imminent harm made by the patient (State laws vary as to whether such a warning is mandatory or permissible).

Is a health care provider permitted to discuss an adult patient's mental health information with the patient's parents or other family members?

In situations where the patient is given the opportunity and does not object, HIPAA allows the provider to share or discuss the patient's mental health information with family members or other persons involved in the patient's care or payment for care. For example, if the patient does not object:

- A psychiatrist may discuss the drugs a patient needs to take with the patient's sister who is present with the patient at a mental health care appointment.
- A therapist may give information to a patient's spouse about warning signs that may signal a developing emergency.

BUT:

- A nurse may not discuss a patient's mental health condition with the patient's brother after the patient has stated she does not want her family to know about her condition.

In all cases, the health care provider may share or discuss only the information that the person involved needs to know about the patient's care or payment for care. See 45 CFR 164.510(b). Finally, it is important to remember that other applicable law (e.g., State confidentiality statutes) or professional ethics may impose stricter limitations on sharing personal health information, particularly where the information relates to a patient's mental health.

When does mental illness or another mental condition constitute incapacity under the Privacy Rule? For example, what if a patient who is experiencing temporary psychosis or is intoxicated does not have the capacity to agree or object to a health care provider sharing information with a family member, but the provider believes the disclosure is in the patient's best interests?

Section 164.510(b)(3) of the HIPAA Privacy Rule permits a health care provider, when a patient is not present or is unable to agree or object to a disclosure due to incapacity or emergency circumstances, to determine whether disclosing a patient's information to the patient's family, friends, or other persons involved in the patient's care or payment for care, is in the best interests of the patient.1 Where a provider determines that such a disclosure is in the patient's best interests, the provider would be permitted to disclose only the PHI that is directly relevant to the person's involvement in the patient's care or payment for care.

This permission clearly applies where a patient is unconscious. However, there may be additional situations in which a health care provider believes, based on professional judgment, that the patient does not have the capacity to agree or object to the sharing of personal health information at a particular time and that sharing the information is in the best interests of the patient at that time. These may include circumstances in which a patient is suffering from temporary psychosis or is under the influence of drugs or alcohol. If, for example, the provider believes the patient cannot meaningfully agree or object to the sharing of the patient's information with family, friends, or other persons involved in their care due to her current mental state, the provider is allowed to discuss the patient's condition or treatment with a family member, if the provider believes it would be in the patient's best interests. In making this determination about the patient's best interests, the provider should take into account the patient's prior expressed preferences regarding disclosures of their information, if any, as well as the circumstances of the current situation. Once the patient regains the capacity to make these choices for herself, the provider should offer the patient the opportunity to agree or object to any future sharing of her information.

Note 1: The Privacy Rule permits, but does not require, providers to disclose information in these situations. Providers who are subject to more stringent privacy standards under other laws, such as certain state confidentiality laws or 42 CFR Part 2, would need to consider whether there is a similar disclosure permission under those laws that would apply in the circumstances.

If a health care provider knows that a patient with a serious mental illness has stopped taking a prescribed medication, can the provider tell the patient's family members?

So long as the patient does not object, HIPAA allows the provider to share or discuss a patient's mental health information with the patient's family members. See 45 CFR 164.510(b). If the provider believes, based on professional judgment, that the patient does not have the capacity to agree or object to sharing the information at that time, and that sharing the information would be in the patient's best interests, the provider may tell the patient's family member. In either case, the health care provider may share or discuss only the information that the family member involved needs to know about the patient's care or payment for care.

Otherwise, if the patient has capacity and objects to the provider sharing information with the patient's family member, the provider may only share the information if doing so is consistent with applicable law and standards of ethical conduct, and the provider has a good faith belief that the patient poses a threat to the health or safety of the patient or others, and the family member is reasonably able to prevent or lessen that threat. See 45 CFR 164.512(j). For example, if a doctor knows from experience that, when a patient's medication is not at a therapeutic level, the patient is at high risk of committing suicide, the doctor may believe in good faith that disclosure is necessary to prevent or lessen the threat of harm to the health or safety of the patient who has stopped taking the prescribed medication, and may share information with the patient's family or other caregivers who can avert the threat. However, absent a good faith belief that the disclosure is necessary to prevent a serious and imminent threat to the health or safety of the patient or others, the doctor must respect the wishes of the patient with respect to the disclosure.

Can a minor child's doctor talk to the child's parent about the patient's mental health status and needs?

With respect to general treatment situations, a parent, guardian, or other person acting in loco parentis usually is the personal representative of the minor child, and a health care provider is permitted to share patient information with a patient's personal representative under the Privacy Rule. However, section 164.502(g) of the Privacy Rule contains several important exceptions to this general rule. A parent is not treated as a minor child's personal representative when: (1) 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, the minor consents to the health care service, and the minor child has not requested the parent be treated as a personal representative; (2) 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; or (3) a parent agrees to a confidential relationship between the minor and a health care provider with respect to the health care service.2 For example, if State law provides an adolescent the right to obtain mental health treatment without parental consent, and the adolescent consents to such treatment, the parent would not be the personal representative of the adolescent with respect to that mental health treatment information.

Regardless, however, of whether the parent is otherwise considered a personal representative, the Privacy Rule defers to State or other applicable laws that expressly address the ability of the parent to obtain health information about the minor child. In doing so, the Privacy Rule permits a covered entity to disclose to a parent, or provide the parent with access to, a minor child's protected health information when and to the extent it is permitted or required by State or other laws (including relevant case law). Likewise, the Privacy Rule prohibits a covered entity from disclosing a minor child's protected health information to a parent when and to the extent it is prohibited under State or other laws (including relevant case law). See 45 CFR 164.502(g)(3)(ii).

In cases in which State or other applicable law is silent concerning disclosing a minor's protected health information to a parent, and the parent is not the personal representative of the minor child based on one of the exceptional circumstances described above, a covered entity has discretion to provide or deny a parent access to the minor's health information, if doing so is consistent with State or other applicable law, and the decision is made by a licensed health care professional in the exercise of professional judgment. For more information about personal representatives under the Privacy Rule, see OCR's guidance for consumers and providers.

In situations where a minor patient is being treated for a mental health disorder and a substance abuse disorder, additional laws may be applicable. The Federal confidentiality statute and regulations that apply to

federally-funded drug and alcohol abuse treatment programs contain provisions that are more stringent than HIPAA. See 42 USC § 290dd–2; 42 CFR 2.11, et. seq.

Note 2: A parent also may not be a personal representative if there are safety concerns. A provider may decide not to treat the parent as the minor's personal representative if the provider believes that the minor has been or may be subject to violence, abuse, or neglect by the parent or the minor may be endangered by treating the parent as the personal representative; and the provider determines, in the exercise of professional judgment, that it is not in the best interests of the patient to treat the parent as the personal representative. See 45 CFR 164.502(g)(5).

At what age of a child is the parent no longer the personal representative of the child for HIPAA purposes?

HIPAA defers to state law to determine the age of majority and the rights of parents to act for a child in making health care decisions, and thus, the ability of the parent to act as the personal representative of the child for HIPAA purposes. See 45 CFR 164.502(g).

Does a parent have a right to receive a copy of psychotherapy notes about a child's mental health treatment?

No. The Privacy Rule distinguishes between mental health information in a mental health professional's private notes and that contained in the medical record. It does not provide a right of access to psychotherapy notes, which the Privacy Rule defines as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record. See 45 CFR 164.501. Psychotherapy notes are primarily for personal use by the treating professional and generally are not disclosed for other purposes. Thus, the Privacy Rule includes an exception to an individual's (or personal representative's) right of access for psychotherapy notes. See 45 CFR 164.524(a)(1)(i).

However, parents generally are the personal representatives of their minor child and, as such, are able to receive a copy of their child's mental health information contained in the medical record, including information about diagnosis, symptoms, treatment plans, etc. Further, although the Privacy Rule does not provide a right for a patient or personal representative to access psychotherapy notes regarding the patient, HIPAA generally gives providers discretion to disclose the individual's own protected health information (including psychotherapy notes) directly to the individual or the individual's personal representative. As any such disclosure is purely permissive under the Privacy Rule, mental health providers should consult applicable State law for any prohibitions or conditions before making such disclosures.

What options do family members of an adult patient with mental illness have if they are concerned about the patient's mental health and the patient refuses to agree to let a health care provider share information with the family?

The HIPAA Privacy Rule permits a health care provider to disclose information to the family members of an adult patient who has capacity and indicates that he or she does not want the disclosure made, only to the extent that the provider perceives a serious and imminent threat to the health or safety of the patient or others and the family members are in a position to lessen the threat. Otherwise, under HIPAA, the provider must respect the wishes of the adult patient who objects to the disclosure. However, HIPAA in no way prevents health care providers from listening to family members or other caregivers who may have concerns about the health and well-being of the patient, so the health care provider can factor that information into the patient's care.

In the event that the patient later requests access to the health record, any information disclosed to the provider by another person who is not a health care provider that was given under a promise of confidentiality (such as that shared by a concerned family member), may be withheld from the patient if the disclosure would be reasonably likely to reveal the source of the information. 45 CFR 164.524(a)(2)(v). This exception to the

patient's right of access to protected health information gives family members the ability to disclose relevant safety information with health care providers without fear of disrupting the family's relationship with the patient.

Does HIPAA permit a doctor to contact a patient's family or law enforcement if the doctor believes that the patient might hurt herself or someone else?

Yes. The Privacy Rule permits a health care provider to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons, when the provider believes the patient presents a serious and imminent threat to self or others. The scope of this permission is described in a letter to the nation's health care providers - PDF

Specifically, when a health care provider believes in good faith that such a warning is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the Privacy Rule allows the provider, consistent with applicable law and standards of ethical conduct, to alert those persons whom the provider believes are reasonably able to prevent or lessen the threat. These provisions may be found in the Privacy Rule at 45 CFR § 164.512(j).

Under these provisions, a health care provider may disclose patient information, including information from mental health records, if necessary, to law enforcement, family members of the patient, or any other persons who may reasonably be able to prevent or lessen the risk of harm. For example, if a mental health professional has a patient who has made a credible threat to inflict serious and imminent bodily harm on one or more persons, HIPAA permits the mental health professional to alert the police, a parent or other family member, school administrators or campus police, and others who may be able to intervene to avert harm from the threat.

In addition to professional ethical standards, most States have laws and/or court decisions which address, and in many instances require, disclosure of patient information to prevent or lessen the risk of harm. Providers should consult the laws applicable to their profession in the States where they practice, as well as 42 USC 290dd-2 and 42 CFR Part 2 under Federal law (governing the disclosure of alcohol and drug abuse treatment records) to understand their duties and authority in situations where they have information indicating a threat to public safety. Note that, where a provider is not subject to such State laws or other ethical standards, the HIPAA permission still would allow disclosures for these purposes to the extent the other conditions of the permission are met.

If a law enforcement officer brings a patient to a hospital or other mental health facility to be placed on a temporary psychiatric hold, and requests to be notified if or when the patient is released, can the facility make that notification?

The Privacy Rule permits a HIPAA covered entity, such as a hospital, to disclose certain protected health information, including the date and time of admission and discharge, in response to a law enforcement official's request, for the purpose of locating or identifying a suspect, fugitive, material witness, or missing person. See 45 CFR § 164.512(f)(2). Under this provision, a covered entity may disclose the following information about an individual: name and address; date and place of birth; social security number; blood type and rh factor; type of injury; date and time of treatment (includes date and time of admission and discharge) or death; and a description of distinguishing physical characteristics (such as height and weight). However, a covered entity may not disclose any protected health information under this provision related to DNA or DNA analysis, dental records, or typing, samples, or analysis of body fluids or tissue. The law enforcement official's request may be made orally or in writing.

Other Privacy Rule provisions also may be relevant depending on the circumstances, such as where a law enforcement official is seeking information about a person who may not rise to the level of a suspect, fugitive, material witness, or missing person, or needs protected health information not permitted under the above provision. For example, the Privacy Rule's law enforcement provisions also permit a covered entity to respond to an administrative request from a law enforcement official, such as an investigative demand for a patient's protected health information, provided the administrative request includes or is accompanied by a written statement specifying that the information requested is relevant, specific and limited in scope, and that de-identified information would not suffice in that situation. The Rule also permits covered entities to respond to court orders and court-ordered warrants, and subpoenas and summonses issued by judicial officers. See 45 CFR § 164.512(f)(1). Further, to the extent that State law may require providers to make certain disclosures,

the Privacy Rule would permit such disclosures of protected health information as "required-by-law" disclosures. See 45 CFR § 164.512(a).

Finally, the Privacy Rule permits a covered health care provider, such as a hospital, to disclose a patient's protected health information, consistent with applicable legal and ethical standards, to avert a serious and imminent threat to the health or safety of the patient or others. Such disclosures may be to law enforcement authorities or any other persons, such as family members, who are able to prevent or lessen the threat. See 45 CFR § 164.512(j).

If a doctor believes that a patient might hurt himself or herself or someone else, is it the duty of the provider to notify the family or law enforcement authorities?

A health care provider's "duty to warn" generally is derived from and defined by standards of ethical conduct and State laws and court decisions such as Tarasoff v. Regents of the University of California. HIPAA permits a covered health care provider to notify a patient's family members of a serious and imminent threat to the health or safety of the patient or others if those family members are in a position to lessen or avert the threat. Thus, to the extent that a provider determines that there is a serious and imminent threat of a patient physically harming self or others, HIPAA would permit the provider to warn the appropriate person(s) of the threat, consistent with his or her professional ethical obligations and State law requirements. See 45 CFR 164.512(j). In addition, even where danger is not imminent, HIPAA permits a covered provider to communicate with a patient's family members, or others involved in the patient's care, to be on watch or ensure compliance with medication regimens, as long as the patient has been provided an opportunity to agree or object to the disclosure and no objection has been made. See 45 CFR 164.510(b)(2).

Does HIPAA prevent a school administrator, or a school doctor or nurse, from sharing concerns about a student's mental health with the student's parents or law enforcement authorities?

Student health information held by a school generally is subject to the Family Educational Rights and Privacy Act (FERPA), not HIPAA. HHS and the Department of Education have developed guidance clarifying the application of HIPAA and FERPA - PDF

In the limited circumstances where the HIPAA Privacy Rule, and not FERPA, may apply to health information in the school setting, the Rule allows disclosures to parents of a minor patient or to law enforcement in various situations. For example, parents generally are presumed to be the personal representatives of their unemancipated minor child for HIPAA privacy purposes, such that covered entities may disclose the minor's protected health information to a parent. See 45 CFR § 164.502 (g)(3). In addition, disclosures to prevent or lessen serious and imminent threats to the health or safety of the patient or others are permitted for notification to those who are able to lessen the threat, including law enforcement, parents or others, as relevant. See 45 CFR § 164.512(j).

Additional FAQs on Sharing Information Related to Treatment for Mental Health or Substance Use Disorder—Including Opioid Abuse

ADULT PATIENTS

Does having a health care power of attorney (POA) allow access to the patient's medical and mental health records under HIPAA?

Generally, yes. If a health care power of attorney is currently in effect, the named person would be the patient's personal representative (The period of effectiveness may depend on the type of power of attorney: Some health care power of attorney documents are effective immediately, while others are only triggered if and when the patient lacks the capacity to make health care decisions and then cease to be effective if and when the patient regains such capacity).

"Personal representatives," as defined by HIPAA, are those persons who have authority, under applicable law, to make health care decisions for a patient. HIPAA provides a personal representative of a patient with the same rights to access health information as the patient, including the right to request a complete medical record containing mental health information. The patient's right of access has some exceptions, which would also apply to a personal representative. For example, with respect to mental health information, a psychotherapist's separate notes of counseling sessions, kept separately from the patient chart, are not included in the HIPAA right of access.

Additionally, a provider may decide not to treat someone as the patient's personal representative if the provider believes that the patient has been or may be subject to violence, abuse, or neglect by the designated person or the patient may be endangered by treating such person as the personal representative, and the provider determines, in the exercise of professional judgment, that it is not in the best interests of the patient to treat the person as the personal representative. See 45 CFR 164.502(g)(5).

Does HIPAA permit health care providers to share protected health information (PHI) about an individual who has mental illness with other health care providers who are treating the same individual for care coordination/continuity of care purposes?

HIPAA permits health care providers to disclose to other health providers any protected health information (PHI) contained in the medical record about an individual for treatment, case management, and coordination of care and, with few exceptions, treats mental health information the same as other health information. Some examples of the types of mental health information that may be found in the medical record and are subject to the same HIPAA standards as other protected health information include:

- medication prescription and monitoring
- counseling session start and stop times
- the modalities and frequencies of treatment furnished
- results of clinical tests
- summaries of: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

HIPAA generally does not limit disclosures of PHI between health care providers for treatment, case management, and care coordination, except that covered entities must obtain individuals' authorization to disclose separately maintained psychotherapy session notes for such purposes. Covered entities should determine whether other rules, such as state law or professional practice standards place additional limitations on disclosures of PHI related to mental health.

For more information see:

Does HIPAA provide extra protections for mental health information compared with other health information?

Does HIPAA permit health care providers to share protected health information (PHI) about an individual with mental illness with a third party that is not a health care provider for case management or continuity of care purposes? For example, can a health care provider refer a homeless patient to a social services agency, such as a housing provider, when doing so may reveal that the basis for eligibility is related to mental health?

HIPAA, with few exceptions, treats all health information, including mental health information, the same. HIPAA allows health care providers to disclose protected health information (PHI), including mental health information, to other public or private-sector entities providing social services (such as housing, income support, job training) in specified circumstances. For example:

- A health care provider may disclose a patient's PHI for treatment purposes without having to obtain the authorization of the individual. Treatment includes the coordination or management of health care by a health care provider with a third party. Health care means care, services, or supplies related to the health of an individual. Thus, health care providers who believe that disclosures to certain social service entities are a necessary component of, or may help further, the individual's health or mental health care may disclose the minimum necessary PHI to such entities without the individual's authorization. For example, a provider may disclose PHI about a patient needing mental health care supportive housing to a service agency that arranges such services for individuals.
- A covered entity may also disclose PHI to such entities pursuant to an authorization signed by the individual. HIPAA permits authorizations that refer to a class of persons who may receive or use the PHI. Thus, providers could in one authorization identify a broad range of social services entities that may receive the PHI if the individual agrees. For example, an authorization could indicate that PHI will be disclosed to "social services providers" for purposes of "supportive housing, public benefits, counseling, and job readiness."

EMERGENCIES, EMERGENCY HOSPITALIZATION OR DANGEROUS SITUATIONS

When does HIPAA allow a doctor to notify an individual's family, friends, or caregivers that a patient has overdosed, e.g., because of opioid abuse?

As explained more thoroughly below, when a patient has overdosed, a health care professional, such as a doctor, generally may notify the patient's family, friends, or caregivers involved in the patient's health care or payment for care if:

> (1) the patient has the capacity to make health care decisions at the time of the disclosure, is given the opportunity to object, and does not object;
>
> (2) the family, friends, or caregivers have been involved in the patient's health care or payment for care and there has been no objection from the patient;
>
> (3) the patient had the capacity to make health care decisions at the time the information is shared and the doctor can reasonably infer, based on the exercise of professional judgment, that the patient would not object;
>
> (4) the patient is incapacitated and the health care professional determines, based on the exercise of professional judgment, that notification and disclosure of PHI is in the patient's best interests;
>
> (5) the patient is unavailable due to some emergency and the health care professional determines, based on the exercise of professional judgment, that notification and disclosure of PHI is in the patient's best interests; or
>
> (6) the notification is necessary to prevent a serious and imminent threat to the health or safety of the patient or others.

If the patient who has overdosed is incapacitated and unable to agree or object, a doctor may notify a family member, personal representative, or another person responsible for the individual's care of the patient's location, general condition, or death. See 45 CFR 164.510(b)(1)(ii). Similarly, HIPAA allows a doctor to share additional information with a patient's family member, friend, or caregiver as long as the information shared is directly related to the person's involvement in the patient's health care or payment for care. 45 CFR 164.510(b)(1)(i). Decision-making incapacity may be temporary or long-term. If a patient who has overdosed regains decision-making capacity, health providers must offer the patient the opportunity to agree or object to sharing their health information with involved family, friends, or caregivers before making any further disclosures. If a patient becomes unavailable due to some emergency, a health care professional may

determine, based on the exercise of professional judgment, that notification and disclosure of PHI to someone previously involved in their care is in the patient's best interests. For example, if a patient who is addicted to opioids misses important medical appointments without any explanation, a primary health care provider at a general practice may believe that there is an emergency related to the opioid addiction and under the circumstances, may use professional judgment to determine that it is in the patient's best interests to reach out to emergency contacts, such as parents or family, and inform them of the situation. See 45 CFR 164.510(b)(3).

If the patient is deceased, a doctor may disclose information related to the family member's, friend's, or caregiver's involvement with the patient's care, unless doing so is inconsistent with any prior expressed preference of the patient that is known to the doctor. If the person who will receive notification is the patient's personal representative, that person has a right to request and obtain any information about the patient that the patient could obtain, including a complete medical record, under the HIPAA right of access. See 45 CFR 164.524.

When a patient poses a serious and imminent threat to his own or someone else's health or safety, HIPAA permits a health care professional to share the necessary information about the patient with anyone who is in a position to prevent or lessen the threatened harm--including family, friends, and caregivers--without the patient's permission. See 45 CFR 164.512(j). HIPAA expressly defers to the professional judgment of health care professionals when they make determinations about the nature and severity of the threat to health or safety. See 45 CFR 164.512(j)(4). Specifically, HIPAA presumes the health care professional is acting in good faith in making this determination, if the professional relies on his or her actual knowledge or on credible information from another person who has knowledge or authority. For example, a doctor whose patient has overdosed on opioids is presumed to have complied with HIPAA if, based on talking with or observing the patient, the doctor determines that the patient poses a serious and imminent threat to his or her own health. Even when HIPAA permits this disclosure, however, the disclosure must be consistent with applicable state law and standards of ethical conduct. HIPAA does not preempt any state law or professional ethics standards that would prevent a health care professional from sharing protected health information in the circumstances described here. For example, the doctor in this situation still may be subject to a state law that prohibits sharing information related to mental health or a substance use disorder without the patient's consent in all circumstances, even if HIPAA would permit the disclosure.

For more information see OCR's guidance, *How HIPAA Allows Doctors to Respond to the Opioid Crisis*, https://www.hhs.gov/sites/default/files/hipaa-opioid-crisis.pdf

When does HIPAA allow a hospital to notify an individual's family, friends, or caregivers that a patient who has been hospitalized for a psychiatric hold has been admitted or discharged?

Hospitals may notify family, friends, or caregivers of a patient in several circumstances:

- **When the patient has a personal representative**

A hospital may notify a patient's personal representative about their admission or discharge and share other PHI with the personal representative without limitation. However, a hospital is permitted to refuse to treat a person as a personal representative if there are safety concerns associated with providing the information to the person, or if a health care professional determines that disclosure is not in the patient's best interest.

- **When the patient agrees or does not object to family involvement**

A hospital may notify a patient's family, friends, or caregivers if the patient agrees, or doesn't object, or if a health care professional is able to infer from the surrounding circumstances, using professional judgment that the patient does not object. This includes when a patient's family, friends, or caregivers have been involved in the patient's health care in the past, and the individual did not object.

- **When the patient becomes unable to agree or object and there has already been family involvement**

When a patient is not present or cannot agree or object because of some incapacity or emergency, a health care provider may share relevant information about the patient with family, friends, or others involved in the patient's care or payment for care if the health care provider determines, based on professional judgment, that doing so is in the best interest of the patient.

For example, a psychiatric hospital may determine that it is in the best interests of an incapacitated patient to initially notify a member of their household, such as a parent, roommate, sibling, partner, or spouse, and inform them about the patient's location and general condition. This may include, for example, notifying a patient's spouse that the patient has been admitted to the hospital.

If the health care provider determines that it is in the patient's interest, the provider may share additional information that is directly related to the family member's or friend's involvement with the patient's care or payment for care, after they clarify the person's level of involvement. For example, a nurse treating a patient may determine that it is in the patient's best interest to discuss with the patient's adult child, who is the patient's primary caregiver, the medications found in a patient's backpack and ask about any other medications the patient may have at home.

Decision-making incapacity may be temporary or long-term. Upon a patient's regaining decision-making capacity, health providers should offer the patient the opportunity to agree or object to sharing their health information with involved family, friends, or caregivers.

- **When notification is needed to lessen a serious and imminent threat of harm to the health or safety of the patient or others**

A hospital may disclose the necessary protected health information to anyone who is in a position to prevent or lessen the threatened harm, including family, friends, and caregivers, without a patient's agreement. HIPAA expressly defers to the professional judgment of health professionals in making determinations about the nature and severity of the threat to health or safety. For example, a health care provider may determine that a patient experiencing a mental health crisis has ingested an unidentified substance and that the provider needs to contact the patient's roommate to help identify the substance and provide the proper treatment, or the patient may have made a credible threat to harm a family member, who needs to be notified so he or she can take steps to avoid harm. OCR would not second guess a health care professional's judgment in determining that a patient presents a serious and imminent threat to their own, or others', health or safety.

What constitutes a "serious and imminent" threat that would permit a health care provider to disclose PHI to prevent harm to the patient, another person, or the public without the patient's authorization or permission?

HIPAA expressly defers to the professional judgment of health professionals in making determinations about the nature and severity of the threat to health or safety posed by a patient. OCR would not second guess a health professional's good faith belief that a patient poses a serious and imminent threat to the health or safety of the patient or others and that the situation requires the disclosure of patient information to prevent or lessen the threat. Health care providers may disclose the necessary protected health information to anyone who is in a position to prevent or lessen the threatened harm, including family, friends, caregivers, and law enforcement, without a patient's permission.

See Guidance on Sharing Information Related to Mental Health, https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html

If an adult patient who may pose a danger to self stops coming to psychotherapy sessions and does not respond to attempts to make contact, does HIPAA permit the therapist to contact a family member to check on the patient's well-being even if the patient has told the therapist that they do not want information shared with that person?

Yes, under two possible circumstances:

1. Given that the patient is no longer present, if the therapist determines, based on professional judgment, that there may be an emergency situation and that contacting the family member of the absent patient is in the patient's best interests; or
2. If the disclosure is needed to lessen a serious and imminent threat and the family member is in a position to avert or lessen the threat.

In making the determination about the patient's best interests, the provider may take into account the patient's prior expressed preferences regarding disclosures of their information, if any, as well as the circumstances of the current situation. In either case, the health care provider may share or discuss only the information that the family member involved needs to know about the patient's care or payment for care or the minimum necessary for the purpose of preventing or lessening the threatened harm.

Additionally, if the family member is a personal representative of the patient, the therapist may contact that person. However, a provider may decide not to treat someone as a personal representative if the provider believes that the patient has been or may be subject to violence, abuse, or neglect by the personal representative, or the patient may be endangered by treating the person as the personal representative; and the provider determines, in the exercise of professional judgment, that it is not in the best interests of the patient to treat the person as the personal representative. See 45 CFR 164.502(g)(5).

See Guidance on Sharing Information Related to Mental Health, https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html

Guidance on Personal Representatives, https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/personal-representatives/index.html

Does HIPAA require a mental health provider to let a patient know that the provider is going to share information with others before disclosing PHI to prevent or lessen a serious and imminent threat?

Not at the time of disclosure; however, the Notice of Privacy Practices should contain an example of this type of disclosure so patients are informed in advance of that possibility. See 45 CFR 164.520(b). In situations that also involve reports to the appropriate government authority that the patient may be an adult victim of abuse, neglect, or domestic violence, the mental health provider must promptly inform the patient that a report has been or will be made, unless:

- informing the patient would create a danger to the patient; or
- the provider would be informing a personal representative, and the provider reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the patient is determined by the provider, in the exercise of professional judgment. See 45 CFR 164.512(c).

Other standards, such as clinical protocols, ethics rules, or state laws, may also be applicable to patient notification about disclosures in situations involving threats of imminent harm.

SUBSTANCE USE DISORDER TREATMENT

How does HIPAA interact with the federal confidentiality rules for information about substance use disorder treatment, including treatment for opioid abuse, in an emergency situation—which rules should be followed?

A health provider that provides treatment for substance use disorders, including opioid abuse, needs to determine whether it is subject to 42 CFR Part 2 (i.e., a "Part 2 program") and whether it is a covered entity under HIPAA. Generally, the Part 2 rules provide more stringent privacy protections than HIPAA, including in emergency situations. If an entity is subject to both Part 2 and HIPAA, it is responsible for complying with the more protective Part 2 rules, as well as with HIPAA. HIPAA is intended to be a set of minimum federal privacy standards, so it generally is possible to comply with HIPAA and other laws, such as 42 CFR Part 2, that are more protective of individuals' privacy.

For example, HIPAA permits disclosure of protected health information (PHI) for treatment purposes (including in emergencies) without patient authorization, and allows PHI to be used or disclosed to lessen a threat of serious and imminent harm to the health or safety of the patient or others (which may occur as part of a health emergency) without patient authorization or permission. Because HIPAA permits, but does not require, disclosures for treatment or to prevent harm, if Part 2 restricts certain disclosures during an emergency, an entity subject to both sets of requirements could comply with Part 2's restrictions without violating HIPAA.

For more information about applying 42 CFR Part 2 in an emergency, see https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs