Communication With Other Health Professionals

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

I was reminded of this principle of law by a consultation I had with a practitioner who was being manipulated by a patient. The patient was being treated for an eating disorder and was telling the therapist that she would not sign an authorization for the therapist to speak with her physician, even though the therapist thought that such communication was appropriate and necessary. (I recall a number of cases where a patient with an eating disorder tried to limit the ability of the therapist to communicate with other health care providers or with family members, even in cases of possible imminent self-harm.) What the patient did not know is that the therapist was free to talk with or otherwise communicate with the doctor without the written and signed authorization of the patient. Unfortunately, the therapist was also not aware of this basic information. If the therapist would have been aware, this basic principle of law could have been disclosed in any required or voluntary disclosure form or information statement (sometimes referred to as “informed consent”) given to the patient at the outset of treatment.

Patients should understand at the outset of treatment that they cannot tie the hands of their therapists or counselors by limiting their communications with other health care providers for purposes of diagnosis or treatment, thereby exposing them to potential liability for the provision of inadequate or incompetent care. Simply put, therapists generally do not, and should not, treat patients in such a vacuum. Communication with other health care providers or facilities, whether former or current, is often necessary or desirable for the provision of competent and reasonable care. As indicated above, HIPAA recognizes this reality, as do most state laws, at least to a significant degree. If patients are not comfortable with this, they can search for a practitioner who may be willing to let the patient set the rules, rather than abiding by the public policy determinations made by the state legislature or by federal regulators. The practitioner is not necessarily in a direct power struggle with the patient, but rather, the public policy regarding these kinds of permitted disclosures has already been long decided. Usually, disclosures to other health care professionals for purposes of diagnosis or treatment of the patient are not mandated by law, but are permitted. If

a practitioner wants to agree to restrictions on or exceptions to this basic principle (requested by a patient), he or she may agree, but there is some degree of risk in doing so.

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

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

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