CONFIDENTIALITY AND PRIVILEGE

Jeffrey L. Metzner M.D.

1. What is confidentiality?

Confidentiality refers to the ethical duty of the physician not to disclose information learned from the patient to any other person or organization without the consent of the patient or under proper legal compulsion. The Hippocratic Oath describes the duty of confidentiality as follows:

Whatsoever I shall see or hear in the course of my profession as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.

This duty is described by the American Medical Association in Section 4 of the Principles of Medical Ethics.[]

A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of law.

The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry elaborates in Section 4, Annotation 1, that:

Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern between the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard.[3]

2. Does the psychiatrist have a legal duty of confidentiality?

The existence of a legal obligation to protect the confidentiality of communications arising from the physician-patient relationship has evolved primarily through court decisions, although statutory regulations also may be pertinent. Successful lawsuits against physicians for breach of confidentiality have been based on the following legal theories:

• Implied contract to keep information confidential
• Invasion of privacy
• Tortious breach of duty of confidentiality
• Statutory regulations.

Courts have awarded damages for breach of confidentiality based on the contractual relationship between the physician and patient, which was determined to include an implied agreement that the physician would keep confidential any information received from the patient. Recovery also has been based on invasion of privacy, which has been defined as an unjustified disclosure of a person’s private affairs with which the public has no legitimate concern in such a fashion as to cause humiliation and/or emotional suffering to ordinary persons. The nature of the physician-patient relationship has been determined to create for the physician a fiduciary duty (i.e., to act primarily for the benefit of another) to keep information obtained through such a relationship confidential. Therefore, a tort action can be used to recover damages. A tort is a civil wrong, other than breach of contract, for which the court will provide a remedy in the form of an action for damages. Finally, courts occasionally have allowed recovery based on licensing statutes that focus on issues of privileged communications.

3. When are physician’s disclosures legally justified?

A valid consent for a release of information protects the psychiatrist ethically and legally. State law and/or relevant rules and regulations often specify the requirements for such a release. A valid consent minimally means that the patient was competent to provide such authorization and did so knowingly and voluntarily. It is recommended that written consent be obtained, specifying the purpose and scope of information to be released. Written consent often provides more clarity to the patient regarding the nature of the disclosure and provides documentation—a useful risk-management measure—for the physician.

Many evaluations for medical/legal (i.e., forensic) purposes, performed at the request of third parties to address issues such as impairment ratings for worker’s compensation, disability insurance payments, and appropriateness of treatment, are not confidential. The Ethical Guidelines for the Practice of Forensic Psychiatry, developed by the American Academy of Psychiatry and the Law, state that

[1]the psychiatrist maintains confidentiality to the extent possible given the legal context. Special attention is paid to any limitations on the usual precepts of medical confidentiality. An evaluation for forensic purposes begins with notice to the evaluatee of any limitations on confidentiality. Information or reports derived from the forensic evaluation are subject to the rules of confidentiality as apply to the evaluation and any disclosure is restricted accordingly.

Reports and/or information obtained from such examinations can be disclosed to the third party that requested the examination without risk of a successful lawsuit by the evaluatee concerning breach of confidentiality. Consent is implied when the person proceeds with the evaluation after having been provided appropriate information concerning the nature of the evaluation and lack of or limits of confidentiality.

Disclosures without consent from the patient have been found to be permissible by courts when an overriding public
suspected child abuse

diseases

governmental agencies certain conditions such as
State statutes often require physicians to report to various
consent from the patient in states without such a duty.
warning to a third party is provided without obtaining valid
physician could be liable for breach of confidentiality if a
such a duty, and it is important for the clinician to be familiar
jurisdictions differ concerning recognition and discharge of
such a circumstance, be legally discharged by warning of
the patient’s intended victim (whether or not the patient
consents to releasing such information). However, jurisdictions differ concerning recognition and discharge of
such a duty, and it is important for the clinician to be familiar
with the law in his/her state concerning this issue. A
physician could be liable for breach of confidentiality if a
warning to a third party is provided without obtaining valid
consent from the patient in states without such a duty.

State statutes often require physicians to report to various
governmental agencies certain conditions such as infectious
diseases (e.g., sexually transmitted diseases, tuberculosis), suspected child abuse, and gunshot wounds. States have
taken very different approaches regarding confidentiality and
reporting issues relevant to HIV/AIDS infection. Physicians
need to be familiar with pertinent statutes in their own states
concerning both the conditions that are to be reported and the
threshold criteria for making such reports.

4. Are there any reporting requirements concerning
patients who may have a medical or psychiatric condition
that could cause impairments in their driving ability?

Most states clearly indicate in their statutes, and in the
information they provide to motorists licensed in their state,
that the driver is primarily responsible for his or her own
safety and the safety of others. Ten states have clearly written
guidelines under which drivers must inform their state of
their medical conditions. However, few states have written
criteria for determining driver safety, and physician reporting
of unsafe drivers generally is not required by state law. There
generally has not been a great impetus to interfere with the
physician-patient relationship, although physicians are
encouraged to report individuals who they feel would be
unsafe behind the wheel to the Department of Motor
Vehicles. Physicians generally are granted some form of
immunity from liability when making such reports in good
faith.

Physicians in Pennsylvania appear to have the strictest
reporting requirements. Judicial decisions have held
physicians liable for injuries in motor vehicle accidents
involving their patients who drive. Several significant duty to
warn and/or to protect third party cases involving
psychiatrists arose from driving cases. Physicians should be
familiar with pertinent statutes and case law within their
jurisdiction concerning these issues.

5. Are there statutes pertinent to confidentiality other
than the reporting statutes?

A number of states have enacted mental health
confidentiality statutes that establish a rule of

interest (e.g., public safety) was at issue. However, a careful
risk-benefit analysis needs to be made prior to such
disclosures. Consultation with a colleague and/or attorney
should be part of the risk-benefit analysis process.

Information released under such circumstances should be
relevant to the potential public harm and provided only to
those in need of the information.

Many state court decisions and/or statutes have adopted a
psychotherapist’s duty to protect principle, as described in the
Tarasoff II (Tarasoff v. Regents of the University of
California, 551 P.2d 334 [1976]) decision. This duty may, in
certain circumstances, be legally discharged by warning of
the patient’s intended victim (whether or not the patient
consents to releasing such information). However, jurisdictions differ concerning recognition and discharge of
such a duty, and it is important for the clinician to be familiar
with the law in his/her state concerning this issue. A
physician could be liable for breach of confidentiality if a
warning to a third party is provided without obtaining valid
consent from the patient in states without such a duty.

State statutes often require physicians to report to various
governmental agencies certain conditions such as infectious
diseases (e.g., sexually transmitted diseases, tuberculosis), suspected child abuse, and gunshot wounds. States have
taken very different approaches regarding confidentiality and
reporting issues relevant to HIV/AIDS infection. Physicians
need to be familiar with pertinent statutes in their own states
concerning both the conditions that are to be reported and the
threshold criteria for making such reports.

4. Are there any reporting requirements concerning
patients who may have a medical or psychiatric condition
that could cause impairments in their driving ability?

Most states clearly indicate in their statutes, and in the
information they provide to motorists licensed in their state,
that the driver is primarily responsible for his or her own
safety and the safety of others. Ten states have clearly written
guidelines under which drivers must inform their state of
their medical conditions. However, few states have written
criteria for determining driver safety, and physician reporting
of unsafe drivers generally is not required by state law. There
generally has not been a great impetus to interfere with the
physician-patient relationship, although physicians are
encouraged to report individuals who they feel would be
unsafe behind the wheel to the Department of Motor
Vehicles. Physicians generally are granted some form of
immunity from liability when making such reports in good
faith.

Physicians in Pennsylvania appear to have the strictest
reporting requirements. Judicial decisions have held
physicians liable for injuries in motor vehicle accidents
involving their patients who drive. Several significant duty to
warn and/or to protect third party cases involving
psychiatrists arose from driving cases. Physicians should be
familiar with pertinent statutes and case law within their
jurisdiction concerning these issues.

5. Are there statutes pertinent to confidentiality other
than the reporting statutes?

A number of states have enacted mental health
confidentiality statutes that establish a rule of

confidentiality and describe exceptions. For example, the
Colorado statute which establishes procedures for
involuntary commitment provides that “all information
obtained and records prepared in the course of providing any
services [for the care and treatment of the mentally ill] …
shall be confidential and privileged matter” (C.R.S. 27–10–
120). This law specifies a variety of exceptions such as peer
review, communications between qualified professional
personnel in the provision of services or appropriate referrals,
releasing information to the courts as necessary to the
administration of the provisions of this article, certain
circumstances for releasing confidential information to
family member(s) of an adult with mental illness, and
appropriate research (C.R.S. 27–10–101, 102, 116, 120,
120.5 as amended).

Legislation often requires that rules and regulations be
promulgated by the state’s Division of Mental Health or
equivalent agency concerning confidentiality. Physicians
should be familiar with these rules and regulations within
their own jurisdiction, because they vary significantly among
states. There also are Federal rules and regulations regarding
confidentiality applicable to substance abuse treatment
programs that receive federal funds (42 C.F.R. Part 2).
Records and information from such programs can be released
only under conditions as specified in the regulations. These
regulations provide detailed information concerning the
nature of the written release required. Access to information
concerning patients and records in the Veterans
Administration Hospitals is determined by a variety of
Federal laws and regulations, such as the Freedom of
Information Act and Privacy Act.

6. How do the ethical guidelines address issues relevant to
confidentiality?

The American Psychiatric Association (APA) has
emphasized that:

[The] continuing duty of the psychiatrist to protect the patient
includes fully apprizing him/her of the connotations of
waiving the privilege of privacy … Ethically the psychiatrist
may disclose only that information which is relevant to a
given situation. He/she should avoid offering speculation as
fact …

It is good practice, both clinically and from a risk-
management perspective, to provide the patient with a copy
of the information (e.g., report, completed insurance form) to
be disclosed prior to releasing the information. Generating
the report in the presence of the patient and/or with direct
input from the patient often can be therapeutic and contribute
to good treatment planning. The most frequent request for
information comes from insurance companies related to
diagnosis, treatment progress, and planning, or issues
relevant to disability and/or insurability.

Confidentiality may be breached ethically in the interest of
protecting the patient:

Psychiatrists at times may find it necessary, in order to
protect the patient or the community from imminent danger,
to reveal confidential information disclosed by the patient.

Thus, it often is clinically and ethically appropriate for the
physician to inform a patient’s relative or roommate about a
considerations relevant to confidentiality and the treatment of
and chapters by Macbeth, Benedek, and Weintrob provide
of confidentiality in the treatment of minors. The American
State statutes often provide some guidance regarding issues
population.
increased right to privacy enjoyed by the older adolescent
was sparse concerning issues specific to confidentiality with
minors?
counseling, should be maintained. Such information may be
information disclosed during an exam, interview, or in
should permit a competent minor to consent to medical care
that “when the law does not require otherwise, physicians
confidentiality that the sharing of care-taking responsibility
and those of parents or guardians. He/she should also be
confidentiality in regard both to his/her own communication
minors due to both developmental differences and an
increased right to privacy enjoyed by the older adolescent
population.
State statutes often provide some guidance regarding issues
of confidentiality in the treatment of minors. The American
Academy of Child and Adolescent Psychiatry Code of Ethics
and chapters by Macbeth, Benedek, and Weintrob provide
detailed discussions concerning legal, clinical, and ethical
considerations relevant to confidentiality and the treatment of
minors. For example, the AACAP’s Code of Ethics indicates
that “it is necessary that the child or adolescent, within
his/her capacity for understanding, be clearly apprized of
confidentiality in regard both to his/her own communication
and those of parents or guardians. He/she should also be
informed of the limits to the general principle of
confidentiality that the sharing of care-taking responsibility
requires.”
The AMA’s Council on Ethical and Judicial Affairs indicated
that “when the law does not require otherwise, physicians
should permit a competent minor to consent to medical care
and should not notify parents without the patient’s consent ...
for minors who are mature enough to be unaccompanied by
their parents for their examination, confidentiality of
information disclosed during an exam, interview, or in
counseling, should be maintained. Such information may be
disclosed to parents when the patient consents to disclosure ...
... confidentiality may be justifiably breached in situations
for which confidentiality for adults may be breached … or
when such a breach is necessary to overt serious harm to the
minor… .”

7. How does confidentiality apply to the treatment of
minors?

Until the 1990s, the general and forensic psychiatric literature
was sparse concerning issues specific to confidentiality with
children and adolescents. From a legal perspective, the
psychiatrist generally can assume that a parent has a legal
right to full information about the treatment of a minor if the
parent is legally entitled to authorize treatment for a minor
child. However, full implementation of such a legal principle
often causes significant clinical problems. Such problems can
be minimized by establishing ground rules of
confidentiality and exceptions with patients and parents
prior to beginning the treatment process. The ground rules
generally are different for adolescents as compared to young
minors due to both developmental differences and an
increased right to privacy enjoyed by the older adolescent
population.

State statutes often provide some guidance regarding issues
of confidentiality in the treatment of minors. The American
Academy of Child and Adolescent Psychiatry Code of Ethics
and chapters by Macbeth, Benedek, and Weintrob provide
detailed discussions concerning legal, clinical, and ethical
considerations relevant to confidentiality and the treatment of
minors. For example, the AACAP’s Code of Ethics indicates
that “it is necessary that the child or adolescent, within
his/her capacity for understanding, be clearly apprized of
confidentiality in regard both to his/her own communication
and those of parents or guardians. He/she should also be
informed of the limits to the general principle of
confidentiality that the sharing of care-taking responsibility
requires.”
The AMA’s Council on Ethical and Judicial Affairs indicated
that “when the law does not require otherwise, physicians
should permit a competent minor to consent to medical care
and should not notify parents without the patient’s consent ...
for minors who are mature enough to be unaccompanied by
their parents for their examination, confidentiality of
information disclosed during an exam, interview, or in
counseling, should be maintained. Such information may be
disclosed to parents when the patient consents to disclosure ...
... confidentiality may be justifiably breached in situations
for which confidentiality for adults may be breached … or
when such a breach is necessary to overt serious harm to the
minor… .”

8. What is the physician-patient privilege?

Most state legislatures have created a testimonial privilege
that prohibits a physician from disclosing in a judicial or
quasi-judicial proceeding, with certain exceptions, any
confidential information learned during the course of
treatment with a patient. Thus, testimonial privilege is an
evidentiary rule, applicable to judicial settings and limited in
scope, that is created by statute. The privilege belongs to the
patient—not to the physician. A breach of privileged
communication can result in a lawsuit against the physician.
Physician-patient privilege statutes have enacted due to the
recognition that confidentiality is needed to maintain the
therapeutic relationship, which also may have benefits for the
community (e.g., people receive necessary treatment for
illness). The recognition of the importance of a patient’s
privacy interests also has been a justification for such
statutes.

In 1996, the U.S. Supreme Court in its Jaffee v. Redmond,
116 S.Ct. 1923 (1996), decision held that federal law
recognizes privilege protecting confidential communications
between a psychotherapist and his/her patient.

9. What exceptions to privilege exist?

Exceptions to the privilege generally include:

- When a valid waiver of privilege is executed by a
  competent adult patient or his/her legal guardian
- The patient-litigant exception, in which the
  patient has initiated litigation when his/her mental
  or emotional condition is an element of a claim or
  defense in a legal proceeding
- Most court-ordered examinations involving a
  wide range of legal issues
- Malpractice proceedings initiated by the patient
  against the physician
- Involuntary civil commitment proceedings
- Will contest
- Certain criminal proceedings
- Reports required by various mandatory reporting
  statutes.

The above list is not inclusive, and the type of exceptions
differs from state to state. For example, some state statutes
allow for the waiver of a physician-patient privilege, at the
discretion of the judge, in child custody disputes. Familiarize
yourself with the appropriate law in your state.

Disclosures made to the physician for purposes other than
obtaining treatment are not covered by the privilege. States
vary regarding the presence of privilege if disclosure occurs
when third parties (e.g., family members) are present during
the course of the communication. Jurisdictions also differ
whether communications arising in the course of couple’s
and/or group psychotherapy are privileged. Nonphysician
providers supervised by physicians generally are not covered
by the patient-physician privilege statute, although they may
be covered by a statute specific to their profession.

10. How should the psychiatrist respond to a subpoena?

A subpoena duces tecum is a subpoena issued by a court, at
the request of one of the parties to a lawsuit, to require a
physician to bring (i.e., produce) pertinent medical records. A
subpoena ad testificandum requires the attendance of the
physician for testimony purposes. Neither subpoena compels
the physician; ethical and legal principles may properly

Exception to the privilege generally include:

- When a valid waiver of privilege is executed by a
  competent adult patient or his/her legal guardian
- The patient-litigant exception, in which the
  patient has initiated litigation when his/her mental
  or emotional condition is an element of a claim or
  defense in a legal proceeding
- Most court-ordered examinations involving a
  wide range of legal issues
- Malpractice proceedings initiated by the patient
  against the physician
- Involuntary civil commitment proceedings
- Will contest
- Certain criminal proceedings
- Reports required by various mandatory reporting
  statutes.

The above list is not inclusive, and the type of exceptions
differs from state to state. For example, some state statutes
allow for the waiver of a physician-patient privilege, at the
discretion of the judge, in child custody disputes. Familiarize
yourself with the appropriate law in your state.

Disclosures made to the physician for purposes other than
obtaining treatment are not covered by the privilege. States
vary regarding the presence of privilege if disclosure occurs
when third parties (e.g., family members) are present during
the course of the communication. Jurisdictions also differ
whether communications arising in the course of couple’s
and/or group psychotherapy are privileged. Nonphysician
providers supervised by physicians generally are not covered
by the patient-physician privilege statute, although they may
be covered by a statute specific to their profession.

10. How should the psychiatrist respond to a subpoena?

A subpoena duces tecum is a subpoena issued by a court, at
the request of one of the parties to a lawsuit, to require a
physician to bring (i.e., produce) pertinent medical records. A
subpoena ad testificandum requires the attendance of the
physician for testimony purposes. Neither subpoena compels
the physician; ethical and legal principles may properly

Exception to the privilege generally include:

- When a valid waiver of privilege is executed by a
  competent adult patient or his/her legal guardian
- The patient-litigant exception, in which the
  patient has initiated litigation when his/her mental
  or emotional condition is an element of a claim or
  defense in a legal proceeding
- Most court-ordered examinations involving a
  wide range of legal issues
- Malpractice proceedings initiated by the patient
  against the physician
- Involuntary civil commitment proceedings
- Will contest
- Certain criminal proceedings
- Reports required by various mandatory reporting
  statutes.

The above list is not inclusive, and the type of exceptions
differs from state to state. For example, some state statutes
allow for the waiver of a physician-patient privilege, at the
discretion of the judge, in child custody disputes. Familiarize
yourself with the appropriate law in your state.

Disclosures made to the physician for purposes other than
obtaining treatment are not covered by the privilege. States
vary regarding the presence of privilege if disclosure occurs
when third parties (e.g., family members) are present during
the course of the communication. Jurisdictions also differ
whether communications arising in the course of couple’s
and/or group psychotherapy are privileged. Nonphysician
providers supervised by physicians generally are not covered
by the patient-physician privilege statute, although they may
be covered by a statute specific to their profession.
prevent the psychiatrist from testifying and/or disclosing the subpoenaed medical records.

The psychiatrist may release medical records and/or testify when the subpoena is accompanied by a valid consent form signed by the patient. Reasonable attempts should be made to inform the patient or his/her attorney about the subpoena, to verify the validity of the consent and discuss relevant issues.

The psychiatrist should contact the patient or the patient’s attorney when a signed consent form is not attached to the subpoena, to determine whether the patient has consented, explicitly or implicitly, to waive the privilege. Remember that the privilege belongs to the patient, and not to the physician. However, the physician has an ethical and legal obligation to withhold information obtained during the course of treatment as privileged from disclosure in a legal context unless it is clear that an exception exists (e.g., signed consent obtained) or a court directs the physician to testify and/or release the record.

The psychiatrist should discuss with the attorney, when appropriate, issues concerning disclosure of very sensitive information that appears not to be pertinent to the issues being litigated. The patient’s attorney or the psychiatrist have the option of filing a motion to quash the subpoena or limit the nature of the information to be disclosed, based on protection under the physician-patient privilege and the duty to maintain confidentiality, when the patient has not consented to waive the privilege. A hearing will be held in which the judge will rule on the motion. The psychiatrist can ethically testify and/or release medical records when ordered to do so by the court, despite lack of consent from the patient. The psychiatrist should not rely on the statements or opinions of the attorney who has requested the subpoena concerning issues relevant to waiver of the privilege.

11. What are the principles of confidentiality following a patient’s death?

The U.S. Supreme Court decision in Swidler § Berlin v. United States, 118 S.Ct. 2081 (1998), which held that the attorney-client privilege survives the death of the client, provides support that the physician-patient privilege also generally is maintained following a patient’s death. The ethics committee of the APA has written that confidentiality ethically survives a patient’s death unless disclosures are required by statute or case law. Some state statutes allow the executor or administrator of the deceased patient’s estate or certain relatives to have access to the patient’s medical record. Additionally, the physician-patient privilege may be waived in certain states following the patient’s death. The psychiatrist should obtain guidance from legal counsel or the court concerning this issue when questions exist concerning the waiver of the privilege.

Similar issues arise which are not addressed by statute or case law. The psychiatrist may be questioned by the police during the course of an investigation involving the death of a patient, or may be asked specific questions by grieving family members. The psychiatrist should not disclose specific information obtained from the patient, although answering questions in terms of general psychiatric principles is appropriate. The psychiatrist’s liability for breach of confidentiality is minimized by obtaining authorization from the patient’s legal representative and close family members.

12. Is it a breach of confidentiality to use a collection agency or attorney in an attempt to collect unpaid bills?

There are no ethical principles that preclude psychiatrists from using the legal system or collection agencies for bill collection. The physician-patient privilege does not prevent a doctor from suing to collect proper fees. However, the legal and ethical obligations of the psychiatrist to protect the patient’s confidentiality continue despite the breach of the treatment contract by the patient caused by not paying the bill. Patients may sue for breach of confidentiality when the psychiatrist discloses their status as patients to an attorney or collection agency. In general, the only information that needs to be disclosed to the collection agency is the patient’s name, balance due, and dates of services. Confidentiality is best preserved by describing the dates of services as office visits in contrast to psychotherapy or medication management visits.

Due to issues of confidentiality and risk management, the psychiatrist should first use other methods of recovering fees. A matter-of-fact letter to the patient requesting either payment in full within a specified time frame or a proposal for a payment schedule is a useful alternative. If there is not a response to such letter within a reasonable period of time, another letter should be sent which requests a similar response within a specified time period and informs the patient that referral will be made to an attorney or collection agency for initiation of appropriate legal action if the patient does not respond.

Select a responsible collection agency or attorney—for professional reasons and to minimize the risk that the patient will retaliate by filing a counterclaim for malpractice, ethical complaint, or a complaint to the Board of Medical Examiners or equivalent agency. Learn about any pertinent laws within your state that specify procedures that must be followed before using a collection agency or attorney to recover unpaid bills.

13. What confidentiality issues are involved with new technology?

The availability of voicemail, cellular telephones, and fax machines can lead to unintentional breaches of confidentiality. Voicemail messages may be played back by persons other than the patient; cellular telephone conversations may be heard by other parties; and records sent via fax machines may be sent to the wrong number. Therefore, detailed voicemail messages should not be left for patients unless assurances have been given by them that other persons do not have access to their voicemail box. Patients should be told when a cellular telephone is being used and reminded that confidentiality is not guaranteed under such circumstances. Fax machines should not be used for routine transmission of confidential information, and procedures should be implemented to ensure safeguarding of confidential information that needs to be sent promptly.

The use of computerized medical records by healthcare providers and systems has increased rapidly. Medical data are being used for nontraditional purposes (i.e., other than clinical assessment or treatment) that are not governed by regulations, laws, or professional practices. The rapidly emerging infrastructure of healthcare information and its relation to patient privacy have been described in the literature. The advantage of these information systems for
the organization, delivery, and financing of health care is attractive to policymakers. Future electronic databases will contain a vast amount of personal information, including demographic, financial, medical, genomic, and social data. Unfortunately, there is significant potential for erosion of patient privacy in such systems.

The APA has developed resource documents for preserving patient confidentiality in the era of information technology and a guide to security relevant to computerized records. These documents provide direction to policymakers, as they establish ground rules for the management of patient records in electronic form in new healthcare systems. A complete medical record security program should include policies, standards, training, technical and procedural controls, risk assessment, auditing and monitoring, sanctions for violations, and assigned responsibility for management of the program. Extra levels of security should be developed for information generally regarded as sensitive by tradition, or by agreement between the physician and patient.

The genetic revolution has taken a markedly clinical turn as evidenced by the work of the Human Genome Project, which soon will map the entire genetic code embedded in human DNA. This project and other research in molecular genetics raise new ethical and legal issues for physicians, who will be able to accurately predict the risk of future onset of many genetic diseases as well as the likely current and future health status of relatives of the patient who share genetic material. Physicians will face a dilemma when a patient chooses not to disclose information that could be significant to genetic relatives. Berry summarizes issues that will need to be reviewed by legislative and judicial lawmakers to clarify under what circumstances may or must a physician disclose genetic information to interested third parties, and under what circumstances may or must the physician, instead, keep such information confidential.

14. I'm confused—can you give me some practical pointers regarding confidentiality and privilege?

The concepts of confidentiality and privilege often are confusing due to overlapping principles and the many exceptions, which have been briefly summarized. Confidentiality is an important element in developing a therapeutic alliance with patients. A breach of confidentiality can result in legal liability, ethical complaints, adverse actions pertinent to a physician’s license to practice medicine, and criminal prosecution in certain circumstances.

<table>
<thead>
<tr>
<th>Practical Pointers Concerning Confidentiality and Privilege</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Follow the general principle to honor a patient’s confidences unless a legally cognizable exception applies.</td>
</tr>
<tr>
<td>2. Have your own written “Authorization for Release of Medical/Mental Health Information” form that can be tailored to specific circumstances. If requested to release AIDS/HIV information, check with legal counsel or your state’s Department of Health to ensure that the authorization you obtain is specific enough to meet legal requirements.</td>
</tr>
<tr>
<td>3. When in doubt about the validity of consent to release information, call your patient to discuss information and to verify consent.</td>
</tr>
<tr>
<td>4. When performing an evaluation (e.g., worker’s compensation), clarify limits of confidentiality at the outset. Explain who will/will not receive a copy of the report.</td>
</tr>
<tr>
<td>5. Obtain competent advice before releasing information to anyone after a patient’s death.</td>
</tr>
<tr>
<td>6. Apprise group therapy members about parameters of confidentiality.</td>
</tr>
<tr>
<td>7. When subpoenaed to testify/release records, seek advice from legal counsel. Generally, you will wish to ensure that the patient executes written, informed consent or that a court order is obtained.</td>
</tr>
<tr>
<td>8. Do not automatically assume that a managed care company has obtained patient consent to have information released to them. Try to discuss such authorization with the patient at the outset of treatment. Obtain written consent.</td>
</tr>
<tr>
<td>9. If using a collection agency or small claims court to collect an unpaid bill, make sure that you send the patient appropriate advance notice in writing and reveal the least amount of information necessary (Caveat: collections often lead to malpractice counterclaims.)</td>
</tr>
</tbody>
</table>