14.2 Health Records and HIPAA[1]

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations at Chapter 45 of the Code of Federal Regulations, Parts 160 and 164 (the "privacy rule") govern the use and disclosure of health care information. Generally, information acquired or created in connection with providing health care is confidential and may not be disclosed except as permitted or required by the privacy rule. *See* 45 C.F.R. Parts 160 and 164.

Note, mental health records are governed by both the privacy rule and the state law discussed in section 14.3. The use and disclosure of mental health records must comply with both laws. Substance use disorder treatment records are governed by the privacy rule, the state law discussed in section 14.3, below, and a federal law discussed in section 14.4, below. The use and disclosure of substance use disorder treatment records must comply with all three laws.

HIPAA is a complex federal law. For purposes of this Manual, this section focuses on disclosure of information by a covered health care provider when there is cause to suspect or a substantiation by DSS that a child is abused, neglected, or dependent. This section is an introductory overview of the relevant provisions of HIPAA and does not provide a comprehensive review of this federal law. Additionally, it does not address when DSS is subject to HIPAA requirements as a covered entity.

Resource: For information about whether DSS is a HIPAA covered entity, see Aimee Wall, *Should a Local Government Be a HIPAA Hybrid Entity?*, UNC SCH. OF GOV'T: COATES' CANONS: NC LOCAL GOVERNMENT LAW BLOG (April 28, 2015).

A. Covered Health Care Providers

The privacy rule applies to any "health care provider" that transmits health information in electronic form in connection with certain transactions, including the electronic transmission of information to a health plan for purposes of obtaining authorization or payment for health care services. *See* 45 C.F.R. 160.103, 164.500. While the transmission of information in electronic form for specified activities makes a health care provider a "covered entity" under the privacy rule, once covered, the privacy rule protects health information maintained by the provider in any form, whether electronic or on paper. (Other covered entities include health plans and health care clearinghouses.) "Health care provider" is defined broadly to include any person or organization that, in the normal course of business, furnishes, bills, or is paid for care, services, or supplies related to the health of the individual. This includes services relating to the mental condition or functional status of an individual. *See* 45 C.F.R. 160.103 for definitions of "health care provider" and "health care".

[1] This section of Chapter 14 of the Abuse, Neglect, Dependency – TPR Manual (Dec. 31, 2023 ed., forthcoming) was written by School of Government faculty member Mark Botts.

B. Protected Health Information

The privacy rule governs health information that is maintained in any form or medium (e.g., electronic, paper, or oral) that

- is created or received by a health care provider, health plan, or health care clearinghouse;
- identifies an individual or provides a reasonable basis to believe that the information can be used to identify an individual; and
- relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

C. Duty to Comply with HIPAA

A covered entity, including a covered health care provider, may use and disclose protected health information only as permitted or required by the privacy rule. Any person or organization alleging a HIPAA violation may file a complaint with the U.S. DHHS Office of Civil Rights (OCR). OCR has the authority to impose significant civil monetary penalties for impermissible disclosures of protected health information. Anyone seeking information from a health care provider will often be asked to point to a provision of the privacy rule that authorizes the provider to disclose the information. *See* 45 C.F.R. 160.402.

D. Impact on Abuse, Neglect, Dependency Laws

The privacy rule contains many provisions allowing a covered health care provider to disclose protected health information in particular circumstances. These exceptions to confidentiality recognize that the patient's privacy interests sometimes must give way to important public interests. When disclosing health information as permitted by the privacy rule, including under the laws discussed below, the privacy rule requires covered entities to disclose only as much information as is necessary to comply with the law requiring disclosure. Generally, a disclosure must comply with and be limited to the relevant requirements of the law, the covered entity must verify a requesting person's legal authority to acquire protected health information, and the covered entity must verify the requestor's identity if their identity is not already known to the entity disclosing information. *See* 45 C.F.R. 164.512(a) and 45 C.F.R. 164.514(h).

1. Reporting child abuse, neglect, or dependency. Anyone who has cause to suspect that a child is abused, neglected, or dependent, or has died as a result of maltreatment, has a legal duty under state law to report the case to the department of social services in the county where the child resides or is found. G.S. 7B-301. The HIPAA privacy rule permits a covered health care provider or other covered entity to disclose protected health information to a government authority authorized by law to receive reports of child abuse or neglect. *See* 45 C.F.R. 164.512(b). Thus, the privacy rule does not prevent a covered provider from complying with North Carolina's reporting law nor does it bar the provider from disclosing protected health information when making a report required by G.S. 7B-301.

2. Assessment and protective services. The department of social services is required to assess every abuse, neglect, and dependency report that falls within the scope of the Juvenile Code. G.S.7B-302. The director of social services (or the director's representative) may make a *written* demand for any information or reports, whether or not confidential, that in the director's opinion may be relevant to the assessment of a report or to the provision of protective services. G.S. 7B-302(e). Upon such demand, any agency or individual is required to provide access to and copies of confidential information to the extent permitted by federal law. The privacy rule permits a health care provider to disclose protected health information to the extent the disclosure is required by law. *See* 45 C.F.R. 164.512(a). Thus, the privacy rule permits a covered provider to disclose protected health information to DSS when DSS makes a written demand for the information pursuant to G.S. 7B-302(e).

3. The child's GAL access to information. G.S. 7B-601 authorizes the court to appoint a guardian ad litem (GAL) to represent children alleged to be abused, neglected, or dependent in juvenile court proceedings. The GAL has the authority to obtain "any information or reports, whether or not confidential, that may in the guardian ad litem's opinion be relevant to the case." G.S. 7B-601(c). Because the privacy rule says a health care provider may disclose protected health information to the extent that such disclosure is required by law, 45 C.F.R. 164.512(a), and because state law requires disclosure of information to a GAL appointed under G.S. 7B-601, the privacy rule permits a health care provider to disclose protected health information to the GAL as necessary to comply with G.S. 7B-601.

The form order used by courts to appoint a GAL includes the authorizing language of G.S. 7B-601(c) and adds that the authority includes the ability to obtain information protected by the HIPAA privacy rule. *See* AOC-J-207, Order to Appoint or Release Guardian ad Litem and Attorney Advocate (June 2014), quoted in section 14.1.D, above.

4. Interagency information sharing. As discussed in section 14.1.E, G.S. 7B-3100 of the Juvenile Code requires the adoption of rules designating local agencies that are *required* to share with one another, upon request and to the extent permitted by federal law and regulations, information in their possession that is relevant to

- any assessment of a report of child abuse, neglect, or dependency;
- the provision or arrangement of protective services in a child abuse, neglect, or dependency case by a local department of social services;
- any case in which a petition is filed alleging that a juvenile is abused, neglected, dependent, undisciplined or delinquent; or
- any case in which a vulnerable juvenile is receiving juvenile consultation services.

To the extent that the rules designate health care providers or other HIPAA covered entities to disclose information pursuant to G.S. 7B-3100, the HIPAA privacy rule permits the information sharing because it authorizes a covered entity to disclose protected health information to the extent that such disclosure is required by law. 45 C.F.R. 164.512(a). The state law requirement to share information, combined with the privacy law's permission to disclose information when required by state law, requires the health care provider to disclose information in accordance with G.S. 7B-3100 if the health care provider is a designated

agency by rule. Presently, local health departments and area mental health authorities (see "area authority" definition in section 14.3.A below) are the only health care providers or HIPAA-covered entities designated by rule, but the rule permits other health care providers to be designated by administrative court order. *See* 14B N.C.A.C. 11A.0301 for a list of agencies designated by rule to share information and the authority of district courts to issue an administrative order designating other agencies.

5. Disclosure pursuant to a subpoena. The privacy rule permits a health care provider or other covered entity to disclose protected health information in response to a subpoena if the covered entity receives *satisfactory assurance* from the party seeking the information that reasonable efforts have been made by the party either to

- ensure that the individual who is the subject of the information has been given notice of the request or
- secure a qualified protective order.

See 45 C.F.R. 164.512(e).

Satisfactory assurance of notice means a written statement and accompanying documentation that the party requesting records has made a good faith attempt to provide written notice to the individual that includes sufficient information about the proceeding to permit the individual to raise an objection to the court and the time for the individual to raise objections has elapsed and either no objections were filed or all objections filed were resolved by the court and the disclosures being sought are consistent with such resolution.

Satisfactory assurance of a qualified protective order means a written statement and accompanying documentation demonstrating that the parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court or tribunal, or the party seeking the information has requested a qualified protective order. (*See* 45 C.F.R. 164.512(e) for more information on protective orders.)

Practice Note: The HIPAA privacy rule does not preempt state and federal confidentiality laws that place greater restrictions on the disclosure of protected information. Because the state mental health confidentiality law and the federal law governing substance use disorder patient records do not permit the disclosure of protected information in response to a subpoena alone, information that is governed by those laws cannot be disclosed pursuant to a subpoena, notwithstanding the fact that the same information also may be subject to the HIPAA privacy rule. See sections 14.3 and 14.4, below.

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6. Disclosure pursuant to a court order. A health care provider or other HIPAA covered entity may disclose protected health information in response to an order of a court or administrative tribunal, provided that the covered entity discloses only the information expressly authorized by the order. 45 C.F.R. 164.512(e)(1)(i). The privacy rule expresses no particular procedure or criteria for obtaining a court order to disclose protected health information.

7. Disclosure with patient authorization. A health care provider may disclose protected health information as authorized by the patient. The authorization must be voluntary and in writing. It also must be informed, which means that the individual signing the authorization must understand what information will be shared, with whom it will be shared, and for what purpose. Toward this end, the privacy rule specifies required content for a valid authorization. *See* 45 C.F.R. 164.508(c).

The patient's written authorization permits, but does not require, the health care provider or other covered entity to disclose information. Any disclosure made by a health care provider pursuant to a patient's authorization must be consistent with, and may not exceed, the terms of the written authorization. The patient may revoke the authorization at any time.

Resources:
For a detailed guide to HIPAA, see "The HIPAA Privacy Rule" section of the U.S. Department of Health and Human Services website.

For a chart of "required by law" disclosures of protected health information by HIPAA-covered local health departments to county departments of social services, see Kirsten Leloudis, "Required by Law" Disclosures of PHI to DSS: G.S. 7B-302 and 7B-3100 (Chart) (UNC School of Government, 2023).

For a sample patient-authorization-to-disclose form that meets the requirements of the HIPAA privacy rule, see Mark F. Botts, LaToya B. Powell, Rachel Johnson, Jessica Jones, *North Carolina Juvenile Justice - Behavioral Health Information Sharing Guide* (UNC School of Government, 2015).

14.3 Mental Health Records and G.S. Chapter 122C[2]

The Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, G.S. Chapter 122C, governs providers of mental health, developmental disabilities, and substance abuse services (MH/DD/SA services). G.S. 122C-52 through -56 govern the information relating to those services.

A. Covered Providers

G.S. Chapter 122C applies to any "facility"—meaning any individual, agency, company, area authority, or state facility—at one location *whose primary purpose* is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or those with substance use disorder. This definition includes public and private agencies, providers of outpatient as well as inpatient services, state-operated psychiatric hospitals, psychiatric residential treatment centers, and agencies and individuals who contract with area authorities to provide services to area authority clients.

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[2] This section of Chapter 14 of the Abuse, Neglect, Dependency – TPR Manual (Dec. 31, 2023 ed., forthcoming) was written by School of Government faculty member Mark Botts.

An "area authority" is commonly referred to as a "local management entity/managed care organization" or "LME/MCO." Though these terms have distinct meanings in some contexts, for the purposes of this section of the Manual, the terms are interchangeable and refer to the public authorities responsible for contracting for the provision of publicly-funded MH/DD/SA services within a specified geographic service area. *See* G.S. 122C-3 for the definitions of these terms.

In addition to G.S. Chapter 122C, rules at 10A N.C.A.C. 26B impose additional confidentiality requirements on a subset of MH/DD/SA facilities: area authorities, state facilities, and the individuals and agencies that contract to provide services on behalf of area authorities and state facilities.

B. Confidential Information

Any information, whether recorded or not, relating to an individual served by a "facility" and received in connection with the performance of any function of the facility is confidential and may not be disclosed except as authorized by G.S. 122C-52 through -56 and, where applicable, 10A N.C.A.C. 26B. *See* G.S. 122C-3(9); 122C-52.

C. The Duty of Confidentiality

"No individual" having access to confidential information may disclose it except as authorized by G.S. Chapter 122C and, where applicable, 10A N.C.A.C. 26B. *See* G.S. 122C-52(b). The unauthorized disclosure of confidential information is a Class 3 misdemeanor (*see* G.S. 122C-52(e)) and could result in civil liability for the treatment facility or its employees. Further, because employees of area and state facilities are subject to disciplinary action if they disclose information in violation of G.S. Chapter 122C (*see* 10 N.C.A.C. 26B.0104), agencies subject to G.S. Chapter 122C will generally insist on identifying the legal authority for a disclosure before making the disclosure.

Note that the duty of confidentiality is not limited to MH/DD/SA treatment providers ("facilities"). The duty extends to any "individual having access to confidential information." G.S. 122C-52(b). Thus, the duty of confidentiality applies to departments of social services that receive confidential information from a facility, and these departments may not redisclose such information except as permitted or required by G.S. 122C-53 through G.S. 122C-56 (*e.g.,* pursuant to patient consent, court order, or a provision of law like those discussed in 14.3.D, below). In this respect, the state law governing MH/DD/SA records is similar to the federal law governing substance use disorder records, for an "individual" having access to information protected by state law has a duty much like the duty of a "lawful holder" of information protected by 42 C.F.R Part 2. *See* section 14.4.C, below, for the confidentiality duty of DSS as a lawful holder of protected substance use disorder information.

D. Impact on Abuse, Neglect, Dependency Laws

1. Reporting child abuse, neglect, or dependency. Anyone who has cause to suspect that a child is abused, neglected, or dependent, or has died as a result of maltreatment, is required to report the case to the department of social services in the county where the child resides or is found. G.S. 7B-301. Under G.S. 122C-54(h), providers of MH/DD/SA services are required to disclose confidential information for purposes of complying with Article 3 of G.S. Chapter 7B, which includes 7B-301. Thus, the state law governing the confidentiality of MH/DD/SA services is not a bar to complying with the state's child abuse reporting statute, and providers of services must disclose confidential information when necessary to comply with the mandatory reporting law.

2. Assessment and protective services. The department of social services is required to assess every abuse, neglect, and dependency report that falls within the scope of the Juvenile Code. G.S.7B-302. The director or director's representative may make a *written* demand for any information or reports, whether or not confidential, that in the director's opinion may be relevant to the assessment or to the provision of protective services. Upon such demand, any agency or individual must provide access to and copies of confidential information to the extent permitted by federal law.

The state mental health confidentiality law requires individuals and agencies subject to the law to disclose confidential information for purposes of complying with Article 3 of G.S. Chapter 7B, which includes 7B-302. *See* G.S. 122C-54(h). Thus, even if DSS seeks information that falls within the scope of the confidentiality protections of G.S. Chapter 122C, providers of MH/DDSA services must provide access to and copies of the requested information, unless disclosure is prohibited by federal law and regulations.

3. The child's GAL access to information. A guardian ad litem (GAL) appointed under G.S. 7B-601 to represent children who are alleged to be abused, neglected, or dependent, has the authority to obtain "any information or reports, whether or not confidential, that may in the guardian ad litem's opinion be relevant to the case." G.S. 7B-601(c).

G.S. 122C-54(h) provides that facilities governed by G.S. Chapter 122C must disclose confidential information "as required by other State or federal law." Thus, when a court order appoints someone to be a GAL under G.S. 7B-601, the GAL must be granted access to any information, whether or not protected by G.S. Chapter 122C, that the GAL believes is relevant to the case.

4. Interagency information sharing. As discussed in sections 14.1.E and 14.2.D.4, above, the Juvenile Code requires the adoption of rules designating local agencies that are *required* to share with one another, upon request and to the extent permitted by federal law and regulations, information that is in their possession that is relevant to

- any assessment of a report of child abuse, neglect, or dependency;
- the provision or arrangement of protective services in a child abuse, neglect, or dependency case by a local department of social services;

- any case in which a petition is filed alleging that a juvenile is abused, neglected, dependent, undisciplined or delinquent; or
- any case in which a vulnerable juvenile is receiving juvenile consultation services.

To the extent that the applicable rules, 14B N.C.A.C. 11A.0301, designate MH/DD/SA service providers among the agencies required to share information in accordance with G.S. 7B-3100, those service providers would be required to share information upon the request of another designated agency because G.S. Chapter 122C requires providers to disclose confidential information as required by other state law. *See* G.S. 122C-54(h).

The rules designate area mental health, developmental disabilities, and substance abuse authorities among the agencies required to share information pursuant to the statute, as well as any "local agency designated by an administrative order issued by the chief district court judge of the district court district in which the agency is located." 14B N.C.A.C. 11A.0301(10). Because the rules do not designate individuals and agencies who contract with area authorities to provide services to area authority clients, such providers of services do not come under G.S. 7B-3100 and, therefore, would not be permitted to disclose confidential information pursuant to the statute unless they are designated by an administrative court order as provided for in the rule. *See* 14B N.C.A.C. 11A.0301 for a list of agencies designated to share information pursuant to G.S. 7B-3100.

5. Disclosure pursuant to a subpoena. Unlike the privacy rule governing health records, discussed in section 14.2, above, G.S. Chapter 122C does not include a provision permitting a provider of MH/DD/SA services to disclose confidential information in response to a subpoena alone. A subpoena would compel disclosure of confidential information only if the confidentiality bar is removed by the client's written authorization to disclose, a court order requiring disclosure, or some other legal mandate, such as a statute or regulation, that requires disclosure under the particular circumstances.

6. Disclosure pursuant to a court order. A facility must disclose confidential information if a court of competent jurisdiction issues an order compelling disclosure. G.S. 122C-54(a). G.S. 122C-54(a) expresses no standard or criteria for the issuance of a court order. Presumably, the court should use a public interest test similar to the test articulated in the regulations governing substance use disorder records, which requires the court to balance the public interest and need for the disclosure against the potential injury to the patient, the patient-provider relationship, and the provider's on-going treatment services. *See* section 14.4.D.6, below.

The evidentiary privilege statutes for mental health professionals may provide some guidance to the court. The privilege statutes for psychologists and other mental health professionals provide that a judge may order disclosure of privileged information when "necessary to the proper administration of justice" (e.g., in order that the truth be known and justice done). *See* G.S. 8-53.3 (psychologists); 8-53.5 (marital and family therapists); and 8-53.7 (social workers) and case annotations.

7. Disclosure with patient authorization. A facility may disclose confidential information regarding a client if the client or his or her legally responsible person consents in writing to the release of the information. *See* G.S. 122C-53(a).

The state rules that apply to area authorities and their contracted providers of services require patient consent to be voluntary, informed, and in writing. See 10A N.C.A.C. 26B .0200. The client's consent is revocable, and it permits, but does not require, a facility to disclose confidential information.

Any consent form used for the disclosure of information that is confidential under G.S. Chapter 122C will probably need to conform to the HIPAA privacy rule requirements for patient authorization, as most MH/DD/SA providers also are healthcare providers covered by the privacy rule. The most effective way to ensure that you are using a consent form that meets the requirement of law is to have the patient sign and fully complete the treatment provider's own consent form.

Legislative Note: The state rules applicable to area authorities and their contract providers specify particular elements for the written consent form (10A NCAC 26B .0202(a)), including an automatic one-year expiration date. However, some of these requirements were superseded by an amendment to G.S. 122C-53(a), which reads, "[a] written release that contains the core elements for authorizations as set forth in Subpart E of Part 164 of Title 45 of the Code of Federal Regulations [the HIPAA privacy rule] shall be valid for the purposes of this subsection." S.L. 2023-95. Now, there is no automatic one-year expiration date, and the patient need only specify a date, condition, or event upon which consent will expire (e.g., when my protective services case ends).

Resources:
For sample patient-authorization-to-disclose forms designed to meet the requirements of the HIPAA privacy rule and G.S. Chapter 122C, see

- Mark F. Botts, LaToya B. Powell, Rachel Johnson, Jessica Jones, *North Carolina Juvenile Justice - Behavioral Health Information Sharing Guide* (UNC School of Government, 2015).
- The SUN Project—Interagency Sharing of Confidential Information to Coordinate Care and Treatment for Pregnant Women, *Patient Authorization to Disclose*.

14.4 Substance Use Disorder Records and 42 C.F.R. Part 2[3]

Federal law restricts the use and disclosure of patient information received or acquired by a federally assisted alcohol or drug abuse program. 42 U.S.C. 290dd-2; 42 C.F.R. Part 2.

[3] This section of Chapter 14 of the Abuse, Neglect, Dependency – TPR Manual (Dec. 31, 2023 ed., forthcoming) was written by School of Government faculty member Mark Botts.

A. Covered Programs

The federal law governs federally assisted programs. A "program" is

- an individual or entity (other than a general medical facility) that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment;
- an identified unit within a general medical facility that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or
- medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers.

See 42 C.F.R. 2.11 (definition of "substance use disorder").

A program is considered "federally assisted" if it participates in Medicare, has tax exempt status, is registered to dispense a controlled substance used in the treatment of substance use disorders, receives federal financial assistance in any form even if the financial assistance does not directly pay for substance use disorder treatment, or is a local government unit that receives federal funds that could be but are not necessarily spent for a substance use disorder program. *See* 42 C.F.R. 2.12(b). By participating in Medicaid and receiving federal block grant funding, area authorities (LME/MCOs) and the agencies that contract with them to provide substance use disorder diagnosis, treatment, or referral for treatment are federally assisted programs governed by 42 C.F.R. Part 2.

The federal regulations cover those treatment or rehabilitation programs, employee assistance programs, programs in general hospitals, and school-based programs who hold themselves out as providing and provide substance use disorder diagnosis, treatment, or referral for treatment. A private practitioner who specializes, and holds herself out as specializing, in diagnosing substance use disorders and referring patients elsewhere for treatment is covered by the regulations even though she does not treat substance use disorders.

As noted above there are three separate "program" definitions, or three independent ways that a person or entity may fall within the definition of "program." Two of the definitions apply to "general medical facilities," a term not defined in the regulations. Looking at the definitions above, and considering a general or acute care hospital to be a general medical facility, we can see that the federal regulations would not apply to hospital emergency department personnel who refer a patient to the hospital's intensive care unit for an apparent drug overdose unless the *primary* function of such personnel is the provision of substance use disorder diagnosis, treatment, or referral for treatment and they are identified as providing such services. Alternatively, if the general hospital has promoted its emergency department or other identified unit, such as a detox unit, to the community as a provider of such services, the identified unit, but not the rest of the general hospital, would be a program covered by the regulations.

Practice Note: If a hospital emergency room treating a trauma patient performs a blood test that identifies cocaine or other drugs in the patient's blood, this alone would not make the hospital emergency room a "program" covered by the regulations and, therefore, the drug test results would not be protected by 42 C.F.R. Part 2. If, however, a substance use disorder counselor evaluates the same patient for drug abuse and referral for treatment after the patient is admitted to a medical floor of the hospital, then the substance use disorder counselor would be considered a "program."

B. Confidential Information

The federal restrictions on disclosure apply to any information, whether recorded or not, that

- would identify a "patient" (defined as an individual who has applied for or been given substance use disorder treatment, diagnosis, or referral for treatment) as having or having had a substance use disorder and
- is alcohol or drug abuse information obtained by a federally assisted alcohol or drug abuse program for the purpose of treating substance use disorder, making a diagnosis for that treatment, or making a referral for that treatment.

The mere acknowledgement by program staff of the presence of an identified patient at a residential or inpatient facility would involve the disclosure of confidential information if the facility is publicly identified as a place where only substance use disorder diagnosis, treatment, or referral for treatment is provided. Acknowledging the presence of a patient in this circumstance would require either the patient's written consent or an authorizing court order issued in compliance with the regulations. For disclosures pursuant to a court order or patient consent, *see* section 14.4.D, below (discussing the impact of confidentiality law on abuse and neglect laws).

Practice Note: Suppose a child protective services worker investigating a report of child neglect requests access to a child's mental health record. The family/social history section of the child's record states that the mother, during the intake interview with the child's mental health counselor, disclosed that she uses cocaine. This information is not covered by 42 C.F.R. Part 2 because it was not obtained for the purpose of treating or diagnosing the mother or referring her for treatment. The information also would not be covered because it does not identify the mother as a person who has applied for or received substance use disorder treatment, diagnosis, or referral for treatment.

A diagnosis that is made solely for the purpose of providing evidence for use by law enforcement agencies or officials is not confidential information because it is not obtained for the purpose of treating substance use disorder, making a diagnosis for treatment, or making a referral for that treatment. On the other hand, a diagnosis that is initially prepared by a program in connection with treatment or referral for treatment of a substance use disorder patient is covered by the regulations even if the diagnosis is not used for treatment because the patient does not follow up on the referral.

C. Duty Imposed by Federal Substance Use Disorder Records Law

The regulations prohibit the *disclosure* and *use* of patient records except as permitted by the regulations themselves. Anyone who violates the law is subject to a criminal penalty in the form of a fine (up to $500 for a first offense, up to $5,000 for each subsequent offense).

It is important for social services departments, guardians ad litem (GALs), and others who receive substance use disorder (SUD) information from a "program" to understand that the duty of confidentiality imposed by the federal regulations may extend to them. For example, when a department of social services receives SUD information from a treatment program pursuant to the patient's written authorization, the department becomes a "lawful holder" of protected information that may not be redisclosed except as permitted or required by the federal law. The restrictions on disclosure apply to individuals and entities who receive patient information directly from a program or other lawful holder of information if they are notified of the prohibition on redisclosure in accordance with section 2.32 of the regulations. That section requires a program that discloses information pursuant to the patient's written consent to notify the recipient that the information continues to be protected by 42 C.F.R. Part 2 and may be redisclosed only as permitted by the regulations. The recipient, a lawful holder of protected information, is bound by the restrictions on disclosure in the same way that a "program" is bound.

D. Impact on Abuse, Neglect, Dependency Laws

If the federal law does not expressly permit the disclosure of confidential patient information in a particular circumstance, then the disclosure is prohibited. To understand the impact of 42 C.F.R. Part 2 on North Carolina's laws pertaining to child abuse, neglect, and dependency, we must start with the federal law's own rule regarding its relationship to state law: "no state law may either authorize or compel any disclosure prohibited by this part." 42 C.F.R. 2.20. Thus, where the Juvenile Code or other state law authorizes or compels a disclosure that is not permitted by 42 C.F.R. Part 2, the federal prohibition on disclosure must be followed. Conversely, the federal regulation does not preempt the field of state law. If the federal law permits a particular disclosure, but state law prohibits it, then state law controls. The federal law does not compel disclosure under any circumstance.

In addition to restricting the *disclosure* of information, the regulations also restrict the *use* of information to initiate or substantiate criminal charges against a patient. Generally, when a department of social services or guardian ad litem seeks and receives information from SUD programs for the purpose of carrying out their functions relating to child abuse, neglect, or dependency, only the restrictions on *disclosures* will apply.s. The restrictions on the *use* of information for purposes of criminal investigation or prosecution generally will not apply and are not discussed here. *See* 42 C.F.R. 2.12 for the restrictions on *use* of information for purposes of criminal investigation and prosecution of a patient.

Legislative Note: The U.S. Department of Health and Human Services has issued a notice of proposed rulemaking that would, among other things, expand the restrictions on *use* to *civil* proceedings. The proposed rule would prohibit the use of SUD information, or testimony that

describes such information, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient unless authorized by the consent of the patient or a court order issued in accordance with [42 CFR 2.64] or 2.65. See 42 C.F.R. § 2.12(d). This proposed rule change would extend the restrictions on use to court proceedings relating to child abuse, neglect, or dependency, and would apply to any person who obtains SUD information from a program or other lawful holder. *See* Federal Register, Vol. 87, No. 231, p. 74276 (December 2, 2022).

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1. Reporting child abuse, neglect, or dependency. The federal restrictions on the disclosure of confidential information do not apply to the reporting of suspected child abuse or neglect under state laws mandating such reports. 42 C.F.R. 2.12(c)(6). Therefore, the federal law does not bar compliance with North Carolina's mandatory reporting statute (G.S. 7B-301), even if it means disclosing patient identifying information.

2. Assessment and protective services. Although substance use disorder programs (or third party payers who have received information from such programs) must make a report of suspected abuse, neglect, or dependency as mandated by G.S. 7B-301, they are not authorized to provide information beyond the initial report when DSS requests further information pursuant to its duty under G.S. 7B-302(e) to assess the report. The federal rules permit the disclosure of information for follow-up investigations or for court proceedings that may arise from the report only with the patient's written *consent* or a *court order* issued pursuant to Subpart E of the federal regulations. 42 C.F.R. 2.12(c)(6).

3. The child's GAL access to information. A guardian ad litem (GAL) appointed under G.S. 7B-601 to represent children who are alleged to be abused, neglected, or dependent, has the authority to obtain "any information or reports, whether or not confidential, that may in the guardian ad litem's opinion be relevant to the case." G.S. 7B-601(c). However, the federal regulations governing substance use disorder treatment records do not recognize this as a policy exception to the confidentiality of patient information. (The federal regulations do not contain a provision permitting disclosure in this circumstance.) The federal rules permit the disclosure of information to a GAL only with the patient's written consent or a court order issued in compliance with Subpart E of the federal regulations.

4. Interagency information sharing. Although the HIPAA privacy rule and state mental health law permit the interagency sharing of confidential information required by G.S. 7B-3100 and 14B N.C.A.C. 11A.0301, as discussed in sections 14.2.D.4 and 14.3.D.4, above, the federal drug and alcohol confidentiality law and its implementing regulations at 42 C.F.R. Part 2 do not permit the disclosure of confidential information pursuant to these state laws. (The federal regulations do not contain a provision permitting disclosure in these or similar circumstances.)

5. Disclosure pursuant to a subpoena. Unlike the privacy rule governing health records, discussed in section 14.2, above, but like the state confidentiality law governing MH/DD/SA services, 42 C.F.R. Part 2 does not include a provision permitting a provider of services to disclose confidential information in response to a subpoena alone. A subpoena compels disclosure of confidential information only if accompanied by the client's authorization to

disclose, a court order to disclose, or some other legal mandate, such as a statute or regulation that requires disclosure under the circumstances.

6. Disclosure pursuant to a court order. Under Subpart E of 42 C.F.R. Part 2, a court of competent jurisdiction may authorize a use or disclosure that would otherwise be prohibited under the regulations. *See* 42 C.F.R. 2.61. Such an order does not compel disclosure; to compel disclosure a subpoena or similar mandate must be issued.

Subpart E sets forth the procedure and criteria for court orders authorizing

- disclosure for noncriminal purposes,
- disclosure and use of information to criminally investigate or prosecute patients,
- disclosure and use of information to investigate or prosecute a program or the person holding the records, and
- the use of undercover agents and informants to investigate employees or agents of a program in connection with a criminal matter.

The kind of order needed by a department of social services to obtain confidential information in the context of child abuse, neglect, or dependency proceedings is an order authorizing disclosure for noncriminal purposes. Any person having a legally recognized interest in the disclosure that is sought may apply for the order. The application may be filed separately or as part of a pending action and must use a fictitious name, such as John Doe, to refer to the patient unless the court orders the record of the proceeding sealed from public scrutiny. *See* 42 C.F.R. 2.64. When seeking a court order where there is no pending action, *see In re Albemarle Mental Health Center,* 42 N.C. App. 292 (1979) (where no civil or criminal proceeding has been commenced, the superior court has jurisdiction to hear a motion requesting an in camera hearing to determine whether information in the possession of a mental health center should be disclosed; the action is in the nature of a special proceeding.).

When the information is sought for noncriminal purposes, the patient and person holding the records must be given adequate notice and opportunity to file a written response or appear in person for the limited purpose of providing evidence on the legal criteria for issuance of the order. 42 C.F.R. 2.64. The judge may examine the records before making a decision. Any oral argument, review of evidence, or hearing on the application must be held in camera.

To order disclosure, the court must find "good cause" for the disclosure. For an order authorizing disclosure for noncriminal purposes, this means the court must find that

- other ways of obtaining the information are not available or would not be effective and
- the public interest and need for disclosure outweigh the potential injury to the patient, the patient's relationship to the program, and the program's ongoing treatment services.

Any order authorizing disclosure must (i) limit disclosure to those parts of the record that are essential to fulfill the purpose of the order, (ii) limit disclosure to those persons whose need for the information forms the basis for the order, and (iii) include any other measures that are necessary to limit disclosure for the protection of the patient, the patient-treatment provider

relationship, and the program's ongoing treatment services (e.g., sealing from public scrutiny the record of any proceeding for which the disclosure of information has been ordered). *See* 42 C.F.R. 2.64.

The disclosure of certain information—the things a patient says to program personnel—requires additional findings by the court. A court may order the disclosure of "confidential communications" made by a patient to a program in the course of diagnosis, treatment, or referral for treatment only if the disclosure is

- necessary to protect against an existing threat to life or serious bodily injury, including circumstances that constitute suspected child abuse and neglect and verbal threats against third parties;
- necessary to the investigation or prosecution of an extremely serious crime; or
- in connection with litigation in which the patient offers testimony or other evidence pertaining to the content of the confidential communications. 42 C.F.R. 2.63.

7. Disclosure with patient authorization. A program may disclose confidential information with the consent of the patient. As with the HIPAA privacy rule and the state mental health law, patient consent must be voluntary and in writing. It also must be informed, which means that the individual signing the authorization must understand what information will be shared, with whom it will be shared, and for what purpose. Toward this end, the federal law governing substance use disorder programs specifies certain content that must be included in the written consent for it to be considered valid. *See* 42 C.F.R. 2.31.

Any consent form used for the disclosure of information that is confidential under 42 C.F.R. Part 2 will need to conform to the state law requirements for consent because G.S. Chapter 122C also applies to substance use disorder treatment services. In addition, if the program is a covered entity under the HIPAA privacy rule, the privacy rule's requirements for patient authorization will apply. The most effective way to ensure that you are using a consent form that meets the requirements of law is to have the patient sign and fully complete the treatment program's own consent form.

Resources:

For sample consent-to-disclose forms that meets the requirements of the HIPAA privacy rule, G.S. Chapter 122C, and 42 C.F.R. Part 2, see

- Mark F. Botts, LaToya B. Powell, Rachel Johnson, Jessica Jones, *North Carolina Juvenile Justice - Behavioral Health Information Sharing Guide* (UNC School of Government, 2015).
- The SUN Project—Interagency Sharing of Confidential Information to Coordinate Care and Treatment for Pregnant Women, *Patient Authorization to Disclose*.