



Minnesota Office of the Revisor of Statutes

Legislature Home | Links to the World | Help | Ac

House | Senate | Joint Departments and Commissions | Bill Search and Status | Statutes, Laws, and Rules

Minnesota Statutes 2005, 144.335

Copyright 2005 by the Office of Revisor of Statutes, State of Minnesota.

[Minnesota Statutes 2005, Table of Chapters](#)

[Table of contents for Chapter 144](#)

144.335 Access to health records.

Subdivision 1. **Definitions.** For the purposes of this section, the following terms have the meanings given them:

(a) "Patient" means a natural person who has received health care services from a provider for treatment or examination of a medical, psychiatric, or mental condition, the surviving spouse and parents of a deceased patient, or a person the patient appoints in writing as a representative, including a health care agent acting pursuant to chapter 145C, unless the authority of the agent has been limited by the principal in the principal's health care directive. Except for minors who have received health care services pursuant to sections [144.341](#) to [144.347](#), in the case of a minor, patient includes a parent or guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

(b) "Provider" means (1) any person who furnishes health care services and is regulated to furnish the services pursuant to chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148C, 148D, 150A, 151, 153, or 153A, or Minnesota Rules, chapter 4666; (2) a home care provider licensed under section [144A.46](#); (3) a health care facility licensed pursuant to this chapter or chapter 144A; (4) a physician assistant registered under chapter 147A; and (5) an unlicensed mental health practitioner regulated pursuant to sections [148B.60](#) to [148B.71](#).

(c) "Individually identifiable form" means a form in which the patient is or can be identified as the subject of the health records.

Subd. 2. **Patient access.** (a) Upon request, a provider shall supply to a patient complete and current information possessed by that provider concerning any diagnosis, treatment and prognosis of the patient in terms and language the patient can reasonably be expected to understand.

(b) Except as provided in paragraph (e), upon a patient's written request, a provider, at a reasonable cost to the patient, shall promptly furnish to the patient (1) copies of the patient's health record, including but not limited to laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's health condition, or (2) the pertinent portion of the record relating to a condition

specified by the patient. With the consent of the patient, the provider may instead furnish only a summary of the record. The provider may exclude from the health record written speculations about the patient's health condition, except that all information necessary for the patient's informed consent must be provided.

(c) If a provider, as defined in subdivision 1, clause (b) (1), reasonably determines that the information is detrimental to the physical or mental health of the patient, or is likely to cause the patient to inflict self harm, or to harm another, the provider may withhold the information from the patient and may supply the information to an appropriate third party or to another provider, as defined in subdivision 1, clause (b) (1). The other provider or third party may release the information to the patient.

(d) A provider as defined in subdivision 1, clause (b) (3), shall release information upon written request unless, prior to the request, a provider as defined in subdivision 1, clause (b) (1), has designated and described a specific basis for withholding the information as authorized by paragraph (c).

(e) A provider may not release a copy of a videotape of a child victim or alleged victim of physical or sexual abuse without a court order under section [13.03](#), subdivision 6, or as provided in section [611A.90](#). This paragraph does not limit the right of a patient to view the videotape.

Subd. 3. **Provider transfers and loans.** A patient's health record, including but not limited to, laboratory reports, x-rays, prescriptions, and other technical information used in assessing the patient's condition, or the pertinent portion of the record relating to a specific condition, or a summary of the record, shall promptly be furnished to another provider upon the written request of the patient. The written request shall specify the name of the provider to whom the health record is to be furnished. The provider who furnishes the health record or summary may retain a copy of the materials furnished. The patient shall be responsible for the reasonable costs of furnishing the information.

Subd. 3a. **Patient consent to release of records; liability.** (a) A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release, unless the release is specifically authorized by law. Except as provided in paragraph (c) or (d), a consent is valid for one year or for a lesser period specified in the consent or for a different period provided by law.

(b) This subdivision does not prohibit the release of health records:

(1) for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency; or

(2) to other providers within related health care entities

when necessary for the current treatment of the patient.

(c) Notwithstanding paragraph (a), if a patient explicitly gives informed consent to the release of health records for the purposes and pursuant to the restrictions in clauses (1) and (2), the consent does not expire after one year for:

(1) the release of health records to a provider who is being advised or consulted with in connection with the current treatment of the patient;

(2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purposes of payment of claims, fraud investigation, or quality of care review and studies, provided that:

(i) the use or release of the records complies with sections [72A.49](#) to [72A.505](#);

(ii) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited; and

(iii) the recipient establishes adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient.

(d) Notwithstanding paragraph (a), health records may be released to an external researcher solely for purposes of medical or scientific research only as follows:

(1) health records generated before January 1, 1997, may be released if the patient has not objected or does not elect to object after that date;

(2) for health records generated on or after January 1, 1997, the provider must:

(i) disclose in writing to patients currently being treated by the provider that health records, regardless of when generated, may be released and that the patient may object, in which case the records will not be released; and

(ii) use reasonable efforts to obtain the patient's written general authorization that describes the release of records in item (i), which does not expire but may be revoked or limited in writing at any time by the patient or the patient's authorized representative;

(3) authorization may be established if an authorization is mailed at least two times to the patient's last known address with a postage prepaid return envelope and a conspicuous notice that the patient's medical records may be released if the patient does not object, and at least 60 days have expired since the second notice was sent; and the provider must advise the patient of the rights specified in clause (4); and

(4) the provider must, at the request of the patient,

provide information on how the patient may contact an external researcher to whom the health record was released and the date it was released.

In making a release for research purposes the provider shall make a reasonable effort to determine that:

(i) the use or disclosure does not violate any limitations under which the record was collected;

(ii) the use or disclosure in individually identifiable form is necessary to accomplish the research or statistical purpose for which the use or disclosure is to be made;

(iii) the recipient has established and maintains adequate safeguards to protect the records from unauthorized disclosure, including a procedure for removal or destruction of information that identifies the patient; and

(iv) further use or release of the records in individually identifiable form to a person other than the patient without the patient's consent is prohibited.

(e) A person who negligently or intentionally releases a health record in violation of this subdivision, or who forges a signature on a consent form, or who obtains under false pretenses the consent form or health records of another person, or who, without the person's consent, alters a consent form, is liable to the patient for compensatory damages caused by an unauthorized release, plus costs and reasonable attorney's fees.

(f) Upon the written request of a spouse, parent, child, or sibling of a patient being evaluated for or diagnosed with mental illness, a provider shall inquire of a patient whether the patient wishes to authorize a specific individual to receive information regarding the patient's current and proposed course of treatment. If the patient so authorizes, the provider shall communicate to the designated individual the patient's current and proposed course of treatment. Paragraph (a) applies to consents given under this paragraph.

(g) Notwithstanding paragraph (a), a provider must disclose health records relating to a patient's mental health to a law enforcement agency if the law enforcement agency provides the name of the patient and communicates that the:

(1) patient is currently involved in an emergency interaction with the law enforcement agency; and

(2) disclosure of the records is necessary to protect the health or safety of the patient or of another person.

The scope of disclosure under this paragraph is limited to the minimum necessary for law enforcement to respond to the emergency. A law enforcement agency that obtains health records under this paragraph shall maintain a record of the requestor, the provider of the information, and the patient's name. Health records obtained by a law enforcement agency under this paragraph are private data on individuals as defined in section [13.02](#) and must not be used by law enforcement for any other

purpose.

(h) In cases where a provider releases health records without patient consent as authorized by law, the release must be documented in the patient's health record. In the case of a release under paragraph (g), the documentation must include the date and circumstances under which the release was made, the person or agency to whom the release was made, and the records that were released.

Subd. 3b. **Release of records to commissioner of health or Health Data Institute.** Subdivision 3a does not apply to the release of health records to the commissioner of health or the Health Data Institute under chapter 62J, provided that the commissioner encrypts the patient identifier upon receipt of the data.

Subd. 3c. **Independent medical examination.** This section applies to the subject and provider of an independent medical examination requested by or paid for by a third party. Notwithstanding subdivision 3a, a provider may release health records created as part of an independent medical examination to the third party who requested or paid for the examination.

Subd. 4. **Additional patient rights.** The rights set forth in this section are in addition to the rights set forth in sections [144.651](#) and [144.652](#) and any other provision of law relating to the access of a patient to the patient's health records.

Subd. 5. **Costs.** (a) When a patient requests a copy of the patient's record for purposes of reviewing current medical care, the provider must not charge a fee.

(b) When a provider or its representative makes copies of patient records upon a patient's request under this section, the provider or its representative may charge the patient or the patient's representative no more than 75 cents per page, plus \$10 for time spent retrieving and copying the records, unless other law or a rule or contract provide for a lower maximum charge. This limitation does not apply to x-rays. The provider may charge a patient no more than the actual cost of reproducing x-rays, plus no more than \$10 for the time spent retrieving and copying the x-rays.

(c) The respective maximum charges of 75 cents per page and \$10 for time provided in this subdivision are in effect for calendar year 1992 and may be adjusted annually each calendar year as provided in this subdivision. The permissible maximum charges shall change each year by an amount that reflects the change, as compared to the previous year, in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U), published by the Department of Labor.

(d) A provider or its representative must not charge a fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act. For the

purpose of further appeals, a patient may receive no more than two medical record updates without charge, but only for medical record information previously not provided. For purposes of this paragraph, a patient's authorized representative does not include units of state government engaged in the adjudication of Social Security disability claims.

Subd. 5a. **Notice of rights; information on release.**

A provider shall provide to patients, in a clear and conspicuous manner, a written notice concerning practices and rights with respect to access to health records. The notice must include an explanation of:

(1) disclosures of health records that may be made without the written consent of the patient, including the type of records and to whom the records may be disclosed; and

(2) the right of the patient to have access to and obtain copies of the patient's health records and other information about the patient that is maintained by the provider.

The notice requirements of this paragraph are satisfied if the notice is included with the notice and copy of the patient and resident bill of rights under section [144.652](#) or if it is displayed prominently in the provider's place of business. The commissioner of health shall develop the notice required in this subdivision and publish it in the State Register.

Subd. 6. **Violation.** A violation of this section may be grounds for disciplinary action against a provider by the appropriate licensing board or agency.

HIST: 1977 c 380 s 1; 1985 c 298 s 40; 1986 c 444; 1987 c 347 art 1 s 18; 1987 c 378 s 1; 1988 c 670 s 8; 1989 c 64 s 1,2; 1989 c 175 s 3; 1989 c 209 art 1 s 15; 1990 c 573 s 20; 1991 c 292 art 2 s 3; 1991 c 319 s 15; 1992 c 569 s 8-11; 1993 c 345 art 12 s 7; 1993 c 351 s 24,25; 1994 c 618 art 1 s 19; 1994 c 625 art 8 s 42,43; 1995 c 205 art 2 s 3; 1995 c 234 art 5 s 23; 1995 c 259 art 1 s 34; art 4 s 5; 1996 c 440 art 1 s 36; 1Sp1997 c 3 s 24; 1998 c 317 s 1; 1998 c 399 s 1; 2001 c 211 s 2; 2002 c 375 art 3 s 6; 2004 c 290 s 30; 2005 c 147 art 1 s 3

Please direct all comments concerning issues or legislation
to your [House Member](#) or [State Senator](#).

For Legislative Staff or for directions to the Capitol, visit the [Contact Us](#) page.

[General questions or comments.](#)