

- Determining if any particular exchange of health information is appropriate and permitted under Minnesota law;
- Communicating with patients about the mechanisms that permit them to control the disclosure of their health information; and
- Explaining to patients when and how their health information can be disclosed.

During Legal Work Group discussions of the two fundamental issues, it was clear that providers do not all have the same interpretation of the statutory language. In particular, they do not agree on when consent is needed or how the consent should be obtained. Specifically, different interpretations of the following undefined terms lead to fundamentally different interpretations of Minnesota’s statutory requirements:

- Current Treatment
- Medical Emergency
- Related Health Care Entity

**Two Views of “Current Treatment” and the Impact on Patient Consent Requirements**

Minnesota Statutes, section 144.335, subdivision 3a, states that a patient’s consent is valid for no longer than one year. However, the statute provides an exception to the one-year time limit in paragraph (c), where it states:

*(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;*

Almost all health care providers respond to this portion of the statute in the same way. During a patient’s initial visit, providers ask the patient to complete a general consent for the release of health records to providers who are being advised or consulted with in connection with the patient’s current treatment. This general consent does not expire, but may be revoked at any time.

To understand when the general consent permits a health care provider to release health records to another provider, it is necessary to understand what is included in the term “current treatment.” Unfortunately, the statutes do not define the term “current treatment.” Consequently, health care providers have adopted at least two different interpretations for the term with very different implications:

- **Interpretation 1:** This interpretation holds that the general consent permits the provider to disclose any health information at any time to any provider who is currently treating the patient. Note: Any health information means information not covered by another law (e.g., substance abuse treatment data and genetic data).

This first interpretation reads subdivision 3a, (c)(1) as though the statute were written as:

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

- **Interpretation 2:** This interpretation holds that the general consent only permits the provider to disclose health records to other providers being advised or consulted in relation to the releasing provider’s current treatment of the patient (e.g., for continuity of care or referrals).

This second interpretation reads subdivision 3a, (c)(1) as though the statute were written as:

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

These two different interpretations yield substantially different answers to our questions of when patient consent is needed and how it should be obtained. These differences are illustrated in the following example:

*Patient X has hip replacement surgery at Good Hospital. As part of the admission paperwork, Patient X signs a general consent the permits Good Hospital to release Patient X's health records to providers being advised or consulted with in connection with Patient X's current treatment. After the surgery, Patient X is referred to Fine Rehabilitation Center for physical therapy associated with the hip replacement. Good Hospital and Fine Rehabilitation Center are unrelated and are not under common ownership.*

*Two years after hip surgery, Patient X injures his knee and visits Superior Clinic. The doctors at Superior Clinic would like to get Patient X's health records from Good Hospital to have a more complete understanding of the overall situation with Patient X's knee and leg. Superior Clinic is unrelated and not under common ownership with Good Hospital or Fine Rehabilitation Center.*

When and How Patient X's Consent is Obtain to Exchange Health Records		
Providers Exchanging Patient X's Health Records	Interpretation 1	Interpretation 2
From Good Hospital to Fine Rehabilitation Center	<p>The general consent obtained at admission to Good Hospital is sufficient, because Fine Rehabilitation Center is now <u>currently treating</u> Patient X.</p> <p>No additional or more specific consent is needed.</p>	<p>The general consent obtained at Good Hospital is sufficient because Patient X <u>is being referred</u> to Fine Rehabilitation <u>by Good Hospital</u> in connection with the hip surgery.</p> <p>No additional or more specific consent is needed.</p>
From Good Hospital to Superior Clinic	<p>The general consent obtained two years earlier at Good Hospital is sufficient consent, because Superior Clinic is now <u>currently treating</u> Patient X.</p> <p>No additional or more specific consent is needed.</p>	<p>Good Hospital would require Patient X to provide a written consent that specifically authorizes Good Hospital to release Patient X's health records to Superior Clinic. Patient X's care at Superior Clinic is <u>not part of the care that was being provided by Good Hospital</u> and is therefore <u>not covered by the general consent</u> obtained at Good Hospital.</p> <p>This new, specific consent is valid for no more than one year.</p>

In the example, when patient consent is required (or at least when specific patient consent versus general patient consent is required) depends on whether a provider adheres to Interpretation 1 or Interpretation 2.



To appreciate the practical difficulties that can arise in exchanging Patient X's health records, imagine that Good Hospital adheres to Interpretation 2 and Superior Clinic adheres to Interpretation 1. That situation raises the following difficult questions concerning the exchange of Patient X's health records:

- How will Superior Clinic know if a specific consent from Patient X is needed for Good Hospital to release the records the clinic has requested?
- How will Superior Clinic know what advice to provide Patient X about actions to take to ensure that the clinic has the appropriate records for Patient X?
- How will Superior Clinic know if it should assist Patient X in completing a patient consent for the requested records?
- How will the electronic exchange of information be automated if the parties to the exchange cannot agree on the requirements for the exchange to occur?

Without a definition of "current treatment" and without agreement on the appropriate interpretation of section 144.335, subdivision 3a, (c)(1), it will be difficult to get widespread agreement on when and how patient consent is required within a health information exchange. The wide spectrum covered by the providers' interpretations of "current treatment" means that Minnesota does not have a uniform foundation on which to build its electronic health information exchange efforts. This lack of a common foundation will complicate and delay the development of electronic exchange and create variability in patients' privacy protections.

#### **Definition of "Medical Emergency" and the Need for Patient Consent**

Section 144.335, subdivision 3a provides two additional exceptions to the patient consent requirements. The first exception is during a "medical emergency", although there is no statutorily-based definition for the term.

As noted earlier, in the absence of a specific definition, Minnesota's rules of statutory construction direct the reader to the plain meaning of the term and thus to the dictionary. However even with these directions, health care providers do not universally agree on whether or not specific situations are considered medical emergencies. Providers generally agree on the emergency nature of situations when immediate medical care is necessary to:

- Preserve life;
- Prevent serious impairment to bodily functions; or
- Prevent placing the patient's physical or mental health in serious jeopardy.

However, providers do not always agree on the emergency nature of situations that test the boundaries of the definition, for example:

- A dazed and confused patient shows up in the emergency department, although the patient's life and body function are not in immediate danger; or
- A patient is brought to the emergency department unconscious, but in stable condition.

The health care provider releasing a patient's health records bears all responsibility for ensuring that the release of records is appropriate and permitted under law. Consequently, prior to releasing a patient's health records, the releasing provider generally needs to make some assessment that the patient is in a medical emergency and unable to provide consent. When the releasing provider and the treating provider disagree about the emergency nature of the patient's situation, they will also disagree about the need for patient