

RECORDS ACCESS BY PATIENTS

THE LAW

"1. **Access** to treatment records by a subject individual **during his or her treatment** may be **restricted** by the director of the treatment facility. However, **access may not be denied** at any time to records of all **medications** and **somatic [physical health] treatments** received by the individual.

2. The subject individual shall have a right, **following discharge** under s. 51.35(4), to a **complete record of all medications and somatic treatments** prescribed during admission or commitment and to a copy of the **discharge summary** which was prepared at the time of his or her discharge. A reasonable and uniform charge for reproduction may be assessed.

3. **In addition** to the information provided under subd. 2, the subject individual shall, **following discharge**, if the individual so requests, have **access** to and have the right to receive from the facility a photostatic **copy of any or all of his or her treatment records**. A reasonable and uniform charge for reproduction may be assessed. The director of the treatment facility or such person's designee and the treating physician have a right to be present during inspection of any treatment records. **Notice of inspection** of treatment records shall be provided to the director of the treatment facility and the treating physician **at least one full day**, excluding Saturdays, Sundays and legal holidays, **before inspection** of the records is made. Treatment records **may be modified** prior to inspection **to protect the confidentiality of other patients** or the names of any other persons referred to in the record who gave information subject to the condition that his or her identity remain confidential. **Entire documents may not be withheld** in order to protect such confidentiality.

4. **At the time of discharge** all individuals shall be **informed** by the director of the treatment facility or such person's designee **of their rights** as provided in this subsection."

§ 51.30(4)(d), Wis. Stats. [Emphasis added]

"PATIENT ACCESS TO TREATMENT RECORDS. (1) ACCESS DURING TREATMENT.

(a) Every patient shall have access to his or her treatment records **during treatment** to the extent authorized by s. 51.30(4)(d)1, Stats., and this subsection.

(b) The treatment facility director or designee may **only deny access** to treatment records **other** than records of **medication** and **somatic treatment**.

1. **Denial** may be made **only** if the director has **reason to believe** that the **benefits** of allowing access to the patient are **outweighed** by the **disadvantages** of allowing access.
2. The **reasons** for any restriction shall be **entered** into the treatment record.

(c) Each patient, patient's guardian and parent of a minor patient shall be **informed** of all **rights of access** upon **admission** or as soon as clinically feasible, as required under s. 51.61(1)(a), Stats., and upon discharge as required under s. 51.30(4)(d)(4), Stats. If a minor is receiving alcohol or other drug abuse services, the parents shall be informed that they have a right of access to the treatment records only with the minor's consent or in accordance with 42 CFR 2.15.

(d) The secretary of the department or designee, upon request of a director, may grant **variances** from the notice requirements under par. (c) for units or groups or patients who are unable to understand the meaning of words, printed materials or signs due to their mental condition but these variances shall not apply to any specific patient within the unit or group who is able to understand. Parents or guardians shall be notified of any variance."

DHS 92.05(1), Wis. Admin. Code. [Emphasis added.]

"ACCESS AFTER DISCHARGE FOR INSPECTION OF TREATMENT RECORDS. (a) After discharge from treatment, a patient shall be allowed access to inspect all of his or her treatment records with **one working day notice** to the treatment facility...

(b) A patient making a request to inspect his or her records shall **not be required** to **specify particular information.** Requests for "all information" or "all treatment records" shall be **acceptable.**

(c) When administrative **rules or accreditation standards** permit the treatment facility to take up to 15 days or some other specified period after discharge to complete the **discharge summary**, the discharge summary need not be provided until it is completed in accordance with those rules or standards."

DHS 92.05(2), Wis. Admin. Code. [Emphasis added.]

"COPIES OF TREATMENT RECORDS. (a) After being discharged a patient may request and shall be provided with a **copy of his or her treatment records** as authorized by s. 51.30(4)(d) Stats., and as specified in this subsection.

(b) **Requests** for information under this subsection shall be **processed within 5 working days** after receipt of the request.

(c) A **uniform and reasonable fee** may be charged for a copy of the records. The **fee may be reduced or waived**, as appropriate, for those clients who establish an inability to pay."

DHS 92.05(3), Wis. Admin. Code. [Emphasis added.]

"MODIFICATION OF TREATMENT RECORDS. (a) A patient's treatment records **may be modified** prior to inspection by the patient but only as authorized under s. 51.30 (4) (d) 3., Stats., and this subsection.

(b) Modification of a patient's treatment records prior to inspection by the patient shall be **as minimal as possible.**

1. Each patient shall have access to all information in the treatment record, including correspondence written to the treatment facility regarding the patient, except that these records **may be modified to protect confidentiality of other patients**.
2. The **names of the informants** providing the information **may be withheld** but the **information itself shall be available** to the patient.

(c) **Under no circumstances may an entire document or acknowledgement of the existence of the document be withheld** from the patient in order to protect confidentiality of other patients or informants.

(d) Any person who provides or seeks to provide information subject to a condition of confidentiality shall be told that the provided information will be made available to the patient although the identity of the informant will not be revealed.

(e) The identity of an informant providing information and to whom confidentiality has not been pledged shall be accessible to the patient as provided under this chapter.

DHS 92.05(4), Wis. Admin. Code. [Emphasis added.]

[NOTE: The federal Health Information Portability and Accountability Act of 1996 (**HIPAA**) went into effect April 14, 2003. That act contains provisions concerning record access that affect or may supercede state law. Those provisions are:]

"Except as otherwise provided in paragraph (a)(2) or (a)(3) of this section, an individual has a right of **access** to **inspect** and obtain a **copy** of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set, **except for**:

- (i) **Psychotherapy notes**; and
- (ii) **Information** compiled in reasonable **anticipation** of, or for use in, a **civil, criminal, or administrative action** or proceeding."

45 CFR Sec. 164.524(a)(1) [Emphasis added.]

"...A [service provider] **may deny** an individual **access** without providing the individual an opportunity for review, in the following circumstances.

- (i) The protected health information is excepted from the right of access by paragraph (a)(1) of this section.
- (ii) A [service provider] that is a **correctional institution** or a [service provider] acting under the direction of the correctional institution may deny, in whole or in part, an **inmate's** request to obtain a copy of protected health information, if obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for the transporting of the inmate.
- (iii) An individual's access to protected health information created or obtained by a covered health care provider in the course of **research** that includes treatment may be **temporarily suspended** for as long as the research is in progress, provided that

the individual has agreed to the denial of access when consenting to participate in the research that includes treatment, and the covered health care provider has informed the individual that the right of access will be reinstated upon completion of the research.

(iv) An individual's access to protected health information that is contained in records that are subject to the Privacy Act... may be **denied**, if the denial of access under the Privacy Act would meet the requirements of that law.

(v) An individual's access may be **denied** if the protected health information was **obtained from someone other** than a health care provider under a promise of **confidentiality** and the access requested would be reasonably **likely to reveal** the **source** of the information." 45 CFR Sec. 164.524(a)(2) [Emphasis added.]

DECISIONS

1. Subsection 51.30(4)(b)5 **allows access without consent** "...to qualified **staff members of the department**... as is necessary to determine progress and adequacy of treatment..." Thus **the State Grievance Examiner is allowed to obtain otherwise confidential records without the informed consent** of the complainant. (Level IV decision in Case No. 98-SGE-02 on 1/22/99.)
2. A discharged patient **asked** the hospital to **return his personal journal**. It should be returned to him since **it is his property**, whether or not the hospital considered it part of his treatment record. (Level III decision in Case No. 01-SGE-06 on 10/18/01.)
3. A parent filed a **complaint about a doctor giving the wrong pills to her minor children**. But she **refused to sign a consent** form allowing the Level I Client Rights Specialist (CRS) access to the children's treatment records. This limited the CRS to trying to resolve the matter informally. Although it was the parent's right to refuse access to the treatment records, it **prevented the CRS from conduct a complete, formal grievance investigation**. Given the lack of a formal grievance, **the appeal to Level III was denied**. (Level III decision in Case No. 02-SGE-01 on 5/2/02.)
4. Sec. 51.30(4)(e), Stats., requires that, **when records are released**, "a notation shall be made in the records by the custodian thereof that includes the following: the name of the person to whom the information is released; the identification of the information released; the purpose of the release; and the date of the release". **Handwritten notes in the margin** of records request documents, due to their brief nature, are **unlikely to satisfy** all the requirements of this statute. Subsequent to April 14, 2003, entities releasing records must also comply with the even more stringent federal Health Information Portability and Accountability Act (**HIPAA**). (Level IV decision in Case No. 02-SGE-04 on 9/19/03, overturning the Level III.)
5. A complainant was **denied access to the records of his joint meetings with his wife and her therapist**. There was no rights violation because **these were individual**

sessions with his wife in which he was invited to be present. If his wife wants access to those records, **she has the right request copies from the facility.** (Level IV decision in Case No. 02-SGE-07 on 3/10/04.)

6. A client wanted copies of all of her records, including the **private psychotherapy notes** that her therapist made during the course of her treatment. Those notes were not part of her **treatment record** as defined in § 51.30(1)(b), Wis. Stats., because they were **maintained for personal use** during the provision of therapy and they **were not shared** with others. (Level III Grievance Decision in Case No. 04-SGE-07, affirmed at Level IV on 8/15/05)
7. The **full panoply of patient rights did not attach to an independent outpatient evaluation.** However, the complainant still had rights in regard to access to the records generated by that evaluation. (Level IV decision in Case No. 06-SGE-09 on 9/27/06)
8. A patient who had been discharged from a Methadone clinic requested access to two federal forms from our department. The forms she request were **internal operations forms** between methadone treatment provider agencies and the **federal government.** Clients **do not have a right to either of those forms.** (Level III decision in Case No. 06-SGE-13 on 11/30/06)
9. A client requested copies of records the provider had **received from an outside source** that **led to the change in his diagnosis.** The Level III decision found a rights violation when the provider refused him access to those records. The provider's attorney **argued on appeal that the records were not "treatment records"** under the latest definition in the statutes. However, the purpose of DHS 92.05(4)(b) was to specifically include correspondence sent to the provider (such as information from "informants") in the set of records to which a patient could have access. It is written to allow patient access "to all information in the treatment record" (with some modifications to allow protection of any informants). It does not say "to treatment records" but instead refers to "all information" in the records, despite the source of origin. Whether or not this rule expands the statute on which it is based beyond acceptable legal limits or does not comport with the latest definition of "treatment records" is for the courts to decide, not the grievance process. It is concluded, however, that the information in question here fell within the intent of DHS 92.05(4)(b) and was therefore subject to the legal provisions for denying access. (Level IV decision in Case No. 08-SGE-07 on 6/23/10)
10. A client requested copies of records the provider had **received from an outside source** that led to the change in his diagnosis. The Level III decision found a rights violation when the provider refused him access to those records. The provider's attorney **argued on appeal that the provider had "good cause" not to disclose** that information to the client. That may well be true. However, **regardless of the cause, the denial should have been more specific**, such as identifying the section of the HIPAA rules that was relied on for the denial. **Just saying, "per HIPAA" was insufficient.** Also, if the denial was based upon clinical reasons, then there had to be some documentation weighing the advantages and the disadvantages of allowing

access. If there was such documentation, it was not made a part of this grievance record. There is no question that the provider acted in good faith here. The only question is whether the provider was in compliance with the process of denying access to the information in question. It was concluded that, **because of the lack of explanatory documentation, they were not in compliance** in this case. (Level IV decision in Case No. 08-SGE-07 on 6/23/10)

11. A client claimed that the **provider was not forthcoming in its release of information to her and her husband**. The patient signed a request for her treatment records. **The records department prepared the copies and sent a bill to the patient**. A second bill was sent 11 days later. **No payment was received and the request was cancelled by the corporate office** 25 days later. On the date that payment was received the treatment record was sent to the patient. **The grieving party did not claim that the length of time it took her to receive the records damaged her ability to file the grievance. The records were provided in a timely manner**. No violation of the client's right to timely provision of her records was found. (Level III decision in 13-SGE-0004 decided on 11/5/2013)
12. A patient's mother acted on her daughter's behalf and claimed that services received through the Treatment Alternative and Diversion program run by the County violated her daughter's patient rights. The grievant alleged that her daughter's right to access her records was violated when it took the provider a month after the discharge to provide the records. The records requested were positive lab results taken immediately prior to discharge. The provider claims that the patient requested the records several times and received them each time. Evidence showed that on at least one occasion the grievant requested records that were not yet in the grievant's record. **Failure to provide access to records that are not yet in a provider's possession is not a violation of a patient's right to access her records**. (Level IV decision in Case No. 16-SGE-0006 on 10/23/2017)
13. A patient grieved that she did not receive all of her treatment records. The **patient submitted six different requests to obtain her treatment records and the provider eventually provided the records. After realizing some of the records had been omitted, the provider sent additional pieces of the patient's treatment record**. Some of the records were also deleted, but the provider was unable to prove the claim that the deleted records were blank. The provider also failed to provide the records within 5 days of the request. It was determined that the grievant's right to access her treatment records was violated. (Level III Grievance Decision in Case No. 18-SGE-04)
14. A mother/guardian complained, on behalf of her adult son about a number of his rights having been violated at a day treatment service provider. It was concluded that the participant's right to **receive a copy of his complete treatment records** was not violated. While it was **impossible to determine whether all the records had been provided to the grieving party**, if the provider failed to give the grieving party all of the treatment records, it was not best practice, but doing so would not

rise to the level of a violation of the right to inspect and copy records when **no further clarifications or requests were made to the provider**. (Level III Grievance Decision, upheld at Level IV, in Case No. 19-SGE-02)

15. A patient requested to receive a copy of her service plan. It was determined in the **Level I-B decision that there was not enough evidence to suggest the patient received a copy. The Level I-B provided the document as part of the resolution**. The provider violated the patient's right to access her treatment record, however, any remedy that could be provided already was when the Program Administrator gave a copy to the patient. The issue was dismissed as resolved. (Level III Grievance Decision in Case No. 20-SGE-02)
16. A patient requested information as to who has accessed her record. The patient made the request in relation to her entire record, which would include both medical and behavioral health information. It is then **reasonable the Privacy Officer for the provider treated the request as a medical records request**, rather than as a treatment record request. The patient's right to access her treatment record was not violated. (Level III grievance decision in Case No. 20-SGE-07)
17. A patient requested copies of her grievance complaints. The Patient Experience Department denied this request as it is not within their policy to provide patients copies of complaints. It was determined this was a violation of the patient's right to access her treatment record, as **a grievance document is considered a treatment record under Wisconsin Statute 51.30**. (Level III grievance decision in Case No. 20-SGE-07)
18. A patient requested to restrict all employees at the provider from accessing her record. This request was denied, as employees are able to access the request on a need to know basis. There was **no evidence to suggest employees were wrongfully accessing the patient's treatment record**. Therefore, this denial was not a violation of her right to confidentiality of her treatment record. (Level III grievance decision in Case No. 20-SGE-07)
19. A patient complained that his **CCS provider denied his requests for information about the provider's financial and legal history, as well as the contract with the County for provision of CCS**. Patients are entitled to view and access information related to their treatment, per federal and Wisconsin law, however the information requested by the patient was outside the scope of what would be considered information to which he was entitled. There was no violation of his right to access information related to his treatment. (Level III decision in case 22-SGE-09)
20. A grievant alleged that their right to have access to their treatment record was violated when they **verbally requested to see their treatment record twice**. The grievant was made aware that they were going to be discharge from Comprehensive Community Services and disagreed with this decision. The treatment team informed the grievant that this was a planned discharge for several months and that internal conversations were documented by staff in the grievant's record. The grievant

requested to see those conversations and was not provided the record. There was **no evidence to suggest that the grievant verbally requested their treatment record and no evidence to suggest the grievant received or did not receive the treatment records.** The first documentation of the record request was in the Level IA Decision where a record request form was included for the grievant to request the records. This allegation is unable to be substantiated. (Level III Decision in 24-SGE-00955)

[See: "Introduction to Digest-Date Last Updated" page]