

# A Survey of Florida's Laws Regarding Medical Records

By Mark A. Dresnick, Esq.

Dresnick & Rodriguez, P.A.  
201 Alhambra Circle  
Suite 701  
Coral Gables, Florida  
(305) 461-1975

[www.dresnicklaw.com](http://www.dresnicklaw.com)

## Table of Contents

Florida’s Medical Record Owner’s Statute.....	1
Retention and Disposition of Medical Records for Deceased, Retired, and Relocating Medical Doctors .....	4
Hospital Medical Records: Statutory Exceptions to the Rule of Confidentiality ...	5
Department of Health Subpoenas and Inspection Requests .....	6
Civil and criminal subpoenas for hospital patient records require proper notice by the parties seeking such records to the patient or their legal representative. ....	7
Criminal Investigation Search Warrants for Medical Records.....	8
Department of Health Search Warrants.....	9
Subpoena for Identity of Patients .....	9
Fifth Amendment Objection Inapplicable to Production of Medical Records .....	9
It is a Misdemeanor to Fraudulently Alter, Deface, or Falsify Medical Records. ....	10
Access to Medical Records of Medicaid Recipients.....	11
Patient Entitlement to Obtain a Copy of their Own Medical Records .....	11
Authorized Charges for the Cost of Reproducing Medical Records. ....	11
Patient/Psychiatrist Privilege .....	12
Requirements for the Sufficiency of Medical Records Applicable to Medical Doctors Enforced by the Florida Board of Medicine .....	14
Florida Statutory provision regarding the detail of information required for written prescriptions for medicinal drugs .....	14
Some Provisions Pertaining to Medical Record Keeping Requirements Pertaining to Various Licensed Health Care Professionals .....	16
Nursing Home Medical Records .....	16

Hospice Records .....	16
Provisions Requiring Maintenance of Medical Records .....	17
Reports Concerning Diseases of Public Health Significance .....	17
HIV Testing Records .....	19
Baker Act Confidentiality Provisions .....	19
Access to Medical Records to Investigate Allegations of Abuse or Neglect of Children or Vulnerable Adults.....	20
Special Confidentiality Provisions for Medical Records Regarding Treatment for Substance Abuse.....	20
Documentation Requirements in Medical Records for Medical Care to Minors Without Parental Consent .....	21

I. Florida's Medical Record Owner's Statute, § 456.057

- A. This extensive and detailed statute provides numerous provisions pertaining to the confidentiality, disclosure, and administration of medical records.
  - 1. Its detailed provisions include some provisions similar to the provisions of HIPAA. Of course, HIPAA provisions preempt only those state privacy provisions that are less stringent than the HIPAA ones. 45 CFR § 160.203.
- B. Section 456.057 applies to both licensed health care providers and to employers of licensed health care providers such as a corporation's operating group practices and other non-licensed employers of health care practitioners.
- C. The statute does not apply to certain entities specified in § 456.057(2) and (3): including hospitals, ambulatory surgical centers, pharmacies, nursing home administrators, and specified allied health professionals.
- D. Violations of provisions of this patient records statute by a licensed health care professional are subject to discipline by their licensing board. § 456.057(14)
  - 1. A violation of the statute by a record owner not otherwise licensed by the state may be enforced through injunctive relief and fines of up to \$5,000 per violation. § 456.057(15)
- E. The statute includes a statutory obligation to provide medical records in a timely manner to a patient or a patient's legal representative. § 456.057(4)
  - 1. Mental health records are treated differently in that a mental health provider may provide a report of the examination and treatment in lieu of copies of the patient records. However, upon a patient's written request, a complete copy of psychiatric records must be provided directly to a subsequent treating psychiatrist.
- F. Confidentiality of patient records:
  - 1. This statute provides the statutory foundation for the confidentiality of patient records and information concerning the medical condition of a patient for health care providers which are not exempt from the applicability of the statute. The statute provides that (except as to workers compensation records which are treated differently), all medical records and any information concerning the medical condition of a patient may not be discussed with any person other than the patient or the patient's legal representatives or other health care practitioners and providers involved in the care or treatment of

the patient without written authorization of the patient unless certain statutory exemptions are met.

2. This provision was discussed in *Lemieux vs. Tandem Health Care of Florida, Inc.*, 862 So.2d 745 (Fla. 2d DCA 2003) by the court explaining the following:

Under the plain language of this statute, patient information is privileged and may not be disclosed unless the disclosure falls within one of the statutory exceptions. ...These exceptions allow for disclosure (1) to other health care providers involved in the care and treatment of the patient; (2) if permitted by written authorization from the patient; (3) if compelled by subpoena; and (4) to attorneys, experts, and other individuals necessary to defend the physician in a medical negligence action in which the physician is or expects to be a defendant. ... No other disclosures are statutorily permitted, and an order allowing for disclosure in any other context departs from the essential requirements of the law.

G. Definition of Legal Representative Entitled to Obtain Copies of Physician Records.

1. Rule 64B8-10.004 promulgated by the Board of Medicine defines legal representative as follows:

Legal representative is defined for the purpose of Section 456.057, Florida Statutes, as a patient's attorney who has been designated by the patient to receive copies of the patient's medical records; any legally recognized guardian of the patient; any court appointed representative of the patient; or any other person either designated by the patient or by a court of competent jurisdiction to receive copies of the patient's medical records.

H. Production by virtue of subpoenas in civil or criminal actions. § 456.057(5)(a)3

1. This provision requires proper notice to the patient or the patient's legal representative by the parties seeking such records.

I. Production of records pursuant to subpoenas issued by the Department of Health. See, discussion in section IV, *infra*.

J. Use of patient information for solicitation or marketing the sale of goods or services is prohibited without a specific written release or authorization from the patient. § 456.057(5)(b)

- K. The statute and case law provide that attorneys are not permitted to communicate ex parte with a plaintiff's treating physicians unless the health care provider reasonably expects to be named as a defendant in a medical negligence action. § 456.057(6), *Acosta v. Richter*, 671 So.2d 149 (Fla. 1996), *Lemieux v. Tandem Health Care of Florida, Inc.*, 862 So.2d 745 (Fla. 2d DCA 2003).
  
- L. Health care practitioners providing care and treatment of a patient are entitled to share information about the patient's medical condition. § 456.057(5)(a)
  - 1. However, once health care providers are no longer "involved in the care or treatment of the patient," they may not continue to discuss a patient's confidential medical records for their own or anyone else's purposes. *Lemieux vs. Tandem Health Care of Florida, Inc.*, 862 So.2d 745 (Fla. 2d DCA 2003) and *Knitel v. Beverly Health and Rehabilitative Services, Inc.*, 863 So.2d 1279 (Fla. 2d DCA 2004).
  
- M. Accounting for Disclosures:
  - 1. Medical records owners must maintain a record of all disclosures of information contained in a medical record to a third party and must include a record of the purpose for the disclosure.
    - a. The third party is also prohibited from further disclosing any information in the medical record without the express written consent of the patient or the patient's legal representative. § 456.057(10)
  
- N. Special provisions for physicians and other health care providers employed by group practices and other businesses:
  - 1. The treating physician is considered the medical record owner unless an employment contract or agreement between the employer and the health care practitioner designates the employer as the records owner. § 456.057(1)
    - a. Record owners have a duty to provide employed physicians with access to medical records after employment:
      - (1) The medical records owner statute specifically provides that an employee of the records owner that previously provided treatment to a patient may have access to those records generated by the health care practitioner requesting the record. § 456.057(18)
        - (a) Records must be released to an employee or former employee who provided treatment to a patient. However, the records released pursuant to this subsection must be limited to the notes, plans of care, and orders and summaries that

were actually generated by the health care practitioner requesting the record.

II. Retention and Disposition of Medical Records for Deceased, Retired, and Relocating Medical Doctors

A. Section 456.057 provides for provisions in addition to the provisions contained within § 456.058 and in the Florida Administrative Code for various licensed professionals requiring notification to patients in writing or the placement of advertisement in local newspapers when practices are terminated or relocated. § 456.057(11)

1. Licensed health care providers must also notify their appropriate licensing board identifying the new records owner and where the medical records can be found. § 456.057(12)

a. Whenever a records owner has turned over medical records to a new records owner, the new records owner shall be responsible for providing a copy of the complete medical record upon written request of the patient or the patient's legal representative. § 456.057(13)

B. Medical records of deceased M.D.'s. Rule 64B8-10.001, Florida Administrative Code

1. The personal representative or survivor of a deceased physician licensed under Chapter 458 shall retain medical records upon the death of a physician for at least two years from the date of death.

a. Within one month from the date of death, the personal representative or survivor shall publish a notice indicating that the deceased physician's medical records are available to patients or their representatives from a specific person at a certain location. A copy of this notice shall also be submitted to the Board of Medicine within one month from the date of death of the physician.

b. Twenty-two months after the death of the physician or thereafter, the personal representative or survivor shall cause to be published for four consecutive weeks a notice indicating to patients of the deceased physician that the medical records will be disposed of or destroyed one month or later than the last day of the fourth week of publication of the notice.

C. Medical records of M.D.'s relocating or terminating practice. Rule 64B8-10.002, Florida Administrative Code

1. This rule provides physicians must keep adequate medical records for a period of at least five years from the last patient contact.

- a. The rule also states this is a minimum requirement and physicians may be required to keep medical records for longer if required by community standards.
  - b. This rule states that physicians have the legal obligation to maintain the full and total responsibility and control of all files and records relating to patients and that such files must remain confidential except as otherwise provided by law and maintained in the physician's office or in possession of the physician.
2. When a physician terminates practice or relocates, the physician must publish a notice for four weeks in the newspaper advising of certain information including an address at which the records may be obtained.
    - a. A copy of this notice must be submitted to the Board of Medicine within one month from the date of termination, sale, or relocation of practice.

III. Hospital Medical Records: Statutory Exceptions Contained in § 395.3025 to the Rule of Confidentiality Include the Following:

- A. Licensed facility personnel and attending physicians for use in connection with the treatment of the patient;
  1. Licensed facility personnel only for administrative purposes or risk management and quality assurance functions;
  2. AHCA, for purposes of health care cost containment;
  3. In any civil or criminal action, unless otherwise prohibited by law, upon issuance of a subpoena and proper notice by the parties seeking such record to the patient or his legal representative;
  4. To the Department of Health pursuant to an administrative investigative subpoena;
  5. To the Department of Children and Family Services for the purpose of investigations of abuse, neglect, or exploitation of children or vulnerable adults;
  6. To the State Long Term Care Ombudsman Council, with respect to records of patients admitted from a nursing home or long-term care facility. However, disclosure under this section may only be made after a competent patient or the patient's representative has been advised that the disclosure may be made and the patient has not objected; and
  7. To the Medicaid Fraud Control Unit.
  8. Patient information from hospital records may not be used for solicitation or marketing purposes without a specific written release or authorization. § 395.3025(7)(b).

#### IV. Department of Health Subpoenas and Inspection Requests

- A. Section 456.071, Florida Statutes, is the general statutory authority for the issuance of investigative subpoenas by the Department of Health.
1. This provision provides that subpoenas shall be supported by affidavit and may compel the attendance of witnesses and the production of books, papers, documents and other evidence.
    - a. Challenges to the enforcement of subpoenas issued under this section are handled as provided in § 120.569, Florida Statutes.
    - b. The provisions in this statute should be compared with the provisions in § 456.057 which specifically provide that Department subpoenas for patient records from physician offices issued by the Department require a finding of reasonable cause by the Department and the Probable Cause Panel of the appropriate licensing board. See § 456.057(7).
- B. The provisions of § 395.3025(4)(e) authorize the disclosure of hospital records without consent of the patient in response to an administrative subpoena for the purpose of a license disciplinary investigation.
1. The records produced must be maintained as confidential by the Department of Health and used solely for the purpose of the Agency and appropriate professional boards in their investigation, prosecution and appeal of disciplinary proceedings.
- C. Section 456.057(7) provides that the Department of Health may obtain patient records from a physician's office pursuant to a subpoena without the written authorization from the patient if the Department and the Probable Cause Panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner:
1. Excessively or inappropriately prescribed any controlled substances;
  2. Practiced his or her profession below the standard of care;
  3. Provided inadequate medical care based on termination of insurance;
  4. Has engaged in billing fraud, solicited patients fraudulently, received a kickback, or violated the patient brokering statutes.
- D. The provisions of § 456.057 state the Department is required to make a finding that appropriate reasonable attempts were made to obtain a patient release, or the patient was a participant in a fraud or scheme, before obtaining an administrative subpoena for medical records.
1. A 2003 amendment to the statute provides that when the Department investigates a professional liability claim, the Department may obtain patient records pursuant to a subpoena without written authorization if the patient refuses to cooperate or if the Department

attempts to obtain a patient release and the failure to obtain the patient records would be detrimental to the investigation.

E. These provisions provide a procedure for the Department of Health to subpoena physician patient records. State agencies are not entitled to review medical records through inspection of a physician's practice or clinic unless they are authorized by some other law to inspect the records. *See, e.g., Florida Department of Health and Rehabilitative Services v. VMR, Inc.*, 591 So.2d 944 (Fla. 3d DCA 1991), which held that although HRS licensed abortion clinics, it lacked the statutory authority to inspect patient records which were confidential by statute.

F. Enforcement of Department of Health Subpoenas Against Physicians

1. The court held in *Carrow v. Department of Professional Regulation*, 453 So.2d 842 (Fla. 1<sup>st</sup> DCA 1984), that when a physician raises justiciable issues concerning the validity of a questioned subpoena duces tecum, the Department may not charge the physician by Administrative Complaint with failure to comply with the subpoena until it has first sought enforcement of the subpoena in circuit court under § 120.58(3), Florida Statutes.

2. Department of Health's inspection authority, § 456.069, Florida Statutes.

a. This statute provides that agents of the Department of Health have the power to inspect in a lawful manner at all reasonable hours any pharmacy or any establishment at which the services of a licensee authorized to prescribe controlled substances are offered.

b. The inspection shall be the purpose of determining if any of the provisions of the statutes regulating the practice of a profession are being violated, or for the purpose of securing such evidence as may be needed for prosecution.

V. Civil and criminal subpoenas for hospital patient records require proper notice by the parties seeking such records to the patient or his or her legal representative. § 395.3025(4)(d)

A. This provision of Florida law which permits disclosure pursuant to court order only after reasonable notice to non-party patients was found to be more stringent than the provisions of HIPAA which authorize the disclosure of records in a court proceeding without prior notice to a patient if the disclosure occurs pursuant to a protective order issued by the court. *United States ex rel. Pogue v. Diabetes Treatment Centers of America*, 2004 US Dist. Lexis 21830 (DC. 2004). *See*, 45 CFR §§ 164.102-164.534 which discuss the disclosure of patient records in a court proceeding

without prior notice to a patient if the disclosure occurs pursuant to a protective order issued by the court.

- B. A criminal conviction has been reversed when police obtained hospital records of a criminal defendant without the issuance of a subpoena and proper notice to the patient in the absence of a search warrant.
- C. The court held the police officer illegally violated the statutory procedure in obtaining the medical records, and suppression of the medical records as evidence in the case would serve the exclusionary rule's historic purpose by encouraging police officers to become familiar with the proper legal procedures before impulsively seizing private patient records. *Sneed v. State*, 876 So.2d 1235 (3d DCA 2004).
- D. Patient medical records enjoy a confidential status by virtue of the right to privacy contained in the Florida Constitution and any attempt on the part of the government to obtain such records must first meet constitutional muster. *State v. Johnson*, 814 So.2d 390 (Fla. 2002).
  - 1. Section 395.3025 recognizes the "confidential nature of medical records and provides that before the medical records can be made available in any civil or criminal action, the patient must be put on notice and a subpoena must issue from a court of competent jurisdiction. The obvious purpose behind the notification requirement is to permit the patient to assert any legal objection he or she may have to the subpoena before the records are produced."

## VI. Criminal Investigation Search Warrants for Medical Records

- A. The recently publicized case of *Rush Limbaugh v. State of Florida*, 887 So.2d 387 (Fla. 4<sup>th</sup> DCA 2004), held that the right of state criminal investigators to obtain property relevant to the commission of a crime permitted the State to obtain medical records unilaterally and without notice to the patient by means of a search warrant supported by probable cause.
- B. The court held the constitutional right of privacy in medical records is not implicated by the state's seizure and review of medical records under a valid search warrant without prior notice.
  - 1. The provisions of § 456.057 would require notice to the patient in the event the records were obtained by means of a criminal investigatory subpoena. However, this notice requirement is not applicable when the records are obtained by means of a search warrant.

- C. This issue in the *Limbaugh* case was recently certified on November 17, 2004 to the Florida Supreme Court, as a matter of great public importance:

“Do §§ 395.3025(4) and 456.057(5)(a) bar the state from obtaining a search warrant to seize and inspect a patient’s medical records without providing the patient notice in a prior hearing to oppose the seizure and inspection?”

*Rush Limbaugh v. State* (Fla. 4<sup>th</sup> DCA, Case No. 4D03-4973, Opinion Filed November 17, 2004)

VII. Department of Health Search Warrants. § 458.341, Florida Statutes

- A. This provision provides that the Department of Health may secure a search warrant from a judge for investigations regarding improper prescribing of medicinal drugs or controlled substances.
- B. This statute specifically states that the evidence to be secured shall not include any medical records of patients unless pursuant to the patient’s written consent.
1. The search warrant in the *Limbaugh* case was issued by the State Attorney, not by the Department of Health.

VIII. Subpoena for Identity of Patients

- A. The provisions of § 458.343 specifically authorize the Department of Health to issue a subpoena duces tecum requiring the names and addresses of some or all of the patients of a physician against whom a complaint has been filed to be produced.

IX. Fifth Amendment Objection Inapplicable to Production of Medical Records

- A. Although licensed professionals have a Fifth Amendment right to remain silent in license disciplinary proceedings, the Fifth Amendment right does not extend to medical records required to be maintained by Florida law. *See, e.g., Shepard v. State Board of Dentistry*, 369 So.2d 629 (Fla. 1<sup>st</sup> DCA 1979), *Nach v. Department of Professional Regulation*, 528 So.2d 908 (Fla. 2d DCA 1988).

X. It is a Misdemeanor to Fraudulently Alter, Deface, or Falsify Medical Records. § 395.302

- A. A conviction is also grounds for restriction, suspension, or termination of licensed privileges.

XI. Access to Medical Records of Medicaid Recipients

- A. Each Medicaid Recipient Consents to Release of Their Medical Records to the Medicaid Program
1. As a condition of Medicaid eligibility, AHCA and the Department of Children and Family Services shall insure that each recipient of Medicaid consents to the release of his or her medical records to AHCA and the Medicaid Fraud Control Unit of the Department of Legal Affairs.
  2. Inspection of Medicaid provider medical records. § 409.913(9), Florida Statutes
    - a. Medical records must be provided for inspection by representatives of Medicaid during normal business hours. However, 24 hour notice must be provided if patient treatment would be disrupted.
      - (1) Medicaid records of Medicaid recipients must be retained for a period of five years after the date of furnishing services.
      - (2) Medicaid providers are responsible for keeping the Agency informed of the location of the provider's Medicaid related records.
- B. The Fourth DCA held that a criminal investigation concerning Medicaid fraud permits the statewide prosecutor to obtain by search warrant or subpoena medical records, including HIV testing records, of Medicaid recipients without a hearing or prior court order. *Community Health Centerone, Inc. v. State of Florida*, 852 So.2d 322 (Fla. 4<sup>th</sup> DCA 2003), superseding *Butterworth v. X Hospital*, 763 So.2d 467 (Fla. 4<sup>th</sup> DCA 2000), (because the Medicaid fraud investigation statute was expanded since the holding in the *Butterworth* case).
1. Statutory changes in 2000 to § 409.920(9)(b) permit Medicaid fraud investigators to subpoena materials, including medical records, pertaining to Medicaid recipients to collect evidence for possible use in either civil or criminal judicial proceedings; § 409.920(9)(a) provides that physicians participating in the Medicaid program must make available any accounts or records that may in any manner be relevant in determining the existence of fraud in the Medicaid program, alleged abuse or neglect to patients, or alleged misappropriation of patient's private funds.
    - a. However, the accounts or records of non-Medicaid patients may not be reviewed by or turned over to the Attorney General without the patient's written consent.

- b. The provisions of § 409.920(8)(f) provide that Medicaid fraud investigators must safeguard the privacy rights of all individuals and prevent the use of patient medical records for any reason beyond the scope of the investigation without the patient's written consent.
- c. Clinical records of psychiatric patients who are Medicaid recipients must also be furnished to the Medicaid fraud control unit upon request. § 394.4615(6). This statutory provision was added in 2000 and is another reason the holding in *Butterworth v. X Hospital, supra* has been superseded.
- d. The general statute providing for confidentiality of hospital records was also amended in 2000 to provide that hospital records may be disclosed to the Medicaid fraud control unit without the necessity of patient consent. § 395.3025(4)(k)
- e. Medicaid provider agreements also require Medicaid providers to permit the federal and state government and their agents to have access to all Medicaid related information including patient records. § 409.907

XII. A Patient is Entitled to Obtain a Copy of their Own Medical Records:

- A. The Florida Supreme Court recognized the statutory right of the person to obtain a copy of their own medical records to be so substantial that an adult was found to have the right to obtain copies of his birth records even though the records may disclose the identity of a mother that did not want to be in touch with her son. *Atwell v. Sacred Heart Hospital Pensacola*, 520 So.2d 30 (Fla. 1988)

XIII. Cost of Reproducing Medical Records. Rule 64B8-10.003, Florida Administrative Code

- A. Physicians licensed pursuant to Chapter 458 shall not charge more than \$1.00 per page for the first 25 pages and \$0.25 per page thereafter.
  - 1. Reasonable costs for reproducing x-rays and other types of special records shall be at actual cost.

XIV. Patient/Psychiatrist Privilege. § 456.059

- A. This statute provides communication between a patient and a psychiatrist are confidential and shall not be disclosed except upon request of the patient or the patient legal representative.

- B. Psychiatric information may be disclosed when a patient has made an actual threat to physically harm an identifiable victim or victims while a patient is engaged in a treatment relationship with the psychiatrist, and the treating psychiatrist makes a clinical judgment that the patient has the apparent capability to commit such an act and it is more likely than not that in the near future the patient will carry out that threat.
- C. The psychiatrist is permitted to disclose patient communications to the extent necessary to warn any potential victim or to communicate the treat to law enforcement.

XV. Statutory Requirements for the Sufficiency of Medical Records Applicable to Medical Doctors Enforced by the Florida Board of Medicine:

- A. (1) The following acts constitute grounds for denial of a license or disciplinary action, ....:

...

(m) Failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

- B. M.D.'s are required to produce itemized bills for services rendered to patients, insurer's, or health care programs responsible for paying the bill upon request. § 458.323, Florida Statutes
- C. In *Breeseaman v. Department of Professional Regulation*, 567 So.2d 469 (Fla. 1<sup>st</sup> DCA 1990), the Board of Medicine suspended the license of a cardiologist for six months for failing to keep medical records justifying his treatment of a patient. The patient had told him that she wanted no treatment and instructed him not to write her request in the hospital chart. The First District Court of Appeal reversed the Board's decision and dismissed the case holding the statutory requirement in effect at that time requiring a physician to keep medical records justifying the course of treatment of the patient, could not be interpreted as authorizing disciplinary action for a physician's failure to document in a patient's chart a basis for not undertaking a particular course of treatment.
  - 1. In response to the *Breeseaman* decision, the Board of Medicine subsequently issued a rule directing physicians to keep written

records “with sufficient detail to clearly demonstrate why the course of treatment was undertaken or why an apparently indicated course of treatment was not taken.” Rule 64B8-9.003(2), Florida Administrative Code.

a. In the recent case of *Colbert v. Department of Health*, (Fla. 1<sup>st</sup> DCA 2004), the Board again unsuccessfully attempted to discipline a physician for failing to document why he did not undertake an indicated course of treatment.

D. The Florida Board of Medicine has promulgated an extensive rule regarding standards for adequacy of medical records. Rule 64B8-9.003, Florida Administrative Code

E. Pertinent portions of this Rule include the following provisions:

(2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken or why an apparently indicated course of treatment was not undertaken.

(3) The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

(4) All entries made into the medical records shall be accurately dated and timed. Late entries are permitted, but must be clearly and accurately noted as late entries and dated and timed accurately when they are entered into the record. However, office records do not need to be timed, just dated.

F. Sufficiency of Medical Records

1. *Robertson v. Department of Professional Regulation*, 574 So.2d 153 (Fla. 1<sup>st</sup> DCA 1990), upheld an administrative law judge’s findings that the need for a minimum amount of information to conform with community medical standards was the amount so that “neutral third parties can observe what transpired during the course of treatment of a patient.”

- XVI. Florida Statutes contain a provision regarding the detail of information required for written prescriptions for medicinal drugs in § 456.42 which provides as follows:

Written prescriptions for medicinal drugs.--A written prescription for a medicinal drug issued by a health care practitioner licensed by law to prescribe such drug must be legibly printed or typed so as to be capable of being understood by the pharmacist filling the prescription; must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed in both textual and numerical formats, and the directions for use of the drug; must be dated with the month written out in textual letters; and must be signed by the prescribing practitioner on the day when issued.

- XVII. Some Provisions Pertaining to Medical Record Keeping Requirements Pertaining to Various Types of Licensed Health Care Professionals:

A. Osteopathic physicians

1. The Osteopathic medical practice act provides it is a second-degree misdemeanor to fraudulently, deface, or falsify any records relating to patient care. § 459.013(3)a
2. The Osteopathic Board also specifically provides that fraudulently altering or destroying records relating to patient care or treatment is a disciplinary violation. § 459.015(1)(p)
3. The Osteopathic practice act also provides by statutes that osteopaths must keep legible medical records that identify the licensed osteopathic physician, or the physician extender, and supervising osteopathic physician by name and professional title, and the records must justify the course of treatment of the patient. § 459.015(1)(o)

B. Dentists

1. The Dental Practice Act contains a specific and detailed provision requiring there to be a dentist of record and discussing his or her responsibility for dental records. § 466.018
2. The dentist of record must be identified in the record of the patient, and is subject to certain responsibilities pertaining to the patient's care when the care is provided by a dental hygienist or assistant.
3. Every dentist shall maintain written dental records that justify the course of treatment of the patient. §§ 466.018 and 466.028(1)(m), Florida Statutes
4. Dental records must be maintained for a period of four years from the date of the patient's last appointment. § 466.018(5)

5. Failing to make available to a patient or client or their legal representative, or to the Department of Health, if authorized in writing by the patient, is a disciplinary violation. § 466.028(1)(n)
- C. Chiropractors
1. See § 460.413(1)(m) for chiropractic medical record requirements and § 460.41 regarding requirements for itemized patient billing.
- D. Podiatrists
1. See § 461.013(1)(l) for requirements to keep written medical records justifying the course of treatment and § 461.009 regarding requirements to provide an itemized bill for services rendered.
- E. Naturopathy
1. See § 462.14(1)(n) regarding medical record keeping requirements.
- F. Optometry
1. Optometrists must keep on file for a period of at least two years any prescription they have written; and must make available to a patient or his agent copies of spectacle and contact lens prescriptions. § 463.012, Florida Statutes
- G. Psychologists
1. Section 490.0147 discusses the confidentiality and privileged nature of communications between psychologists and their patients or clients.
  2. Failing to maintain the privileged nature of communications of a patient is a disciplinary violation. See, e.g., § 490.009(1)(u)
  3. Patients of a psychologist have a right to obtain upon written request copies of test results, reports, or documents in the possession or under control of a psychologist which have been prepared for and paid for by the patient or client. § 490.009(1)(n)
  4. The Florida Board of Psychology has promulgated detailed regulations regarding standards for psychological records, maintenance and retention of the records, releasing the records, and concerning the scope of confidentiality concerning psychological records. These rules are located at Chapter 64B19-19, Florida Administrative Code and a full discussion of these regulations is beyond the scope of this outline.
- H. Clinical social work, marriage and family therapy, and mental health counseling records
1. Similar to records of psychologists, the provisions of § 491.0147 provide for the confidential and privileged nature of records

concerning marriage and family therapists and mental health counselors, and rules of the board discuss specific requirements for records at Chapter 64B4-9, Florida Administrative Code.

2. Disciplinary provisions relating to the failure to make patients records available are located at § 491.009(1)(n), Florida Statutes.

XVIII. Nursing Home Medical Records:

- A. Nursing homes must maintain records which clearly identify the resident, his diagnosis and treatment, and results. The medical records must be complete, accurate, accessible and systematically organized. Rule 59A-4.118, Florida Administrative Code
  1. The medical records must be retained for a period of five years from the date of discharge and, in the case of minors, must be retained for three years after the resident reaches legal age.
  2. Nursing homes are required to designate a full time employee as being responsible and accountable for the facility's medical records, and the person responsible for the medical records must have specified training in the field of medical records keeping.
- B. Nursing homes are required to provide complete copies of resident's records to comply with the facility's good faith discovery requirements when claims are presented. § 400.0234, Florida Statutes
- C. Fraudulently altering, defacing or falsifying a nursing home's medical record or the release of medical records for the purpose of solicitation or marketing without proper authorization constitutes a second-degree misdemeanor. § 400.1415, Florida Statutes

XIX. Hospice Records § 400.611, Florida Statutes

- A. Interdisciplinary records of care being given to the patient and family statutes shall be kept. The records shall contain past and current medical, nursing, social and other therapeutic information.
  1. Records shall be retained for five years after termination of hospice services and, in the case of a minor, the five-year period shall begin on the date the patient would have reached the age majority.
  2. Hospice records are confidential, and a hospice may not release a record or any portion without patient or legal guardian consent, pursuant to an order of the court, or to the extent a state or federal agency acting under statutory authority requires submission of aggregate statistical data.

XX. Miscellaneous Provisions Requiring Maintenance of Medical Records:

- A. Abortion clinics are required to maintain clinical records. Rule 59A-9.031, Florida Administrative Code
- B. Licensed birth centers are required to maintain clinical records. § 383.32, Florida Statutes
- C. HMO's are required to maintain a medical records system, including clinical information concerning patients. Rule 59A-12.005, Florida Administrative Code
- D. Home health agencies are required to maintain clinical records, and they must be maintained for five years following termination of services. § 400.491, Florida Statutes, see also Rule 59A-8.022, Florida Administrative Code
  - 1. Clients who receive non-skilled care must be maintained by the home health agency for one year following termination of services.
  - 2. A plan of care must be established in consultation with a physician and included in the clinical record. Rule 59A-8.0215, Florida Administrative Code

XXI. Reports Concerning Diseases of Public Health Significance § 381.0031, Florida Statutes

- A. This statute requires physicians, hospitals, and laboratories to report diseases of "public health significance" to the Department of Health. The Department will periodically issue a list of infectious or non-infectious diseases determined to be a threat to the public health subject to the statute.
- B. Reports required by this section are confidential and may be used only when necessary for the public health.
  - 1. A report submitted to the Department pursuant to this statute is not a violation of the confidential relationship between a practitioner and patient, and no health care practitioner may be held liable in any manner for damages and is not subject to criminal penalties for providing patient records to the Department as authorized by this statute.
  - 2. The statute gives the Department the authority to obtain and inspect copies of medical reports, records of laboratory tests, and other medical related information for reporting cases of diseases of public health significance, but the Department may examine the records only for this purpose.

- a. The statute provides that health care practitioners and licensed facilities shall allow the Department to inspect and obtain copies of such records and medical related information notwithstanding any other law to the contrary.
- b. The list of notifiable diseases or conditions is contained in Rule 64D-3.002, Florida Administrative Code. There is a long list of diseases and conditions beginning with AIDS, certain animal bites, anthrax, botulism, HIV, going all the way through yellow fever. There are 84 different disease categories listed.
  - (1) Also, any disease outbreak in a community, a hospital, any other institution, or food borne or water borne outbreak is to be reported as is any grouping or clustering of patients having similar disease, symptoms, or syndromes that may indicate the presence of a disease outbreak including those of biological agents associated with terrorism.
  - (2) Each hospital and ambulatory surgical facility and each freestanding radiation therapy center is required to report to the Department of Health each diagnosis of cancer along with the stage of the disease, and other specified information. (This does not include non-melanoma skin cancer.) § 385.202, Florida Statutes and Rules 64D-3.002 and 64D-3.006, Florida Administrative Code
- 3. Reporting of sexually transmittable diseases. Rule 64D-3.016, Florida Administrative Code
  - a. This rule discusses requirements to report eleven different categories of sexually transmitted diseases.
- 4. Partner notification. Rule 64D-3.018, Florida Administrative Code
  - a. The Department and its authorized representative, when deemed necessary to protect public health, shall interview, or cause to be interviewed all persons infected or suspected of being infected with a sexually transmittable disease.
- 5. Penalties for failing to report. Rule 64D-3.0120, Florida Administrative Code
  - a. Up to \$500 for each offense
- 6. Congenital anomalies as defined by the Department of Health shall be reported by each licensed hospital or licensed practitioner.

XXII. HIV Testing. § 381.004, Florida Statutes

- A. This statute provides extensive and specific requirements concerning confidentiality pertaining to HIV testing, exceptions to the confidentiality, detailed procedures pertaining to informed consent prior to performing the test, procedures relating to informing the patient of test results, procedures to be followed when a health care worker is accidentally exposed to blood from a patient that may result in an HIV infection, and many other detailed provisions concerning HIV testing. A discussion of the full scope and details of this statute are beyond the scope of this outline.
  - 1. It should be noted that a violation of the strict confidentiality provisions of the HIV testing statute is a criminal offense. § 381.004(6)(b), (c)
    - a. A violation of the statute by a licensed facility or a licensed health care provider is also a basis for disciplinary action against the provider's license.

XXIII. Baker Act Confidentiality Provisions. § 394.4615, Florida Statutes

- A. This statute provides that a clinical record must be maintained for each patient.
  - 1. The clinical record is confidential unless waived by express and informed consent by the patient or the patient's guardian or guardian advocate, or if the patient is deceased, by the patient's personal representative or the family member who stands next in line of succession. The confidential status of the record shall not be lost by either authorized or unauthorized disclosure.
  - 2. The clinical record shall be released when:
    - a. The patient or patient's guardian authorizes the release, and the guardian or guardian advocate shall be provided access to clinical records.
  - 3. When a Baker Act patient is represented by counsel, his or her counsel is entitled to access to the records when they are needed for adequate representation.
  - 4. A court may authorize release when there is good cause for the disclosure.
  - 5. Records may be disclosed to the Department of Corrections if a patient is committed to the Department of Corrections.
  - 6. Information from the clinical record may be released when the patient has declared an intention to harm other persons to provide adequate warning to the person threatened with harm.
  - 7. Records may be released to assist with the placement of the patient for the preparation of treatment plan.

8. The statute permits information from clinical records to be used by AHCA, DCF, or the Florida Advocacy Council for the purpose of monitoring facility activity and complaints.
9. Clinical records pertaining to Medicaid recipients may be furnished to the Medicaid fraud control unit upon request.
10. The statute provides that parents and next of kin are entitled to information from the records in accordance with ethical requirements of mental health professionals.
11. Patients are entitled to reasonable access to their clinical records unless it is determined that access would be harmful to the patient and written notice of this restriction is placed in the record.
12. Fraudulently altering, defacing or falsifying a Baker Act clinical record is a misdemeanor of the second degree. § 395.4615(11)

XXIV. Access to Medical Records to Investigate Allegations of Abuse or Neglect of Children or Vulnerable Adults

- A. The Department of Children and Family Services is entitled to access to hospital records for the purpose of investigations in cases of abuse, neglect, or exploitation of children or vulnerable adults. § 395.3025(4)(g)
- B. In cases of known or suspected abuse, abandonment, or neglect of children or vulnerable adults, the privileged nature of communications between health care providers and patients is considered abrogated and does not constitute any grounds for the failure of the health care provider to fail to report suspected abuse or neglect or to fail to cooperate with law enforcement and government regulators in conjunction with abuse and neglect investigations. *See* § 39.204 (child abuse) and § 415.1045 (abuse of neglect of vulnerable adults).

XXV. Special Confidentiality Provisions for Medical Records Regarding Treatment for Substance Abuse. § 397.501(7), Florida Statutes

- A. This statutory provision provides that patient records which pertain to the identity, diagnosis and prognosis by substance abuse treatment service providers to any individual client are confidential pursuant to this statute and also pursuant to applicable federal laws and regulations pertaining to the confidentiality of substance abuse treatment records.
  1. The confidentiality includes the obligation not to affirmatively reveal that an identified individual has been or is being diagnosed or treated for substance abuse. § 397.501(7)(d)
  2. Disclosure of this information without consent of the patient is subject to significant restrictions and limited exceptions.

- a. Disclosure may be made upon a court order. However, the court must determine that there is good cause for disclosure and the need for disclosure outweighs the potential injury to the client, to the service provider-client relationship, and to the service provider itself. [The patient and the person holding the records from whom disclosure is sought must be given adequate notice of a court proceeding in a manner that will not disclose patient identifying information to other persons.]
  - b. Court hearings are to occur in chambers unless the client consents to an open hearing, and an application for an authorizing court order must use a fictitious name such as “John Doe.”
3. A complete explanation of the applicability, procedures, and exemptions regarding the confidentiality of substance abuse treatment records is beyond the scope of this outline, and persons requiring more detailed information should review § 397.501 and also review the federal laws and regulations relating to the confidentiality of substance abuse treatment records contained within the Drug Abuse Prevention, Treatment, and Rehabilitation Act, 42 USC §§ 290ee-3 and 42 CFR § 2.1 et seq.

- B. AHCA has access to clinical records of any client of a licensee or designated facility providing substance abuse or mental health services under the Community Substance Abuse and Mental Health Services Act. § 394.90, Florida Statutes.

#### XXVI. Documentation Required in Medical Records for Medical Care to Minors Without Parental Consent

- A. When emergency medical care is required to a minor and parents are not available to provide consent, § 743.064, Florida Statutes, permits health care providers to provide emergency medical care.
  1. Notification to the parents must be accomplished as soon as possible after the emergency medical care and treatment is administered, and the hospital records must reflect the reason such consent was not initially obtained and shall contain a statement by the attending physician that immediate emergency medical care and treatment was necessary for the patient’s health or physical well being.
    - a. These hospital records shall be open for inspection by the person legally responsible for the minor.
- B. Section 743.0645 provides a listing of persons who may consent for medical care or treatment of a minor when parents are not available.

1. These persons include in descending order individuals possessing a power of attorney, stepparents, grandparents, adult brothers and sisters of minors, and adult aunts or uncles.
2. Section 743.0645 provides that the treatment provider must maintain in their record documentation that a reasonable attempt was made to contact the person who has the power to consent. The medical records shall also include documentation that the medical provider notified the parent or the person who has the power to consent as soon as possible after the medical care or treatment is administered, the medical records must reflect the reason consent as otherwise authorized by law was not initial obtained, and shall be open for inspection by the parent or other person who has the power to consent.