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Navigating a New (and Confusing) Law for Access to Mental Health Records

BY MATTHEW R. DAVISON

Of all the new laws that went into effect on January 1, 2024, one in particular continues to cause confusion and concern regarding access to records of mental health recipients. Specifically, Public Act 103-0474, in part, amended the Mental Health and Developmental Disabilities Confidentiality Act by establishing a new category of persons entitled (upon request) to inspect and copy a recipient's record or any part of the same.[1] The law now recognizes requests for access to records by "the personal representative under HIPAA, 45 CFR 164.502(g), of a recipient, regardless of the age of the recipient."[2]

For context, access to certain records, such as those of a recipient between the

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Legislature Revises the Mental Health and Developmental Disabilities Confidentiality Act

BY JOSEPH T. MONAHAN

Beginning January 1, 2024, an amendment to section 4 of the Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 110/ *et seq.*, came into effect regarding persons entitled to inspect and copy a recipient's record.

P.A. 103-474 (S.B. 188) adds a new category of persons entitled to access another individual recipient's mental health information: "the personal representative under HIPAA, 45 CFR 164.502(g), of a recipient, regardless of the age of the recipient."

This legislative change may impact the confidentiality and disclosure/non-

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ages of 12 and 17, have historically been afforded strict processes and protections, particularly when a recipient objects or when a therapist determines there are compelling reasons for a denial of access.[3] However, this new law, ushered in by certain advocates, injects a broad new provision that carries implications for a wide variety of mental health recipients, especially those between the ages of 12 and 17 who have historically been assured they have some autonomy over their records.[4] Indeed, the amendment upends some of these well-established frameworks and presents just as many questions as answers. The provision has already prompted several considerations for practitioners, which are set forth below. The ongoing issues from this new law are not merely academic, but will likely arise in everyday practice for therapists, providers, and those whom they serve.

Who Qualifies as a Personal Representative?

Under the new law, a personal representative may initiate a request to inspect or copy a recipient's record.[5] By its own language, the Illinois law for the descriptor of "personal representative" cites to HIPAA as well as the accompanying Code of Federal Regulations ("CFR").[6] Accordingly, practitioners should be mindful of any changes and commentary on HIPAA's own consideration of the phrase and how it has evolved alongside caselaw. Currently, the cited provision in the CFR simply sets out that "a covered entity must, except as provided in paragraphs (g)(3) and (g)(5) of this section, treat a personal representative as the individual for purposes of this subchapter."[7] The Federal Register includes a fuller discussion of "personal representative" and its legislative development as a limited category: "[i]n general, under the final regulation, the 'personal representatives' provisions are directed at the **more formal representatives**, while [a separate rule provision] addresses situations in which persons are informally acting on behalf of an individual."[8] The same content from the Federal Regulation goes on to provide additional insight into the original purpose of the category by relaying, "[w]e make disclosure to personal representatives mandatory to ensure that an individual's rights [] are preserved even when individuals are incapacitated or otherwise unable to act for themselves to the same degree as other individuals. If the covered entity were to have the discretion to recognize a personal representative as the individual, there could be situations in which no one could invoke an individual's rights under these sections."[9] Thus, the nuance that accompanies the cited provisions found in HIPAA is noticeably absent in this new Illinois framework. Meaning, the (arguably) broad provision now found in the Illinois framework for access is incongruent with the original design of its federal counterpart. Instead, Illinois appears to have conflated the CFR's separate approach to informal requests (made by family members and related individuals) with the CFR's other formal framework for "personal representatives".[10] The result is a broad and unwieldy state law.

Some state courts have previously contemplated and firmed up their region's own law on this phrase and its relation to the CFR and HIPAA. For instance, a reviewing court in California noted, "[i] n substance, a personal representative is defined as a person who holds a healthcare power of attorney for an adult, a parent or guardian of a minor, or an executor or administrator of an individual's estate. Attorneys retained by an individual are **not** included in the definition of a personal representative."[11] Other states have taken efforts to legislate their own definition of "personal representative" in similar frameworks and have corresponding state law that contemplates who is included in such a category.[12]

For now, Illinois law on this novel phrase remains tethered to HIPAA's own statutory guidance (or lack thereof). Accordingly, the Federal Regulations may provide some

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OFFICE
ILLINOIS BAR CENTER
424 S. SECOND STREET
SPRINGFIELD, IL 62701
PHONES: 217-525-1760 OR 800-252-8908
WWW.ISBA.ORG

EDITOR
Sandra M. Blake

PUBLICATIONS MANAGER
Sara Anderson
sanderson@isba.org

insight and arguments for (or against) someone's role as a "personal representative". In any event, Illinois healthcare providers and their staff are now tasked with an unenviable role of sorting out a requesting party's status and qualifications for each request. Moreover, as detailed next, providers should also consider applicable factors that may very well disqualify a person from being considered a "personal representative" in certain circumstances.

When May an Entity Elect Not to Treat a Person as a Personal Representative?

Because the new Illinois law for accessing records by a personal representative is anchored in the CFR and HIPAA's definition of the same, practitioners and providers should heed the CFR's own provisions that detail when a covered entity may elect *not* to treat a person as the personal representative of an individual.

First, those who would otherwise qualify as personal representatives can "assent to an agreement of confidentiality between a covered health care provider and the minor" with regard to health care services.[13] Meaning, parents or guardians can yield their ability to invade such records by agreeing that the services between a provider and a minor are confidential. If a parent or guardian assents to an agreement of confidentiality between a minor and their provider, a covered entity may then provide or deny access to that parent or guardian, if such action is consistent with State (or other applicable law), and "provided that such decision [to provide or deny access] must be made by a licensed health care professional, in the exercise of professional judgment."[14] Put together, it is expected that, given the new law in Illinois on this issue, providers might now regularly seek written assent to an agreement of confidentiality from parents and guardians at the outset of services when minors are involved. Further, providers and practitioners should consider drafting language for such agreements that accommodate any foreseeable (or even unforeseeable) revocations or challenges to said agreements.

Second, even if a parent or guardian otherwise qualifies as a personal representative and seeks access to certain records of a minor, an additional analysis should occur wherein the provider determines whether to recognize that individual in their capacity as a personal representative. Specifically, the federal provisions set out several scenarios in which an entity may decide not to recognize someone as a personal representative in conjunction with a request for access to records:

> Notwithstanding a State law or any requirement of this paragraph to the contrary, a covered entity may elect not to treat a person as the personal representative of an individual if:
>
> (i) The covered entity has a reasonable belief that:
>
> (A) The individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or
>
> (B) Treating such person as the personal representative could endanger the individual; and
>
> (ii) The covered entity, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual's personal representative.[15]

This statutory safeguard provides an entity multiple pathways for denying access to a putative personal representative. Accordingly, if confronted with a request by a purported personal representative, providers and their staff should consider whether a reasonable belief exists as to any of these elements. Such internal inquiry and reflection by the provider should contemplate not only whether there is a reasonable belief concerning *prior* instances of violence, abuse, or neglect associated with the requesting individual, but providers should also contemplate *prospective* harms associated with that same requesting party and the recipient of services. It is expected that some scenarios will be heavily fact-dependent and turn on a few central issues such as: whether an entity's beliefs are reasonable (and why); what amounts to the "best interest" of a recipient as it relates to a request; or even what behavior or actions qualify as to mean "endanger" under the provision. Regardless, an analysis and consideration of whether to treat someone as a "personal representative" can only be achieved on a case-by-case basis and (ideally) with the involvement of those who are familiar with the recipient and their personal circumstances (in contrast to a keeper of records who may be unaware of or unfamiliar with the nuances of each matter).

Harmonizing the Current Statute and Its Contradictions

Another glaring issue under the new law is how it should be read alongside 740 ILS 110/4(a)(3)'s current language and protections for recipients between the ages of 12 and 17. For instance, existing law therein allows access to records for the "parent or guardian of a recipient who is at least 12 but under 18 years, if the recipient is informed **and** does not object **or** if the therapist does not find that there are compelling reasons for denying the access."[16] However, a dilemma arises when a requesting party (such as a parent), who also qualifies as a personal representative, makes a request to inspect a 16-year-old recipient's records, for example. Historically, providers would assess whether the recipient was informed and did not object or whether the therapist concluded that there were not any compelling reasons for denying the request.[17] However, the new law (which follows directly in statutory sequence) specifically grants access to a personal representative for records of a recipient, regardless of their age. Furthermore, a separate issue arises in those instances where a parent does not qualify as a personal representative due to an entity's reasonable belief of past neglect, but that same parent otherwise asserts that their request for certain information is instead in accordance with provisions of 740 ILCS 110/4(a)(3). Bedrock principles of statutory construction command that the provisions should be read in harmony, when possible. But again, the burden of demystifying this statutory quagmire may regularly fall upon everyday healthcare providers and well-meaning therapists.

Conclusion

Settled law may become unsettled. Similarly, established workflows, forms, and boilerplate analyses by providers that were once all-encompassing may require

reconsideration and refinement. While this article highlights several known and expected issues with this new law, others abound. For instance, providers are sometimes contacted to enter a statement concerning new or disputed information associated with a record and the authority to do this is described as belonging to "any person entitled to access,"[18] which may now include personal representatives who harbor unclear personal agendas. Overall, there are two likely paths ahead (not mutually exclusive) for clarity on these new statutory issues: litigation and legislation; for providers and their advisors, the latter should be a priority.■

Matthew R. Davison is an attorney with the Monahan Law Group, LLC, in Chicago. The firm focuses its practice in mental health, confidentiality, guardianship, probate, and health care law. He may be contacted at mdavison@monahanlawllc.com.

1. 740 ILCS 110/4 (a)(3.5)(Lexis 2024).
2. *Id*.
3. *See* 740 ILCS 110/4(a)(3) (Lexis 2024).
4. Mackenzie LaPorte, *Closing the loophole: New Illinois law restores parental rights to access children's healthcare records*, August 8, 2023, https://newschannel20.com/news/local/closing-the-loophole-new-illinois-law-restores-parental-rights-to-access-childrens-healthcare-records.
5. 740 ILCS 110/4 (a)(3.5)(Lexis 2024).
6. *Id*.
7. 45 CFR 164.502(g)(1) (Lexis 2024).
8. 65 FR 82462, 82500 (emphasis added).
9. *Id*. at 82501.
10. *Compare* 45 CFR 164.502(g)(1) with § 164.510(b).
11. *Bugarin v. Chartone*, *Inc*., 135 Cal. App. 4th 1558, 1562 (emphasis added).
12. *2009 Fla. Div. Adm. Hear*. LEXIS 801, *34.
13. 45 CFR 164.502(g)(3)(i)(c) (Lexis 2024). The author is grateful to attorney John W. Whitcomb for his insight (and citation) on this issue.
14. *Id*.
15. 45 CFR 164.502(g)(5) (Lexis 2024).
16. 740 ILCS 110/4(a)(3) (Lexis 2024) (emphasis added).
17. *Id*.
18. 740 ILCS 110/4(c) (Lexis 2024).

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disclosure of mental health records of minors ages 12 to 17, especially relating to requests for information from parents or guardians. Under the new law, minors ages 12 to 17 may lose their right to object to disclosure of their confidential mental health information to parents or guardians who have the legal ability to consent to treatment for the minor.

There are, however, limited exceptions for potential risk of harm to the minor and disclosures against the minor's best interest. See article by Matthew R. Davison in this newsletter.■

This article was provided by Joseph T. Monahan, MSW, ACSW, JD, the founding partner of Monahan Law Group, LLC, in Chicago. The firm focuses its practice in mental health, confidentiality, guardianship, probate and health care law. He may be contacted at jmonahan@monahanlawllc.com.

How to Properly Issue Subpoenas for Mental Health Records and Depositions

BY SCOTT D. HAMMER & COURTNEY L. WOOD

When issuing subpoenas for mental health records and depositions of mental health professionals, attorneys must strictly follow the Illinois Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 110/1 et seq. (hereinafter the "Confidentiality Act"). Most often attorneys issue subpoenas for "medical" records with a "Qualified HIPAA Protective Order." However, that HIPAA Protective Order usually indicates the following:

> Nothing in this Order relieves any party from complying with the requirements of the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

The reason mental health records are given extra protection under the law and require an "extra" step is that the courts have acknowledged the importance of maintaining the confidentiality of mental health records except in the circumstances specifically enumerated in the Confidentiality Act. The courts and General Assembly strongly believe that keeping mental health records confidential is the key to establishing a true therapeutic alliance between patients and therapists. If patients truly want to express their innermost secrets, desires and faults to a therapist, then those communications must be kept confidential for the relationship to have any therapeutic value.

As noted by the United States Supreme Court in *Jaffe v. Redmond,* 518 U.S. 1, 10, 116 S. Ct. 1923, 1928, 135 L.Ed.2d, 337, 345 (1996):

> Effective psychotherapy.... depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.

In fact, all 50 states, the District of Columbia and federal courts recognize a psychiatrist-patient privilege, either by statute or common law. *Jaffe,* 518 U.S. 12, 116 S. Ct. 1929, 135 L.E.2d 346.

Accordingly, it is of paramount importance for attorneys seeking mental health records to read and understand the requirements of the Confidentiality Act. Over the years, the Confidentiality Act has been revised in an attempt to make it "idiot-proof." Yet, despite the recent changes in the Confidentiality Act, which make it easier than ever to obtain mental health records, most attorneys are unaware of what is required and rarely follow the Confidentiality Act. In our 40 years of experience representing mental health clinicians, more than 90 percent of all subpoenas for mental health records and/or depositions of mental health professionals are technically invalid since they do not strictly conform with the Confidentiality Act.

The Confidentiality Act mandates that except as provided therein, the recipient of mental health services and the therapist, on behalf and in the interest of a recipient has the privilege to refuse to disclose and to prevent disclosure of the recipient's records and communications. Section 10 of the Confidentiality Act lists a number of exceptions in which mental health records may be disclosed. One of the most common exceptions is when the recipient of mental health services introduces his mental condition or any aspect of his services received for such condition as an element of his claim or defense. When a party "introduces" his mental health into the case, it is commonly referred to as "placing one's mental health at issue."

Section 10(d) of the Confidentiality Act provides specific instructions on how to issue a subpoena for mental health records:

> *No party to any proceeding...shall serve a subpoena seeking to obtain access to records or communications under this Act unless the subpoena is accompanied by a written order issued by a judge or by the written consent under Section 5* of this Act of the person whose records are being sought, authorizing the disclosure of the records or the issuance of the subpoena. No such written order shall be issued without written notice of the motion to the recipient and the treatment provider. Prior to issuance of the order, each party or other person entitled to notice shall be permitted an opportunity to be heard pursuant to subsection (b) of this Section. In the absence of the written consent under Section 5 of this Act of the person whose records are being sought, no person shall comply with a subpoena for records or communications under this Act, unless the subpoena is accompanied by a written order authorizing the issuance of the subpoena or the disclosure of the records. Each subpoena issued by a court or administrative agency or served on any person pursuant to this subsection (d) *shall include the following language*: "No person shall comply with a subpoena for mental health records or communications pursuant to Section 10 of the Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 110/10, unless the subpoena is accompanied by a written order that authorizes the issuance of the subpoena and the disclosure of records or communications or by the written consent under Section 5 of that Act of the person whose records are being sought."
>
> (*Emphasis added*).

The Confidentiality Act was revised to allow attorneys to issue subpoenas for mental health records with written consent (Release of Information) of the patient. Prior to this revision, subpoenas for mental health records required a separate court order authorizing the disclosure of the mental health records and the issuance of the subpoena. Since the Confidentiality Act now allows for either a court order or a consent form to be used to obtain mental health records, attorneys may choose which way to proceed. Whichever option the attorney decides to use still requires strict compliance with the Confidentiality Act.

Using a written consent of the patient is a quicker and often easier way to obtain mental health records. However, the consent form must strictly conform to section 5 of the Confidentiality Act.

> Section 5 of the Confidentiality Act states in part:
>
> (b) Every consent form shall be in writing and shall specify the following:
>
> (1) the person or agency to whom disclosure is to be made;
>
> (2) the purpose for which disclosure is to be made;
>
> (3) the nature of the information to be disclosed;
>
> (4) the right to inspect and copy the information to be disclosed;
>
> (5) the consequences of a refusal to consent, if any;
>
> (6) the calendar date on which the consent expires, provided that if no calendar date is stated, information may be released only on the day the consent form is received by the therapist; and
>
> (7) the right to revoke the consent at any time.

> The consent form shall be signed by the person entitled to give consent and the signature shall be witnessed by a person who can attest to the identity of the person so entitled.

It is important to note that standard HIPAA authorizations/releases of information forms do not strictly comply with section 5 of the Confidentiality Act. Standard HIPAA authorizations do not contain the calendar date on which the consent expires, consequences of refusal to consent, and the necessity of having the signature witnessed. Accordingly, attorneys must use consent forms that address the seven requirements noted in section 5 above. However, there is currently a pending bill in the state legislature that would remove the requirement of having the signature witnessed.

If the attorney decides to obtain a court order, the Confidentially Act requires written notice of the motion to the recipient and the treatment provider. This written notice allows both the patient and the therapist the opportunity to be heard and object to the motion or request an *in camera* review under section 10(b) of the Confidentiality Act. Sending written notice of the motion to both the patient and the patient's attorney (usually the plaintiff's attorney) is recommended, since patients and their attorneys do not always share the same interests in protecting the patient's mental health records. Notice to the therapist allows the therapist to object or discuss the significance of the disclosure of mental health records with the patient.

If the motion is granted and the court enters an order authorizing the disclosure of the records or the issuance of the subpoena, there is still one more step that needs to be followed. As noted above, the subpoena itself must contain the following language:

> "No person shall comply with a subpoena for mental health records or communications pursuant to Section 10 of the Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 110/10, unless the subpoena is accompanied by a written order that authorizes the issuance of the subpoena and the disclosure of records or communications or by the written consent under Section 5 of that Act of the person whose records are being sought."

This language simply rehashes the specific requirements of section 10(d) of the Confidentiality Act. Mandating this language be inserted into every subpoena for mental health records acts as a "safety check" to all attorneys and a notice to all mental health providers: Don't comply with this subpoena if it's not accompanied by a written order or by written consent.

For attorneys, these requirements seem like another hurdle/obstacle to obtaining records in cases. However, the sanctity of mental health records demands these additional procedural steps to obtain these documents. More importantly, the Confidentiality Act provides penalties for those who do not strictly comply with the Confidentiality Act. Section 15 allows persons aggrieved by violation of the Confidentiality Act to sue for damages, including attorney's fees and costs. Section 16 mandates criminal penalties: "Any person who knowingly and willfully violates any provision of this Act is guilty of a Class A misdemeanor."

Attorneys should take note that they can be sued for violation of the Confidentiality Act if they do not follow the requirements set forth in section 10(d).

In *Mandziara v. Canulli,* 299 Ill. App.3d 593, 701 N. E.2d, 127 (1st Dist. 1988), the First District Appellate Court held that an attorney violated the Mental Health Confidentiality Act by serving a subpoena for records without first obtaining a court order, even though the subpoena called for the records to be produced to the trial judge for an *in camera* review. The underlying case involved a husband seeking a modification of an award of custody of his children to his wife. His wife had attempted suicide and the husband filed a petition to determine the wife's fitness to retain sole custody of the children. The husband's attorney served a subpoena *duces tecum* on the records custodian at the hospital where the wife was admitted following her suicide attempt. Thereafter, the records custodian for the community hospital came to court in response to the subpoena and handed the records directly to the trial judge for his review. The judge asked the records custodian some questions and then directed his questions to the wife. The wife sued both the hospital and the husband's attorney for violation of the Confidentiality Act. The appellate court found the attorney violated the Confidentiality Act by serving a subpoena on the hospital without a separate court order. The court found that the subpoena violated the specific terms of section 10(d) because the attorney served it on the hospital without first obtaining a court order.

Since attorneys can be successfully sued for failing to follow section 10(d) of the Confidentiality Act, it would be in every attorney's best interest to learn and comply with the necessary requirements before issuing a subpoena for mental health records.■

Scott D. Hammer and Courtney L. Wood are attorneys with Wilson Elser Moskowitz Edelman & Dicker LLP in Chicago. They can be contacted at scott.hammer@wilsonelser.com and courtney.wood@wilsonelser.com, respectively.