

Commonwealth of Pennsylvania
Department of Drug and Alcohol Programs



Federal and State
Confidentiality Regulations



CONFIDENTIALITY TRAINING SUPPLEMENTAL MATERIALS

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FEDERAL CONFIDENTIALITY REGULATIONS

PART 2—CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS

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AUTHORITY: 42 U.S.C. 290dd-2.

SOURCE: 82 FR 6115, Jan. 18, 2017, unless otherwise noted.

Subpart A—Introduction

§2.1 Statutory authority for confidentiality of substance use disorder patient records.

Title 42, United States Code, Section 290dd-2(g) authorizes the Secretary to prescribe regulations. Such regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this statute, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

§2.2 Purpose and effect.

(a) *Purpose.* Pursuant to 42 U.S.C. 290dd-2(g), the regulations in this part impose restrictions upon the disclosure and use of substance use disorder patient records which are maintained in connection with the performance of any part 2 program. The regulations in this part include the following subparts:

(1) Subpart B of this part: General Provisions, including definitions, applicability, and general restrictions;

(2) Subpart C of this part: Disclosures with Patient Consent, including disclosures which require patient consent and the consent form requirements;

(3) Subpart D of this part: Disclosures without Patient Consent, including disclosures which do not require patient consent or an authorizing court order; and

(4) Subpart E of this part: Court Orders Authorizing Disclosure and Use, including disclosures and uses of patient records which may be made with an authorizing court order and the procedures and criteria for the entry and scope of those orders.

(b) *Effect.* (1) The regulations in this part prohibit the disclosure and use of patient records unless certain circumstances exist. If any circumstance exists under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure but it does not compel disclosure. Thus, the regulations do not require disclosure under any circumstances.

(2) The regulations in this part are not intended to direct the manner in which substantive functions such as research, treatment, and evaluation are carried out. They are intended to ensure that a patient receiving treatment for a substance use disorder in a part 2 program is not made more vulnerable by reason of the availability of their patient record than an individual with a substance use disorder who does not seek treatment.

(3) Because there is a criminal penalty for violating the regulations, they are to be construed strictly in favor of the potential violator in the same manner as a criminal statute (see *M. Kraus & Brothers v. United States*, 327 U.S. 614, 621-22, 66 S. Ct. 705, 707-08 (1946)).

§2.3 Criminal penalty for violation.

Under 42 U.S.C. 290dd-2(f), any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined in accordance with Title 18 of the U.S. Code.

§2.4 Reports of violations.

(a) The report of any violation of the regulations in this part may be directed to the United States Attorney for the judicial district in which the violation occurs.

(b) The report of any violation of the regulations in this part by an opioid treatment program may be directed to the United States Attorney for the judicial district in which the violation occurs as well as to the Substance Abuse and Mental Health Services Administration (SAMHSA) office responsible for opioid treatment program oversight.

Subpart B—General Provisions

§2.11 Definitions.

For purposes of the regulations in this part:

Central registry means an organization which obtains from two or more member programs patient identifying information about individuals applying for withdrawal management or maintenance treatment for the purpose of avoiding an individual's concurrent enrollment in more than one treatment program.

Diagnosis means any reference to an individual's substance use disorder or to a condition which is identified as having been caused by that substance use disorder which is made for the purpose of treatment or referral for treatment.

Disclose means to communicate any information identifying a patient as being or having been diagnosed with a substance use disorder, having or having had a substance use disorder, or being or having been referred for treatment of a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person.

Federally assisted—see §2.12(b).

Informant means an individual:

(1) Who is a patient or employee of a part 2 program or who becomes a patient or employee of a part 2 program at the request of a law enforcement agency or official; and

(2) Who at the request of a law enforcement agency or official observes one or more patients or employees of the part 2 program for the purpose of reporting the information obtained to the law enforcement agency or official.

Maintenance treatment means long-term pharmacotherapy for individuals with substance use disorders that reduces the pathological pursuit of reward and/or relief and supports remission of substance use disorder-related symptoms.

Member program means a withdrawal management or maintenance treatment program which reports patient identifying information to a central registry and which is in the same state as that central registry or is in a state that participates in data sharing with the central registry of the program in question.

Minor, as used in the regulations in this part, means an individual who has not attained the age of majority specified in the applicable state law, or if no age of majority is specified in the applicable state law, the age of 18 years.

Part 2 program means a federally assisted program (federally assisted as defined in §2.12(b) and program as defined in this section). See §2.12(e)(1) for examples.

Part 2 program director means:

(1) In the case of a part 2 program that is an individual, that individual.

(2) In the case of a part 2 program that is an entity, the individual designated as director or managing director, or individual otherwise vested with authority to act as chief executive officer of the part 2 program.

Patient means any individual who has applied for or been given diagnosis, treatment, or referral for treatment for a substance use disorder at a part 2 program. *Patient* includes any individual who, after arrest on a criminal charge, is identified as an individual with a substance use disorder in order to determine that individual's eligibility to participate in a part 2 program. This definition includes both current and former patients.

Patient identifying information means the name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient, as defined in this section, can be determined with reasonable accuracy either directly or by reference to other information. The term does not include a number assigned to a patient by a part 2 program, for internal use only by the part 2 program, if that number does not consist of or contain numbers (such as a social security, or driver's license number) that could be used to identify a patient with reasonable accuracy from sources external to the part 2 program.

Person means an individual, partnership, corporation, federal, state or local government agency, or any other legal entity, (also referred to as "individual or entity").

Program means:

(1) An individual or entity (other than a general medical facility) who holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or

(2) An identified unit within a general medical facility that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or

(3) Medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers.

Qualified service organization means an individual or entity who:

(1) Provides services to a part 2 program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, accounting, population health management, medical staffing, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and

(2) Has entered into a written agreement with a part 2 program under which that individual or entity:

(i) Acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the part 2 program, it is fully bound by the regulations in this part; and

(ii) If necessary, will resist in judicial proceedings any efforts to obtain access to patient identifying information related to substance use disorder diagnosis, treatment, or referral for treatment except as permitted by the regulations in this part.

Records means any information, whether recorded or not, created by, received, or acquired by a part 2 program relating to a patient (e.g., diagnosis, treatment and referral for treatment information, billing information, emails, voice mails, and texts). For the purpose of the regulations in this part, records include both paper and electronic records.

Substance use disorder means a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems such as impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal. For the purposes of the regulations in this part, this definition does not include tobacco or caffeine use.

Third-party payer means an individual or entity who pays and/or agrees to pay for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of the patient's family or on the basis of the patient's eligibility for federal, state, or local governmental benefits.

Treating provider relationship means that, regardless of whether there has been an actual in-person encounter:

- (1) A patient is, agrees to, or is legally required to be diagnosed, evaluated, and/or treated, or agrees to accept consultation, for any condition by an individual or entity, and;
- (2) The individual or entity undertakes or agrees to undertake diagnosis, evaluation, and/or treatment of the patient, or consultation with the patient, for any condition.

Treatment means the care of a patient suffering from a substance use disorder, a condition which is identified as having been caused by the substance use disorder, or both, in order to reduce or eliminate the adverse effects upon the patient.

Undercover agent means any federal, state, or local law enforcement agency or official who enrolls in or becomes an employee of a part 2 program for the purpose of investigating a suspected violation of law or who pursues that purpose after enrolling or becoming employed for other purposes.

Withdrawal management means the use of pharmacotherapies to treat or attenuate the problematic signs and symptoms arising when heavy and/or prolonged substance use is reduced or discontinued.

§2.12 Applicability.

(a) *General*—(1) *Restrictions on disclosure.* The restrictions on disclosure in the regulations in this part apply to any information, whether or not recorded, which:

(i) Would identify a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person; and

(ii) Is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972 (part 2 program), or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (part 2 program); or if obtained before the pertinent date, is maintained by a part 2 program after that date as part of an ongoing treatment episode which extends past that date; for the purpose of treating a substance use disorder, making a diagnosis for that treatment, or making a referral for that treatment.

(2) *Restriction on use.* The restriction on use of information to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient (42 U.S.C. 290dd-2(c)) applies to any information, whether or not recorded, which is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972 (part 2 program), or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (part 2 program); or if obtained before the pertinent date, is maintained by a part 2 program after that date as part of an ongoing treatment episode which extends past that date; for the purpose of treating a substance use disorder, making a diagnosis for the treatment, or making a referral for the treatment.

(b) *Federal assistance.* A program is considered to be federally assisted if:

(1) It is conducted in whole or in part, whether directly or by contract or otherwise by any department or agency of the United States (but see paragraphs (c)(1) and (2) of this section relating to the Department of Veterans Affairs and the Armed Forces);

(2) It is being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States including but not limited to:

(i) Participating provider in the Medicare program;

(ii) Authorization to conduct maintenance treatment or withdrawal management; or

(iii) Registration to dispense a substance under the Controlled Substances Act to the extent the controlled substance is used in the treatment of substance use disorders;

(3) It is supported by funds provided by any department or agency of the United States by being:

(i) A recipient of federal financial assistance in any form, including financial assistance which does not directly pay for the substance use disorder diagnosis, treatment, or referral for treatment; or

(ii) Conducted by a state or local government unit which, through general or special revenue sharing or other forms of assistance, receives federal funds which could be (but are not necessarily) spent for the substance use disorder program; or

(4) It is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program or through the granting of tax exempt status to the program.

(c) *Exceptions— (1) Department of Veterans Affairs.* These regulations do not apply to information on substance use disorder patients maintained in connection with the Department of Veterans Affairs' provision of hospital care, nursing home care, domiciliary care, and medical services under Title 38, U.S.C. Those records are governed by 38 U.S.C. 7332 and regulations issued under that authority by the Secretary of Veterans Affairs.

(2) *Armed Forces.* The regulations in this part apply to any information described in paragraph (a) of this section which was obtained by any component of the Armed Forces during a period when the patient was subject to the Uniform Code of Military Justice except:

(i) Any interchange of that information within the Armed Forces; and

(ii) Any interchange of that information between the Armed Forces and those components of the Department of Veterans Affairs furnishing health care to veterans.

(3) *Communication within a part 2 program or between a part 2 program and an entity having direct administrative control over that part 2 program.* The restrictions on disclosure in the regulations in this part do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of patients with substance use disorders if the communications are:

(i) Within a part 2 program; or

(ii) Between a part 2 program and an entity that has direct administrative control over the program.

(4) *Qualified service organizations.* The restrictions on disclosure in the regulations in this part do not apply to communications between a part 2 program and a qualified service organization of information needed by the qualified service organization to provide services to the program.

(5) *Crimes on part 2 program premises or against part 2 program personnel.* The restrictions on disclosure and use in the regulations in this part do not apply to communications from part 2 program personnel to law enforcement agencies or officials which:

(i) Are directly related to a patient's commission of a crime on the premises of the part 2 program or against part 2 program personnel or to a threat to commit such a crime; and

(ii) Are limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

(6) *Reports of suspected child abuse and neglect.* The restrictions on disclosure and use in the regulations in this part do not apply to the reporting under state law of incidents of suspected child abuse and neglect to the appropriate state or local authorities. However, the restrictions continue to apply to the original substance use disorder patient records maintained by the part 2 program including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

(d) *Applicability to recipients of information—* (1) *Restriction on use of information.* The restriction on the use of any information subject to the regulations in this part to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient applies to any person who obtains that information from a part 2 program, regardless of the status of the person obtaining the information or whether the information was obtained in accordance with the regulations in this part. This restriction on use bars, among other things, the introduction of that information as evidence in a criminal proceeding and any other use of the information to investigate or prosecute a patient with respect to a suspected crime. Information obtained by undercover agents or informants (see §2.17) or through patient access (see §2.23) is subject to the restriction on use.

(2) *Restrictions on disclosures—*(i) *Third-party payers, administrative entities, and others.* The restrictions on disclosure in the regulations in this part apply to:

(A) Third-party payers with regard to records disclosed to them by part 2 programs or under §2.31(a)(4)(iii)(A);

(B) Entities having direct administrative control over part 2 programs with regard to information that is subject to the regulations in this part communicated to them by the part 2 program under paragraph (c)(3) of this section; and

(C) Individuals or entities who receive patient records directly from a part 2 program or other lawful holder of patient identifying information and who are notified of the prohibition on re-disclosure in accordance with §2.32.

(ii) [Reserved]

(e) *Explanation of applicability—(1) Coverage.* These regulations cover any information (including information on referral and intake) about patients receiving diagnosis, treatment, or referral for treatment for a substance use disorder created by a part 2 program. Coverage includes, but is not limited to, those treatment or rehabilitation programs, employee assistance programs, programs within general hospitals, school-based programs, and private practitioners who hold themselves out as providing, and provide substance use disorder diagnosis, treatment, or referral for treatment. However, the regulations in this part would not apply, for example, to emergency room personnel who refer a patient to the intensive care unit for an apparent overdose, unless the primary function of such personnel is the provision of substance use disorder diagnosis, treatment, or referral for treatment and they are identified as providing such services or the emergency room has promoted itself to the community as a provider of such services.

(2) *Federal assistance to program required.* If a patient's substance use disorder diagnosis, treatment, or referral for treatment is not provided by a part 2 program, that patient's record is not covered by the regulations in this part. Thus, it is possible for an individual patient to benefit from federal support and not be covered by the confidentiality regulations because the program in which the patient is enrolled is not federally assisted as defined in paragraph (b) of this section. For example, if a federal court placed an individual in a private for-profit program and made a payment to the program on behalf of that individual, that patient's record would not be covered by the regulations in this part unless the program itself received federal assistance as defined by paragraph (b) of this section.

(3) *Information to which restrictions are applicable.* Whether a restriction applies to use or disclosure affects the type of information which may be disclosed. The restrictions on disclosure apply to any information which would identify a patient as having or having had a substance use disorder. The restriction on use of information to bring criminal charges against a patient for a crime applies to any information obtained by the part 2 program for the purpose of diagnosis, treatment, or referral for treatment of patients with substance use disorders. (Note that restrictions on use and disclosure apply to recipients of information under paragraph (d) of this section.)

(4) *How type of diagnosis affects coverage.* These regulations cover any record of a diagnosis identifying a patient as having or having had a substance use disorder which is initially prepared by a part 2 provider in connection with the treatment or referral for treatment of a patient with a substance use disorder. A diagnosis prepared for the purpose of treatment or referral for treatment but which is not so used is covered by the regulations in this part. The following are not covered by the regulations in this part:

(i) Diagnosis which is made solely for the purpose of providing evidence for use by law enforcement agencies or officials; or

(ii) A diagnosis of drug overdose or alcohol intoxication which clearly shows that the individual involved does not have a substance use disorder (e.g., involuntary ingestion of alcohol or drugs or reaction to a prescribed dosage of one or more drugs).

§2.13 Confidentiality restrictions and safeguards.

(a) *General.* The patient records subject to the regulations in this part may be disclosed or used only as permitted by the regulations in this part and may not otherwise be disclosed or used in any civil, criminal, administrative, or legislative proceedings conducted by any federal, state, or local authority. Any disclosure made under the regulations in this part must be limited to that information which is necessary to carry out the purpose of the disclosure.

(b) *Unconditional compliance required.* The restrictions on disclosure and use in the regulations in this part apply whether or not the part 2 program or other lawful holder of the patient identifying information believes that the person seeking the information already has it, has other means of obtaining it, is a law enforcement agency or official or other government official, has obtained a subpoena, or asserts any other justification for a disclosure or use which is not permitted by the regulations in this part.

(c) *Acknowledging the presence of patients: Responding to requests.* (1) The presence of an identified patient in a health care facility or component of a health care facility which is publicly identified as a place where only substance use disorder diagnosis, treatment, or referral for treatment is provided may be acknowledged only if the patient's written consent is obtained in accordance with subpart C of this part or if an authorizing court order is entered in accordance with subpart E of this part. The regulations permit acknowledgement of the presence of an identified patient in a health care facility or part of a health care facility if the health care facility is not publicly identified as only a substance use disorder diagnosis, treatment, or referral for treatment facility, and if the acknowledgement does not reveal that the patient has a substance use disorder.

(2) Any answer to a request for a disclosure of patient records which is not permissible under the regulations in this part must be made in a way that will not affirmatively reveal that an identified individual has been, or is being, diagnosed or treated for a substance use disorder. An inquiring party may be provided a copy of the regulations in this part and advised that they restrict the disclosure of substance use disorder patient records, but may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient.

(d) *List of disclosures.* Upon request, patients who have consented to disclose their patient identifying information using a general designation pursuant to §2.31(a)(4)(iii)(B)(3) must be provided a list of entities to which their information has been disclosed pursuant to the general designation.

(1) Under this paragraph (d), patient requests:

(i) Must be made in writing; and

(ii) Are limited to disclosures made within the past two years;

(2) Under this paragraph (d), the entity named on the consent form that discloses information pursuant to a patient's general designation (the entity that serves as an intermediary, as described in §2.31(a)(4)(iii)(B)) must:

(i) Respond in 30 or fewer days of receipt of the written request; and

(ii) Provide, for each disclosure, the name(s) of the entity(-ies) to which the disclosure was made, the date of the disclosure, and a brief description of the patient identifying information disclosed.

(3) The part 2 program is not responsible for compliance with this paragraph (d); the entity that serves as an intermediary, as described in §2.31(a)(4)(iii)(B), is responsible for compliance with the list of disclosures requirement.

§2.14 Minor patients.

(a) *State law not requiring parental consent to treatment.* If a minor patient acting alone has the legal capacity under the applicable state law to apply for and obtain substance use disorder treatment, any written consent for disclosure authorized under subpart C of this part may be given only by the minor patient. This restriction includes, but is not limited to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. These regulations do not prohibit a part 2 program from refusing to provide treatment until the minor patient consents to the disclosure necessary to obtain reimbursement, but refusal to provide treatment may be prohibited under a state or local law requiring the program to furnish the service irrespective of ability to pay.

(b) *State law requiring parental consent to treatment.* (1) Where state law requires consent of a parent, guardian, or other individual for a minor to obtain treatment for a substance use disorder, any written consent for disclosure authorized under subpart C of this part must be given by both the minor and their parent, guardian, or other individual authorized under state law to act in the minor's behalf.

(2) Where state law requires parental consent to treatment, the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other individual authorized under state law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with subpart C of this part; or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the part 2 program director under paragraph (c) of this section.

(c) *Minor applicant for services lacks capacity for rational choice.* Facts relevant to reducing a substantial threat to the life or physical well-being of the minor applicant or any other

individual may be disclosed to the parent, guardian, or other individual authorized under state law to act in the minor's behalf if the part 2 program director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under subpart C of this part to their parent, guardian, or other individual authorized under state law to act in the minor's behalf; and

(2) The minor applicant's situation poses a substantial threat to the life or physical well-being of the minor applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other individual authorized under state law to act in the minor's behalf.

§2.15 Incompetent and deceased patients.

(a) *Incompetent patients other than minors—(1) Adjudication of incompetence.* In the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage their own affairs, any consent which is required under the regulations in this part may be given by the guardian or other individual authorized under state law to act in the patient's behalf.

(2) *No adjudication of incompetency.* In the case of a patient, other than a minor or one who has been adjudicated incompetent, that for any period suffers from a medical condition that prevents knowing or effective action on their own behalf, the part 2 program director may exercise the right of the patient to consent to a disclosure under subpart C of this part for the sole purpose of obtaining payment for services from a third-party payer.

(b) *Deceased patients—(1) Vital statistics.* These regulations do not restrict the disclosure of patient identifying information relating to the cause of death of a patient under laws requiring the collection of death or other vital statistics or permitting inquiry into the cause of death.

(2) *Consent by personal representative.* Any other disclosure of information identifying a deceased patient as having a substance use disorder is subject to the regulations in this part. If a written consent to the disclosure is required, that consent may be given by an executor, administrator, or other personal representative appointed under applicable state law. If there is no such applicable state law appointment, the consent may be given by the patient's spouse or, if none, by any responsible member of the patient's family.

[82 FR 6115, Jan. 18, 2017, as amended at 83 FR 251, Jan. 3, 2018]

§2.16 Security for records.

(a) The part 2 program or other lawful holder of patient identifying information must have in place formal policies and procedures to reasonably protect against unauthorized uses and disclosures of patient identifying information and to protect against reasonably anticipated

threats or hazards to the security of patient identifying information. These formal policies and procedures must address:

(1) Paper records, including:

(i) Transferring and removing such records;

(ii) Destroying such records, including sanitizing the hard copy media associated with the paper printouts, to render the patient identifying information non-retrievable;

(iii) Maintaining such records in a secure room, locked file cabinet, safe, or other similar container, or storage facility when not in use;

(iv) Using and accessing workstations, secure rooms, locked file cabinets, safes, or other similar containers, and storage facilities that use or store such information; and

(v) Rendering patient identifying information non-identifiable in a manner that creates a very low risk of re-identification (*e.g.*, removing direct identifiers).

(2) Electronic records, including:

(i) Creating, receiving, maintaining, and transmitting such records;

(ii) Destroying such records, including sanitizing the electronic media on which such records are stored, to render the patient identifying information non-retrievable;

(iii) Using and accessing electronic records or other electronic media containing patient identifying information; and

(iv) Rendering the patient identifying information non-identifiable in a manner that creates a very low risk of re-identification (*e.g.*, removing direct identifiers).

(b) [Reserved]

§2.17 Undercover agents and informants.

(a) *Restrictions on placement.* Except as specifically authorized by a court order granted under §2.67, no part 2 program may knowingly employ, or enroll as a patient, any undercover agent or informant.

(b) *Restriction on use of information.* No information obtained by an undercover agent or informant, whether or not that undercover agent or informant is placed in a part 2 program pursuant to an authorizing court order, may be used to criminally investigate or prosecute any patient.

§2.18 Restrictions on the use of identification cards.

No person may require any patient to carry in their immediate possession while away from the part 2 program premises any card or other object which would identify the patient as having a substance use disorder. This section does not prohibit a person from requiring patients to use or carry cards or other identification objects on the premises of a part 2 program.

§2.19 Disposition of records by discontinued programs.

(a) *General.* If a part 2 program discontinues operations or is taken over or acquired by another program, it must remove patient identifying information from its records or destroy its records, including sanitizing any associated hard copy or electronic media, to render the patient identifying information non-retrievable in a manner consistent with the policies and procedures established under §2.16, unless:

(1) The patient who is the subject of the records gives written consent (meeting the requirements of §2.31) to a transfer of the records to the acquiring program or to any other program designated in the consent (the manner of obtaining this consent must minimize the likelihood of a disclosure of patient identifying information to a third party); or

(2) There is a legal requirement that the records be kept for a period specified by law which does not expire until after the discontinuation or acquisition of the part 2 program.

(b) *Special procedure where retention period required by law.* If paragraph (a)(2) of this section applies:

(1) Records, which are paper, must be:

(i) Sealed in envelopes or other containers labeled as follows: "Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date]";

(A) All hard copy media from which the paper records were produced, such as printer and facsimile ribbons, drums, etc., must be sanitized to render the data non-retrievable; and

(B) [Reserved]

(ii) Held under the restrictions of the regulations in this part by a responsible person who must, as soon as practicable after the end of the required retention period specified on the label, destroy the records and sanitize any associated hard copy media to render the patient identifying information non-retrievable in a manner consistent with the discontinued program's or acquiring program's policies and procedures established under §2.16.

(2) Records, which are electronic, must be:

(i) Transferred to a portable electronic device with implemented encryption to encrypt the data at rest so that there is a low probability of assigning meaning without the use of a confidential process or key and implemented access controls for the confidential process or key; or

(ii) Transferred, along with a backup copy, to separate electronic media, so that both the records and the backup copy have implemented encryption to encrypt the data at rest so that there is a low probability of assigning meaning without the use of a confidential process or key and implemented access controls for the confidential process or key; and

(iii) Within one year of the discontinuation or acquisition of the program, all electronic media on which the patient records or patient identifying information resided prior to being transferred to the device specified in (i) above or the original and backup electronic media specified in (ii) above, including email and other electronic communications, must be sanitized to render the patient identifying information non-retrievable in a manner consistent with the discontinued program's or acquiring program's policies and procedures established under §2.16; and

(iv) The portable electronic device or the original and backup electronic media must be:

(A) Sealed in a container along with any equipment needed to read or access the information, and labeled as follows: "Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date];" and

(B) Held under the restrictions of the regulations in this part by a responsible person who must store the container in a manner that will protect the information (*e.g.*, climate controlled environment); and

(v) The responsible person must be included on the access control list and be provided a means for decrypting the data. The responsible person must store the decryption tools on a device or at a location separate from the data they are used to encrypt or decrypt; and

(vi) As soon as practicable after the end of the required retention period specified on the label, the portable electronic device or the original and backup electronic media must be sanitized to render the patient identifying information non-retrievable consistent with the policies established under §2.16.

§2.20 Relationship to state laws.

The statute authorizing the regulations in this part (42 U.S.C. 290dd-2) does not preempt the field of law which they cover to the exclusion of all state laws in that field. If a disclosure permitted under the regulations in this part is prohibited under state law, neither the

regulations in this part nor the authorizing statute may be construed to authorize any violation of that state law. However, no state law may either authorize or compel any disclosure prohibited by the regulations in this part.

§2.21 Relationship to federal statutes protecting research subjects against compulsory disclosure of their identity.

(a) *Research privilege description.* There may be concurrent coverage of patient identifying information by the regulations in this part and by administrative action taken under section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c) and the implementing regulations at 21 CFR part 1316); or section 301(d) of the Public Health Service Act (42 U.S.C. 241(d) and the implementing regulations at 42 CFR part 2a). These research privilege statutes confer on the Secretary of Health and Human Services and on the Attorney General, respectively, the power to authorize researchers conducting certain types of research to withhold from all persons not connected with the research the names and other identifying information concerning individuals who are the subjects of the research.

(b) *Effect of concurrent coverage.* These regulations restrict the disclosure and use of information about patients, while administrative action taken under the research privilege statutes and implementing regulations protects a person engaged in applicable research from being compelled to disclose any identifying characteristics of the individuals who are the subjects of that research. The issuance under subpart E of this part of a court order authorizing a disclosure of information about a patient does not affect an exercise of authority under these research privilege statutes.

§2.22 Notice to patients of federal confidentiality requirements.

(a) *Notice required.* At the time of admission to a part 2 program or, in the case that a patient does not have capacity upon admission to understand his or her medical status, as soon thereafter as the patient attains such capacity, each part 2 program shall:

(1) Communicate to the patient that federal law and regulations protect the confidentiality of substance use disorder patient records; and

(2) Give to the patient a summary in writing of the federal law and regulations.

(b) *Required elements of written summary.* The written summary of the federal law and regulations must include:

(1) A general description of the limited circumstances under which a part 2 program may acknowledge that an individual is present or disclose outside the part 2 program information identifying a patient as having or having had a substance use disorder;

(2) A statement that violation of the federal law and regulations by a part 2 program is a crime and that suspected violations may be reported to appropriate authorities consistent with §2.4, along with contact information;

(3) A statement that information related to a patient's commission of a crime on the premises of the part 2 program or against personnel of the part 2 program is not protected;

(4) A statement that reports of suspected child abuse and neglect made under state law to appropriate state or local authorities are not protected; and

(5) A citation to the federal law and regulations.

(c) *Program options.* The part 2 program must devise a notice to comply with the requirement to provide the patient with a summary in writing of the federal law and regulations. In this written summary, the part 2 program also may include information concerning state law and any of the part 2 program's policies that are not inconsistent with state and federal law on the subject of confidentiality of substance use disorder patient records.

§2.23 Patient access and restrictions on use.

(a) *Patient access not prohibited.* These regulations do not prohibit a part 2 program from giving a patient access to their own records, including the opportunity to inspect and copy any records that the part 2 program maintains about the patient. The part 2 program is not required to obtain a patient's written consent or other authorization under the regulations in this part in order to provide such access to the patient.

(b) *Restriction on use of information.* Information obtained by patient access to his or her patient record is subject to the restriction on use of this information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient as provided for under §2.12(d)(1).

Subpart C—Disclosures With Patient Consent

§2.31 Consent requirements.

(a) *Required elements for written consent.* A written consent to a disclosure under the regulations in this part may be paper or electronic and must include:

(1) The name of the patient.

(2) The specific name(s) or general designation(s) of the part 2 program(s), entity(ies), or individual(s) permitted to make the disclosure.

(3) How much and what kind of information is to be disclosed, including an explicit description of the substance use disorder information that may be disclosed.

(4)(i) The name(s) of the individual(s) to whom a disclosure is to be made; or

(ii) *Entities with a treating provider relationship with the patient.* If the recipient entity has a treating provider relationship with the patient whose information is being disclosed, such as a hospital, a health care clinic, or a private practice, the name of that entity; or

(iii) *Entities without a treating provider relationship with the patient.*

(A) If the recipient entity does not have a treating provider relationship with the patient whose information is being disclosed and is a third-party payer, the name of the entity; or

(B) If the recipient entity does not have a treating provider relationship with the patient whose information is being disclosed and is not covered by paragraph (a)(4)(iii)(A) of this section, such as an entity that facilitates the exchange of health information or a research institution, the name(s) of the entity(-ies); and

(1) The name(s) of an individual participant(s); or

(2) The name(s) of an entity participant(s) that has a treating provider relationship with the patient whose information is being disclosed; or

(3) A general designation of an individual or entity participant(s) or class of participants that must be limited to a participant(s) who has a treating provider relationship with the patient whose information is being disclosed.

(i) When using a general designation, a statement must be included on the consent form that the patient (or other individual authorized to sign in lieu of the patient), confirms their understanding that, upon their request and consistent with this part, they must be provided a list of entities to which their information has been disclosed pursuant to the general designation (*see* §2.13(d)).

(ii) [Reserved]

(5) The purpose of the disclosure. In accordance with §2.13(a), the disclosure must be limited to that information which is necessary to carry out the stated purpose.

(6) A statement that the consent is subject to revocation at any time except to the extent that the part 2 program or other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer

(7) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is provided.

(8) The signature of the patient and, when required for a patient who is a minor, the signature of an individual authorized to give consent under §2.14; or, when required for a patient who is incompetent or deceased, the signature of an individual authorized to sign under §2.15. Electronic signatures are permitted to the extent that they are not prohibited by any applicable law.

(9) The date on which the consent is signed.

(b) *Expired, deficient, or false consent.* A disclosure may not be made on the basis of a consent which:

(1) Has expired;

(2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;

(3) Is known to have been revoked; or

(4) Is known, or through reasonable diligence could be known, by the individual or entity holding the records to be materially false.

§2.32 Prohibition on re-disclosure.

(a) *Notice to accompany disclosure.* Each disclosure made with the patient's written consent must be accompanied by one of the following written statements:

(1) This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65; or

(2) 42 CFR part 2 prohibits unauthorized disclosure of these records.

(b) [Reserved]

§2.33 Disclosures permitted with written consent.

(a) If a patient consents to a disclosure of their records under §2.31, a part 2 program may disclose those records in accordance with that consent to any person or category of persons identified or generally designated in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of §§2.34 and 2.35, respectively.

(b) If a patient consents to a disclosure of their records under §2.31 for payment and/or health care operations activities, a lawful holder who receives such records under the terms of the written consent may further disclose those records as may be necessary for its contractors, subcontractors, or legal representatives to carry out payment and/or health care operations on behalf of such lawful holder. Disclosures to contractors, subcontractors, and legal representatives to carry out other purposes such as substance use disorder patient diagnosis, treatment, or referral for treatment are not permitted under this section. In accordance with §2.13(a), disclosures under this section must be limited to that information which is necessary to carry out the stated purpose of the disclosure.

(c) Lawful holders who wish to disclose patient identifying information pursuant to paragraph (b) of this section must have in place a written contract or comparable legal instrument with the contractor or voluntary legal representative, which provides that the contractor, subcontractor, or voluntary legal representative is fully bound by the provisions of part 2 upon receipt of the patient identifying information. In making any such disclosures, the lawful holder must furnish such recipients with the notice required under §2.32; require such recipients to implement appropriate safeguards to prevent unauthorized uses and disclosures; and require such recipients to report any unauthorized uses, disclosures, or breaches of patient identifying information to the lawful holder. The lawful holder may only disclose information to the contractor or subcontractor or voluntary legal representative that is necessary for the contractor or subcontractor or voluntary legal representative to perform its duties under the contract or comparable legal instrument. Contracts may not permit a contractor or subcontractor or voluntary legal representative to re-disclose information to a third party unless that third party is a contract agent of the contractor or subcontractor, helping them provide services described in the contract, and only as long as the agent only further discloses the information back to the contractor or lawful holder from which the information originated.

§2.34 Disclosures to prevent multiple enrollments.

(a) *Restrictions on disclosure.* A part 2 program, as defined in §2.11, may disclose patient records to a central registry or to any withdrawal management or maintenance treatment program not more than 200 miles away for the purpose of preventing the multiple enrollment of a patient only if:

(1) The disclosure is made when:

- (i) The patient is accepted for treatment;
- (ii) The type or dosage of the drug is changed; or
- (iii) The treatment is interrupted, resumed or terminated.

(2) The disclosure is limited to:

- (i) Patient identifying information;
- (ii) Type and dosage of the drug; and
- (iii) Relevant dates.

(3) The disclosure is made with the patient's written consent meeting the requirements of §2.31, except that:

(i) The consent must list the name and address of each central registry and each known withdrawal management or maintenance treatment program to which a disclosure will be made; and

(ii) The consent may authorize a disclosure to any withdrawal management or maintenance treatment program established within 200 miles of the program, but does not need to individually name all programs.

(b) *Use of information limited to prevention of multiple enrollments.* A central registry and any withdrawal management or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not re-disclose or use patient identifying information for any purpose other than the prevention of multiple enrollments unless authorized by a court order under subpart E of this part.

(c) *Permitted disclosure by a central registry to prevent a multiple enrollment.* When a member program asks a central registry if an identified patient is enrolled in another member program and the registry determines that the patient is so enrolled, the registry may disclose:

(1) The name, address, and telephone number of the member program(s) in which the patient is already enrolled to the inquiring member program; and

(2) The name, address, and telephone number of the inquiring member program to the member program(s) in which the patient is already enrolled. The member programs may communicate as necessary to verify that no error has been made and to prevent or eliminate any multiple enrollments.

(d) *Permitted disclosure by a withdrawal management or maintenance treatment program to prevent a multiple enrollment.* A withdrawal management or maintenance treatment program which has received a disclosure under this section and has determined that the patient is already enrolled may communicate as necessary with the program making the disclosure to verify that no error has been made and to prevent or eliminate any multiple enrollments.

§2.35 Disclosures to elements of the criminal justice system which have referred patients.

(a) A part 2 program may disclose information about a patient to those individuals within the criminal justice system who have made participation in the part 2 program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:

(1) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress (e.g., a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or post-trial release, probation or parole officers responsible for supervision of the patient); and

(2) The patient has signed a written consent meeting the requirements of §2.31 (except paragraph (a)(6) of this section which is inconsistent with the revocation provisions of paragraph (c) of this section) and the requirements of paragraphs (b) and (c) of this section.

(b) *Duration of consent.* The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

(1) The anticipated length of the treatment;

(2) The type of criminal proceeding involved, the need for the information in connection with the final disposition of that proceeding, and when the final disposition will occur; and

(3) Such other factors as the part 2 program, the patient, and the individual(s) within the criminal justice system who will receive the disclosure consider pertinent.

(c) *Revocation of consent.* The written consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

(d) *Restrictions on re-disclosure and use.* An individual within the criminal justice system who receives patient information under this section may re-disclose and use it only to carry out that individual's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

Subpart D—Disclosures Without Patient Consent

§2.51 Medical emergencies.

(a) *General rule.* Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained.

(b) *Special rule.* Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

(c) *Procedures.* Immediately following disclosure, the part 2 program shall document, in writing, the disclosure in the patient's records, including:

- (1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;
- (2) The name of the individual making the disclosure;
- (3) The date and time of the disclosure; and
- (4) The nature of the emergency (or error, if the report was to FDA).

§2.52 Research.

(a) Notwithstanding other provisions of this part, including paragraph (b)(2) of this section, patient identifying information may be disclosed by the part 2 program or other lawful holder of part 2 data, for the purpose of conducting scientific research if the individual designated as director or managing director, or individual otherwise vested with authority to act as chief executive officer or their designee makes a determination that the recipient of the patient identifying information:

(1) If a HIPAA-covered entity or business associate, has obtained and documented authorization from the patient, or a waiver or alteration of authorization, consistent with the HIPAA Privacy Rule at 45 CFR 164.508 or 164.512(i), as applicable; or

(2) If subject to the HHS regulations regarding the protection of human subjects (45 CFR part 46), either provides documentation that the researcher is in compliance with the requirements of the HHS regulations, including the requirements related to informed consent

or a waiver of consent (45 CFR 46.111 and 46.116) or that the research qualifies for exemption under the HHS regulations (45 CFR 46.101(b) and any successor regulations; or

(3) If both a HIPAA covered entity or business associate and subject to the HHS regulations regarding the protection of human subjects, has met the requirements of paragraphs (a)(1) and (2) of this section; and

(4) If neither a HIPAA covered entity or business associate or subject to the HHS regulations regarding the protection of human subjects, this section does not apply.

(b) Any individual or entity conducting scientific research using patient identifying information obtained under paragraph (a) of this section:

(1) Is fully bound by the regulations in this part and, if necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by the regulations in this part.

(2) Must not re-disclose patient identifying information except back to the individual or entity from whom that patient identifying information was obtained or as permitted under paragraph (c) of this section.

(3) May include part 2 data in research reports only in aggregate form in which patient identifying information has been rendered non-identifiable such that the information cannot be re-identified and serve as an unauthorized means to identify a patient, directly or indirectly, as having or having had a substance use disorder.

(4) Must maintain and destroy patient identifying information in accordance with the security policies and procedures established under §2.16.

(5) Must retain records in compliance with applicable federal, state, and local record retention laws.

(c) *Data linkages*—(1) *Researchers*. Any individual or entity conducting scientific research using patient identifying information obtained under paragraph (a) of this section that requests linkages to data sets from a data repository(-ies) holding patient identifying information must:

(i) Have the request reviewed and approved by an Institutional Review Board (IRB) registered with the Department of Health and Human Services, Office for Human Research Protections in accordance with 45 CFR part 46 to ensure that patient privacy is considered and the need for identifiable data is justified. Upon request, the researcher may be required to provide evidence of the IRB approval of the research project that contains the data linkage component.

(ii) Ensure that patient identifying information obtained under paragraph (a) of this section is not provided to law enforcement agencies or officials.

(2) *Data repositories.* For purposes of this section, a data repository is fully bound by the provisions of part 2 upon receipt of the patient identifying data and must:

(i) After providing the researcher with the linked data, destroy or delete the linked data from its records, including sanitizing any associated hard copy or electronic media, to render the patient identifying information non-retrievable in a manner consistent with the policies and procedures established under §2.16 Security for records.

(ii) Ensure that patient identifying information obtained under paragraph (a) of this section is not provided to law enforcement agencies or officials.

(2) Except as provided in paragraph (c) of this section, a researcher may not redisclose patient identifying information for data linkages purposes.

§2.53 Audit and evaluation.

(a) *Records not copied or removed.* If patient records are not downloaded, copied or removed from the premises of a part 2 program or other lawful holder, or forwarded electronically to another electronic system or device, patient identifying information, as defined in §2.11, may be disclosed in the course of a review of records on the premises of a part 2 program or other lawful holder to any individual or entity who agrees in writing to comply with the limitations on re-disclosure and use in paragraph (d) of this section and who:

(1) Performs the audit or evaluation on behalf of:

(i) Any federal, state, or local governmental agency that provides financial assistance to a part 2 program or other lawful holder, or is authorized by law to regulate the activities of the part 2 program or other lawful holder;

(ii) Any individual or entity which provides financial assistance to the part 2 program or other lawful holder, which is a third-party payer covering patients in the part 2 program, or which is a quality improvement organization performing a utilization or quality control review, or such individual's or entity's or quality improvement organization's contractors, subcontractors, or legal representatives.

(2) Is determined by the part 2 program or other lawful holder to be qualified to conduct an audit or evaluation of the part 2 program or other lawful holder.

(b) *Copying, removing, downloading, or forwarding patient records.* Records containing patient identifying information, as defined in §2.11, may be copied or removed from the premises of a part 2 program or other lawful holder or downloaded or forwarded to another electronic system or device from the part 2 program's or other lawful holder's electronic records by any individual or entity who:

(1) Agrees in writing to:

(i) Maintain and destroy the patient identifying information in a manner consistent with the policies and procedures established under §2.16;

(ii) Retain records in compliance with applicable federal, state, and local record retention laws; and

(iii) Comply with the limitations on disclosure and use in paragraph (d) of this section; and

(2) Performs the audit or evaluation on behalf of:

(i) Any federal, state, or local governmental agency that provides financial assistance to the part 2 program or other lawful holder, or is authorized by law to regulate the activities of the part 2 program or other lawful holder; or

(ii) Any individual or entity which provides financial assistance to the part 2 program or other lawful holder, which is a third-party payer covering patients in the part 2 program, or which is a quality improvement organization performing a utilization or quality control review, or such individual's or entity's or quality improvement organization's contractors, subcontractors, or legal representatives.

(c) *Medicare, Medicaid, Children's Health Insurance Program (CHIP), or related audit or evaluation.* (1) Patient identifying information, as defined in §2.11, may be disclosed under paragraph (c) of this section to any individual or entity for the purpose of conducting a Medicare, Medicaid, or CHIP audit or evaluation, including an audit or evaluation necessary to meet the requirements for a Centers for Medicare & Medicaid Services (CMS)-regulated accountable care organization (CMS-regulated ACO) or similar CMS-regulated organization (including a CMS-regulated Qualified Entity (QE)), if the individual or entity agrees in writing to comply with the following:

(i) Maintain and destroy the patient identifying information in a manner consistent with the policies and procedures established under §2.16;

(ii) Retain records in compliance with applicable federal, state, and local record retention laws; and

(iii) Comply with the limitations on disclosure and use in paragraph (d) of this section.

(2) A Medicare, Medicaid, or CHIP audit or evaluation under this section includes a civil or administrative investigation of a part 2 program by any federal, state, or local government agency with oversight responsibilities for Medicare, Medicaid, or CHIP and includes administrative enforcement, against the part 2 program by the government agency, of any remedy authorized by law to be imposed as a result of the findings of the investigation.

(3) An audit or evaluation necessary to meet the requirements for a CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) must be conducted in accordance with the following:

(i) A CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) must:

(A) Have in place administrative and/or clinical systems; and

(B) Have in place a leadership and management structure, including a governing body and chief executive officer with responsibility for oversight of the organization's management and for ensuring compliance with and adherence to the terms and conditions of the Participation Agreement or similar documentation with CMS; and

(ii) A CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) must have a signed Participation Agreement or similar documentation with CMS, which provides that the CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE):

(A) Is subject to periodic evaluations by CMS or its agents, or is required by CMS to evaluate participants in the CMS-regulated ACO or similar CMS-regulated organization (including a CMS-regulated QE) relative to CMS-defined or approved quality and/or cost measures;

(B) Must designate an executive who has the authority to legally bind the organization to ensure compliance with 42 U.S.C. 290dd-2 and this part and the terms and conditions of the Participation Agreement in order to receive patient identifying information from CMS or its agents;

(C) Agrees to comply with all applicable provisions of 42 U.S.C. 290dd-2 and this part;

(D) Must ensure that any audit or evaluation involving patient identifying information occurs in a confidential and controlled setting approved by the designated executive;

(E) Must ensure that any communications or reports or other documents resulting from an audit or evaluation under this section do not allow for the direct or indirect identification (*e.g.*, through the use of codes) of a patient as having or having had a substance use disorder; and

(F) Must establish policies and procedures to protect the confidentiality of the patient identifying information consistent with this part, the terms and conditions of the Participation Agreement, and the requirements set forth in paragraph (c)(1) of this section.

(4) Program, as defined in §2.11, includes an employee of, or provider of medical services under the program when the employee or provider is the subject of a civil investigation or administrative remedy, as those terms are used in paragraph (c)(2) of this section.

(5) If a disclosure to an individual or entity is authorized under this section for a Medicare, Medicaid, or CHIP audit or evaluation, including a civil investigation or administrative remedy, as those terms are used in paragraph (c)(2) of this section, the individual or entity may further disclose the patient identifying information that is received for such purposes to its contractor(s), subcontractor(s), or legal representative(s), to carry out the audit or evaluation, and a quality improvement organization which obtains such information under paragraph (a) or (b) of this section may disclose the information to that individual or entity (or, to such individual's or entity's contractors, subcontractors, or legal representatives, but only for the purposes of this section).

(6) The provisions of this paragraph do not authorize the part 2 program, the federal, state, or local government agency, or any other individual or entity to disclose or use patient identifying information obtained during the audit or evaluation for any purposes other than those necessary to complete the audit or evaluation as specified in paragraph (c) of this section.

(d) Limitations on disclosure and use. Except as provided in paragraph (c) of this section, patient identifying information disclosed under this section may be disclosed only back to the part 2 program or other lawful holder from which it was obtained and may be used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by a court order entered under §2.66.

[82 FR 6115, Jan. 18, 2017, as amended at 83 FR 252, Jan. 3, 2018]

Subpart E—Court Orders Authorizing Disclosure and Use

§2.61 Legal effect of order.

(a) *Effect.* An order of a court of competent jurisdiction entered under this subpart is a unique kind of court order. Its only purpose is to authorize a disclosure or use of patient information which would otherwise be prohibited by 42 U.S.C. 290dd-2 and the regulations in this part. Such an order does not compel disclosure. A subpoena or a similar legal mandate must be issued in order to compel disclosure. This mandate may be entered at the same time as and accompany an authorizing court order entered under the regulations in this part.

(b) *Examples.* (1) A person holding records subject to the regulations in this part receives a subpoena for those records. The person may not disclose the records in response to the subpoena unless a court of competent jurisdiction enters an authorizing order under the regulations in this part.

(2) An authorizing court order is entered under the regulations in this part, but the person holding the records does not want to make the disclosure. If there is no subpoena or other

compulsory process or a subpoena for the records has expired or been quashed, that person may refuse to make the disclosure. Upon the entry of a valid subpoena or other compulsory process the person holding the records must disclose, unless there is a valid legal defense to the process other than the confidentiality restrictions of the regulations in this part.

§2.62 Order not applicable to records disclosed without consent to researchers, auditors and evaluators.

A court order under the regulations in this part may not authorize qualified personnel, who have received patient identifying information without consent for the purpose of conducting research, audit or evaluation, to disclose that information or use it to conduct any criminal investigation or prosecution of a patient. However, a court order under §2.66 may authorize disclosure and use of records to investigate or prosecute qualified personnel holding the records.

§2.63 Confidential communications.

(a) A court order under the regulations in this part may authorize disclosure of confidential communications made by a patient to a part 2 program in the course of diagnosis, treatment, or referral for treatment only if:

(1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties;

(2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime allegedly committed by the patient, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect; or

(3) The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

(b) [Reserved]

§2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.

(a) *Application.* An order authorizing the disclosure of patient records for purposes other than criminal investigation or prosecution may be applied for by any person having a legally recognized interest in the disclosure which is sought. The application may be filed separately or as part of a pending civil action in which the applicant asserts that the patient records are needed to provide evidence. An application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying

information unless the patient is the applicant or has given written consent (meeting the requirements of the regulations in this part) to disclosure or the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice.* The patient and the person holding the records from whom disclosure is sought must be provided:

(1) Adequate notice in a manner which does not disclose patient identifying information to other persons; and

(2) An opportunity to file a written response to the application, or to appear in person, for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order as described in §2.64(d).

(c) *Review of evidence: Conduct of hearing.* Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceeding, the patient, or the person holding the record, unless the patient requests an open hearing in a manner which meets the written consent requirements of the regulations in this part. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria for entry of order.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find that:

(1) Other ways of obtaining the information are not available or would not be effective; and

(2) The public interest and need for the disclosure outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.

(e) *Content of order.* An order authorizing a disclosure must:

(1) Limit disclosure to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those persons whose need for information is the basis for the order; and

(3) Include such other measures as are necessary to limit disclosure for the protection of the patient, the physician-patient relationship and the treatment services; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

§2.65 Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients.

(a) *Application.* An order authorizing the disclosure or use of patient records to investigate or prosecute a patient in connection with a criminal proceeding may be applied for by the person holding the records or by any law enforcement or prosecutorial officials who are responsible for conducting investigative or prosecutorial activities with respect to the enforcement of criminal laws. The application may be filed separately, as part of an application for a subpoena or other compulsory process, or in a pending criminal action. An application must use a fictitious name such as John Doe, to refer to any patient and may not contain or otherwise disclose patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice and hearing.* Unless an order under §2.66 is sought in addition to an order under this section, the person holding the records must be provided:

(1) Adequate notice (in a manner which will not disclose patient identifying information to other persons) of an application by a law enforcement agency or official;

(2) An opportunity to appear and be heard for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order as described in §2.65(d); and

(3) An opportunity to be represented by counsel independent of counsel for an applicant who is a law enforcement agency or official.

(c) *Review of evidence: Conduct of hearings.* Any oral argument, review of evidence, or hearing on the application shall be held in the judge's chambers or in some other manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceedings, the patient, or the person holding the records. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria.* A court may authorize the disclosure and use of patient records for the purpose of conducting a criminal investigation or prosecution of a patient only if the court finds that all of the following criteria are met:

(1) The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect.

(2) There is a reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.

(3) Other ways of obtaining the information are not available or would not be effective.

(4) The potential injury to the patient, to the physician-patient relationship and to the ability of the part 2 program to provide services to other patients is outweighed by the public interest and the need for the disclosure.

(5) If the applicant is a law enforcement agency or official, that:

(i) The person holding the records has been afforded the opportunity to be represented by independent counsel; and

(ii) Any person holding the records which is an entity within federal, state, or local government has in fact been represented by counsel independent of the applicant.

(e) *Content of order.* Any order authorizing a disclosure or use of patient records under this section must:

(1) Limit disclosure and use to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those law enforcement and prosecutorial officials who are responsible for, or are conducting, the investigation or prosecution, and limit their use of the records to investigation and prosecution of the extremely serious crime or suspected crime specified in the application; and

(3) Include such other measures as are necessary to limit disclosure and use to the fulfillment of only that public interest and need found by the court.

§2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a part 2 program or the person holding the records.

(a) *Application.* (1) An order authorizing the disclosure or use of patient records to investigate or prosecute a part 2 program or the person holding the records (or employees or agents of that part 2 program or person holding the records) in connection with a criminal or administrative matter may be applied for by any administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency having jurisdiction over the program's or person's activities.

(2) The application may be filed separately or as part of a pending civil or criminal action against a part 2 program or the person holding the records (or agents or employees of the part 2 program or person holding the records) in which the applicant asserts that the patient records are needed to provide material evidence. The application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny or the patient has provided written consent (meeting the requirements of §2.31) to that disclosure.

(b) *Notice not required.* An application under this section may, in the discretion of the court, be granted without notice. Although no express notice is required to the part 2 program, to the person holding the records, or to any patient whose records are to be disclosed, upon implementation of an order so granted any of the above persons must be afforded an opportunity to seek revocation or amendment of that order, limited to the presentation of evidence on the statutory and regulatory criteria for the issuance of the court order in accordance with §2.66(c).

(c) *Requirements for order.* An order under this section must be entered in accordance with, and comply with the requirements of, paragraphs (d) and (e) of §2.64.

(d) *Limitations on disclosure and use of patient identifying information.* (1) An order entered under this section must require the deletion of patient identifying information from any documents made available to the public.

(2) No information obtained under this section may be used to conduct any investigation or prosecution of a patient in connection with a criminal matter, or be used as the basis for an application for an order under §2.65.

§2.67 Orders authorizing the use of undercover agents and informants to investigate employees or agents of a part 2 program in connection with a criminal matter.

(a) *Application.* A court order authorizing the placement of an undercover agent or informant in a part 2 program as an employee or patient may be applied for by any law enforcement or prosecutorial agency which has reason to believe that employees or agents of the part 2 program are engaged in criminal misconduct.

(b) *Notice.* The part 2 program director must be given adequate notice of the application and an opportunity to appear and be heard (for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order in accordance with §2.67(c)), unless the application asserts that:

(1) The part 2 program director is involved in the suspected criminal activities to be investigated by the undercover agent or informant; or

(2) The part 2 program director will intentionally or unintentionally disclose the proposed placement of an undercover agent or informant to the employees or agents of the program who are suspected of criminal activities.

(c) *Criteria.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find all of the following:

(1) There is reason to believe that an employee or agent of the part 2 program is engaged in criminal activity;

(2) Other ways of obtaining evidence of the suspected criminal activity are not available or would not be effective; and

(3) The public interest and need for the placement of an undercover agent or informant in the part 2 program outweigh the potential injury to patients of the part 2 program, physician-patient relationships and the treatment services.

(d) *Content of order.* An order authorizing the placement of an undercover agent or informant in a part 2 program must:

(1) Specifically authorize the placement of an undercover agent or an informant;

(2) Limit the total period of the placement to six months;

(3) Prohibit the undercover agent or informant from disclosing any patient identifying information obtained from the placement except as necessary to investigate or prosecute employees or agents of the part 2 program in connection with the suspected criminal activity; and

(4) Include any other measures which are appropriate to limit any potential disruption of the part 2 program by the placement and any potential for a real or apparent breach of patient confidentiality; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

(e) *Limitation on use of information.* No information obtained by an undercover agent or informant placed in a part 2 program under this section may be used to investigate or prosecute any patient in connection with a criminal matter or as the basis for an application for an order under §2.65.

RE-DISCLOSURE PROHIBITION STATEMENT

Redis~~closure~~

42 CFR - §2.32
Excerpts from the Federal Law Relating to the
Prohibition on Redis

Notice to accompany disclosure. Each disclosure made with the patient's written consent must be accompanied by of the the following written statements:

This information has been disclosed to you from records protected by federal confidentiality rules (*42 CFR part 2*). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is *NOT* sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

OR

42 CFR part 2 prohibits unauthorized disclosure of these records

Pennsylvania Drug and Alcohol Abuse Control Act (Act 63 of 1972)

71 P.S. §§1690.102-1690.112

Excerpts from the State Law Relating to the Confidentiality of Records of Substance Abuse Treatment Services

§ 1690.108. Confidentiality of records

(a) A complete medical, social, occupational, and family history shall be obtained as part of the diagnosis, classification and treatment of a patient pursuant to this act. Copies of all pertinent records from other agencies, practitioners, institutions, and medical facilities shall be obtained in order to develop a complete and permanent confidential personal history for purposes of the patient's treatment.

(b) All patient records (including all records relating to any commitment proceeding) prepared or obtained pursuant to this act, and all information contained therein, shall remain confidential, and may be disclosed only with the patient's consent and only (i) to medical personnel exclusively for purposes of diagnosis and treatment of the patient or (ii) to government or other officials exclusively for the purpose of obtaining benefits due the patient as a result of his drug or alcohol abuse or drug or alcohol dependence except that in emergency medical situations where the patient's life is in immediate jeopardy, patient records may be released without the patient's consent to proper medical authorities solely for the purpose of providing medical treatment to the patient. Disclosure may be made for purposes unrelated to such treatment or benefits only upon an order of a court of common pleas after application showing good cause therefor. In determining whether there is good cause for disclosure, the court shall weigh the need for the information sought to be disclosed against the possible harm of disclosure to the person to whom such information pertains, the physician-patient relationship, and to the treatment services, and may condition disclosure of the information upon any appropriate safeguards. No such records or information may be used to initiate or substantiate criminal charges against a patient under any circumstances.

(c) All patient records and all information contained therein relating to drug or alcohol abuse or drug or alcohol dependence prepared or obtained by a private practitioner, hospital, clinic, drug rehabilitation or drug treatment center shall remain confidential and may be disclosed only with the patient's consent and only (i) to medical personnel exclusively for purposes of diagnosis and treatment of the patient or (ii) to government or other officials exclusively for the purpose of obtaining benefits due the

patient as a result of his drug or alcohol abuse or drug or alcohol dependence except that in emergency medical situations where the patient's life is in immediate jeopardy, patient records may be released without the patient's consent to proper medical authorities solely for the purpose of providing medical treatment to the patient.

§ 1690.112. Consent of minor

Notwithstanding any other provisions of law, a minor who suffers from the use of a controlled or harmful substance may give consent to furnishing of medical care or counseling related to diagnosis or treatment. The consent of the parents or legal guardian of the minor shall not be necessary to authorize medical care or counseling related to such diagnosis or treatment. The consent of the minor shall be valid and binding as if the minor had achieved his majority. Such consent shall not be voidable nor subject to later disaffirmance because of minority. Any physician or any agency or organization operating a drug abuse program, who provides counseling to a minor who uses any controlled or harmful substance may, but shall not be obligated to inform the parents or legal guardian of any such minor as to the treatment given or needed.

§ 1690.112a. Commitment of Minors

(a) A parent or legal guardian who has legal or physical custody of a minor may petition the court of common pleas of the judicial district where the minor is domiciled for commitment of the minor to involuntary drug and alcohol treatment services, including inpatient services, if the minor is incapable of accepting or unwilling to accept voluntary treatment. The petition shall set forth sufficient facts and good reason for the commitment. Such matters shall be heard by the division or a judge of the court assigned to conduct proceedings under 42 Pa.C.S. Ch. 63.

CHAPTER 255. MANAGEMENT INFORMATION, RESEARCH, AND EVALUATION

Sec.

- 255.1. Statement of policy.
- 255.2. UDCS: purposes.
- 255.3. UDCS: facets.
- 255.4. UDCS: confidentiality and access to information.
- 255.5. Projects and coordinating bodies: disclosure of client-oriented information.
- 255.6. Project responsibility for security of information.
- 255.7. Research and evaluation.

§ 255.1. Statement of Policy.

(a) A primary goal of the Council is to evaluate the effectiveness and integrity of the prevention, intervention, and treatment delivery system. In order to meet that goal, the Council has established a Uniform Data Collection System (UDCS).

(b) The Council hereby delegates to the SCA the authority to implement the UDCS in all projects geographically located in the respective SCA. Failure to comply with the SCA implementation of the UDCS by projects will lead to administrative action by the Council.

(c) When the UDCS is installed, the use of all other reporting systems shall cease. Exceptions may be granted by the Executive Director. Projects shall use such forms in reporting as the Council may direct and shall submit such forms at the times specified by the Council.

(d) As mandated by section 8 of Act 63 (71 P. S. § 1690.108), the Council will require all projects, SCAs and governmental agencies to insure that all persons treated or rehabilitated or both, including all persons formerly treated or rehabilitated or both, for drug and alcohol abuse and dependence, be secure in their right to privacy except as disclosure is permitted by law.

Source

The provisions of this § 255.1 amended June 15, 1979, effective June 16, 1979, 9 Pa.B. 1862. Immediately preceding text appears at serial page (35069).

§ 255.2. UDCS: purposes.

(a) UDCS shall serve several purposes including, but not limited to, the following:

- (1) Provide feedback to prevention, intervention and treatment projects.
 - (2) Provide information necessary for the Council and other State agencies.
 - (3) Provide information necessary for the SCAs in carrying out their management and coordinating responsibilities.
 - (4) Generate such data as required by Federal agencies.
 - (5) Provide data necessary for exploratory research.
 - (6) Provide information as necessary for the Council to develop policy.
- (b) In order to effectively implement the UDCS, the Council will consult with the SCAs.

Source

The provisions of this § 255.2 amended June 15, 1979, effective June 16, 1979, 9 Pa.B. 1862. Immediately preceding text appears at serial page (35070).

§ 255.3. UDCS: facets.

All programs designated by the Council shall implement the UDCS which has three facets:

- (1) *Client facet.* Provides data on the demography, characteristics and problems of those persons receiving drug and alcohol treatment services. In addition, client progress is evaluated by the use of follow-up reports.
- (2) *Fiscal management facet.* Provides planning, budgeting and performance data as a part of the fiscal management system. This facet includes program budgeting, fiscal reporting and performance reporting requirements which serve to link the client, fiscal and program management facets. Reported expenditures are evaluated against planned expenditures.
- (3) *Program management facet.* Provides basic information on the characteristics of the facilities and identifies them by activities, approaches, and budgeted capacity. This facet also produces reports showing actual clients versus budgeted capacity.

Source

The provisions of this § 255.3 amended June 15, 1979, effective June 16, 1979, 9 Pa.B. 1862. Immediately preceding text appears at serial page (35070).

§ 255.4. UDCS: confidentiality and access to information.

- (a) Reports developed from the UDCS shall be made available to the SCA, the projects and the Council. In addition, summary reports shall be made available to the public.

(b) It is the policy of the Council that reliable researchers wishing to use the data base may obtain access by approval of the Council. All requests to use that data base will be reviewed on their individual merits by the Council.

(c) The Council will not enter names of clients or any other client-identifying information on any list or into any data processing system except as required by law. Instead, the Council will require and direct projects and coordinating bodies to randomly assign numbers to clients. These numbers will be entered on Client Forms in such a manner that record continuity and client confidentiality are maintained. One copy of these forms shall be sent to the Council.

Cross References

This section cited in 28 Pa. Code § 710.23 (relating to patient records).

§ 255.5. Projects and coordinating bodies: disclosure of client-oriented information.

(a) *Disclosure.* Information systems and reporting systems shall not disclose or be used to disclose client oriented data which reasonably may be utilized to identify the client to any person, agency, institution, governmental unit, or law enforcement personnel. Project staff may disclose client oriented data only under the following situations:

(1) With or without the consent of the client information may be released to those judges who have imposed sentence on a particular client where such sentence is conditioned upon the client entering a project. Information released shall be limited to that provided for in subsection (b).

(2) With or without the consent of the client, information may be released to those duly authorized probation or parole officers or both who have assigned responsibility to clients in treatment if the probation or parole of the client is conditioned upon his being in treatment. Information released shall be limited to that provided for in subsection (b).

(3) With or without the consent of the client, to judges who have assigned a client to a project under a pre-sentence, conditional release program. Presentence conditional release programs include preindictment or preconviction conditional release such as Accelerated Rehabilitative Disposition, probation without verdict or disposition in lieu of trial under sections 17 and 18 of Act 64 (35 P. S. § 780-117 and 780-118).

(4) With the consent of the client, in writing, to a judge in order to assist that judge in deciding whether to initiate conditional release programs including those specified in paragraph (3).

(5) Projects may disclose any information to the attorney of a client provided as follows:

(i) The client consents, in writing to the disclosure of information.

(ii) The attorney is representing the client in a criminal, civil or administrative proceeding.

(6) Projects may disclose with the consent of a client, in writing, the information to employers of a client to further the rehabilitation of a client; or, to a prospective employer who affirmatively expresses that information is sought to enable the employer to engage the client as an employee. Such information shall be limited to whether the client has or is receiving treatment with the project.

(7) Projects may disclose information as set forth in subsection (b) with the consent of a client, in writing, to an insurance company, health, or hospital plan or facsimile thereof, which has contracted with the client to provide or will provide medical, hospital, disability or similar benefits. In the event that an insurance company, health, or hospital plan remains dissatisfied with the content of the information released with regard to a client in accordance with this paragraph, such insurance company, health or hospital plan may apply to the Executive Director for additional information with the written consent of the client and, upon approval by the Executive Director, such information may be released.

(8) Projects may disclose information as set forth in subsection (b) with the consent of a client, in writing, to governmental officials for the purpose of obtaining governmental benefits due the client as a result of his drug or alcohol abuse or dependence.

(9) In emergency medical situations where the life of the client is in immediate jeopardy, projects may release client records without the consent of the client to proper medical authorities solely for the purpose of providing medical treatment to the client.

(10) Projects shall keep and maintain a written record of all information and data which are disclosed under this section.

(b) *Restrictions.* Information released to judges, probation or parole officers, insurance company health or hospital plan or governmental officials, under subsection (a)(1), (2), (4), (7) and (8), is for the purpose of determining the advisability of continuing the client with the assigned project and shall be restricted to the following:

(1) Whether the client is or is not in treatment.

(2) The prognosis of the client.

(3) The nature of the project.

(4) A brief description of the progress of the client.

(5) A short statement as to whether the client has relapsed into drug, or alcohol abuse and the frequency of such relapse.

(c) *Record transfer.* The Client Admission Forms, the Treatment/Discharge Forms, and Discharge Summary Records are the only client records which may be transferred for treatment purposes. The transfer may be initiated upon the request of a client or by the present project of a client. In any case, the client shall fully understand the nature of the information, the purpose of

the record transfer, and the identity of the recipient of the information. Only after these conditions are met, may the client authorize the transfer by signing a Release Form provided by the UDCS.

(d) *Coordinating bodies.* Coordinating bodies can gather and retain client oriented data provided they will receive or send only those forms as listed in subsection (c) in assigning or transferring clients and those bodies will not disclose such data, except to the Council, in a manner that is consistent with this chapter and Act 63.

Cross References

This section cited in 4 Pa. Code § 257.4 (relating to case management); 28 Pa. Code § 709.28 (relating to confidentiality); 28 Pa. Code § 710.23 (relating to patient records); 28 Pa. Code § 711.43 (relating to client records); 28 Pa. Code § 711.53 (relating to client records); 28 Pa. Code § 711.62 (relating to client records); 28 Pa. Code § 711.72 (relating to client records); 28 Pa. Code § 711.83 (relating to client records); 28 Pa. Code § 711.93 (relating to client records); and 55 Pa. Code § 5230.17 (relating to confidentiality).

§ 255.6. Project responsibility for security of information.

- (a) This chapter shall take effect in a project when the UDCS is installed therein.
- (b) Each project shall develop and implement security measures for all information.
- (c) Prior to the date of installation, the project shall notify the Executive Director in writing of the name of a member of the staff who has been assigned the responsibility of insuring that the project complies with this part and Act 63.
- (d) The project shall immediately notify the Executive Director, in writing, of the transfer of these responsibilities to another staff member.

§ 255.7. Research and evaluation.

- (a) General requirements shall be as follows:
 - (1) This section is intended to protect the confidentiality of client oriented data.
 - (2) External evaluations and research shall be implemented in such a manner as to protect client confidentiality.
 - (3) Prior to the initiation of all external evaluations and research, a proposal shall be submitted to the Executive Director in which the procedures for protecting client confidentiality shall be fully explained. Initiation of external evaluations and research shall be contingent upon written approval from the Executive Director.
- (b) Research shall be as follows:

(1) Basic research has been viewed as the prerogative of the Federal Government. While the Council supports that policy, it has determined that it, too, will play a role in research efforts that are directed toward expanding the body of theoretical and empirical knowledge concerning drug and alcohol use, abuse, and dependence. To this end, the Council will engage in the following activities:

(i) The Council will engage in the direct funding of certain research efforts. The Executive Director or his designee is authorized to review all proposals in this area and to make evaluations and recommendations to the Council.

(ii) The Council will also coordinate and review all drug and alcohol research projects operating within this Commonwealth. In order to undertake such activity, all researchers shall be requested to submit to the Council annual reports concerning their drug and alcohol research activities.

(iii) Research may also be conducted by projects and SCA's. An independent contractor may be hired by any of these levels of organization. In each case, all research proposals must be submitted to the Executive Director or his designee for final approval. A copy of all final reports shall be submitted to the Executive Director or his designee for review and approval. If a project desires to carry out a study, it should contact its SCA. The SCA, in turn, shall either arrange for the project to deal directly with an independent contractor, or it shall direct the project to the Council. The assistance given by the Council will be a function, in part, of the level of expertise possessed by the project or SCA staffs.

(iv) The Council will conduct its own program of research. This program will use data collected from UDACS, Statewide incidence and prevalence studies, and special studies. The objective of these investigations will be to define the parameters of drug and alcohol use, abuse, and dependence in this Commonwealth, to test hypotheses derived from theories about substance use and abuse, and to expand existing theory. The research efforts will also be directed toward determining the types of clients who are most effectively served by various treatment approaches supported by the Council.

(c) Evaluation shall be as follows:

(1) There are two major ways in which evaluations shall be conducted: uniform and unique. The uniform evaluation shall consist of the appraisal of all prevention, intervention and treatment projects in accordance with a set of objectives designated by the Council. This system shall be implemented Statewide, and all prevention, intervention, and treatment projects operated in this Commonwealth shall be subject to uniform evaluation.

(2) The objectives of uniform evaluation for prevention, intervention, and treatment projects will be determined by the Council and issued as guidelines.

(3) Unique evaluation shall consist of a self-appraisal of a project relative to treatment objectives derived from its particular goals. Unique evaluations shall apply to prevention, intervention, and treatment projects. The criteria of success to be used in conducting unique

evaluations should reflect a unique orientation and circumstances of a project. All unique evaluations must be in accordance with guidelines issued by the Council.

(4) SCAs are responsible to conduct at least one unique evaluation of each SCA funded project per year. A copy of the completed report shall be filed with the Office of Research and Evaluation no later than 30 days after the completion of the report.

(5) An evaluation system provides a useful data base to projects in order to assist them in the realization of their goals. The ultimate goal of evaluation efforts in this Commonwealth is the improvement of treatment, intervention, and prevention services.

Source

The provisions of this § 255.7 amended June 15, 1979, effective June 16, 1979, 9 Pa.B. 1862. Immediately preceding text appears at serial pages (41905) and (41906).

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§ 709.28. Confidentiality.

(a) A written procedure shall be developed by the project director which shall comply with 4 Pa. Code § 255.5 (relating to projects and coordinating bodies: disclosure of client-oriented information). The procedure must include, but not be limited to:

(1) Confidentiality of client identity and records. Procedures must include a description of how the project plans to address security and release of electronic and paper records and identification of the person responsible for maintenance of client records.

(2) Identification of project staff having access to records, and the methods by which staff gain access.

(b) The project shall secure hard copy client records within locked storage containers. Electronic records must be stored on secure, password protected data bases.

(c) The project shall obtain an informed and voluntary consent from the client for the disclosure of information contained in the client record. The consent must be in writing and include, but not be limited to:

(1) Name of the person, agency or organization to whom disclosure is made.

(2) Specific information disclosed.

(3) Purpose of disclosure.

(4) Dated signature of client or guardian as provided for under 42 CFR 2.14(a) and (b) and 2.15 (relating to minor patients; and incompetent and deceased patients).

(5) Dated signature of witness.

(6) Date, event or condition upon which the consent will expire.

(d) A copy of a client consent shall be offered to the client and a copy maintained in the client record.

(e) When consent is not required, the project personnel shall:

(1) Fully document the disclosure in the client records.

(2) Inform the client, as readily as possible, that the information was disclosed, for what purposes and to whom.

Authority

The provisions of this § 709.28 amended under section 2301-A of The Administrative Code of 1929 (71 P. S. § 613.1).

Source

The provisions of this § 709.28 amended October 17, 2014, effective October 18, 2014, 44 Pa.B. 6660. Immediately preceding text appears at serial page (293158).

Cross References

This section cited in 28 Pa. Code § 715.11 (relating to confidentiality of patient records).

709-10

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**DIVISION OF DRUG AND ALCOHOL
PROGRAM LICENSING**

CHAPTER 709
SUBCHAPTER C. GENERAL STANDARDS FOR FREE-STANDING
TREATMENT ACTIVITIES¹

Interpretive Guideline

28 PA Code §709.28 Confidentiality

(a) A written procedures shall be developed by the project director which shall comply with the provisions of 4 PA Code §255.5 (relating to projects and coordinating bodies: disclosure of client information). This procedure shall include, but not be limited to:

- (1) Confidentiality of client identity and records.
- (2) Staff access to client records.

Chapter 255.5 State Plan of the Prevention, Treatment and Control of Drug and Alcohol Abuse

Projects and Coordinating Bodies: Disclosure of Client –Oriented Information.
With or without the client’s consent,² information may be released to those judges who have imposed sentence on a particular client where such sentence is conditioned upon the client entering a project. Information released shall be limited to that provided for in subsection (b) of this section.

With or without the client’s consent, information may be released to those duly authorized probation or parole officers who have assigned responsibility to clients in treatment if the client’s probation or paroled is conditioned on his being in treatment. Information released shall be limited to that provided for in subsection (b) of this section. With or without the client’s consent, information may be released to judges who have assigned a client to a project under a pre-sentence, conditional release program. Pre-sentence conditional release programs include pre-indictment or pre-conviction conditional release (such as ARD) probation without verdict or disposition in lieu of trial pursuant to section 17 and 18 of Act 64 (35 P.S. 780-117 and 780-118).

¹ Also applicable for Chapter 711, Standards for Certification of Treatment Activities which are part of a Health Care Facility.

² Refer to the Federal Register 42 CFR Part 11, Subpart C, Confidentiality of Alcohol and Drug Abuse Patient Records, and 71 P.S. §1690.108(b) which requires written client consent.

In emergency medical situations where the client's life is in immediate jeopardy, projects may release client records without the client's consent to proper medical authorities solely for the purpose of providing medical treatment to the client.

Information released to judges, probation or parole officers, insurance company, health or hospital plan or governmental officials, pursuant to paragraphs (1), (2), (4), (7), (8) or subsection (a) of this section, is for the purpose of determining the advisability of continuing the client with the assigned project and shall be restricted to the following.

- (1) Whether the client is or is not in treatment.
- (2) Client's prognosis.
- (3) The nature of the project.
- (4) A brief description of the client's progress.
- (5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

The Division has further defined the types of information that are consistent with the intent of the restrictions and are described as follows:

(1) Whether the client is or is not in treatment.

With the client's written consent the provider may tell whether the client is or is not in treatment and can further elaborate on this theme by providing an estimate of the length of time the client may be required to stay with the program in order to complete treatment. The provider can disclose if and when a client terminated treatment (unless the client revokes his/her consent to release information prior to terminating treatment) and can elaborate on the client's attendance patterns, which may include date of session(s), types of service provided, and length of session.

(2) Client's prognosis.

Webster's Dictionary defines 'prognosis' as "the prospect of recovery as anticipated from the usual course of disease or peculiarities of the case." With the client's written consent, the provider may disclose the client's diagnosis which can be considered a part of the prognosis. The provider may provide his/her opinion of how treatment will or will not benefit the client. The provider would be basing his/her opinion on personal observations and the information the provider obtained during the intake process. The provider can discuss any peculiarities of a case only in a very general way. Intimate details provided by the client to the provider and included in the psychosocial history and evaluation are

not appropriate for release and should not be released to or discussed with any entity covered by 4 PA Code §255.5. The provider can present his/her own recommendations regarding the client's continuation with the treatment project.

(3) The nature of the project.

The provider can describe the purpose and philosophy of his/her project. The provider can describe the program structure, the methodology of treatment and the treatment models that are utilized by the project. The provider can describe the type of services that would be offered to a client in a standard course of treatment at that agency. Supportive services and support groups that are commonly used by this agency could be described. The provider cannot release the treatment plan itself, but may give a clear indication of the typical services provided by describing the nature of the project as indicated above.

(4) A brief description of the client's progress.

With the client's written consent, the provider can speak about the client's progress in treatment. The provider can speak in general terms of the client's progress or lack of progress as it relates to recovery in general. The provider can speak in general terms of the client's cooperation or lack of cooperation with the treatment plan and the facility rules, and acceptance of his/her condition, but may not identify the specific components of the treatment plan.

(5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

The provider can, with the client's written consent, report relapses into drug or alcohol abuse and the frequency of such relapse. The project should be careful in training staff in the difference between an incidence of "use" and a relapse. Depending on project philosophy an isolated incident of use may or may not constitute "relapse." These reports should be brief and to the point, in accordance with the written consent to release information form obtained from the client. These reports should never indicate the nature of the relapse to the extent of naming the substances with which the client relapsed. The restrictions here do not appear to allow the provider to release copies of the actual toxicology reports or blood workups. It is important to remember that the Federal regulations prohibit the use of any information obtained during the provision of drug and alcohol treatment; the diagnosis for the need for drug and alcohol treatment; or the referral for drug or alcohol treatment; for any criminal, civil, administrative or legislative actions against the client.



BULLETIN



COMMONWEALTH OF PENNSYLVANIA

Department of Public Welfare -- Office of Children, Youth and Families

Department of Public Welfare -- Office of Mental Health and Substance Abuse Services

Department of Health -- Health Promotion and Disease Prevention

Department of Health -- Quality Assurance

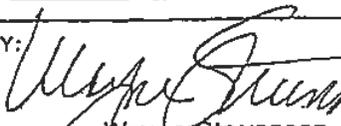
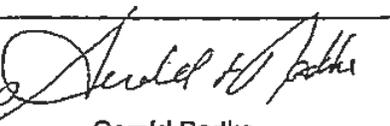
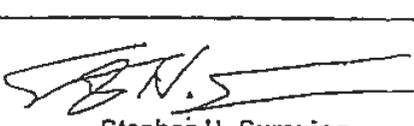
Juvenile Court Judges' Commission

ISSUE DATE: JUN 01 2002	EFFECTIVE DATE: Immediately	NUMBER: 00-02-03
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SUBJECT:

PROTOCOL FOR SHARING DRUG & ALCOHOL INFORMATION

BY:

 Wayne Stevenson Deputy Secretary for Children, Youth and Families	 Gerald Radke Deputy Secretary for Mental Health and Substance Abuse Services	 Stephen H. Suroviec Deputy Secretary for Health Promotion and Disease Prevention
 Richard Lee Deputy Secretary for Quality Assurance	 James E. Anderson Executive Director, Juvenile Court Judges' Commission	

SCOPE: CHIEF JUVENILE PROBATION OFFICERS
 COUNTY CHILDREN AND YOUTH SOCIAL SERVICE AGENCIES
 COUNTY CHILDREN AND YOUTH ADVISORY COMMITTEES
 COUNTY COMMISSIONERS AND EXECUTIVES
 JUVENILE COURT JUDGES
 JUVENILE COURT JUDGES' COMMISSION
 JUVENILE DETENTION CENTERS
 LICENSED DRUG AND ALCOHOL TREATMENT PROVIDERS
 PRIVATE CHILDREN AND YOUTH SOCIAL SERVICE AGENCIES
 SINGLE COUNTY AUTHORITIES

REFER COMMENTS AND QUESTIONS REGARDING THIS BULLETIN TO:

APPROPRIATE REGIONAL OFFICE

ORIGIN: Ms. Cindi Manuel, Telephone: 717-783-7372

JUN 20 2002

PURPOSE:

To provide information and procedures to Single County Authorities (SCAs); licensed drug and alcohol treatment providers; juvenile probation offices; and County Children and Youth Agencies (CCYAs) for the sharing of drug and alcohol information in compliance with federal and state law, consistent with best practice standards related to issues of child safety and family and individual privacy. The bulletin is intended to provide direction and set forth operational protocols and is not intended to be and should not be considered legal advice.

BACKGROUND:

Act 126 of 1998, effective January 1, 1999, amended the Juvenile Act, 42 Pa. C.S. §§ 6301 - 6365, to allow for the release of drug and alcohol treatment information to a court, a CCYA or a juvenile probation officer (JPO) in conformance with federal regulations. As permitted by federal regulation state law generally imposes greater restrictions on the release of drug and alcohol information than found in federal law, see 42 C.F.R. §2,20; 71 P.S. § 1690.108; 4 Pa. Code § 255.5(b). By eliminating the restrictions imposed by other provisions of state law, Act 126 allows for the release of drug and alcohol treatment and other records regarding a child who is alleged to be or adjudicated dependent or delinquent, or the child's parents, to an extent not permitted in other proceedings or anywhere else in Pennsylvania law. The purpose of the amendment was to allow for joint case planning between the child welfare, juvenile justice and drug and alcohol systems; it affects each of these systems as they provide services to children and their families while continuing to meet their respective mandates.

This bulletin addresses one very essential component of the collaboration needed for successful joint case planning - the sharing of drug and alcohol information. Prepared by a workgroup of professionals from across the disciplines, it provides direction to all of those who come in contact with families whose children are in a situation of risk or who are in substitute care. The bulletin establishes protocols to share drug and alcohol information in compliance with federal and state law, consistent with best practice and respectful of the need to balance the issues of child safety, family and individual privacy and the integrity of the therapeutic process. It also encourages professionals to reach across their traditional service delivery boundaries in order to achieve better outcomes for the entire family, not just for the individual receiving services. While the individual case circumstances will shape the way that the protocols in this bulletin are applied, the essential framework for information sharing and case planning should remain consistent.

DISCUSSION

Historically, state confidentiality regulations have limited the ability of drug and alcohol treatment providers to share treatment information. Confidentiality protections

are important to encourage people to seek treatment; to protect the client-counselor therapeutic relationship; and to guard against the release of information that may be adversely used in people's personal and professional lives. Yet the reciprocal sharing of information among the child welfare, juvenile justice, drug and alcohol and judicial systems is often critical to promote the best outcome for the client and his or her family. Act 126 balances these competing interests by removing state law restrictions and requiring compliance only with federal confidentiality provisions, thereby expanding the degree to which systems are allowed to share confidential information.

CONFIDENTIALITY REQUIREMENTS

Even with the enactment of Act 126, drug and alcohol providers may release information to a CCYA or JPO only as permitted by federal law. Federal requirements are found at 42 U.S.C. §§ 290dd-2 and 42 C.F.R. Chapter I, Part 2 (§§2.1-2.67).

Under federal law, records of the identity, diagnosis, prognosis, or treatment of any client maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research are confidential. In general, disclosure of information contained in such records is permitted only with the client's written consent, or by a court order authorizing disclosure, or to medical personnel in a medical emergency or other specified personnel for research, audit, or program evaluations. Disclosure must be limited to the information that is necessary to carry out the purpose of the disclosure. Information may not otherwise be disclosed or used in any civil, criminal, administrative or legislative proceedings conducted by any federal, state or local authority. Finally, information received with the written consent of the client may not be used to initiate a criminal investigation or to prosecute the client.

Once an agency receives information, it may disclose that information, either verbally or in writing, only to such entities as authorized by the client's written consent or by court order. Disclosure to any other person or entity constitutes an illegal redisclosure of information.

Violation of any of these confidentiality requirements is subject to criminal penalties, but claimed violations are construed in favor of the potential violator.

Although federal confidentiality provisions are very broad, they are not absolute. Federal law does not, for example, protect any information relating to suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. Nor does federal law prohibit drug and alcohol providers from communicating information to law enforcement officials about a client relating to a crime committed or threatened to be committed at the provider's facility or against any person who works for the provider.

The child welfare and the juvenile justice systems are bound by different confidentiality requirements, which are less restrictive than the federal drug and alcohol

confidentiality provisions. In order for the child welfare system or the juvenile justice system to release information to drug and alcohol treatment providers, the child welfare worker (CWW) or JPO must adhere to the restrictions and follow the procedures in the following statutes and regulations:

- Child Protective Services Cases, 23 Pa. C.S. § 6339, 55 Pa. Code §§ 3490.91 - 95; 55 Pa. Code § 3130.44
- General Protective Services Cases, 55 Pa. Code § 3130.44; 55 Pa. Code § 3490.242
- Juvenile Court Records, 42 Pa. C.S. § 6307

JOINT CASE PLANNING

The child welfare and juvenile justice systems often need to rely on the expertise of the drug and alcohol treatment provider to help make informed decisions about how to best plan for children and their families. At the same time, both the child welfare and the juvenile justice systems have a responsibility to share information with those drug and alcohol providers who are either completing assessments or providing treatment to the children and families served by all three systems. Most of the decision making and planning needs of all three systems can be met through joint case planning or case consultation. This kind of planning allows for the full and active participation of child welfare and juvenile probation in identifying those issues especially related to the disposition of the child. Once identified, these issues may be included, if appropriate, in the specific drug and alcohol treatment plan.

Joint case planning is also essential to appropriate court dispositions. In a delinquency case, the court is required to make a disposition that provides balanced attention to the protection of the community, the imposition of accountability for offenses committed and the development of competencies to enable the child to become a responsible and productive member of the community. In a case where a referral for a drug and alcohol assessment or treatment is made, it is essential that the juvenile court judge obtain case information regarding a delinquent child and the child's parent(s) with such specificity as to allow the judge to make well-informed and appropriate decisions concerning the child's future.

In a dependency case, the court is required to make a disposition that is best suited to the protection and physical, mental and moral welfare of the child. Effective January 1, 1999, the Juvenile Act was amended, consistent with the federal Adoption and Safe Families Act of 1997 (ASFA), Pub. L. 105-89, to place new emphasis on time-limited attempts to reunify families when children have been adjudicated dependent and placed out of their homes. Parents of these children face new time frames in which to resolve their problems and become active parents. When a dependent child has been in out-of-home placement for 15 of the most recent 22 months, the CCYA must file a petition to terminate parental rights, unless certain statutory exceptions are met. See 42 Pa. C.S. § 6351(f)(9). One of these exceptions is when the child's family has not been provided with necessary services (including drug and alcohol treatment) within the time

frames set forth and listed in the permanency plan. See 42 Pa. C.S. § 6351(f)(9)(iii). It is the child welfare system's responsibility to balance a child's safety and right to permanency with a parent's right to parent his or her child and to provide services to achieve those goals. In order for the CWW to make an appropriate recommendation and ultimately for the judge to make the best-informed decision, it is essential that information regarding a child's or parent's substance abuse problem and treatment be available to the court.

Joint case planning and case consultation clearly constitute best practice when clients are involved in multiple systems. As such, joint case planning should be viewed as the expectation rather than the exception. An open dialogue and sharing of information can only improve the planning and development of services and enhance the appropriateness of delinquency and dependency dispositions under the Juvenile Act.

Examples of Information Which May Be Requested and Exchanged

County Children and Youth Agencies

Court Order
Court Report
Permanency Plan
Risk Assessment
Social Summary

Drug and Alcohol Providers and SCAs

Treatment Plan
Aftercare Plan
Service Plan (Intensive Case Management)
Discharge Summary
Progress Report (verbal and written)

With the client's consent, a CWW or JPO may participate with drug and alcohol professionals in joint case planning without a court order. Obtaining client consent may eliminate the need in most cases for court-ordered participation of the CCYA or JPO in the development of the actual drug and alcohol treatment plan. However, recognizing the importance of joint case planning, in the absence of consent, Act 126 allows the court to "order the participation of the county agency or juvenile probation officer in the development of a treatment plan for the child as necessary to protect the health, safety or welfare of the child, to include discussions with the individual, facility or program providing treatment and the child or the child's parent in furtherance of a disposition" of a dependent or delinquent child. See 42 Pa. C.S. § 6352.1.

The following protocols describe procedures that agencies should follow to facilitate joint case planning. As a first resort, every agency working with children and their families should seek the client's consent to release and exchange drug and alcohol information. Only after the client has refused to give such consent should agencies seek to obtain a court order. Regardless of whether the release of drug and alcohol information is authorized by consent or by other available means, the same protocol for sharing such information applies. Questions regarding disclosure of confidential drug and alcohol treatment information in particular cases should be referred to an attorney for advice.

PROTOCOL FOR INFORMATION SHARING AMONG THE DRUG AND ALCOHOL,
JUVENILE JUSTICE AND CHILD WELFARE SYSTEMS

1. When a CWW or JPO suspects that a client or, as applicable, a client's parent or guardian, has a substance abuse problem, a referral should be made to the SCA, or other qualified assessment site, for an alcohol and other drug assessment. The assessment should include: a determination as to whether a substance use disorder exists, a description of the severity of the problem, a determination of the appropriate level of care (treatment), if treatment is warranted, and a recommendation for a facility in which the client may be most appropriately treated.

The treatment funding source, e.g., managed care organizations or commercial insurance plans, may dictate who is responsible for conducting the assessment. The referring CWW or JPO should attempt to ascertain insurance information prior to making a referral for an assessment. If the SCA is to complete the assessment, the SCA will establish what funding may be available to pay for the recommended treatment services and advise the CWW or JPO of possible resources.

2. At the time the CWW or JPO makes the referral for an assessment, all information that is known about the client's suspected use and related issues should be provided for the drug and alcohol assessor. This information may include worker observations, police reports, any known legal involvement, specific concerns around parenting and supervision issues, and specific client behaviors. The information is helpful to the assessor who can then use the information to probe specific areas related to addiction symptomatology. Referral information from the CWW or JPO should also address specific concerns or issues that he or she would like to see the treatment provider address and specify the time frame in which the results of the assessment are needed, e.g., date of upcoming court hearing, and allow ample time for the assessment to be completed. (There are a variety of time frames and access standards related to a face-to-face assessment.) In the event the SCA is not involved in the assessment or referral process, the same referral information should be forwarded to the treatment provider.
3. If requested, and with appropriate authorization, the provider will forward the assessment and any recommendations to the referring CWW or JPO.
4. After a recommended course of action has been determined, the CWW or JPO will forward the Permanency Plan, including the Family Service Plan, Social Summary, Drug and Alcohol Assessment and all other available relevant information to the treatment provider.
5. Once the client is admitted to treatment, the treatment provider and the referring CWW or JPO should discuss what information would be needed, e.g., progress reports; and the frequency of information sharing (see Examples of Information That May Be Exchanged). This process will allow for clear expectations by each of the systems involved in the coordination of care.

6. At the earliest possible stage, the treatment facility should discuss aftercare recommendations and plans with the CWW or JPO in order to allow for appropriate follow up by the CWW or JPO.

GUIDELINES FOR OBTAINING CLIENT CONSENT

The first thing that any entity seeking to obtain consent for the release or disclosure of drug and alcohol information should consider is the purpose and need for the communication of information. Once these have been identified, it is easier to determine how much and what kind of information needs to be released.

It is important that any entity seeking to obtain consent for the release or disclosure of drug and alcohol information confirm that the client understands the nature of the information that is being requested or exchanged. The client should understand exactly what information will be released, why it is being released, how it will be used and the possible consequences of refusing to consent.

Regardless of the age of the client, unless the client lacks mental capacity, only the person referred for or receiving the alcohol or other drug treatment may consent to the release of his or her drug and alcohol information. In order for a consent to be valid, a client must consent in writing to the specific treatment information, e.g., the treatment plan, discharge summaries, progress reports, or aftercare plans that is to be released; the specified purpose for which the released information will be used; and the individual(s) or agency(cies) which is to receive the information.

The length of time for which a consent may be valid is not defined in federal or state law. The consent should generally remain in effect until the client has completed treatment at the facility specified on the consent form.

In most cases, a separate consent form should be used for each type of disclosure and for each different recipient of information. However, a single consent form may suffice for a series of disclosures of the same type of information to the same recipient as long as the type and amount of information, the identity of the recipient, the purpose of the disclosure and the duration of the consent are specified on the form.

The client may revoke his or her consent at any time except to the extent that action has already been taken in reliance on the consent. Revocation of consent does not require the facility to retrieve information that has already been disclosed; nor does it negate actions or determinations based on information already disclosed.

A sample consent form that conforms to federal requirements is reproduced at Attachment A. Agencies are strongly encouraged to use this sample form, as any deviation could render the consent invalid. The drug and alcohol provider has an obligation to refuse to honor a consent that does not comply with federal regulations, has expired, or is known to be revoked, false or invalid. See 42 C.F.R. § 2.31(c).

PROTOCOL FOR OBTAINING A COURT ORDER TO ALLOW INFORMATION
SHARING AMONG THE DRUG AND ALCOHOL, JUVENILE JUSTICE AND CHILD
WELFARE SYSTEMS

The following protocol is based on federal requirements at 42 C.F.R. §§ 2.61 – 2.67

1. If the CWW or JPO is not able to obtain the proper consent, or if consent is obtained but the treatment facility refuses to disclose the information, disclosure may be authorized by court order. Although a court order will authorize the facility to disclose information, it will not compel an unwilling facility to disclose the information. In such cases, the party seeking disclosure must obtain and serve a subpoena along with the court order authorizing disclosure.
2. The party seeking disclosure must file an application with the court. If the facility has refused to disclose the information even though the client gave consent, the client may apply for a court order, or the parties may apply jointly. In those delinquency proceedings that are not closed to the public, in accordance with 42 Pa. C.S. § 6336(e), the party seeking the court order must request that the application and order, as well as all associated proceedings, be filed under seal. If there is any doubt whether the court will grant the request in its entirety, then the application must refer to the client using a fictitious name (such as John or Jane Doe), and may not contain information identifying the client. A similar request need not be made explicitly in other delinquency or in dependency proceedings because such proceedings are mandated to be closed to the public and the records are by law protected from public scrutiny.
3. The court must give the client and the record custodian adequate notice and afford them the opportunity to respond, in writing or in person, to the application for a court order.
4. If either the client or the record custodian requests to respond to the application in person so that the court holds a hearing on the application, the hearing must be conducted in chambers.
5. The court may issue an order only if it determines that good cause exists. To determine whether such good cause exists, the court must consider whether other effective ways of obtaining the information are available, and whether the public interest and need for disclosure outweigh potential injury to the patient, the physician-patient relationship, and the treatment services.

6. A court order authorizing disclosure must limit disclosure to the parts of the record necessary to fulfill the order's objective, restricting the recipients of the information to those persons whose need for information is the basis for the order, and must include such other measures as are necessary to limit disclosure for the protection of the client.
7. If the court order is sought for disclosure of drug and alcohol treatment information that is or may be related to a criminal investigation or prosecution, the procedures are similar, but the applicant must meet additional, heightened requirements to establish good cause.

NOTE: The CCYA or JPO does not need to wait to apply for a court order until it wants a drug and alcohol treatment provider to testify or provide records in court. Application for a court order may be made at any point in a delinquency or dependency proceeding, as necessary to, for example, monitor the child's or parent's progress in treatment.

DEFINITIONS:

Aftercare Plan - A continuing care plan for clients to follow after they leave formal treatment in the Drug and Alcohol system. It is the client's individualized plan for the future, including an identification of the client's personal goals and objectives.

Child in Substitute Care – A child living outside his or her home in the legal custody of a CCYA or under the jurisdiction of the juvenile probation department in any of the following settings: shelter home, foster home, group home, supervised independent living, residential treatment facility and secure and non-secure residential placement.

Dependent Child – As defined in the Juvenile Act, 42 Pa. C.S. § 6302.

Delinquent Child – A child ten years of age or older whom the court has found to have committed a delinquent act and to be in need of treatment, supervision or rehabilitation:

Discharge Summary - A clinical summary-used in the drug and alcohol system, completed within one week of discharge, describing the reasons for treatment, services offered, response to treatment and client's status or condition upon discharge.

Disposition – An outcome of a juvenile court case, as ordered by the Court.

Joint Case Planning – A process coordinating the services that will be provided by the agencies directly involved in the client's case, providing an opportunity for each agency to identify specific client concerns and program mandates. The planning meeting should discuss general strategies to be utilized by each agency in addressing

the client's issues as well as identifying the areas of responsibility of each involved agency.

Permanency Plan – The document that is presented to the court at a Permanency Hearing on behalf of a dependent or delinquent child or youth. It consists of two parts:

- (a) **Family Service Plan** – The document prepared when a family has been accepted for services through the CCYA or is under the jurisdiction of the juvenile probation department. It contains:
- identifying information about the family;
 - a description of the circumstances under which the case was accepted;
 - the service objectives for the family;
 - changes needed to protect the children from abuse, neglect or exploitation and to prevent placement;
 - child safety issues;
 - the services to be provided;
 - the actions to be taken by the parties;
 - the date the actions will be completed; and
 - the results of reviews and permanency hearings.
- (b) **Child's Permanency Plan (formerly known as the placement amendment)** – The document prepared when a child enters substitute care. It contains:
- a description of the circumstances that make placement necessary;
 - to the extent available and accessible, health and education information on the child as detailed in Title 55, Pa. Code, Chapter 3130 (Administration of County Children and Youth Social Service Programs);
 - a description of efforts that have been made and the services that have been provided to prevent placement (required only at initial placement);
 - an identification of the type of home or facility in which the child will be placed and a discussion of the appropriateness of the placement;
 - the anticipated duration of the placement, stated in months;
 - an identification of the appropriate permanency goal;
 - a description of the service objectives that shall be achieved by the parents or child to attain the identified goal for the child;
 - an identification of services to be provided to the family, the child and if applicable, the foster family;
 - the schedule for visits between the child and parents; and
 - the results of permanency hearings and administrative reviews.

Progress Report – A tool utilized by the drug and alcohol system to summarize the client's status with regard to meeting treatment goals, which may include comments related to the client's understanding of the goals, progress in achieving goals, and degree of cooperation with program rules.

Protective Services – Protective services for children includes two categories – child protective services and general protective services.

(a) Child Protective Services (CPS) – Those services and activities provided by the Department of Public Welfare and each CCYA for child abuse cases. Reports of child abuse include non-accidental serious physical injury, serious mental injury, serious physical neglect, sexual abuse and imminent risk of serious physical injury or imminent risk of sexual abuse. 23 Pa. C.S. §§ 6301-6385 (relating to the Child Protective Services Law)

(b) General Protective Services (GPS) – Those services to prevent the potential for harm to a child who is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental or emotional health or morals as well as those additional conditions enumerated in Title 55 Pa. Code § 3490.223 (ii) through (ix).

Service Plan - An individualized, strengths based, specific plan developed jointly by a client and his/her Drug and Alcohol Intensive Case Manager, which includes specific action steps required to achieve goals related to the acquisition and maintenance of needed ancillary or support services. Support services might include housing, transportation, medical, family/social, mental health, legal counseling, education, employment, life skills, childcare or basic needs.

Treatment Plan - A time limited, individualized, specific plan detailing the treatment services to be provided within the confines of the drug and alcohol treatment program. The treatment plan includes short and long-term goals for treatment, the type and frequency of treatment and rehabilitation services, and the proposed type of support service.

