MEDICO-LEGAL GUIDELINES

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Preamble to Medico-Legal Guidelines

History Leading to the Proposed Revision of the N.C. Medico-Legal Code

Since the adoption of the original Medico-Legal Code by the North Carolina Bar Association and North Carolina Medical Society in 1956, the environment in which the physician and lawyer interact has changed radically. With the introduction of standard rules of civil procedure and evidence, the broad bounds of contact between attorney, witnesses, and parties were defined. Adoption and subsequent revision of Rules of Professional Conduct further defined the lawyer's ethical conduct and served as a guide in contact with physicians. Physicians, largely unfamiliar with these legal rules and guides, reacted only within the boundaries of professional respect, dignity, decorum, and the ethical principles of their health care profession. With the rise in importance and frequency of medical litigation, the professions have scrutinized attorney and physician conduct and have reached a consensus that there is a need to revise their inter-professional code. The Code was previously revised in 1972, 1986, and 1991 in attempts to update the original 1956 Code. The 1991 version was called "The Medico-Legal Guidelines of North Carolina" (the term "Guidelines" as used hereafter refers to all such versions as well as this document).

Recent Revisions

In 1997, the Joint Committee of the North Carolina Medical Society and North Carolina Bar Association decided the Guidelines should be updated for two reasons.[1] First, the practices of medicine and law had changed dramatically since 1991.[2] Second, the Guidelines had not been effective in resolving certain recurring disputes between physicians and attorneys.[3] Significant revisions were made, and finally, in 2000, the Medical Society and the Bar Association adopted the 2000 Medico-Legal Guidelines.

In 2005, the Medico-Legal Liaison Committee updated the Guidelines to incorporate HIPAA privacy regulations and update other cited authorities. In 2008, the Medico-Legal Guidelines were revised to include information concerning appropriate handling of mental health, substance abuse, and psychotherapy records.

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1 The Joint Committee delegated this task to the Bar Association Medico-Legal Liaison Committee.

2 Other health care professionals are now licensed to perform medical services which were traditionally provided only by physicians. Major changes in the health insurance industry have altered traditional health care delivery systems. Alternative Dispute Resolution is now employed to resolve many claims involving physicians which were previously resolved in litigation. Technological advances challenge medical and legal attempts to protect confidential medical information and patient/client rights to privacy.

3 Despite the presence of the Guidelines, recurring disputes persist between physicians and lawyers in the litigation context. Some of these disputes have been addressed to the Joint Committee of the North Carolina Medical Society and North Carolina Bar Association for dispute resolution. Other disputes have been explored by the North Carolina Bar Association Medico-Legal Liaison Committee, which conducted public hearings prior to preparing a new draft version of the North Carolina Medico-Legal Guidelines. The Committee invited speakers to the hearings who had experienced difficulty with the implementation of the Guidelines, and believed that the Guidelines needed change.

Physician Complaints

Physicians complain about attorney misuse of subpoena power and failure to pay expert witness fees of both treating and retained medical expert witnesses. In the case of treating physicians, this complaint arises often when the physician testifies pursuant to subpoena and without a fee agreement with the subpoenaing attorney, and the subpoenaing party does not prevail at trial.[4]

Physicians complain that they are uncertain of their legal duties in certain areas. Physicians are frequently confused about the duties attendant to their release of confidential medical information. They are not certain as to when they may, may not, and when they must release confidential medical records or speak with an attorney about a patient. They are often unsure about what services to bill for, whom to bill, and how to ensure payment resulting from services rendered in legal cases involving medical issues. They complain that they receive conflicting responses from lawyers regarding their duties and rights.[5]

Treating physicians, who may be potential defendants in professional liability litigation, complain that attorneys investigating those claims mislead them. The climate of inter-professional mistrust created in the professional liability context invades all areas of litigation.

Attorney Complaints

Attorneys complain that physicians fail to comply with subpoenas for their records or presence as a witness, that they fail to provide complete medical records, and that they bill excessively for medical records, consultation and testimony. Attorneys also complain that treating physicians refuse or are reluctant to consult with their patient's attorney or to provide live testimony on behalf of their patient. These areas of conflict cause problems for patients and attorneys, who of necessity rely on medical evidence in cases involving medical factual issues.

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4 N.C. Gen. Stat. § 7A-314 (2008) addresses the discretionary award of expert witness fees as costs in civil cases, but does not compel parties to seek a judicial determination of expert witness fees or who is to pay them. N.C. Gen. Stat. § 7A-454 (2008) addresses under what circumstances a court may order payment of expert witnesses who testify on behalf of indigent criminal defendants. N.C. Rule of Evidence 706 governs who shall pay, and what amount, shall be paid to expert witnesses appointed by the Court in civil and criminal actions. N.C. Gen. Stat. § 15-7 (2008) governs the payment of physicians appointed to conduct post-mortem examinations of homicide victims. In cases before the Industrial Commission, expert witness fees are set by the Commissioner or Deputy Commissioner hearing the case. See N.C. Gen. Stat. §§ 97-90 and 97-26.1 (2008).

5 This occurs, in part, because the law is unclear in certain areas and uncertain in others. See Footnote 48 regarding the subpoena of medical records by way of example.

Scope

Throughout its history, the scope of various versions of the Guidelines was limited to physician-attorney interactions. The Guidelines did not apply to other health care professionals, and also did not apply to a physician who was a party-defendant in a malpractice action. The Guidelines did not distinguish between treating and non-treating medical expert witnesses. The Guidelines did not complement and did not reference specific rules of conduct required by laws or regulations in areas such as workers' compensation, criminal prosecutions, or cases involving drug and alcohol abuse medical records. The newly adopted Guidelines have made some changes in these areas.

Professional Liability

Historically, the Guidelines have not addressed the interaction between attorneys and physicians who are defendants in professional liability actions. This relationship is governed by mandatory statutes, rules of ethics, and rules of procedure, and is not appropriately a subject of these Guidelines. However, these Guidelines seek to clarify duties arising in those situations where the physician is not a party-defendant but the legal action is based on a claim of professional negligence made by a person treated or evaluated by the physician.[6] The Guidelines address some of the recurring concerns in this difficult area.

Treating Versus Non-Treating Witnesses

In earlier editions, the Guidelines did not always distinguish between physicians who were retained expert medical opinion witnesses and those medical witnesses who were fact witnesses by virtue of treating the attorney's client as a patient. The relationship between a physician who is a retained expert and an attorney is voluntary and reciprocal, and fee arrangements between them are business agreements restricted only by prevailing law and their professional guidelines of ethics. By contrast, interactions between treating physicians and patient's attorneys are not chosen, arising instead from their respective connections and duties to their mutual patient/client. The Guidelines, recognizing this distinction, preclude retained experts and attorneys from invoking the assistance of the Joint Committee in fee disputes arising between them.

6 In such situations, the physician or other health care provider may be a potential defendant and/or may be required to provide expert testimony affecting defendant(s) who are co-workers and colleagues.

I. INTRODUCTION

The North Carolina Medico-Legal Guidelines are the product of collaboration between the North Carolina Medical Society and North Carolina Bar Association. The Guidelines are the end-product of decades of cooperation between physicians and lawyers aimed at improving their inter-professional interactions in medical litigation.

The relationship between a physician and an attorney should be based upon mutual respect, courtesy, and understanding. Medical testimony is generally indispensable in legal cases to prove or disprove the nature or extent of injuries or other legally relevant medical conditions. Therefore, when accepting a patient, a physician also accepts the incidental obligation to cooperate in any legal proceedings in which the patient may become involved.[7] When attorneys make inappropriate or inconsiderate demands on physicians, they cause animosity between the professions. Without mutual cooperation by physicians and attorneys, their patients/clients become the unfortunate victim of professional ill will.

To promote inter-professional cooperation and courtesy, the particular responsibilities of physicians and attorneys should be more clearly defined. These Guidelines set out these responsibilities, citing legal and/or medical authority where applicable. These Guidelines are not exclusive, nor do they cover all situations or seek to define the outer limits of professional interrelationships. The Guidelines establish minimum standards for those relationships and encourage civility between the professions.

II. SPECIFIC REGULATIONS

These Guidelines are not intended to supplant any mandatory rules, laws or regulations. Mandatory rules (for example the Rules of Professional Conduct governing attorney behavior, the North Carolina Rules of Civil Procedure governing court procedure, and the North Carolina Rules of Evidence governing the admissibility of evidence in court proceedings), statutes, and regulations take precedence over these Guidelines. Some relevant citation to applicable rules, laws, professional codes and position statements, and/or regulations are contained in the text of these Guidelines**.**

7 See AMA Code of Medical Ethics, §9.07 "Medical Testimony," (2008-09 ed.) (regarding ethical duty to testify if patient requests "in order to secure the patient's legal rights."). AMA Code of Medical Ethics provisions are aspirational rather than mandatory.

III. DEFINITIONS

The following definitions apply throughout these Guidelines:

A. **"Physician" Defined**: A physician is a person licensed to practice medicine by the North Carolina Medical Board as that term has historically been understood, i.e., medical and osteopathic physicians.[8] The Guidelines also cover a physician assistant licensed by the North Carolina Medical Board.

B. **"Medical Record" Defined**: The medical record is a collection of protected health information for a particular individual, that: is created or received by a physician or other health care provider; relates to the past, present, or future physical or mental health or condition of the individual; and includes information about the provision of health care to that individual and the past, present, or future payments by or on behalf of that individual for the provision of health care.[9] Medical records are inherently sensitive and personal and contain information that relates to an individual's physical or mental condition, medical history, medical diagnosis, or medical treatment,[10] as well as demographic and other information that identifies or has the potential to identify the individual (e.g., patient name, address, social security number, unique identifier, etc.).[11]

C. **"Medical Report" Defined**: A medical report is a report generated by a physician at the request of an attorney in order to assist the attorney in preparing for litigation which involves a patient's medical condition, treatment, or prognosis. A medical report may be a narrative summary of the medical record, or it may be a response to requests for expert opinions regarding the patient's condition, treatment, or prognosis not contained in the medical record. The preparation of a medical report may, in some instances, require the physician to

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8 N.C. Gen. Stat. Ch. 90, Art. 1 (2008) governs the licensure of medical and osteopathic physicians in North Carolina. N.C. Gen. Stat. § 90-18.1 (2008) governs the licensure of physician assistants in North Carolina. Like physicians, other health care providers also are encouraged to follow the Guidelines but are not required to do so unless otherwise instructed by their regulatory Board. Attorneys should follow the provisions of the Guidelines in dealings with all health care professionals.

9 Relevant HIPAA citations include: 45 C.F.R. § 160.013 (2008) for the definitions of "health information" and "individually identifiable health information" and § 164.501 (2008) for the definitions of "designated record set" and "protected health information." See Appendix A-1, Relevant HIPAA Definitions.

10 Medical Records are defined by the following North Carolina statutory and regulatory provisions: N.C. Gen. Stat. §§ 8-44.1 (2008), 90-410(2) (2008), 58-39-15(18) (2008), 130A-372 (2008), 10A N.C.A.C. 13B.3900 et seq. (2008). Other provisions of North Carolina and federal law refer to information about patients' medical services using terms other than "Medical Records." See N.C. Gen. Stat. § 122C-3(9) (2008) and 42 C.F.R. §§ 2.11 and 2.13 (2008). See these Guidelines, Part IV(A)(4) (regarding records of patients receiving services for drug or alcohol abuse), and Appendix A-2, Pertinent N.C. Statutes and Regulations regarding Medical Records.

11 See AMA Code of Medical Ethics Sec. 5.07, "Confidentiality: Computers" and Sec. 5.075 Confidentiality: Disclosure of Records to Data Collection Companies" (2008-09 ed.) (regarding confidentiality and computerized data bases).

obtain a current evaluation of the patient.[12]

D. **"Independent Medical Examination" Defined:** An independent medical examination is a medical examination in which a person is required or agrees to submit to a medical examination by a physician selected or approved by a court, administrative agency or other adjudicatory body or by the mutual agreement of the parties.[13]

E. **"Medical Witness" Defined**: A medical witness is a physician who provides testimony concerning one or more medical issues involved in a lawsuit or claim.[14] Three types of medical witnesses are recognized by the N.C. Medico-Legal Guidelines.[15] They are:

1. **"Retained Expert Witness" Defined**: A retained expert witness is a physician who has been retained by one of the parties to litigation to provide expert opinion testimony or evidence concerning one or more medical issues involved in the lawsuit or claim.

2. **"Fact Expert Witness" Defined:** A fact expert witness is a physician who is called upon to testify or provide evidence because they have treated a patient who is a party or witness in a lawsuit or claim.

3. **"Independent Expert Witness" Defined:** An independent expert witness is a physician who has been selected or approved by a court, administrative agency or other adjudicatory body or by the mutual agreement of the parties to perform an independent medical examination.

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12 See N.C. Gen. Stat. 90-411 (2008) (regarding reasonable fees for the preparation of medical reports). See also N.C. Rule of Civil Procedure 35.

13 Independent medical examinations occur in a number of contexts. For civil actions in North Carolina's state courts, see N.C. Rule of Civil Procedure 35. In workers' compensation cases, independent medical examinations can occur upon agreement of the parties, order of the Industrial Commission, or pursuant to N.C. Gen. Stat. § 97-27 (2008). Reference should be made to any Rules adopted by the Industrial Commission for guidance regarding communications with independent medical witnesses in workers' compensation cases. With regard to social security disability claims, see 20 C.F.R. §§ 404.1517 and 416.917 (2008), which discuss when the Social Security Administration will purchase a consultative examination of a disability claimant. The reports generated from these examinations are kept in the claimant's file and are available for review by the claimant and/or the claimant's representative by going to the office that has the file. The reports are not automatically sent to the claimant or the claimant's representative. The claimant may direct the Social Security Administration to release the report to his or her own doctor. See also 20 C.F.R. §§ 404.1519 to 404.1519t, 416.919 to 404.1519t, 409.1512, and 416.927 (2008) (regarding Social Security Administration Medical Advisors).

14 "Medical experts should have recent and substantive experience in the area in which they testify and should limit testimony to their sphere of expertise." AMA Code of Medical Ethics, Sec. 9.07, "Medical Testimony" (2008-09 ed.).

15 The obligations of medical witnesses under the Guidelines may differ, depending upon which type of medical witness they are.

IV. SPECIFIC SITUATIONS

A. Medical Records

1. Ownership of Medical Records

Usually, records made or collected by or at the direction of a physician in connection with the treatment and evaluation of a patient are maintained and retained by the physician, hospital or other individual or institutional care giver. The original record is deemed to be the property of the physician, hospital, or other individual or institutional care giver. The patient has a qualified right to say who may receive information contained in the record.[16]

2. Inspection and Copying of Medical Records

a. Required Authorization

An original medical record should not be removed from the possession of a physician, hospital, or other individual or institutional care giver except upon court order, but the original should be available for inspection or copying with proper written authorization.[17] Proper written authorization is to be provided by the patient, an individual empowered by law to act in the patient's behalf regarding disclosure of medical records, or by order of a court or administrative agency having jurisdiction and authority to mandate such disclosure.[18]

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16 See AMA Code of Medical Ethics, "Fundamental Elements of the Patient-Physician Relationship" (2008-09 ed.) ("The patient has the right to receive information from physicians. . . and [patients] are also entitled to obtain copies or summaries of their medical records [and] to have their questions answered."); See also N.C. Medical Board, "Access to Physician Records" (Position Statement adopted 11/93, amended 5/96, 5/97, 3/02, and 8/03) ("Each physician has a duty on the request of a patient or the patient's representative to release a copy of the record in a timely manner to the patient or the patient's representative, unless the physician believes that such release would endanger the patient's life or cause harm to another person"). Complex rules govern the disclosure of medical information about an individual's substance abuse, diagnosis or treatment, and the disclosure of such information is excluded from the scope of these Guidelines. See Part IV(A)(4), infra, and N.C. Gen. Stat. § 122C-3(9) (2008). HIPAA citation regarding personal representatives can be found at 45 C.F.R. 164.502(g) (2008).

17 HIPAA mandates that a valid authorization must contain, at a minimum: (1) a description of the information to be used or disclosed; (2) the name(s) of those authorized to make the requested use or disclosure; (3) the name of the person(s) to whom the covered entity may make the requested use or disclosure; (4) the purpose of the use or disclosure; (5) an expiration date or event (e.g., end of research study); and (6) the signature of the individual and date (if the authorization is signed by a personal representative of the individual, a description of such representative's authority). 45 C.F.R. § 164.508(c) (1)(i-iv) (2008). Also, § 164.508(c)(2) requires that the authorization contain statements adequate to place the individual on notice that the individual has the right to revoke the authorization, the ability or inability to condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization, and the potential for information to be disclosed pursuant to the authorization to be subject to redisclosure.

18 In workers' compensation cases, "an employer paying medical compensation to a provider rendering treatment. .may obtain records of the treatment without the express authorization of the employee." N.C. Gen. Stat. § 97-25.6 (2008). Reference should be made to the Rules of the Industrial Commission or contact made with the Industrial Commission regarding the right of the employer or others acting on its behalf to obtain medical records without the express authorization of the employee. HIPAA permits such disclosure under an exemption that reads: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation…." 45 C.F.R. § 164.512(l) (2008). See also AMA Code of

b. Permissible Charges for Copying Medical Records

In personal injury liability and social security disability cases, permissible charges for copies of medical records are governed by N.C. Gen. Stat. 90-411. Further, in personal injury liability cases, a physician may not charge for copies of medical records requested by a patient's attorney if they wish to preserve a lien for their medical services against the patient's recovery of monetary damages for personal injury from a third party.[19] In workers' compensation cases, permissible charges for copies of medical records are governed by N.C. Gen. Stat. § 97-26.1 (2008)[20]. In social security disability cases, see 20 C.F.R. §§ 404.1514 and 416.914 (2008), and N.C.. Gen Stat. § 90-411 (2008). In other circumstances, a physician may charge a reasonable fee for copies of medical records.[21]

c. Withholding Records where Patient Account for Medical Services Not Paid

A physician may not refuse to provide copies of medical records (including the bill for services provided to the patient) on the ground that the patient has not paid the amount due on his account for medical and other services.[22]

3. Requesting Medical Records or a Medical Report From a Treating Physician

a. Notice

An attorney should give a patient's treating physician reasonable notice of the need for inspection and copying of medical records, or of the need for preparation of a medical report. The notice should clearly specify the information requested. Notice may be provided by written

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Medical Ethics, Sec. 5.09 "Confidentiality: Industry-Employed Physicians and Independent Medical Examiners," (2008-09 ed.) (Finding no physician patient relationship where "a physician's services are limited to pre-employment physical examinations or examinations to determine if an employee who has been ill or injured is able to return to work" but finding a physician-patient relationship where "a physician renders treatment to an employee, even though the physician is paid by the employer" and noting that release of such information is governed by workers' compensation laws).

19 See N.C. Gen. Stat. §§ 44-49 and 44-50 (2008). See also N.C. Rule of Professional Conduct 1.15-1 (1997) and N.C. RPC 69, ("Payment of Client Funds to Medical Provider" (1989)) and N.C. RPC 125 ("Disbursement of Settlement Proceeds" (1992)) (requiring lawyer to obey client's instruction not to pay medical providers from the proceeds of settlement in the absence of a valid physician's lien).

20 North Carolina Industrial Commission Minutes, January 12, 1995. See Appendix E for additional information.

21 See N.C. Gen. Stat. § 90-411 (2008) and N.C. Medical Board, "Access to Physician Records" (Position Statement adopted 11/93, amended 5/96, 9/97, 3/02, and 8/03).

22 See N.C. Medical Board, "Access to Physician Records" (Position Statement, adopted 11/93, amended 5/96, 9/97, 3/02 and 8/03) ("Medical records should not be withheld because an account is overdue or a bill is owed."). An attorney may not pay client bills for treatment, although they may advance medical litigation expenses on behalf of a client. See N.C. Rule of Professional Conduct 1.8(e) (1997), RPC 80, "Lending Money to a Client," (1990) (Attorney may advance cost of medical examination if same is litigation expense.).

correspondence, or by a subpoena, and should be accompanied by appropriate authorization to release the information requested.

b. Authorization

Proper authorization is necessary before a physician can release medical information. No attorney should request and no physician should furnish any medical information concerning the history, physical or mental examination, condition, diagnosis or prognosis of a patient except with the written consent of the patient, the patient's authorized representative, a judicial or administrative order, or in conformity with other applicable legal authority.[23] The scope of the authorization determines the scope of the inspection, release, copying or report. If the requesting attorney wants information beyond what is authorized to be released, the attorney must obtain additional authorization.

c. Promptness

The physician, with proper authorization from the patient or the patient's authorized representative, should promptly furnish the attorney with a complete medical record or medical report. Delay in providing the medical record or medical information may prejudice the opportunity of the patient to settle their claim or lawsuit, may delay the trial of a case, or may cause additional expense or the loss of important testimony.[24]

4. Special Considerations for Substance Abuse, Mental Health, and Psychotherapy Records

Under federal and state law, information about an individual's substance abuse or mental health diagnosis or treatment can be a trap for the unwary litigator seeking this information as well as for the physician or health care facility holding the information. Protected information includes any information about an individual, whether or not the information is in writing or recorded in some other form, and includes the patient's identity, address, medical or treatment information, and all communications by the patient to program staff.[25] The facility is prohibited from even acknowledging whether the individual is or ever was a patient at the facility.[26]

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23 See N.C. Gen. Stat. §§ 8-53 and 8-44.1 (2008); N.C. Rule of Civil Procedure 45(c); the Rules of the Industrial Commission. See RPC 162, "Communications with Opposing Party's Physicians" (1994) (prohibiting attorney from communicating with opposing party's non-party treating physicians unless the opposing party consents, in non-workers' compensation setting); RPC 180 "Communications with Opposing Party's Physicians" (1994) (extending that prohibition to passive listening); RPC 224 (1997) (extending prohibition to employer's attorney in workers' compensation setting). See also RPC 184 "Communications with Physicians Performing Autopsy" (1994) (allowing opposing counsel to communicate with pathologist performing autopsy without decedent's personal representative's consent). See also AMA Code of Medical Ethics §§ 5.05 "Confidentiality," ("The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law"); Sec. 5.055 "Confidential Care for Minors," and Sec. 5.06 "Confidentiality: Attorney-Physician Relation" (2008-09 ed.).

24 N.C. Medical Board "Medical Record Documentation" (Position Statement, adopted 5/94, amended 5/96) (medical record "provides a legal document to verify the delivery of care").

25 42 C.F.R. § 2.11 (2008).

26 42 C.F.R. § 2.13 (2008).

Disclosure—and subsequent re-disclosure—of records generated at a federally-assisted drug or alcohol abuse facility is strictly prohibited by complex federal rules, with criminal penalties for violation.[27] See Appendices G-1 and G-2 for an authorization form that complies with all federal and state laws and rules regarding release of substance abuse and mental health records.

a. Substance Abuse Records: (Mental health information that is part of a substance abuse record is treated in the same manner as described herein.)

A subpoena alone is never sufficient to compel disclosure; the party seeking disclosure must provide either highly specific written consent from the patient which meets the requirements of the rules, or a court order framed in precise accord with the rules along with a subpoena.[28] There are separate federal rules governing procedures and criteria for issuance of court orders authorizing disclosure of substance abuse records for noncriminal and criminal purposes.[29] A court order allowing disclosure of substance abuse records must:

1. Limit disclosure to those parts of the patient's record essential to fulfill the objective of the order.

2. Limit disclosure to those persons whose need for information is the basis for the order.

3. Include necessary measures to limit disclosure for the protection of the patient, physician-patient relationship and treatment services, i.e. sealing the case record.

Disclosure of substance abuse records may only occur if other ways of obtaining the information are not available or would not be effective and the public interest and need for disclosure outweigh the potential injury to the patient, physician-patient relationship and treatment services.[30]

b. Mental Health Records:

State laws governing release of mental health records are no more stringent than applicable federal laws.[31, 32]

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27 See 42 U.S.C. 290dd2; 42 C.F.R. § 2.1 et seq. (2008) Examples of federal assistance triggering coverage of the rules include tax exemption and participation in Medicare or Medicaid. 42 C.F.R. § 2.12(B) (2008). Also, see N.C. Gen. Stat. §§ 122C-51 et seq. (2008).

28 See 42 C.F.R. §§ 2.31, 2.33 (2008) (written consent); 42 C.F.R. § 2.61 et seq. (2008) (court orders).

29 See 42 C.F.R. §§ 2.64, 2.65 (2008) (State law reporting exemption for incidents of suspected child abuse and neglect to appropriate State or local authorities per 42 USC §§290dd-2 and NCGS §122C-52 through 55.)

30 See Appendix I for sample court order allowing disclosure of substance abuse and mental health records.

31 See NCGS §§122C-52 through 56.

32 See Appendices G-1, G-2, and I for sample releases and court order satisfying requirements for

c. Psychotherapy notes

HIPAA provides extra protections for psychotherapy notes.[33] A specific authorization separate from any other authorizations must be obtained for any use or disclosure of psychotherapy notes. For more information see 45 C.F.R. § 164.508(a)(2) (2008).[34]

B. Consultation and Testimony

1. Consultations

It is professional courtesy for physicians and lawyers to cooperate with one another and to abide by applicable statutes and rules so that the medical questions involved in controversies are fairly and adequately explored and presented. Where appropriate, a frank discussion between the patient's physician and the patient's attorney is helpful to give each a complete understanding of the medical and legal issues involved. When such a discussion occurs, their mutual patient/client benefits: time is saved, confusion is minimized (making settlement more likely), and inter-professional understanding is enhanced. To that end, the patient's physician(s) and attorney(s) should attempt, when appropriate, to discuss the medical questions prior to mediation, deposition, or trial.

However, patients' physicians may not communicate with an attorney or any other person about a patient's treatment, evaluation, or condition without the written authorization of the patient or the patient's authorized representative, or a court order, or other lawful authority.[35]

A physician has an obligation to consult with a patient's attorney if the patient has given them written consent to do so.[36] However, this obligation to consult may be limited if the patient has, or may have, a potential malpractice claim against the physician. If a physician is unclear whether the obligation to consult with a patient's attorney may be limited, the physician is encouraged to consult with legal counsel for the North Carolina Medical Society, their own

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disclosure of substance abuse and mental health records.

33 See Appendix A-1 for definition of *psychotherapy notes*.

34 See Appendices G-3 and G-4 for sample authorization form satisfying HIPAA requirements for release of psychotherapy notes.

35 In workers' compensation cases, there may be circumstances under which the employer or its representative may communicate with physicians. Contact the N.C. Industrial Commission to ascertain the current status of the law on this issue.

36 See AMA Code of Medical Ethics §§ 9.07, "Medical Testimony," ("If a patient who has a legal claim requests a physician's assistance, the physician should furnish medical evidence, with the patient's consent, in order to secure the patient's legal rights. The attorney for the party who calls the physician as a witness should be informed of all favorable and unfavorable information developed by the physician's evaluation of the case.") and 8.12, "Patient Information" (2008-09 ed.) (requiring physicians to be honest and open in their dealings with patients even in situations where "a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient.").

attorney, or ask the advice of their professional liability insurer.

An attorney investigating a potential professional liability claim should avoid misleading the physician regarding the physician's potential malpractice liability. Where the patient's attorney is investigating a specific physician's potential professional liability or reasonably foresees that the physician's actions may be the basis of a claim, the attorney has an obligation to so advise that physician.[37]

2. Physician Deposition Testimony

Deposition testimony of a physician is sometimes necessary and is preferably arranged at a scheduled time in the physician's office.[38] Depositions are necessary for one or more reasons: for discovery;[39] to perpetuate testimony;[40] or for later use instead of the physician's appearance at trial.[41] Physicians' appearance in court is usually the most effective way to present testimony. However, physicians cannot always be present in court, and sometimes their personal testimony may be of secondary value. Physicians should agree to videotaped depositions when requested. North Carolina Rules of Evidence and of Civil Procedure sometimes prohibit an attorney from using a deposition in state civil court. In those instances, the physician must appear in court to testify.[42]

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37 See Rule 4.3 of the North Carolina Revised Rules of Professional Conduct (1997).

38 In criminal cases in North Carolina state courts, medical witnesses usually testify at the trial because medical testimony is rarely taken by deposition.

39 A deposition is a discovery tool which allows one side of a lawsuit to discover the information known to witnesses for the other side. Typically, the attorney opposing the patient's claim is prohibited from communicating with the patient's physician prior to trial except at a deposition. The opposing attorney is frequently in need of the physician's deposition testimony in order to defend against the patient's claim. The deposition is usually that attorney's only opportunity to discern the physician's opinion regarding the patient's medical condition.

40 This occurs when the witness may be legally unavailable at the time of a subsequent trial.

41 This occurs to accommodate the physician's schedule notwithstanding that live medical testimony is considered to be more effective than deposition medical testimony.

42 For example, absent the consent of the opposing party, witness depositions may not be used in lieu of live testimony unless the court finds certain apply. N.C. R.Civ. P. 32(a)(4).

V. TRIAL SITUATIONS

A. Subpoenas

1. Witness Subpoenas

a. North Carolina State Courts

Under North Carolina law, physicians, acting as medical witnesses[43] are required to be subpoenaed before the Court may award them an expert witness fee after they have testified at a deposition or trial.[44] Physicians should not attempt to avoid service of subpoenas.[45]

In issuing trial subpoenas to physicians, attorneys must be aware of the physician's patient scheduling needs. For that reason, the attorney should notify the physician by letter of the intent to subpoena the physician to trial. The trial subpoena itself should be issued as soon as practical, but in no event should a subpoena be issued later than seven days before trial. Only a rare emergency calls for later issuance of the subpoena.[46] Where appropriate, the subpoena for attendance at the trial as a witness should reflect the actual time for the physician to appear and/or "will call when needed" or "on standby," if the actual time is uncertain. If the actual time is uncertain, the attorney or someone in the attorney's office should keep the physician informed on a daily basis as to the status of the trial. An attorney has little or no control over scheduling a

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43 See Section III(E) above defining the types of medical witnesses recognized under the Guidelines. Where the Guidelines refer to a physician as a 'medical witness' the statement refers to all types of medical witnesses defined therein.

44 N.C. Gen. Stat. § 7A-314(d) (2008) allows the Court in its discretion to authorize payment of expert witness fees and allowances, but only when the witness has testified (either at trial or deposition) after having been served with a subpoena. State v. Johnson, 282 N.C. 1, 191 S.E.2d 641 (1972); Town of Chapel Hill v. Fox, 120 N.C. App. 630, 463 S.E.2d 421 (1995). N.C. Gen. Stat. § 7A-314 (2008) does not compel parties to seek a judicial determination of expert witness fees or who is to pay them. N.C. Gen. Stat. § 7A-454 (2008) addresses under what circumstances a court may order payment of expert witnesses who testify on behalf of indigent criminal defendants. N.C. Rule of Evidence 706 governs who shall pay, and what amount, shall be paid to expert witnesses appointed by the Court in civil and criminal actions. N.C. Gen. Stat. § 15-7 (2008) governs the payment of physicians appointed to conduct post-mortem examinations of homicide victims. In cases before the Industrial Commission, expert witness fees are set by the Commissioner or Deputy Commissioner hearing the case. See N.C. Gen. Stat. §§ 97-90(c) and 97-26.1 (2008).

45 See AMA Code of Medical Ethics, Section 9.07, "Medical Testimony" (2008-09 ed.) (" As a citizen and as a professional with special training and experience, the physician has an ethical obligation to assist in the administration of justice. If a patient who has a legal claim requests a physician's assistance, the physician should furnish medical evidence, with the patient's consent, in order to secure the patient's legal rights. . . Medical witnesses should be adequately prepared and should testify honestly and truthfully to the best of their medical knowledge."). See also N.C. Medical Board Position Statement "The Physician-Patient Relationship (adopted 7/95, amended 7/98, 1/00, 2/02, 8/03, and 9/06): "[I]t is the position of the North Carolina Medical Board that any act by a physician that violates or may violate the trust a patient places in the physician places the relationship between physician and patient at risk**.."). .** Finally, N.C. Gen. Stat. § 90-14 (2008) (regulating physician and physician assistant conduct finds impermissibly unprofessional conduct "contrary to honesty, justice, or morals").

46 A specific example of a "rare emergency" arises pursuant to the statutory provisions of N.C. Gen. Stat. § 50B-2 (2008), which permits a party alleging acts of domestic violence to seek a hearing on an ex parte or expedited basis.

case.[47] Accordingly, physicians should not necessarily alter the office schedule but should bear in mind the possibility of being called to court. At the same time, the attorney or someone in the attorney's office should keep the physician informed on a daily basis as to the status of the calendar. When a case is postponed or not reached during a court session, the attorney should immediately notify the physician. Physicians have continuing and often unpredictable responsibilities to their patients and, insofar as they are able, attorneys should make arrangements with a minimum of inconvenience or delay.

Court calendaring systems vary between judicial district[48] in North Carolina. Under court calendaring rules in some judicial districts, a case will automatically reappear on a trial calendar if it has previously been postponed or not reached. The new trial session, and the case's position on the trial calendar, if known, should be relayed to the physician by letter as soon as possible. If for some reason the new trial week is inconvenient for the physician, they should notify the attorney immediately and in no event later than one week after notice of the new trial date.[49]

b. Workers' Compensation Cases[50]

In workers' compensation cases, medical witnesses typically testify by deposition scheduled after lay testimony has been received. A party to a workers' compensation case must obtain permission from the Industrial Commission before a medical witness can offer live testimony. In those rare instances when physicians are subpoenaed, they will be on telephone standby until notified.

2. Subpoenas for Medical Records

Often parties to a lawsuit will subpoena medical records to a trial without requesting the presence of the physician who made them. As in the case of trial subpoenas to physicians (see Section V.A.1. above), subpoenas for medical records should be issued as soon as possible, but in no event should a subpoena be issued later than seven days before trial. Only a rare emergency calls for later issuance of the subpoena.[51] A physician's options in responding to a subpoena for medical records depends in part on who is subpoenaing the records, and on what

47 Each time a case is scheduled for trial, an attorney must prepare the case fully and subpoena all the witnesses. Most cases are scheduled for trial several times before they are actually called for trial by the Court.

48 Judicial Districts in North Carolina typically include one or more counties, depending upon whether the district is primarily urban or rural.

49 This is because attorneys do not have power to postpone scheduled trials and must apply to a Judge for a continuance. The later the application for a continuance, the less likely it is that the Court will grant the requested postponement.

50 In workers' compensation hearings, physicians may testify in hearings before the Industrial Commission regarding facts communicated or learned by physicians while attending or examining the employee patient without the specific consent of the employee.

51 As noted in Section V.A.1.a., a "rare emergency" may arise pursuant to the statutory provisions of N.C. Gen. Stat. § 50B-2 (2008), which permits a party alleging acts of domestic violence to seek a hearing on an ex parte or expedited basis.

authorization that person has to view the records. Subpoenas for medical records containing substance abuse and psychiatric information are addressed in section IV A. 4. of these Guidelines.

a. Records Subpoenaed With Authorization and/or Pursuant to Court Order or Other Authority

If the party subpoenaing the medical record has the written consent of the patient or the patient's personal representative to inspect the records, or if the subpoena is accompanied by a judicial or administrative order, or is issued in conformity with other applicable legal authority the subpoena may be complied with in one of several ways. The custodian of the records may bring them to court and testify to their authenticity and completeness, or the records may be mailed to the presiding judge or their designee accompanied by an affidavit authenticating them signed by the medical record custodian.[52] Only those medical records expressly authorized by the order should be released in accordance with the order.[53]

b. Records Subpoenaed Without Authorization and Without Court Order or Other Authority

Medical records are often subpoenaed to North Carolina state courts by parties without authorization to inspect the records and without a court order requiring their disclosure.[54] This happens often in personal injury cases, where defense attorneys routinely subpoena plaintiffs' medical records for a variety of legitimate reasons.[55] The method of subpoenaing such records varies widely across the state. A party may properly subpoena medical records they lack authorization to inspect by stating in writing on the subpoena that the records are being subpoenaed by one without legal authority to inspect them, and who will not inspect them absent the written consent of the patient or the patient's personal representative or judicial or

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52 See N.C. Rule of Civil Procedure 45(c). Although Rule 45(c) specifically authorizes the "custodian of hospital medical records" to respond to a subpoena for "hospital medical records as defined in N.C. Gen. Stat. § 8-44.1" by certified mailing of the records, it has become common practice in North Carolina state courts for all types of medical records to be sent by certified mail unless an issue arises as to the authorization of the subpoenaing party to inspect the records. N.C. Gen. Stat. § 8-44.1 (2008) broadly defines "hospital medical records."

53 45 C.F.R. § 164.512(e) (2008).

54 N.C. Gen. Stat. § 8-53 (2008) authorizes a resident or presiding judge, in the trial division where the case is pending, or the Industrial Commission pursuant to law, to order the disclosure of the records without authorization at or before trial where to do so is necessary to a proper administration of justice.

55 Defense counsel may subpoena to a court proceeding the records of current and/or prior treating physicians they have no authority to inspect. In this situation, the attorneys involved expect that, if the patient's attorney objects to disclosure of the records to the defense counsel, the presiding judge at the trial of the action will examine the records in camera (privately) to determine whether the records should be ordered released for the inspection of the subpoenaing party. See N.C. Rule of Professional Conduct 1.2(c) and RPC 236 "Misuse of Subpoena Process" (1997) (prohibiting abuse of the subpoena process by subpoenaing medical records to a lawyer's office where no legal proceeding is occurring).

administrative order, or in conformity with other applicable legal authority.[56]

Prior to the release of medical records subpoenaed without authorization and without court order or other authority, it is imperative to make sure that the release of such information is permitted under HIPAA. HIPAA will not allow health care providers to release health information pursuant to a subpoena that is not accompanied by an order of court or administrative tribunal, unless the health care provider receives "satisfactory assurance" from the requesting party that reasonable efforts have been made to (1) provide notice to the person whose records are being requested or (2) secure a qualified protective order for the records. Each of these alternatives must meet the requirements enumerated in the HIPAA rules. In the absence of such "satisfactory assurances" from outside sources, the health care provider must make a reasonable effort to provide the notice or seek a qualified protective order sufficient to meet the requirements of the rule.

Also, before releasing medical records subpoenaed without authorization and without court order or other authority, a physician should receive one of the following:

1. The patient's written authorization to release the information requested;
2. A court order to release the requested information;
3. A qualified protective order meeting the requirements of Section 164.512 (e);
4. Evidence demonstrating that reasonable efforts have been made to provide written notice to the individual whose records are being requested, in accordance with the requirements of Section 164.512 (e)(1)(iii); or
5. Evidence demonstrating that reasonable efforts have been made to secure a qualified protective order for the requested records, in accordance with the requirements of Section 164.512 (e)(1)(iv).

Absent one of the above, a written objection to the subpoena may be made on the grounds that compliance would be in violation of HIPAA Section 164.512(e). The objection must be (1) in writing, (2) delivered to the party or attorney designated in the subpoena and (3) made within 10 days after service of the subpoena or before the time specified for compliance if the time is less than 10 days after service.[57]

In the event of an objection or a question about compliance, records-subpoenaed without authority may be placed in a sealed envelope addressed to the Judge presiding at the session of court to which the records have been subpoenaed, and marked: "To remain sealed until otherwise ordered by the presiding Judge."[58]

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56 See Appendix B, Sample Subpoena for Medical Records without Authorization and without Court Order or Other Authority to Inspect.

57 See 45 C.F.R. . § 164.512(e) (2008) for detailed information regarding subpoenas.

58 See Appendix C, Sample Letter to Accompany Records sent to Court in Response to Sample Subpoena for Medical Records without Authorization and without Court Order or Other Authority to Inspect.

B. Notice for Trial

1. Initial Trial Settings

It is imperative both from the standpoint of the efficient administration of justice and the physician's scheduling needs that fact expert witnesses receive as much notice as possible in the setting of a particular case for trial. Under present calendaring procedures in North Carolina state court civil actions, only the week for trial can be designated specifically. There can be no assurances as to when or if the case will be reached that particular week.

2. Fact Expert Witness Availability

Once an attorney has first received notification that a trial is to be scheduled, they should contact their fact expert witnesses regarding availability for trial. At that time, the fact expert witness should inform the attorney of those weeks when they will not be available to testify. Once the case has received a definite trial setting, the attorney should immediately confirm the fact expert witness' availability for that particular week by letter.

3. Final Trial Calendar

When a case appears on the final trial calendar for a particular week, the attorney should notify the fact expert witness regarding the calendaring of the case, its status on the calendar, and an estimate as to the day when the case will be reached. This should be confirmed in writing to the witness. If the fact expert witness has not already been subpoenaed, that should be done at this time.

4. Court Appearance

The business of the courts cannot be governed by the convenience of witnesses, whoever they may be. However, court appearances interrupt medical witness' professional schedule and attorneys should make every reasonable effort to minimize that interruption. The attorney should not require medical witnesses to come in court and sit for long periods of time waiting to be put on the witness stand. The attorney should give the medical witness as much advance notice as is reasonably possible, so that their patient schedule may be rearranged with a minimum of disruption. The medical witness should be alerted by telephone a reasonable time before he or she is actually needed in court.

Medical witnesses are obligated to be in court at the time requested, and should notify the attorney of their arrival. Timing is important not only for the orderly presentation of the case, but also for the convenience of everyone involved in the proceedings. Physicians have ongoing and often unpredictable responsibilities to patients. In such instances, courtroom procedure should permit medical witnesses to testify out of order or at another time. When a medical emergency arises, attorneys should be notified immediately in order to make alternative arrangements and, if appropriate, to seek the court's release of the medical witness or postponement of the medical witness' appearance until the emergency has passed.

C. Medical Witnesses

1. Generally

a. Expert Status

As a medical witness, the physician's role is to provide information, not to advocate a position. The attorneys serve as the advocates. The medical witnesses, the court, and the attorneys should show mutual respect and consideration to each other.

In general, there are two types of witnesses—fact and expert. Expert witnesses, because they possess knowledge not generally known to the jury, are allowed to express opinions. In order to be an expert, it is necessary to know more than the jury knows and to have an opinion about the subject under inquiry. Evolving but unsettled law may require a more stringent standard. The presiding judge at trial may make an initial inquiry into the qualifications of a witness to testify and either permit or limit the testimony.

Because medical witnesses virtually always testify as experts, even when they may also be fact witnesses, the Guidelines treat all medical witnesses as expert witnesses, and differentiate between the types of expert medical witnesses.[59] In order to be accepted as an expert in a trial in North Carolina state courts, the presiding judge must find that the witness has expertise.[60]

Treating physicians typically testify as hybrid fact-expert witnesses, because of their training and knowledge and by virtue of their treatment of a patient whose medical condition is at issue. They may testify about medical observations,[61] or to observations of facts unrelated to their medical expertise. They may also testify about their expert opinions within the scope of their medical expertise. These witnesses are referred to as fact expert witnesses in the Guidelines.

It is not necessary that a medical witness have treated or examined a patient in order to testify as an expert. Expert medical testimony may be based upon a review of the medical chart or a hypothetical set of facts. Witnesses who testify in this fashion typically have been retained by one of the parties for the purpose of providing expert opinion testimony, and do not have a physician-patient relationship with the party whose medical condition is at issue. These witnesses are referred to as retained expert witnesses in the Guidelines.

b. Preparation

Proper preparation for conferences, depositions, and trial testimony includes a review of the relevant medical records. The physician's office staff should cooperate in scheduling

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59 See II (E) above for definition of the three types of medical expert witnesses.

60 If a medical witness is not tendered to and accepted by the presiding judge as an expert, they may not express expert medical opinions and the judge will not have authority to award them an expert witness fee.

61 Medical observations will often be based on medical expertise and therefore be based on expert opinion. For example, when testifying to their medical diagnosis of a patient, the fact witness is expressing an expert medical opinion.

preparatory conferences and depositions at a mutually convenient time, when they are least likely to be interrupted by patient problems, other appointments or operating times.

c. Independent Medical Examinations

Attorneys should provide independent medical witnesses with the ground rules of the independent medical examination submitted to them in writing, including who is to get a report, where copies should be sent, who is to pay for the examination, and the purpose and extent of the examination. Where the examination has been ordered selected or approved by a court, administrative agency or other adjudicatory body, attorneys should also provide the independent medical witness with a copy of the order approving or selecting them.

2. Fees

a. General Considerations

Medical witness charges for assisting attorneys in legal matters should be reasonable, reflecting the physician's experience, the level of specialization, the environment in which the physician practices, and the demand for his or her services.

The recommended fee for a medical witness' court appearance should be measured from the time the medical witness leaves their office to go to court until they return to their office from court, and should also include compensation for time spent preparing to testify. Under certain circumstances, the presiding judge will set a fee for the physician.[62]

b. Fees in Workers' Compensation Cases

In workers' compensation cases, all expert witness fees, and attorney fees, must be approved by the Industrial Commission. See N.C. Gen. Stat. § 97-90 (2008). Receipt of a fee without the approval of the Industrial Commission is a Class 1 misdemeanor prohibited by N.C. Gen. Stat. § 97-90 (2008).

c. Prohibition Against Contingent Fees

Attorneys are prohibited from offering and physicians are prohibited from accepting fees wholly or partially contingent upon the outcome of the matter in which medical testimony is offered.[63] A fee shall not be deemed contingent for the reason that the patient's financial

62 This only occurs on motion of the party prevailing in a matter, if they have called the medical witness, the witness has testified pursuant to subpoena, and has been received by the court as an expert witness. In this instance, the prevailing party seeks to have the fee set and taxed against the losing party as a court cost. See N.C. Gen. Stat. § 7A-314 (2008). This fee may not necessarily represent the entire fee owed a retained or fact medical witness by virtue of their contractual relationship with the attorney and/or their patient or client. Nothing compels a party to move for expert witness fees to be taxed as costs. See also N.C. Gen. Stat. §§ 6-20 and 7A-305 (2008).

63 See AMA Code of Medical Ethics §§ 6.01 "Contingent Physician Fees" (prohibiting the same) and 8.10 "Lien Laws" (2008-09 ed.) (allowing liens only where "the fee is fixed in amount and not contingent on the amount of settlement of the patient's claim against a third party). Cf. N.C. Gen. Stat. §§ 44-49 through 44-51 (2008) (N.C. lien laws allocating fees based on pro rata share of percentage of recovery).

condition may render collection difficult in the event that the patient does not prevail in a legal action.

d. Fees for Fact Expert Witnesses

In civil cases in North Carolina state courts, fact expert witnesses are entitled to reasonable compensation for time spent in conferences, preparation of medical reports, depositions, time spent out of the office for court or other appearances, and for travel costs.

An attorney is ethically prohibited from having an economic interest in a client's claim. Therefore, while an attorney may advance fees which are incurred in pursuing claims,[64] all such fees are ultimately the responsibility of the patient/client.[65]

An attorney should not place an undue burden on fact medical witnesses for services rendered at an attorney's request on behalf of a patient/client. No attorney should request a fact medical witness to consult with them or prepare a medical report for them where the client is unable to pay for the same, unless they are willing to advance the cost of such litigation expenses or they have informed the medical witness that the client is unable to pay for their services. If the client is unwilling to ultimately pay for the same, the attorney should not request such services.

The fact expert witness may require payment for depositions, conferences, and consultations at the time of the service. For some patients and clients, prepayment is not feasible and alternative methods of payment must be considered. The fact expert witness, attorney, and the patient may agree to any lawful method of payment**.**

e. Fees for Retained Expert Witnesses

All services and fees of retained expert witnesses are subject to negotiation between the physician and the contracting party. Also, unless agreed to between the parties, any such service rendered does not create a physician/patient relationship.

Retained expert witnesses are permitted to charge a reasonable fee if their court appearance is canceled without sufficient time for the physician to reschedule patients, surgery, and consultations. However, retained expert witnesses should make a reasonable effort to profitably reschedule their time in order to minimize expense or loss.

f. Fees for Independent Medical Witnesses

Independent medical witness fees may either be established by the court, administrative agency or other adjudicatory body selecting or approving them, or by the party seeking their appointment, or by the parties by agreement. Independent medical witnesses should determine

64 Such fees are called 'litigation expenses' and are to be distinguished from charges for treatment, which may not be ethically advanced by attorneys. See footnote 24.

65 Where the attorney incurring the fee does not represent the patient, the fee is nonetheless a litigation expense to be borne by his or her client. This typically happens when the defense attorney takes the deposition of a treating expert witness, and is responsible for their fees for testifying.

how they will be paid, and by whom, prior to conducting the independent medical examination.

g. Pro Bono/Criminal Cases

When an attorney stipulates in writing that they are handling a client's case without charge or expectation of payment from any recovery, then a treating physician should consider providing medical reports and testimony free of charge. Should an attorney be awarded payment unexpectedly, the physician should be notified promptly by the attorney so that a charge may be made by the physician if appropriate.

If the patient is a victim in a criminal prosecution case, then the physician should provide a medical report to the investigating law enforcement agency free of charge.

VI. N.C. BAR ASSOCIATION MEDICO-LEGAL LIAISON COMMITTEE

The N.C. Bar Association Medico-Legal Liaison Committee is composed of attorneys whose professional practice includes working with individuals and businesses who regularly represent or serve as legal counsel for patients, hospitals and related entities, insurance carriers, physicians, and other licensed and non-licensed health care providers. Its purpose is to create a better understanding, a closer relationship, and unity between the medical and legal professions, so that each may better serve the other and the public. In order to fulfill that purpose, the Medico-Legal Liaison Committee shall meet at least annually to:

- Promulgate revisions to these Guidelines as necessary to keep them legally current and effective.

- Report annually to the N.C. Medical Society and N.C. Bar Association about the work of the Committee and make any appropriate recommendations.

- Accept and mediate reported complaints of attorneys and physicians who experience problems related to a failure to comply with these Guidelines[66] and, where appropriate, forward such reports to the proper disciplinary authorities.

66 However, the Medico-Legal Liaison Committee will not mediate fee disputes between retained expert witnesses and attorneys, or between independent medical witnesses and attorneys.

APPENDIX A-1

RELEVANT HIPAA DEFINITIONS

45 C.F.R. 160.103 Definitions.

Health information means any information, whether oral or recorded in any form or medium, that:

1. Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
2. Related to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
   That identifies the individual; or
   With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

45 C.F.R. 164.501 Definitions.

Designated record set means:

1. A group of records maintained by or for a covered entity that is:
   (i) The medical records and billing records about individuals maintained by or for a covered health care provider;
   (ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
   (iii) Used, in whole or in part, by or for the covered entity to make decision about individuals.
2. For purposes of the paragraph, the term records means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

Protected health information means individually identifiable health information:

1. Except as provided in paragraph (2) of this definition, that is:
    (i) Transmitted by electronic media;
    (ii) Maintained in any medium described in the definition of electronic media at §162.103 of this subchapter; or
    (iii) Transmitted or maintained in any other form or medium.
2. *Protected health information* excludes individually identifiable health information in:
    (i) Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g;
    (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and
    (iii) Employment records held by a covered entity in its role as employer.

Psychotherapy notes means notes records (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.
Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

APPENDIX A-2

PERTINENT NORTH CAROLINA STATUTES AND REGULATIONS REGARDING MEDICAL RECORDS

"Medical records" are defined by the following North Carolina statutory or regulatory provisions:

- N.C. Gen. Stat. § 8-44.1 (2005)[1]
- N.C. Gen. Stat. § 90-410(2) (2005)[2]
- N.C. Gen. Stat. § 58-39-15(18) (2005)[3]
- N.C. Gen. Stat. § 130A-372 (2005)[4]
- 10A N.C. Admin. Code § 14J.0101 (2005)[5]
- 10A N.C. Admin. Code § 14J.1701 (2005[6]

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[1] "Hospital medical records" are defined as "records made in connection with the diagnosis, care and treatment of any patient or the charges for such services except that records covered by N. C. Gen. Stat. § 122-8.1, N. C. Gen. Stat. § 90-109.1 and federal statutory or regulatory provisions regarding alcohol and drug abuse, are subject to the requirements of said statutes." (Please note that N.C. Gen. Stat. § 122-8.1 and N.C. Gen. Stat. § 90-109.1 have been repealed).

[2] Medical records are defined as "personal information that relates to an individual's physical or mental condition, medical history, or medical treatment, excluding X-rays and fetal monitor records."

[3] Information about patients is subject to three definitions under N.C. Gen. Stat. § 58-39-15 of the North Carolina insurance statutes:

> (18) "Medical-record information" means personal information that:
>
> a. Relates to an individual's physical or mental condition, medical history, or medical treatment; and
>
> b. Is obtained from a medical professional or medical-care institution, from the individual, or from the individual's spouse, parent, or legal guardian.
>
> (19) "Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. "Personal information" includes an individual's name and address and medical-record information, but does not include privileged information.
>
> (22) Privileged information" means any individually identifiable information that (i) relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual, and (ii) is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual: Provided, however, information otherwise meeting the requirements of this subsection shall nevertheless be considered personal information under this Article if it is disclosed in violation of N.C. Gen. Stat. § 58-39-75 (2005).

[4] Medical records are defined as "health data relating to the diagnosis or treatment of physical or mental ailments of individuals."

[5] The medical record of an inmate of a local confinement facility is defined as "a record of medical problems, examinations, diagnoses and treatments."

[6] The definition in footnote 4 also applies to inmates in municipal lock-up facilities.

Other provisions of North Carolina law refer to information about patients' medical services using terms other than "medical record":

- Individuals receiving services for mental health, substance abuse, or mental retardation are referred to as "clients," and information about their treatment is called "confidential information," defined in N.C. Gen. Stat. § 122C-3(9) (2005).[7] Compilations of such information are sometimes called the "client record."[8] Note that substance abuse information also is likely to be subject to the strict provisions of the federal drug and alcohol abuse facility law.

- Both §130A-45.8 (2005),[9] concerning patient information held by public health authorities, and §131E-97 (2005),[10] addressing patient information held by

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[7] "Confidential information" is defined in § 122C-3(9) as:

> …any information, whether recorded or not, relating to an individual served by a facility that was received in connection with the performance of any function of the facility. 'Confidential information' does not include statistical information from reports and records or information regarding treatment or services which is shared for training, treatment, habilitation, or monitoring purposes that does not identify clients either directly or by reference to publicly known or available information.

10A N.C. Admin. Code 26B.0103(b)(3) (2005) further provides that confidential information as defined in Section 122C-3 "includes but is not limited to photographs, videotapes, audiotapes, client records, reimbursement records, verbal information relative to clients served, client information stored in automated files, and clinical staff member client files."

[8] The Administrative Code has several slightly differing definitions for this information. 10A N.C. Admin. Code 26B.0103(b)(1) (2005) defines "client record" as "any documentation made of confidential information." 10A N.C. Admin. Code 26D.0103(8) (2005) defines "client record" as "a written account of all mental health and mental retardation services provided to an inmate the time of acceptance of the inmate as the client until termination of services. This information is documented on standard forms which are filed in a standard order in an identifiable folder." 10A N.C. Admin. Code 27G.0103(b)(12) (2005) defines "client record" as "a documented account of all services provided to a client." 10A N.C. Admin. Code 21A.0201(22) (2005) contains this definition: "'client information' or 'client record' means any information, including information stored in computer data banks or computer files relating to a client that was received in connection with the performance of any function of the agency." 10A N.C. Admin. Code 28A.0102(b)(6) (2005) defines "client record" as "any record made of confidential information."

[9] N.C.G.S. §130A-45.8 (2004) provides:

> (a) Medical records compiled and maintained by public health authorities in connection with the admission, treatment, and discharge of individual patients are not public records as defined by Chapter 132 of the General Statutes.
>
> (b) Charges, accounts, credit histories, and other personal financial records compiled and maintained by public health authorities in connection with the admission, treatment and discharge of individual patients are not public records as defined by Chapter 132 of the General Statutes.

[10] Section 131E-97 (2005) provides:

> (a) Medical records compiled and maintained by health care facilities in connection with the admission, treatment, and discharge of individual patients are not public records as defined by Chapter 132 of the General Statutes.
>
> (b) Charges, accounts, credit histories, and other personal financial records compiled and maintained by health care facilities in connection with the admission, treatment, and

"health care facilities," draw a distinction between the patient's medical records and financial records.

- N.C. Gen. Stat. § 131E-214.1 (2005) defines both "patient data" and "patient identifying information."[11]

- Medical information governed by the Division of Aging and the Division of Social Services is considered "client information."[12]

- 10A N.C. Admin. Code 47B.0102(6) (2005) defines "identifying information" with respect to cancer patients.[13]

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discharge of individual patients are not public records as defined by Chapter 132 of the General Statutes.

[11] Section 131E-214.1, concerning statewide data processing of certain information about patients, includes the following definitions:

> (4) "Patient data" means data that includes a patient's age, sex, zip code, third-party coverage, principal and other diagnosis, date of admission, procedure and discharge date, principal and other procedures, total charges and components of the total charges, attending physician identification number, and hospital or freestanding ambulatory surgical facility identification number.
>
> (5) "Patient identifying information" means the name, address, social security umber, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a number assigned to a patient by a health care provider if that number does not consist of or contain numbers, including social security or drivers license numbers, that could be used to identify a patient with reasonable accuracy and speed from sources external to the health care provider.

[12] Both 10A N.C. Admin. Code 5J.0101(3) (2005) and 10A N.C. Admin. Code 69.0101(3) (2005) provide that "'client information' or 'client record' means any information, whether recorded or not, including information stored in computer data banks or files, relating to a client which was received in connection with the performance of any function of the agency."

[13] The pertinent regulation defines "identifying information" as "any portion of any abstract or incidence report that might reveal the personal identity of a cancer patient." All health care facilities and providers that detect, diagnose, or treat cancer shall report to the central cancer registry each diagnosis of cancer in any person who is screened, diagnosed or treated.

STATE OF NORTH CAROLINA

_____ County

File No.

In The General Court Of Justice
☐ District ☐ Superior Court Division

Additional File Numbers

VERSUS

SUBPOENA

G.S. 1A-1, Rule 45

Party Requesting Subpoena
☐ State/Plaintiff ☐ Defendant

NOTE TO PARTIES NOT REPRESENTED BY COUNSEL: *Subpoenas may be produced at your request, but must be signed and issued by the office of the Clerk of Superior Court, or by a magistrate or judge.*

TO

Name And Address Of Person Subpoenaed

Alternate Address

Telephone No.

Telephone No.

YOU ARE COMMANDED TO: *(check all that apply):*

☐ appear and testify, in the above entitled action, before the court at the place, date and time indicated below.
☐ appear and testify, in the above entitled action, at a deposition at the place, date and time indicated below.
☐ produce and permit inspection and copying of the following items, at the place, date and time indicated below.
☐ See attached list. *(List here if space sufficient)*

Name And Location Of Court/Place Of Deposition/Place To Produce

Date To Appear/Produce

Time To Appear/Produce
☐ AM ☐ PM

Name And Address Of Applicant Or Applicant's Attorney

Date

Signature

Telephone No.

☐ Deputy CSC ☐ Assistant CSC ☐ Clerk Of Superior Court ☐ Superior Court Judge
☐ Magistrate ☐ Attorney/DA ☐ District Court Judge

RETURN OF SERVICE

I certify this subpoena was received and served on the person subpoenaed as follows:

By ☐ personal delivery.
☐ registered or certified mail, receipt requested and attached.
☐ telephone communication *(For use only by the sheriff's office for witness subpoenaed to appear and testify.)*
☐ I was unable to serve this subpoena.

Service Fee		Date Served	Signature of Authorized Server	Title
$	☐ Paid ☐ Due			

NOTE TO PERSON REQUESTING SUBPOENA: *A copy of this subpoena must be delivered, mailed or faxed to the attorney for each party in this case. If a party is not represented by an attorney, the copy must be mailed or delivered to the party. This does not apply in criminal cases.*

(Please See Reverse Side)

NOTE: Rule 45, North Carolina Rules of Civil Procedure, Parts (c) and (d).

(c) Protection Of Persons Subject To Subpoena

(1) Avoid undue burden or expense. - A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing an undue burden or expense on a person subject to the subpoena. The court shall enforce this subdivision and impose upon the party or attorney in violation of this requirement an appropriate sanction that may include compensating the person unduly burdened for lost earnings and for reasonable attorney's fees.

(2) For production of public records or hospital medical records. - Where the subpoena commands any custodian of public records or any custodian of hospital medical records, as defined in G.S. 8-44.1, to appear for the sole purpose of producing certain records in the custodian's custody, the custodian subpoenaed may, in lieu of personal appearance, tender to the court in which the action is pending by registered or certified mail or by personal delivery, on or before the time specified in the subpoena, certified copies of the records requested together with a copy of the subpoena and an affidavit by the custodian testifying that the copies are true and correct copies and that the records were made and kept in the regular course of business, or if no such records are in the custodian's custody, an affidavit to that effect. When the copies of records are personally delivered under this subdivision, a receipt shall be obtained from the person receiving the records. Any original or certified copy of records or an affidavit delivered according to the provisions of this subdivision, unless otherwise objectionable, shall be admissible in any action or proceeding without further certification or authentication. Copies of hospital medical records tendered under this subdivision shall not be open to inspection or copied by any person, except to the parties to the case or proceedings and their attorneys in depositions, until ordered published by the judge at the time of the hearing or trial. Nothing contained herein shall be construed to waive the physician-patient privilege or to require any privileged communication under law to be disclosed.

(3) Written objection to subpoena. - Subject to subsection (d) of this rule, a person commanded to appear at a deposition or to produce and permit the inspection and copying of records may, within 10 days after service of the subpoena or before the time specified for compliance if the time is less than 10 days after service, serve upon the party or the attorney designated in the subpoena written objection to the subpoena, setting forth the specific grounds for the objection. The written objection shall comply with the requirements of Rule 11. Each of the following grounds may be sufficient for objecting to a subpoena:

a. The subpoena fails to allow reasonable time for compliance.
b. The subpoena requires disclosure of privileged or other protected matter and no exception or waiver applies to the privilege or protection.
c. The subpoena subjects a person to an undue burden.
d. The subpoena is otherwise unreasonable or oppressive.
e. The subpoena is procedurally defective.

(4) Order of court required to override objection. - If objection is made under subdivision (3) of this subsection, the party serving the subpoena shall not be entitled to compel the subpoenaed person's appearance at a deposition or to inspect and copy materials to which an objection has been made except pursuant to an order of the court. If objection is made, the party serving the subpoena may, upon notice to the subpoenaed person, move at any time for an order to compel the subpoenaed person's appearance at the deposition or the production of the materials designated in the subpoena. The motion shall be filed in the court in the county in which the deposition or production of materials is to occur.

(5) Motion to quash or modify subpoena. - A person commanded to appear at a trial, hearing, deposition, or to produce and permit the inspection and copying of records, books, papers, documents, or other tangible things, within 10 days after service of the subpoena or before the time specified for compliance if the time is less than 10 days after service, may file a motion to quash or modify the subpoena. The court shall quash or modify the subpoena if the subpoenaed person demonstrates the existence of any of the reasons set forth in subdivision (3) of this subsection. The motion shall be filed in the court in the county in which the trial, hearing, deposition, or production of materials is to occur.

(6) Order to compel; expenses to comply with subpoena. - When a court enters an order compelling a deposition or the production of records, books, papers, documents, or other tangible things, the order shall protect any person who is not a party or an agent of a party from significant expense resulting from complying with the subpoena. The court may order that the person to whom the subpoena is addressed will be reasonably compensated for the cost of producing the records, books, papers, documents, or tangible things specified in the subpoena.

(7) Trade secrets, confidential information. - When a subpoena requires disclosure of a trade secret or other confidential research, development, or commercial information, a court may, to protect a person subject to or affected by the subpoena, quash or modify the subpoena, or when the party on whose behalf the subpoena is issued shows a substantial need for the testimony or material that cannot otherwise be met without undue hardship, the court may order a person to make an appearance or produce the materials only on specified conditions stated in the order.

(8) Order to quash; expenses. - When a court enters an order quashing or modifying the subpoena, the court may order the party on whose behalf the subpoena is issued to pay all or part of the subpoenaed person's reasonable expenses including attorney's fees.

(d) Duties In Responding To Subpoena

(1) Form of response. - A person responding to a subpoena to produce documents shall produce them as they are kept in the usual course of business or shall organize and label the documents to correspond with the categories in the request.

(2) Specificity of objection. - When information subject to a subpoena is withheld on the objection that is is subject to protection as trial preparation materials, or that it is otherwise privileged, the objection shall be made with specificity and shall be supported by a description of the nature of the communications, records, books, papers, documents, or other tangible things not produced, sufficient for the requesting party to contest the objection.

INFORMATION FOR WITNESS

NOTE: I*f you have any questions about being subpoenaed as a witness, you should contact the person named on the other side of this Subpoena in the box labeled "Name And Address Of Applicant Or Applicant's Attorney.*

DUTIES OF A WITNESS

- Unless otherwise directed by the presiding judge, you must answer all questions asked when you are on the stand giving testimony.
- In answering questions, speak clearly and loudly enough to be heard.
- Your answers to questions must be truthful.
- If you are commanded to produce any items, you must bring them with you to court or to the deposition.
- You must continue to attend court until released by the court. You must continue to attend a deposition until the deposition is completed.

BRIBING OR THREATENING A WITNESS

It is a violation of State law for anyone to attempt to bribe, threaten, harass, or intimidate a witness. If anyone attempts to do any of these things concerning your involvement as a witness in a case, you should promptly report that to the district attorney or the presiding judge.

WITNESS FEE

A witness under subpoena and that appears in court to testify, is entitled to a small daily fee, and to travel expense reimbursement, if it is necessary to travel outside the county in order to testify. (The fee for an "expert witness" will be set by the presiding judge.) After you have been discharged as a witness, if you desire to collect the statutory fee, you should immediately contact the Clerk's office and certify to your attendance as a witness so that you will be paid any amount due you.

AOC-G-100, Side Two, Rev. 10/03

APPENDIX C

SAMPLE LETTER TO ACCOMPANY RECORDS SENT TO COURT IN RESPONSE TO SAMPLE SUBPOENA FOR MEDICAL RECORDS WITHOUT AUTHORIZATION AND WITHOUT COURT ORDER OR OTHER AUTHORITY TO INSPECT

Instructions:

- Place the subpoenaed records and an affidavit certifying their authenticity in a sealed envelope. Mark the outside of the sealed envelope: "To remain sealed until otherwise ordered by the presiding Judge at the trial (or hearing) of [Case name and file number]".
- Attach the following letter to the exterior of the sealed envelope containing the records and the authenticating affidavit.
- Place the sealed envelope and attached letter in a separate envelope addressed to 'Presiding Judge' in care of the Clerk of Superior Court for the County in which the action is pending.

Date

Superior or District Court Judge Presiding over Trial (or Hearing)

Clerk of Superior Court, Civil or Criminal Division

Address

Re: Case Caption

Name of Patient:

Dear Presiding Judge:

The records of our patient, (name), have been subpoenaed to the trial (or hearing) above-captioned by, (name of subpoenaing, attorney or party), who has not presented us with evidence of legal authority or authorization to inspect, copy, or disclose these records. Therefore, we are sending these records to you sealed and marked "To remain sealed until otherwise ordered by the presiding Judge at the trial (or hearing) above-captioned." We ask that these records remain sealed from inspection until it is judicially determined that the subpoenaing party may lawfully unseal and inspect them. Thank you for your attention to this request.

Sincerely yours,

Medical Records Custodian

Enclosure (sealed records)

APPENDIX D
AFFIDAVIT OF MEDICAL RECORD CUSTODIAN

STATE OF NORTH CAROLINA

COUNTY OF _____

IN THE GENERAL COURT OF JUSTICE
[SUPERIOR or DISTRICT] COURT DIVISION
FILE NO.: _____

(NAME OF PLAINTIFF)
Plaintiff;

vs.

(NAME OF DEFENDANT)
Defendant.

AFFIDAVIT OF MEDICAL RECORD CUSTODIAN

_____, being first duly sworn, deposes and says that I am a custodian of records for NAME OF FACILITY and the attached records are:

1. A true and accurate copy of the medical records incurred for the medical treatment of NAME OF PATIENT;

2. These records were made and kept in the regular course of business at or near the time of the acts, conditions, or events recorded; and

3. They were made by persons having knowledge of the information set forth in those records.

_____
AFFIANT

Subscribed and sworn to before me, this_____day of _____, 20_____

_____
NOTARY PUBLIC

My commission expires:_____

NOTARY SEAL

APPENDIX E

SAMPLE LETTER REQUESTING MEDICAL RECORDS

Date

Health Care Provider or Facility Name and Address
Attn: Medical Records Custodian

RE: Names: <<John Patient>>
DOB:
SS#:

Dear Medical Records Custodian:

Please be advised that this law firm has been authorized to obtain the medical records of <<John Patient>>. Enclosed is an authorization for the release of medical records.[1]

[Optional] If the case involves a personal injury liability claim, the letter must so indicate and should reference the statutory charges at the time:

These records are sought with regard to a personal injury liability claim. **N.C. Gen. Stat § 90-411 (2005) sets the maximum charges permissible for medical records requested in personal injury liability claims as follows:** "The maximum fee for each request shall be seventy-five (75) cents per page for the first 25 pages, fifty (50) cents per page for pages 26 through 100, and twenty-five (25) cents for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of up to ten dollars ($10.00), inclusive of copying costs."

Please forward to the office of the undersigned counsel the following items:

1. A complete copy of all medical records, as defined in the *2005 Medico-Legal Guidelines*[2], including laboratory reports, interpretations of all diagnostic images and studies, and all other information in your possession regarding <<John Patient>>;
2. All billing information, including ledger cards, insurance claim forms, etc., whether stored on paper or in electronic format, as the same pertains

---

[1] See N.C. Gen. Stat. § 8-53 to determine who should execute authorizations regarding decedents.

[2] **"Medical Record" Defined**: The medical record is a collection of protected health information for a particular individual, that: is created or received by a physician or other health care provider; relates to the past, present, or future physical or mental health or condition of the individual; and includes information about the provision of health care to that individual and the past, present, or future payments by or on behalf of that individual for the provision of health care. Medical records are inherently sensitive and personal and contain information that relates to an individual's physical or mental condition, medical history, medical diagnosis, or medical treatment as well as demographic and other information that identifies or has the potential to identify the individual (e.g., patient name, address, social security number, unique identifier, etc.).

to medical services rendered to <<John Patient>>. (For additional information, see Appendix A-1); and

3. All correspondence, whether stored on paper or in electronic format, to and from any other person or entity concerning <<John Patient>>.

[Optional] Our firm's check will be forwarded to you upon receipt of your bill for any copying costs consistent with fees set out in North Carolina General Statute § 90-411, a copy of which is attached for your information.

[Optional] Please note that, in the event that you wish to preserve a provider's lien created by N.C.G.S. §§ 44-49 and 44-50, you must provide, without charge, a copy of the records and billing information requested above.

Thank you for your assistance.

Law & Jones, PLLC
1 Lawyers Drive
Anytown, North Carolina

PLEASE NOTE FOR WORKERS' COMPENSATION CASES SPECIAL RULES APPLY: This form is suggested for personal injury cases pending in the Courts. Special rules apply to Workers' Compensation cases. When a health care provider bills an employer's compensation insurance carrier or third-party administrator (adjusting agency), one free copy of medical records associated with the services must be provided, unless arrangements have been made to provide the free copy to a rehabilitation nurse. Fees for additional copies to these or other parties are set by the N.C. Industrial Commission (as an exception to N.C. Gen. Stat. § 90-411, codified at § 97-26.1) at a maximum of $.50 per page for the first 40 pages, and $.20 per page for additional pages, with an allowable minimum fee of $10.00 (inclusive of per page charges). (See January 12, 1995, *Minutes* of the N.C. Industrial Commission.) Industrial Commission Rule 607 provides that, if requested, parties must provide each other with copies of medical and rehabilitation records in their possession within 30 days, and with copies of additional records they obtain thereafter within 15 days after they come into the party's possession.

APPENDIX F

SELECTED STATEMENTS OF THE NORTH CAROLINA MEDICAL BOARD

- The Physician-Patient Relationship
- Medical Record Documentation
- Access to Medical Records
- Retention of Medical Records

THE PHYSICIAN-PATIENT RELATIONSHIP

The North Carolina Medical Board recognizes the movement toward restructuring the delivery of health care and the significant needs that motivate that movement. The resulting changes are providing a wider range and variety of health care delivery options to the public. Notwithstanding these developments in health care delivery, the duty of the physician remains the same: to provide competent, compassionate, and economically prudent care to all his or her patients. Whatever the health care setting, the Board holds that the physician's fundamental relationship is always with the patient, just as the Board's relationship is always with the individual physician. Having assumed care of a patient, the physician may not neglect that patient nor fail for any reason to prescribe the full care that patient requires in accord with the standards of acceptable medical practice. Further, it is the Board's position that it is unethical for a physician to allow financial incentives or contractual ties of any kind to adversely affect his or her medical judgment or patient care.

Therefore, it is the position of the North Carolina Medical Board that any act by a physician that violates or may violate the trust a patient places in the physician places the relationship between physician and patient at risk. This is true whether such an act is entirely self-determined or the result of the physician's contractual relationship with a health care entity. The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship remains inviolate. The physician who puts the physician-patient relationship at risk also puts his or her relationship with the Board in jeopardy.

Elements of the Physician-Patient Relationship

The North Carolina Medical Board licenses physicians as a part of regulating the practice of medicine in this state. Receiving a license to practice medicine grants the physician privileges and imposes great responsibilities. The people of North Carolina expect a licensed physician to be competent and worthy of their trust. As patients, they come to

the physician in a vulnerable condition, believing the physician has knowledge and skill that will be used for their benefit.

Patient trust is fundamental to the relationship thus established. It requires that:

- there be adequate communication between the physician and the patient;
- the physician report all significant findings to the patient or the patient's legally designated surrogate/guardian/personal representative;
- there be no conflict of interest between the patient and the physician or third parties;
- personal details of the patient's life shared with the physician be held in confidence;
- the physician maintain professional knowledge and skills;
- there be respect for the patient's autonomy;
- the physician be compassionate;
- the physician respect the patient's right to request further restrictions on medical information disclosure and to request alternative communications;
- the physician be an advocate for needed medical care, even at the expense of the physician's personal interests; and
- the physician provide neither more nor less than the medical problem requires.

The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship, founded on patient trust, is considered sacred, and when the elements crucial to that relationship and to that trust—communication, patient primacy, confidentiality, competence, patient autonomy, compassion, selflessness, appropriate care—are foremost in the hearts, minds, and actions of the physicians licensed by the Board.

This same fundamental physician-patient relationship also applies to mid-level health care providers such as physician assistants and nurse practitioners in all practice settings.

Termination of the Physician-Patient Relationship

The Board recognizes the physician's right to choose patients and to terminate the professional relationship with them when he or she believes it is best to do so. That being understood, the Board maintains that termination of the physician-patient relationship must be done in compliance with the physician's obligation to support continuity of care for the patient.

The decision to terminate the relationship must be made by the physician personally. Further, termination must be accompanied by appropriate written notice given by the physician to the patient or the patient's representative sufficiently far in advance (at least 30 days) to allow other medical care to be secured. Should the physician be a member of a group, the notice of termination must state clearly whether the termination involves only the individual physician or includes other members of the group. In the latter case, those members of the group joining in the termination must be designated. It is advisable

that the notice of termination also include instructions for transfer of or access to the patient's medical records.

(Adopted July 1995)
(Amended July 1998, January 2000; March 2002, August 2003)

MEDICAL RECORD DOCUMENTATION

North Carolina Medical Board takes the position that physicians and physician extenders should maintain accurate patient care records of history, physical findings, assessments of findings, and the plan for treatment. The Board recommends the Problem Oriented Medical Record method known as SOAP (developed by Lawrence Weed).

SOAP charting is a schematic recording of facts and information. The S refers to "subjective information" (patient history and testimony about feelings). The O refers to objective material and measurable data (height, weight, respiration rate, temperature, and all examination findings). The A is the assessment of the subjective and objective material that can be the diagnosis but is always the total impression formed by the care provided after review of all materials gathered. And finally, the P is the treatment plan presented in sufficient detail to allow another care provider to follow the plan to completion. The plan should include a follow-up schedule.

Such a chronological document

- records pertinent facts about an individual's health and wellness;
- enables the treating care provider to plan and evaluate treatments or interventions;
- enhances communication between professionals, assuring the patient optimum continuity of care;
- assists both patient and physician to communicate to third party participants;
- allows the physician to develop an ongoing quality assurance program;
- provides a legal document to verify the delivery of care; and
- is available as a source of clinical data for research and education.

Certain items should appear in the medical record as a matter of course:

- the purpose of the patient encounter;
- the assessment of patient condition;
- the services delivered--in full detail;
- the rationale for the requirement of any support services;
- the results of therapies or treatments;
- the plan for continued care;
- whether or not informed consent was obtained; and, finally,
- that the delivered services were appropriate for the condition of the patient.

The record should be legible. When the care giver will not write legibly, notes should be dictated, transcribed, reviewed, and signed within reasonable time. Signature, date, and

time should also be legible. All therapies should be documented as to indications, method of delivery, and response of the patient. Special instructions given to other care givers or the patient should be documented: Who received the instructions and did they appear to understand them?

All drug therapies should be named, with dosage instructions and indication of refill limits. All medications a patient receives from all sources should be inventoried and listed to include the method by which the patient understands they are to be taken. Any refill prescription by phone should be recorded in full detail.

The physician needs and the patient deserves clear and complete documentation.

(Adopted 5/94)
(Amended 5/96)

ACCESS TO MEDICAL RECORDS

A physician's policies and practices relating to medical records under their control should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient's care. Such policies and practices should conform to applicable federal and state laws governing health information.

It is the position of the North Carolina Medical Board that notes made by a physician in the course of diagnosing and treating patients are primarily for the physician's use and to promote continuity of care. Patients, however, have a substantial right of access to their medical records and a qualified right to amend their records pursuant to the HIPAA privacy regulations.

Medical records are confidential documents and should only be released when permitted by law or with proper written authorization of the patient. Physicians are responsible for safeguarding and protecting the medical record and for providing adequate security measures.

Each physician has a duty on the request of a patient or the patient's representative to release a copy of the record in a timely manner to the patient or the patient's representative, unless the physician believes that such release would endanger the patient's life or cause harm to another person. This includes medical records received from other physician offices or health care facilities. A summary may be provided in lieu of providing access to or copies of medical records only if the patient agrees in advance to such a summary and to any fees imposed for its production.

Physicians may charge a reasonable fee for the preparation and/or the photocopying of medical and other records. To assist in avoiding misunderstandings, and for a reasonable fee, the physician should be willing to review the medical records with the patient at the

patient's request. Medical records should not be withheld because an account is overdue or a bill is owed (including charges for copies or summaries of medical records).

Should it be the physician's policy to complete insurance or other forms for established patients, it is the position of the Board that the physician should complete those forms in a timely manner. If a form is simple, the physician should perform this task for no fee. If a form is complex, the physician may charge a reasonable fee.

To prevent misunderstandings, the physician's policies about providing copies or summaries of medical records and about completing forms should be made available in writing to patients when the physician-patient relationship begins.

Physicians should not relinquish control over their patients' medical records to third parties unless there is an enforceable agreement that includes adequate provisions to protect patient confidentiality and to ensure access to those records. [1]

When responding to subpoenas for medical records, unless there is a court or administrative order, physicians should follow the applicable federal regulations.

---

[1] See also Position Statement on Departures from or Closings of Medical Practices.

(Adopted November 1993)
(Amended May 1996, September 1997, March 2002, August 2003)

RETENTION OF MEDICAL RECORDS

The North Carolina Medical Board supports and adopts the following language of Section 7.05 of the American Medical Association's current *Code of Medical Ethics* regarding the retention of medical records by physicians.

7.05: Retention of Medical Records
Physicians have an obligation to retain patient records which may reasonably be of value to a patient. The following guidelines are offered to assist physicians in meeting their ethical and legal obligations:

1. Medical considerations are the primary basis for deciding how long to retain medical records, For example, operative notes and chemotherapy records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time.

2. If a particular record no longer needs to be kept for medical reasons, the physician should check state laws to see if there is a requirement that records be kept for a

minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.

3. In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information.

4. Whatever the statue of limitations, a physician should measure time from the last professional contact with the patient.

5. If a patient is a minor, the statute of limitations for medical malpractice claims may not apply until the patient reaches the age of majority.

6. Immunization records always must be kept.

7. The record of any patient covered by Medicare or Medicaid must be kept at least five years.

8. In order to preserve confidentiality when discarding old records, all documents should be destroyed.

9. Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity.

Please Note:
(a.) *North Carolina has no statute relating specifically to the retention of medical records.*
(b.) Several North Carolina statutes relate to time limitations for the filing of malpractice actions. Legal advice should be sought regarding such limitations.

(Adopted 5/98)

APPENDIX G-1

Sample Authorization Form to Use and Disclose Health Information
(Meets federal and North Carolina state law requirements for disclosure of mental health and substance abuse records)

Individual's name: **Date of Birth:**_____
_____

Individual's address: **Individual's ID#:**_____
_____
_____
_____

I hereby voluntarily authorize the use and disclosure of my protected health information as described below:

1. **Specific description of the information to be used or disclosed:**
_____
_____

The above information will be called "authorized information" throughout the rest of this form.

2. **Person (or class of persons) authorized to make the use or disclosure of authorized information:**
_____
_____

3. **Person (or class of persons) to whom the use or disclosure of authorized information may be made:**
_____
_____

4. **Authorized information will be used and/or disclosed for the following purpose(s):**
_____
_____

5. **This authorization expires (must be no longer than reasonable to accomplish purposes in Paragraph 4):**
_____

6. **Furthermore, by signing below, I understand that:**
   - my personal information will be released to the person or class of persons listed above;
   - this information may include information regarding mental health, drugs & alcohol, HIV/AIDS and other communicable diseases, and/or genetic testing (unless specifically excluded above);
   - I may revoke this authorization at any time by a written notification of my desire to revoke it to the medical provider named in number 2 above;
   - any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions;
   - the medical provider named in number 2 above may not condition its treatment of me on whether or not I sign this authorization; and
   - information released may no longer be protected by federal privacy regulations except information concerning substance abuse is subject to the following requirements:
     - This information has been disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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.

Individual's Signature _____ Date:_____

APPENDIX G-2

Authorization Form to Use and Disclose Protected Health Information
(By Authorized Personal Representative)
(Meets federal and North Carolina state law requirements for disclosure of mental health and substance abuse records)

Patient's name:_____ **Date of birth:**_____

Representative's name and address: _____ **Relationship:**_____
_____
_____ **Patient's ID #:**_____
_____

On behalf of _____, I hereby voluntarily authorize the use and disclosure of his/her
(patient name)
protected health information:

1. **Specific description of the information to be used or disclosed:**
_____
_____

The above information will be called "authorized information" throughout the rest of this form.

2. **Person (or class of persons) authorized to make the use or disclosure of authorized information:**
_____
_____

3. **Person (or class of persons) to whom the use or disclosure of authorized information may be made:**
_____
_____

4. **Authorized information will be used and/or disclosed for the following purpose(s):**
_____
_____

5. **This authorization expires (must be no longer than reasonable to accomplish purposes in Paragraph 4):**
_____

6. **Furthermore, by signing below, I understand that:**
   - the personal information will be released to the person or persons listed in number 3 above;
   - this information may include information regarding mental health, drugs & alcohol, HIV/AIDS and other communicable diseases, and/or genetic testing (unless specifically excluded above);
   - I may revoke this authorization at any time by a written notification of my desire to revoke it to the medical provider named in number 2 above;
   - any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions;
   - the medical provider named in number 2 above may not condition treatment of _____ on whether or not I sign this authorization; and (patient name)
   - information released may no longer be protected by federal privacy regulations except information concerning substance abuse treatment is subject to the following requirements:
     - This information has been disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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.

Personal Representative's signature_____ **Date:**_____

APPENDIX G-3

Sample Authorization Form to Use and Disclose Health Information Regarding Psychotherapy Notes

Individual's name: **Date of birth:**_____

_____

Individual's address: **Individual's ID#:**_____

_____

_____

I hereby voluntarily authorize the use and disclosure of my protected health information regarding psychotherapy notes defined in 45 CFR 164.501 as follows and as described below:

> "Psychotherapy notes means notes records (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.
>
> Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date."

1. **Specific description of the information to be used or disclosed:**

_____
_____
_____

The above information will be called "authorized information" throughout the rest of this form.

2. **Person (or class of persons) authorized to make the use or disclosure of authorized information:**

_____
_____
_____

3. **Person (or class of persons) to whom the use or disclosure of authorized information may be made:**

_____
_____
_____

4. **Authorized information will be used and/or disclosed for the following purpose(s):**

_____
_____
_____

5. **This authorization expires:** _____

6. **Furthermore, by signing below, I understand that:**
   - my personal information will be released to the person or class of persons listed above;
   - this information includes information regarding psychotherapy notes as defined above;
   - I may revoke this authorization by a written notification of my desire to revoke it to the medical provider named in number 2 above;
   - any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions;
   - the medical provider named in number 2 above may not condition its treatment of me on whether or not I sign this authorization; and
   - information released may no longer be protected by federal privacy regulations.

Individual's Signature _____ Date:_____

APPENDIX G-4

Authorization Form to Use and Disclose Protected Health Information Regarding Psychotherapy Notes (By Authorized Personal Representative)

Patient's name:_____ **Date of birth:**_____

Representative's name and address: _____ **Relationship:**_____

_____

_____ **Patient's ID #:**_____

On behalf of _____, I hereby voluntarily authorize the use and disclosure of his/her protected
(patient name)
health information regarding psychotherapy notes defined in 45 CFR 164.501 as follows and as described below:

> "Psychotherapy notes means notes records (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.
>
> Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan."

1. **Specific description of the information to be used or disclosed:**

_____
_____
_____

The above information will be called "authorized information" throughout the rest of this form.

2. **Person (or class of persons) authorized to make the use or disclosure of authorized information:**

_____
_____
_____

3. **Person (or class of persons) to whom the use or disclosure of authorized information may be made:**

_____
_____
_____

4. **Authorized information will be used and/or disclosed for the following purpose(s):**

_____
_____
_____

5. **This authorization expires:** _____

6. **Furthermore, by signing below, I understand that:**
   - the personal information will be released to the person or persons listed in number 3 above;
   - this information includes information regarding psychotherapy notes as defined above;
   - I may revoke this authorization by a written notification of my desire to revoke it to the medical provider named in number 2 above;
   - any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions;
   - the medical provider named in number 2 above may not condition treatment of _____ on whether or not I sign this authorization; and (patient name)
   - information released may no longer be protected by federal privacy regulations.

Personal Representative's signature_____ **Date:**_____

APPENDIX H

North Carolina Laws Addressing Licensed Professionals and Other Designated Officials Authorization To Disclose Confidential Information or Protected Health Information

NCGS §7B-302 Confidential information disclosed by a director of the department of social services to any federal, State, or local governmental entity, or its agent pursuant to mandated responsibilities shall not be redisclosed except for purposes connected with carrying out their mandated responsibilities.

NCGS §7B-601 Guardian ad litem may obtain confidential information or reports regarding abused or neglected juvenile

NCGS §8-53.3 Psychologist shall not disclose confidential information obtained in the course of rendering professional services unless compelled by court order or statutory duty to report suspected abuse or neglect

NCGS §8-53.4 School counselor shall not disclose confidential information obtained in the course of rendering professional services unless compelled by court order or student waives privilege

NCGS §8-53.5 Licensed marital and family therapists, or any of the person's employees or associates, shall not disclose confidential information obtained in the course of rendering professional services unless compelled by court order

NCGS §8-53.7 Social worker shall not disclose confidential information obtained in the course of rendering professional services unless compelled by court order

NCGS §8-53.8 Counselor shall not disclose confidential information obtained in the course of rendering professional services unless compelled by court order

NCGS §8-53.9 Optometrist shall not disclose confidential information obtained the course of rendering professional services unless compelled by court order

NCGS §8-53.10 Peer support group counselor privilege shall not be grounds for the failure to report suspected child abuse or neglect to the appropriate county department of social services, or for failure to report a disabled adult suspected to be in need of protective services to the appropriate county department of social services by the law enforcement officer or civilian employee of a law enforcement agency who also services in the capacity of a peer support group counselor

NCGS §8-53.13 Nurse shall not disclose confidential information obtained in the course of rendering professional nursing services unless compelled by court order

APPENDIX I
SAMPLE Court Order Allowing Release of Mental Health, Substance Abuse, and/or Psychotherapy Records
Including Protected Health Information Pursuant to 42 CFR 2.64

_____
Plaintiff

vs.

_____
Defendant

This cause coming on to be heard upon motion of (Petitioner) for release of mental health or substance abuse records including protected health information; and this Court having considered the pleadings and the arguments of counsel; this Court makes the following:

FINDINGS OF FACT

1. (Petitioner) seeks substance records including protected health information because (state reason).

2. The patient and person from whom disclosure is sought has been given adequate notice in a manner which will not disclose patient identifying information to other persons and 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.

Based upon the foregoing Findings of Fact, this Court makes the following:

CONCLUSIONS OF LAW

1. Disclosure of the requested mental health or substance abuse protected health information sought is not otherwise available or would not be effective.

2. The public interest and need for the disclosure of the requested mental health or substance abuse protected health information outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.

Based upon the foregoing Conclusions of Law, it is therefore Ordered that:

ORDER

1. The person from whom disclosure is sought provide the requested mental health or substance abuse protected health information to (petitioner) limiting disclosure to those parts of the patient's record which are essential to fulfill the objective of the order.

2. The requested mental health or substance abuse protected health information be provided limiting disclosure to those persons whose need for information is the basis for the order.

3. The requested mental health or substance abuse protected health information disclosed to (petitioner) pursuant to this court order included in the records of this proceeding shall be sealed. (optional)

This the _____ day of _____, _____.

_____
Judge's Signature