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The Honorable Patricia Rehmer
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Ave.
Hartford, CT 06134

Dear Commissioner Rehmer:

This opinion responds to your request for advice about whether P.A. 13-03, §§ 10 and 11 provide exceptions to the psychiatrist-patient privilege contained in Conn. Gen. Stat. § 52-146e and whether the disclosure required by the 2013 legislation is permitted under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Pub. L. 104-191, 110 Stat. 1936, and the HIPAA regulations promulgated by the Department of Health and Human Services 45 C.F.R. Parts 160 and 164. I understand that a number of hospitals as well as the Connecticut Hospital Association have made this same inquiry to your agency.

For the reasons that follow, I conclude that P.A. 13-03 §§ 10 and 11 must be read as legislatively enacted exceptions to Conn. Gen. Stat. § 52-146e, authorizing the Department of Mental Health and Addiction Services ("DMHAS") to collect data from hospitals about voluntary admissions and permitting DMHAS to re-disclose the voluntary admissions data to the Commissioner of the Department Emergency Services and Public Protection ("DESPP") without the patient's consent. Additionally, because P.A. 13-03 §§ 10 and 11 specifically permit the use and disclosure of a patient's involuntary admission without the patient's consent, I conclude that 45 C.F.R. § 164.512 (a HIPAA regulation) permits this disclosure.

Background

By statute DMHAS promotes comprehensive, client-based services in the areas of mental health and substance abuse treatment. Conn. Gen. Stat. § 17a-450(b). Services are provided to clients by DMHAS run facilities such as Connecticut Valley Hospital, as well as by private providers that enter into provider agreements with DMHAS to provide services to DMHAS clients. See e.g., Conn. Gen. Stat. § 17a-453a. With some exceptions, federal and state laws protect the confidentiality of DMHAS clients, including their identity. See e.g., Conn. Gen. Stat. § 52-146d et seq, 45 C.F.R. §164.500 et seq. Privately run hospitals are subject to these confidentiality laws in the same manner as DMHAS or DMHAS-contracted facilities.

P.A. 2013-03

Prior to the enactment of P.A. 13-03, Conn. Gen. Stat. § 17a-500 only obligated DMHAS to maintain information about probate court orders that required involuntary commitment of persons to hospitals for psychiatric disabilities and to then report this information, when requested, to the Commissioner of DESPP. Conn. Gen. Stat. § 17a-499 requires probate courts to report to DMHAS orders of involuntary commitment.

Several months after the Sandy Hook Elementary School tragedy in Newtown, the General Assembly passed Public Act 13-03. Section 10 of that Act requires hospitals to report to DMHAS whenever a person is voluntarily admitted to a hospital for psychiatric disabilities, as defined in Conn. Gen. Stat. § 17a-495,¹ for care and treatment of a psychiatric disability. The hospital is required to include in its report the patient's name, address, sex, date of birth and date of admission. Public Act 13-03, § 11 amends Conn. Gen. Stat. § 17a-500 to require DMHAS to report this information to the Commissioner of the DESPP if such a person holds, applies for or seeks renewal of² any firearm permit or certificate pursuant to Conn. Gen. Stat. §§ 29-28 through 29-38, 53-202d, as amended by P.A. 13-3 §§ 2 through 5, 28 and 58.³ The Commissioner of DESPP is required to keep the voluntary admission information confidential and only use the data for purposes of fulfilling his obligations under Conn. Gen. Stat. §§ 53-202d, 29-28 through 29-38. Specifically, pursuant to Sections 2, 57, and 58 of Public Act 13-03, the DESPP Commissioner is prohibited from issuing firearms certificates and permits to any person voluntarily confined in a hospital for persons with psychiatric disabilities within the preceding six months for care and treatment of a psychiatric disability. The DESPP Commissioner also must revoke any certificate or permit issued to such a person who has been voluntarily confined in a hospital

¹ Pursuant to Conn. Gen. Stat. § 17a-495, "hospital for psychiatric disabilities" means "any public or private hospital, retreat, institution, house or place in which any mentally ill person is received or detained as a patient;" and "mentally ill person" means "any person who has a mental or emotional condition which has substantial adverse effects on his or her ability to function and who requires care and treatment . . ."

² Pursuant to Section 8(a) of P.A. 13-03, when DESPP receives an application for a permit, a certificate or a renewal, it must "verify" that the applicant has not been voluntarily admitted "by making inquiry to" DMHAS.

³ Because the information provided to DMHAS from the hospitals will not be provided in DMHAS' capacity as a covered entity, HIPAA does not apply as to the provision of the reported information in accord with § 11 of Public Act 2013-13 to DESPP.

for persons with psychiatric disabilities within the preceding six months for care and treatment of a psychiatric disability.

Conn. Gen. Stat. § 52-146e Psychiatrist-Patient Confidentiality

Your first question concerns whether Conn. Gen. Stat. § 52-146e, the Psychiatrist-Patient Confidentiality statute, prevents your agency from making the disclosure that Public Act 13-03 directs. Connecticut General Statutes § 52-146e and provides in relevant part:

- (a) All communications and records as defined in section 52-146d⁴ shall be confidential and shall be subject to the provisions of section 52-146d to 52-146j, inclusive. Except as provided in section 52-146f to 52-146i, inclusive, no person may disclose or transmit any communications and records or the substance or any part or any resume thereof which identify a patient to any person, corporation or governmental agency without the consent of the patient or his authorized representative. (emphasis supplied)

As is plain from the language of the statute, Conn. Gen. Stat. § 52-146e protects against disclosing the identity of a psychiatric patient. See Falco v. Institute of Living, 254 Conn. 321, 329 (2000)(purpose of § 52-146e privilege is to preserve the therapeutic relationship between the patient and psychiatrist and includes the identity of the patient). None of the exceptions referenced in § 52-146e itself apply to the present circumstance.

⁴ Conn. Gen. Stat. § 52-146d contain the following relevant definitions: “(2) ‘Communications and records’ means all oral and written communications and records thereof relating to diagnosis or treatment of a patient’s mental condition between the patient and a psychiatrist, or between a member of the patient’s family and a psychiatrist, or between any such persons and a person participating under the supervision of a psychiatrist in the accomplishment of the objectives of diagnosis and treatment, wherever made, including communications and records which occur in or are prepared at a mental health facility;”...

“(4) ‘Identifiable’ and ‘identify a patient’ refer to communications and records which contain (A) names or other descriptive data from which a person acquainted with the patient might reasonably recognize the patient as the person referred to, or (B) codes or numbers which are in general use outside of the mental health facility which prepared the communications and records;...”

“(6) ‘Patient’ means a person who communicates with or is treated by a psychiatrist in diagnosis or treatment.”

Your agency is concerned that P.A. 13-03, §§ 10 and 11 do not specifically amend §§ 52-146f through 52-146j to create an exception to the confidentiality requirement of § 52-146e. Further, DMHAS is concerned that the Public Act contains no language specifically authorizing DMHAS to disregard the confidentiality requirement of § 52-146e when fulfilling its reporting obligations under P.A. 13-03.

When faced with statutory provisions that appear to impose conflicting obligations, courts seek to read them together and if possible construe the provisions to avoid conflict. Specifically, when more than one statutory provision is involved, our Supreme Court presumes that the legislature intended those provisions to be read together to create a harmonious body of law. In Re Jessica W., 308 Conn. 652, 672 (2012). If the two statutory provisions cannot be reconciled, the following well-established statutory construction principles apply:

[S]pecific terms covering the given subject matter will prevail over general language of the same or another statute which might otherwise prove controlling. . . . Where there are two provisions in a statute, one of which is general and designed to apply to cases generally, and the other is particular and relates to only one case or subject within the scope of a general provision, then the particular provision must prevail; and if both cannot apply, the particular provision will be treated as an exception to the general provision. . . . Additionally, if the expressions of legislative will are irreconcilable, the latest prevails. . . . see also 2B N. Singer & J. Singer, Sutherland Statutory Construction (7th Ed.2008) § 51:2, p. 228 (“where two statutes deal with the same subject matter, the more recent enactment prevails as the latest expression of legislative will”).

Tomlinson v. Tomlinson, 305 Conn. 539, 552-553 (2012)(Citations omitted; internal quotation marks omitted.). Finally, if possible, a court will not construe a statutory provision in way that the provision becomes “superfluous, void or insignificant.” PJM & Associates, LC v. Bridgeport, 292 Conn. 125, 138 (2009).

Applying these rules of statutory construction, I conclude that P.A. 13-03 §§ 10 and 11 are legislatively enacted exceptions to Conn. Gen. Stat. § 52-146e, even though these provisions do not contain an explicit exception to Conn. Gen.

Stat. § 52-146e. Because Public Act 13-03 is the most recent articulation of legislative intent, and a more specific articulation of state policy regarding the treatment of psychiatric information in the specific context of preventing firearm violence, I conclude that P.A. 13-03, §§ 10 and 11 provide a further statutory exception to the psychiatric privilege. The disclosures contemplated by P.A. 13-03, §§ 10 and 11 are required so that the DESPP Commissioner can fulfill his obligations under the statute to revoke or deny any permit or certificate for a firearm to any person voluntarily admitted to a psychiatric hospital within the preceding six months for care and treatment of a psychiatric disability. Construing Public Act 13-03 in a way that does not create a legislative exception to § 52-146e could effectively undermine the entire purpose of the mandated disclosures under the Public Act, rendering it “superfluous, void or insignificant.”

Neither Falco v. Institute of Living, 254 Conn. 321, 329 (2000), nor State v. Jenkins, 271 Conn. 165, 181-182 (2004), support a conclusion that the only exceptions permitted to § 52-146e are those listed in § 52-146f through § 52-146i. In Falco, the plaintiff, who had been a patient at the Institute of Living, was attacked by another patient during a group meeting. The plaintiff sought to learn the identity of the other patient at the Institute through a Bill of Discovery. The Supreme Court agreed with the Institute that protecting communications that identify a patient were central to the purpose of § 52-146e and were protected. Although the Court stated at one point in the opinion that “no exception is available beyond those contained in § 52-146f”; *id.* at 330; the holding of the case is contained the Court’s conclusion “that the psychiatrist-patient privilege may be overridden only by legislatively enacted exceptions, and that the facts of this case do not fall within the narrowly drawn exceptions delineated by the legislature.” *Id.* at 333. I am aware of no principle of law that would require a properly enacted legislative exception to the privilege be contained in the statute that creates the privilege.⁵

⁵ Of course it is self-evident that there are in fact exceptions to § 52-146e “beyond those contained in § 52-146f” because § 52-146e itself recognizes that there are exceptions found in “52-146d to 52-146j, inclusive.” Moreover, two other statutes explicitly contain exceptions to § 52-146e but are not contained in §§ 52-146f through 52-146j. Conn. Gen. Stat § 17a-465b authorizes DMHAS Commissioner to permit a report to DESPP that a person receiving in-patient services is missing and provides that the report may be made, “Notwithstanding the provision of . . . § 52-146e . . .” Conn. Gen. Stat. § 54-56d(k)(3)(A) permits a health guardian appointed by the court for a criminal defendant to have access to the defendant’s psychiatric records and provides that the health guardian shall have access to the records, “Notwithstanding the provisions of § 52-146e . . .” Finally, in addition to these statutes, Conn. Gen. Stat. § 17a-506 requires a report to the probate court whenever a hospital for psychiatric disabilities admits a conserved person and Conn. Gen. Stat. § 19a-498b requires a nursing home administrator or its designee to notify DMHAS of the admission to a nursing home of a patient with psychiatric diagnosis confirmed by Medicaid assessment. Neither statute references 52-146e.

In Jenkins, the trial judge admitted into evidence, over objection, the defendant's mental health records, which contained statements made by the defendant to a nurse under the supervision of a psychiatrist. The State argued that the defendant had impliedly waived his right to keep the mental health records confidential when he claimed during testimony that he was intoxicated at the time the crime was committed. The Supreme Court held that it was improper for the defendant's mental health records to be disclosed without the defendant's express consent and that § 52-146e does not provide for an implied waiver of the privilege. The Court reiterated that courts are without authority to authorize the release of psychiatric records without the patient's consent. The Court held:

The exceptions to the general rule of nondisclosure of communications between psychiatrist and patient were drafted narrowly to ensure the confidentiality of such communications will be protected unless important countervailing considerations require their disclosure. . . It is the responsibility of the legislature, not the courts, to balance the patient's right to confidentiality against any other opposing considerations. . . . As we have stated, it is contrary to the language of the statute and the intent of the legislature for courts to make discretionary case-by-case determinations of when the privilege may be overridden. . . .

Id. at 183-84 (emphasis supplied)(citations omitted; internal quotation marks omitted.)

In my view, Public Act 13-03, §§ 10 and 11 provide exceptions to § 52-146e. I reach this conclusion with reservations about the wisdom of this policy. I fully understand the reluctance of providers to make this disclosure without a patient's consent as it might discourage individuals from seeking necessary treatment or otherwise interfere with the therapeutic relationship between patients and their psychiatrists. Ultimately, however, as our Supreme Court has concluded, it is for the Legislature to "balance the patient's right to confidentiality against any other opposing considerations." Id. at 183-84. The Legislature has quite apparently done so in enacting Public Act 13-03, §§ 10 and 11.

HIPPA

You have also asked whether disclosure by providers to DMHAS or by DMHAS to DESPP would result in a violation of HIPPA, thereby compelling a

conclusion that HIPAA preempts the disclosure provisions of Public Act 13-03, §§ 10 and 11.

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) Pub. L. 104-191, 110 Stat. 1936, and regulations under HIPAA promulgated by the Department of Health and Human Services 45 C.F.R. Parts 160 and 164 are federal laws that protect the confidentiality of an individual’s medical records. The federal regulations contain exceptions that permit otherwise protected health information to be disclosed without an individual’s consent.

In particular, 45 C.F.R. § 164.512 provides that protected health information may be disclosed or used by a covered entity, in this case all public or private hospitals, without the individual’s written authorization “in situations covered by this section, subject to the applicable requirements of this section.” More specifically, §164.512(a)(1) permits disclosure of protected health information without an individual’s consent “to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.” “Required by law means a mandate contained in law that compels an entity to make a use or disclosure of protected health information and that is enforceable in a court of law.” 45 CFR §164.103. A disclosure mandated by a statute is included in this definition. *Id.*

Disclosures pursuant to section 10 of Public Act 2013-3 by public or private hospitals to DMHAS of the voluntary admission of a patient for psychiatric services fall within the “required by law” exception. The final commentary accompanying HIPAA regulations makes this clear. In addressing concerns raised about the inclusion of § 164.512(a), the commentary provides that this provision was included “to preserve access to information considered important enough by state or federal authorities to require its disclosure by law. The importance of these required uses or disclosures is evidenced by the legislative or other public process necessary for the government to create a legally binding obligation on a covered entity.” Standards for Privacy of Individually Identifiable Health Information 65 Fed. Reg. 82462, 82667 (December 28, 2000). The commentary notes that the phrase “required by law” “is intended to be read broadly to include the full array of binding legal authority, such as constitutions, statutes, rules, regulations [1]t encompasses federal, state or local actions with legally binding effect” 65 Fed. Reg. at 82668. The commentary also states that § 164.512(a) was generally meant not to interfere with, or add onto, the requirements of those other laws:

[W]e intend this provision to preserve access to information considered important enough by state or federal authorities to require its disclosure by law. . . . [S]uch required uses and disclosures arise

in a myriad of other areas of law, ranging from topics addressing national security (uses and disclosures to obtain security clearances), to public health (reporting of communicable diseases), to law enforcement (disclosures of gunshot wounds). Required uses and disclosures also may address broad national concerns or particular regional or state concerns. It is not possible, or appropriate, for [Health and Human Services] to reassess the legitimacy of or the need for each of these mandates in each of their specialized contexts.

65 Fed. Reg. at 82667 (emphasis supplied).

Further, the reporting obligation is enforceable both through regulatory action and injunctive relief. Pursuant to the Public Health Code, licensed facilities that provide care for mentally ill persons are obligated to comply with applicable law. See Conn. Gen. Stat. §§ 17-227-14c(D) (hospitals for mentally ill persons); 19a-495-550(b)(5)(A)(ii) (private freestanding mental health day treatment facilities and psychiatric outpatient clinics for adults); 19a-495-551(b)(4)(ii) (private freestanding mental health residential living centers). The Commissioner of Public Health is authorized to enforce the Public Health Code regulations. See Conn. Gen. Stat. §§ 19a-2a, 19a-495. See also Conn. Gen. Stat. § 3-5 (authority of Governor to institute actions).

Of note, § 164.512(a)(2) provides that disclosures required by law about victims of abuse, neglect or domestic violence for judicial or administrative proceedings, or for law enforcement purposes, require covered health care entities to meet additional applicable requirements contained in § 164.512(c), (e), or (f). However, the additional requirements contained in § 164.512(a)(2) only apply to the specific laws that govern the subject matter specified in (c), (e), or (f). These additional requirements should not be read as the only circumstances under which disclosure or use “required by law” may be made pursuant to (a)(1). The section-by-section description of the HIPAA regulations issued by Department of Health and Human Services, the promulgating agency, further supports that § 164.512(a)(2) was included to clearly indicate where there are additional provisions in § 164.512 with which covered entities must comply before disclosing protected health information required by laws.

To more clearly address where the substantive and procedural requirements of other provisions in this section apply, . . . in § 164.512 (a)(2) we list the

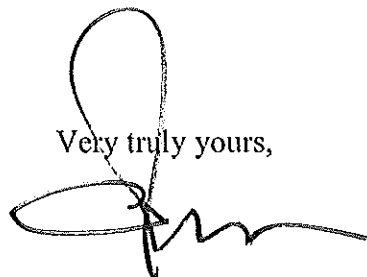
specific paragraphs that have additional requirements with which covered entities must comply. They are disclosures about victims of abuse, neglect or domestic violence (§ 164.512(c)), for judicial and administrative proceedings (§ 164.512(e)), and for law enforcement purposes (§ 164.512(f)).

65 Fed. Reg. at 82525. "Only when the disclosure involves the particular topics covered by paragraphs (c), (e), or (f) must the covered entity also comply with the additional requirements set forth in those paragraphs. Because the topics covered by paragraphs (c), (e), or (f) are narrow, the 'required by law' exception would lose its force if all required disclosures had to fit within those topics in order for HIPAA to permit them." Ohio Legal Rights Serv. v. Buckeye Ranch, Inc., 365 F. Supp. 2d 877, 889-90 (S.D. Ohio 2005).⁶

As explained above, notwithstanding my reservations about the wisdom of this policy, I conclude that Public Act 13-03 §§ 10 and 11 must be interpreted as a legislatively created exception to Conn. Gen. Stat. § 52-146e and thereby authorizes psychiatric hospitals to disclose to DMHAS and for DMHAS to re-disclose to DESPP the voluntary admission of patients for care and treatment of a psychiatric disability. Thus, I further conclude that for purposes of HIPAA the disclosures are "required by law" in Connecticut and would not violate federal law.

I trust this answers your questions.

Very truly yours,



GEORGE JEPSEN

⁶ See also "Health Information Privacy, Frequently Asked Questions, May a covered entity disclose protected health information to a Protection and Advocacy system where the disclosure is required by law?" U.S. Dept. of Health & Human Services, http://www.hhs.gov/ocr/privacy/hipaa/faq/disclosures_required_by_law/909.html (last visited at 9/9/13). ("Section 164.512(a)(2) provides that in making a "required by law" disclosure about adult abuse, neglect or domestic violence (section 164.512(c)), for judicial or administrative proceedings (section 164.512(e)), or for law enforcement purposes (section 164.512(f)), covered entities must also comply with any additional privacy requirements in these provisions that apply.")