A bill to be entitled

An act relating to access to adverse medical incident records; creating s. 381.028, F.S.; providing a popular name; providing a purpose; providing legislative findings; providing definitions; specifying a patient's right of access to records relating to adverse medical incidents; prohibiting disclosure of a patient's identity and requiring the maintenance of federal privacy restrictions; providing application; providing construction; limiting the discoverability or admissibility into evidence of certain records; providing requirements and limitations for health care facilities and health care providers in the production of records, including copy fees; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 381.028, Florida Statutes, is created to read:

381.028 Adverse medical incidents. --

- (1) POPULAR NAME. -- This section may be cited as the "Patients' Right to Know about Adverse Medical Incidents Act."
- (2) PURPOSE; LEGISLATIVE FINDINGS.--It is the purpose of this section to implement s. 25, Art. X of the State

  Constitution. The Legislature finds that s. 25, Art. X of the State Constitution is intended to grant patient access to records of adverse medical incidents made or received in the course of business by a health care facility or provider and not

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to repeal or otherwise modify existing laws regulating the use of these records and the information contained therein. The Legislature further finds that all existing laws extending criminal and civil immunity to persons providing information to quality-of-care committees or organizations and all existing laws concerning the discoverability or admissibility into evidence of records of an adverse medical incident in any judicial or administrative proceeding should remain in full force and effect.

- (3) DEFINITIONS.--As used in s. 25, Art. X of the State Constitution and for purposes of this section:
- (a) "Agency" means the Agency for Health Care Administration.

- (b) "Adverse medical incident" means medical negligence, intentional misconduct, or any other act, neglect, or default of a health care facility or health care provider that caused or could have caused injury to or death of a patient, including, but not limited to, those incidents that are required by state or federal law to be reported to any governmental agency or body and incidents that are reported to or reviewed by any health care facility peer review, risk management, quality assurance, credentials, or similar committee or any representative of any such committee.
  - (c) "Department" means the Department of Health.
- (d) "Access" means, in addition to any other procedure for producing records provided by general law, making records available for inspection and copying upon formal or informal request by the patient or representative of the patient,

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provided current records that have been made publicly available

by publication or on the Internet may be provided by reference

to the location at which the records are publicly available.

(e) "Health care provider" means a physician licensed under chapter 458 or chapter 459.

- (f) "Health care facility" means a facility licensed under chapter 395.
- (g) "Identity" means any individually identifiable health information as defined by the Health Insurance Portability and Accountability Act of 1996 or its implementing regulations.
- (h) "Patient" means an individual who has sought, is seeking, is undergoing, or has undergone care or treatment in a health care facility or by a health care provider.
- (i) "Privacy restrictions imposed by federal law" means the provisions relating to the disclosure of patient privacy information under federal law, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-91, and its implementing regulations, the Federal Privacy Act, 5 U.S.C. s. 552(a), and its implementing regulations, and any other federal law, including, but not limited to, federal common law and decisional law, that would prohibit the disclosure of patient privacy information.
- (j) "Records" means the final report of any adverse medical incident. Medical records that are not the final report of any adverse medical incident, including drafts or other nonfinal versions or notes, and any documents or portions thereof that constitute, contain, or reflect any attorney-client communications or any attorney-client work product, shall not be

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considered records for purposes of s. 25, Art. X of the State Constitution and this section.

- (k) "Representative of the patient" means a parent of a minor patient, a court-appointed guardian for the patient, a health care surrogate, or a person holding a power of attorney or notarized consent appropriately executed by the patient granting permission to a health care facility or health care provider to disclose the patient's health care information to that person. The term "representative of the patient" in the case of a deceased patient also means the personal representative of the estate of the deceased patient; the deceased patient's surviving spouse, surviving parent, or surviving adult child; the parent or guardian of a surviving minor child of the deceased patient; or the attorney for any of such persons.
- (4) PATIENT RIGHT OF ACCESS.--Patients have a right of access to any records made or received in the course of business by a health care facility or health care provider relating to any adverse medical incident. In providing access to these records, the health care facility or health care provider shall not disclose the identity of patients involved in the incidents and shall maintain any privacy restrictions imposed by federal law.
- (5) APPLICABILITY.--Section 25, Art. X of the State

  Constitution shall apply to records created, incidents

  occurring, and actions pending on or after November 3, 2004.

  Section 25, Art. X of the State Constitution shall not apply to records created, incidents occurring, or actions pending prior

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to November 3, 2004. A patient requesting records on or after

November 3, 2008, shall be eligible to receive records created

within 4 years prior to the date of the request.

(6) USES OF RECORDS.--

- (a) Nothing in this section shall be construed to repeal or otherwise alter any existing restrictions on the discoverability or admissibility of records relating to adverse medical incidents otherwise provided by law, including, but not limited to, restrictions contained in ss. 395.0191, 395.0193, 395.0197, 766.101, and 766.1016, or to repeal or otherwise alter any immunity provided to, or prohibition against compelling testimony by, persons providing information or participating in any peer review panel, medical review committee, hospital committee, or other hospital board otherwise provided by law, including, but not limited to, ss. 395.0191, 395.0193, 766.101, and 766.1016.
- (b) Except as otherwise provided by act of the
  Legislature, records of adverse medical incidents, including any
  information contained in such records, obtained pursuant to s.
  25, Art. X of the State Constitution shall not be discoverable
  or admissible into evidence for any purpose, including
  impeachment in any civil or administrative action against a
  health care facility or health care provider. This prohibition
  includes information relating to performance or quality
  improvement initiatives and information relating to the identity
  of reviewers, complainants, or any person providing information
  contained in or used in or person participating in the creation
  of the records of adverse medical incidents.

(7) PRODUCTION OF RECORDS. --

- (a) Pursuant to s. 25, Art. X of the State Constitution, adverse medical incident records to which a patient is granted access are those of the facility or provider of which he or she is a patient and that pertain to any adverse medical incident affecting the patient or affecting any other patient whose condition, treatment, or diagnosis is the same as or substantially similar to that of the patient requesting access.
- (b)1. Using the process provided in s. 395.0197, a health care facility is responsible for identifying records as records of an adverse medical incident, as defined in s. 25, Art. X of the State Constitution.
- 2. Using the process provided in s. 458.351, a health care provider is responsible for identifying records as records of an adverse medical incident, as defined in s. 25, Art. X of the State Constitution, occurring in an office setting.
- (c)1. Fees charged by a health care facility for copies of records requested by a patient pursuant to s. 25, Art. X of the State Constitution shall not exceed the reasonable and actual cost to comply with the request, including a reasonable charge for the staff time necessary to prevent the disclosure of the identity of any patient involved in the adverse medical incident through redaction or other means as required by the Health Insurance Portability and Accountability Act of 1996 or its implementing regulations. The health care facility may require payment, in full or in part, prior to acting on the records request.

2. Fees charged by a health care provider for copies of records requested by a patient pursuant to s. 25, Art. X of the State Constitution shall not exceed the amount established pursuant to s. 456.057(16), which may include a reasonable charge for the staff time necessary to prevent the disclosure of the identity of any patient involved in the adverse medical incident through redaction or other means as required by the Health Insurance Portability and Accountability Act of 1996 or its implementing regulations. The health care provider may require payment, in full or in part, prior to acting on the records request.

- (d)1. Requests for production of adverse medical incident records shall be processed by a health care facility or health care provider in a timely manner after having a reasonable opportunity to determine whether the requested record is a record subject to disclosure and to prevent the disclosure of the identity of any patient involved in the adverse medical incident through redaction or other means.
- 2. A request for production of records must be submitted in writing and identify the patient requesting access to the records by name, address, and the last four digits of the patient's social security number, describe the patient's condition, treatment, or diagnosis, and provide the name of the health care providers whose records are being sought.
  - Section 2. This act shall take effect July 1, 2005.