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James M. Madden

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PATIENT ACCESS TO MEDICAL RECORDS IN WASHINGTON

Patients have traditionally had no right of access to their own medical records.¹ Patients' access to their mental health records has been especially restricted. Recently, however, a number of jurisdictions have enacted legislation granting patients access to their medical and mental health records. In addition to this legislative trend, the Washington Supreme Court recently interpreted the state's Public Disclosure Act² as creating a right of patient access to public hospital records.³

Part I of this Comment evaluates the desirability of allowing patients a general right of access to their medical and mental health records. While this Comment finds that there is a clear need for patient access to both mental and general medical records, it takes the position that physician discretion to withhold records from patients should be preserved in certain cases. Such discretion is particularly necessary with respect to mental records, due to the sensitive nature of mental illness and treatment. Part I then reviews the existing law on patient access to health records. Part II analyzes Washington law on this subject, and concludes that Washington law is deficient in its handling of the problems of the patient access process. Finally, Part II proposes a statutory solution to the problems in Washington's patient access law. This statute would provide a general right of patient access to records and would limit physician discretion to withhold the record to narrowly prescribed cases. The statute would also regulate third-party access to patient records.

I. PATIENT ACCESS TO MEDICAL AND MENTAL HEALTH RECORDS

A. *The Policies*

Because of the sensitive nature of medical record information, physicians generally must obtain patient consent before disclosing patient records to third parties. However, informed patient consent to disclosure is possible only when patients are familiar with the information in their records. In addition, patient access to the record before disclosure can serve as a control on the release of sensitive medical information.⁴ With a right

1. This Comment is not concerned with medical record evidentiary problems. Therefore, discovery procedures for obtaining medical records are beyond the scope of this Comment.

2. WASH. REV. CODE ch. 42.17 (Supp. 1982).

3. *Oliver v. Harborview Medical Center*, 94 Wn. 2d 559, 618 P.2d 76 (1980).

4. The Federal Privacy Act of 1974, 5 U.S.C. § 552a (1976), cited individual access to federal

of access to the record, patients will have an opportunity to refuse consent to the release of information, or edit information irrelevant to the concerns of the party requesting disclosure.⁵ Without such a right, opportunities to secure employment, insurance, and credit could be lost when sensitive medical information is released to the wrong parties.

Nevertheless, patients traditionally have been unable to inspect their own records.⁶ The rationale for this has been that the physician, in accept-

records as one safeguard against the misuse of personal information contained in those records. *See* Pub. L. No. 93-579, § 2(b)(3), 88 Stat. 1896, 1896 (1974). Nevertheless, the Privacy Act does not require that patients have direct access to medical records held by government agencies. Instead it requires each agency to adopt special procedures for the disclosure of medical or psychological records to a patient. 5 U.S.C. § 552a(f)(3) (1976).

The Privacy Commission created by the Act recommended in a 1977 study that patients should have the right personally to inspect and copy their medical records. *See* PRIVACY PROTECTION STUDY COMMISSION, PERSONAL PRIVACY IN AN INFORMATION SOCIETY 298 (1977) [hereinafter cited as PRIVACY REPORT]. Nevertheless, none of the access procedures adopted by the various agencies provide for a right of direct patient access. The most liberal access procedures, adopted by the Department of Health, Education, and Welfare, only allow access through a "responsible individual," not necessarily a medical professional, designated by the patient. The Department of Defense, on the other hand, will only release the records to a physician of the patient's choice. The Veterans Administration takes a middle ground. It permits indirect access through a person designated by the patient, but it requires that records containing "sensitive information" be referred to a physician or other professional person meeting the Veterans Administration's professional standards or licensed in the appropriate professional specialty. *See id.* at 297.

Recently the District of Columbia and Illinois have passed statutes that provide for direct patient access to mental health records as a means of controlling the disclosure of sensitive information to third parties. *See* note 57 and accompanying text *infra*.

5. As a practical matter, however, patients are not always wholly free to refuse consent to release the record or to edit sensitive information that is not relevant to the concerns of the requesting party. Medical insurance coverage is frequently conditioned upon the release of relevant medical records to the insurance company. The same is true for obtaining certain kinds of employment. In such cases, patient access to records may have little effect in restricting the release of sensitive medical information.

6. *E.g.*, *Gotkin v. Miller*, 379 F. Supp. 859 (E.D.N.Y. 1974), *aff'd*, 514 F.2d 125 (2d Cir. 1975) (former state mental patient who was writing a book about her experiences with psychiatry denied access to her records). The district court emphasized that mental patients' records "are viewed in a more restrictive light" than the files of patients in general. 379 F. Supp. at 868.

A well-known reference manual on medicolegal issues, designed for health professionals, states that there is no constructive purpose for allowing patient access to records:

It is undesirable to allow a patient or his family to inspect his chart. He or they may find comments by nurses, interns, or other members of the professional staff which may be considered uncomplimentary or incorrect. The patient may then attempt to have the record changed, or cause annoyance to the administration or the professional staff. He may even bring a lawsuit for libel or some other fancied grievance.

E. HAYT, MEDICOLEGAL ASPECTS OF HOSPITAL RECORDS 114 (2d ed. 1977). *See also* E. HAYT, L. HAYT, AND A. GROESCHEL, LAW OF HOSPITAL, PHYSICIAN, AND PATIENT 658 (2d ed. 1952).

Some courts also have claimed that patients have no reason to inspect their records:

[R]ecords taken by a doctor in the examination and treatment of a patient become property belonging to the doctor. Generally speaking, an individual does not seek out a doctor for the purpose of obtaining records for his personal use, but seeks the personal services of his physician in the area of examination, diagnosis and treatment. . . . The records and notes that accordingly

ing responsibility for the patient's health, needs broad discretion to withhold medical information that the physician deems harmful to the patient.⁷ Such broad physician discretion is incompatible with a general right of patient access to medical records. Therefore, this Comment begins by examining the justifications for physician discretion to withhold records from patients, to determine when physician discretion or patient access is the more important value.

1. *Physician Discretion and Mental Health Records*

The primary reason cited by proponents of broad physician discretion to withhold records from patients is that patients must be protected from information that would be detrimental to their health.⁸ Traditionally, patient access to mental health records has been especially restricted. Nev-

come into the possession of the physician constitute a history of the case of benefit only to a physician as part of his clinical record concerning a particular patient.

In re Culbertson's Will, 57 Misc. 2d 391, 292 N.Y.S.2d 806, 807-08 (Sur. Ct. 1968). *See also* *Gotkin v. Miller*, 379 F. Supp. 859, 867 (E.D.N.Y. 1974), *aff'd*, 514 F.2d 125 (2d Cir. 1975). *But see* *Application of Striegel*, 92 Misc. 2d 113, 399 N.Y.S.2d 584, 586 (Sup. Ct. 1977) (holding that a patient has a right of "reasonable access" to her medical records). *See also* note 21 *infra* (discussing cases holding that patients have property rights in their medical records).

7. *See, e.g.*, *Wallace v. University Hospitals of Cleveland*, 82 Ohio Law Abs. 257, 164 N.E.2d 917 (1959), *modified and aff'd*, 84 Ohio Law Abs. 224, 170 N.E.2d 261 (Ohio App. 1960), discussed in note 21 *infra*. On appeal the Wallace court limited a patient's right of access to those records which, in the hospital's judgment, were in the "beneficial interest" of the patient to inspect. 170 N.E.2d at 261-62.

8. *See, e.g.*, *Gotkin v. Miller*, 379 F. Supp. 859, 866 (E.D.N.Y. 1974) (access to patient's record "could be detrimental to that individual's current well being"), *aff'd*, 514 F.2d 125 (2d Cir. 1975). Other arguments frequently offered for withholding medical records from patients are that the record will be unintelligible to the patient or that the patient may be led to attempt self-treatment. *See id.* *See also* Memel, *Medical Records and the Patient's Right to Access*, THE HOSPITAL MEDICAL STAFF 13, 14 (July 1976) (discussing patient misunderstanding and danger of self-treatment). Two clinical studies, however, tend to negate these arguments. In both studies patients were issued copies of their records to read. Both studies reached the same results even though one involved patients at a health care center and the other involved patients in a psychiatric ward. In response to post-study questionnaires, a majority of patients indicated that access to the record helped them understand their illnesses. In addition, patients reported that they were now much more careful about following specific recommendations for medication, and were more willing to take an active role in making decisions about their treatment. *See* Bouchard, Tufo, Van Buren, Eddy, Twitchel, and Bedard, *The Patient and His Problem-Oriented Record*, in APPLYING THE PROBLEM-ORIENTED SYSTEM 42, 46 (H. Walker, J. Hurst, and M. Woody eds. 1973); Simonton, Neuffer, Stein, and Furedy, *The Open Medical Record: An Educational Tool*, 15 J. PSYCHIATRIC NURSING & MENTAL HEALTH SERVICES 25, 28 (Dec. 1977) [hereinafter cited as *Renton Study #1*].

It has also been argued that creation of a patient access right to medical records will result in physicians keeping dual sets of records, with a record "cleansed" of embarrassing or uncomplimentary remarks available for patient inspection. It is unlikely, however, that the creation of a patient access right would result in a sufficient number of access requests to make such dual recordkeeping worthwhile. In any case, a well-drafted access statute would require that patients have access to the entire record upon request, which would include any "parallel" records.

ertheless, three recent clinical studies have concluded that the benefits of patient access to mental health records outweigh the detriments for most patients.⁹ One study concluded that "even though patients were sometimes upset by what they read, they were generally comfortable with reading their records and felt better informed and more involved in their treatment."¹⁰ Another study concluded that patient access to the record was helpful in allaying suspicions, developing trust, and obtaining consent for treatments.¹¹ Nevertheless, two of the studies emphasized that knowledgeable staff should be present when patients inspect records to help interpret potentially disturbing material.¹² The studies therefore favor a general right of patient access to mental health records, but suggest a need to protect patients from potentially disturbing material.

There are valid reasons for denying patients access to mental health records in certain cases. Mental illnesses and treatments are more sensitive to a patient's psychological response to the record than are non-mental illnesses and treatments. For example, the patient's misconceptions about material in the mental health record may lead to feelings of hopelessness, which could impair treatments.¹³ A more serious case is where the patient interprets the diagnosis in the record as a "label," which reinforces the patient's tendencies towards destructive behavior.¹⁴ If a dangerously unstable patient reads a diagnosis of possible homicidal tendencies, the diagnosis may convince the patient that actual homicidal

9. In one study, patients of a psychiatric unit of a general hospital in Renton, Washington, were given their complete records to read daily. The Renton study is reported in two articles: *Renton Study #1*, *supra* note 7; and Stein, Furedy, Simonton, & Neuffer, *Patient Access to Medical Records on a Psychiatric Inpatient Unit*, 136 AM. J. PSYCHIATRY 327 (1979) [hereinafter cited as *Renton Study #2*].

In two other studies, patients at psychiatric units in hospitals were allowed access to their records upon request. Roth, Wolford, & Meisel, *Patient Access to Records: Tonic or Toxin?*, 137 AM. J. PSYCHIATRY 592 (1980) [hereinafter cited as *Pittsburgh Study*]; McFarlane, Bowman, & MacInnes, *Patient Access to Hospital Records*, 25 CAN. J. PSYCHIATRY 497 (1980) [hereinafter cited as *Canada Study*].

All three studies concluded either that no detrimental effects resulted from patient access, *Canada Study*, *supra*, at 501, or that the benefits outweighed the detriments. *Renton Study #2*, *supra*, at 329; *Pittsburgh Study*, *supra*, at 595.

10. *Renton Study #2*, *supra* note 9, at 329. The Canada study found that "[p]atients who availed themselves of the right of access to their record were more likely to have correct information about their condition and treatment." *Canada Study*, *supra* note 9, at 501.

11. *Canada Study*, *supra* note 9, at 501.

12. *Pittsburgh Study*, *supra* note 9, at 595; *Renton Study #1*, *supra* note 8, at 29. In the latter study the authors state that "it is crucial that knowledgeable staff be available to answer questions the patient might have as he reads, and to discuss his feelings about what he reads." *Id.*

13. The Renton study cites misconceptions about material in the record as a possible disadvantage of patient access to psychiatric records. *Renton Study #1*, *supra* note 8, at 26. Misconceptions could be prevented, the study suggests, by having a staff member present during patient access to offer explanations and interpretations. *Id.* at 30.

14. *Id.* at 26.

behavior is inevitable. A similar problem could arise with a diagnosis of suicidal tendencies. This possibility of “self-fulfilling diagnoses” justifies withholding information from the patient, at least until the danger of destructive behavior has passed. A general right of patient access to mental health records is therefore desirable, but some discretion should be reserved to the physician to withhold the record in certain cases. This discretion, however, should be limited to cases in which the withholding is necessary to protect the patient or another person from a risk of imminent and serious physical or psychological harm.¹⁵

2. *Physician Discretion and General Medical Records*

The justification for allowing physician discretion to withhold general medical records is, as with mental records, to protect patients from information that would be detrimental to their health. For non-mental health records, the usual example of detrimental information is a fatal prognosis or a diagnosis of a malignant disease. Physicians frequently elect not to disclose fatal diagnoses to patients.¹⁶ It is not at all clear, however, that a fatal prognosis must automatically be withheld from patients.¹⁷ The assumption that terminally ill patients will be harmed by the knowledge of their condition ignores the fact that many patients respond to this knowledge with courage and dignity. Indeed, for many patients, their final months or weeks may be richer and more meaningful if they are lived in the awareness of that finality. There is, therefore, little need for physician discretion to withhold general medical records. Nevertheless, physicians should retain limited discretion to withhold records when it is necessary to protect the patient or another person from a risk of imminent and serious physical or psychological harm.¹⁸

15. The District of Columbia Mental Health Information Act takes this approach. D.C. CODE ANN. § 6-2001 to -2076 (1981). The Act creates a general right of patient access to mental health records upon request, but also provides: (1) that a mental health professional shall have the opportunity to discuss the information with the patient at the time of inspection, *id.* at § 6-2041; and (2) that information may be withheld only if the mental health professional “reasonably believes” that withholding is necessary to protect the patient from a “substantial risk of imminent psychological impairment” or to protect the patient or another individual from a “substantial risk of imminent and serious physical injury.” *Id.* at § 6-2042 (1981).

16. See Shenkin & Warner, *Giving the Patient His Medical Record: A Proposal to Improve the System*, 289 NEW ENG. J. MED. 688, 691 (1973) (citing a British study that found that only six percent of terminally ill patients were told of the diagnosis).

17. Shenkin and Warner disapprove of withholding this information, stating “it would frequently be better for patients if the situation were confronted openly.” *Id.* at 691 (footnote omitted). See also Kaiser, *Patients’ Rights of Access to Their Own Medical Records: The Need For New Law*, 24 BUFFALO L. REV. 317, 326 (1974) (discussing reasons for disclosure of fatal diagnoses).

18. See note 15 and accompanying text *supra*.

B. *The Law*

1. *Access to General Medical Records*

Many jurisdictions have recognized the need for patient access to medical records. There are three basic ways in which patient access to medical records has been created. First, courts have used common law theories to allow patient access to records. Second, courts have derived rights of access from general records disclosure statutes. Third, legislatures have passed statutes providing for patient access.

a. *Common Law Rights*

Courts have used three common law theories to create patients' rights of access to medical records. The first applies the common law "public records" doctrine to medical records.¹⁹ This right of access applies only to records required to be kept by law, and has been limited to persons whose interest in the record is relevant to a potential legal action.²⁰

The second theory is based on the "fiducial qualities" of the physician-patient relationship. Under this theory, a physician must allow patients access to their medical records because the physician has a common law duty "to reveal to the patient that which in his best interests it is important that he should know."²¹

19. *Pyramid Life Ins. Co. v. Masonic Hosp. Ass'n of Payne County*, 191 F. Supp. 51 (W.D. Okla. 1961). In *Pyramid*, an insurance company sought access to a patient's hospital records to determine the company's liability on the patient's insurance claim. The court held that medical records are "quasi-public" records and that the patient, or someone authorized by the patient, was entitled to inspect and copy the records without resort to litigation. *Id.* at 54. See also *Morris v. Hoerster*, 377 S.W.2d 841, 844 (Tex. Civ. App. 1964) (discussed in note 24 *infra*).

Under the common law public records doctrine, the public has a right of access to records which are required to be kept by law, or are necessary to be kept in the discharge of a duty imposed by law. Public records include the records of transactions made by public officers and writings filed in public office. See, e.g., *State ex rel. Kavanaugh Henderson*, 350 Mo. 968, 169 S.W.2d 389, 392 (1943); *Emmertson v. State Tax Comm'n*, 93 Utah 219, 72 P.2d 467, 470 (1937).

20. See *Pyramid Life Ins. Co. v. Masonic Hosp. Ass'n of Payne County*, 191 F. Supp. 51, 54 (W.D. Okla. 1951), where the court stated: "Inspection can be made by any person who has an interest such as would enable him to maintain or defend an action for which the document or record sought can furnish evidence or necessary information." Cf. *McCoy v. Providence Journal Co.*, 190 F.2d 760, 765 (5th Cir. 1951) (public in general has common law right to inspect municipal tax records).

21. *Cannell v. Medical and Surgical Clinic*, 21 Ill. App. 3d 383, 315 N.E.2d 278, 280 (1974) (quoting *Emmett v. E. Dispensary and Casualty Hosp.*, 396 F.2d 931, 935 (D.C. Cir. 1967)). The "duty to disclose" doctrine cited in *Cannell* has served primarily to toll the statute of limitations in medical malpractice cases where the hospital or doctor refused to allow the patient or the patient's heirs to examine the patient's medical records. See, e.g., *Emmett v. E. Dispensary and Casualty Hosp.*, 396 F.2d 931, 939 (D.C. Cir. 1967) (hospital's failure to disclose medical records to decedent's personal representative tolls statute); *Sheets v. Burman*, 322 F.2d 277, 279-80 (5th Cir. 1963) (physician's fraudulent concealment of acts of malpractice tolls statute); *Hudson v. Moore*,

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The third common law theory advanced is that patients have property rights in medical record information.²² The existence of the right is inferred from the rule requiring patient permission before physicians can disclose information to third parties.²³ Under this theory, the physician is regarded as the custodian rather than the owner of the information contained in medical records.²⁴

239 Ala. 130, 194 So. 147, 149 (1940) (same); *Guy v. Schuldt*, 236 Ind. 101, 138 N.E.2d 891, 895 (1956) (same). The *Cannell* case is significant because it carries the doctrine beyond the statute of limitations context, and holds that the "duty to disclose" requires a physician to allow patient access to medical records at any time upon request. 315 N.E.2d at 280.

22. See *Wallace v. Univ. Hospitals of Cleveland*, 164 N.E.2d 917 (Ohio Ct. Common Pleas 1959), *modified*, 170 N.E.2d 261 (Ohio App. 1960). The lower court held that "a patient has a property right in the information contained in the record and as such is entitled to a copy of it." 164 N.E.2d at 918. On appeal, the patient's right of access was limited to those records that, in the hospital's judgment, were in the "beneficial interest" of the patient to inspect. 170 N.E.2d at 261-62.

New York courts have adopted the position that patients have a property right in their medical records. See, e.g., *Application of Striegel*, 92 Misc. 2d 113, 399 N.Y.S.2d 584, 586 (Sup. Ct. 1977) ("patient has a 'property' right sufficient to afford her the privilege of reasonable access to her medical and dental records"; this right is independent of discovery statutes and is effective regardless of whether any litigation is contemplated). New York courts had previously ruled that medical records were the property of the doctor. *In re Culbertson's Will*, 57 Misc. 2d 391, 292 N.Y.S.2d 806, 807-08 (Sur. Ct. 1968). Arguably, the statement in *Striegel* is dictum, because the court also allowed access to the record under state discovery statutes. 399 N.Y.S.2d at 585. Nevertheless, the holding has been cited with approval in later New York cases. See, e.g., *In re Gerkin*, 106 Misc. 2d 643, 434 N.Y.S.2d 607, 608 (Sup. Ct. 1980); *People v. Cohen*, 98 Misc. 2d 874, 414 N.Y.S.2d 642, 644 (Dist. Ct. 1979).

23. See, e.g., *Pyramid Life Ins. Co. v. Masonic Hosp. Ass'n of Payne County*, 191 F. Supp. 51, 54 (W.D. Okla. 1961).

24. *Id.* Another court, without reference to a specific theory, has simply upheld a patient's "common law right to inspect his or her own records." *Hutchins v. Texas Rehabilitation Comm'n*, 544 S.W.2d 802, 803 (Tex. Civ. App. 1976). In allowing a former patient of a state hospital to inspect her medical records, the *Hutchins* court cited its earlier rulings on patient access in *Morris v. Hoerster*, 348 S.W.2d 642 (Tex. Civ. App. 1961), and *Morris v. Hoerster*, 377 S.W.2d 841 (Tex. Civ. App. 1964). Both *Morris* cases, which involved a former patient of a state mental hospital, reached the same result as *Hutchins*. The two *Morris* cases, however, used different theories to support the patient's right of access.

In the first *Morris* appeal the court cited a statute that prohibited disclosure of state mental hospital records without the patient's consent. The court held that it was possible under the statute for the patient to consent to release records to himself. 348 S.W.2d at 643-44. On remand the trial court denied the patient's request for a writ of mandamus to compel the hospital to release the records. The appellate court reversed, citing its earlier decision in the case, but added that "the records which appellant desires to inspect are public records and while not available for inspection by the general public they are . . . accessible to inspection by appellant." 377 S.W.2d at 844. Cf. *Pyramid Life Ins. Co. v. Masonic Hosp. Ass'n of Payne County*, 191 F. Supp. 51, 54 (W.D. Okla. 1961) (medical records are public records, available for inspection by the patient when relevant to a potential cause of action). See note 20 and accompanying text *supra*.

The "public records" theory cited in the second *Morris* appeal is much broader than the statutory right granted in the first *Morris* opinion. The public records theory creates a right of patient access to all medical records, whether of state hospitals or private practitioners, since all are "required by law to be kept." The statutory right of access, however, is limited by the statute from which it is derived to state mental hospital records. The *Hutchins* court, in upholding a patient's "common law right" to

In *Gotkin v. Miller*,²⁵ a patient argued that a patient's property right in medical records was protected by the Federal Constitution. The patient claimed that the hospital's refusal to allow her to inspect her records deprived her of property without due process of law.²⁶ The Court of Appeals for the Second Circuit rejected this claim, and stated that the fourteenth amendment is not an independent source of property rights.²⁷ Due process "protects only those property interests already acquired as a result of 'existing rules or understandings that stem from an independent source such as state law . . .'"²⁸ Under *Gotkin* federal courts will, for constitutional purposes, defer to state definitions of patients' rights of access to their medical records.²⁹

b. Access Rights Derived from Statutes

Courts have found an implied right of patient access to medical records in two types of statutes. First, a statute requiring patient consent before the disclosure of patient records to third parties has been interpreted as providing patient access to the record before that disclosure.³⁰ Second, a general state public records or freedom of information act has been construed to allow patients access to their medical records in public hospitals.³¹

c. Express Statutory Rights of Access

There are three types of state statutes that provide for patient access to medical records.³² The first type, access statutes, creates broad, direct

inspect his or her own medical records, appears to adopt the common law "public records" theory of the second *Morris* opinion.

25. 379 F. Supp. 859 (E.D.N.Y. 1974), *aff'd*, 514 F.2d 125 (2d Cir. 1975). Ms. Gotkin was writing a book about her experiences as a former patient at a state mental hospital and was seeking access to her records to verify her recollection of various incidents.

26. 379 F. Supp. at 864. Ms. Gotkin also claimed that her first amendment right to information and ideas, her fourth amendment right against unreasonable search and seizure, and her ninth amendment right to privacy were violated. The court summarily dismissed these claims. *Id.* at 862-64.

27. 514 F.2d 125 (2d Cir. 1975).

28. *Id.* at 128 (quoting Board of Regents of State College v. Roth, 408 U.S. 564, 577 (1972)).

29. The trial court in *Gotkin* followed *In re Culbertson's Will*, 57 Misc. 2d 391, 292 N.Y.S.2d 806, 807-08 (Sur. Ct. 1968), in deciding that Gotkin was not entitled to access to her records. 379 F. Supp. at 867.

30. *Sullivan v. State*, 352 So.2d 1212 (Fla. Dist. Ct. App. 1977). See note 54 and accompanying text *infra*.

31. *Oliver v. Harborview Medical Center*, 94 Wn. 2d 559, 618 P.2d 76 (1980). See notes 59-68 and accompanying text *infra*.

32. The laws of the fifty states as of 1973 are compiled in Helfman, Jarrett, Lutzker, Schneider, & Stein, *Access to Medical Records*, in U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, APPENDIX, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE at 177 (1973). The HEW

patient access rights to medical records without requiring legal action to compel record production. The second type, confidentiality statutes, prohibits general disclosure of certain medical records except to designated parties, one of whom may be the patient. The third type, state freedom of information acts, sometimes has provided for the release to patients of medical records from public hospitals, while at the same time barring public inspection of the records.

i. Access Statutes

Fourteen jurisdictions, including the District of Columbia, have access statutes.³³ These statutes vary greatly in scope and detail. Three create rights of access to the records of all licensed hospitals and practitioners of health care services,³⁴ but five others create rights of access only to hospital records.³⁵ Two statutes exempt mental health records from patient access,³⁶ while two others cover only mental health records.³⁷

report also reports on state administrative regulations affecting patients' rights of access to medical records. This Comment updates the survey of state statutes, but does not review state administrative regulations.

33. COLO. REV. STAT. §§ 25-1-801, -802 (Supp. 1981); CONN. GEN. STAT. ANN. § 4-104 (West 1969); D.C. CODE ANN. §§ 6-2001 to -2076 (1981); FLA. STAT. ANN. § 455.241 (West 1981); ILL. STAT. ANN. ch. 91½, §§ 801-817 (Smith-Hurd Supp. 1981); LA. REV. STAT. ANN. § 40:2014.1 (West 1977); MASS. ANN. LAWS ch. 111, § 70 (Michie/Law. Co-op. Supp. 1981); MINN. STAT. ANN. § 144.335 (West Supp. 1982); MISS. CODE ANN. § 41-9-65 (1972); NEV. REV. STAT. § 629.061 (1979); OKLA. STAT. ANN. tit. 76, § 19 (West Supp. 1981-1982); OR. REV. STAT. § 192.525 (1980); S.D. CODIFIED LAWS ANN. § 36-2-16 (1977); TENN. CODE ANN. § 53-1322 (1977).

The essential features of an access statute are that it provide 1) a *right* of access to a medical record, 2) exercisable by a *patient*, 3) independently of whether the record is relevant to any pending litigation. Thus, the California, Virginia, and Utah statutes which provide that a patient may designate an attorney to inspect medical records are not access statutes. CAL. EVID. CODE § 1158 (West Supp. 1982); VA. CODE § 8.01-413 (Supp. 1982); UTAH CODE ANN. § 78-25-25 (1977).

The access statutes range from a brief and general statement of state policy to provide for patient access to health records, OR. REV. STAT. § 192.525 (1980), to detailed treatments of the patient access process, with provisions for judicial review and civil and criminal sanctions. D.C. CODE ANN. §§ 6-2001 to -2076 (1981); ILL. ANN. STAT. ch. 91½ §§ 801-07 (Smith-Hurd Supp. 1981).

34. COLO. REV. STAT. §§ 25-1-801, -802 (Supp. 1981); NEV. REV. STAT. § 629.061 (1979); S.D. CODIFIED LAWS § 36-2-16 (1977). Nevada's statute, for example, creates a right of patient access to the records of all "providers of health care," including all licensed physicians and hospitals, opticians, optometrists, physical therapists, podiatrists, psychologists, chiropractors, "doctor[s] of traditional Oriental medicine in any form," medical laboratory directors or technicians, and pharmacists. NEV. REV. STAT. § 629.031 (1979).

35. CONN. GEN. STAT. ANN. § 4-104 (West 1969); LA. REV. STAT. ANN. § 40:2014.1 (West 1977); MASS. ANN. LAWS ch. 111, § 70 (Michie/Law. Co-op. Supp. 1981); MISS. CODE ANN. § 41-9-65 (1972); TENN. CODE ANN. § 53-1322 (1977). Connecticut's statute applies only to hospitals receiving "state aid." In *Doe v. Institute of Living, Inc.*, 175 Conn. 49, 392 A.2d 491 (1978), "state aid" was construed to mean legislative grants or appropriations, but not property tax exemptions, payments from state agencies under contract with the hospital, or reimbursements from the state for services rendered to indigent patients. *Id.* at 494-95.

The extent of patient access rights created by these statutes also varies. Although six statutes appear to grant patients unqualified access to their records,³⁸ the other statutes either require the patient to show "good cause" for access³⁹ or restrict patient access to certain types of information. For example, information that is detrimental to the patient's health⁴⁰ or that creates a danger to others⁴¹ may be restricted. Several statutes also allow the treating physician to withhold "personal notes."⁴²

Procedures available to enforce the access right also vary. The major non-judicial method for resolving record disputes is professional review of the decision by the record holder to refuse access.⁴³ When patient access is refused or restricted, the patient may designate a second professional of the same professional class to review the record. The second professional may release the disputed information or may reaffirm the original refusal of access. If access is again denied, one statute allows the patient to bring a lawsuit, in which the health care provider has the burden of proving that the denial of access was justified.⁴⁴

In addition to access rights, two jurisdictions give patients the right to correct misleading or false information in the record.⁴⁵ When the patient submits in writing a proposed amendment to the record, the health care provider can then either amend the record or include the patient's objection along with the disputed information.

36. MASS. ANN. LAWS ch. 111, § 70 (Michie/Law. Co-op. Supp. 1981); OKLA. STAT. ANN. tit. 76, § 19 (West Supp. 1981-1982). Colorado has a special provision for psychiatric records, which allows a physician to release a summary of the record to the patient, so long as the physician finds it will have no significant negative psychological impact upon the patient. COLO. REV. STAT. §§ 25-1-801, -802 (Supp. 1981).

37. D.C. CODE ANN. §§ 6-2001 to -2076 (1981); ILL. STAT. ANN. ch. 91½, §§ 800-817 (Smith-Hurd Supp. 1981).

38. CONN. GEN. STAT. ANN. § 4-104 (West 1969); FLA. STAT. ANN. § 458.16 (West 1981); LA. REV. STAT. ANN. § 40:2014.1 (West 1977); MASS. ANN. LAWS ch. 111, § 70 (Michie/Law. Co-op. Supp. 1981); OKLA. STAT. ANN. tit. 76, § 19 (West Supp. 1981-1982); S.D. CODIFIED LAWS ANN. § 36-2-16 (1977). The Florida statute does not even require that the patient pay duplication costs.

39. MISS. CODE ANN. § 41-9-65 (1972); TENN. STAT. ANN. § 53-1322 (1977).

40. D.C. CODE ANN. § 6-2042 (1981); MINN. STAT. ANN. § 144.335(2) (West Supp. 1982); VA. CODE § 8.01-413(B) (Supp. 1982). The District of Columbia statute, which applies only to mental health records, states that information may be withheld if the physician "reasonably believes" that withholding is necessary to protect the patient from a "substantial risk of imminent psychological impairment" or "serious physical injury." D.C. CODE ANN. § 6-2042 (1981).

41. D.C. CODE ANN. § 6-2042 (1981).

42. COLO. REV. STAT. § 25-1-802(3) (Supp. 1982); D.C. CODE ANN. § 6-2003 (1981); ILL. STAT. ANN. ch. 91½, § 802(4)(iii) (Smith-Hurd Supp. 1981). Illinois defines personal notes as the treating professional's "speculations, impressions, hunches and reminders." *Id.*

43. Two statutes provide for professional review. D.C. CODE ANN. § 6-2043 (1981); MINN. STAT. ANN. § 144.335(2) (West Supp. 1982).

44. D.C. CODE ANN. § 6-2044 (1981).

45. D.C. CODE ANN. § 6-2045 (1981); ILL. STAT. ANN. ch. 91½, § 804(c) (Smith-Hurd Supp. 1981).

ii. Confidentiality Statutes

Nearly every state has a confidentiality statute that applies to state mental institution records. These statutes generally require patient consent for the disclosure of mental health records, but allow disclosure to specified parties without patient consent.⁴⁶ Only seven confidentiality statutes permit patient inspection of the records.⁴⁷ Each of these seven statutes also limits patient access in certain cases. For example, if a physician considers access detrimental to the patient's health⁴⁸ or "inconsistent with therapeutic care,"⁴⁹ the physician may refuse patient access.

iii. Freedom of Information Statutes

Forty-five states have enacted some form of freedom of information or open records statute.⁵⁰ These statutes create a right of public access to the records of most state, county, and city agencies. Typically the statutes exempt the medical records of public health agencies from public inspection.⁵¹ The statutes of two states, however, in exempting medical records from public inspection, provide that patients may examine their own records.⁵²

46. See, e.g., WASH. REV. CODE § 71.05.390 (Supp. 1982).

47. HAWAII REV. STAT. § 334-5 (1976); IND. CODE ANN. § 16-14-1.6-8(c) (Burns Supp. 1982); MICH. STAT. ANN. § 14.800(748)(5)(b) (Callaghan 1980); OHIO REV. CODE ANN. § 5122.31(E) (Page 1981); OR. REV. STAT. § 179.505(7) (1981); S.D. CODIFIED LAWS § 27A-12-28 (1977); WIS. STAT. ANN. § 51.30(4)(d) (West Supp. 1982-1983).

48. MICH. STAT. ANN. § 14.800(748)(5)(b) (Callaghan 1980); OR. REV. STAT. § 179.505(7) (1981); S.D. CODIFIED LAWS § 27A-12-28 (1977).

49. OHIO REV. CODE ANN. § 5122.31(E) (Page 1981). The Indiana statute permits a denial of patient access "for good cause" until the patient is discharged. IND. CODE ANN. § 16-14-1.6-8(c) (Burns Supp. 1982).

The Wisconsin statute distinguishes between current and discharged patients. Discharged patients have the right to inspect any and all treatment records. WIS. STAT. ANN. 51.30(4)(d)(3) (West Supp. 1982-1983). Current patients' access rights are limited to the inspection of records pertaining to medications and somatic treatments. *Id.* § 51.30(4)(d)(1). The statute also gives all patients the right to submit a written correction proposal to the record holder. *Id.* § 51.30(4)(f).

50. See Henry, *A Summary of Freedom of Information and Privacy Laws of the 50 States*, Access Reports, Dec., 1975. States without such statutes are Delaware, Mississippi, Rhode Island, Vermont, and West Virginia. The Washington statute is the Public Disclosure Act, WASH. REV. CODE ch. 42.17 (Supp. 1982).

51. The statutes follow the Federal Freedom of Information Act's exemption for "personnel and medical files," 5 U.S.C. § 552(b)(6) (1976). Washington's statute reads in part: "The following shall be exempt from inspection and copying: (a) Personal information in any files maintained for students in public schools, patients or clients of public institutions or public health agencies, welfare recipients, prisoners, probationers, or parolees." WASH. REV. CODE § 42.17.310 (Supp. 1982).

52. COLO. REV. STAT. § 24-72-204(3)(a)(I) (Supp. 1981); VA. CODE § 2.1-342(3) (Supp. 1982). Washington's Public Disclosure Act was construed as creating a patient right of access to public health records in *Oliver v. Harborview Medical Center*, 94 Wn. 2d 559, 618 P.2d 76 (1980). See text accompanying notes 59-68 *infra*.

2. Access to Mental Health Records

Despite the trend to recognize patients' right of access to medical records, courts have been reluctant to permit patient access to mental health records because of the sensitive nature of the mental illness treatment process.⁵³ Recently, however, some courts have allowed patient access to mental health records. A Florida court created a patient right of access to state mental hospital records based on a statute that restricted disclosure of these records except to persons designated by the patient.⁵⁴ The court found that the legislature must have intended that the patient also have access to the record to properly determine whether and to whom the record should be released.⁵⁵

Legislatures have also been reluctant to grant access to mental health records. The patient access statutes of two states specifically exempt mental health records from patient inspection.⁵⁶ Nevertheless, recent legislation in several jurisdictions has granted patient access to mental health records. For example, Illinois and the District of Columbia have comprehensive legislation creating a patient right of access to mental health records.⁵⁷ These statutes also set limits upon the disclosure of mental health records to third parties.⁵⁸

53. See *Gotkin v. Miller*, 379 F. Supp. 859 (E.D.N.Y. 1974), *aff'd*, 514 F.2d 125 (2d Cir. 1975); note 8 and accompanying text *supra*.

54. *Sullivan v. State*, 352 So. 2d 1212 (Fla. Dist. Ct. App. 1977). The Florida statute reads: "The clinical record shall not be a public record and no part of it shall be released, except . . . as designated by the patient . . ." FLA. STAT. ANN. § 394.459(9) (West Supp. 1982). For a similar holding, see *Morris v. Hoerster*, 348 S.W.2d 642, 643-44 (Tex. Civ. App. 1961) (discussed at note 23 *supra*).

55. *Sullivan*, 352 So. 2d at 1213.

56. See note 36 and accompanying text *supra*.

57. The Illinois statute, passed in 1979, is entitled "Mental Health and Developmental Disabilities Confidentiality Act." ILL. STAT. ANN. ch. 91½, §§ 801-817 (Smith-Hurd Supp. 1981). The District of Columbia statute, passed in 1978, is entitled "Mental Health Information." D.C. CODE ANN. §§ 6-2001 to -2076 (1981). These statutes are similar to the MODEL LAW ON CONFIDENTIALITY OF HEALTH AND SOCIAL SERVICE RECORDS (American Psychiatric Ass'n 1978), published in 136 AM. J. PSYCHIATRY 138 (1979).

58. Both the Illinois and District of Columbia statutes prohibit the use of patient "blanket consent" forms, by which the patient consents to the release of any and all information requested. Instead they require that the patient be informed of the nature of the information requested, the party requesting disclosure, and the patient right to inspect the record before each disclosure. ILL. STAT. ANN. ch. 91½, §§ 805(b), 805(c) (Smith-Hurd Supp. 1981); D.C. CODE ANN. § 6-2012 (1981). In addition, the statutes prohibit the further disclosure of information by the third party requestor without specific patient consent. ILL. STAT. ANN. ch. 91½, § 805(d) (Smith-Hurd Supp. 1981); D.C. CODE ANN. § 6-2013 (1981).

II. PATIENT ACCESS TO MEDICAL RECORDS IN WASHINGTON: THE NEED FOR A STATUTORY SOLUTION

A. *The Oliver Decision*

In *Oliver v. Harborview Medical Center*,⁵⁹ the Washington Supreme Court created a right of patient access to public health records under the Washington Public Disclosure Act.⁶⁰ Sharma Oliver, a former patient at Harborview Medical Center, sought copies of her medical records to convince her employer that her work record had been affected by illness. When the hospital denied all her requests, Oliver filed a class action to compel disclosure of the records.⁶¹ In a unanimous decision, the court held that public hospital patient records were “public records” under that Act and therefore must be disclosed.⁶²

Washington’s Public Disclosure Act is modeled on the Federal Freedom of Information Act.⁶³ The state Act imposes a duty upon public agencies to make their records available to the public for inspection and copying.⁶⁴ Certain personal records, including information in files maintained for “patients or clients of public institutions or public health agencies,” are exempted from public inspection.⁶⁵ These records must be disclosed, however, if the record keeper can delete information violating personal privacy or interfering with vital governmental interests.⁶⁶ In addition, if a court determines that the exemption in a particular case is “clearly unnecessary to protect any individual’s right of privacy or any vital government function,” the court can order the record keeper to allow the patient to inspect the records.⁶⁷ Applying this section of the Act, the *Oliver* court held that public hospital patients may obtain access to their own health records.⁶⁸

59. 94 Wn. 2d 559, 618 P.2d 76 (1980).

60. WASH. REV. CODE ch. 42.17 (Supp. 1982).

61. Besides claiming a right of access under the Public Disclosure Act, Oliver claimed a common law right of access to the records based on the “contractual and fiduciary” relationship of a hospital to its patients. 94 Wn. 2d at 568, 618 P.2d at 82. In addition, Oliver claimed a right of access under the privacy clause of the state constitution. The court did not rule on these claims. 94 Wn. 2d at 563, 618 P.2d at 78.

62. 94 Wn. 2d at 566, 618 P.2d at 81.

63. 5 U.S.C. §§ 552–552a (1976). See McClintock, Crumb, and Tuffley, *Washington’s New Public Records Disclosure Act: Freedom of Information in Municipal Labor Law*, 11 GONZAGA L. REV. 13, 17 n.11 (1975).

64. WASH. REV. CODE § 42.17.250 (Supp. 1982).

65. *Id.* § 42.17.310(1)(a).

66. *Id.* § 42.17.310(2).

67. *Id.* § 42.17.310(3).

68. 94 Wn. 2d at 567, 618 P.2d at 82. The court misquoted the Public Disclosure Act at this point. The court stated that patients may obtain access to their public health records if there is proof to

The use of the Public Disclosure Act as a patient access statute creates several problems. First, the Public Disclosure Act applies only to patient records in public hospitals. The need for a patient right of access to health records also extends to the records of private health practitioners.⁶⁹ Broadening the right of patient access to all health records can best be achieved by legislation.

Second, the Public Disclosure Act does not allow adequate physician discretion to withhold the record when necessary. Under the Act, the court will permit patient inspection of a record if it finds that withholding the record is unnecessary to protect any individual's right to privacy or any vital government function.⁷⁰ The "privacy" limitation will protect information in the record pertaining to confidential disclosures to the physician made by third parties. However, since the patient's own privacy is not threatened by patient access, the patient can compel disclosure of the record in every other case. For example, when a mental health record contains information that the physician believes would be detrimental to the patient's health,⁷¹ the physician apparently has no discretion under the Act to withhold the information from the patient.⁷² A new statute is

support a judicial determination that exemption of the records is "clearly unnecessary to protect the patient's right to privacy or any vital governmental function." 94 Wn. 2d at 567-68. 618 P.2d at 81-82. The justification under the Act for nondisclosure of exempt records is to protect "any individual's right to privacy," WASH. REV. CODE § 42.17.310(3) (Supp. 1982) (emphasis added), not merely "the patient's right to privacy." Thus, under the Act, patient access to medical records could be denied to protect information in the record pertaining to confidential disclosures made by third parties.

The court also erroneously stated that the patient has the burden of proving that no personal privacy or vital governmental functions would be violated by access to the record. 94 Wn. 2d at 568, 618 P.2d at 82. In fact, the Act provides that, on the motion of the person seeking access to a public record, the court may require the responsible agency to show cause why it has refused to allow inspection of the records. In this proceeding, "the burden of proof shall be on the agency to establish that refusal to permit public inspection and copying is required." WASH. REV. CODE § 42.17.340(1) (Supp. 1982).

69. See, e.g., NEV. REV. STAT. § 629.061 (1979). The limited scope of the Public Disclosure Act is understandable, given the Act's stated purpose of providing "full access to information concerning the conduct of government on every level." WASH. REV. CODE § 42.17.010(11) (Supp. 1982) (emphasis added).

70. WASH. REV. CODE § 42.17.310(3) (Supp. 1982).

71. For example, when the record contains a possible "self-fulfilling diagnosis" of suicidal tendencies, it should not be released to the patient. See note 14 and accompanying text *supra*.

72. Under the Act, a physician might withhold a record to prevent a "self-fulfilling diagnosis" of homicidal tendencies, claiming that disclosure would violate a possible victim's "right of privacy." Such a strained interpretation of the Act's "privacy" language, however, is clearly undesirable. Alternatively, the Act's failure to allow for physician discretion to withhold records from patients could be remedied by a future court ruling providing such discretion. A court could cite, for example, the traditional restrictions on access to mental health records, see *Gotkin v. Miller*, 379 F. Supp. 859 (E.D.N.Y. 1974), *aff'd*, 514 F.2d 125 (2d Cir. 1975), or uphold a physician's property right in the records, see *In re Culbertson's Will*, 57 Misc. 2d 391, 292 N.Y.S.2d 806, 807-808 (Sur. Ct. 1968). However, unless the court-created discretion to withhold is carefully limited, such a ruling

needed which provides for physicians' discretion to withhold medical records in certain cases.

Third, the only remedy under the Act if the record holder refuses access to records is for the patient to seek judicial review.⁷³ However, litigation is unduly expensive and time consuming. A better approach would be to institute an initial review of the decision in a non-judicial setting. This could be done either by a neutral professional⁷⁴ or by an administrative entity within the health care facility.

Fourth, the Act does not address the subject of release of patient records to third parties. As discussed above,⁷⁵ patient access to records should be a control upon the release of personal information to employers, insurance companies, and others. A health records access statute should address both patient and third-party rights to the patient's medical records.

In summary, two points are clear. First, broad patient access rights to medical and mental health records are desirable. Second, limited discretion should be reserved to the physician to withhold records in certain cases. The Public Disclosure Act does not provide for broad patient access nor for adequate physician discretion to withhold records. Nor does the Act adequately treat the issue of third-party rights to patients' medical records. Therefore, a new statute is needed to properly balance patient, physician, and third-party rights concerning patients' medical records.

B. Elements of a Statutory Solution for Access to Medical Records

A statute creating a right of patient access to medical and mental health records should include the following elements:

(1) The scope of the statute should be broad. It should apply to all medical and mental health records in public and private facilities.⁷⁶

(2) Patients should have access to their records after submitting a written access request.⁷⁷

(3) Two restrictions should be placed on patient access. First, information pertaining to confidential communications by third parties to the rec-

would weaken the *Oliver* result of creating a broad right of patient access to medical records in public hospitals. A better approach is to enact legislation that balances a broad right of patient access with a narrow physician discretion to withhold. *See, e.g.*, the District of Columbia Mental Health Information Act, D.C. CODE ANN. §§ 6-2001 to -2076 (1981).

73. WASH. REV. CODE § 42.17.340(1) (Supp. 1982).

74. *See* note 43 and accompanying text *supra*.

75. *See* note 4 and accompanying text *supra*.

76. *See, e.g.*, COLO. REV. STAT. §§ 25-1-801, -802 (Supp. 1981); NEV. REV. STAT. § 629.061 (1979); S.D. CODIFIED LAWS ANN. § 36-2-16 (1977); note 20 *supra*.

77. Reasonable duplication and clerical costs may be charged to the patient. *See, e.g.*, MINN. STAT. ANN. § 144.335(3) (West Supp. 1982).

ord holder should not be disclosed to the patient without consent of the third party. Patient access should not infringe upon the privacy rights of third parties. Second, information should be withheld that, if released to the patient, would create a substantial risk of serious physical or psychological harm to the patient or another party.⁷⁸

(4) The statute should state in detail the rules governing the disclosure of patient records to third parties. The statute should generally prohibit disclosure without patient authorization, except in clearly specified instances.⁷⁹ The statute should also prohibit redisclosure of information by third parties without authorization and bar the use of blanket consents by patients authorizing the release of any and all information requested.⁸⁰

(5) It is important that patients be notified in writing of their right to inspect the record and to approve release of the record to third parties. Patients should also be notified of those cases in which information may be released without their consent.

(6) Patients should be allowed to submit a written proposal for correction of false or misleading information in the record. If the record holder does not correct the record, the patient's proposed correction should be included in the record accompanying the disputed information.⁸¹

(7) A process of non-judicial review of denials of patient access should precede appeal to a court. Two alternatives are feasible. First, the patient could designate a second medical professional to whom the record will be released for a second opinion on patient access.⁸² Second, the health care facility could create a board composed of both treating professionals and administrators to review patient access requests. If access is denied after non-judicial review, patients should have the right to judicial review. The record holder should have the burden to prove that the denial of access was justified under the access restriction provisions of the statute.⁸³

78. See, e.g., D.C. CODE ANN. § 6-2042 (1981); note 15 *supra*.

79. Examples of such instances include: disclosures within the health care facility; disclosures in emergencies; disclosures in legal actions for the collection of fees; disclosures required by law or subpoena; disclosures for research, management audits, or program evaluations. See, e.g., D.C. CODE ANN. §§ 6-2021 to -2025 (1981). See also PRIVACY REPORT, *supra* note 4, at 308-12 (listing exceptions to patient authorization requirement).

80. See note 58 *supra*.

81. See, e.g., D.C. CODE ANN. § 6-2045 (1981); ILL. STAT. ANN. ch. 91½, §§ 804(c), 804(d) (Smith-Hurd Supp. 1981). See note 45 and accompanying text *supra*.

82. See note 44 and accompanying text *supra*.

83. The District of Columbia's Mental Health Information Act, D.C. STAT. ANN. §§ 6-2001 to -2076 (1981), contains most of the elements recommended in this section of the Comment, except it is unnecessarily limited to mental health records. If extended to all medical and mental records in public and private facilities, the Mental Health Information Act could serve as a model for an appropriate medical records access statute.

III. CONCLUSION

Traditionally, all medical patients have had little right to inspect their medical records. Patient rights to mental health records have been even more restricted. However, with third-party demands for patients' medical and mental health information increasing, patient access is needed as a control upon the release of sensitive personal information. In addition, clinical studies suggest that the treatment benefits of patient access to mental health records outweigh the risk of harm to the patient. Therefore, a general right of patient access to medical and mental records is desirable.

In certain cases, however, patients should be shielded from information in their records that would cause them, or others through them, serious psychological or physical harm. This can be accomplished by granting the treating physician discretion to limit access in a narrow range of cases. Decisions not to disclose should be subject to non-judicial review, with a subsequent right of judicial review. A statute is needed in Washington to recognize patient access rights, to control third-party access to patient records, and to provide the machinery necessary for the assertion and adjudication of access rights.

James M. Madden