Unauthorized Disclosure of Medical Information, Patient Rights and Legal Consequences as it affect Patients and Healthcare Providers.

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Abstract
Health records are maintained precisely because the information contained in it is of the highest value to the patients, organization and the public. The health information management specialist should always remember that an authorization for release of information signed by the patient/legal representative or other responsible party is always necessary when the confidential information is to be released in the absence of any specific law to the contrary to avoid dispute and litigations form the patient. Therefore, disclosure of patient health information without consent or from the conditions stated by law such as reporting of notifiable diseases (public health control diseases act 1984) would be viewed as actionable breach of confidential relationship between the patient, the physician and the hospital, therefore unauthorized disclosure of patient information could lead to litigation, colossal loss of money, lost of organizational reputation which could scare the patients and the public from patronizing the hospital due to unethical profession practices.

Keywords: *Unauthorized Disclosure, Medical Information, Patient Rights, legal consequences, Healthcare Providers.*

I. Introduction

Medical Information

Health information is the clear concise and accurate history of a patient's life and illness written from the medical point of view, it is a collection of recorded facts concerning a particular patient and also it is a device used for recording the significant characteristics of a particular patient and his/her illness and the events occurring in the course of professional care for the purpose of providing the best medical care to the patient, for teaching, research and study appraisal of medical practice and legal requirements. The quality of health care depends on proper management of patient health information, therefore efficient health care delivery system rest solemnly on a good system of health information storage and preservation (Benjamin 2010)

Huffman (1991) Asserts that health information contains more than an accommodation of a patient history, findings and events, it is useful in the health planning process through available data by means of collection, compilation, analysis, interpretation and presentation of numerical data relating to health, it is a records of response of responses and as a guide to future therapy. Furthermore to person seeking fair compensation for injuries received at work or settlement for those arising due to negligence of others or coverage for the cost of illness for which they carry insurance, the health information is indispensable. It is for the conscientious physician a protection and armors in defense being a permanent documentation of the observation he has made and of the programme he has recommended or carried out as a result of them.

The importance of confidentiality is underwritten by the law and the penalties entails by a breach can be very severe. If a patient feels that he has been damaged by the disclosure information he can sue the hospital authority and could join in the action any Member of staff who he feels is part of the people (circle) bound by the confidence. This is Justified because society feels that patient ought information in the hospital to be secured in disclosing information to their doctor so that the doctor will be able to treat them fully. Medical records is admissible in the court of law, the health information there in contains the unbiased report of activities carried out or recorded down during patient hospitalization in the hospital, therefore all contributors to patient care must document accurately, write legibly, used approved abbreviations and medical terminology, signed, date, and indicate rank and time of event at the end of each documentation or individual services offered patient so that it will be easy to know the particular officer that might have committed an error or have done bad practices at a particular time (Foster C & Peacock N, 2000).:

II. Literature Review

Disclosure of Health Information

A patient may authorize disclosure by giving written authorization for the inspection of his records by a lawyer or insurance agent, when the requesting party presents this signed and dated authorization, it becomes a part of the records and a carbon copy of the information released is filed in the record. It is advisable that a third party witness the signing of an authorization to avoid dispute. It would be a protection for the hospital if at least one person can verify the facts that he witnessed the signing of the authorization by the patient, and that to the best of his knowledge the patient knew what he was signing. Although the physician has no legal right to patient information, as a matter of policy the hospital needs to collect the written authorization before releasing information from medical records.

In the case of minors or other legally incompetent persons, the authorization may be signed by the parent, guardian, or legal representative. When the patient dies, the administrator or executor of the estate usually has the right to authorize disclosure. Such a person presents a proof of eligibility before the health information director allows inspection of the records. Such proof may be a court document, a letter of authorization from the attorney for the estate, or other indications of legitimate power to authorize disclosure such authorization from patients are usually to lawyers and insurance agents when patients is contemplating proceeding for claims or the patient is engaged in litigation with a third party. Any disclosure/ release of information without due authorization from the patient or his/her representative is regarded unauthorized disclosure/release (Mulligan 2001) .

Confidentiality of Medical Information

Osundina (2005) asserts that Information in medical records is confidential because it contain secret information relating to the well being of a particular patient and it is held that the relationship between patient and physician is special and that their communication should be protected from disclosure. This is supported in the physician's code of ethics and ethics guiding health information management profession and in the law court, therefore the protection of the bond of confidence between the patient and the doctor or those providing medical care is extremely important to the success of that care. The importance of confidentiality is underwritten by the law and the penalties entails by a breach can be very severe. If a patient feels that he has been damaged by the disclosure of information he can sue the hospital authority and could join in the action any member of staff who he feels is part of the people (circle) bound by the confidence. This is justified because the society feels that patient's information in the hospital ought to be secured.

Ownership of patient health information

Ownership carries with it the power of dominion and control, but this type of ownership does not extend to medical records because of the confidential information and the responsibility of the health care providers on patients in the course of treatment. Therefore, ownership of patient records is vested in the government or the hospital, the hospital should not release or divulge patient medical information without the authority or permission of the patient, and otherwise it may lead to court case. A patient wishing to see his health information should be requested to consult his doctor or procure a written authorization from his doctor. . If the hospital allows the patient or his representatives to see his/her records, few conflicts will appear due to misinterpretation of the medical terminology used in documenting the records and legal questions are raised.(Solomon, 2006)

In Nigeria, the hospital owns patients' records, according to the Public Service Rules (2011) (Chapter 7, section 1 rule 2. (070102) which states that patients' record, medical certificates and medical documents are to be treated as confidential in both government and private hospitals and no copies should be furnished except the rules guiding the release of patient information are applied. Health records are maintained precisely because the information it contains is of the highest value to the individuals and organization having a legitimate need to know its contents. The majority of requests come from third party payment plans such as blue cross legal representatives, medical care agencies, and commercial insurance companies. Moreover patients and their relatives, the members of the medical staff other physicians and hospitals concerned with the care of patients, governments and other agencies also request information. Sound rules and good public relationship are the important consideration in the developments of policies governing the release of information. Hospital receives many legitimate inquires from welfare organizations, court insurance cases, and other organizations. Such inquires are for the benefits of patients and the release of information without written authorization of the patient would not meet with criticism; but for the protection of patients therefore the health information director should always require proper authorization from the patient for release of information.(Osundina 2005)

Policies for Release of Information

The health information specialist should always remember that an authorization for release of information signed by the patient or other responsible party is always necessary when the confidential information is to be released in the absence of any specific law to the contrary to avoid dispute and litigations.

The administrator of each hospital after due consultation with legal counsel, the health information directors and the medical records committee should adopt definite regulations governing the release of information from the health records.

The following policies may be adaptable to the average general hospital.

1. Any information of a medical nature in possession of the hospital must not be revealed by an employee of the hospital except as permitted in the hospital regulation.
2. It shall be the general policy that the hospital will not voluntarily use the records in any manner which will jeopardize any of the interests of the patient, with the exception that the hospital itself will use the records to defend itself or its agents.
3. Members of the resident and attending medical staff may freely consult in the medical records departments such records as pertain to their work. In no instance should copies of medical records be made without the specific approval of the medical record director, who will confer with the administration in case of doubt. No members of the resident medical staff may issue any verbal or written approval of the administration in each such instance.
4. Staff doctors may not give authorization to insurance companies or attorney's to secure records.

5. Requests by patients for information concerning their own records shall be referred to the attending physician in charge of the case.
6. Verbal request for information are to be discourage in favour of written requests.
7. Information from medical records shall be given not only on written authorization signed and dated by the patient (guardians, if a minor or if mentally incompetent or nearest relative). Authorization should also be signed and dated by the person viewing the medical records and filed with it.
8. Information in medical records may be turned over to the hospital's legal representative to protect the interests of the hospitals in cases involving liability or compensation.
9. Original medical records shall not be taken out of the hospital except upon receipt of a subpoena duces tecum and the proper fee or the specific written authorization.
10. An authorization for release of information should contain an indication of the period or periods of hospitalization. The authorization should be honoured only for the period of hospitalization indicated by the date there in stated. (Bloomrosen, 2006).

Disclosure of confidential clinical information

Generally disclosure of confidential clinical material to someone other than the patient will be an actionable breach of confidence. There are however three circumstances

when clinicians can release confidential clinical information.
When the patient has given their consent.
When the law requires disclosure (either under statute or a court order)
When there is a public interests in disclosure. (Huffman 1994)

III. Unauthorised Disclosure / Disclosure without Consent

Holmes- Rover (2002).Discussed consent as a rational free act which assumes the knowledge on the part of individual which he gives agreements or permission. Also consent connotes the dual ingredients of awareness and assent. To establish consent to a risk, It must be shown that the patient (in case of consent to operation) was aware of the risk and assented to the encountering of it, otherwise failure to obtain the consent of patient for surgical and medical treatment could leads to court cases.

The medical officers or surgeons should always seek consent for medical and surgical treatment before embarking on patient treatment to avoid legal embarrassment in the hospital.

However situation arises when the hospital does not need the consent of a patient or his representative to release information such cases are:

1. Subpoena duces tecum (court order). This requires the witness to come with certain specified records of patient.
2. On higher duty:- This requires that certain information must be reported.
   (a) Notification of certain disease.
   (b) Treatment of persons suspected for robbery or murder e.g. The treatment of bullet wound.
   (c) Accident cases, when the hospital is expected to record cases treated.
   Statistical Report on:
   (d) Industrial poisoning.
   (e) Births/deaths.
   (f) Epidemics.
3. On hospital lien law – A lien law gives a hospital the right to file its claims for payments for services which it rendered to a person injured by neglect of another person.
4. When the hospital's interest is involved.
5. For patient care to another physician.
6. For research, study and teaching (a large number of records are involved and there is no particular records of interest, any outcome should not identify a particular patients.

IV. Patient Rights

Solomon (2006) Stressed that hospital owns the health records and that common law does not give an unconditional right of access to one's own medical records as confirmed by court of appeal in the case of` R&mid Glamorgan FHSA exparte martion (1995) a patient with a long mental health history was refused access to his chemical records on the grounds that disclosure would be detrimental to him. the court found that a health authority had a general duty to act at all times in the patients best interests and thus could deny access to the patient where it was in the patients best interest to do so. .In view of the confidential nature of medical records and other records containing information about individual patients. Such records should not be made available for public inspection in the place of repository (library).

He claimed that hospital patient is a recipient of charity and he has these undeniable elementary basic rights.

The patient right include;

-Considerate and respectful care.-Care privacy and safety.

-The hospitals reasonable response to their request/need for care. The right to refuse treatment.

-Collaborate with the physician to make informed decision regarding their plan of care.

-Implementation of an advance directive, or to have the next of kin, guardian, or legal designee to exercise these rights, within legal limits. If the patient is unable to do so.

-The right to be free from abuse or embarrassment.

-The right to communicate and make informed decision.

-The right to sue the hospital in case of breach of confidential trust between the patient and the hospital.

He has the right to be treated as quickly.

He has the right to have the best treatment a hospital can provide him.

He has the right to be given adequate information about his condition and his progress.

He has the right to be fed and cared for generally, supplied with drugs and surgical appliances.

He has the right to be provided with all reasonable facilities to enable him to be efficiently treated for the illness or injury from which he is suffering(Millar,2003).

Patients Responsibilities.

-Following the institutions rules and regulations.

-Providing accurate and complete information regarding identity, complaints, past illness, hospitalization, medication.

-Making it known to clearly understand the contemplated course of action and what is expected of them,

-Following the plans of care recommended by the health practitioners.

-Consequences if they refuse treatment or do not follow the practitioners instruction.

-Keeping appointment and unable to do so, notifying the responsible practitioners or health care facility.

-Being considerate of the right of others including health care www.mean medical centre. net / index.

In developing countries patients" are not accorded most of the rights elaborated about, the health professionals in many ways trampled upon the right of their patients believing that majority of the patients doesn't know their rights to seek redress in the court of law. This could be attributed to the level of ignorance amongst our patients or thinking on the effect it might have on their jobs, or lack of the knowledge of confidentiality of patients records, that treatment given to patients have to be standardized and without bias, that if in anyway the patient feels aggrieved due to the treatment given to him/her or found out that the procedure used in treating him was deficient thereby causing an injury or body harm to the patient could constitute a legal action against the hospital and join with it the physician and other health professionals that are within the bound of confidence. This could be a great loss to the hospital authority in terms of financial and loss of image within the public.

V. Legal Consequences

Patients are becoming aware of their rights towards hospitals and doctors in recent years and there is an increasing tendency to sue. In addition hospitals are losing their immunity to liability for this reason the health information officer should analysed each medical records carefully to see that it substantiate all facets of the medical care rendered. Hospitals and other health institution are require b y law to maintain medical records these requirement are found either in statutes or administrative regulations in most countries , because it was based on the premise that human memory is too short and unreliable, in that we cannot remember all what has been done to patients in their last clinic attendances that is the more reasons why all health institutions rendering care to the patients are compelled to create a records for the patients they treat, and record the significant data concerning their ailment such as patient's identification data, patient complaint, family or civic history, tests, findings, result of examination, diagnosis, treatment and final result of treatment, these prognoses, constitute the most important document in medical practice. (McWay 2010)

Medical records are needed in order to provide the best health care system, today medical care is of high quality and all segment of the health care system are striving to increase that quality. Medical record is not only the documentation of care of a particular patient. It is also part of the continually growing database of medical and scientific knowledge. Taking together medical records that contains available information concerning the progress which he has made in health care. One of the important reasons for keeping medical records is the medico legal aspects which could be used during claim by aggrieved patients, and as defense for hospital and staff. The responsibility to maintain medical records and ensure they are secure, reliable and accurate has been delegated to the medical records officers.

Furthermore medical records is used to seek redress in the court for bad practices, for persons seeking fair compensation for injuries received at work or settlement for those arising due to negligence of others or coverage for the cost of illness for carry insurance, the health serves as a protection and amour in defense being a permanent documentation of the observation he has made. **(**Pozgar,. and Pozgar, 2007).

Authorization

A written authorization be collected from the patient whenever a lawyer or insurance agent wish to see or inspect patient records most especially when the patient is contemplating proceeding for claims or the patient is engaged in litigation with a third party such authorization may need to be witnessed or notarized. Failure to obtain an authorization may leads to court case. The patient may sue the hospital for

disclosure of information, then the lawyer or insurance agent may not be working for the interests of the patient, their report may leads to sacking of the patient from his place of work. Furthermore, a written authorization should be obtain from the registration desk and part of the information to be documented in the hospital before treatment authorization for medical and surgical treatment should form part of the patient document signed by the patient and filed in his records to avoid unnecessary court cases or embarrassment from patients during the course of treatment.

Authorization is required before the following procedure could be performed.

- Consent for surgical operation.
- Administration of anesthesia.
- Administration of electro convulsive therapy.
- Removal of organs.
- For sterilization (in case of primary sterilization it is usual to obtain the consent of both patients/spouse).
- For Insemination.
- Consent for autopsy.
- Discharge against medical advice.
- Consent for disposal of corpse.(Berner,2008).

Improper Release Unauthorized Disclosure

Holmes- Rover (2002) argued that Legal actions for damaged or unauthorized disclosure of information from medical records without consent may probably cause. three legal theories that may be employed to support the suit.

1. The theory of defarmation: That is libel or slander complaining party sues because of a written or oral communication of false statement which tends to injure his character or reputation.
2. Breach of a confidential relationship: This occurs when a claim for damages is made for disclosure of information without consent. It arises in an existing physician – patient's relationship when the physician discloses to a third party information about a patient, which he has learnt in the course of treating the patient, but the physician will be liable if he reveals the information in response to a superior or higher duty.
3. Invasion of privacy:- It occurs when information is disclosed and the patient is held up to ridicule, scorn, or humiliate in the community liability will follow (precarious liability)

   Other forms of common actionable unethical practices are:

   Malpractice: this is an unlawful activity usually for personal advantage by health worker e.g. doctor, nurse etc that are in a position of trust or responsibilities.

   Negligence: is the act of being careless in the process of rendering care to the patients, thereby causing harm or injury to the patients.

   Impersonation: the idea of pretending to be a medical doctor, or a nurse or a health worker by copying the appearance, behavior etc of another person with the intension of gaining unmerited favour or for the purpose of collecting unsolicited financial benefit.

Disclosure of patient health information without consent or from the conditions that were not mentioned above such as reporting of notifiable diseases(public health control diseases act 1984) would be viewed as actionable breach of confidential relationship between the patient, the physician and the hospital, therefore unauthorized disclosure of patient information could lead to litigation, colossal loss of money, image which could scare the patient and the public from patronizing the hospital due to unethical profession practices. http://pb.rcpsych.org/cgi/content/full

Conclusion and Recommendations

The unavailable legal framework on patient right of access to health care, the lip service paid to the issue of confidentiality and disclosure of patient information and other unethical practices involving the health professionals had led many hospitals and healthcare providers to series of litigations. Legal Consequences of unauthorized disclosure of health information had caused distress, embarrassment, arguments, loss of trust in medical services, loss of employment, undue compensation and insurance entitlements, wastage of money and Medical Officers precious time, to both the patients and the healthcare providers.

Based on the findings of this study, the following recommendations were made: All unethical practices should be corrected to avoid medical errors which could claim patient life and colossal loss of money on the part of healthcare providers. Registered licensed practioners from various health bodies should be allow to practice in the hospital, informed consent, that is patient should be informed of the risk involved in carrying out a medical procedure or operation and finally two form of consent must be signed by a patient before embarking on treatment, consent to medical procedure and consent for surgical operation, which are kept in the patient record in case of any issue relating to liability or court case.

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