CHAPTER 2005-265

Committee Substitute for Senate Bill No. 938

An act relating to adverse medical incidents; creating s. 381.028, F.S.; providing a short title; providing a purpose; defining terms; specifying patients' right of access to records relating to an adverse medical incident; prohibiting the disclosure of the identity of certain patients; providing for maintaining privacy restrictions imposed by federal law; providing for the applicability of s. 25, Art. X of the State Constitution; providing for applicability of this section; providing restrictions upon the use of the records; providing for the identification and production of the records; providing for fees charged for copies of records; 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) SHORT TITLE.—This section may be cited as the "Patients' Right-to-Know About Adverse Medical Incidents Act."

(2) PURPOSE.—It is the purpose of this act to implement s. 25, Art. X of the State Constitution. The Legislature finds that this section of the State Constitution is intended to grant patient access to records of adverse medical incidents, which records were made or received in the course of business by a health care facility or provider, and not to repeal or otherwise modify existing laws governing 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 remain in full force and effect.

(3) DEFINITIONS.—As used in s. 25, Art. X of the State Constitution and this act, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Adverse medical incident" means medical negligence, intentional misconduct, and any other act, neglect, or default of a health care facility or health care provider which caused or could have caused injury to or the 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, incidents that are 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) "Have access to any records" means, in addition to any other procedure for producing the records provided by general law, making the records available for inspection and copying upon formal or informal request by the patient or a representative of the patient, provided that 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, chapter 459, or chapter 461.

(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; notes; and any documents or portions thereof which constitute, contain, or reflect any attorney-client communications or any attorney-client work product may not be considered "records" for purposes of s. 25, Art. X of the State Constitution and this act.

(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. In the case of a deceased patient, the term 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 such person.

(4) PATIENTS' RIGHT OF ACCESS.—Patients have a right to have 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 may 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 applies to records created, incidents occurring, and actions pending on or after November 2, 2004. Section 25, Art. X of the State Constitution does not apply to records created, incidents occurring, or actions pending before November 2, 2004. A patient requesting records on or after November 2, 2008, shall be eligible to receive records created within 4 years before the date of the request.

(6) USE OF RECORDS.—

(a) This section does not 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, those contained in ss. 395.0191, 395.0193, 395.0197, 766.101, and 766.1016, or 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 therein, obtained under s. 25, Art. X of the State Constitution, are not discoverable or admissible into evidence and may not be used for any purpose, including impeachment, in any civil or administrative action against a health care facility or health care provider. This 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 any 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, the 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 which pertain to any adverse medical incident affecting the patient or any other patient which involves the same or substantially similar condition, treatment, or diagnosis as that of the patient requesting access.

(b)1. Using the process provided in s. 395.0197, the health care facility shall be 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, the health care provider shall be 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 under s. 25, Art. X of the State Constitution may not exceed the reasonable and actual cost of complying with the request, including a reasonable charge for the staff time necessary to search for records and 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, before acting on the records request.

2. Fees charged by a health care provider for copies of records requested by a patient under s. 25, Art. X of the State Constitution may not exceed the amount established under 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, before acting on the records request.

(d)1. Requests for production of adverse medical incident records shall be processed by the health care facility or health care provider in a timely manner, after having a reasonable opportunity to determine whether or not 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 must 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 upon becoming a law.

Approved by the Governor June 20, 2005.

Filed in Office Secretary of State June 20, 2005.