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In re Miguel M.

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Like the attorney-client privilege, the doctor-patient relationship is built on trust and privacy.¹ Patients entrust physicians with private information about their health and personal lives. Doctors, in turn, are expected to maintain confidentiality and keep patients' records private. Only in the most extenuating circumstances is medical information permitted to be released without authorization to third parties.² Yet, despite explicit statutory protections governing the privacy of medical information, exceptions exist under which doctors and hospitals can disclose information without a patient's knowledge, consent, or authorization.³ The dividing line between unauthorized and authorized disclosure of private medical information, therefore, often rests on precise interpretations of law and legislative intent. When a court ignores precedent and legislative intent, the privacy protections on which patients rely can be circumvented.

In *In re Miguel M.*, the New York State Appellate Division, Second Department, affirmed a lower court decision holding that a physician may obtain a patient's clinical records from outside medical facilities without the patient's authorization, and may then use those records in a legal proceeding to order treatment for the patient.⁴ In affirming the lower court, the Second Department utilized an unprecedented interpretation of the term "public health" to justify what should have been an unauthorized inter-hospital transfer of a patient's medical records. The holding allowed the Second Department to sidestep federal statutory privacy requirements and dodge a potential federal supremacy challenge. This case comment contends that the Second Department's interpretation of "public health" was overly broad, not supported by precedent, and threatens to weaken federal statutory patient privacy protections.

Dr. Charles Barron, Director of the Department of Psychiatry at Elmhurst Hospital Center,⁵ sought a court order authorizing Assisted Outpatient Treatment (AOT) for his patient, Miguel M.⁶ AOT is an umbrella term for various outpatient mental health services intended to help "treat [a patient's] mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a

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1. See generally RICHARD A. LORD, 23 WILLISTON ON CONTRACTS § 62:12 (4th ed. 2010).
 2. *Summary of the HIPAA Privacy Rules*, U.S. DEP'T OF HEALTH & HUMAN SERVS. 7 (2003), <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>. For example, health care providers may disclose certain protected health information regarding victims of abuse, neglect, or domestic violence. *Id.*
 3. *Id.* An exception exists, for example, for providers to release certain health information through an order from a court or administrative tribunal. *Id.*
 4. 882 N.Y.S.2d 698, 706 (2d Dep't 2009). The clinical treatment involved in this case was Assisted Outpatient Treatment (AOT). See *infra* text accompanying notes 7–8. AOT is defined as "categories of outpatient services which have been ordered by the court pursuant to this section." N.Y. MENTAL HYG. LAW § 9.60 (a)(1) (McKinney 2005).
 5. Elmhurst Hospital Center is a 545-bed facility in Elmhurst, Queens. *Elmhurst Hospital Center*, NYC. Gov, <http://www.nyc.gov/html/hhc/ehc/html/home/home.shtml> (last visited Oct. 18, 2010). Psychiatric services are among the Center's offerings. *Id.*
 6. *Miguel M.*, 882 N.Y.S.2d at 700.

relapse.”⁷ Examples of AOT care include the provision of medication, blood and urine testing, individual or group therapy, and educational and vocational training.⁸ Patients involved in AOT proceedings usually remain anonymous to the court and, other than details of two prior hospitalizations, published records do not further describe “Miguel M.”⁹ When a medical provider such as Dr. Barron believes that a patient requires this form of outpatient treatment, he or she can seek a court order mandating AOT care.¹⁰ Section 9.60 of New York Mental Hygiene Law,¹¹ also known as “Kendra’s Law,”¹² sets forth the criteria by which an individual may be ordered by a court to undergo AOT.

[A] person may be ordered to receive assisted outpatient treatment if the court finds that such person: (1) is eighteen years of age or older; and (2) is suffering from a mental illness; and (3) is unlikely to survive safely in the community without supervision, based on a clinical determination; and (4) has a history of lack of compliance with treatment for mental illness.¹³

At the hearing seeking an order to provide AOT to Miguel M., Dr. Barron presented supporting testimony from Dr. Daniel Garza, Director of AOT at Elmhurst Hospital.¹⁴ During direct testimony, Dr. Garza stated that, among his duties at Elmhurst, “he investigate[d] and evaluate[d] referrals to [the hospital’s] AOT program.”¹⁵ Dr. Garza explained that he had recently diagnosed Miguel M. with schizoaffective disorder.¹⁶ The basis for Dr. Garza’s diagnosis included a review of clinical records from Holliswood Hospital, a facility which had previously treated Miguel M.¹⁷ When asked how he came into possession of Miguel M.’s records from Holliswood, Dr. Garza replied: “As part of the investigatory process under AOT, the

7. MENTAL HYG. § 9.60(a)(1).

8. *Id.*

9. *Miguel M.*, 882 N.Y.S.2d at 700.

10. Dr. Barron sought the order for treatment from the New York Supreme Court, Queens County, pursuant to MENTAL HYG. § 9.60(e)(1)(iii).

11. MENTAL HYG. § 9.60(c).

12. S.B. 5762, 222nd Leg., 1999th Reg. Sess. (N.Y. 1999). Kendra’s Law is named after Kendra Webdale who, on January 3, 1999, was “pushed to her death before an oncoming subway train by a man diagnosed with paranoid schizophrenia who had neglected to take his prescribed medication.” *In re K.L.*, 1 N.Y.3d 362, 366 (2004). The New York State legislature responded to Webdale’s death by enacting section 9.60 of the New York Mental Hygiene Law. MENTAL HYG. § 9.60; S.B. 5762, 222nd Leg., 1999th Reg. Sess. (N.Y. 1999).

13. MENTAL HYG. § 9.60(c).

14. *In re Miguel M.*, 882 N.Y.S.2d at 700.

15. *Id.*

16. *Id.* at 700; AM. PSYCHIATRIC ASS’N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS 298 (4th ed. 2000) (describing schizoaffective disorder as “a disorder in which a mood episode and the active phase of Schizophrenia occurs together”).

17. *Miguel M.*, 882 N.Y.S.2d at 700. Holliswood Hospital is a 125-bed private psychiatric hospital located in Queens, New York. THE HOLLISWOOD HOSPITAL, <http://www.holliswoodhospital.com> (last visited

office requests records from institutions that have treated the individuals under such investigations. We received these records [upon] a request for [Miguel M.'s records] and the hospitalizations in question.”¹⁸ Dr. Barron claimed that Dr. Garza was entitled to obtain Miguel M.'s records under New York Mental Hygiene Law section 33.13(c)(12), which states that “information about patients or clients . . . shall not be released by the offices or its facilities to any person or agency outside of the offices except . . . to a director of community services [for the mentally disabled] . . . in the exercise of his or her statutory functions, powers and duties.”¹⁹

Miguel M. moved to preclude admission of the clinical records on the ground that they were obtained from Holliswood without his authorization under the federal Health Information Portability and Accountability Act (HIPAA).²⁰ HIPAA, according to Miguel M., preempted those portions of the New York Mental Hygiene Law concerning AOT investigations.²¹ The State law, he alleged, “is both contrary to and less stringent than HIPAA regulations since it authorizes the disclosure of a subject individual’s clinical records without either a court order or the subject individual’s authorization.”²² Moreover, he argued, HIPAA’s Privacy Rule sets a constitutional “floor of federal privacy protections whereby state laws that are ‘contrary’ to the Privacy Rule are preempted unless a specific exception applies.”²³ The trial court denied Miguel M.’s motion, admitted the records, and ordered Miguel M. to undergo AOT.²⁴

Miguel M. appealed, arguing that the unauthorized transfer of records from Holliswood to the provider psychiatrist at Elmhurst violated HIPAA.²⁵ Miguel M. claimed that, although the Mental Hygiene Law permitted Dr. Garza to obtain his records without a court order or patient authorization, federal preemption of state law proscribed the transfer. Specifically, Miguel M. argued that HIPAA preempted portions of the state law concerning AOT investigations and prohibited unauthorized disclosure.²⁶ Thus, according to Miguel M., before Dr. Garza could lawfully obtain hospital records, “he was required to comply with the HIPAA Privacy Rule by obtaining either a court order or a HIPAA-compliant authorization executed by Miguel M.”²⁷

Oct. 18, 2010). Therapeutic programs for patients with a “broad range of psychiatric diagnoses” are among its services. *Id.*

18. *Miguel M.*, 882 N.Y.S.2d at 700.

19. N.Y. MENTAL HYG. LAW § 33.13(c)(12) (McKinney 2005).

20. *Miguel M.*, 882 N.Y.S.2d at 700.

21. *Id.* at 701.

22. *Id.* at 705.

23. *Id.*

24. *Id.* at 702.

25. *Id.* at 699–700.

26. *Id.* at 701.

27. *Id.*

The Second Department affirmed the lower court's order for AOT, basing its decision on multiple grounds.²⁸ Each of the court's arguments were based on an unprecedented interpretation of the term "public health."²⁹ First, the court held that HIPAA itself authorized disclosures of "protected health information" to "[a] *public health authority*" for the conduct of "*public health investigations . . . and public health interventions.*"³⁰ Second, the court stated that even if HIPAA did not authorize disclosure, Miguel M.'s argument still failed because "HIPAA specifically excepts from the scope of its preemption provision . . . circumstances in which [t]he provision of State law . . . provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of *public health* surveillance, *investigation[s]*, or *intervention[s]*."³¹

The court's determination that an AOT investigation is considered a "public health investigation" or "intervention" is legally flawed for two reasons. First, the court ignored one of the fundamental goals of HIPAA: while recognizing a need to improve the nation's health care system through greater accessibility of information, federal—and, by implication, state—regulations must still adhere to a core principle of privacy.³² Second, no other jurisdiction has ever applied the public health HIPAA exception to the health and well-being of an individual.³³ In doing so, the court has cleared a path for health care providers to potentially sidestep HIPAA's privacy goals through a broadened meaning of the public health exception to include evaluation of individuals. The public health exception should have been interpreted as limited to systematic health investigations and interventions at the population or community level, rather than clinician requests at the individual level.

The Second Department justified its decision to uphold the transfer of Miguel M.'s medical records on two grounds. First, the court held that, under HIPAA, AOT qualified as a public health investigation and public health intervention, thus triggering a HIPAA exception.³⁴ Because of this exception, according to the court, the hospitals did not require authorization to transfer Miguel M.'s patient records. Second, the court held that, even if HIPAA did not authorize disclosure under this

28. *Id.* at 703–06.

29. *Id.* at 705–06.

30. *Id.* at 702 (emphasis added).

31. *Id.* at 706 (citations omitted) (emphasis added).

32. H.R. REP. No. 104-736, at 60 (1996) (Conf. Rep.), reprinted in 1996 U.S.C.C.A.N. 1990 ("Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.")

33. Multiple electronic searches of published legal decisions including "HIPAA" and "public health" yielded no published federal or state cases regarding similar exceptions.

34. *Miguel M.*, 882 N.Y.S.2d at 705.

exception, the federal statute did not preempt state law.³⁵ Therefore, according to the court, any constitutional challenge under the Supremacy Clause must fail.³⁶

The Second Department began its qualification analysis by correctly noting that HIPAA did not offer a controlling statutory definition for a public health investigation or intervention.³⁷ However, instead of defining the terms or looking to other jurisdictions for clarification, the court proposed its own two criteria by which an AOT investigation qualified as a public health investigation.³⁸ First, the court held that Kendra's Law, under which Dr. Barron sought the original court order, had a public health purpose.³⁹ The court noted that "Kendra's Law was adopted to . . . enable mentally ill persons to lead more productive and satisfying lives, while at the same time reducing the risk of violence posed by mentally ill patients" to the public.⁴⁰ Second, the court stated that an AOT investigation was "in accordance with the state's police and *parens patriae* powers" to protect its citizens.⁴¹ Thus, the *Miguel M.* court interpreted a public health investigation to mean *any action* that protects the safety and health of the public, even if it is directed at an individual rather than at the public at large. While public safety is a noble goal, this interpretation of public health is simply inaccurate; such a definition is not an appropriate application in this case, not the meaning ascribed to the phrase by other jurisdictions, and not in accordance with the intent of HIPAA.

The Second Department stated that, in the absence of a "controlling statutory definition," it would first "construe words and phrases in accordance with their plain, ordinary, [and] functional meanings."⁴² However, although several definitions of public health were available, nowhere in its decision does the court construe or cite *any* meaning for public health, public health investigation, or public health intervention—the critical terms on which the case hinged.

Use of the term dates back to at least 1920, when author and Yale University "founder of public health," Charles-Edward Amory Winslow, emphasized the organizational nature of the term.⁴³ Winslow defined public health as "the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private,

35. *Id.*

36. *Id.* at 705–06.

37. *Id.* at 704.

38. *Id.* at 704–05.

39. *Id.* at 704.

40. *In re K.L.*, 1 N.Y.3d 362, 367 (2004) (quoting 1999 N.Y. LAWS 408 § 2).

41. *Miguel M.*, 882 N.Y.S.2d at 704–05.

42. *Id.* at 704.

43. See C.E.A. Winslow, *The Untilled Fields of Public Health*, 51 SCIENCE MAG., Jan. 9, 1920, at 23, 30 (defining the term "public health"). In 1915, Winslow became the first "Chairman in Public Health" at the Yale School of Medicine. Further information about Winslow and his work at Yale is available at *Our History*, YALE SCH. OF PUB. HEALTH, <http://publichealth.yale.edu/about/history/history.aspx> (last visited Oct. 18, 2010).

communities and individuals.⁴⁴ Today, the community-based goals of public health are highlighted in the two definitions in *Black's Law Dictionary*: “1. The health of the community at large; [and] 2. The healthful or sanitary condition of the general body of people or the community en masse; esp., the methods of maintaining the health of the community, as by preventive medicine and organized care for the sick.”⁴⁵ The Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry commonly define “public health surveillance” as “the ongoing systematic collection, analysis and interpretation of outcome-specific data for use in the planning, implementation, and evaluation of public health practice.”⁴⁶

Other sources of guidance were also available to the court. For example, while there is no applicable statutory definition of public health in New York, state case law provides a single published example of a public health intervention: the closing of New York City public bath houses to stop the spread of HIV.⁴⁷ In *City of New York v. New St. Mark's Baths*, the New York State Public Health Council, with the approval of the State's Commissioner of Health, adopted an emergency resolution authorizing city officials to close any facilities “in which high risk sexual activity [took] place.”⁴⁸ The Council based its recommendation on the Commissioner's findings that “[a]ppropriate *public health intervention* . . . is essential to interrupting the epidemic [of AIDS] among the people of the State of New York.”⁴⁹ Thus, in the State's lone relevant legal precedent, a public health intervention describes measures taken by a city of over seven million people⁵⁰ to halt an epidemic that was resulting in almost two hundred new cases a month of a disease with a fatality rate of “nearly 85%,” and for which “effective treatment [was] wholly lacking.”⁵¹ This use of public health intervention is distinguishable from, and hardly applicable to, ordering AOT for a single individual.

Given the absence of controlling statutory guidance in New York, the court should have looked to other states in order to appropriately clarify undefined terms. Both extra-jurisdictional statutory law and case law offer persuasive guidance as to the meaning of public health. First, extra-jurisdictional statutes are strongly suggestive as to how other states interpret the “plain, ordinary, [and] functional” meanings of the

44. Winslow, *supra* note 43, at 30.

45. BLACK'S LAW DICTIONARY 787 (9th ed. 2009).

46. Stephen B. Thacker, *Historical Development*, in PRINCIPLES AND PRACTICE OF PUBLIC HEALTH SURVEILLANCE 1 (Steven M. Teutsch & R. Elliott Churchill eds., 2d ed., 2000).

47. *City of New York v. New St. Mark's Baths*, 497 N.Y.S.2d 979 (Sup. Ct. N.Y. County 1986).

48. *Id.* at 913.

49. *Id.* at 913–14 (emphasis added).

50. According to U.S. Census Bureau statistics, the population of New York City was 7,071,639 in 1980 and 7,322,564 in 1990. *Population of the 100 Largest Urban Places: 1980*, U.S. CENSUS BUREAU (June 15, 1998), <http://www.census.gov/population/www/documentation/twps0027/tab21.txt>; *Population of the 100 Largest Urban Places: 1990*, U.S. CENSUS BUREAU (June 15, 1998), <http://www.census.gov/population/www/documentation/twps0027/tab22.txt>.

51. *New St. Mark's Baths*, 497 N.Y.S.2d at 980.

various terms. For example, when discussing confidentiality of public health investigations, Louisiana defines threats to public health as nuisances “including but not limited to communicable, contagious, and infectious diseases, as well as illnesses, diseases, and genetic disorders or abnormalities.”⁵² North Carolina defines public health investigations as the “surveillance of an illness, condition, or symptoms that may indicate the existence of a communicable disease or condition.”⁵³

Case law from other jurisdictions is also instructive. In *Ruiz v. Johnson*, the U.S. District Court for the Southern District of Texas reviewed a complaint involving alleged unconstitutional practices and conditions in the Texas prison system.⁵⁴ Evidence included testimony from Dr. Steven Jenison, the Physician Administrator of the Infectious Diseases Bureau, Public Health Division, at the New Mexico Department of Health.⁵⁵ Dr. Jenison argued for a public health intervention to determine whether an inmate with tuberculosis had exposed and infected other prisoners.⁵⁶ In his testimony, Dr. Jenison stated that prior reviews of prisoner deaths in the facility included an investigation of seventy-two fatalities from HIV-related complications, potentially including tuberculosis contracted from others within the prison population.⁵⁷

In *Hannis v. Sacred Heart Hospital*, the plaintiff-parents appealed a lower court order denying their motion to compel the local health bureau to produce the names of possible class members in connection with a class action negligence suit.⁵⁸ The potential class consisted of individuals who may have been exposed to infectious tuberculosis by a doctor who had treated them. The parents claimed that a doctor who had treated their children knew or should have known that he had the illness.⁵⁹ The Bureau of Health argued that the information sought—persons identified by the Bureau as having been exposed to the infectious doctor, the results of medical tests, and details regarding the coordination of their medical treatment—was obtained and maintained as a result of a public health investigation and was, therefore, confidential.⁶⁰ In its decision to uphold the privacy of the information, the court cited the Bureau’s investigatory work as part of its mission to “prevent and control communicable diseases.”⁶¹

In both *Ruiz* and *Hannis*, as well as in numerous cases from other jurisdictions, public health intervention and public health investigation describe population-based

52. LA. REV. STAT. ANN. § 40:3.1 (2001).

53. N.C. GEN. STAT. § 130A-141.1(a) (2010).

54. 37 F. Supp.2d 855, 860 (S.D. Tex. 1999).

55. *Id.* at 896.

56. *Id.* at 897.

57. *Id.* at 896.

58. 789 A.2d 368, 370 (Pa. Commw. Ct. 2001).

59. *Id.*

60. *Id.* at 371.

61. *Id.* at 372.

measures taken by a municipal agency in order to oversee the health of numerous citizens. The available public health investigations or interventions were either conducted by municipal public health departments or were aimed at the health of a community.⁶² Thus, established case law in New York and elsewhere underscores the definition of public health investigations and public health interventions as population-based practices, rather than interventions at the individual level. In short, the *Miguel M.* court's unique interpretation was not plain, ordinary, or functional.

In addition to using the "plain, ordinary, [and] functional meanings" of public health and its relative terms, the court also stated it would "[interpret] those terms under HIPAA . . . to effectuate the legislative intent."⁶³ Again, the court strayed from its stated course and from Congress's intent in passing HIPAA. First, Congress's intent was never to include the sharing of clinical records in the name of a *private* investigation in order to determine whether or not to provide treatment for a *single* individual.⁶⁴ When Congress enacted HIPAA in 1996, its goal was "to improve the efficiency and effectiveness of the [nation's] health care system."⁶⁵ HIPAA was designed to establish the nation's first set of standards for electronic health care transactions and information transfer.⁶⁶ While Congress's primary purpose in passing HIPAA was to facilitate communication, Congress also recognized that advances in technology could endanger the privacy of certain health information.⁶⁷ Indeed, HIPAA's drafters went to great lengths to ensure that the Secretary of Health and

62. The "investigations" include: *In re* Att'y Gen. for Investigative Subpoenas, 766 N.W.2d 675 (Mich. Ct. App. 2009) (authorizing the Michigan Department of Community Health to subpoena a number of patients seen by a psychologist); *Stobierski v. Walnut Hill, Inc.*, No. CV030518847, 2004 Conn. Super. LEXIS 284 (Conn. Super. Ct. Jan. 28, 2004) (reliance by plaintiff on public health investigation as basis for claims); *In re* Phillip Morris, Inc., 97-2708 (La. App. 4 Cir. 1/28/98); 706 So.2d 665 (a suit regarding research performed at a university medical center); *Marquez v. Turnock*, 765 F.Supp. 1376 (C.D. Ill. 1991) (a proceeding for falsification of records in an Illinois Department of Health investigation); *Bomba's Rest. & Cocktail Lounge, Inc. v. Lord de la Warr Hotel, Inc.*, 389 A.2d 766 (Del. 1978) (compliance with a Delaware investigation of a restaurant). The "interventions" include: *Vance v. T.R.C.* 494 S.E.2d 714 (Ga. Ct. App. 1997) (a Georgia response to a herpes outbreak); *In re* Stilinovich, 479 N.W.2d 731 (Minn. Ct. App. 1992) (a Minnesota response to an HIV-positive man's intent to spread the virus throughout the community).
63. *In re* Miguel M., 882 N.Y.S.2d 698, 704 (2d Dep't 2009).
64. See, e.g., *Keshecki v. St. Vincent's Med. Ctr.*, 785 N.Y.S.2d 300, 303 (Sup. Ct. Richmond County 2004) ("HIPAA contains a privacy rule which prevents protected health information . . . by identifiable *individuals* from being disclosed by 'covered entities' to others without written consent of the *individual* or the opportunity to formally object." (emphasis added)).
65. *Holzle v. Healthcare Serv. Grp., Inc.*, No. 110376, 2005 WL 1252597, at *3 (Sup. Ct. N.Y. County May 24, 2005).
66. See, e.g., Ilene N. Moore et. al., *Confidentiality and Privacy in Health Care from the Patient's Perspective: Does HIPAA Help?*, 17 HEALTH MATRIX 215, 217-18 (2007).
67. See, e.g., H.R. REP. NO. 104-736, at 270 (1996) (Conf. Rep.), reprinted in 1996 U.S.C.C.A.N 1865, 1893 ("[W]ith respect to the privacy of individually identifiable health information . . . [t]he conferees recognize that technological innovation with respect to electronic transmission of health-care related transactions is progressing rapidly in the marketplace. The conferees do not intend to stifle innovation in this area.").

Human Services developed “procedures to assure that the privacy of individuals receiving health care services” was “appropriately protected.”⁶⁸ Congress, therefore, incorporated into HIPAA numerous provisions mandating the privacy of individual health information.⁶⁹ Sections of the new law pertaining to patient privacy became known as the HIPAA Privacy Rule.⁷⁰ Among its ramifications, the Privacy Rule prohibits, at a minimum, the transfer of medical records by clinicians absent written consent from the patient.⁷¹

Congress understood that there would be situations when, in the health interests of the greater population, health care providers should be allowed to disclose private health information without the need to obtain authorization from a patient. Examples include reports of child abuse, investigations into Food and Drug Administration-regulated products, and workplace medical surveillance.⁷² Thus, Congress incorporated “non-authorization” exceptions into HIPAA to account for these circumstances.⁷³ If conditions trigger one of these exceptions, a health care provider is not required to seek a patient’s authorization prior to disclosure of health information.

Another non-authorization HIPAA exception is for “[use] and [disclosure] for public health activities.”⁷⁴ According to this exception, entities permitted to disclose protected health information without authorization include:

A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, *public health investigations*, and *public health interventions*; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority.⁷⁵

When it ruled that an AOT investigation qualified as a public health investigation, the court in *Miguel M.* effectively circumvented Congress’s explicit legislative intent to limit unauthorized disclosure to authorities acting on behalf of community health. In addition to its qualification argument, the Second Department held that even if HIPAA did not directly authorize disclosure, the federal statute did not preempt state law and, therefore, Miguel M.’s constitutional challenge under the Supremacy

68. *Id.* at 77.

69. *See, e.g.,* Paul N. Otto, *Reasonableness Meets Requirements: Regulating Security and Privacy in Software*, 59 DUKE L.J. 309, 325 (2009).

70. *Id.* at 325–26 (“The Privacy Rule begins by laying out a key guiding principle: the standard restricts uses or disclosures of ‘protected health information’ to what is expressly and explicitly authorized by the Privacy Rule.”).

71. *See Keshecki v. St. Vincent’s Med. Ctr.*, 785 N.Y.S.2d 300, 303 (Sup. Ct. N.Y. County 2004).

72. These exceptions are provided for in 45 C.F.R. §§ 164.512(b)(1)(ii)–(v) (2010).

73. *See* 45 C.F.R. § 164.512(b)(1)(i).

74. *Id.* § 164.512(b).

75. *Id.* § 164.512(b)(1)(i) (emphasis added).

Clause must fail.⁷⁶ Here again, the court used its novel public health interpretation to overcome Miguel M.'s valid argument. The U.S. Constitution provides that federal law "shall be the supreme Law of the Land,"⁷⁷ and "vests in Congress the power to supersede . . . State statutory or regulatory law . . ."⁷⁸ There are three ways in which federal law may preempt state law: (1) "express preemption," where Congress explicitly states its intent to preempt state law; (2) "field preemption," where federal legislation is so inclusive that it implies that Congress intended to fully govern the subject matter; or (3) "implied conflict preemption," where "conflicts between federal and state laws [exist] or when the state law acts as an obstacle to accomplishing Congress's purpose and objective in enacting the federal legislation."⁷⁹ *In re Miguel M.* involved a combination of the first and third forms of preemption.⁸⁰

The court began its federal preemption analysis by acknowledging that "preemption is a question of legislative intent."⁸¹ Nevertheless, the court did not adhere to congressional objectives. In fact, the court ignored Congress's legislative goals and sidestepped the constitutional challenge completely. Once again, the court's interpretation of public health played a crucial role in its decision. First, HIPAA explicitly preempts contrary state law. Under HIPAA's "General Rule" section, a HIPAA "standard, requirement, or implementation specification adopted under this subchapter that is contrary to a provision of State law preempts the provision of State law."⁸² However, Congress considered only *less* protective state privacy laws to be "contrary" to HIPAA: state laws that are "more stringent than a [HIPAA] standard, requirement, or implementation specification" are explicitly *not* preempted.⁸³ HIPAA thus acts as a "floor of federal privacy protections."⁸⁴ States can provide additional protections, according to Congress's intent, but they cannot provide fewer.⁸⁵ Because Kendra's Law privacy protections do not rise to the federal "floor," it is contrary to and expressly preempted by HIPAA.

Furthermore, Kendra's Law acts as an obstacle to HIPAA and triggers implied conflict preemption. Miguel M. did not dispute that Kendra's Law allowed disclosure

76. *In re Miguel M.*, 882 N.Y.S.2d 698, 705 (2d Dep't 2009).

77. U.S. CONST. art. VI, cl. 2 ("[The] Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.").

78. *Guice v. Charles Schwab & Co.*, 89 N.Y.2d 31, 39 (1996).

79. *Miguel M.*, 882 N.Y.S.2d at 705.

80. *Id.*

81. *Id.*

82. 45 C.F.R. § 160.203 (2002).

83. *Id.* § 160.203(b).

84. *Arons v. Jutkowitz*, 9 N.Y.3d 393, 414 (2007).

85. *See, e.g., Summary of the HIPAA Privacy Rule*, U.S. DEP'T OF HEALTH & HUMAN SERVS. 17 (2003), available at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>.

of medical records without authorization.⁸⁶ Rather, he argued that compliance with both HIPAA and Kendra's Law was impossible because the latter "authorizes the disclosure of a subject individual's clinical records without either a court order or the subject individual's authorization."⁸⁷ The state law, Miguel M. contended, thereby acted as an obstacle to federal legislation and should defer to HIPAA under implied conflict preemption.

The court negated these challenges by applying its misguided interpretation of public health to HIPAA's scope of preemption. HIPAA preemption includes an exception for circumstances where "[s]tate law . . . provides for the reporting of disease or injury, child abuse, birth or death, or for the conduct of *public health* surveillance, *investigation*, or *intervention*."⁸⁸ Thus, state laws that provide for this type of reporting are exempt from HIPAA's authorization requirements. According to the court, because the AOT hearing qualified as a public health investigation and intervention, the action fell under an exception, and HIPAA's scope of preemption did not apply. The court reasoned that HIPAA did not preempt Kendra's Law under express or implied conflict preemption and, as a result, Miguel M.'s constitutional challenge was moot. By ruling that an AOT investigation is a public health investigation, the court used HIPAA to defeat congressional intent and the federal law itself.

In both its qualification and its preemption arguments, the Second Department used an unprecedented interpretation of public health. While dictionary definitions and legal precedent emphasized the "organized," "systematic," and "community" nature of public health, the court viewed the term as including any activity that affects the safety of any individual member of the public. The court's overly broad definition allowed it to hold that a provision of outpatient care for a single individual by a private institution was the functional equivalent of community-based health programs for population-level care and surveillance. This is unprecedented in New York State case law as well as case law found in other jurisdictions. The court's interpretation also allowed it to circumvent what it recognized as the leading criterion supporting a constitutional Supremacy Clause challenge—congressional intent. Instead, the court should have applied the narrow "plain meaning" definition of public health used extensively in statutory and case law across the nation, and respected the privacy protections Congress intended under HIPAA.

Both of the court's arguments set standards that threaten to diminish many of the physician-patient privacy protections codified in the HIPAA Privacy Rule. *Miguel M.* may therefore have opened judicial doors for health care providers to argue around HIPAA's privacy goals by using a broadened meaning of public health exceptions. Future courts interpreting similar statutory public health qualifications should recognize the specific meaning of such language and the clear, narrow legislative intent behind it.

86. *Miguel M.*, 882 N.Y.S.2d at 701.

87. *Id.* at 705.

88. 45 C.F.R. § 160.203(c) (emphasis added).