



## MEMORANDUM

To: Hospital Executive Directors and Administrators, General Counsels, Chiefs of Emergency Medicine, Directors of Nursing – Emergency Services

From: Legal Action Center

Subject: Privacy Rights of Patients Treated for Overdose in Emergency Departments

Date: March 16, 2018

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### Overview

This memorandum provides guidance for hospital emergency department (“ED”) staff on how to notify patients’ family members after an overdose, while complying with the Health Insurance Portability and Privacy Act (“HIPAA”), the HIPAA Privacy Rule at 45 CFR Parts 160 and 164, and the federal law and regulations protecting the confidentiality of substance use disorder (“SUD”) treatment records, 42 U.S.C. § 290dd-2 and 42 CFR Part 2 (referred to collectively here as “Part 2”). This memorandum builds upon the recent guidance by the U.S. Department of Health and Human Services (“HHS”) clarifying the way that HIPAA and its regulations permit healthcare professionals to notify patients’ families after an overdose, even without patient consent.<sup>1</sup>

In the vast majority of cases, Part 2 does not apply to communications by ED staff to patients’ family members after an overdose, because the staff do not meet the definition of a “Part 2 program,” and the information is not otherwise protected by Part 2.<sup>2</sup> In these cases, ED staff need only comply with HIPAA<sup>3</sup> (and any applicable privacy protections in state law), not with Part 2, in determining when and how to notify families after an overdose.

Hospital EDs with specialized SUD services or providers, however, need to determine whether Part 2 applies and how to comply with that law, as well as HIPAA, when notifying patient’s family after an overdose in those situations where the specialized SUD providers participate in the provision of care. The advent of integrated care models and specialized SUD services in

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<sup>1</sup> U.S. DEP’T OF HEALTH & HUMAN SERVS., OFFICE FOR CIVIL RIGHTS, HOW HIPAA ALLOWS DOCTORS TO RESPOND TO THE OPIOID CRISIS (Oct. 27, 2017), <https://www.hhs.gov/sites/default/files/hipaa-opioid-crisis.pdf>.

<sup>2</sup> 42 CFR § 2.11. See discussion *infra*, Section I.

<sup>3</sup> State laws that provide greater privacy protections to patients supersede HIPAA, and therefore providers should be careful to comply with whichever applicable law is most protective of patient privacy. 45 CFR §§ 160.201-160.205.

hospital EDs brings more healthcare providers into contact with Part 2-protected information, which will require staff to be trained on how to comply with Part 2's privacy protections. In addition, two rounds of recent amendments to the Part 2 regulations in January 2017 and January 2018 may necessitate new training for providers who are only familiar with the previous version of the Part 2 regulations.<sup>4</sup>

This memorandum sets forth the analytic framework to determine when and how hospitals can make disclosures to patients' family while complying with healthcare providers' legal and ethical obligations.

- **Section I** describes when and how HIPAA allows disclosures to families in the event of an overdose.
- **Section II** identifies the key definitions and relevant factors to determine whether Part 2 applies to any portion of the ED patient's records.
- **Section III** explains how ED staff can notify patients' families after an overdose under HIPAA, and even if Part 2 applies, including in settings where:
  - The ED does not have any specialty SUD providers;
  - The ED has an SUD overdose team, embedded SUD services, or specialty SUD providers; or
  - A doctor from the ED accessed Part 2-protected information from an SUD clinic in order to address a medical emergency.
- **Section IV** explores ethical and practical considerations when disclosing a patient's substance use information to a family member, including in cases where such a communication is legally permissible.

## **I. Notifying Patient's Families after Overdose As Allowed by the HIPAA Privacy Rule**

The HIPAA Privacy Rule outlines the circumstances in which ED healthcare providers may share the health information of a patient experiencing a drug or alcohol overdose with family, close friends, or others involved with the patient's care or payment.<sup>5</sup> While HIPAA generally requires that a healthcare provider obtain the patient's authorization prior to disclosing HIPAA-protected information to a third party,<sup>6</sup> the Privacy Rule permits certain un-consented disclosures to a patient's family or close friends. Whether and when a treating provider may make such disclosures without consent depends on the nature of the disclosure, the nature of the family or friend's involvement in the patient's care, the patient's capacity to make healthcare decisions, and the healthcare provider's professional judgment about the patient's health and safety.<sup>7</sup>

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<sup>4</sup> Confidentiality of Substance Use Disorder Patient Records Final Rule, 82 Fed. Reg. 6052, 6053 (Jan. 18, 2017); Confidentiality of Substance Use Disorder Patient Records Final Rule, 83 Fed. Reg. 239 (Jan. 3, 2018).

<sup>5</sup> See 45 CFR § 160.103 (definitions of "covered entity," "protected health information"). See generally HOW HIPAA ALLOWS DOCTORS TO RESPOND TO THE OPIOID CRISIS, *supra* note 1.

<sup>6</sup> 45 CFR § 164.508.

<sup>7</sup> 45 CFR §§ 164.510, 164.512.

ED staff may disclose very limited information – the patient’s location, general condition, or death – to the patient’s family, personal representative, or a person involved in the patient’s care, without the patient’s authorization or consent.<sup>8</sup>

When disclosing additional health information, including the fact that the patient has experienced symptoms consistent with an overdose, a provider may share information with the patient’s family or close friend involved in the patient’s care, so long as it is *directly relevant* to the person’s involvement in the patient’s care.<sup>9</sup>

- **If the patient has the capacity to make health decisions**, and if the patient agrees – or does not object when given the opportunity – a healthcare provider may discuss the patient’s health with a family member or friend.<sup>10</sup> HIPAA also permits a healthcare provider to exercise her professional judgment and make a “reasonable infer[ence]” that the patient does not object to the disclosure.<sup>11</sup>
- **If the patient does not have capacity to make health decisions** – for example, an unconscious patient who arrives at the ED with signs that she is experiencing an overdose – a provider may share information about the patient with her family and close friends who are involved in her care, if the provider determines that doing so is in the *best interests* of the patient.<sup>12</sup>

Regardless of whether the patient has capacity, or whether the patient objects or agrees to the disclosure, HIPAA also permits providers to disclose information in certain circumstances in order to prevent or lessen a *serious or imminent threat to a patient’s health or safety*.<sup>13</sup> The official HIPAA guidance published recently clarified that in an overdose context:

A doctor whose patient has overdosed on opioids is presumed to have complied with HIPAA if the doctor informs family, friends, or caregivers of the opioid abuse after determining, based on the facts and circumstances, that the patient poses a serious and imminent threat to his or her health through continued opioid abuse upon discharge.<sup>14</sup>

HIPAA therefore offers both discretion and a presumption of compliance to providers who determine that the disclosure is necessary for the patient’s health or safety.

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<sup>8</sup> 45 CFR § 164.510(b)(1)(ii).

<sup>9</sup> 45 CFR § 164.510(b)(1)(i).

<sup>10</sup> 45 CFR § 164.510(b).

<sup>11</sup> 45 CFR § 164.510(b)(2)(iii).

<sup>12</sup> See 45 CFR §§ 164.510(b)(1)(i) and 164.510(b)(3). See also HOW HIPAA ALLOWS DOCTORS TO RESPOND TO THE OPIOID CRISIS, *supra* note 1.

<sup>13</sup> 45 CFR § 164.512(j)(1)(i).

<sup>14</sup> HOW HIPAA ALLOWS DOCTORS TO RESPOND TO THE OPIOID CRISIS, *supra* note 1.

## II. Determining Whether Part 2 Applies to ED Patient Records

Hospital emergency departments must also be aware of when Part 2, meaning the federal substance use disorder records confidentiality law and regulations, applies in addition to HIPAA. Part 2 protects any information – whether recorded or not – that identifies a patient’s SUD and is maintained by a “Part 2 program,” which may be an entity or an individual provider.<sup>15</sup> Protected information includes information created, received, or acquired by a Part 2 program relating to a patient with SUD.<sup>16</sup> Most emergency departments and their staff do not meet the definition of “Part 2 program,” and therefore their treatment records are not protected by Part 2, even if they are providing treatment to a patient experiencing an overdose. In this case, as described above in Section 1, staff are only legally bound to comply with the privacy protections in HIPAA, as well as any other state and federal laws that may apply. These staff should still consider, however, the ethical considerations discussed in **Section IV** of this memorandum.

In order to be considered a “Part 2 program,” an individual or entity must be (1) federally assisted<sup>17</sup> and (2) meet the definition of “program,” defined as:

- (1) An individual or entity (other than a general medical facility) who holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or
- (2) An identified unit within a general medical facility that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or
- (3) Medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers.<sup>18</sup>

First, hospitals should determine whether their EDs satisfy the definition of a Part 2 program. Although few, if any, EDs meet this definition because their staff provide general medical care and do not principally practice addiction medicine, such a scenario is possible. The key inquiry is

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<sup>15</sup> 42 CFR § 2.11 (definitions of “Part 2 program” and “records”); § 2.12(a), (e) (explanation of applicability).

<sup>16</sup> 42 CFR § 2.11 defines records as “any information, whether recorded or not, created by, received, or acquired by a part 2 program relating to a patient (*e.g.*, diagnosis, treatment and referral for treatment information, billing information, emails, voice mails, and texts). For the purpose of the regulations, in this part, records include both paper and electronic records.”

<sup>17</sup> 42 CFR § 2.12(b). Most hospitals meet the definition of “federally assisted,” by virtue of being a participating provider in the Medicare program, receiving federal funds, or receiving assistance from the Internal Revenue Service through the allowance of income tax deductions for contributions or through the granting of tax exempt status. The question of whether individual staff meet the definition of “Part 2 program,” including whether they meet the definition of “federally-assisted,” is discussed in greater detail below.

<sup>18</sup> 42 CFR § 2.11 (emphasis added).

whether the ED (i.e., an identified unit within a general medical facility<sup>19</sup>) provides SUD services<sup>20</sup> as its “principal practice” and advertises itself as such. Even though all EDs likely provide substance use treatment in the form of treating conditions resulting from overdoses, SAMHSA’s sub-regulatory guidance requires that, for the more stringent confidentiality requirements of Part 2 to apply, the SUD services must be considered a provider’s “principal” practice.<sup>21</sup> The guidance does not define what proportion or percentage of a provider’s work qualifies it to be considered the “principal” practice, which leaves some room for providers to determine for themselves whether their provision of SUD diagnosis, treatment, or referrals constitutes their “principal” practice.<sup>22</sup>

SAMHSA’s sub-regulatory guidance also offers several illustrative examples of what it means to “hold [oneself] out” as providing SUD services, including advertising, branding, and other activities that “would lead one to reasonably conclude” that the provider offers SUD diagnosis, treatment, or referral for treatment.<sup>23</sup> Note that even if the hospital advertises itself as providing SUD-specific treatment, or there is a dedicated SUD clinic within the hospital, the question is whether the ED *holds itself out as providing the SUD services*. In most if not all cases, the answer will be “no.”

Second, hospitals must determine whether any of the staff providing care to patients in the ED fall within the ambit of Part 2. Staff may be a Part 2 program in their individual capacities, or be subject to Part 2 by working in a dedicated Part 2 program (SUD unit) within the hospital and lending their services to the ED. As above, Part 2 does not apply to the clear majority of ED staff, except as discussed below.

Certain staff may meet the definition of a Part 2 program in their individual capacities; for example, a doctor whose “principal” practice involves diagnosing and treating SUD, and who holds herself out as providing these services, qualifies as a Part 2 program, if she or he also meets one of the definitions for “federally assisted.”<sup>24</sup> For example:

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<sup>19</sup> The term “general medical facility” includes most hospitals, according to sub-regulatory guidance published by SAMHSA. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., APPLYING THE SUBSTANCE ABUSE CONFIDENTIALITY REGULATIONS, <https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs> (last updated Sept. 15, 2017).

<sup>20</sup> The Part 2 definitions of diagnosis and treatment are broad, and are not limited to medical care: “Diagnosis means any reference to an individual’s substance use disorder or to a condition which is identified as having been caused by that substance use disorder which is made for the purpose of treatment or referral for treatment;” “Treatment means the care of a patient suffering from a substance use disorder, a condition which is identified as having been caused by the substance use disorder, or both, in order to reduce or eliminate the adverse effects upon the patient.” 42 CFR § 2.11. Both Part 2 and HIPAA consider treatment to include, for example, individual or group counseling.

<sup>21</sup> APPLYING THE SUBSTANCE ABUSE CONFIDENTIALITY REGULATIONS, *supra* note 19.

<sup>22</sup> *See id.*

<sup>23</sup> *Id.*

<sup>24</sup> 42 CFR § 2.12(b).

- The doctor is licensed by the Drug Enforcement Administration (“DEA”) to provide controlled substances for the treatment of SUD, such as methadone, benzodiazepines, or buprenorphine;<sup>25</sup>
- The doctor is a certified Medicare provider;<sup>26</sup> or
- The doctor receives federal funds in any form, even if the funds do not pay directly for the SUD services.<sup>27</sup>

If a doctor who is “federally assisted” as defined above and whose principal practice involves diagnosing and treating a patient suffering an overdose in the hospital’s ED, this doctor’s record of the treatment – including impressions and oral communications – would be protected by Part 2, and the doctor could only disclose information about the patient pursuant to the mechanisms discussed in **Section III**, below.

Staff employed by the hospital may also qualify as a Part 2 program if their “primary function” is to provide SUD diagnosis, treatment, or referral for treatment, and they are identified as providing these services.<sup>28</sup> Again, “primary function” is not defined by the regulations or the sub-regulatory guidance, leaving providers some discretion to determine for themselves if their “primary function” is providing SUD diagnosis, treatment, or referral for treatment, and whether they are identified this way. Staff who work in hospitals that meet the definition of “federally assisted” are also considered federally assisted for the purposes of the “Part 2 program” definition.<sup>29</sup> Staff may also be federally assisted in their own capacities, e.g., by being licensed by the DEA to provide controlled substances for SUD treatment.<sup>30</sup>

### **III. Overview of Permitted Communications of Substance Use Disorder Records**

This section outlines HIPAA’s and Part 2’s application to some common scenarios in the ED context. (A full discussion of the confidentiality of SUD treatment records, and permitted communications, is beyond the scope of this memorandum.)<sup>31</sup>

**EXAMPLE A: A patient arrived at the ED with symptoms of an overdose. The patient is currently unconscious. The patient’s doctor, who does not**

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<sup>25</sup> 42 CFR § 2.12(b)(2)(iii).

<sup>26</sup> 42 CFR § 2.12(b)(2)(i).

<sup>27</sup> 42 CFR § 2.12(b)(3)(i).

<sup>28</sup> 42 CFR § 2.11 (definition of “program,” paragraph (3)).

<sup>29</sup> 42 CFR § 2.12(b).

<sup>30</sup> 42 CFR § 2.12(b)(2).

<sup>31</sup> For additional information, including fact sheets, model forms, trainings, and information about the forthcoming edition of Legal Action Center’s book, CONFIDENTIALITY & COMMUNICATION, please visit our resources at <https://lac.org/resources/substance-use-resources/confidentiality-resources/>.

**meet the definition of a Part 2 program, wants to discuss the patient’s status with the patient’s family or a close friend.**

This disclosure is permitted. HIPAA allows the doctor to share the patient’s information, and Part 2 does not apply.<sup>32</sup> HIPAA permits disclosures about incapacitated or unconscious patients to their family or friends, so long as it is relevant to the patient’s care,<sup>33</sup> and the patient’s treatment information is not protected by Part 2 because the patient was not treated by a Part 2 program.

**EXAMPLE B: A patient arrived at the ED with symptoms of an overdose. The patient is currently unconscious. The patient was evaluated by a general ED provider. The patient’s doctor, who is not a Part 2 program, wants to discuss the patient’s treatment with the hospital’s specialty SUD overdose team.**

Part 2 permits communication between the doctor and the specialty SUD overdose team if the communication is necessary to address a medical emergency and the patient’s prior informed consent could not be obtained.<sup>34</sup> Section 2.51 permits a Part 2 program – such as the overdose team – to make a disclosure to medical personnel in the event of a “*bona fide*” medical emergency, so long as the Part 2 program documents the communication in the patient’s health record. The 2017 amendments to the Part 2 regulations allowed providers to have additional discretion to determine when a medical emergency exists.<sup>35</sup> Providers may not, however, “automate” the determination of a medical emergency through their electronic health information systems; the electronic system may only be programmed to flag relevant information to be used by personnel in deciding if there is a medical emergency.<sup>36</sup> This communication is also permitted under HIPAA without the patient’s written consent, as a disclosure of information for the purposes of providing treatment.<sup>37</sup>

Note that Part 2 does not apply to the communications by the doctor to the specialty SUD overdose team since the doctor is not covered by Part 2. Thus, the doctor can disclose information about the patient even in the absence of a medical emergency – subject, of course, to

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<sup>32</sup> Note, however, that state privacy laws may apply.

<sup>33</sup> See 45 CFR §§ 164.510(b)(1)(i), 164.510(b)(3); see also HOW HIPAA ALLOWS DOCTORS TO RESPOND TO THE OPIOID CRISIS, *supra* note 1.

<sup>34</sup> 42 CFR § 2.51.

<sup>35</sup> Previously, the regulations permitted Part 2 programs to disclose protected information “for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.” Confidentiality of Alcohol and Drug Abuse Patient Records, 52 Fed. Reg. 21795, 21811 (June 9, 1987). In the preamble to the January 2017 Final Rule, SAMHSA indicated that it replaced the specific definition with the term “*bona fide*” medical emergency “to give providers more discretion.” 82 Fed. Reg. at 6054.

<sup>36</sup> 82 Fed. Reg. at 6095.

<sup>37</sup> 45 CFR § 164.506.

other applicable laws and ethical considerations, discussed in greater detail in **Section IV** of this memorandum.

**EXAMPLE C: A patient arrived at the ED with symptoms of an overdose and is currently unconscious. The patient was treated by a specialty SUD overdose team that meets the definition of Part 2 program. The patient was then transferred to the intensive care unit (“ICU”) and attended by the ICU staff.**

**The patient’s ICU doctor, who is not a Part 2 program and does not work in the specialty SUD overdose team, wants to discuss the patient’s status with the patient’s family or close friend.**

Part 2 does not apply to the ICU doctor’s communications with the patient’s family, and HIPAA allows this disclosure as discussed above in Example A. However, when communicating with the patient’s family or close friend, the ICU doctor may not re-disclose information that the doctor received from the specialty SUD overdose team that identifies the patient as being diagnosed, treated, or referred for SUD treatment, without first obtaining the patient’s written consent.

Since Part 2 does not apply to the ICU doctor’s communications about the patient’s current status in the hospital’s ICU or her prognosis, the ICU doctor may discuss all of that information with the patient’s family or close friend as HIPAA permits. Part 2 protects, however, the information about the specialty SUD overdose team’s treatment.<sup>38</sup> While Section 2.51 permits medical personnel to disclose protected SUD information in order to respond to a medical emergency, this only permits the disclosure of the information from the specialty SUD overdose team (the Part 2 program) to the ICU doctor; it does not permit the re-disclosure of the information from the ICU doctor to the patient’s family or friends without the written consent of the patient.<sup>39</sup>

The ICU doctor should check to see if the patient has a valid written authorization for disclosure on file at the hospital. If the patient has visited the hospital before, there may already be a consent permitting the hospital to disclose SUD-related information to certain designated family members or caregivers.<sup>40</sup>

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<sup>38</sup> An illustrative example would be a situation where the ICU doctor tells the patient’s family or close friend that the patient is being treated in the ICU for heart failure. The ICU doctor could not reveal that the heart failure was the result of a drug or alcohol overdose without the patient’s prior consent.

<sup>39</sup> 42 CFR § 2.51.

<sup>40</sup> 42 CFR § 2.31 (consent requirements). Note that the requirements for the “to whom” section of written consents are generally much stricter than the “from whom” section. *Compare* § 2.31(a)(2) *with* § 2.31(a)(4). When designating the party authorized to *make* the disclosure of Part 2-protected information, the patient may list the name of the hospital, or even a general designation like “my emergency treatment providers.” § 2.31(a)(2).



**EXAMPLE D: A hospital’s on-site SUD clinic (a Part 2 program) transferred a patient to the ED after she showed signs of an overdose. The patient is conscious and objects to the SUD clinic disclosing any information to the ED. The patient is treated by a doctor in the ED, who is not a Part 2 program. Can the doctor access the on-site SUD clinic records?**

It depends. While Part 2 permits medical personnel to “break the glass” and access patients’ Part 2-protected information in emergency scenarios, there are two elements that must be satisfied: (1) the doctor must determine that in her or his medical opinion, a *bona fide* medical emergency exists for which she or he needs Part 2-protected information; and (2) the Part 2 program was not able to obtain the patient’s prior informed consent.<sup>41</sup> Here, even if the doctor has determined a *bona fide* medical emergency exists, the patient has refused to consent. It will be a matter of state law and clinical judgement to determine whether the patient was legally competent to refuse to consent to the disclosure.<sup>42</sup> If the patient is not legally competent under state law at the time of refusing to consent to the disclosure, the on-site SUD clinic (Part 2 program) may disclose information to the doctor in order to meet the *bona fide* medical emergency since the patient’s prior informed consent could not be obtained.<sup>43</sup>

The patient’s doctor should also talk to the patient to convey the importance of disclosing her or his SUD treatment information from the on-site SUD clinic team to other health providers to provide the best care for the patient’s condition. See additional discussion in **Section IV**, below.

#### **IV. Ethical and Practical Considerations**

Patient-doctor confidentiality is the cornerstone of the treatment relationship, and federal law’s heightened privacy protections for SUD treatment reflect the importance of confidentiality to SUD treatment. Clinically, SUD is a chronic disease, like hypertension or diabetes. Unlike other chronic diseases, however, SUD is unique due to the criminalization of many behaviors associated with the illness, and the widespread stigma and discrimination against people living with SUD (including people in recovery). Clinicians must remain aware that disclosing patients’ substance use to a family member or others without the applicable confidentiality safeguards may have grave consequences for the patients’ well-being, including their criminal and civil legal rights.<sup>44</sup>

Neither HIPAA nor Part 2 *mandate* disclosures of a patient’s substance use history to a patient’s family member. As discussed above, most clinicians treating patients with overdoses in the ED

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<sup>41</sup> 42 CFR § 2.51; *see* 82 Fed. Reg. at 6095.

<sup>42</sup> *Id.*

<sup>43</sup> *See* 82 Fed. Reg. at 6094.

<sup>44</sup> Karla Lopez & Deborah Reid, *Discrimination Against Patients with Substance Use Disorders Remains Prevalent and Harmful: The Case for 42 CFR Part 2*, HEALTH AFFAIRS: BLOG (Apr. 13, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170413.059618/full/>.

setting will not be bound by Part 2, but the confidentiality concerns reflected in Part 2 should still be applied to a clinician's decision about whether and how to share a patient's substance use history with family members and others.

HIPAA also requires any disclosure to comply with other applicable standards, including ethical standards.<sup>45</sup> When determining whether and how to inform a patient's family, close friend, or caretaker about the patient's substance use, a clinician should consider the following factors:

- **Is it feasible to discuss the potential disclosure first with the patient?**
  - The patient may readily consent to the doctor discussing her or his substance use with a sibling, but not with an estranged spouse, for example. Discussing the importance of the disclosure may also serve the overall treatment goals and open an opportunity to discuss treatment options for an underlying SUD.
- **If it is *not feasible* to discuss the potential disclosure with the patient before making the disclosure:**
  - Who is the most appropriate party to whom the disclosure should be made?
  - If there are multiple people in the room, is it possible to speak to the identified confidant in private to make the disclosure, rather than informing the entire group?
  - What is the minimum amount of information necessary to adequately inform the patient's family or caretaker while also protecting the patient's confidentiality to the greatest extent possible?

Many clinicians may automatically consider some or all of these factors. Some providers, however, may be unaware of the rationale for treating SUD information differently from other types of health information. Health providers may be unaware of the multitude of negative consequences that can stem from the unauthorized disclosure of a patient's substance use history, especially for patients on probation, parole, or otherwise involved with the criminal justice system. Alternatively, health providers may be familiar with the criminal justice consequences, but unaware of the numerous other risks posed by unauthorized disclosures of a patient's SUD treatment records, such as the loss of child custody, employment, and housing, or the threat of using a patient's SUD treatment records against them in civil litigation.<sup>46</sup> This lack of awareness, in turn, may be exacerbated by continuing stigma and discrimination against patients with SUD in healthcare settings.<sup>47</sup>

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<sup>45</sup> See 45 CFR § 164.512(j)(1); see also HOW HIPAA ALLOWS DOCTORS TO RESPOND TO THE OPIOID CRISIS, *supra* note 1.

<sup>46</sup> Karla Lopez & Deborah Reid, *supra* note 34.

<sup>47</sup> See, e.g., NAT'L ACADS. OF SCI., ENGINEERING & MED., ENDING DISCRIMINATION AGAINST PEOPLE WITH MENTAL AND SUBSTANCE USE DISORDERS: THE EVIDENCE FOR STIGMA CHANGE 37 (2016), <http://nap.edu/23442>;

## **Conclusion**

In the vast majority of cases, both HIPAA and Part 2 permit ED healthcare providers to notify a patient's family, close friends, and others involved in the patient's care after the patient experiences a drug or alcohol overdose, even if the patient is unable or unwilling to authorize the disclosure. Part 2 does not apply to records in most hospital EDs, and HIPAA permits disclosures to family in the event the patient is incapable of consenting or in order to prevent a threat to the patient's safety. EDs in hospitals with specialized SUD service providers that meet the definition of a "Part 2 program," whether individually or as an embedded entity within the ED, should train staff to recognize and avoid disclosing Part 2-protected information without patient consent when sharing information about the patient's status with the patient's family or friends. Finally, prior to making a legally permissible disclosure, healthcare providers should also ask themselves whether the disclosure is consistent with applicable ethical standards, especially in light of the devastating consequences associated with inappropriate disclosures of a patient's substance use information.

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Colleen L. Barry et al., *Stigma, Discrimination, Treatment Effectiveness, and Policy: Public Views About Drug Addiction and Mental Illness*, 65 PSYCHIATRIC SERVS. 1269 (Oct. 2014), <https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201400140>; Leonieke C. van Boekel et al., *Stigma among Health Professionals towards Patients with Substance Use Disorders and Its Consequences for Healthcare Delivery: Systematic Review*, 131 DRUG & ALCOHOL DEPENDENCE 23-35 (2013), [http://www.drugandalcoholdependence.com/article/S0376-8716\(13\)00067-7/fulltext](http://www.drugandalcoholdependence.com/article/S0376-8716(13)00067-7/fulltext).