Ethical Record Retrieval

Presented by

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Outline

- Ethics
- HIPAA & Privacy
- Gathering Evidence, the Deposition Officer
- Government Records
- Sister-State Subpoena Power
- Road Blocks & Challenges
- You Want Us to Do What?
Rule 1.6 (a) Confidential Information of a Client

(a) A lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or the disclosure is permitted by paragraph (b).
Ethics are moral principles and obligations.

Laws are an enforced rules of conduct.

Laws are a codifying of ethics with penalties.

In the past personal information was not always protected even though it was ethical to do so.

As a result, laws were written to provide protection for the individual and punishment for the offenders.
Sensitive personally identifiable information (PII) is personally identifiable information, which if lost, compromised, or disclosed without authorization, could result in substantial harm, embarrassment, inconvenience, or unfairness to an individual. Personal and medical record retrieval laws are federal, including HIPAA, and state.

- HIPAA uses the term Protected Health Information (PHI) to refer to protected data, but the concept is very similar to the term Personally Identifiable Information (PII), which is used in other compliance regimes.
Ethics

- PII includes data such as a Social Security number, driver's license number, financial accounts, email addresses, login credentials and passwords, addresses, phone numbers and birth date.

- PII is almost always included in every type of record, for instance: medical, educational, financial and employment information.

- Attorneys have the responsibility to protect these records once they are in their possession pursuant to Rule 1.6 (a) Confidential Information of a Client.
California's new data privacy law, the **California Consumer Privacy Act (CCPA)** was unanimously passed with new guidelines that any firm doing business with California consumers and companies must comply. The law went into effect in 2020. If a company is found noncompliant, they could be fined anywhere between $100 - $750 in damages **per exposed individual**.
There are many different types of medical records. Some have more legal protection than others.

- Standard Doctor Visit Records
- Hospital
- Clinic Records
- Physical Therapist
- Substance Abuse
- Psychological
- HIV/AIDS
Records concerning substance abuse, psychological, genetic, sexually-transmitted disease and HIV/AIDS information have more legal protection because of the social stigma that may attach to them.

Most facilities will only release these records with a special patient-signed authorization that specifically authorizes the release of these records.

A subpoena may be used ONLY when plaintiff has raised the issue and the claim of injury is related to drug, alcohol, psych/stress, genetic, sexually-transmitted disease or HIV/AIDS.
Privileged or Not?

California Evidence Code §912(a): The right of any person to claim a privilege provided by §954 (lawyer-client privilege), §966 (lawyer referral service-client privilege), …. §994 (physician-patient privilege), §1014 (psychotherapist-patient privilege), ……… is waived with respect to a communication protected by the privilege if any holder of the privilege, without coercion, has disclosed a significant part of the communication or has consented to disclosure made by anyone.
Rule 1.6 (a) Confidential Information of a Client

HIPAA
The HIPAA Privacy Rule 45 CFR § 164.501 et seq., regulates the release of PHI information held by hospitals, health plans and associates, which the HIPAA law designates as covered entities.

The privacy rule requires that PHI records cannot be released unless:

A HIPAA-compliant authorization, signed by the patient or assignee, with sufficient information to identify the specific patient and the exact wording and permissions is presented to the covered entity.
Requirements for a HIPAA Compliant Authorization:

- Identify the information to be disclosed,
- The name of the facility that is the custodian of the patient’s records,
- The name of the entity that is entitled to receive the records and their agent,
- The purpose of the disclosure,
- A statement informing the patient of the right to revoke, the procedure to revoke and any exceptions to that right,
- The date on which the authorization will expire or the occurrence upon which it will expire,
- The signature of the patient and the date the patient signed.
- You must use HIPAA compliant authorizations to obtain medical records.
- You must protect the information you receive.
- HIPAA does not apply to lawful subpoenas.
- The Macro-Pro authorization is HIPAA compliant.
HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

1. I hereby authorize:

2. To disclose to:
   Name of Requesting Party (Requestor): Insurance Carrier/Third Party Administrator/Self-Insured Employer/Attorney Firm
   and/or their attorneys, through Macro-Pro their agent, to review, inspect, and/or photocopy any and all of the following from any and all dates which are in your possession or control:

   - Medical records, to include but not limited to: Medical files, reports, charts, graphs, notes, tests, x-rays, MRI’s, billings and laboratory reports.
   - Employment and/or Union records to include but not limited to: Personnel file, medical and insurance, pension benefit records and wage records.
   - EDD Disability and Unemployment Records
   - Police, Prison or Probation Records
   - Scholastic Records
   - Insurance and Claim Records
   - Pharmacy Records

3. SENSITIVE INFORMATION: By initialing below, I hereby authorize the release of information concerning:

   - Initial

   - Psychiatric and Mental Health Information
   - HIV and/or AIDS Information
   - Alcohol and/or Drug Information
   - Genetic Records
   - Sexually Transmitted Disease Information

4. The health information authorized on this form will be used for the following purposes only:

   - Discovery for a Liability or Workers’ Compensation claim.

5. DURATION: This authorization shall become effective immediately and shall remain in effect until ___________ or for ONE full year from date of signature.

6. REVOCATION: This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization. Written revocation is to be sent to those parties listed on line 1) and line 2) above.

7. PROHIBITION OF USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION: Except as required by state or federal laws, use of information released for other than the stated purpose or redisclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its redisclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

8. I understand that I have the right to receive a copy of this authorization. A copy of this authorization shall be considered as valid as the original.

Signature

Print Name

Date

If Signed by Other than Patient, Indicate Relationship

CA 14 Point Font
HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

1.) I hereby authorize:

Name of Facility with Records/Releasing Party

2.) To disclose to:

Name of Receiving Party (Recipient): Insurance Carrier/Third Party Administrator/Outside Employer/Attorney Firm

and/or their attorneys, through Macro-Pro their agent, to review, inspect, and/or photocopy any and all of the following from any and all dates which are in your possession or control.

Name of Patient (List Other Names Used) Date of Birth

- Medical records, to include but not limited to: Medical files, reports, charts, graphs, notes, tests, x-rays, MRIs, billings and laboratory reports.
- Employment and/or Union records to include but not limited to: Personnel file, medical and insurance, pension benefit records and wage records.
- EDD Disability and Unemployment Records
- Police, Prison or Probation Records

SENSITIVE INFORMATION: By initialing below, I hereby authorize the release of information concerning:

Initial Initial
- Psychiatric and Mental Health Information
- HIV and/or AIDS Information
- Alcohol and/or Drug Information
- Genetic Records
- Sexually Transmitted Disease Information

Initial Initial
Date Range of Records to be Released / / to

The health information authorized on this form will be used for the following purposes only:

- Discovery for a Liability or Workers' Compensation claim.

DURATION: This authorization shall become effective immediately and shall remain in effect until or for ONE full year from date of signature.

REVOCATION: This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the requester or others have acted in reliance upon this authorization. Written revocation is to be sent to those parties listed on line 1.) and line 2.) above.

PROHIBITION OF USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION: Except as required by state or federal laws, use of information released for other than the stated purpose or disclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its disclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

I understand that I have the right to receive a copy of this authorization.

A copy of this authorization shall be considered as valid as the original.

Signature Print Name Date
HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

1.) I hereby authorize: [Leave this BLANK]

2.) To disclose to:
   Name of Requesting Party (Requestor) Insurance Carrier/Third Party Administrator/Attorney For
   and/or their attorneys, through Macro-Pro their agent, to review, inspect, and/or photocopy any
   and all of the following from any and all dates which are in your possession or control:

Name of Patient [List Other Names Used] Date of Birth

- Medical records, to include but not limited to: Medical files, reports, charts, graphs, notes,
  tests, x-rays, MRI’s, billings and laboratory reports.
- Employment and/or Union records to include but not limited to: Personnel file, medical and
  insurance, pension benefit records and wage records.
- EDD Disability and Unemployment Records
- Police, Prison or Probation Records
- Scholastic Records
- Insurance and Claim Records
- Pharmacy Records

SENSITIVE INFORMATION: By initialing below, I hereby authorize the release of information
concerning:

- Psychiatric and Mental Health Information
- HIV and/or AIDS Information
- Alcohol and/or Drug Information
- Genetic Records
- Sexually Transmitted Disease Information

Initial Initial Initial

Date Range of Records to be Released / / to

The health information authorized on this form will be used for the following purposes only:

Discovery for a Liability or Workers' Compensation claim.

DURATION: This authorization shall become effective immediately and shall remain in effect
until or for ONE full year from date of signature.

REVOCATION: The authorization is subject to written revocation by the undersigned at any time
between now and the disclosure of information by the disclosing party. My written revocation will
be effective upon receipt but will not be effective to the extent that the requester or others have acted in
reliance upon this authorization. Written revocation is to be sent to those parties listed on line
1.) and line 2.) above.

PROHIBITION OF USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION. Except as
required by state or federal laws, use of information released for other than the stated purpose or
redisclosure or transfer of this information to any person or entity not named herein is prohibited. An
additional written authorization must be obtained for any proposed new use or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

I understand that I have the right to receive a copy of this authorization.

A copy of this authorization shall be considered as valid as the original.

Signature Print Name Date
HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

1.) I hereby authorize ________________________________ (Name of Facility with Records/Releasing Party)

2.) To disclose to: Kivo & Adami LLP

______________________________ (Name of Requesting Party/Requestor)

and/or their attorneys, through Macro-Pro their agent, to review, inspect, and/or photocopy any and all of the following from any and all dates which are in your possession or control:

Name: Jane Doe aka Jane Jackson, Janie Jackson, JJ Jackson
Date of Birth: 11/05/1965

- Medical records, to include but not limited to: Medical files, reports, charts, graphs, notes, tests, x-rays, M.R.I.s, billings and laboratory reports.
- Employment and/or Union records to include but not limited to: Personnel file, medical and insurance, pension benefit records and wage records.
- EDD Disability and Unemployment Records
- Police, Prison or Probation Records
- Scholastic Records
- Insurance and Claim Records
- Pharmacy Records
- Genetic Records

SENSITIVE INFORMATION: By initialing below, I hereby authorize the release of information concerning:

Psychiatric and Mental Health Information
HIV and/or AIDS Information
Alcohol and/or Drug Information
Genetic Records
Sexually Transmitted Disease Information

Initial: ____________________________ Initial: ____________________________

Date Range of Records to be Released: __________/________/________

The health information authorized on this form will be used for the following purposes only:

1. Discovery for a Liability or Workers’ Compensation claim.

DURATION: This authorization shall become effective immediately and shall remain in effect until __________ or for ONE full year from date of signature.

REVOCATION: This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the requester or others have acted in reliance upon this authorization. Written revocation is to be sent to those parties listed on line 1.) and line 2.) above.

PROHIBITION OF USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION: Except as required by state or federal laws, use of information released for other than the stated purpose or redisclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its redisclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

I understand that I have the right to receive a copy of this authorization. A copy of this authorization shall be considered as valid as the original.

Signature: ____________________________ Print Name: ____________________________ Date: ____________________________
HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

1.) I hereby authorize:

Name of Facility with Records Disclosing Party

2.) To disclose to:

Kivo & Adamie LLP

Name of Requesting Party/Requester: insurance Carrier/Third Party Administrator/Self-insured Employer/Attorney/Person

and/or their attorneys, through Macro-Pro their agent, to review, inspect, and/or photocopy any and all of the following from any and all dates which are in your possession or control:

Jane Doe aka Jane Jackson, Jamie Jackson, JJ Jackson 11/05/1965

Name of Patient (Last Other Names Used) Date of Birth

• Medical records, to include but not limited to: Medical files, reports, charts, graphs, notes, charts, x-rays, MRI's, billings and laboratory reports.

• Employment and/or Union records to include but not limited to: Personnel file, medical and insurance, pension benefit records and wage records.

• EDD Disability and Unemployment Records

• Police, Prison or Probation Records

Sensitive Information: By initialing below, I hereby authorize the release of information concerning:

- Psychiatric and Mental Health Information
- Alcohol and/or Drug Information
- Sexually Transmitted Disease Information
- HIV and/or AIDS Information
- Genetic Records

Date Range of Records to be Released ______/_____/_______ to ______/_____/_______

The health information authorized on this form will be used for the following purposes only: Discovery for a Liability or Workers’ Compensation claim.

Duration: This authorization shall become effective immediately and shall remain in effect until _____ or for one full year from date of signature.

Revocation: This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the requester or others have acted in reliance upon this authorization. Written revocation is to be sent to those parties listed on line 1.) and line 2.) above.

Prohibition of usage, Transfer or Redisclosure of Information: Except as required by state or federal laws, use of information released for other than the stated purpose or redisclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its redisclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

I understand that I have the right to receive a copy of this authorization. A copy of this authorization shall be considered as valid as the original.

Signature: __________________________________________________________________________

Print Name: _______________________________________________________________________

Date: _______________________________________________________________________________
HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

1.) I hereby authorize, Name of Family with Records/Releasing Party
2.) To disclose to: Kivo & Adamie LLP
Name of Releasing Party (Receivers), insurance Company/Third Party Administrator/GHSA Issuing Employment
and/or their attorneys, through Macro-Pro their agent, to review, inspect, and/or photocopy any
and all of the following from any and all dates which are in your possession or control.
Jane Doe aka Jane Jackson, Jamie Jackson, JJ Jackson 11 / 05 / 1965
Name of Patient (Last Other Names Used) Date of Birth

- Medical records, to include but not limited to: Medical files, reports, charts, graphs, notes,
tests, x-rays, MRI’s, billings and laboratory reports.
- Employment and/or Union records to include but not limited to: Personal file, medical and
insurance, pension benefit records and wage records.
- EDD Disability and Unemployment Records
- Police, Prison or Probation Records
- Scholastic Records
- Insurance and Claim Records
- Pharmacy Records

SENSITIVE INFORMATION: By initialing below, I hereby authorize the release of information
concerning:

Initial Initial
Psychiatric and Mental Health Information HIV and/or AIDS Information

Initial
Alcohol and/or Drug Information Genetic Records

Initial
Sexually Transmitted Disease Information

Date Range of Records to be Released 7 / 07 / 2010 to present

The health information authorized on this form will be used for the following purposes only:
Discovery for a Liability or Workers’ Compensation claim.

DURATION: This authorization shall become effective immediately and shall remain in effect
until 11 / 07 / 2023 or for ONE full year from date of signature.

REVOCATION: This authorization is subject to written revocation by the undersigned at any time
between now and the disclosure of information by the disclosing party. My written revocation will
be effective upon receipt but will not be effective to the extent that the requester or others have acted in
reliance upon this authorization. Written revocation is to be sent to those parties listed on line
1.) and line 2.) above.

PROHIBITION OF USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION: Except as
required by state or federal laws, use of information released for other than the stated purpose or
redisclosure or transfer of this information to any person or entity not named herein is prohibited. An
additional written authorization must be obtained for any proposed new use of the information or its
redisclosure or transfer of such information. Authorized information may be subject to redisclosure
by the recipient and no longer protected by the privacy regulations.

I understand that I have the right to receive a copy of this authorization.
A copy of this authorization shall be considered as valid as the original.

Signature Print Name Date
HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

1.) I hereby authorize, 
   Name of Authorizing Party

2.) To disclose to, 
   Kivo & Adamie LLP
   Name of Disclosing Party

   and/or their attorneys, through Macro-Pro their agent, to review, inspect, and/or photocopy any 
   and all of the following from any and all dates which are in your possession or control:

   Jane Doe aka Jane Jackson, Janie Jackson, JJ Jackson 11 / 05 / 1965
   Name of Patient (Last Other Names Used) Date of Birth

   • Medical records, to include but not limited to: Medical files, reports, charts, graphs, notes, 
     tests, x-rays, MRI's, billings and laboratory reports.
   • Employment and/or Union records to include but not limited to: Personnel file, medical and 
     Insurance, pension benefit records and wage records.
   • EDD Disability and Unemployment Records
   • Police, Prison or Probation Records
   • Scholastic Records
   • Insurance and Claim Records
   • Pharmacy Records

SENSITIVE INFORMATION: By initialing below, I hereby authorize the release of information 
   concerning:

   Psychiatric and Mental Health Information
   HIV and/or AIDS Information
   Alcohol and/or Drug Information
   Genetic Records
   Sexually Transmitted Disease Information

   Date Range of Records to be Released 7 / 7 / 2010 to present

The health information authorized on this form will be used for the following purposes only:
Discovery for a Liability or Workers' Compensation claim.

DURATION: This authorization shall become effective immediately and shall remain in effect 
   until 11 / 7 / 2028 or for ONE full year from date of signature.

REVOCATION: This authorization is subject to written revocation by the undersigned at any time 
   between now and the disclosure of information by the disclosing party. My written revocation will be 
   effective upon receipt but will not be effective to the extent that the requester or others have acted in 
   reliance upon this authorization. Written revocation is to be sent to those parties listed on line 
   1.) and line 2.) above.

PROHIBITON OF USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION: Except as 
   required by state or federal laws, use of information released for other than the stated purpose or 
   redisclosure or transfer of this information to any person or entity not named herein is prohibited. An 
   additional written authorization must be obtained for any proposed new use of the information or its 
   redisclosure or transfer of such information. Authorized information may be subject to redisclosure 
   by the recipient and no longer protected by the privacy regulations.

I understand that I have the right to receive a copy of this authorization. 
A copy of this authorization shall be considered as valid as the original.

Signature X 
Date 6/24/2020
Print Name 

HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

1.) I hereby authorize, Name of Facility with Records/Disclosing Party

2.) To disclose to, Kivo & Adamie LLP

Name of Requesting Party/Requester: Insurance Company/Third Party Administrator/All insured Employee/Attorney Firm

and/or their attorneys, through Macro-Pro their agent, to review, inspect, and/or photocopy any and all of the following from any and all dates which are in your possession or control.

Jane Doe aka Jane Jackson, Janie Jackson, JJ Jackson 11 / 05 / 1965

Name of Patient (Last Name) or Names Used Date of Birth

- Medical records, to include but not limited to: Medical files, reports, charts, graphs, notes, tests, x-rays, MRI’s, billings and laboratory reports.
- Employment and/or Union records to include but not limited to: Personnel file, medical and insurance, pension benefit records and wage records.
- EDD Disability and Unemployment Records
- Police, Prison or Probation Records
- Scholastic Records
- Insurance and Claim Records
- Pharmacy Records

SENSITIVE INFORMATION: By initialing below, I hereby authorize the release of information concerning:

- Psychiatric and Mental Health Information
- Alcohol and/or Drug Information
- HIV and/or AIDS Information
- Sexually Transmitted Disease Information
- Genetic Records

Initial Initial

Date Range of Records to be Released 7 / 7 / 2010 to present

The health information authorized on this form will be used for the following purposes only:

Discovery for a Liability or Workers’ Compensation claim.

DURATION: This authorization shall become effective immediately and shall remain in effect until 11 / 7 / 2023 or for ONE full year from date of signature.

REVOCATION: This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the requesters or others have acted in reliance upon this authorization. Written revocation is to be sent to those parties listed on line 1.) and line 2.) above.

PROHIBITION OF USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION: Except as required by state or federal laws, use of information released for other than the stated purpose or redisclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its redisclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

I understand that I have the right to receive a copy of this authorization.

A copy of this authorization shall be considered as valid as the original.

Jane Doe

Signature

Print Name

Date 8/24/2020

Hours
Gathering Evidence
The Deposition Officer

Rule 4.1 False Statements and Duty to Disclose
Rule 4.1 of the California Rules of Professional Conduct

In the course of representing a client a lawyer shall not knowingly:

(a) Make a false statement of material fact or law to a third person
(b) Fail to disclose a material fact to a third person . . .
Role of the Deposition Officer

The Deposition Officer must:

- Be a Neutral Third Party
- Have No Fiduciary Interest in the Proceedings
- Obtain the Records Efficiently and in a Timely Manner
- Ensure Code Requirement Compliance
- Memorialize, Retain and Distribute Records
- Support Discovery Efforts
Some exceptions allow attorneys to act as a Deposition Officer

“Shall not be financially interested in the action”

“Shall not act as an advocate before a jury which will hear testimony from a member except under specific circumstances” State Bar Rules of Professional Conduct
Role of the Subpoena Service as Deposition Officer

CCP 2020.420 Subpoena for Business Records

- Must be Professional Photocopier as defined in the Business and Professions Code 22450 - 22463
- Registered in the county of their main office location
- Be Bonded
- One member of management must be a Notary Public
- No Felony Conviction, Officers or Employees.
Role of the Subpoena Service as Deposition Officer

- Locates all the evidence and records available.
- Ensures all parties receive the identical records.
- Provides for timely service throughout the state and nationally.
- Has database of custodian requirements/preferences.
- Highly experienced with difficult custodians.
- Can advance fees or can issue checks for fees.
- Provides a secure, encrypted environment for data protection.
Role of the Subpoena Service as Deposition Officer

- Ensure all pertinent jurisdictional code requirements are followed
- Notice all parties properly

For the attorney:
- Be aware of upcoming dates including depositions, mediations, trial and communicate those to your service providers.
- Review your records to make certain you have received everything.
- Contact your service ASAP if you didn’t.
Obtain More Records

How do you word a request so you receive all relevant information?

- Be sure to include clear identifiable information for locating records including date of birth, SSN, policy and account numbers, etc.
- Some facilities have formal description requirements. The Subpoena Service can assist with wording.
- Be mindful that some records are not in the standard file and to ask for specific items as necessary, i.e. brain scan, fetal monitor strips, psychiatric records.
Obtain More Records

Avoid Common Errors

- Ask for the correct spelling of the name, Jr. or Sr.?
- Ask for AKA’s-Maiden name, nickname, previous married name.
- Provide an authorization for each facility or leave the name of the facility off the authorization.
- Make certain the Date of Expiration is NOT identical to the date signed.
- Be aware of upcoming dates, depositions, mediations, trial, and communicate those to your service providers.
- Review your records to make certain you have received everything. Contact your service ASAP if you didn’t.
Why did I Get a Certificate of No Records?

- Social Security Number does not match name or gender
- Multiple people are using the same Social Security Number
- No AKA is provided
- Old records are under a maiden name
- Current records under a married name
- The name is spelled incorrectly
- Auto Insurance - No Claim for medical filed
- Custodian doesn’t look for records or is in error
- The records are lost or destroyed . . .
Gathering Evidence

Government Records
Getting Records from the Federal Government

- The Federal Government does not honor a state subpoena.
- You must use an authorization to obtain records.
- The client must sign and date the authorization forms.
- Some federal agencies can take a year to produce records.
Government Healthcare

- Medicare Authorization - Patient gets their own records
- Medicare Beneficiary Authorization - *Act on behalf of the patient
- Medi-Cal Authorization - Patient gets own records
- Medi-Cal Authorization - *Act on behalf of the patient

*These authorizations used to obtain records for a case.
Social Security Records

- Social Security - Consent Form
  General and Medical, SSA-3288
- Social Security - Earnings & Benefits Detail, SSA-7050

Avoid any delays or having the request rejected:

All required fields must be completed, signed and dated.

Specify the type of records you are requesting. They will not honor “Any and All” or “Entire File”
Military Records

- Military Records - Request for Information Needed to Locate Medical Records - NA-13042

- Military Dependent - Medical Records

- Military Records - SF 180, Request Pertaining to Military Records, All Services and National Guard

- Naval Medical Center (Medical or Dental) - Form DD 2870 Rev.
Military Records

- Military Records - Request for Information Needed to Locate Medical Records - NA-13042

- Military Dependent - Medical Records

- Military Records - SF 180, Request Pertaining to Military Records, All Services and National Guard

- Naval Medical Center (Medical or Dental) - Form DD 2870 Rev.
Local Government Emergency Service Records

- Ambulance Companies
- Paramedics/EMTs
- Fire
- Police

Records are filed by the date and place of incident. Not by the individual’s information.

- It is extremely important to provide the following information: Date, Time, Place of Incident Address, Cross Streets or Freeway Exits
Gathering Evidence

Out-of-State Subpoena Power
Uniform Interstate Depositions and Discovery Act (UIDDA)

- Previously, a subpoena from one state was not valid to obtain records from another state.
- The Interstate Depositions and Discovery Act allows litigants to present to a court, located in the state where discoverable materials are sought, with a California subpoena.
- If all foreign state requirements are met, the court will issue their state subpoena for service.
- The terms of the issued subpoena must incorporate the same terms as the original subpoena and contain the contact information for all Counsel of record and any party not represented by counsel.
8 States have not enacted UIDDA:

- Connecticut
- Nebraska
- Massachusetts
- Missouri
- New Hampshire
- Oklahoma
- Texas
- Wyoming
- US Commonwealth
- Puerto Rico
Out of State Subpoena Power

**IF:**
- The entity being subpoenaed is located out-of-state, and
- The records are located out-of-state, but
- The entity is registered with the California Secretary of State as a foreign corporation, and
- The entity has designated an agent for service of process inside the State of California, and
- The entity performed the service or the incident occurred inside the State of California, and
- The entity is a party or named in the case.

**Then** the entity MUST honor a California subpoena for records.

However, often the entities refuse to honor the California subpoena. Then you resort to the UIDDA process. If the state has not adopted the UIDDA, you must hire an attorney in that state to obtain the records.
Road Blocks and Challenges

Rule 3.4 Fairness to Opposing Party and Counsel
Role of the Deposition Officer

Rule 3.4 Fairness to Opposing Party and Counsel

A lawyer shall not:
(a) unlawfully obstruct another party’s access to evidence, including a witness, or unlawfully alter, destroy or conceal a document . . . .
(b)(c) suppress or falsify evidence
An objection is designed to be used by a non-party to the case, usually the facility whose records are being subpoenaed.

But often the opposing counsel will send an objection letter to the facility telling them not to release records.

Most of the time the opposing counsel wants to limit the scope of the subpoena.

The attorneys confer and, if agreement is not obtained, the opposing counsel may file a Motion to Quash.
Motion to Quash

- All work to obtain records must cease if a Motion to Quash is filed with the court.
- Any Objection or Motion to Quash should be served on the attorney and the record retrieval company.
- If there is an Order to Quash or if the Objection is agreed upon by the attorneys, all records subject to the order or agreement obtained, but not yet distributed, must be destroyed by the record retrieval company.
Receiving Improper Records

Medical records must only be distributed to those authorized to receive them:

- The parties
- The attorneys
- Their agents
- The court
Receiving Improper Records

- The custodian is responsible for releasing only the records called for in the authorization or the subpoena.
- Sometimes the custodian inadvertently releases records which contain substance abuse, psychological, HIV/AIDS records or records which include the medical records of another person.
- Usually these records are discovered by the attorney or their staff as they go through the records page-by-page.
- When these records are discovered, all those in possession of the records should destroy them. This includes the record retrieval company.
Receiving Improper Records

Rule 4.4 Duties Concerning Inadvertently Transmitted Writings

a) Refrain from examining the writing any more than necessary
b) Promptly notify the sender
c) Return or destroy the records
You want us to do WHAT?

Rule 8.4 Misconduct
Maintaining the Integrity of the Profession
You want us to do WHAT?

- Want to delay notice to other parties.
- Want to issue a federal subpoena when a California subpoena wasn’t honored out-of-state.
- Want us to sign an authorization, change or write-in other information.
- Gave a case number when the case wasn’t litigated.
- Gave an incorrect address for the opposing party.
- Want to see the records before having them sent to the opposing party.
Rule 8.4 Misconduct - Maintaining the Integrity of the Profession

- It is professional misconduct for a lawyer to:
  
  (a) violate these rules or knowingly solicit another to violate these rules
  
  (b) commit a criminal act that reflects adversely on the lawyer’s honesty
  
  (c) engage in conduct involving dishonesty, fraud, deceit, or reckless or intentional misrepresentation;
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