Children's Advocacy Section PRMCLE Program
Webinar
May 26, 2020

12:00 PM – 1:00 PM

Welcome/Announcements and Introduction of Moderator
Lisa Giese – Children's Advocacy Chair

Program – GALs and Gathering Information from Third Parties

Speakers - Hon. Linda E. Davenport and Emily Rapp, MagnusonRapp Law LLC

Speakers' Bios – see attached

Presentation Summary
As part of their investigations, a guardian ad litem relies on third parties. The Honorable Judge Davenport and Attorney Emily Rapp will discuss investigations, when and how to perform discovery, filing motions, the impact of HIPPA, Illinois Mental Health and Disabilities Code, Federal Confidentiality Act and more.

Link to Evaluation

The evaluation must be completed in order to receive CLE credit.
https://www.surveymonkey.com/r/ChildAdCLE052620

Family Law CLE

June 16, 2020 - DCFS Investigations and Appeals, Missy Kuffel - Mulyk Laho Law, LLC

DCBA Events:

May 27, 2020 – Lawyers Lending a Hand/DuPage County Courthouse – Joint Drive-thru Food Drive

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Speaker Biographies

Emily Rapp is the founding partner of MagnusonRapp Law, a family law firm in Geneva, Illinois. Emily practices in Kane, DuPage and Kendall counties and additionally practices at the appellate court level.

Emily is a member of the Women & the Law committee for the Illinois State Bar Association and is the Treasurer/Secretary for the Kane County Bar Association. She has presented at Illinois State Bar Association, DuPage County Bar Association and Kane County Bar Association seminars speaking on topics relating to family law. In addition to her speaking engagements, Emily has authored legal articles including a chapter on the Parentage Act for Illinois Institute for Continuing Legal Education.

Judge Linda Davenport has been as Associate Judge at the 18th Judicial Circuit Court for 11 years. She was also a Family Law practitioner since 1979. Judge Davenport was the First Woman President of the DuPage County Bar Association in 1995/1996.

1

Guardian ad litem Rules

1. Illinois Supreme Court Rule 907
2. Section 506 of the Illinois Marriage and Dissolution of Marriage Act
3. Your local Rules (for DuPage, it's 15.14)

2

What can a Guardian ad litem do?

- Section 506 of IMDMA
  - "...The Guardian ad litem shall investigate the facts of the case and interview the child and the parties."
- DuPage County Local Rule 15.14
  - "The Guardian ad litem...may file subsequent pleadings as deemed appropriate."
  - "Guardian Ad Litem is authorized to conduct such discovery as necessary and proper to fulfill his or her appointed role."

3

Supreme Court Rule 907

- "The Guardian ad litem shall have the right to interview his or her client(s) without any limitation or impediment."
- "The trial court shall enter an order to allow access to the child and all relevant documents."
- "The Guardian ad litem shall also take whatever reasonable steps are necessary to obtain all information pertaining to issues affecting the child, including interviewing family members and others possessing special knowledge of the child's circumstances."

4

What about filing pleadings?

5

Supreme Court Rule 907(d)

- The child representative, attorney for the child or guardian ad litem shall take **whatever reasonable steps** are necessary to determine what services the family needs to address the custody or allocation of parental responsibilities dispute, make appropriate recommendations to the parties, and **seek appropriate relief in court**, if required, in order to serve the best interests of the child.

6

DuPage County Local Rule 15.14

- B. (4). The Guardian ad litem/Child Representative/Attorney for the Child appointed in this cause shall file his or her appearance on behalf of the minor children within seven (7) days of the entry of the appointment order and file any appropriate pleadings within twenty eight (28) days of the entry of the appointment order, and may **file subsequent pleadings as deemed appropriate.**

7

To file a motion or not

- Advocacy versus recommendations.
- What motions are permissible?

8

The nanny won't talk

- Issuing discovery is allowed.
- DuPage Local Rule: The Guardian ad litem is authorized to conduct such discovery as necessary and proper to fulfill his or her appointed role.

9

Issuing discovery to medical providers

- Per Illinois Supreme Court Rule 204(c), the discovery depositions of nonparty physicians being deposed in their professional capacity may be taken only with the agreement of the parties and the subsequent consent of the deponent or under a subpoena issued upon order of court.

10

Issues with medical providers

- Requiring a fee/charge to talk to GAL.
- Refuse to discuss patient, despite subpoena/waiver.
- Accidental disclosure.

11

Mental/physical health considerations

- Pursuant to Section 602.7, best interest factors includes (7) the mental and physical health of all individuals involved;

12

Mental/Physical Health

- What happens if a party refuses to discuss their health?
- What happens if the minor child (older than 12) refuses to sign a waiver?
- When is it necessary to speak with health care providers and/or review documents in an investigation?

13

HIPAA and Illinois Mental Health and Developmental Disabilities Confidentiality Act

HIPAA; 45 C.F.R. Part 164

- Restricts the disclosure of identifiable information by health care providers. (does not apply to the Guardian ad litem)

Illinois Mental Health and Developmental Disabilities Confidentiality Act; 740 ILCS 110

- Protects mental health records. (applies to the Guardian ad litem)

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HIPAA
45 C.F.R. Part 164

- Applies to health plans, health care clearinghouses, and to any health care provider who transmits health information.
- The rule protects "individually identifiable health information"
- A covered entity must obtain person's authorization for disclosure. Authorizations must be:
  - in plain language;
  - contain specific information regarding the information to be disclosed;
  - The person disclosing and receiving the information;
  - Expiration;
  - Right to revoke in writing, and other data.

15

Why is it important to consider HIPAA?

- Drafting your own waiver.
  - Proactively send a waiver vs. waiting for the doctor;
  - Control the expiration date.
- Accidental disclosure.
- Redisclosure

16

Illinois Mental Health and Developmental Disabilities Confidentiality Act 740 ILCS 110

- Do you need both parent's signatures on a waiver?
- No: IRMO: Kerman, 253 Ill. App. 3d 492 (2d Dist. 1993)

17

Illinois Mental Health and Developmental Disabilities Confidentiality Act 740 ILCS 110

Sec. 4. (a) The following person shall be entitled, upon request, to inspect and copy a recipient's record of any part thereof:

(5) An attorney or guardian ad litem who represents a minor 12 years of age or older in any judicial or administrative proceeding, provided that the court or administrative hearing officer has entered an order granting the attorney this right;

18

Judge Davenport:

- Have you ever had a GAL request an order in order to collect mental health information of a minor over the age of 12?

19

Disclosure: Illinois Mental Health and Developmental Disabilities Confidentiality Act

- To disclose mental health records, the consent must contain the following:
  - The person or agency to whom disclosure is to be made;
  - The purpose for which disclosure is to be made;
  - The nature of the information to be disclosed;
  - The right to inspect and copy the information to be disclosed;
  - The consequences of a refusal to consent, if any;
  - The calendar date on which the consent expires (if no date, the information may be released on the day the form is received);
  - The right to revoke the consent at any time.

20

Blanket Consent

- 740 ILCS 110/5(c): only information relevant to the purpose for which disclosure is sought may be disclosed. Blanket consent to the disclosure of unspecified information shall not be valid.

- What is blanket consent?
- MAK v. Rush, 198 Ill.2d 249 (2001)
- Wolin v. Dep't of Fin. & Prof'l Regulation, 2012 IL App (1st)112113

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How do I avoid blanket consent?

- Instead of using "any and all" use "only."
- Do not request "all information regarding treatment of…."
- Be specific. Are you requesting a therapist's notes? Drug testing/results? Discharge documents?

22

Redisclosure

- 740 ILCS 110/5(d): **No** person or agency to whom any information is disclosed under this Section may **redisclose** such information unless the person who consented to the disclosure **specifically** consent to such redisclosure.

23

Possible ramifications…

- Any person aggrieved by a violation of this Act may sue for damages, an injunction, or other appropriate relief.
- Any person who knowingly and willfully violates any provision of this Act is guilty of a Class A misdemeanor.

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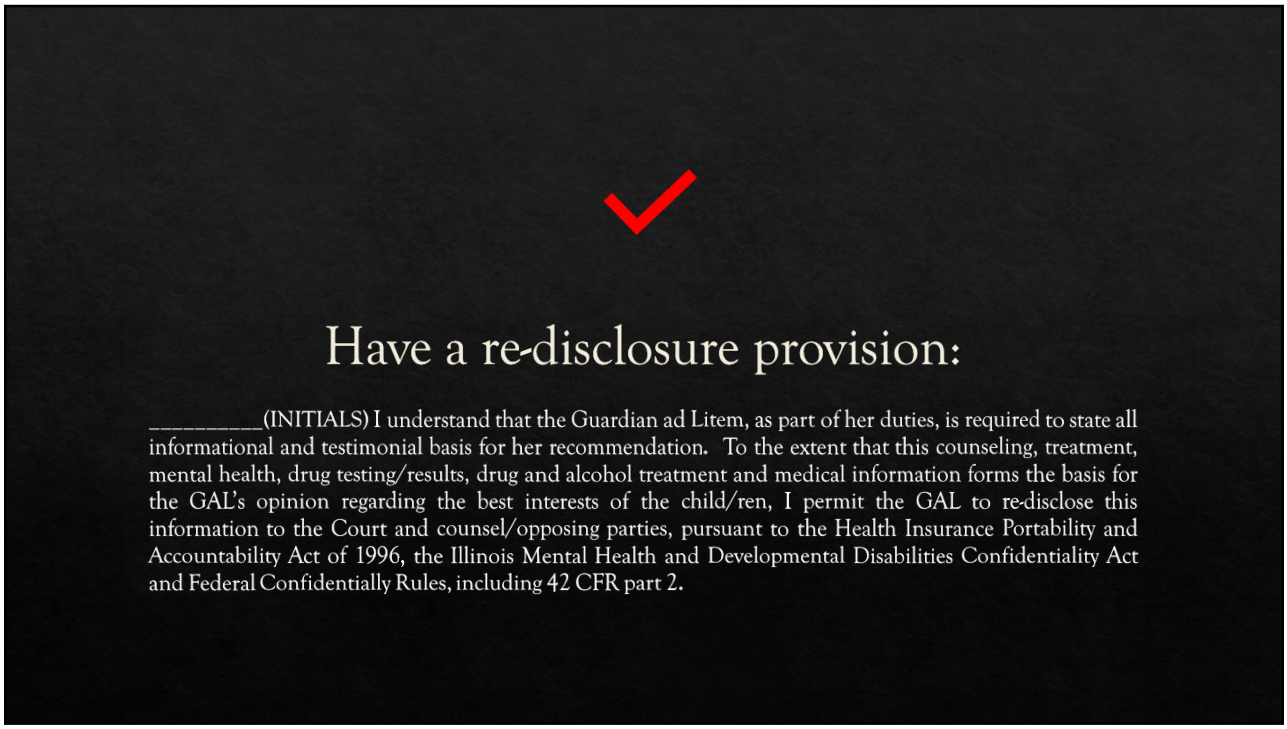

25

Can a party refuse to disclose their mental health information?

- 740 ILCS 110/10: Except as provided herein, in any civil … proceeding, a recipient…has the privilege to refuse to disclose and to prevent the disclosure of the recipient's record or communications.
  - Caveat: can be disclosed if the recipient introduces his or her mental health condition as an element of his or her claim or defense…

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Judge Davenport:

- Is the GAL's investigation considered "a civil proceeding" and is a party therefore able to deny a GAL's access to their mental health records?
- Can a court order a party to allow access (sign a release) to their mental health records?
- Does the fact that a GAL looks to all party's mental health (per the statute) open the door to the party's mental health?
- If a party refuses to turn over mental health records, is that given any weight by the Court?

27

Federal Confidentiality Act
42 C.F.R. Part 2

- This statute was enacted to protect patients who are undergoing substance abuse treatment programs.
- The Act contains certain requirements for disclosure of information by substance abuse treatment programs.

28

Illinois: Substance Use Disorder Act 20 ILCS 301/30-5

- (bb) Records of the identity, diagnosis, prognosis or treatment of any patient maintained in connection with the performance of any service or activity relating to substance use disorder education, early intervention, intervention, training, or treatment that is regulated, authorized, or directly or indirectly assisted by any Department or agency of this State or under any provision of this Act shall be confidential and may be disclosed **only in accordance with the provisions of federal law** and regulations concerning the confidentiality of substance use disorder patient records as contained in 42 U.S.C. Sections 290dd-2 and 42 C.F.R. Part 2, or any successor federal statute or regulation.

29

Who is covered under the Federal Confidentiality Act?

- "Programs" that fall under 42 CFR Part 2 must be federally assisted and hold itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment.
- Most drug and alcohol treatment programs are federally assisted.

30

"Federally Assisted" means:

1) Authorized, licensed, certified, or registered by the federal government; or
2) Receives federal funds in any form, even if the funds do not directly pay for the alcohol or drug abuse services; or
3) Is assisted by the IRS through a grant or tax-exempt status; or
4) Is authorized to conduct business by the federal government; or
5) Is conducted directly by the federal government.

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HIPAA and Federal Confidentiality Act

- Similar in that they apply to treatment providers.
- Federal Confidentiality Acts discusses redisclosure. HIPAA does not expressly prohibit redisclosure.
- Entities covered by both statutes should have their own waivers/release. If not, look at the waiver in your materials.

32

750 ILCS 5/607.6

- (a) The court may order individual counseling for the child, family counseling for one or more of the parties and the child, or parental education for one or more of the parties…
- (d) All counseling sessions shall be confidential. The communications in counseling shall not be used in any manner in litigation nor relied upon by any expert appointed by the court or retained by any party…

33

607.6 interpreted…

- A Cook County Judge interpreted this as excluding a 604.10(b) from being able to talk to therapists in the doctor's evaluation.
- Is a Guardian ad litem considered an "expert" under this Section?
- Can this Section be waived by the party/ies?

34

Conflicting language

The plain language of the statute directly conflicts with superior authority, namely, Supreme Court Rule 907

- (b) Every child representative, attorney for a minor child and guardian ad litem shall have the right to interview his or her client(s) **without any limitation or impediment.** Upon appointment of a child representative, attorney for the child or guardian ad litem, the trial court **shall enter an order to allow access to the child and all relevant documents.**
- AND - Pursuant to Section 602.7, best interests factors includes (7) the mental and physical health of all individuals involved;

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Cases..

No published cases that discuss 607.6.

However, the Courts have interpreted the GAL's role as expansive:

- IRMO: Collingbourne, 204 Ill.2d 498 (2003)
- IRMO: Karonis 296 Ill. App. 3d 86 (2d Dist. 1998)

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When is a 604.10(b) versus 215 appropriate?

- Section 604.10(b)
- Timeline of the case…
- Should GAL's continue to investigate while 604.10(b) is doing evaluation?
- Rule 215 evaluation
- Why 215 versus a 604.10(b)

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Any Questions?

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User Name: Emily Rapp
Date and Time: Thursday, May 7, 2020 10:57:00 AM CDT
Job Number: 116309765

Document (1)

1. *740 ILCS 110/5*

Client/Matter: -None-
Search Terms: 740 ILCS 110/5
Search Type: Natural Language
Narrowed by:

Content Type	Narrowed by
Statutes and Legislation	Content Type: Codes

740 ILCS 110/5 Disclosure; consent

(a) Except as provided in Sections 6 through 12.2 of this Act [*740 ILCS 110/6* through *740 ILCS 110/12.2*], records and communications may be disclosed to someone other than those persons listed in Section 4 [*740 ILCS 110/4*] of this Act only with the written consent of those persons who are entitled to inspect and copy a recipient's record pursuant to Section 4 [*740 ILCS 110/4*] of this Act.

(b) Every consent form shall be in writing and shall specify the following:

(1)the person or agency to whom disclosure is to be made;

(2)the purpose for which disclosure is to be made;

(3)the nature of the information to be disclosed;

(4)the right to inspect and copy the information to be disclosed;

(5)the consequences of a refusal to consent, if any; and

(6)the calendar date on which the consent expires, provided that if no calendar date is stated, information may be released only on the day the consent form is received by the therapist; and

(7)the right to revoke the consent at any time.

The consent form shall be signed by the person entitled to give consent and the signature shall be witnessed by a person who can attest to the identity of the person so entitled. A copy of the consent and a notation as to any action taken thereon shall be entered in the recipient's record. Any revocation of consent shall be in writing, signed by the person who gave the consent and the signature shall be witnessed by a person who can attest to the identity of the person so entitled. No written revocation of consent shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

(c) Only information relevant to the purpose for which disclosure is sought may be disclosed. Blanket consent to the disclosure of unspecified information shall not be valid. Advance consent may be valid only if the nature of the information to be disclosed is specified in detail and the duration of the consent is indicated. Consent may be revoked in writing at any time; any such revocation shall have no effect on disclosures made prior thereto.

(d) No person or agency to whom any information is disclosed under this Section may redisclose such information unless the person who consented to the disclosure specifically consents to such redisclosure.

(e) Except as otherwise provided in this Act, records and communications shall remain confidential after the death of a recipient and shall not be disclosed unless the recipient's representative, as defined in the Probate Act of 1975 [*755 ILCS 5/1-1* et seq.] and the therapist consent to such disclosure or unless disclosure is authorized by court order after in camera examination and upon good cause shown.

(f) Paragraphs (a) through (e) of this Section shall not apply to and shall not be construed to limit insurance companies writing Life, Accident or Health insurance as defined in Section 4 of the Illinois Insurance Code [*215 ILCS 5/4*] in obtaining general consents for the release to them or their designated representatives of any and all confidential communications and records kept by agencies, hospitals, therapists or record custodians, and

utilizing such information in connection with the underwriting of applications for coverage for such policies or contracts, or in connection with evaluating claims or liability under such policies or contracts, or coordinating benefits pursuant to policy or contract provisions.

History

P.A. 85-666; 85-971; *86-1417*; *90-655*, § 169.

Annotations

Notes

Editor's Notes

This section was Ill.Rev.Stat., Ch. 91 1/2, ¶ 805.

The Non-profit Health Care Service Plan Act, referred to in subsection (f) of this section, has been repealed.

Amendment Notes

The 1998 amendment by P.A. 90-655, effective July 30, 1998, added the section heading “Disclosure; consent.”; in subsection (f) deleted the phrase “, and Non-Profit Health Care Service Plan Corporations, writing Health Care Service contracts, under The Non-profit Health Care Service Plan Act,” following “the Illinois Insurance Code”.

CASE NOTES

Confidentiality

—Waiver

Disclosure

—In General

Legislative Intent

Parental Consent

Required Information

Waiver

Confidentiality

—Waiver

A therapist did not waive the therapist-patient privilege of her patient by testifying, with her patient's consent at an administrative hearing against the former psychiatrist of her patient, even though she answered, with the patient's consent, questions during cross-examination concerning prior records received from patient's prior therapists. *Goldberg v. Davis, 215 Ill. App. 3d 930, 159 Ill. Dec. 213, 575 N.E.2d 1273, 1991 Ill. App. LEXIS 982 (Ill. App. Ct. 1st Dist. 1991)*, rev'd, *151 Ill. 2d 267, 176 Ill. Dec. 866, 602 N.E.2d 812, 1992 Ill. LEXIS 150 (Ill. 1992)*.

Disclosure

—In General

Although a report of proceedings or acceptable substitute indicating the exact facts presented to the trial court was lacking, the court ruled that if defendant obtained the information he disclosed through channels regulated by the Mental Health and Developmental Disabilities Confidentiality Act, then redisclosure would be regulated under this section of the act. *People v. Sechler, 262 Ill. App. 3d 226, 199 Ill. Dec. 929, 634 N.E.2d 1283, 1994 Ill. App. LEXIS 861 (Ill. App. Ct. 2d Dist. 1994)*.

Legislative Intent

Although the wording in subsection (d) of this section appears to have been imperfectly drafted, the legislature intended to proscribe redisclosure, regardless of whether consent to the initial disclosure had been given. *Johnson v. Lincoln Christian College, 150 Ill. App. 3d 733, 103 Ill. Dec. 842, 501 N.E.2d 1380, 1986 Ill. App. LEXIS 3240 (Ill. App. Ct. 4th Dist. 1986)*.

Parental Consent

The trial court's interpretation of the Confidentiality Act to require the consent of both parents resulted in an abuse of its discretion in barring parts of therapist's testimony. *In re Marriage of Kerman, 253 Ill. App. 3d 492, 191 Ill. Dec. 682, 624 N.E.2d 870, 1993 Ill. App. LEXIS 1800 (Ill. App. Ct. 2d Dist. 1993)*.

Taken together, *740 ILCS 110/3(a)*, *740 ILCS 110/4(a)*, and subsection (a) of this section establish that the Mental Health and Developmental Disabilities Confidentiality Act does not require the consent of both parents. *In re Marriage of Kerman, 253 Ill. App. 3d 492, 191 Ill. Dec. 682, 624 N.E.2d 870, 1993 Ill. App. LEXIS 1800 (Ill. App. Ct. 2d Dist. 1993)*.

The plain meaning of the wording of this section and the intent of the legislature is to require the written consent of only one of the parents to disclose the records and communications of a child under 12 years old in custody proceedings. *In re Marriage of Markey, 223 Ill. App. 3d 1055, 166 Ill. Dec. 392, 586 N.E.2d 350, 1991 Ill. App. LEXIS 2086 (Ill. App. Ct. 1st Dist. 1991)*.

Required Information

Doctor involved in disciplinary proceedings for improperly treating a patient could not show that the record-release authorizations that the Department served on the doctor to disclose mental health records were invalid and, thus, was not entitled to relief from the indefinite suspension of the doctor's medical license. Such records could be

disclosed pursuant to the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, *740 ILCS 110/1* (Confidentiality Act), they could be disclosed to someone other than those persons permitted by *740 ILCS 110/4* with the written consent of persons allowed access pursuant to ***740 ILCS 110/5***, and the patient could authorize disclosure of the requested mental health records because the record request forms contained the necessary material for validly complied with the *Confidentiality Act. Wolin v. Dep't of Fin. & Prof'l Regulation, Ill. App. 3d , 367 Ill. Dec. 869, 983 N.E. 2d 23, 2012 Ill. App. LEXIS 1026 (1 Dist. 2012)*.*Wolin v. Dep't of Fin. & Prof'l Regulation, 2012 IL App (1st) 112113, 367 Ill. Dec. 869, 983 N.E.2d 23, 2012 Ill. App. LEXIS 1026 (Ill. App. Ct. 1st Dist. 2012)*.

A document the plaintiff signed which did not contain the information required by subsections (b)(4) through (b)(7), although referred to by the parties as consent, did not constitute written consent under the Mental Health and Developmental Disabilities Confidentiality Act. *Capocy v. Kirtadze, 183 F.3d 629, 1999 U.S. App. LEXIS 14845 (7th Cir. Ill. 1999)*.

Waiver

Private coach was not entitled to a student's mental health records for purposes of his declaratory judgment action because any confidential information which may have been shared by the student with board of education officials as to the coach's disciplinary proceeding was released for a limited purpose and did not constitute a general waiver of the confidentiality privilege. *Thompson v. N.J., 2016 IL App (1st) 142918, 403 Ill. Dec. 297, 53 N.E.3d 351, 2016 Ill. App. LEXIS 249 (Ill. App. Ct. 1st Dist. 2016)*.

Father in a divorce case trying to prevent the mother from taking the couple's two minor children to a particular psychologist waived any objection to disclosure of communications privileged under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, *740 ILCS 110/1* et seq., by not objecting at the hearing where those communications were disclosed. While the disclosure of confidential communications was limited pursuant ***740 ILCS 110/5***, the father had a privilege to refuse to disclose and to prevent disclosure of the confidential communications based on *740 ILCS 110/10(a)*, yet waived that privilege by not objecting at the relevant hearing. *In re Marriage of Slomka, 397 Ill. App. 3d 137, 337 Ill. Dec. 178, 922 N.E.2d 36, 2009 Ill. App. LEXIS 1270 (Ill. App. Ct. 1st Dist. 2009)*.

By disclosure of psychiatrist's report as part of FELA proceedings, and by signing general release when settling his FELA suit, the plaintiff waived the protections of the Mental Health and Developmental Disabilities Confidentiality Act with regard to his claim of right to privacy. *Capocy v. Kirtadze, 183 F.3d 629, 1999 U.S. App. LEXIS 14845 (7th Cir. Ill. 1999)*.

Research References & Practice Aids

Research References and Practice Aids

LEGAL PERIODICALS

For comment, "What Constitutes an Invalid 'Blanket Consent' Within the Purview of Illinois' Mental Health and Developmental Disabilities Confidentiality Act?," see *22 N. Ill. U. L. Rev. 535 (2001)*.

Practice Guides and Treatises

Civil Trial Evidence (Illinois) § 7.23 In General (IICLE)

Civil Discovery Practice (Illinois) § 4.28 Mental Health and Alcohol Abuse Records (IICLE)

Practice Forms

Form 114 Consent to Disclosure of Mental Health Records, 3-AppForms Gitlin on Divorce (Forms)

End of Document

User Name: Emily Rapp
Date and Time: Saturday, November 16, 2019 12:17:00 PM CST
Job Number: 103073798

Document (1)

1. *COMMENT: What Constitutes an Invalid "Blanket Consent" Within the Purview of Illinois' Mental Health and Developmental Disabilities Confidentiality Act? , 22 N. Ill. U. L. Rev. 535*

Client/Matter: -None-
Search Terms: 740 ilcs 110/1
Search Type: Natural Language

COMMENT: What Constitutes an Invalid "Blanket Consent" Within the Purview of Illinois' Mental Health and Developmental Disabilities Confidentiality Act? [1]

Summer, 2002

Reporter
22 N. Ill. U. L. Rev. 535 *

Length: 12492 words

Author: Jana L. Fischer+

Text

[*535]

Introduction

Imagine a situation where a recipient [2] of mental health services authorizes her therapist [3] to release her mental health records for purposes of custody litigation. Unbeknownst to the recipient, within these records is her therapist's personal notes suggesting that she may suffer from schizophrenia. Certainly such a suggestion is potentially fatal in the context of a custody dispute. [4] An issue ripe for litigation concerns whether the aforementioned authorization constitutes an invalid "blanket consent" within the purview of Illinois' Mental Health and Developmental Disabilities Confidentiality Act ("Confidentiality Act"). [5]

Section 3 of the Confidentiality Act provides that all mental health and developmental disabilities treatment records and communications [6] shall be confidential and shall not be disclosed except under explicitly **[*536]** enumerated

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[1] *740 Ill. Comp. Stat. 110/1* (2000) [hereinafter Confidentiality Act].

[2] A "recipient" is defined under the Confidentiality Act as "a person who is receiving or has received mental health or developmental disabilities services." *740 Ill. Comp. Stat. 110/2* (2000).

[3] A "therapist" is defined under the Confidentiality Act as "a psychiatrist, physician, psychologist, social worker, or nurse providing mental health or developmental disabilities services or any other person not prohibited by law from providing such services or from holding himself out as a therapist if the recipient reasonably believes that such person is permitted to do so." Id.

[4] See, e.g., *In re Marriage of Scott, 394 N.E.2d 779, 782 (Ill. App. Ct. 1979)* (upholding the trial court's decision to modify custody on the ground that the mother exhibited a history of paranoid schizophrenia).

[5] *740 Ill. Comp. Stat. 110/1* (2000).

[6] Confidential communication" or "communication" is defined under the Confidentiality Act as "any communication made by a recipient or other person to a therapist or to or in the presence of other persons during or in connection with providing mental health or developmental disability services to a recipient . . . including information which indicates that a person is a recipient." *740 Ill. Comp. Stat. 110/2* (2000). "Record" is defined under the Confidentiality Act as "any record kept by a therapist or by an agency in the course of providing mental health or developmental disabilities service to a recipient concerning the recipient and the services provided." Id.

circumstances. [7] Absent circumstances giving rise to one of these enumerated exceptions, a valid authorization form must be obtained in order to preclude liability for the improper disclosure of mental health records. [8] Consistent with the Confidentiality Act's purpose of ensuring broad legal protection for the principle of confidentiality, [9] the legislature made it clear that there is more to ensuring the validity of an authorization form than merely obtaining a signature. [10] "Blanket consent to the disclosure of unspecified information shall not be valid." [11]

This comment argues that Illinois' Confidentiality Act inadequately defines "blanket consent" so as to ensure that an authorization for the disclosure of mental health records is obtained on an informed and consensual basis. This is especially so where a recipient's authorization results in the unintended release of information not thought to be contained in the records. The purpose of this Comment is to suggest that the Illinois legislature should look to the doctrine of informed consent in implementing an operational definition of "blanket consent" in order to make certain that the confidentiality and autonomy rights of recipients include the right to make well-informed decisions in authorizing the disclosure of their mental health records.

Part I of this comment introduces basic legal principles underlying the requirement of obtaining recipient authorization prior to the release of **[*537]** mental health records. [12] These principles provide a foundation for examining why the present language of the Confidentiality Act insufficiently protects the confidentiality and autonomy rights of recipients. [13]

Part II reviews the authorization form requirements of the Confidentiality Act and examines the meaning of the "blanket consent" language found therein. [14] In doing so, the "blanket consent" language is analyzed in light of the Illinois Supreme Court's recent interpretation of the authorization form requirements mandated by the federal Confidentiality of Alcohol and Drug Abuse Patient Records regulations [15] in M.A.K. v. Rush-Presbyterian-St. Luke's Medical Center. [16] Relevant to the purpose of this Comment concerns the following two propositions that the M.A.K. ruling supports: that an authorization form bearing a broad description of the information being disclosed is

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[7] *740 Ill. Comp. Stat. 110/3(a)* (2000) (imposing a legal obligation upon therapists to protect confidential information from unauthorized disclosure); *740 Ill. Comp. Stat. 110/6* to *12.2* (2000) (defining the circumstances where disclosure is permitted without recipient authorization).

[8] *740 Ill. Comp. Stat. 110/5* (2000) (providing for the consensual disclosure of records by a recipient authorization); *740 Ill. Comp. Stat. 110/15* (2000) (providing that a violation of the Confidentiality Act may give rise to a civil action for damages); *740 Ill. Comp. Stat. 110/16* (2000) (providing that one who knowingly and willfully violates the Confidentiality Act is guilty of a Class A misdemeanor); see also Peter H.W. van der Goes, Jr., Comment, Opportunity Lost: Why and How to Improve the HHS-Proposed Legislation Governing Law Enforcement Access to Medical Records, *147 U. Pa. L. Rev. 1009, 1045 (1999)* (outlining the following common law causes of action that may be available where confidential health information has inappropriately been disclosed: breach of fiduciary relationship, negligence, breach of implied term of contract, defamation, and invasion of privacy).

[9] See *740 Ill. Comp. Stat. 110/3(a)* (2000); see, e.g., *Norskog v. Pfiel, 755 N.E.2d 1, 18 (Ill. 2001)* ("It has been universally recognized that significant public and private interests are served by preserving the confidentiality of mental health records and communications. To that end, our legislature has enacted laws which place strict controls on the disclosure of mental health records and communications.").

[10] See *740 Ill. Comp. Stat. 110/5* (2000).

[11] Id. § 110/5(c).

[12] See infra Part I (discussing the importance of confidentiality in the context of mental healthcare and providing an overview of the proper and improper forms of disclosure of mental health records with a special emphasis on the concept of recipient authorization).

[13] See infra Part I.B.2 (explaining that the concept of recipient authorization stems from the confidentiality and autonomy rights of recipients).

permissible and that a valid authorization need only a recipient's consent, not informed consent. [17] Part II concludes that a similar interpretation of the Confidentiality Act would eviscerate the apparent objective underlying the "blanket consent" language, that being to prevent unfair surprise, and undermine the confidentiality and autonomy rights of recipients. [18]

Part III argues that the Illinois legislature should look to the doctrine of informed consent in implementing an operational definition of "blanket consent" so as to ensure that an authorization for the disclosure of mental health records is obtained on an informed and consensual basis. In **[*538]** developing this proposition, an overview of the doctrine of informed consent is initially provided. [19] Next, Part III defines the doctrine's applicability in the context of obtaining recipient authorization for the disclosure of mental health records. [20] Lastly, Part III places an informed consent requirement into the practical context of the mental healthcare industry and establishes that such a requirement would benefit both recipients and therapists in the long run. [21]

I. Basic Legal Principles Underlying the Requirement of Authorization

a. the importance of confidentiality

"As asepsis is to surgery, so is confidentiality to psychiatry." [22] Confidentiality refers to the principle of protecting against the disclosure of information given by an individual in the course of a professional relationship. [23] **[*539]**

The parameters of this principle in the context of a therapist-recipient relationship have long been defined by relevant professional codes of ethics governing each mental health profession. [24] Each of these ethical codes has memorialized the tenet that it is a therapist's primary obligation to protect and respect the confidentiality of the information entrusted to her by a recipient. [25] For example, the American Psychiatric Association explained:

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[14] *740 Ill. Comp. Stat. 110/5* (2000); see infra Part II.A.1-2 (discussing the mandatory format and content requirements for authorization forms and addressing the problems raised by the "blanket consent" language).

[15] *42 C.F.R. § 2.31(a)(1) (2000)*.

[16] *764 N.E.2d 1 (Ill. 2001);* see infra Part II.B-C (arguing that in the aftermath of the M.A.K. ruling, the "blanket consent" language will not likely preclude a reviewing court from sanctioning the release of confidential information based upon uninformed consent obtained through the use of broad authorization forms).

[17] See *M.A.K., 764 N.E.2d at 18-19* (Kilbride, J., dissenting) (disagreeing with the majority's decision to uphold the validity of an "impermissibly broad" authorization form obtained without the plaintiff's informed consent); see also infra Part II.BC (contrasting the opinions of the majority and Justices Freeman and Kilbride and further arguing that the traditional understanding that consent implies informed choice supports the position adopted by Justices Freeman and Kilbride).

[18] See infra Part II.C (discussing the implications of the M.A.K. ruling upon the "blanket consent" language of the Confidentiality Act).

[19] See infra Part III.A-B (providing an overview of the doctrine of informed consent in the context of obtaining consent for medical procedures and discussing the doctrine's present role in the mental healthcare industry relevant to the confidentiality concerns of this Comment).

[20] See infra Part III.C.1 (proposing an operational definition of "blanket consent" under the Confidentiality Act).

[21] See infra Part III.C.2 (arguing that the administrative burdens and costs that would be imposed upon therapists by an informed consent requirement would be minor in comparison to the benefits it will have upon the therapeutic process in the long run).

[22] Barbara A. Weiner, Provider-Patient Relations: Confidentiality and Liability, in The Mentally Disabled and the Law 559, 559 (Samuel Jan Brakel et al. eds., 3d ed. 1985) (quoting Citizens Privacy Protection Act: Hearings Before the Subcommittee on the Constitution of the Senate Committee on the Judiciary [on S. 3162 and S. 3164], 95th Cong., 2d Sess. 223, 255 (1978)

Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care . . . . Because of the sensitive and private nature of the information with which the psychiatrist deals, he must be circumspect in the information that he chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration. [26]

Of primary significance concerns the highly private and personal information shared by the recipient during treatment. [27]

As articulated by the United States Supreme Court in Jaffee v. Redmond, [28] confidentiality in the context of a therapistrecipient **[*540]** relationship is rooted in the interrelated principles of private and public policy interests. [29] In addressing the private interests advanced by confidentiality, the Jaffee Court recognized that confidentiality is essential not only to the treatment process itself, but also to the recipient's right of privacy:

Effective psychotherapy . . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment. [30]

According to survey data released by the California Health Care Foundation in January 1999, public distrust of the healthcare industry respecting confidentiality is pervasive. [31] Buttressing the observations of the Jaffee Court, [32] the Foundation's survey identified that this distrust has manifested in "privacy-protective" behavior, or the intentional withholding of information necessary for treatment so as to preclude the possibility of an embarrassing public disclosure. [33]

(testimony of Jerome S. Beigler, M.D., Chairman of the American Psychiatric Association, Committee on Confidentiality, Aug. 22, 1978) ("Just as a surgeon cannot operate unless he has optimum aseptic conditions without a potential for infection, similarly a psychiatrist cannot work unless he has the absolute confidentiality of the patient, because some of the things that a patient says are very personal and could not be disclosed unless he were assured of the confidentiality.")).

[23] See Emanuel Hayt, Medicolegal Aspects of Hospital Records 79 (2d ed. 1977).

[24] See Leland C. Swenson, Psychology and Law for the Helping Professions 59 (2d ed. 1997). See generally Hayt, supra note 23, at 79 ("Whatever, in connection with my professional practice or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.") (quoting the Hippocratic Oath).

[25] See American Psychiatric Ass'n, Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry § 4 (2001), available at http://www.psych.org/apamembers/medicalethics200142001.cfm (last visited Jan. 5, 2002) [hereinafter Am. Psychiatric Ass'n]; American Psychological Ass'n, Ethical Principles of Psychologists and Code of Conduct Standard 5 (1992), available at http://www.apa.org/ethics/code.html (last visited Jan. 4, 2002) [hereinafter Am. Psychological Ass'n]; National Ass'n of Social Workers, Code of Ethics Standard 1.07 (Rev. 1999) available at http://www.socialworkers.org/pubs/Code/code.htm (last visited Jan. 4, 2002) [hereinafter Nat'l Ass'n of Soc. Workers]; Clinical Social Work Federation, Code of Ethics Principle III (Rev. 1997), available at http://www.cswf.org/confidentiality.htm (last visited Jan. 5, 2002) [hereinafter Clinical Soc. Work Fed'n].

[26] Weiner, supra note 22, at 570 (quoting American Psychiatric Ass'n, Official Actions: The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, 130 Am. J. Psychiatry 1057, 1063 (1973)).

[27] See *Laurent v. Brelji, 392 N.E.2d 929, 931 (Ill. App. Ct. 1979)* ("Presumably, the patient in psychotherapeutic treatment reveals the most private and secret aspects of his mind and soul.").

[28] *518 U.S. 1, 15 (1996)* (ruling that the federal law recognizes a testimonial privilege against the compelled disclosure of communications between patients and psychotherapists).

[29] See, e.g., *Jaffee, 518 U.S. at 10-12.*

[30] *Jaffee, 518 U.S. at 10.*

Private interests aside, the Jaffee Court additionally acknowledged that the principle of confidentiality similarly serves public interests by providing an inducement for persons who need treatment to seek it: "the psychotherapist privilege serves the public interest by facilitating the provision of appropriate treatment for individuals suffering the effects of a mental or emotional problem. The mental health of our citizenry, no less than its physical health is a public good of transcendent importance." [34] Nevertheless, absent sufficient confidentiality protections, individuals in **[*541]** need of treatment may decide that the risk of public disclosure outweighs the benefit of treatment. [35]

b. disclosure of confidential information

Although professionals are expected to protect and respect the confidentiality of the information entrusted to them by recipients, ethical codes do not carry "the weight of law." [36] Accordingly, in recognition of the importance of confidentiality, a myriad of state [37] and federal [38] statutes and regulations have been enacted that impose a legal obligation upon therapists to protect confidential information from unauthorized disclosure. Despite such recognition, the principle of confidentiality is not absolute. [39] Rather, this principle is subject to a web of exceptions and is further diluted by the increasingly high risk of improper disclosure. [40] **[*542]**

1. Proper Forms of Disclosure

Confidentiality laws vary in terms of the restrictions and prohibitions imposed upon the disclosure of records. [41] Typically these laws establish a general rule of non-disclosure [42] and the exceptions carved out of this rule exist principally where it is thought that society's interests are best served by the disclosure. [43] These exceptions are often defined statutorily and generally arise in circumstances where: a recipient is in danger of harming herself or others; the disclosure is being made to government officials; the information was obtained pursuant to a court-ordered examination, or under a court-ordered release; or the communications were made with respect to child

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[31] See Press Release, California Health Care Foundation, Americans Worry About the Privacy of Their Computerized Medical Records, (Jan. 28, 1999), available at http://www.chcf.org/press/view.cfm?itemID=362 (last visited Jan. 7, 2002) [hereinafter Americans Worry].

[32] *Jaffee, 518 U.S. at 10* ("The mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.").

[33] See Americans Worry, supra note 31.

[34] *Jaffee, 518 U.S. at 11.*

[35] Weiner, supra note 22, at 560.

[36] Id. at 570.

[37] See generally Joy Pritts et al., Health Privacy Project, Institute for Health Care Research and Policy, Georgetown University, The State of Health Privacy: An Uneven Terrain: A Comprehensive Survey of State Health Privacy Statutes (1999), available at http://www.healthprivacy.org/usrdoc/35309.pdf (last visited Jan. 7, 2002) [hereinafter Health Privacy]. For an overview of some of Illinois' confidentiality laws, see 20 Ill. Comp. Stat 301/305(bb) (2000) (providing for confidentiality protection in the context of substance abuse treatment);*225 Ill. Comp. Stat. 15/5* (2000) (governing confidentiality for clinical psychologists); *225 Ill. Comp. Stat. 20/16* (2000) (governing confidentiality for a social worker); *225 Ill. Comp. Stat. 55/70* (2000) (governing confidentiality for a marriage and family therapist); *225 Ill. Comp. Stat. 107/75* (2000) (governing confidentiality for a licensed professional counselor); *735 Ill. Comp. Stat. 5/8-803* (2000) (governing confidentiality for clergy); *740 Ill. Comp. Stat. 110/3(a)* (2000) (governing confidentiality for therapistrecipient relationships).

[38] See generally *42 U.S.C. § 290dd-2* (1994) (establishing privilege for confidential information communicated in course of federal substance abuse programs); *42 U.S.C. § 300b-3* (1994) (conditioning receipt of federal research grant on assurance

abuse. [44] Absent any one of these circumstances, written authorization must be obtained from the recipient or someone empowered to act on the recipient's behalf prior to any disclosure. [45]

2. Authorization

The requirement of recipient authorization is the most common restriction found in confidentiality laws. [46] **[*543]** The concept of authorization is rooted in the principle of personal autonomy for "autonomy encompasses the right to control the dissemination of personal health information." [47] Accordingly, the requirement memorializes the notion that the right to renounce confidentiality rests primarily with the recipient. [48]

"Authorization" is used interchangeably with the terms "release" and "consent." [49] To say that a recipient has authorized his therapist to release records to a third party means that he has empowered the therapist with the legal authority to do so. [50] A valid authorization, therefore, waives the recipient's right to the exclusive ownership of that confidential information and the therapist is then entitled to disclose that information without risk of liability. [51] The validity of the authorization often depends upon whether the governing confidentiality law specifies mandatory format and content requirements for the authorization form. [52] Thus, recipients are left with two potential causes of action against a therapist: one for disclosing confidential information absent any authorization and another for failing to obtain a valid authorization. [53]

3. Improper Forms of Disclosure

Aside from the aforementioned exceptions to the general rule of non-disclosure, the principle of confidentiality is further diminished by the increasingly high risk of improper disclosure. [54] According to a 1994 report **[*544]** by the Institute of Medicine, there are three common types of disclosure that pose a threat to confidentiality. [55] These forms include: the "inadvertent disclosure," or the unintentional release of confidential information resulting from

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that confidentiality of tests, records, diagnosis, and counseling of patient is maintained unless patient consents to disclosure or patient identity is redacted); Americans with Disabilities Act, *42 U.S.C. § 12112*(d)(4)(A) (1994) (providing that "a covered entity shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such examinations or inquiry shown to be job-related and consistent with business necessity."); Standards for Privacy of Individually Identifiable Health Information, *65 Fed. Reg. 82462* (Dec. 28, 2000) (to be codified at 45 C.F.R. pts. 160, 164, as corrected by Technical Corrections to Final Rule, ***65 Fed. Reg. 82944*** (Dec. 29, 2000)), available at *http://aspe.hhs.gov/admnsimp* (last visited Jan. 7, 2002) [hereinafter Standards for Privacy].

[39] Weiner, supra note 22, at 565 (noting that the exceptions to confidentiality laws practically swallow up the rule of confidentiality).

[40] See infra Part I.B.1, 3.

[41] See *Health Privacy, supra* note 37 (Executive Summary) (discussing state health privacy laws regarding restrictions on disclosure).

[42] Id.

[43] See Charles C. Sharpe, Medical Records Review and Analysis 57 (1999); Weiner, supra note 22, at 565. See generally *Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334 (Cal. 1976)* (finding that the duty of confidentiality does not involve the protection of the patient's confidences at the peril of public or individual safety); *D.C. v. S.A., 687 N.E.2d 1032 (Ill. 1997)* (finding that the fundamental fairness exception to the therapist recipient privilege is warranted where the interests of substantial justice and fundamental fairness outweigh a plaintiff's right to assert the confidentiality privilege); *People v. Herbert, 438 N.E.2d 1255 (Ill. App. Ct. 1982)* (finding that the physicianpatient privilege did not protect the defendant from disclosure where it was determined that society's interests were best served by a broad grand jury investigation).

[44] See, e.g., 4 Matthew Bender & Co., Treatise on Health Care Law § 20.12(2)-(3) (Michael G. MacDonald et al. eds., 2001).

one's careless conduct; [56] the release of information without authorization; [57] and, most relevant to purposes of this Comment, the "routine" release of information based on the blanket consent of the patient. [58]

What renders a blanket consent improper is the risk of an unintended release of information not known to be in the records. [59] "A signed form may constitute evidence that a patient consented . . . but it does not prove that the consent was truly informed." [60] This risk exists in tension with the recipient's right of autonomous decision-making since a recipient's ignorance impedes his ability to understand the repercussions of his consent. [61] Consequently, the Institute of Medicine regards the "routine" release of information by way of blanket consent as a problem in need of redress. [62]

Although healthcare records have never remained completely confidential, the increasing use of interconnected electronic information systems has given a new meaning to the concept of improper disclosure: [63]

The electronic information revolution is transforming the recording of health information so that the disclosure of information may require only a push of a button. In a matter of seconds, a person's most profoundly private information can be shared with hundreds, thousands, even millions of individuals and organizations at a time. [64]

[*545]

This ease of information sharing, collection, organization, and retention has diluted the financial and logistical obstacles that have traditionally served to protect the confidentiality rights of recipients. [65] Principally, the shift from paper to electronic records has added a new dimension to the notion of "blanket consent," for a recipient's consent to disclosure can, now more than ever, result in the release of more information than the recipient had intended. [66]

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[45] *740 Ill. Comp. Stat. 110/5(a)* (2000); see, e.g., Sharpe, supra note 43, at 45-46.

[46] See *Health Privacy, supra* note 37 (Executive Summary) (discussing state health privacy laws regarding restrictions on disclosure).

[47] Patricia I. Carter, Health Information Privacy: Can Congress Protect Confidential Medical Information in the "Information Age"?, *25 Wm. Mitchell L. Rev. 223, 231 (1999);* see also *Whalen v. Roe, 429 U.S. 589, 599-600, 605 (1977)* (finding that individuals have a privacy interest in avoiding the disclosure of personal matters in the content of medical records); van der Goes, supra note 8, at 1049 (citing Lawrence O. Gostin, Health Information Privacy, *80 Cornell L. Rev. 451, 513-14 (1995)).*

[48] E.g., Hayt, supra note 23, at 100.

[49] E.g., Sharpe, supra note 43, at 45-46 (citing Kristyn S. Appleby & Joanne Tarver, Medical Records Review 156 (2d ed. 1994)).

[50] Id.

[51] See *People v. Herbert, 438 N.E.2d 1255, 1259 (Ill. App. Ct. 1982)* (holding that the forms entitled "Authorization for Release of Medical Information" constituted valid waivers of the physician-patient privilege).

[52] See Sharpe, supra note 43, at 46.

[53] E.g., *Capocy v. Kirtadze, 183 F.3d 629, 631 (7th Cir. 1999)* (finding that a form that does not contain all of this information does not constitute a valid authorization even if referred to by the parties as such).

II. What Constitutes an Invalid "Blanket Consent" Within the Purview of Illinois' Mental Health and Developmental Disabilities Confidentiality Act?

a. the confidentiality act

1. Authorization Form Requirements

Illinois requires authorization forms for the disclosure of mental health records to conform to a certain format as set forth under section 5 of the Confidentiality Act. [67] This format mandates that authorization forms specify the following points of information: to whom disclosure is to be made; the purpose for which the disclosure is to be made; the nature of the information to be disclosed; the right to inspect and copy the information to be disclosed; the consequences of a refusal to consent; the expiration date of the consent; and, the right to revoke the consent at any time. [68] However, in addition to these format requirements, section 5 further provides that the "blanket consent to the disclosure of unspecified information shall not be valid." [69] Neither an operational definition of "blanket consent" is provided under the Confidentiality Act nor have Illinois courts squarely addressed **[*546]** how they would view the inclusion of such language. [70] Although the "blanket consent" language seems to reinforce the requirement that "the nature of the information to be disclosed" is to be expressed on the authorization form, the degree of specificity required remains unclear.

2. "Blanket Consent"

Conventionally, the phrase "blanket consent" in the present context refers to either: an authorization form that attempts to satisfy all of the legal format requirements by a nonspecific recitation of those requirements absent further elaboration; or, a form that purports to grant virtually unlimited authority to the therapist to release a recipient's records at the therapist's discretion. [71] The underlying evil in both of these instances concerns the risk of unfair surprise, or the unintended release of information not thought to be within the disclosure. [72] However, the plain and ordinary meaning of the phrase "blanket consent" is vague. The term "blanket" means "covering a group of conditions or requirements" and "including many or all items." [73] "Consent" is defined as "permission, approval,

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[54] See Carter, supra note 47, at 233-34 (citing Institute of Medicine, Health Data in the Information Age: Use, Disclosure, and Privacy 157-60 (Molla S. Donaldson & Kathleen N. Lohr eds., 1994)).

[55] Id.

[56] Id. (noting that these types of disclosures can best be dealt with by way of internal policies and procedures within the institution).

[57] Id. (observing that this type is the most difficult to control).

[58] Id.

[59] Cf. Karl N. Llewellyn, The Common Law Tradition 370 (1960) ("Instead of thinking about "assent" to boiler-plate clauses, we can recognize that so far as concerns the specific, there is no assent at all.").

[60] Bruce J. Winick, The Right to Refuse Mental Health Treatment 361 (1997).

[61] See Hayt, supra note 23, at 286.

[62] See Carter, supra note 47, at 233-34.

[63] See generally Standards for Privacy, supra note 38, at 82465-66 (discussing the effect the increasing use of interconnected electronic systems has upon privacy).

[64] Id. at 82465.

[65] Id.

[66] See id. at 82473 ("We expressed concern about the coercive nature of consents currently obtained by providers and plans relating to the use and disclosure of health information. We also expressed concern about the lack of information available to the patient during the process, and the fact that patients often were not even presented with a copy of the consent that they have signed.").

or assent" and "implies compliance with something proposed or **[*547]** requested, stressing this as an act of the will." [74] The combination of "blanket" with "consent" illogically implies assent obtained from a recipient without her knowledge as to the information being disclosed. [75]

The issue thus becomes whether the "blanket consent" language provides protection to a recipient who signs an authorization form expressing the nature of the information being disclosed, as required under the Confidentiality Act, [76] but who is unaware of the particular information being disclosed. For example, consider two recipients, X and Y, who sign identical authorization forms for the purpose of custody litigation describing the information being disclosed as "all files in record generated during 1997 and 1998 treatment sessions." Add into the hypothetical the fact that Y's files, to her surprise, contained the therapist's personal notes suggesting that Y may suffer from schizophrenia. Certainly such a suggestion is potentially fatal to Y's claim for custody. [77] **[*548]**

The initial issue raised by the hypothetical concerns whether the descriptions are specific enough to overcome the invalid "blanket consent" language. The second issue raised concerns whether the resolution of the first issue is altered by the fact that Y's files, to her surprise, contained the therapist's notes. More specifically, whether the validity of Y's authorization depends upon her informed consent as to the particular information being disclosed. The Illinois Supreme Court's recent review of the federal Confidentiality of Alcohol and Drug Abuse Patient Records regulations [78] in M.A.K. v. Rush-Presbyterian-St. Luke's Medical Center [79] is instructive for purposes of ascertaining how Illinois courts would likely view the effect of the "blanket consent" language in responding to these issues in the context of the Confidentiality Act. Of particular importance for purposes of this Comment concerns the following two propositions that the M.A.K. holding supports: that an authorization form bearing a broad **[*549]** description of the information being disclosed is permissible and that a valid authorization need only a recipient's consent, not informed consent. [80]

b. m.a.k. v. rush-presbyterian-st. luke's medical center

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[67] *740 Ill. Comp. Stat. 110/5(a)*-(c) (2000).

[68] Id. § 110/5(b).

[69] Id. § 110/5(c).

[70] There is little case law addressing the validity of authorization forms under the Confidentiality Act. Presumably, this is because recipients are unaware that they have any control over their privacy let alone of their rights under the Confidentiality Act. See generally Harris Equifax, Health Information Privacy Study (1993), available at *http://www.epic.org/privacy/medical/polls.html* (last visited Jan. 5, 2002) (noting that over eighty percent of persons surveyed in 1999 agreed with the statement that they had "lost all control over their personal information"). But see generally McInerney v. Fagan, No. 96 C 6633*1997 WL 94725* (N.D. Ill. Mar. 3, 1997) (finding that whether the authorization was valid for purposes of the Confidentiality Act was a question of law and fact and that it would be inappropriate to grant plaintiff's motion to strike this affirmative defense at that time); *Parkson v. Cent. Du Page Hosp., 435 N.E.2d 140 (Ill. App. Ct. 1982)* (noting that the court did not believe that execution of limited waiver evidences intent by patients to allow release of their medical information to unknown individuals or agencies or to public at large); *Capocy v. Kirtadze, 183 F.3d 629 (7th Cir. 1999)* (finding that a form that does not contain all of the statutorily prescribed information does not constitute a valid authorization even if referred to by the parties as such).

[71] See, e.g., 3 Matthew Bender & Co., Treatise on Health Care Law § 17.07(1)(b)(i) (Michael G. MacDonald et al. eds., 2001).

[72] Cf. E. Allan Farnsworth, Farnsworth on Contracts § 4.26 (2d ed. 1998) (explaining that the problem with standard form contracts concerns the risk of inequality between "a person who is meticulous or who chances to have knowledge and a person who is blissfully unknowing"); Llewellyn, supra note 59 (illustrating the notion of "blanket assent" in the context of contract formation and arguing that there is no actual assent to particular form clauses).

[73] Webster's New World Dictionary 146 (3d coll. ed. 1988).

[74] Id. at 296.

[75] C.f. Llewellyn, supra note 59 (explaining the concept of "blanket assent" as lacking knowledge).

In M.A.K., the Illinois Supreme Court reversed the ruling of the Third District Appellate Court [81] and upheld the validity of an authorization form signed by the plaintiff. [82] In arriving at this conclusion, the court addressed the issue of whether the authorization form signed by the plaintiff sufficiently specified "how much and what kind of information" was to be disclosed, [83] as required by the regulation. [84] **[*550]**

The plaintiff argued that the description on the authorization form was too broad. [85] In support of this argument, the plaintiff presented a Department of Health and Human Services publication stating that, in the context of obtaining authorizations, the information being released "should be described as exactly and narrowly as possible in light of the purpose of the release. Releases for 'any and all pertinent information' are not valid." [86] The relevant provisions of the authorization form signed by the plaintiff stated that it applied to "any and all such information," referring to all medical and nonmedical information possessed by the entities making the disclosure. [87] **[*551]**

Despite such a broad description, the court upheld the validity of the authorization form because neither the regulation nor the Department of Health and Human Services formally expressed that a broad description of the information to be released was impermissible. [88]

Additionally, the court had to determine whether the plaintiff's authorization as to subsequently generated records was invalid. [89] The plaintiff argued that, as a matter of law, an authorization for the disclosure of records not yet in existence was invalid because he did not know at the time he signed the authorization form that he would later be hospitalized for alcohol abuse treatment. [90] Thus, his consent was uninformed. [91] Nevertheless, the court upheld the validity of the authorization reasoning that the plaintiff had the right not to sign the authorization form and maintained the right to revoke the authorization. [92] **[*552]**

Both Justice Freeman, in his concurring opinion, and Justice Kilbride, in his dissenting opinion, "strongly" disagreed with the majority's conclusion that the authorization was valid. [93] They took the position that the plaintiff's

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[76] *740 Ill. Comp. Stat. 110/5(b)(3)* (2000).

[77] See, e.g., *In re Marriage of Scott, 394 N.E.2d 779, 782 (Ill. App. Ct. 1979)* (upholding the trial court's decision to modify custody on the ground that the mother exhibited a history of paranoid schizophrenia).

[78] *42 C.F.R. § 2.31(a) (2000)*. Section 2.31(a) mandates that authorization forms for the disclosure of a patient's alcohol or drug abuse treatment records specify the following:

(1) The specific name or general designation of the program or person permitted to make the disclosure.

(2) The name or title of the individual or the name of the organization to which disclosure is to be made.

(3) The name of the patient.

(4) The purpose of the disclosure.

(5) How much and what kind of information is to be disclosed.

(6) The signature of the patient . . . .

(7) The date on which the consent is signed.

(8) A statement that the consent is subject to revocation . . . .

(9) The date, event, or condition upon which the consent will expire if not revoked before . . . .

42 C.F.R. § 2.31(a) (2000).

[79] *764 N.E.2d 1 (Ill. 2001).* In M.A.K., the plaintiff applied for a disability insurance policy with Royal Insurance. *Id. at 3.* In October of 1994, in accordance with his application, the plaintiff executed an authorization for release of his medical records. Id. The plaintiff was then admitted to the defendant hospital for alcohol dependence treatment in January of 1995. Id. During his

authorization was invalid because it was overly broad and thus not a product of his informed consent. [94] As expressed by Justice Kilbride, a ruling that upholds the validity of an uninformed consent "defies logic." [95]

c. implications of the m.a.k. holding upon the "blanket consent" language under the confidentiality act

The traditional understanding that consent implies informed choice supports the position adopted by Justices Freeman and Kilbride. [96] "'Consent' is an act of reason, accompanied by deliberation, where the mind weighs the good and bad on each side." [97] In accord, consent could hardly be based upon a recipient's ignorance of the essential nature and consequences of his authorization. [98] Nevertheless, the majority opinion's **[*553]** disregard for this traditional understanding of the notion of consent will likely have profound implications. As pointed out by the lawyer for the defendant in M.A.K., the court's holding "has broad significance because the type of consent form . . . at issue was one that is frequently used in the health care industry. Hospitals and doctors have been relying on such consent forms for years." [99]

The M.A.K. court's holding has broad significance not only in the context of the disclosure of medical records, but also in the context of the disclosure of mental health records. Like hospitals and doctors, therapists also rely on standard authorization forms in accommodating the countless requests they receive for the production of mental health records. [100] In the aftermath of the M.A.K. ruling, they can now feel more secure in doing so because the ruling sanctions the release of confidential information based upon uninformed consent obtained through the use of broad authorization **[*554]** forms. [101] Yet, before concluding that a court reviewing the validity of an authorization form under the Confidentiality Act will inevitably accept this proposition, one distinguishing factor must first be accounted for. Although similar in many respects, there are differences in the statutory language between the federal regulations in M.A.K. and the Illinois Confidentiality Act. Consider these differences in the context of the issues originally raised by the hypothetical illustrated above. [102]

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treatment, the plaintiff had contacted his insurance agent regarding the possibility of filing a claim for benefits under his policy. Id. Although the plaintiff later decided not to file a claim, in April of 1995, the defendant hospital received the October 1994 authorization form for the release of plaintiff's medical and non-medical information. *M.A.K., 764 N.E.2d at 3.* The defendant hospital then released plaintiff's records, which included his records of alcohol-dependence treatment. Id. The plaintiff sued the defendant hospital for breaching the physicianpatient relationship, invading his privacy, and negligently inflicting emotional distress. Id. In response, the defendant hospital asserted that the release was permissible pursuant to the valid authorization form. *Id. at 4.*

[80] See *M.A.K., 764 N.E.2d at 18-19* (Kilbride, J., dissenting) (disagreeing with the majority's decision to uphold the validity of an "impermissibly broad" authorization form obtained without the plaintiff's informed consent).

[81] See generally ***M.A.K. v. Rush-Presbyterian-St. Luke's Med. Ctr., 736 N.E.2d 129, 132 (Ill. App. Ct. 2000)*** (finding that the authorization form signed by the plaintiff was invalid because the wording of the form was "at best imprecise and far too generic").

[82] *M.A.K., 764 N.E.2d at 10.*

[83] *Id. at 8.*

[84] *42 C.F.R. § 2.31(a)(5) (2000)*.

[85] See *M.A.K., 764 N.E.2d at 8.* The authorization form signed by the plaintiff was entitled "AUTHORIZATION AND ACKNOWLEDGEMENT" and provided, in relevant part, as follows:

I AUTHORIZE any physician, medical practitioner, hospital, clinic, health care facility, or other medical or medically related facility [] *** having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me *** and any other non medical information of me *** to give to Royal *** any and all such information.

I UNDERSTAND the purpose of this authorization is to allow Royal *** to determine eligibility for life or health insurance or a claim for benefits under a life or health policy. ***

The initial issue concerns whether the following description of the information being disclosed is specific enough to overcome the invalid "blanket consent" language of the Confidentiality Act: "all files in record generated during 1997 and 1998 treatment sessions." Unquestionably, this description would satisfy the federal regulations analyzed in M.A.K. [103] The language "any and all such information," as expressed in the M.A.K. authorization form, [104] is as broad if not broader than "all files in record generated during 1997 and 1998 treatment sessions." However, as distinguished from the federal regulations, Illinois' Confidentiality Act not only requires authorization forms to indicate "the nature of the information to be disclosed," [105] but it further declares that the "blanket consent to the disclosure of unspecified information shall not be valid." [106] Nevertheless, the language described in the hypothetical would likely be deemed sufficiently specific because, in accord with the M.A.K. court's reasoning, the Confidentiality Act does not expressly indicate the degree of specificity the description must bear. [107]

Even to the extent that the "blanket consent" language should significantly alter a reviewing court's approach, because it seemingly evidences an attempt by the legislature to preclude overly broad authorizations, courts nevertheless tend to narrowly construe **[*555]** confidentiality statutes so as to promote the free access of information to third parties. [108] Consequently, although the contents of the recipients' files in the above hypothetical significantly differ, the identical descriptions of the information being disclosed would likely be permitted.

The second issue regarding the above hypothetical concerns whether it is significant that Y was unaware of the therapist's personal notes suggesting that she may suffer from schizophrenia. To the extent that a reviewing court accepts the proposition supported by the M.A.K. ruling, [109] Y's ignorance as to the particular contents of her record will likely be of little significance. Consistent with the majority's reasoning, Y had the right to refuse to sign the authorization form. [110] Although a ruling that upholds the validity of an uninformed consent "defies logic," [111] the majority opinion only requires Y's consent, not her informed consent. [112]

In hard cases, courts interpreting the effect of the "blanket consent" language could strain to avoid an inequitable result by applying one of several techniques. [113] Initially, a court could imply that the legislature intended to prevent

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I UNDERSTAND THAT my *** medical records may be protected by certain Federal Regulations, especially as they apply to any drug or alcohol abuse data. I understand that I *** may revoke this authorization at any time as it pertains to any such drug or alcohol abuse data by written notification ***.

***

*** I AGREE this Authorization shall be valid for two and one half years from [October 12, 1994].

M.A.K., 764 N.E.2d at 3-4.

86 *Id. at 8-9* (citing "Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance," Department of Health and Human Services Publication No. 18 (SMA) 963083 (1996)).

87 *Id. at 3-4.*

88 *Id. at 9.* Another issue addressing specificity concerned whether the authorization form signed by the plaintiff sufficiently expressed the "specific name or general designation" of the person or program authorized to make a disclosure, as required by the federal regulations. *M.A.K., 764 N.E.2d at 6.* The authorization form did not include the specific name of the disclosing program or individual but rather designated the individuals and programs entitled to make disclosures as "any physician, medical practitioner, hospital, clinic, health care facility or other medical or medically related facility . . . ." Id. Consequently, the court had to determine whether the authorization form satisfied the "general designation" requirement. Id. The issue was one of first impression. Id. In defining "general designation," the court applied basic principles of statutory construction. *M.A.K., 764 N.E.2d at 5-6.* After concluding that the plain and ordinary meaning of "general designation" was facially vague, the court looked to the purpose of the regulations. *Id. at 67.* Although the purpose of the regulations was to ensure the principle of confidentiality, the court nevertheless concluded that the authorization form was valid because a 1987 amendment to the regulation broadened the permissible wording of authorization forms by permitting a "specific name or general designation" rather than permitting only the specific name. *Id. at 7.*

the risk of unfair surprise by including the "blanket consent" language and, in turn, invalidate an authorization obtained on an uninformed basis. [114] Or, a court struggling to invalidate an authorization form could refuse to uphold its validity on the ground that the therapist had or should have had reason to believe that the recipient would not have authorized the disclosure had the recipient known that the records being disclosed contained the particular information. [115] The fiduciary nature of the therapist-recipient relationship supports this technique because it is a **[*556]** therapist's primary obligation to protect and respect the confidentiality of the information entrusted to her by the recipient. [116]

Nevertheless, the M.A.K. court opted not to apply either of these techniques, and it is doubtful that a court reviewing the "blanket consent" language will either. All too often, signed authorization forms are treated as prima facie evidence of valid consent whether or not they are obtained on an informed basis. [117] Such treatment of the Confidentiality Act is problematic because it would eviscerate the Illinois legislature's apparent intention for including the "blanket consent" language, that being to prevent unfair surprise. [118]

Ultimately, however, whether or not a court interpreting the effect of the "blanket consent" language accepts the propositions supported by the M.A.K. ruling or finds some ground upon which to declare an authorization form invalid, the effect upon a recipient's right of confidentiality remains the same. Consistent with the old cliche, the cat is already out of the bag. Hence the need for an explicit informed consent requirement.

III. Informed Consent as a Solution

a. the doctrine of informed consent

The principle of informed consent for medical procedures is a firmly rooted doctrine in American jurisprudence. [119] The doctrine stems from the notion of personal autonomy and rests upon the presumption that a patient has a right of selfdetermination where the patient's physical and emotional wellbeing is affected. [120] Physicians are required under the doctrine to **[*557]** fully disclose to each patient all of the facts necessary to enable the patient to make an informed decision about whether to undergo a recommended treatment. [121]

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[89] *M.A.K., 764 N.E.2d at 10.*

[90] Id.

[91] See id.

[92] Id.

[93] *M.A.K., 764 N.E.2d at 10, 17* (Freeman, J., concurring) (joining the majority only because he believes a plaintiff "cannot maintain a private damages action where such action is grounded upon a violation of the federal regulations"); see *M.A.K., 764 N.E.2d at 17* (Kilbride, J., dissenting) (agreeing with that portion of Justice Freeman's analysis).

[94] *Id. at 17-18* (Kilbride, J., dissenting) (noting that "it is well established that the alleged waiver of a right will not be upheld unless the waiver was knowing" and that the authorization was "impermissibly broad"); see *id. at 17* (Freeman, J., concurring) (finding the authorization form to be overly broad).

[95] *M.A.K., 764 N.E.2d at 19* (Kilbride, J., dissenting) ("It would defy logic to conclude that a patient may validly waive the right of confidentiality in records that do not even exist at the time, thereby giving informed consent to their disclosure.") (citations omitted).

[96] W. Page Keeton et al., Prosser and Keeton on Torts 112 (5th ed. 1984); see Hayt, supra note 23, at 28586 (defining "consent" as "a free, rational act, which presupposes knowledge of the thing to which consent is given" and indicating that "consent supposes knowledge"). Note that the majority's approach is more consistent with that applied by courts in contracts cases. For example, standard form contracts are routinely enforced even though the terms therein have not been read. See generally Farnsworth, supra note 72 (discussing enforcement of standardized agreements).

[97] Ralph Slovenko, Psychotherapy and Informed Consent: A Search in Judicial Regulation, Law and the Mental Health Professions, Friction at the Interface 51 (Walter E. Barton & Charlotte J. Sanborn eds., 1978).

In order to satisfy the doctrine's requirement of complete and full disclosure, a physician is required to disclose certain points of information that must be conveyed to the patient in a plain and meaningful fashion. [122] These points of information generally include: a diagnosis of the patient's condition; the intended result of the proposed treatment; the nature and purpose of the proposed treatment; the general statistical probability of obtaining the intended result; the physician's personal clinical experience and success rate; any risks of complications; side effects or unfavorable results inherent in the proposed treatment; feasible medical alternatives; and, the prognosis if the patient decides not to undergo the treatment. [123]

Courts look to one of two standards in determining whether a physician's disclosure is sufficient. [124] The reasonable person standard requires a physician to disclose that information that "a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to . . . in deciding whether or not to forego the proposed therapy." [125] In contrast, the prudent physician standard requires a physician to disclose that information that "a reasonably prudent physician in the same or similar circumstances would disclose." [126] **[*558]**

Regardless of the standard applied, the consent of the patient must include the following key elements: (1) the consent must be specific to the treatment; (2) the consent must be voluntary; (3) the patient must have the capacity [127] to consent; and, (4) the consent must be informed. [128]

b. informed consent in the mental healthcare industry

Although the doctrine of informed consent is most often referred to in the context of consent to medical treatment, the doctrine is similarly pervasive in the mental healthcare industry. [129] Not only is informed consent required prior to certain mental healthcare treatments, [130] ethical codes governing the mental healthcare profession also incorporate an informed consent-based approach relevant to the confidentiality concerns of this Comment. [131]

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[98] Hayt, supra note 23, at 286. See generally Standards for Privacy, supra note 38, at 82474 ("We considered and rejected other approaches to consent, including those that involved individuals providing a global consent to uses and disclosures when they sign up for insurance. While such approaches do require the patient to provide consent, it is not really an informed one or a voluntary one.").

[99] John Flynn Rooney, Court Allows Insurers' Access to Treatment Records, Chi. Daily L. Bull., Dec. 20, 2001, at 1. (quoting Jeffrey I. Cummings, lawyer for the defendant).

[100] The following language is typical of many authorization forms for the release of psychiatric records:

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

[Name of hospital or asylum]

Patient:

Social Security No:

Birth Date:

Address:

I authorize you to release to the persons listed below information concerning the medical and psychiatric evaluation and treatment received by the above named patient at [name of hospital or asylum] during the approximate period from date, to date. This information is to be used only for the purposes of [assisting in the pursuit of a legal action and obtaining psychotherapeutic and medical care].

The authorized information is to be provided only to the following persons: [names of persons to receive information].

This authorization is valid [for 90 days only]. I understand that I may revoke this consent at any time by sending a written notice to the [Director of Medical Records or as the case may be] address, city, County, state.

I understand that I may review the disclosed information by contacting the [Director of Medical Records or as the case may be] address, city, County, state.

These codes impose a duty upon mental healthcare professionals to inform recipients of the limits of confidentiality prior to their initial treatment session. [132]

For instance, the American Psychiatric Association requires psychiatrists to caution recipients of the "connotations of waiving the privilege." [133] Likewise, psychologists have a duty to inform recipients of "the relevant limitations on confidentiality" [134] and social workers **[*559]** must discuss with recipients their right to confidentiality. [135] Further, clinical social workers must "discuss fully with clients both the nature of confidentiality, and potential limits to confidentiality" prior to their first treatment session. [136] Accordingly, the concept of informed consent is not new to the mental healthcare industry.

Nonetheless, the present understanding of informed consent in the context of mental healthcare is front-end heavy, in that the therapist's duty of disclosure primarily exists prior to a recipient's treatment. Although informed consent has significant importance at that stage, the doctrine is also fundamental to fair information practices with respect to the disclosure of confidential information. [137]

c. defining and justifying an informed consent-based approach under the confidentiality act

Informed consent is a crucial component of confidentiality because it protects against the unintended release of information that can potentially subject the recipient to social stigma and discrimination by insurance companies, healthcare providers and employers. [138] In light of these significant consequences, recipients ought to have greater control over the disclosure of their records. [139] Accordingly, the Illinois legislature should look to the doctrine of informed consent in implementing an operational definition of "blanket consent" in order to ensure that recipients are afforded the opportunity to make well-informed decisions in authorizing the disclosure of their mental health records. **[*560]**

1. Defining an Operational Definition of "Blanket Consent"

Dated: .

[Signature of patient or other authorized person]

[If signed by other than patient, give relationship]

Attestation

9A Am. Jur. Legal Forms 2d Hospitals and Asylums § 136:115 (Rev. 1995).

[101] See generally supra Part II.B-C.

[102] See supra Part II.A.2 ("For example, consider two recipients, X and Y, who sign identical authorization forms for the purpose of custody litigation describing the information being disclosed as 'all files in record generated during 1997 and 1998 treatment sessions.' Add into the hypothetical the fact that Y's files, to her surprise, contained the therapist's personal notes suggesting that Y may suffer from schizophrenia.").

[103] *42 C.F.R. § 2.31(a)(5) (2000)* (requiring authorization forms to indicate "how much and what kind of information is to be disclosed").

[104] *M.A.K. v. Rush-Presbyterian-St. Luke's Med. Ctr., 764 N.E.2d 1, 3-4 (Ill. 2001).*

[105] *740 Ill. Comp. Stat. 110/5(b)(3)* (2000).

[106] Id. § 110/5(c).

[107] See *M.A.K., 764 N.E.2d at 9* (reasoning that the broad description was permissible because neither the regulation nor the Department of Health and Human Services formally expressed that a "broad description of the information to be released is impermissible.").

[108] See 4 Matthew Bender & Co., supra note 44, at § 20.12.

An operational definition of "blanket consent" would principally necessitate that the authorization form be an informed consent. [140] More specifically, the authorization form should describe in plain language the information being disclosed in a particular and meaningful fashion such that the recipient is enabled to fully appreciate the risks involved with the disclosure. [141] This requirement would essentially be the equivalent of imposing a legal obligation upon therapists to reasonably disclose all information that a recipient would consider material to make an informed decision regarding whether or not to authorize the disclosure of mental health records. [142] Consistent with the standards governing the validity of a patient's informed consent, the validity of a recipient's authorization should depend upon the following factors: (1) whether the recipient acted voluntarily; (2) whether the recipient possessed the legal capacity to authorize the disclosure; (3) whether the recipient's consent was particular to the actual disclosure; and, (4) whether the recipient's decision to authorize the disclosure was an informed one. [143]

In context, consider recipient Y presented in the hypothetical illustrated above who authorized the disclosure of her files for purposes of custody litigation but who was unaware that the files contained her therapist's personal notes suggesting that she may suffer from schizophrenia. [144] An informed consent requirement would legally obligate the therapist to disclose to Y and specify on her authorization form that the files being disclosed contain notes suggesting that she may suffer from schizophrenia. Absent this information, Y would not be able to weigh the consequences of the disclosure and thus give her informed consent. Accordingly, the therapist's use of authorization forms bearing the same description, "all files in record generated during 1997 and 1998 treatment **[*561]** sessions," in obtaining X's and Y's consent was improper because X and Y are not similarly situated.

In order for Y to prevail in a cause of action against the therapist for failure to comply with the informed consent requirement, Y would have the burden of establishing: (1) she was not advised of all of the material information contained in the disclosed records necessary to make an informed decision regarding whether or not to disclose; (2) she was not provided with the same information that another recipient in the same or similar circumstances would usually have been given; (3) she did not understand the content of the records being disclosed to the degree that she was able to make a rational choice; (4) she would not have consented to the disclosure had she had knowledge of the contents of the records, and (5) damages. [145]

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[109] See *M.A.K., 764 N.E.2d at 19* (Kilbride, J., dissenting) (disagreeing with the majority's decision to uphold the validity of an "impermissibly broad" authorization form obtained without the plaintiff's informed consent).

[110] *M.A.K., 764 N.E.2d at 10.*

[111] *M.A.K., 764 N.E.2d at 19* (Kilbride, J., dissenting).

[112] See id.

[113] Cf. Farnsworth, supra note 72 (discussing the various techniques courts apply in refusing to hold a party to a contract in the context of standardized agreements).

[114] See generally *In re B.C., 680 N.E.2d 1355 (Ill. 1997)* (indicating that where the meaning of a statute is unclear from a reading of its language, courts may look beyond the language of the statute and consider the purpose of the law, the evils it was intended to remedy, and the legislative history behind it).

[115] See ***Restatement (Second) of Contracts § 211(3)*** ("Where the other party has reason to believe that the party manifesting such assent would not do so if he knew that the writing contained a particular term, the term is not part of the agreement"); Farnsworth, supra note 72; *W. Page Keeton et al., supra* note 96, at 119.

[116] See supra Part I.A. and accompanying notes.

[117] See, e.g., *M.A.K., 764 N.E.2d at 10* (upholding the validity of an overly broad authorization form obtained without the patient's informed consent); 4 Matthew Bender & Co., supra note 44, at § 20.12 (discussing judicial treatment of authorization forms).

[118] Cf. Farnsworth, supra note 72 (explaining that the problem with standard form contracts concerns the risk of inequality between "a person who is meticulous or who chances to have knowledge and a person who is blissfully unknowing"). But see

2. Practical Considerations

Necessarily, though, the formulation of an informed consent requirement must strike a suitable balance between advancing the autonomy and confidentiality rights of recipients with the practical considerations of therapists. [146] Nevertheless, with a full view of what an informed consent requirement would actually entail, these practicality considerations will likely be outweighed by the benefits that an informed consent requirement will have upon recipients and therapists in the long run.

Initially, it must be acknowledged that an informed consent requirement would impose additional administrative burdens and increased costs upon therapists. [147] However, a legal requirement of informed consent would not excessively burden therapists. Rather, such a requirement would only require therapists to reasonably disclose all information that a recipient would consider material to make an informed decision respecting **[*562]** whether or not to authorize a disclosure. [148] Consequently, therapists would not be required to obtain recipient authorization for each particular document being disclosed. [149]

Moreover, in cases where a disclosure would almost certainly have no impact upon a recipient's decision because the therapist is certain that the recipient is aware of and understands the totality of the information being disclosed, no disclosure would be required. [150] Further, because it is essentially the therapist who develops the recipient's record, and thus is familiar with its contents, therapists would not have to spend hours reviewing the record in order to determine whether and to what extent disclosure is necessary. Lastly, and of particular significance, the burden upon therapists would be minimal because they are already ethically obligated to enable the recipient to make an informed decision regarding whether to authorize a disclosure. [151] A legal obligation will only ensure that this ethical duty is supported by "the weight of law." [152] In turn, courts will be obligated to formulate a standard stricter than that applied in M.A.K. in determining the validity of authorization forms.

Llewellyn, supra note 59 (illustrating the notion of "blanket assent" in the context of contract formation and arguing that there is no actual assent to particular form clauses).

[119] See, e.g., *Cruzan v. Miss. Dep't of Health, 497 U.S. 261, 269 (1990)* (noting that the "notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment" and pointing out that "the informed consent doctrine has become firmly entrenched in American tort law.").

[120] See generally Jay Katz, The Silent World of Doctor and Patient 59-80 (1984) (discussing the birth and development of informed consent).

[121] See Sharpe, supra note 43, at 16 (noting that informed consent requires that "all significant and material facts be presented to a patient -in language that he or she can fully understand -in order that the individual can make an informed decision either to accept or refuse a proposed treatment or procedure.") (alteration in original).

[122] See id.

[123] See id.

[124] See Robert Gatter, Informed Consent Law and the Forgotten Duty of Physician Inquiry, *31 Loy. U. Chi. L.J. 557, 563-567 (2000).*

[125] *Id. at 563-64* (citing *Caterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972)).*

[126] Id. at 566 (citing *Fain v. Smith, 479 So. 2d 1150, 1152 (Ala. 1985)).*

[127] Legal capacity refers to one's "ability to fully comprehend all of the implications and consequences of his or her actions." Sharpe, supra note 43, at 15.

[128] See Winick, supra note 60, at 347 (outlining the elements of informed consent as including: disclosure of information, competency, understanding, voluntariness, and decision making); Erin Nelson, Selected Legal and Ethical Issues Relevant to Pediatric Genetics, 6 Health L.J. 83, 84 (1998) (outlining the following elements as constituting a valid consent in the context of

Moreover, clarifying the "blanket consent" language by expressly including an informed consent requirement could alleviate the heightened sensitivity some therapists experience from not knowing whether or not their authorization forms comply with the Confidentiality Act. [153] Granted, existing in tension with an informed consent requirement is the heightened risk of therapist liability for improper disclosure. [154] However, a clearer **[*563]** statement of the law would nevertheless serve as a more stable benchmark by which therapists could measure their performance in obtaining recipient authorization.

Administrative burdens and costs aside, an informed consent requirement would benefit both recipients and therapists in the long run. Initially, an informed consent requirement would secure the traditional, albeit recently slighted, [155] understanding that consent implies informed choice. [156] Consequently, this requirement would provide assurance that the confidentiality and autonomy rights of recipients will be protected. Moreover, an informed consent requirement would provide an opportunity to educate recipients and answer any questions they may have about their confidentiality rights, thus increasing the level of trust between the recipient and therapist. [157] In sum, an informed consent requirement would promote effective mental health treatment by increasing the level of confidence and trust between the therapist and recipient. [158] "Properly understood, the principle of informed consent is 'the cardinal canon of loyalty' joining patient and therapist together in the therapeutic process." [159]

Although confidentiality is both an ethical and legal concern, it is the law that dictates the basic rules governing confidentiality in practice. In order to ensure compliance with the Confidentiality Act, the Illinois legislature must clarify the "blanket consent" language and implement an operational definition that includes an informed consent requirement. While legislative action will not eradicate all uncertainties regarding authorization requirements for the disclosure of mental health records, a clearer statement of the "blanket consent" language will make it easier for therapists to comply with. Even though it may be impossible to strike a precise balance between the rights of recipients and the practical considerations of therapists, it must be considered that "privacy is a fundamental right. As such, it must be viewed differently than any ordinary economic good." [160] **[*564]**

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consent to treatment: the consent must be voluntary; the person consenting must have the capacity to do so; the consent must be specific to the treatment and to the person who is to administer the treatment; and the consent must be informed).

[129] See generally Paul S. Appelbaum, Almost a Revolution, Mental Health Law and the Limits of Change 124-132 (1994) (discussing the development of informed consent in the context of a recipient's right to refuse treatment).

[130] See id.; Robert M. Levy & Leonard S. Rubenstein, The Rights of People with Mental Disabilities 102-09 (1996).

[131] See Am. Psychiatric Ass'n, supra note 25, at § § 4.02; Am. Psychological Ass'n, supra note 25, at Standard 5.01; Nat'l Ass'n of Social Workers, supra note 25, at Standard 1.07(e).

[132] See Am. Psychiatric Ass'n, supra note 25, at § § 4.02; Am. Psychological Ass'n, supra note 25, at Standard 5.01; Nat'l Ass'n of Social Workers, supra note 25, at Standard 1.07(e).

[133] Am. Psychiatric Ass'n, supra note 25, at § § 4.02.

[134] Am. Psychological Ass'n, supra note 25, at Standard 5.01.

[135] Nat'l Ass'n of Soc. Workers, supra note 25, at Standard 1.07(e).

[136] Clinical Soc. Work Fed'n, supra note 25, at Principle III(a).

[137] See Carter, supra note 47, at 277-78.

[138] See Standards for Privacy, supra note 38, at 82468 ("A breach of a person's health privacy can have significant implications well beyond the physical health of that person, including the loss of a job, alienation of family and friends, the loss of health insurance, and public humiliation.").

[139] See generally Carter, supra note 47 (noting that "patient autonomy is the basis for current theoretical justifications for a right of privacy. This 'autonomy encompasses the right to control the dissemination of personal health information.'"); see also van der Goes, supra note 8, at 1049.

Conclusion

It is the sense of the Congress that each State should review and revise, if necessary, its laws to ensure that mental health patients receive the protection and services they require; and in making such review and revision should take into account . . . the right to confidentiality of such person's records. [161]

The Illinois legislature should review and revise the Confidentiality Act to ensure that recipients are afforded their right of confidentiality. Under the Confidentiality Act, therapists do not have a statutory duty to obtain the informed consent of recipients prior to the disclosure of their mental health records. [162] The increasing ease of information sharing, collection, organization, and retention has added new dimensions to the notion of "blanket consent" and has further diluted the financial and logistical obstacles that have traditionally served to protect the confidentiality rights of recipients. [163] As a result, now more than ever, a recipient's consent to disclosure can have the effect of releasing considerably more information than the recipient had intended. [164] Because such a disclosure can have significant consequences, [165] recipients should be afforded the opportunity to make informed decisions respecting the use and control of their highly private and personal information. **[*565]**

Consequently, an operational definition of "blanket consent" should be implemented under the Confidentiality Act. An operational definition of "blanket consent" would principally necessitate that the authorization form be an informed consent. [166] While this objective appears to be the intent underlying the "blanket consent" language, a more explicit informed consent requirement is necessary in the aftermath of the M.A.K. decision. [167]

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[140] See Hayt, supra note 23, at 286.

[141] Id; see also Sharpe, supra note 43, at 16.

[142] Cf. Gatter, supra note 124, at 563-64 (discussing the reasonable person standard).

[143] Cf. Winick, supra note 60, at 347 (outlining the elements of informed consent as including: disclosure of information, competency, understanding, voluntariness, and decision making); Nelson, supra note 128 (outlining the following elements as constituting a valid consent in the context of consent to treatment: the consent must be voluntary; the person consenting must have the capacity to do so; the consent must be specific to the treatment and to the person who is to administer the treatment; and the consent must be informed).

[144] See supra Part II.A.2.

[145] Cf. Sharpe, supra note 43, at 17-18.

[146] See generally Standards for Privacy, supra note 38, at 82474 (noting that the final privacy standards should be consistent with the objective of reducing the administrative costs of providing and paying for health care).

[147] See generally Charity Scott, Is Too Much Privacy Bad for Your Health? An Introduction to the Law, Ethics, and HIPAA Rule on Medical Privacy, *17 Ga. St. U. L. Rev. 481, 522 (2000)* (noting that the healthcare industry has vociferously complained that obtaining informed consent prior to each disclosure would be inefficient and unbearably bureaucratic); Standards for Privacy,

supra note 38, at 82474 ("The costs of privacy and security are properly attributable to the suite of administrative simplification regulations as a whole . . . .").

[148] Cf. Gatter, supra note 124, at 563-64 (discussing the reasonable person standard).

[149] Cf. Sharpe, supra note 43, at 16 (noting that physicians are not obligated under the doctrine of informed consent to inform patients of "every conceivable risk or side effect . . . but the highest risks and the most adverse possible side effects must be disclosed."); Hayt, supra note 23, at 286 (noting that a patient's knowledge need not be precise).

[150] Hayt, supra note 23, at 286 (noting that informed consent is not required where a patient "knows in general that his diagnosis and cure may entail many procedures, and that his very request for a cure would include the willingness to submit to these ordinary procedures.").

[151] See generally Standards for Privacy, supra note 38, at 82473 ("Many health care practitioners and their representatives argued that seeking a patient's consent to disclose confidential information is an ethical requirement that strengthens the physician-patient relationship.").

[152] See Weiner, supra note 22, at 570.

[153] See generally Kenneth S. Pope & Valerie A. Vetter, Ethical Dilemmas Encountered by Members of the American Psychological Association, 47 Am. Psychologist 397, 399 (1992) (noting that members of the American Psychological Association reported that confidentiality was the most frequently occurring ethical dilemma they faced).

[154] See id.

[155] See Part II.B-C (discussing the M.A.K. ruling).

[156] See, e.g., *W. Page Keeton et al., supra* note 96, at 112.

[157] Cf. Standards for Privacy, supra note 38, at 82473 ("Patient advocates argued that the act of signing focuses the patient's attention on the substance of the transaction and provides an opportunity for the patient to ask questions about or seek modifications in the provider's practices."). See generally Winick, supra note 60, at 362 ("Particularly in the treatment of those with mental illness, the informed consent process, properly undertaken, can be an important therapeutic tool.").

[158] See, e.g., *Jaffee v. Redmond, 518 U.S. 1, 10 (1996).*

[159] Winick, supra note 60, at 362.

[160] Standards for Privacy, supra note 38, at 82464.

[161] *42 U.S.C. § § 9501,* 9501(1)(H) (1994).

[162] Compare *Fla. Stat. Ann. § 394.4615(1)* (West Supp. 2002) (providing that "a clinical record is confidential . . . . Unless waived by express and informed consent . . . the confidential status of the clinical record shall not be lost by either authorized or unauthorized disclosure . . . .") (emphasis added), with *740 Ill. Comp. Stat. 110/5(a)* (2000) (providing that "records and communications may be disclosed . . . only with the written consent of those persons who are entitled to inspect and copy a recipient's record . . . .") (emphasis added).

[163] See Standards for Privacy, supra note 38, at 82465 (discussing the effect the increasing use of interconnected electronic systems has upon privacy).

[164] See id. at 82473 ("We expressed concern about the coercive nature of consents currently obtained by providers and plans relating to the use and disclosure of health information. We also expressed concern about the lack of information available to the patient during the process, and the fact that patients often were not even presented with a copy of the consent that they have signed.").

[165] See id. at 82468 ("A breach of a person's health privacy can have significant implications well beyond the physical health of that person, including the loss of a job, alienation of family and friends, the loss of health insurance, and public humiliation.").

[166] See Hayt, supra note 23, at 286.

[167] See, e.g., *M.A.K., 764 N.E.2d at 10* (upholding the validity of an overly broad authorization form obtained without the patient's informed consent).

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End of Document

Requirements for consent form for Part 2 Program:

A written consent to a disclosure under the Part 2 regulations must be in writing and include all of the following items (42 CFR § 2.31):

1) the specific name or general designation of the program or person permitted to make the disclosure;

2) the name or title of the individual or the name of the organization to which disclosure is to be made;

3) the name of the patient;

4) the purpose of the disclosure;

5) how much and what kind of information to be disclosed;

6) the signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient;

7) the date on which the consent is signed;

8) a statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it.

9) the date, event or condition upon which the consent will expire if not revoked before. This data, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

AUTHORIZATION FOR

RELEASE OF COUNSELING INFORMATION

Please read both sides of this form carefully. The federal Health Insurance Portability and Accountability Act of 1996 (HIPPA), which became effective April 14, 2003, requires that all of the following elements must be completed for an authorization to be valid.

Patient Name:_____

Address:_____

City/State/Zip:_____

Phone Number:_____

Date of Birth:_____

Patient's Relationship to Requesting Person:_____

I hereby authorize that the protected health information regarding the above-named person be forwarded from:

From: Person/Organization: _____

Address: City/State/Zip:_____

Fax number for facility:_____

Please send records to: Emily Rapp, MagnusonRapp Law LLC, 205 ½ W. State Street, Suite C, Geneva, IL 60134; *Court-Appointed Guardian Ad Litem/or the minor child(ren)*

Purpose of Disclosure: The information obtained from the above entity will be used by the Guardian ad litem in conducting her investigation as to the best interests of the child/children in a dispute regarding parenting time, responsibilities and/or relocation.

Disclosure will include:

Other: I understand that I must check one or more of the following types of health information that I **do not** want released to the above-named Recipient. I understand that if I do not check any of the following three items, the health information released to the named Recipient may include any of the following:

___ Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse
___ Records of HTLV-lll or HIV testing (AIDS test) result, diagnosis and/or treatment
___ Psychiatric, psychological records or evaluation and/or treatment for mental, physical, and/or emotional illness including narrative summary, tests, social work assessment; medication, psychiatric examination, progress notes, consultations, treatment plans and/or evaluation.

I understand I have the right to inspect and copy the information to be disclosed.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent the action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in one year after signing. The covered entity may not condition treatment, payment, enrollment or eligibility for benefit on whether the individual signs the authorization.

_____(INITIALS) I understand that the Guardian ad Litem, as part of her duties, is required to state all informational and testimonial basis for her recommendation. To the extent that this counseling, treatment, mental health, drug testing/results, drug and alcohol treatment and medical information forms the basis for the GAL's opinion regarding the best interests of the child/ren, I permit the GAL to re-disclose this information to the Court and counsel/opposing parties, pursuant to the Health Insurance Portability and Accountability Act of 1996, the Illinois Mental Health and Developmental Disabilities Confidentiality Act and Federal Confidentially Rules, including 42 CFR part 2.

Date: _____

_____
Signature of Parent/Guardian

_____
Printed Name of Parent/Guardian

SUBSCRIBED AND SWORN to before me
this _____ day of _____, 20_____.

_____
Notary Public

_____
Signature of Patient (If over 12 and mental health records are being requested)

_____
Printed Name of Patient

SUBSCRIBED AND SWORN to before me
this _____ day of _____, 20_____.

_____
Notary Public