**INFORMATION AND PRIVACY COMMISSIONER OF ALBERTA**

# Investigation Report Concerning the Disclosure of Health Information and Collection of Personal Information

**Investigation Report H2009-IR-001 and P2009-IR-001**

**January 6, 2009**

**Lamont Health Care Centre,**

**Dr. Jaime Wagan Namit**
**&**
**Great-West Life Assurance Company**

**(Investigations H1829, H1830 and P0792)**

## Introduction

[1] On October 5, 2007, the Information and Privacy Commissioner (the "Commissioner") received a complaint from an individual (the "Complainant") related to the disclosure of her health information by her physician (Dr. Jaime Wagan Namit) to her employer (the Lamont Health Care Centre or "LHCC") and an insurance company (the Great-West Life Assurance Company or "GWL").

[2] The Complainant wrote to the Commissioner after learning that Dr. Namit had released the entire contents of her medical record to the LHCC for the purpose of responding to a request for information from GWL. GWL had requested information from Dr. Namit in order to assess the Complainant's application for disability benefits.

[3] The Commissioner authorized me to conduct an investigation under section 85(e) of the *Health Information Act* (HIA) and section 36(2)(e) of the *Personal Information Protection Act* (PIPA). Section 85(e) of the HIA allows the Commissioner to investigate whether health information has been collected, used, disclosed or created by a custodian in contravention of that Act. Section 36(2)(e) of PIPA allows the Commissioner to investigate and attempt to resolve complaints that personal information has been collected, used or disclosed by an organization in contravention of that Act or in circumstances that are not in compliance with that Act.

[4] This report lays out the findings and recommendations resulting from my investigation.

## Background

[5] The Complainant receives health services from Dr. Namit as a patient in his private practice, which is a separate office located within the Lamont Health Care Centre (LHCC). Dr. Namit billed the Alberta Health Care Insurance Plan (AHCIP) for the health services he provided to the Complainant.

[6] The Complainant is an employee of the LHCC. The LHCC subscribes to the Health Organization Benefits Plan of Alberta[1]. As an eligible employee of a public sector health care organization that belongs to that plan, the Complainant is entitled to short term disability benefits and disability support services from theGreat-West Life Assurance Company (GWL).

[7] The Complainant sustained a non-work related injury in August 2007. As this injury prevented her from working for a period of time, she filed a claim with GWL for short term disability benefits in September 2007.

[8] While seeking treatment for the injury that gave rise to the claim, the Complainant states she was advised by Dr. Namit's staff that her entire chart had been provided to the LHCC "for something to do with insurance" and that the LHCC owned the chart.

[9] The Complainant states she went to the LHCC to inquire about the location and ownership of her medical record. Employees of the LHCC, including the Executive Director, advised the Complainant that the LHCC "owns" Dr. Namit's paper charts and that the LHCC had copied and released the records required by GWL. The Complainant states she then found her chart in an unsecure mailbox that was accessible to all staff at the LHCC.

[10] The Complainant lays out eight concerns in her letter to the Commissioner. These are:

> *"My first concern; my personal doctor giving my medical records to "our" boss*
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> *My second concern: my boss asking for and receiving my entire medical chart*
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> *My third concern; "saving money" being the reason my medical chart left the doctor's office*
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> *My fourth concern; how my medical chart was handled*
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> *My fifth concern; not being informed of this practice*
>
> *My sixth concern; Great-West asking for and receiving personal information outside the boundaries of my claim*
>
> *My seventh concern; who had made a poor attempt at making my chart look like I had given informed consent for [the release of] additional information*
>
> *My eighth concern; Lamont Health Care Centre "owning" the medical records from private medical clinics."*

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1 Some employers within the health sector, including the LHCC, are required by collective agreement to offer this plan or an equivalent to employees in various health services roles.

**Application of the HIA and PIPA**

[11] The *Health Information Act* (HIA) applies to "health information" in the custody or under the control of a "custodian".

[12] "Health information" is defined in section 1(1)(k) of the HIA to include "diagnostic treatment and care information", "health services provider information" and "registration information"[2]. The Complainant's chart contains a mixture of diagnostic treatment and care information, health services provider information and registration information. I have reviewed the information at issue in this case and confirm that it is health information.

[13] The term "custodian" is defined in section 1(1)(f) of the HIA, and includes:

> *(f) "custodian" means*
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> *(i) the board of an approved hospital as defined in the Hospitals Act other than an approved hospital that is*
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> *(A) owned and operated by a regional health authority established under the Regional Health Authorities Act, or*
>
> *(B) established and operated by the Alberta Cancer Board continued under the Cancer Programs Act;*
>
> *…*
>
> *(ix) a health services provider who is paid under the Alberta Health Care Insurance Plan to provide health services;*

[14] The Lamont Health Care Centre is a non-regional hospital under the *Hospitals Act* and, as such, is a custodian pursuant to section 1(1)(f)(i) of the HIA. Dr. Namit is a health services provider who is paid under the Alberta Health Care Insurance Plan to provide health services and, therefore, is a custodian under section 1(1)(f)(ix) of the HIA.

[15] In addition to being a custodian under the HIA, the LHCC is also a public body under the *Freedom of Information and Protection of Privacy Act* (the FOIP Act). The FOIP Act regulates the collection, use and disclosure of personal information by public bodies. This raises the question of whether the LHCC collected the Complainant's personal information under the FOIP Act in its capacity as her employer or as a custodian of health information under the HIA.

[16] Commissioner's Orders H2008-003 and F2008-012 consider whether the FOIP Act or the HIA applies when information that falls within the definition of "health information" is collected in an employment relationship by an entity that is both a public body under the FOIP Act and a custodian under the HIA. These Orders found that the application of the FOIP Act and the HIA is contextual and is predicated on the purpose for which the information was collected, used or disclosed. To paraphrase the findings in these Orders, the HIA applies when the information is collected, use or disclosed for the purposes articulated in the HIA

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[2] These terms are further defined in sections 1(1)(i), 1(1)(o) and 1(1)(u) of the *Health Information Act* and section 3 of the *Health Information Regulation.*

(i.e. providing health services or managing the publicly funded health system) and the FOIP Act applies when information is collected, used or disclosed for the purpose of managing an employer/employee relationship.

[17] The LHCC did not contend at any point during this investigation that it collected the Complainant's health information from Dr. Namit in its capacity as the Complainant's employer. It has always been the LHCC's position that it is the legal owner of Dr. Namit's charts, that the HIA applies to these records and that it is the custodian accountable for the management of these records under the HIA. While the LHCC's assertions related to its accountability for these records will be examined further in this report, I accept the fundamental premise that the collection, use and disclosure of the health information in question is regulated by the HIA as opposed to the FOIP Act. Dr. Namit did not provide the records to the LHCC because the Complainant was employed by the LHCC. The records were provided to the LHCC because Dr. Namit believed the LHCC to be the custodian of the records. The request would have been processed the same way regardless of whether the Complainant was employed by the LHCC or not.

[18] As the medical record in question contains the Complainant's health information and both Dr. Namit and LHCC are custodians, I find that the HIA applies to the collection, use and disclosure of health information by the LHCC and Dr. Namit.

[19] In addition to her complaint about the handling of her health information by Dr. Namit and the LHCC, the Complainant also raised a number of issues related to the collection of her information by GWL.

[20] The *Personal Information Protection Act* (PIPA) applies to "personal information" that is collected, used or disclosed by an "organization".

[21] Section 1(k) of PIPA defines "personal information" to be information about an identifiable individual. I have reviewed the information collected by GWL and confirm it to be identifiable information about the Complainant.

[22] Section 1(j) of PIPA defines "organization". It reads:

> *1 (i) "organization" includes*
> *(i) a corporation,*
> *(ii) an unincorporated association,*
> *(iii) a trade union as defined in the Labour Relations Code,*
> *(iv) a partnership as defined in the Partnership Act, and*
> *(v) an individual acting in a commercial capacity,*
>
> *But does not include an individual acting in a personal or domestic capacity…*

[23] GWL is a chartered life insurance company incorporated under the federal *Insurance Companies Act*. GWL is a corporation as defined in section 1(i)(i) of PIPA and is, therefore, an organization under that law.

[24] As the information collected by GWL is personal information and GWL is an organization, I find that PIPA applies to the collection and use of the Complainant's personal information by GWL.

**Issues**

[25] The issues to be considered in this investigation are:

1. Did Dr. Namit have authority to disclose the Complainant's health information to the LHCC?

2. Did the LHCC have authority to collect the Complainant's health information?

3. Did Dr. Namit have authority to disclose the Complainant's health information to GWL?

4. Did GWL have authority to collect the Complainant's personal information?

5. Did GWL limit the collection of personal information to that which was reasonable?

**Analysis**

Preliminary Matter – Custodianship of Records

[26] Both Dr. Namit and the LHCC advised me early in this investigation that they did not believe Dr. Namit to be the custodian of the health information stored in the charts he uses to record patient visits as the LHCC bought the records in 1996. I must resolve the issue of the custodianship of the records stemming from Dr. Namit's private medical practice before reaching findings on the issues laid out above.

[27] Dr. Namit's position is that he did not disclose the Complainant's health information to the LHCC as the LHCC owns the records and is the custodian of the records under the HIA. Dr. Namit states that, on beginning to practice in the town of Lamont in 1996, he was advised by the Executive Director of the LHCC that the LHCC had purchased the clinical records of the physicians who previously owned the clinic and that the LHCC had become the custodian of the records. Dr. Namit states that he was directed that he was to continue to use the records of the previous physicians that had been purchased by the LHCC and that the LHCC would process and respond to any requests for access to health information from these records.

[28] I received similar information from the LHCC with additional clarification that the 1996 purchase of the clinical records was undertaken primarily to ensure that physicians entering practice in Lamont would have access to a comprehensive health record on the residents of the community. The LHCC believes itself, by virtue of the purchase of the clinical records of the physicians

who have left the community, to be the owner and custodian of the records stemming from private medical practice in the community of Lamont.

[29] The sale of clinical records was not recorded, although the LHCC provided minutes from a 1996 Board Meeting where the purchase of clinical records from physicians leaving the community was discussed. The LHCC also provided signed letters from the physicians who left the community in 1996 stating that they sold their records to the LHCC.

[30] The LHCC indicates that they have a similar arrangement with other physicians in the Lamont area. The LHCC stores the inactive clinical records[3] for each of these physicians in a common room at the health centre and provides all of the supplies required to manage the records. This area can be accessed by LHCC health records staff, LHCC senior management and administrators, LHCC medical officers and staff from each of the medical clinics. Staff from each of the community medical clinics can enter the storage area, select the patient files they require, transport the files to the clinic, and return the files to storage when no longer required. The community charts are not stored in the same physical location as the LHCC charts that document health services provided by the LHCC.

[31] Dr. Namit has not received compensation for his medical records from the LHCC, nor does he pay a fee to the Centre for maintaining the records. No agreement related to the sale, purchase or maintenance of the records created by Dr. Namit has been executed. Dr. Namit's practice of maintaining the records in the manner set forth by the LHCC is predicated on a verbal description of the arrangement made by the physicians who left the community in 1996.

[32] The issue of the ownership of clinical records is complex. For guidance in this regard, I consulted the College of Physicians and Surgeons of Alberta (CPSA) Physicians' Office Medical Records Policy[4]. This Policy lays out the following:

- Members in practice must keep clinical patient records
- These records must reflect services provided to the patient in order to justify claims submitted to the Alberta Health Care Insurance Plan
- Clinical office records belong as property to the physician who produced them, with the exception of records and notes created by physicians working in or employed by hospitals, institutions or companies.
- It is recommended that medical records be retained for a period of ten years after the date of last service, after which they can be disposed of.

[33] The CPSA Policy derives from the Supreme Court of Canada's decision in *McInerney v. MacDonald*[5]. In ruling on a patient's right of access to health

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3 Inactive clinical records are those records that are not routinely accessed or used by the physician. For example, the records of a patient who sees the doctor only once a year may be stored in the inactive file room at the LHCC, while the records of a patient who sees the doctor every week will be stored in a filing system within the doctor's office.

4 Available online at: http://www.cpsa.ab.ca/publicationsresources/attachments_policies/Physicians%20Office%20Medical%20Records.pdf and accessed on October 1, 2008.

information, La Forest J. wrote "I am prepared to accept that the physician, institution or clinic compiling the medical record owns the physical record." This decision established that the physical record belongs to the organization or person that compiles the record, while the patient continues to exert a right of access to and a controlling interest in the health information contained within the record.

[34] Instead of attributing responsibility for the management of health information to the owners the information, the HIA attributes accountability for the management of health information to custodians that exercise custody or control of health information. While custody and control are not defined within the body of the HIA, the concept of "custody" implies physical possession of the record while the concept of "control" implies the ultimate authority to manage the information. It is possible for a custodian to have physical possession of a record, but to not exercise the ability to control what happens to that record. Likewise, it is possible for a custodian to have relinquished physical custody of a record, but to have retained the responsibility to control what happens with the record. Physical possession of a record is simply one factor which must be considered when determining custodianship under the HIA.

[35] In Order 99-032, the Commissioner considered whether records that had been transferred to another organization were under the control of a public body subject to the *Freedom of Information and Protection of Privacy Act* (the FOIP Act). The Commissioner cited a decision of the Information and Privacy Commissioner of Ontario that established "factors for consideration" in determining whether an organization or institution that has physical custody of a record also exercises control of the record. These factors are:

1. *Was the record created by an officer or employee of the institution?*
2. *What use did the creator intend to make of the record?*
3. *Does the institution have possession of the record either because it has been voluntarily provided by the creator or pursuant to a mandatory statutory or employment requirement?*
4. *If the institution does not have possession of the record, is it being held by an officer or employee of the institution for the purposes of his or her duties as an officer or employee?*
5. *Does the institution have a right to possession of the record?*
6. *Does the content of the record relate to the institution's mandate and functions?*
7. *Does the institution have the authority to regulate the records use?*
8. *To what extent has the record been relied upon by the institution?*
9. *How closely is the record integrated with other records held by the institution?*
10. *Does the institution have the authority to dispose of the record?*

[36] These factors generally assess whether an organization that has possession of a record controls what happens to the record. The following constitutes my assessment of this case in relation to each of the ten factors:

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5 *McInerney v. MacDonald*, [1992] 2 S.C.R. 138

1. The records were created by Dr. Namit and his staff.
2. The records were created for the purpose of documenting health services provided by Dr. Namit in his private medical practice and to bill and receive compensation from the Alberta Health Care Insurance Plan for the provision of those services. The records were not created for the purpose of documenting health services provided by Dr. Namit when he works at the LHCC. When Dr. Namit provides services at the LHCC, the records of those services are maintained in a chart that describes all services provided to a patient at the LHCC. The LHCC chart is separate and distinct from the chart used to document services provided to a patient when they see Dr. Namit in his private practice.
3. No statutory or employment requirement exists that requires the records to be provided to the LHCC. On the contrary, CPSA policy requires physicians to maintain records related to the health services they provide. Failure to maintain records of services provided can result in disciplinary actions for physicians, up to and including potential loss of a medical license.
4. Dr. Namit's ability to admit and treat patients in the LHCC is independent from his function as a health services provider in the community. When Dr. Namit provides health services as an affiliate of the LHCC, the records he creates are stored in the LHCC chart.
5. CPSA Policy and common law uphold the principle that the physical medical record is the property of the physician that created the record. While the physicians who left the practice in 1996 may have transferred their property rights to the LHCC, this decision did not impact Dr. Namit's rights and obligations in relation to the records he creates to document treatment and care he provides. Dr. Namit was not and is not obligated by law to continue to use the records that had been purchased by the LHCC.
6. The LHCC has no mandate to maintain records of health services provided by community based physicians. The LHCC is required by the *Hospitals Act* to maintain records related to the health services provided by the hospital. Health services provided by Dr. Namit in his private practice and for which he bills the AHCIP are not health services provided by the hospital.
7. The LHCC has no ability to regulate how records stemming from treatment provided in Dr. Namit's private medical practice are used, disclosed or destroyed.
8. As a matter of practice, when a patient presents at the LHCC for treatment, only the LHCC chart is pulled. The LHCC does not pull the physician's community chart to consider when providing health services and vice versa. The records are maintained separately and are not presumed by either party to be interchangeable.
9. The records of the LHCC and community based physicians are not integrated.
10. CPSA policy requires physicians to maintain records for treatments and recommends that they be maintained for a period of ten years after the last treatment was provided to the patient. CPSA policy states that the physician can destroy the records at that point. The LHCC has no

> authority to dispose of records created through Dr. Namit's private medical practice.

[37] After weighing these considerations, I find that Dr. Namit has control of the records he creates in the course of providing health services for which he bills the Alberta Health Care Insurance Plan. As such, I find that Dr. Namit is the custodian of these records under the *Health Information Act.*

Issue 1 - Did Dr. Namit have authority to disclose the Complainant's health information to the LHCC?

[38] The Complainant is a patient of Dr. Namit's. As she was receiving weekly treatment from Dr. Namit, her chart was stored in Dr. Namit's office space. It was not, at the time of the complaint, stored in the shared record area at the LHCC.

[39] Dr. Namit received a written request for the Complainant's health information from a Case Manager at GWL on September 12, 2007. GWL requested this information from Dr. Namit as the Complainant identified him as her attending physician. GWL did not request information from the LHCC.

[40] Dr. Namit forwarded the Complainant's chart to the administration area of the LHCC on September 12, 2007 for the purpose of responding to the request for information from GWL. GWL's submission includes a copy of its letter of request with a notation from Dr. Namit, which states:

> *"Sept 12/07 [name of LHCC Executive Director] I have no problem with this request"*

[41] The chart also contains a note from the Executive Director of the LHCC which states:

> *"[name of LHCC employee] Please attend to this matter"*

[42] The parties agree that the Complainant's chart was provided by Dr. Namit to the LHCC on September 12, 2007, and that the LHCC mailed the requested information to GWL on September 17, 2007. Dr. Namit states that his intent in providing the information to the LHCC was to have the responsive records copied by the LHCC and mailed to GWL. Dr. Namit states that he processed the request this way as he had previously been directed to route all requests for patient records to the LHCC. The LHCC agrees that this direction was given and adds that the direction was given based on their understanding that they had purchased the records in 1996 and that they were the custodian of the records.

[43] The HIA does not define "disclose"; however, previous Orders and Investigation Reports have defined disclose to mean "to provide or make available to". In providing patient information to the LHCC, Dr. Namit disclosed the Complainant's health information to the LHCC. I must now determine whether Dr. Namit was authorized to disclose the Complainant's health information to the LHCC.

[44] The HIA allows health information to be disclosed with individual consent. In this case, the Complainant consented that Dr. Namit could release relevant health information to Great-West Life. The Complainant did not consent to Dr. Namit disclosing her health information to the LHCC, which is also her employer.

[45] The HIA also allows for health information to be disclosed without individual consent in limited and specific circumstances. I asked both Dr. Namit and the LHCC to comment on the potential legal authority for this disclosure without the Complainant's expressed consent. The substance of both representations was that the LHCC was the custodian of the records, therefore no disclosure took place. I have found that Dr. Namit exercises control of the records created through his private medical practice and that he disclosed this information to the LHCC; therefore, this position is not supported.

[46] In the absence of relevant representation from the parties on legislative authority, I reviewed the HIA to determine if authority for disclosure without consent in these circumstances exists. The relevant provisions of the HIA are:

> *35(1) A custodian may disclose individually identifying diagnostic, treatment and care information without the consent of the individual who is the subject of the information*
>
> > *(a) to another custodian for any or all of the purposes listed in section 27(1) or (2), as the case may be,*
> > *(b) to a person who is responsible for providing continuing treatment and care to the individual,*
> > *…*

[47] The LHCC is a custodian of health information, therefore, potential authority exists for Dr. Namit to disclose the Complainant's health information to it under section 35(1)(a) of the HIA. Section 35(1)(a) must be read in conjunction with section 27 of the HIA. Section 27 lays out the purposes for which custodians, including the LHCC, can use health information[6]. Dr. Namit has stated that he disclosed the health information to the LHCC to allow for the information to be copied and mailed. This is not a purpose for which LHCC was authorized to use the health information under section 27 of the HIA; therefore, Dr. Namit was not authorized to disclose health information to the LHCC under section 35(1)(a) of the HIA.

[48] Section 35(1)(b) of the HIA is predicated on "treatment and care" being provided to an individual by the individual or organization that receives the information. The stated purpose for disclosure in this case was to allow for records to be copied and disseminated. The Complainant did not seek or receive treatment or care from the LHCC for her injury. As such, I find that section 35(1)(b) also does not apply in this case.

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6 Section 27 of the HIA defines authorized uses of health information which include providing health services, determining if an individual is eligible to receive a health service and internal management purposes etc.

[49] There is a third provision of the HIA that would have allowed for health information to be disclosed by Dr. Namit to the LHCC. Section 66 of the HIA permits custodians to disclose health information to an information manager for specific purposes, including the storage or retrieval of health information.

[50] Section 66 reads:

> *66(1) In this section, "information manager" means a person or body that*
> *(a) processes, stores, retrieves or disposes of health information,*
> *(b) in accordance with the regulations, strips, encodes or otherwise transforms individually identifying health information to create non-identifying health information, and*
> *(c) provides information management or information technology services.*
> *(2) A custodian may enter into an agreement with an information manager in accordance with the regulations for the provision of any or all of the services described in subsection (1).*
> *(3) A custodian that has entered into an agreement with an information manager may disclose health information to the information manager without the consent of the individuals who are the subjects of the information for the purposes authorized by the agreement.*

[51] The LHCC provides a number of services to Dr. Namit in relation to the management of his charts, including record storage, filing and retrieval. It is my opinion that these are all services that can be offered by an information manager. That being said, the fact that an information manager provides these services to a custodian is not sufficient authority for the information to be disclosed. Section 66(3) of the HIA stipulates that the disclosure of health information to an information manager may occur without individual consent only where the custodian has entered into an agreement with the information manager.

[52] Both Dr. Namit and the LHCC state that they have not entered into any agreement related to the management of Dr. Namit's records. Given that the parties have not entered into an agreement related to the provision of information management services, no authority exists for Dr. Namit to disclose health information to LHCC as an information manager under section 66 of the HIA.

[53] The Complainant did not consent to her health information being provided to the LHCC. In the circumstances of this case there is no authority that would allow for Dr. Namit to make this disclosure without the Complainant's consent. As such, I find that Dr. Namit did not have authority to disclose the Complainant's health information to the LHCC.

Issue 2 - Did the LHCC have authority to collect the Complainant's health information?

[54] Section 1(1)(d) of the HIA defines "collect" as "to gather, acquire, receive or obtain health information". When the LHCC received the Complainant's health information from Dr. Namit on September 12, 2007, it collected the health

information as a custodian under the HIA. It did not collect this information as a public body under the FOIP Act.

[55] I asked the LHCC to describe the legal authority under which it collected the Complainant's health information. In response to my question, the LHCC stated that they were the custodian of the records and that they released the information to GWL as instructed. It did not directly respond to my question and indicate under what legal authority it collected the Complainant's health information.

[56] I have already established that the LHCC is a custodian under the HIA. The collection of health information by custodians is regulated by section 20 of that Act, which states:

> *20 A custodian may collect individually identifying health information*
> *(a) if the collection of that information is expressly authorized by an enactment of Alberta or Canada, or*
> *(b) if that information relates directly to and is necessary to enable the custodian to carry out a purpose that is authorized under section 27.*

[57] In order for the LHCC to collect the Complainant's health information, the collection must be authorized by section 20(a) or 20(b) of the HIA.

[58] Section 20(a) of the HIA permits the collection of health information where the collection of that information is authorized by another law of Alberta or Canada. I have reviewed the relevant legislation and can find no law that authorizes or permits the LHCC to collect health information from community based physicians on services they provide in their clinics. The only law I found which authorizes or permits the LHCC to maintain clinical records of treatment is the *Hospitals Act*. This law requires the LHCC to maintain records of health services it provides. The interpretation of the *Hospitals Act*, when combined with section 20(a) of the HIA, is that the LHCC is authorized to collect health information related to the health services it provides. It is not authorized by this statute to collect health information related to health services provided by other custodians.

[59] Similarly, section 20(b) of the HIA permits a custodian to collect health information if that information is required for the custodian to carry out a purpose authorized by section 27. I have previously determined that the LHCC did not intend to use health information for an authorized section 27 purpose when it collected the Complainant's health information. As the LHCC was not authorized to use the Complainant's health information pursuant to section 27 of the HIA, they were not authorized to collect the Complainant's health information under section 20(b) of the HIA.

[60] I find that the LHCC did not have authority to collect the Complainant's health information.

Issue 3 - Did Dr. Namit have authority to disclose the Complainant's health information to GWL?

[61] The Complainant initiated a claim for disability benefits with GWL on September 7, 2007. As part of the claim initiation process, she completed an "Authorization for Disclosure for Proactive Disability Claims Management Services" form (the consent form).

[62] On September 12, 2007, a GWL Case Manager wrote to Dr. Namit and requested that he provide her with information related to the claim for the period of August 1 to September 12, 2007. The Case Manager provided a copy of the consent form with this request.

[63] GWL provided me with a copy of the request and signed consent form. The consent form contains:

- A description of how GWL manages and uses personal information
- Authorization for GWL, healthcare providers, plan administrators, insurance companies, other benefits programs and organizations working with GWL to exchange information when relevant and necessary for the purpose of assessing the claim
- A statement that the consent will remain valid for the duration of the claim or until otherwise revoked
- A statement confirming a photocopy or electronic copy of the authorization to be as valid as the original
- The name, signature and phone number of the Complainant and the date on which the authorization was executed.

[64] I have previously stated that the HIA allows a custodian to disclose health information with the consent of an individual. That authority is found in section 34 of the HIA, which reads:

> *34(1) Subject to sections 35 to 40, a custodian may disclose individually identifying health information to a person other than the individual who is the subject of the information if the individual has consented to the disclosure.*
>
> *(2) A consent referred to in subsection (1) must be provided in writing or electronically and must include*
>
> > *(a) an authorization for the custodian to disclose the health information specified in the consent,*
> > *(b) the purpose for which the health information may be disclosed,*
> > *(c) the identity of the person to whom the health information may be disclosed,*
> > *(d) an acknowledgment that the individual providing the consent has been made aware of the reasons why the health information is needed and the risks and benefits to the individual of consenting or refusing to consent,*

> *(e) the date the consent is effective and the date, if any, on which the consent expires, and*
> *(f) a statement that the consent may be revoked at any time by the individual providing it.*

[65] Section 34(2) of the HIA requires that a consent to disclose health information contain specific elements. The language in this provision is definitive.

[66] When I reviewed the consent form against the requirements of section 34(2), I found that it contains:

- A statement authorizing a healthcare provider (Dr. Namit in this case) to exchange health information with GWL (s. 34(2)(a))
- A statement that the information is exchanged for the purpose of assessing the Complainant's claim for disability benefits (s. 34(2)(b))
- A statement that the information is to be exchanged with GWL (s. 34(2)(c))
- A date on which the Complainant executed the authorization, which is the date on which consent was given (s. 34(2)(e))
- A statement that the consent is valid for the duration of the claim unless the authorization is revoked ((s. 34(2)(f)).

[67] The consent form does not include an acknowledgement that the Complainant has been made aware of the reasons why the health information is needed and the risks and benefits of the individual consenting or refusing to consent, as required by section 34(2)(d) of the HIA.

[68] GWL no longer uses the consent form that was used in this case. GWL began to use a revised consent form in December 2007. The revised consent form meets all of the criteria for a valid consent laid out in section 34(2) of the HIA.

[69] While GWL revised the consent form in 2007, the consent form executed by the Complainant in this case and which was cited as authority to release the Complainant's information did not meet all the requirement of section 34(2) of the HIA. As such, I must find that Dr. Namit was not authorized to disclose the Complainant's health information to GWL.

Issue 4 - Did GWL have authority to collect the Complainant's personal information?

[70] The Complainant alleged that GWL collected too much personal information about her. Before I can decide whether or not GWL sufficiently limited their collection of personal information, I must establish that it had authority to collect the Complainant's personal information in the first place.

[71] The Complainant states that she voluntarily initiated a claim for disability benefits with GWL on September 7, 2007, after being advised of the availability of this program by her employer. Employees of the LHCC are eligible for this

insurance by virtue of an agreement that the LHCC has with GWL. The LHCC is required to provide this type of insurance to employees under collective agreement, and the costs of the program are shared between the employer and employee.

[72] I have previously established that GWL is an organization subject to the *Personal Information Protection Act* (PIPA). Section 5 of that Act stipulates that an organization is responsible for personal information that is in its custody or under its control. When GWL requested and received information related to this claim, it collected personal information. This information then came into the custody of GWL and became subject to PIPA.

[73] The requirements for the collection of personal information under PIPA are different than the requirements for the collection of health information under the HIA. This difference hinges primarily on the ability of the individual to consent to the collection of their information. The HIA does not recognize the ability of the individual to consent to the collection of health information – health information can only be collected where the collection is authorized or required by law or where the custodian is authorized to use health information. PIPA, on the other hand, allows an organization to collect personal information for reasonable purposes if the individual has consented to the collection of personal information. PIPA also recognizes that consent can be oral or written, where the HIA only recognizes written consent.

[74] The relevant sections of PIPA read:

> *7(1) Except where this Act provides otherwise, an organization shall not, with respect to personal information about an individual,*
>
> *(a) collect that information unless the individual consents to the collection of that information,*
>
> *(b) collect that information from a source other than the individual unless the individual consents to the collection of that information from the other source,*
>
> *…*
>
> *8(1) An individual may give his or her consent in writing or orally to the collection, use or disclosure of personal information about the individual.*
>
> *(2) An individual is deemed to consent to the collection, use or disclosure of personal information about the individual by an organization for a particular purpose if*
>
> *(a) the individual, without actually giving a consent referred to in subsection (1), voluntarily provides the information to the organization for that purpose, and*
>
> *(b) it is reasonable that a person would voluntarily provide that information.*
>
> *(3) Notwithstanding section 7(1), an organization may collect, use or disclose personal information about an individual for particular purposes if*
>
> *(a) the organization*

> *(i) provides the individual with a notice, in a form that the individual can reasonably be expected to understand, that the organization intends to collect, use or disclose personal information about the individual for those purposes, and*
> *(ii) with respect to that notice, gives the individual a reasonable opportunity to decline or object to having his or her personal information collected, used or disclosed for those purposes,*
> *…*

[75] GWL collected the Complainant's personal information from the Complainant, her employer and Dr. Namit.

[76] The Complainant voluntarily provided the following records to GWL for the purpose of initiating a claim for disability benefits:

- A "Notice of Claim" form that included information about the Complainant, including employment information and information related to her injury;
- A "Authorization of Disclosure of Proactive Disability Claims Management Services" form;
- A letter from Dr. Namit indicating she was unable to work for a period of time; and
- A diagnostic imaging report confirming the injury.

[77] I have reviewed the "Authorization for Disclosure" form. It does not contain an explicit statement in which the Complainant consents to the collection of personal information directly from her. That said, section 8(2) of PIPA states that an individual is deemed to have consented to the collection of his or her personal information when he or she voluntarily provides the information to an organization for a particular purpose and where it is reasonable that a person would do so.

[78] The forms to initiate a claim with GWL clearly lay out the purposes for which personal information is collected. They state:

> *"The information about you (i.e. the claim file) may include medical or psychiatric information."*
>
> *"We use the information to investigate and assess your claim and to administer the group benefit plan."*

[79] The form the Complainant completed to initiate her claim for benefits with GWL states that the information provided is used to investigate and assess a claim for benefits. This information was presented to the Complainant at the time she provided all of the information on the "Notice of Claim" form to GWL along with supporting documentation. As the complainant voluntarily provided the information to GWL, and the provision of information for the purpose of establishing a claim for compensation is reasonable, I find the Complainant consented to the collection of her personal information for this purpose.

[80] GWL also collected the Complainant's personal information from the LHCC and Dr. Namit. GWL collected an "Employer's Statement" form from the LHCC that described the Complainant's job responsibilities and the nature of her employment. GWL collected eight pages of medical records related to the Complainant's injury from Dr. Namit.

[81] The "Authorization of Disclosure for Proactive Disability Claims Management Services" form (previously referred to in this report as "the consent form") includes several statements related to the purposes for which information is collected, used and disclosed by GWL. It includes the following statement:

> *"I authorize GWL, any healthcare or rehabilitation provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations or service providers working with GWL to exchange my information when relevant and necessary for the purpose of assessing my claim, administering the group benefits plan or performing independent assessments…"*

[82] When the Complainant executed an authorization that allowed GWL to exchange personal information with healthcare providers and her employer for the purpose of assessing her claim, she consented to GWL collecting her personal information from these sources. While "exchange" is not a term used in PIPA to reflect information transactions, the commonly understood definition of exchange is to transfer something between parties. When information is transferred between parties, the information is disclosed by the organization that released the information and is collected by the organization that receives the information. The Complainant's authorization for GWL to exchange information with Dr. Namit and the LHCC is therefore, her expressed consent for GWL to collect information from these sources under section 8(1) of PIPA. I therefore find that GWL had authority to collect the Complainant's personal information from Dr. Namit and the LHCC.

Issue 5 - Did GWL limit the collection of personal information to that which was reasonable?

[83] Having established that GWL had authority to collect the Complainant's personal information, I must now assess whether that collection was for reasonable purposes and only to the extent reasonable to meet those purposes.

[84] GWL states that it collected the Complainant's information for the purpose of assessing a claim for disability insurance.

[85] In her letter of complaint, the Complainant alleges too much information was collected by GWL and that the consent form in Dr. Namit's chart may have been "tampered with" to expand the terms of her consent, resulting in excessive collection of personal information. I note that the consent form and request letter appear to be identical on the GWL file for this matter and in Dr. Namit's

records. I found no evidence that the consent form on Dr. Namit's chart had been tampered with to alter the terms of the Complainant's consent.

[86] GWL provided me with a comprehensive package of documents related to their management of this claim. One of the documents they provided was the "Notice of Claim" form the Complainant filled out that indicated she was seeking disability coverage for an injury sustained in August 2007. She indicated that the injury was not work related but that she had been precluded from working since the date of the accident. She also advised GWL that her attending physician was Dr. Namit, provided his contact information and completed the previously described consent form.

[87] The GWL case manager wrote to Dr. Namit on September 12, 2007 and requested:

> *"…copies of clinical notes for all examinations from August 1, 2007 to September 12, 2007. Please include copies of any consultation reports, specialist referral letters and investigative test results for the same period."*

[88] Dr. Namit, through the LHCC, released eight pages of records in response to GWL's request. These records are:

1. Copy of letter from GWL requesting medical information
2. Bone scans and x-ray results (exam dated August 31, 2007)
3. A requisition for the diagnostic images described in point # 2
4. X-ray results (exam dated August 13, 2007)
5. Three pages of chart notes from August 6 to August 30, 2007.
6. September 7, 2007 letter from Dr. Namit indicating that the Complainant was under his care for an injury and should be off work for a period of four weeks

[89] These records span August 1, 2007 to September 12, 2007. All of the records that were released relate to examination and treatment of the Complainant's back. The records do not contain reference to injuries or treatments provided for other conditions, ailments or parts of body.

[90] GWL is required by section 11 of PIPA to limit the collection of personal information. Section 11 reads:

> *11(1) An organization may collect personal information only for purposes that are reasonable.*
>
> *(2) Where an organization collects personal information, it may do so only to the extent that is reasonable for meeting the purposes for which the information is collected.*

[91] Section 2 of PIPA defines reasonable as "what a reasonable person would consider appropriate in the circumstances".

[92] The Complainant initiated a claim for benefits with GWL and signed a consent form that gave GWL permission to exchange health information with her healthcare provider and others for the purpose of assessing that claim. It stands to reason that GWL would require knowledge of the nature and severity of the Complainant's injury as part of the claim adjudication process. It would be unreasonable to expect GWL to pay benefits when an injury has not been substantiated by a medical professional or when it does not understand the full breadth of services that a claimant may be entitled to under their respective policy. I find that GWL collected the Complainant's personal information for the purpose of assessing her claim and that this is a reasonable purpose under section 11(1) of PIPA.

[93] Section 11(2) of PIPA imposes further limitations on the collection of personal information; information may only be collected to the extent that is reasonable for meeting the purposes for which the information is collected. Section 11(2) limits the amount of information that can be collected by an organization to that which is reasonable.

[94] GWL requested and received information that pre-dated the injury for which the Complainant claimed benefits. When I asked GWL to explain the collection of personal information that pre-dated the date of injury, GWL responded:

> *"The reason that we asked for information for a short period prior to her accident was to review her functional level pre and post injury to assist in determining what services might be the most helpful to aid in her recovery to pre-injury function, and return to work."*

[95] The two pre-injury chart notes both relate to the Complainant's back problems. GWL collected personal information about the Complainant's treatment for her back over a seven week period. It is my opinion, given the nature of the claim that had been raised, that it is reasonable for GWL to have collected personal information about the Complainant's treatment to the affected part of body and that collection of some information about pre-injury function was required in order to ensure that she received benefits that would return her to pre-injury function.

[96] I find that GWL's collection of personal information was limited to the extent reasonable to meet its purposes.

**Conclusion**

[97] The Complainant in this case clearly stated that her primary concern was that the records of all treatments provided to her by her physician in his private practice were sent to her employer. I agree that this is cause for concern and understand the Complainant's position – patients reasonably expect a measure of confidentiality when seeking treatment and care from a physician; they do not expect their entire chart to be released to their employer. That being said, I also understand how Dr. Namit and the LHCC came to their understanding of the custodianship of Dr. Namit's records, although I have ultimately found this

position to be unsupported within the legal framework of the *Health Information Act* (HIA). It is unfortunate that the custodians did not review the records management practices they adopted in 1996 on proclamation of the HIA in 2001. The LHCC's practice of assuming custodianship of a practicing community based physician's charts is in contravention of the HIA, and resulted in a breach of the Complainant's privacy.

[98] I appreciate the desire on the part of the administrators and Board of the LHCC to ensure that health records of residents are maintained within the community for continuity of care purposes. I advised the parties during this investigation that the HIA provides two mechanisms that would achieve this purpose without the need for the LHCC to assume custodianship of the records stemming from private medical practices. Custodians can transfer records to a successor custodian when they cease to provide health services within a certain geographic area. The HIA also allows custodians to enter into information management agreements where another organization provides information management and information technology services on behalf of the custodian. Both of these mechanisms would allow for the health information of the citizens of Lamont to be maintained within the community and would do so while appropriately ensuring that custodianship of the records definitively resides with the physician that provided the health service.

**Recommendations**

[99] I recommend that:

1. LHCC and Dr. Namit resolve the outstanding issue of the management of records stemming from Dr. Namit's private practice and, within 50 days from the release of this Investigation Report, Dr. Namit advise the Information and Privacy Commissioner of how his records will be managed an secured on an ongoing basis.

[100] The LHCC and Dr. Namit accepted this recommendation on December 29, 2008.

Submitted by

Leahann McElveen
Portfolio Officer, Health Information Act