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COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

ADVICE TO THE PROFESSION

Legislated Reporting & Release of Medical Information

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Disclaimer

This document is provided as a convenient summary to guide physicians and should not be taken as an exhaustive compilation of every statutory provision in Alberta. The focus is on the obligations of the individual practitioner; other provisions not listed in this document apply specifically to institutions. Further, a physician acting as an employer has all the obligations of an employer as outlined in the Alberta *Occupational Health and Safety Act, Regulation and Code*.

Legislated Reporting & Release of Medical Information

Legislated reporting requirements

By law, a physician is required to report:

a) specified communicable diseases (*Public Health Act*)

b) occupational "notifiable disease" (*Occupational Health and Safety Act and Regulation*);

c) suspected child in need of intervention (*Child, Youth and Family Enhancement Act*);

d) suspected abuse of a "person in care" (*Protection for Persons in Care Act*);

e) animal bites (if rabies is reasonably suspected) (*Public Health Act*);

f) deaths under certain conditions (*Fatality Inquiries Act*; *Mental Health Act*);

g) work-related injuries (*Workers' Compensation Act*);

h) results of blood alcohol testing, when blood has been drawn for that purpose, in accordance with a warrant, at the request of a Peace Officer (*Criminal Code*);

i) medical conditions of flight crews, air traffic controllers and others, where the physician believes that the medical condition is likely to constitute a hazard to aviation safety (*Federal Aeronautics Act*);

j) medical conditions that could be a threat to safe railway operations, for railway workers occupying a safety critical position (*Railway Safety Act*);

See Appendices A and B.

Discretionary reporting

A physician **may** choose to report:

a) a patient who is medically unfit to drive (see Appendix A: Patient medically unfit to drive);

b) a patient who, the physician has reason to believe, presents an imminent threat of harm to self or another person. If the physician has enough specific information about who may be the target of the patient's violence, there may even be a duty to warn. Reporting this concern is best made to the police.

c) a patient who has been treated for a mental illness that was associated with violence or threatened or attempted violence on the part of the patient against any person

See Appendix A.

Reporting of suspected criminal activity

A physician is **not obligated** to report injuries or conditions that may be related to criminal activity, for example:

- gunshot wound
- stabbing
- admitted use of illegal drugs

Note: The *Gunshot and Stab Wound Mandatory Disclosure Act* requires Emergency Medical Technicians and hospital facilities to report gunshot and certain stab wounds (excluding those reasonably believed to be self-inflicted or unintentionally inflicted) to the authorities. This is also embedded in Alberta Health Services policy.

See Appendix A.

Mandatory release of medical information

A physician is required to release medical information upon the request of:

a) a patient (unless there is a risk of harm to self or others – see below for more detail);

b) a Court Order;

c) a Medical Officer of Health, under Section 19(1) of the *Public Health Act*;

d) a third party (including physicians not involved in the patient's care), when accompanied by authorization to release from the patient;

e) a patient's legal guardian or agent;

f) a parent of a minor patient who is less than the age of consent (the child is not a "mature minor" – see below for more detail);

g) a separated/divorced parent of a minor patient who is not a mature minor;

h) the Administrator or Executor of the estate of a deceased patient;

i) the College of Physicians & Surgeons of Alberta, pursuant to an investigation, inspection or practice visit under the *Health Professions Act*;

j) the Workers' Compensation Board, pursuant to the *Workers Compensation Act*;

k) an Order of a Statutory Board which has the authority to order disclosure of patient information;

l) the Therapeutic Products Directorate, Health Canada, relating to narcotic drugs;

m) an agent of the Federal Minister of Health who is undertaking an investigation under Section 55 of the Narcotic Control Regulations under the *Controlled Drugs and Substances Act* (information relating to narcotic prescriptions only);

n) a radiation medical officer, relating to the radiation health or safety of workers and the public;

o) a Director under the *Child, Youth and Family Enhancement Act* who has exclusive custody of a child, when the guardian of the child is unable or unavailable to consent

   (In this situation, the Director may authorize the provision of essential medical, surgical, dental or other remedial treatment for the child that is recommended by a physician or a dentist. This authorization extends to when a child in need of intervention has a guardian refusing consent only when the Director has obtained an Order of the Court to apprehend the child. If a child who is the subject of a temporary Guardianship Order, permanent Guardianship Agreement or permanent Guardianship Order refuses to consent to essential, medical, surgical, dental or other remedial treatment recommended by physician or dentist, the Director must apply to the Court for an Order authorizing the treatment.)

p) a Director of Medical Services under the *Occupational Health and Safety Act and Regulation*

q) other individuals in circumstances defined under Section 17 of the *Mental Health Act* and Section 24 of the *Hospitals Act*

See Appendix A for detailed references and comments.

Discretionary release of medical information

A physician may release:

a) individually identifying diagnostic treatment and care information without consent under circumstances outlined in the Health Information Act (HIA), as a custodian under that Act (see Appendix C)
b) information relating to a person receiving diagnostic and treatment services in a center designated in the Mental Health Act, under circumstances outlined in that Act (see Appendix D).

Appendix A: Detailed references and comments

Legislated Reporting Requirements	References
a) Specified communicable diseases	*Public Health Act*; see Appendix B.
b) Notifiable diseases – patients affected with or suffering from an occupational "notifiable disease," by notifying a Director of Medical Services in writing of the name, address and place of employment of that patient and the name of the notifiable disease, within seven (7) days of making the diagnosis	Section 6 of the *Occupational Health and Safety Regulation* lists the following notifiable diseases for the purpose of section 22 of the Act: i. Asbestosis; ii. Mesothelioma; iii. Asbestos-induced lung cancer; iv. Asbestos-induced laryngeal cancer; v. Asbestos-induced gastrointestinal cancer; vi. Any other asbestos-induced cancer; vii. Coal worker's pneumoconiosis; viii. Silicosis; ix. Elevated blood lead level, that is, a worker's blood lead level greater than 0.5 micromoles per litre (µmol/L); and x. Noise-induced hearing loss. A bulletin entitled "Notifiable Occupational Diseases – Information for Physicians," which gives additional guidance for physicians and

which includes a sample notification form which can be used to fulfill the mandatory reporting requirements under section 22 of the *Occupational Health and Safety Act* is available online at https://work.alberta.ca/documents/OHS-bulletin-MG030.pdf

Section 23 of the *Occupational Health and Safety Act* requires a physician performing a medical examination of a worker under the Occupational Health and Safety Act, Regulation or Code to, on the request of a Director of Medical Services, furnish any medical reports the Director may require.

The contact information for the Director of Medical Services is:

Director of Medical Services
Alberta Jobs, Skills, Training and Labour

Email: jstl.ohsmedicalunit@gov.ab.ca

Fax: (780) 643-9264
Mail:

8th Floor, Labour Building
10808 99 Avenue NW
Edmonton, AB T5K 0G5

c) Suspected child abuse

The *Child, Youth and Family Enhancement Act* in Section 4(1) reads: "Any person who has reasonable and probable grounds to believe that a child is in need of intervention shall forthwith report the matter to a Director." 'Child' is defined in 1(1)(d) as a

person under the age of eighteen years and includes a youth unless specifically stated otherwise. 'Youth' is defined in 1(1)(cc) as a child who is sixteen years of age or older.

Section 1(2) states: 'For the purposes of this Act, a child is in need of intervention if there are reasonable and probably grounds to believe that the survival, security or development of the child is endangered because of any of the following:

a) the child has been abandoned or lost;

b) the guardian of the child is dead and the child has no other guardian;

c) the child is neglected by the guardian;

d) the child has been or there is substantial risk that the child will be physically injured or sexually abused by the guardian of the child;

e) the guardian of the child is unable or unwilling to protect the child from physical injury or sexual abuse;

f) the child has been emotionally injured by the guardian of the child;

g) the guardian of the child is unable or unwilling to protect the child from emotional injury;

h) the guardian of the child has subjected the child to or is unable or unwilling to protect the child from cruel and unusual treatment or punishment.'

Section 1(2.1) reads: 'For the purposes of subsection 2(c), a child is neglected if the guardian:

a) is unable or unwilling to provide the child with the necessities of life;

b) is unable or unwilling to obtain for the child, or to permit the child to receive, essential medical, surgical or other remedial treatment that is necessary for the health or well-being of the child, or

c) is unable or unwilling to provide the child with adequate care or supervision.'

Section 1(3) reads: 'For the purposes of this Act,

a) a child is emotionally injured

(i) if there is impairment of the child's mental or emotional functioning or development, and

(ii) if there are reasonable and probable grounds to believe that the emotional injury is the result of:

(A) rejection,

(A.1) emotional, social, cognitive or physiological neglect,

(B) deprivation of affection or cognitive stimulation,

(C) exposure to domestic violence or severe domestic disharmony,

(D) inappropriate criticism, threats, humiliation, accusations or expectations of or toward the child,

(E) the mental or emotional condition of the guardian of the child or of anyone living in the same residence as the child;

(F) chronic alcohol or drug abuse by the guardian or by anyone living in the same residence as the child,

b) a child is physically injured if there is substantial and observable injury to any part of the child's body as a result of the non-accidental application of force or an agent to the child's body that is evidenced by a laceration, a contusion, an abrasion, a scar, a fracture or other bony injury, a dislocation, a sprain, hemorrhaging, the rupture of viscus, a burn, a scald, frostbite, the loss or alteration of consciousness or physiological functioning or the loss of hair or teeth;

c) a child is sexually abused if the child is inappropriately exposed or subjected to sexual contact, activity or behavior

including prostitution related activities.'

c) Suspected abuse of a "person in care"

Section 7(1) of the *Protection for Persons in Care Act* reads:" every individual who has reasonable grounds to believe that there is or has been abuse involving a client shall report that abuse within the time period referred to in section 8(1) (a) to a complaints officer, (b) to a police service, or (c) to a committee, body or person authorized under another enactment to investigate such abuse." Section 7(2) states this applies "notwithstanding that the information on which the belief is founded is confidential and its disclosure is prohibited under any other Act."

The definition of abuse is quite broad defining first what is meant and then outlining exceptions. Section 1(2) defines 'abuse' as "an act or an omission with respect to a client receiving care or support services from a service provider that (a) causes serious bodily harm, (b) causes serious emotional harm, (c) results in the administration, withholding or prescribing of medication for an inappropriate purpose, resulting in serious bodily harm, (d) subjects an individual to non-consensual sexual contact, activity or behaviour, (e) involves misappropriating or improperly or illegally converting a significant amount of money or other valuable possessions, or (f) results in failing to provide adequate nutrition, adequate medical attention or another necessity of life without

a valid consent, resulting in serious bodily harm."

Section 1(3) notes however that "Notwithstanding subsection (2), an act or omission does not constitute abuse (a) if a service provider carries out the service provider's duties in accordance with professional standards or practices or any standards established by or adopted pursuant to another enactment, (b) if the care or support services provided by the service provider are reasonably necessary in the circumstances, (c) where the act or omission is the result of, or is attributable to, a client's refusing care or support services, (d) when the act or omission is based on a decision made on behalf of a client (i) by a co-decision-maker or a specific decision maker under the *Adult Guardianship and Trusteeship Act*, (i.1) by an agent under the *Personal Directives Act*, or (ii) by an attorney under the *Powers of Attorney Act*, or (e) in the circumstances prescribed in the regulations."

The Act applies to service providers and via Section 1(1)(m) includes "(i) a lodge accommodation as defined in the *Alberta Housing Act*, (ii) an approved hospital as defined in the *Hospitals Act*, (iii) a facility designated under the *Mental Health Act*, (iv) a nursing home as defined in the *Nursing Homes Act*, (v) a hostel or other establishment operated to provide accommodation and maintenance for unemployed or indigent persons, (vi) a facility as defined in the *Social Care Facilities Review*

		Committee Act, or (vii) any person designated by the regulations as a service provider." A physician attending upon a patient in one of those setting would be obliged to report suspected abuse. A physician may also be charged with an obligation to report suspected abuse if a patient came to the physician and reported being subjected to "abuse" while a "client" at one of the designated locations.
d)	Animal bites (if rabies is reasonably suspected)	Required under the *Public Health Act*. See Appendix B.
e)	Deaths under certain conditions	Under the *Fatality Inquiries Act*, physicians have an obligation to report: 1) unexplained deaths; 2) unexpected deaths when the deceased was in apparent good health; 3) deaths as a result of violence, accident or suicide; 4) maternal deaths during or following pregnancy and that might reasonably be related to pregnancy; 5) deaths that may have occurred as a result of improper or negligent treatment by any person; 6) deaths that occur within 10 days of an operative procedure or while under or during recovery from anesthesia; 7) deaths that result from poisoning; 8) death of a person not under the care of a physician; 9) death of a young person under Child Welfare custody; 10) deaths resulting from any disease, ill health, injury, or toxic substance arising from a person's employment, or occupation now or in the past; 11) if a person dies in custody, or is a formal patient of any facility under the *Mental Health Act*, the

death must be notified whether or not he or she is on the premises at the time. (Sections 11 and 12 of the *Fatality Inquiries Act*).

f) Work-related injuries

Workers' Compensation Act. Section 34(1) says "A physician who attends an injured worker shall (a) forward a report to the Board (i) within 2 days after the date of the physician's first attendance on the worker if the physician considers that the injury to the worker will or is likely to disable the worker for more than the day of the accident or that it may cause complications that may contribute to disablement in the future, and (ii) at any time when requested by the Board to do so, (b) advise the Board when, in the physician's opinion, the worker will be or was able to return to work, either in the physician's report referred to in clause (a)(i) or in a separate report forwarded to the Board not later than 3 days after the worker was, in the physician's opinion, so able, and (c) without charge to the worker, give all reasonable and necessary information, advice and assistance to the worker and the worker's dependents in making a claim for compensation and in furnishing any certificates and proofs that are required in connection with the claim."

The report must only contain information relating to the work related injury and relevant prior medical history. The physician has a duty to review the patient's chart to determine what information is and is not relevant to the work related history.

	The physician must also advise the Board when, in the physician's opinion, a worker will be or was able to return to work. This can be either in the initial report to the WCB or in a separate report to the WCB forwarded no later than three days after the date when the worker was fit to return to work. If the physician is uncertain as to whether or not prior medical history is relevant to a work related injury, it is recommended that the physician seek the advice of a medical specialist with expertise relevant to the circumstances. The physician must not disclose the previous medical history of the worker to the WCB, without the worker's consent, unless it is relevant to the work related injury or the worker's ability to return to work. Further information is also available from the Workers Compensation Board including information on the need for workers to submit consent when they file a claim and a fact sheet that includes the *FOIP Act* as it relates to this topic.
g) Results of blood alcohol testing, when blood has been drawn for that purpose at the request of a Peace Officer;	Blood for such testing can only be drawn with the consent of the patient or upon production of a warrant under the Criminal Code for a blood sample.
h) Medical conditions of flight crews, air traffic controllers and others,	Required under the *Federal Aeronautics Act*. Section 6.5 says "(1) Where a physician or an optometrist believes on reasonable grounds

where the physician believes that the medical condition is likely to constitute a hazard to aviation safety;

that a patient is a flight crew member, an air traffic controller or other holder of a Canadian aviation document that imposes standards of medical or optometric fitness, the physician or optometrist shall, if in his opinion the patient has a medical or optometric condition that is likely to constitute a hazard to aviation safety, inform a medical adviser designated by the Minister forthwith of that opinion and the reasons therefore." It is further noted in 6.5(4) that "No legal, disciplinary or other proceedings lie against a physician or optometrist for anything done by him in good faith in compliance with this section."

Of interest the Act also places responsibility on the patient to both notify the physician and provide consent in that 6.5(2) says "The holder of a Canadian aviation document that imposes standards of medical or optometric fitness shall, prior to any medical or optometric examination of his person by a physician or optometrist, advise the physician or optometrist that he is the holder of such a document." And Section 6.5(6) says "The holder of a Canadian aviation document that imposes standards of medical or optometric fitness shall be deemed, for the purposes of this section, to have consented to the giving of information to a medical adviser designated by the Minister under subsection (1) in the circumstances referred to in that subsection."

i) Medical conditions that could be a threat to safe railway operations, for railway workers occupying a safety critical position; and	Section 35 of the federal *Railway Safety Act* requires notification of the railway company's Chief Medical Officer, with a copy to the patient. It is the patient's responsibility to inform the physician that he/she holds a designated safety critical position at the time of the examination.

Mandatory Release of Medical Information upon request of:	**References**
a) Patient	Supreme Court of Canada decision in McInerney v. MacDonald, issued June 12, 1992.The Court stated that in the ordinary case, the records should be disclosed upon the request of the patient unless there is a significant likelihood of a substantial adverse effect on the physical, mental or emotional health of the patient or harm to a third party.
b) Court Order	McInerney v. MacDonald (SCC); also, Alberta Rules of Court.
c) Medical Officer of Health	Section 19(1) of the *Public Health Act* says "Where a medical officer of health knows or has reason to believe (a) that a person suffering from a communicable disease is or may be in or has frequented or may have frequented a public place, or (b) that a public place may be contaminated with a communicable disease, the medical officer of health may by notice in writing to the person in charge of the public place require that person to provide to the medical officer of health within the time specified in the notice any information relating to public place, the person

d) Third party (including physicians not involved in the patient's care), when accompanied by authorization to release	and the communicable disease that is specified in the notice." An agreement by the patient for the release of information to third parties must be honoured by the physician, just as the physician must honour such a request from the patient. The exception is when there is a significant likelihood of substantial adverse effect on the physical, mental or emotional health of the patient or harm to a third party (see McInerney v. MacDonald – Supreme Court of Canada).
e) Patient's legal guardian, with documentation	By Order of the Court for the appointment of a guardian of a mentally incompetent adult or child who is not a mature minor. A guardian of a minor child can also be appointed under the will of a deceased parent. As well, a person appointed as agent of an adult patient under a Personal Directive when the patient is not competent to provide consent and the agent needs the patient's information to fulfill the duties as agent of the patient.
f) Patient's parent, when patient is not a mature minor	Note that age of mature minor, rather than age of majority, is the operative phrase. There is no specific age when a minor becomes a "mature minor," but previous Court decisions would indicate that it is around the age of 15 or 16. Child Welfare decisions involve input form children starting at age 12. Whether a specific child can be considered a mature minor will depend on the maturity and independence of the minor and the gravity of the decision. The Canadian Medical Protective Association (CMPA) has produced a thorough guide for physicians on the issue of informed consent (see *Consent: A Guide for Canadian Physicians – 3rd Edition*). The CMPA

	Guide briefly discusses consent on behalf of minor children and the related topic of a mature minor. A fairly common example of a challenging situation is the 16-year old girl who does not want her parents to know she is on birth control. A parent must be the legal guardian of the child in order to be entitled to medical information about the child. Not all biological parents are automatically guardians of their child. Section 20 of the *Family Law Act* lists a number of factors considered in determining when a biological parent is a guardian. Generally, all mothers are automatically guardians. Unmarried fathers may or may not automatically be a child's guardian. All fathers who are married or in a common-law relationship with the child's mother are legal guardians of their child. A step-parent who has not become an adoptive parent would not be the child's guardian. Section 48 of the *Family Law Act* states a person who is standing in the place of a parent can be held responsible for supporting the child, but that does not create guardianship. A specific Court Order declaring that person to be a guardian of the child is required.
g) Patient's separated/ divorced parent, when the parent has legal custody and the patient is less than the age of consent	A non-custodial divorced/separated parent is still a guardian of a child unless guardianship has been removed or limited by Court Order, which is relatively rare. Custody means the physical care and control of the child by the parent. Guardianship is the legal authority to make decisions in the best interest of the child. There are specific rights under the *Family Law Act* for a non-custodial parent to access information about their child.

h) Executor or Administrator of the estate for a deceased patient	The next-of-kin do not legally represent the deceased patient's estate. If there is no Executor of the estate, the physician can release medical information to: a) FIRST choice would be the spouse. b) If the spouse is no longer alive, then the SECOND choice would be to release the information to the children. However, if there is more than one child, ALL children must agree to the release of information. If there is no Executor appointed under a will, the only other option would be for the family to speak with a lawyer and get the Court to appoint an Administrator of the estate. The *Health Information Act*, in Section 35(1)(d) and (d.1) indicates physicians may release limited information to the family or close friends of the deceased under certain conditions.
i) College of Physicians & Surgeons of Alberta pursuant to an investigation, inspection or practice visit under the *Health Professions Act*	See *Health Professions Act*, Sections 51, 53.2, and 63.
j) Workers' Compensation Board pursuant to the *Workers' Compensation Act*	*Workers' Compensation Act*. Section 34(1) says "A physician who attends an injured worker shall (a) forward a report to the Board (i) within 2 days after the date of the physician's first attendance on the worker if the physician considers that the injury to the worker will or is likely to disable the worker for more than the day of the accident or that it may cause complications that may

contribute to disablement in the future, and (ii) at any time when requested by the Board to do so, (b) advise the Board when, in the physician's opinion, the worker will be or was able to return to work, either in the physician's report referred to in clause (a)(i) or in a separate report forwarded to the Board not later than 3 days after the worker was, in the physician's opinion, so able, and (c) without charge to the worker, give all reasonable and necessary information, advice and assistance to the worker and the worker's dependents in making a claim for compensation and in furnishing any certificates and proofs that are required in connection with the claim."

The report must only contain information relating to the work related injury and relevant prior medical history. The physician has a duty to review the patient's chart to determine what information is and is not relevant to the work related history.

The physician must also advise the Board when, in the physician's opinion, a worker will be or was able to return to work. This can be either in the initial report to the WCB or in a separate report to the WCB forwarded no later than three days after the date when the worker was fit to return to work.

If the physician is uncertain as to whether or not prior medical history is relevant to a work related injury, it is recommended that the physician seek the advice of a medical specialist with expertise relevant to the circumstances. The physician must not disclose the previous medical history of the worker to the WCB, without the worker's consent,

	unless it is relevant to the work related injury or the worker's ability to return to work.
k) Order of a Statutory Board	Section 17(5) The Board has the same powers as the Court of Queen's Bench for compelling the attendance of witnesses and of examining them under oath and compelling the production and inspection of books, papers, documents and things. Any Board or Tribunal, empowered by statute to issue a subpoena to compel the attendance of witnesses and the production of documents may order a physician to produce relevant medical records. By way of example, an order from the Attendance Board, established under the *School Act*, issued to a physician to attend as a witness with medical records of a student, who is the subject of the hearing. The Attendance Board deals with truancy by school aged children.
l) Agent of the Federal Minister of Health, who is undertaking an investigation under Section 55 of the *Narcotic Control Regulations* under *Controlled Drugs and Substances Act* (information relating to narcotic prescriptions only)	Described by the *Federal Controlled Drugs and Substances Act*. The agent must be specifically identified with documentation as conducting an investigation under Section 55 of those Regulations.
m) Radiation medical officer, relating to the radiation health or safety of workers and the public	See the *Radiation Protection Act*, Section 15. The Act states a doctor may release the information upon a request of the radiation medical officer; however should the doctor refuse to release the information, the radiation medical officer may obtain a Court Order restraining the doctor from interfering with the radiation medical officer in obtaining access and making copies of the

medical records. Failure to comply with the Court Order may result in the doctor being subject to civil contempt proceedings.

n) Director under the *Child, Youth and Family Enhancement Act* who has exclusive custody of a child, when the guardian of the child is unable or unavailable to consent; or when a child in need of intervention has a guardian refusing consent and the Director has obtained an Order of the Court.

Section 22.1 of the *Child, Youth and Family Enhancement Act* says

"(1) If the guardian of a child who has been apprehended is unable or unavailable to consent to the provision of essential medical, surgical, dental or other remedial treatment for the child that is recommended by a physician or dentist, a director may authorize the provision of any recommended treatment for the child. (2) If the guardian of a child who has been apprehended refuses to consent to essential medical, surgical, dental or other remedial treatment for the child that is recommended by a physician or dentist, the director must apply to the Court for an order authorizing the treatment. (3) Despite section 23(4), notice of the date, time and place at which an application under subsection (2) is to be heard must be served not less than one day before the date fixed for the hearing. (4) A director may make an application by telephone or other means of telecommunication to a judge of the Court in accordance with section 19(5) to (10), in which case section 19(11) applies to the order. (5) If it is satisfied that the treatment is in the best interests of the child, the Court may authorize the treatment notwithstanding that the guardian of the child refuses to consent to the treatment. (6) If the Court authorizes treatment under this section, the authorization extends to the conclusion of the course of treatment unless the Court orders otherwise, even if a director ceases to have custody or guardianship of the child. (7) If

a child is treated pursuant to an order under this section, no liability attaches to the person treating the child by reason only that the guardian of the child did not consent to the treatment."

Section 22.2 of the *Child, Youth and Family Enhancement Act* says "(1) If a child who is the subject of a temporary guardianship order or a permanent guardianship agreement or order refuses to consent to essential medical, surgical, dental or other remedial treatment that is recommended by a physician or dentist, the director must apply to the Court for an order authorizing the treatment. (2) Despite section 23(4), notice of the date, time and place at which an application under subsection (1) is to be heard must be served not less than one day before the date fixed for the hearing. (3) If the Court authorizes treatment under this section, the authorization extends to the conclusion of the course of treatment unless the Court orders otherwise, even if a director ceases to have guardianship of the child. (4) If a child is treated pursuant to an order under this section, no liability attaches to the person treating the child by reason only that the child did not consent to the treatment."

o) A Director of Medical Services under the *Occupational Health and Safety Act*

Section 23 of the *Occupational Health and Safety Act* says, "(1) A physician who performs or supervises a medical examination of a worker as required under this Act, the regulations or the adopted code shall, on the request of the Director of Medical Services, furnish any medical reports that a Director may require. (2) A physician, nurse or first aid attendant who attends a worker who

	became ill or was injured while engaged in an occupation shall, on the request of a Director of Medical Services, furnish any reports that a Director may require."
p) Other individuals in defined circumstances	The disclosure of such reports as requested does not required patient consent beforehand. Section 17 of the *Mental Health Act* (Appendix D) and Section 24 of the *Hospitals Act* sets out a list of persons to whom the health facility or staff can release patient information. Explanatory Note: these statutory provisions set out to whom and what type of information can be released. These provisions refer to disclosure requirements in other statues which are noted in this Guide.

Discretionary Reporting	**Comments:**
a) Patient medically unfit to drive	There is no mandatory requirement in Alberta for reporting an individual's fitness to drive. However, a physician that does report is protected from legal action. The *Traffic Safety Act*, Section 60, states "No liability accrues to a physician, optometrist or other health care provider by reason only that the physician, optometrist or other health care provider provides to the Registrar under this Act information respecting a person's medical condition that may impair that person's ability to operate a motor vehicle in a safe manner." A physician is encouraged to report all instances where a patient fails to meet the

	medical standards for operation of a motor vehicle. The Canadian Medical Association has published a comprehensive list of medical fitness standards. A physician should be familiar with the spectrum of medical conditions that may affect a patient's ability to drive. Standards are written to enable a physician to be as objective as possible in conducting a clinical assessment. Some examples of medical conditions that may affect safe driving include stroke, seizures, diabetes, dementia, syncope and double vision. A physician is not required to declare a patient to be unfit to drive: there is an exercise of discretion left to the physician. Should a physician have concerns, he or she may choose to report a failure to meet a published medical standard to the to the Driver Fitness and Monitoring Branch of the Alberta Ministry of Transportation. This office reviews every driver's medical form and report. Where a clinical condition fails a medical standard, the driver will be notified of restrictions on his or her driving or required to surrender his or her driver's license. There is an exclusion of liability if the physician does report medical concerns under Section 60 of the *Traffic Safety Act*. Section 60.1 of that statute also provides assurance of confidentiality that the physician reported the patient.
b) Patient who, the physician has reason to believe, presents a clear and present danger to society	This is a provision established by Common Law through decisions of the Courts. The test is whether or not there is a perceived threat to the public which outweighs the duty of confidentiality to the patient. We are unaware of any judgments in Canada against physicians who have disclosed

	confidential medical information on the basis of a perceived real threat to the public. See also *Health Information Act*, Section 35(1)(m) – see Appendix C.
c) Patient who has been treated for a mental illness that was associated with violence or threatened or attempted violence on the part of the patient against any person	Section 55 of the federal *Firearms Act* may require an applicant for a firearms permit or authorization (i.e., the patient) to submit information relevant for determining eligibility. Section 55(2) provides the chief firearms officer with broad investigatory powers in making that determination. In response to such a request, physicians should obtain written authorization from their patient prior to releasing such information. There is no express duty to provide a prediction of patients' potential for causing harm.
Discretionary Release of Medical Information	**Comments**
a) Patient receiving diagnostic and treatment services in a center designated in the *Mental Health Act*, under circumstances outlined in the Act	This section says that a physician may disclose information to the persons or organizations identified, but does not require that disclosure. Should the physician decline to provide information, the person or organization may seek a Court Order directing disclosure. Failure to comply with such a Court Order may result in the doctor being subject to civil proceedings and assignment of associated legal and court costs.
b) Individually identifying diagnostic treatment and care information without consent under circumstances outlined	*Health Information Act*, see Sections 27 and 35 attached as Appendix C. Completion of reporting

in the *Health Information Act* (HIA), as a custodian under that Act

forms for the AMA Committee on Reproductive Care is also covered under these provisions.

Appendix B: Excerpts from the *Public Health Act*

Communicable Diseases Regulation AR 238/85

Schedule 1

(Notifiable Communicable Diseases)
(Section 6(1) of this Regulation; sections 20(1) and 22(1) of the Act)

Acquired Immunodeficiency Syndrome (AIDS)	Kawasaki Disease	Reye Syndrome
Amebiasis	Lassa Fever	Rickettsial Infections
Anthrax	Legionella Infections	Rocky Mountain Spotted Fever
Arboviral Infections (including Dengue)	Leprosy	Rubella (including Congenital Rubella)
Botulism	Leptospirosis	Rubeola
Brucellosis	Listeriosis	Salmonella Infections
Campylobacter	Malaria	Severe Acute Respiratory Syndrome (SARS)
Cerebrospinal fluid isolates	Measles	Shigella Infections
Chickenpox	Meningitis (all causes)	Smallpox
Cholera	Meningococcal Infections	Stool Pathogens, all types. See note below.
Congenital Infections (includes Cytomegalovirus, Hepatitis B, Herpes simplex, Rubella, Toxoplasmosis, Varicella-zoster)	Mumps	Tetanus
Dengue	Neonatal Herpes	Toxic Shock Syndrome

Diphtheria	Nosocomial Infections	Trichinosis
Encephalitis, specified or unspecified	Ophthalmia Neonatorum (all causes)	Tuberculosis
Enteric Pathogens. See note below.	Paratyphoid	Tularemia
Foodborne Illness. See note below.	Pandemic Influenza	Typhoid
Gastroenteritis, epidemic. See note below.	Pertussis	Typhus
Giardiasis	Plague	Varicella
Haemophilus influenzae Infections (invasive)	Poliomyelitis	Viral Hemorrhagic Fevers (including Marburg, Ebola, Lassa, Argentinian, African Hemorrhagic Fevers)
Hemolytic Uremic Syndrome	Psittacosis	Waterborne Illness (all causes). See note below.
Hepatitis A, B, Non-A, Non-B	Q-fever	West Nile Infection
Human Immunodeficiency Virus Infections	Rabies	Yellow Fever

Note: Enteric Pathogens, Foodborne Illness, Gastroenteritis, epidemic and Waterborne Illness include the following and any other identified or unidentified cause: *Aeromonas*; *Bacillus cereus*; *Campylobacter*; *Clostridium botulinum* and *C. perfringens*; *E.coli* (enteropathogenic serotypes); *Salmonella*; *Shigella*; *Staphylococcus*; Viruses such a Norwalk and Rotavirus, *Yersinia*.

AR 238/85 Sched.1;357/88;37/88;96/2005;58/2006

Schedule 2

(Notifiable Sexually Transmitted Communicable Diseases)
(Section 6(2) of this Regulation; Section 20(2) of the Act)

Chancroid	*Lymphogranuloma venereum*	Syphilis
Chlamydia trachomatis Infections (genito-urinary)	Muco-purulent Cervicitis	
Gonococcal Infections	Non-gonococcal Urethritis	

AR 238/85 Sched.2;357/88;96/2005

Schedule 3

(Diseases for which a Certificate, Isolation Order or Warrant for Examination May be Issued)
(Section 6(3) of this Regulation; Sections 39(1), 44(1) and 47(1) of the Act)

Acquired Immunodeficiency Syndrome (AIDS)	Gonococcal Infections	Plague
Anthrax	Human Immunodeficiency Virus Infections	Severe Acute Respiratory Syndrome (SARS)
Cholera	Lassa Fever	Smallpox
Chancroid	Leprosy	Syphilis
Chlamydia trachomatis Infections (genitor-urinary)	*Lymphogranuloma venereum*	Tuberculosis
Diphtheria	Pandemic Influenza	Viral Hemorrhagic Fevers

AR 238/85 Sched.3;357/88;96/2005;58/2006

Schedule 4

1 For the purposes of section 29(2) of the Act, a medical officer of health shall, unless this Schedule provides to the contrary, take all reasonable steps to ensure that the provisions of this Schedule respecting Investigation of Contacts and Source of Infection, Isolation Procedures, Quarantine and Special Measures are complied with.

This Schedule is 44 pages long and too comprehensive to include in this document.

Appendix C: Excerpts from the *Health Information Act*

(Chapter H-4.8; Section 27 and 35 of the Act)

Use of individually identifying health information

27(1) A custodian may use individually identifying health information in its custody or under its control for the following purposes:

a) providing health services;

b) determining or verifying the eligibility of an individual to receive a health service;

c) conducting investigations, discipline proceedings, practice reviews or inspections relating to the members of a health profession or health discipline;

d) conducting research

i) if the custodian has submitted a proposal to an ethics committee in accordance with section 49,

ii) if the ethics committee is satisfied as to the matters referred to in section 50(1)(b),

iii) if the custodian has complied with or undertaken to comply with the conditions, if any, suggested by the ethics committee, and

iv) where the ethics committee recommends that consents should be obtained from the individuals who are the subjects of the health information to be used in the research, if those consents have been obtained;

e) providing for health services provider education;

f) carrying out any purpose authorized by an enactment of Alberta or Canada;

g) for internal management purposes, including planning, resource allocation, policy development, quality improvement, monitoring, audit, evaluation, reporting, obtaining or processing payment for health services and human resource management.

(2) A custodian referred to in section 1(1) (f) (iii), (iv), (vii), (xii) or (xiii) may, in addition, use individually identifying health information in its custody or under its control to carry out the following functions within the geographic area in which the custodian has jurisdiction to promote the objectives for which the custodian is responsible:

a) planning and resource allocation;

b) health system management;

c) public health surveillance;

d) health policy development.

Disclosure of diagnostic, treatment and care information

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,

c) to family members of the individual or to another person with whom the individual is believed to have a close personal relationship, if the information is given in general terms and concerns the presence, location, condition, diagnosis, progress and prognosis of the individual on the day on which the information is disclosed and the disclosure is not contrary to the express request of the individual,

d) where an individual is injured, ill or deceased, so that family members of the individual or another person with whom the individual is believed to have a close personal relationship or a friend of the individual can be contacted, if the disclosure is not contrary to the express request of the individual,

    i. where an individual is deceased, to family members of the individual or to another person with whom the individual is believed to have had a close personal relationship, if the information relates to circumstances surrounding the death of the individual or to health

services recently received by the individual and the disclosure is not contrary to the express request of the individual,

e) to an official of a penal or other custodial institution in which the individual is being lawfully detained if the purpose of the disclosure is to allow the provision of health services to the individual,

f) to a person authorized to conduct an audit of the information if the person agrees in writing,

   i. to destroy the information at the earliest opportunity after the audit is concluded, and

   ii. not to disclose the information to any other person, except as required to accomplish the audit or to report unlawful or improper conduct by the custodian or a health services provider,

g) to a committee that has as its primary purpose the carrying out of quality assurance activities within the meaning of section 9 of the *Alberta Evidence Act*.

h) for the purpose of a court proceeding or a proceeding before a quasi-judicial body to which the custodian is a party,

i) for the purpose of complying with a subpoena, warrant or order issued or made by a court, person or body having jurisdiction to compel the production of information or with a rule of court that relates to the production of information,

j) to a municipal or provincial police service for the purpose of investigating an offence involving a life-threatening personal injury to the individual, if the disclosure is not contrary to the express request of the individual,

k) to another custodian where the custodian disclosing the information has a reasonable expectation that disclosure will detect or prevent fraud, limit abuse in the use of health services or prevent the commission of an offence under an enactment of Alberta or Canada,

l) to an officer of the Legislature if the information is necessary for the performance of the officer's duties,

m) to any person if the custodian believes, on reasonable grounds, that the disclosure will avert or minimize an imminent danger to the health or safety of any person,

n) if that individual lacks the mental capacity to provide a consent and, in the opinion of the custodian, disclosure is in the best interests of the individual,

o) to a descendant of a deceased individual, a person referred to in section 104(1) (c) to (i) who is acting on behalf of the descendant or a person who is providing health services to the descendant if, in the custodian's opinion,

   i. the disclosure is necessary to provide health services to the descendant, and

   ii. the disclosure is restricted sufficiently to protect the privacy of the deceased individual,

p) if the disclosure is authorized or required by an enactment of Alberta or Canada, or

q) to its successor where,

   i. the custodian is transferring its records to the successor as a result of the custodian ceasing to be a custodian, and

   ii. the successor is a custodian.

(2) A committee to which health information is disclosed pursuant to subsection (1) (g) must not disclose the information to any other person except in accordance with subsection (3).

(3) A committee referred to in subsection (2) may disclose non-identifying health information to another committee that has as its primary purpose the carrying out of quality assurance activities within the meaning of section 9 of the *Alberta Evidence Act*.

(4) A custodian may disclose individually identifying diagnostic, treatment and care information to a health professional body for the purpose of an investigation, a discipline proceeding, a practice review or an inspection if:

a) the custodian has complied with any other enactment authorizing or requiring the custodian to disclose that information for that purpose, and

b) the health professional body agrees in writing,

i. not to disclose the information to any other person except as authorized by or under the Act governing the health professional body, and

ii. to destroy the information,

   A. at the earliest opportunity if the investigation, discipline proceeding, practice review or inspection is abandoned, or

   B. at the earliest opportunity after a final decision has been made relating to the investigation, discipline proceeding, practice review or inspection, including any decision made by a body authorized to hear appeals.

Appendix D: Excerpts from the *Mental Health Act*

17(7) The Minister, a person authorized by the Minister, a board, an employee of a board or a physician may disclose any health information relating to a person receiving diagnostic and treatment services in a center:

(a) – (c) repealed RSA 2000 cH-5 s119;

(d) to the Public Guardian if the health information is, in the opinion of the person making the disclosure, relevant to the making of a guardianship order under the *Dependent Adults Act* in respect of the person to whom the health information relates;

(e) to the Public Trustee if the health information is, in the opinion of the person making the disclosure, relevant to the making of a trusteeship order under the *Dependent Adults Act* in respect of the person to whom the diagnosis, record or information relates;

(f) to a review panel that is to hear or is hearing an application from the person to whom the health information relates, or to the Court of Queen's Bench for the purposes of an appeal under section 43;

(g) repealed RSA 2000 cH-5 s114;

(h) to a Director of Medical Services under the *Occupational Health and Safety Act* when the health information relates to an accident that occurred in respect of the person's occupation or one or more of the person's former occupations, or to a disease that is related to the person's occupation or one or more of the person's former occupations;

(i) to The Workers' Compensation Board, the Provincial Health Authorities of Alberta or a provincial hospital insurance authority if the information is required in order to establish responsibility for payment;

(j) to the Department of Health (Canada) for purposes in connection with the *Canada Health Act* (Canada);

(k) repealed RSA 2000 cH-5 s119;

(l) to a Review Board appointed pursuant to the Criminal Code (Canada) that is to review the case of the person to whom the health information relates;

(m) to the council of the College of Physicians and Surgeons of the Province of Alberta or an investigating committee under the *Medical Profession Act* or the Professional Conduct Committee or the Appeals Committee under the *Nursing Profession Act*, if:

(i) an officer of the College or the Alberta Association of Registered Nurses, as the case may be, makes a written request for the health information and the disclosure is consented to by the person to whom the health information relates or the person's legal representative, or

(ii) the disclosure is made in compliance with a notice under section 59 of the *Medical Profession Act* or section 72 of the *Nursing Profession Act* to attend as a witness or to produce documents;

(n) to a person conducting an investigation, a hearing tribunal or the council of the dental profession under the *Health Professions Act* if:

(i) an officer of The Alberta Dental Association and College makes a written request for it and the disclosure is consented to by the patient or the patient's legal representative, or

(ii) the disclosure is made in compliance with a notice under sections 73 and 74 of the *Health Professions Act* to attend as a witness or to produce documents;

(o) repealed RSA 2000 cH-5 s119;

(o.1) to a hearing director of a college under the *Health Professions Act*, if the disclosure is made in compliance with a notice under section 73 or 74 of the *Health Professions Act*;

(p) to the Health Disciplines Board or:

(i) to the Committee of a designated health discipline governed by a Committee, or

(ii) in the case of a designated health discipline governed by a health discipline association, to the conduct and competency committee established by the health discipline association, if the disclosure is made in compliance with a notice under section 38(1) of the *Health Disciplines Act*;

(q) to a person conducting a preliminary investigation or the Discipline Committee under the *Psychology Profession Act* if:

(i) an officer of The College of Alberta Psychologists makes a written request for it and the disclosure is consented to by the patient or the patient's legal representative, or

(ii) the disclosure is made in compliance with a notice under section 44 of the *Psychology Profession Act* to attend as a witness or to produce documents.