



Adherence, Inc.

## Pharmacist-Patient Confidentiality

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**The Ohio State Board of Pharmacy has approved Adherence Inc. as a provider of Pharmacy Continuing Education. This program is approved for 0.1 CEUS of jurisprudence continuing education**

**Ohio 036-309-09-001-H03**

**Expires 2/2/12**

Virtually everyone has a feel for what the term "confidential " means. It would be difficult to imagine a society that in which a need for confidentiality does not exist. Historically, confidentiality has been of singular importance to health care professionals, and the importance of patient confidentiality has gained greater interest and importance among pharmacists with the advent of pharmaceutical care. This module looks closely at the issue of patient confidentiality in community pharmacy practice and Ohio law.

### **Goals and objectives:**

1. The pharmacist should become more sensitive to the issue of patient confidentiality.
2. The pharmacist should become familiar with Ohio laws and state board of pharmacy rules that address patient confidentiality.
3. The pharmacist should become more familiar with the patient's perspective on confidentiality.

4. The pharmacist should acquire a practical information of addressing issues involving patient confidentiality.
5. The pharmacist should realize that the issue of confidentiality is impacted by the concept of pharmaceutical care, especially as it becomes more a part of everyday practice.

We believe the material presented in this educational module to be accurate and current at the time of publication. We would remind the reader, however, that he or she is responsible for utilizing professional judgment and for confirming or interpreting the findings presented here before utilizing the information. We would further remind the reader that the author is not an attorney. If there is any question about the contents of this module they should be clarified by contacting the state board of pharmacy or a licensed attorney, particularly one familiar with pharmacy.

## Health Insurance Portability & Accountability Act (HIPAA) 1996

*HIPAA was enacted into law in 1996. It represented a first effort to establish federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers and took effect on April 14, 2003. Developed by the Department of Health and Human Services (HHS), the new standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country.*

*HIPAA is not the specific focus of this program and will be only briefly discussed. More specific and thorough information concerning HIPAA should be sought from the HHS, the pharmacist's employer, or professional organizations.*

Originally, HIPAA gave patients the right to review their medical records and required patient consent for the transfer of oral, written and electronic communications and set criminal penalties for improper handling of confidential information. It was an omnibus bill that was impractical and all encompassing as originally proposed. Initially, for example, the pharmacist would have quite literally needed a patient consent form before filling a prescription. With public comment there was considerable modification of the ACT so it became less burdensome for professionals. This part of HIPAA was amended in July 2002, and the patient consent form is no longer required for pharmacies to fill prescriptions under the revised HIPAA rules. A release form, a notice of rights statement and an internal rule as to who in the facility should have access to information is still required. Samples of release forms and notice of rights statements are readily available on the Internet.

More than anything else HIPAA is concerned with privacy and privacy is certainly associated with confidentiality. Communication between a pharmacist and a patient is many times privileged. **HIPAA defines protected health information (PHI) as information transmitted or maintained in any form or medium, including oral communications. PHI includes any information concerning treatment, payment or**

**health care operations.** For health care providers HIPAA actually applies only to those who transmit health information in electronic form in connection with any transaction.

The need for an understanding of the nature of confidentiality thus supersedes HIPAA. For instance, a patient who purchases only over-the-counter products and always pays cash enjoys a patient-pharmacist relationship equal to that of those protected under HIPAA.

Privacy and confidentiality are ancient values in medicine, pharmacy and other allied health professions. They were not originally the laws of legislation. In other words, they are values that have always seemed necessary and inherent to health care professional. Physicians and pharmacists have always not that these values are essential to patient care. Not only that but they are also values that the public has come to expect from all health care providers.

One of the concerns with HIPAA is that these essential values may become subordinate to compliance officers, risk managers and legal counsel. This makes it even more important that these values are emphasized in the professional-patient relationship.

### The value of confidentiality

Anita L Allen of the University of Pennsylvania published an excellent paper in 2008 Describing how confidentiality is an expectation in health care. She explains the value of confidentiality as follows:

“Encounters with health care professionals convert persons confronting illness into patients with charts. Everyone and every entity participating in the delivery of health-care related services is ascribed the duty of patient confidentiality. Health care providers are ethically bound to keep charts and other medical information obtained in the context of care, confidential. Confidentiality is a clear ethical obligation of physicians: ‘A physician shall respect the rights of patients...and shall safeguard patient confidences and privacy within the constraints of law.’ (AMA, 2001)”

“Practicing respect for patient confidentiality benefits individuals and promotes public health. Ethicists defend confidentiality on several utilitarian grounds, each premised on the twin understandings that health is vital to human well-being and flourishing, and that a good and just society will be committed to securing public health.”

“First, confidentiality encourages individuals to seek essential medical care. Individuals will be more inclined to pursue medical attention if they believe they can do so privately and perhaps even secretly.”

“Second, confidentiality practices lay a foundation for frank disclosures in inpatient and out-patient settings. Individuals seeking care can be more open and honest if they believe the facts and impressions reported to health providers will not be broadcast to the world at large. People are often embarrassed and humiliated by symptoms of illness. They may

go to see a doctor and yet be reluctant to reveal bowel incontinence, loss of memory, or hallucinations.”

“Third, preventive medicine, early diagnosis and treatment save money. More people sick with more chronic illnesses means higher care costs. The cost of health care and insurance might be considerably higher if people passed on routine check-ups and prompt medical attention because confidentiality was not credibly promised.”

These thoughts are expressed well in the AMA’s Code of Medical Ethics (Issued December 1983; Updated June 1994 and June 2007)

The information disclosed to a physician by a patient should be held in confidence. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential information without the express consent of the patient, subject to certain exceptions which are ethically justified because of overriding considerations.

When a patient threatens to inflict serious physical harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, which may include notification of law enforcement authorities.

When the disclosure of confidential information is required by law or court order, physicians generally should notify the patient. Physicians should disclose the minimal information required by law, advocate for the protection of confidential information and, if appropriate, seek a change in the law

### **Basic Ethical Principles:**

It is not difficult to demonstrate that confidentiality is essential if we truly hold to well recognized ethical principles. Frank J Lane, for example, of the American Rehabilitation Counseling Association in discussing ethics and confidentiality laid out these basic ethical principles in a presentation for rehabilitative counselors. I have taken the liberty of adapting these to fit the role of pharmacist.

**Autonomy:** Pharmacists will act in a way that respects and promotes a patient’s right to make his or her own decisions.

**Beneficence:** Pharmacists will promote the good of others. Pharmacists enter the helping professions to help others so it is expected that they will promote the good of others.

**Justice (fairness):** Pharmacists ensure equal treatment and resources for all.

**Fidelity:** Pharmacists make an agreement with patients and consumers and establish trust by living up to this agreement.

**Veracity (truthfulness):** Without trust, the pharmacist will not be able to establish a working relationship with the patient or consumer.

By their very nature it can be argued that for the pharmacist all these ethical principle principles are equally important.

## **Ohio Law and confidentiality**

Ohio law or Ohio State Board of Pharmacy rules tend not to discuss the issue of confidentiality of communication between patients and pharmacists. In general the law will grant that the professional understands and accepts the concept of confidentiality as an integral part of his or her practice. We can discuss this issue later by referring to other methods that guide other health care professionals, e.g. physicians, who have long enjoyed more intimate relationships with their patients, relationships that necessitate the sharing of sensitive information.

## **But first a word about Public Records**

It is important to understand that there are fundamental differences between records that are considered “public” and those considered “medical” in nature.

**Public Records** by definition **are available to the public**. ORC 149.43 defines public records as those records kept by any public office, including, but not limited to, state, county, city, village, township, and school district units. **It is important to note that medical records are not considered public.**

**Medical records**, as described in OAC 5122-14-01, ” means the account, compiled by health care professionals, of a patient’s history, present illness, findings on examination, details of care and services, and notes on progress. ORC 4729-5-29, which is discussed below specifically states that records related to the practice of pharmacy are not records. This, in turn, means that the availability to the public of such records is restricted – by law, and by the rights of the individual to confidentiality.

## **Patient’s rights to medical records (ORC 3701.741)**

A patient, a patient’s personal representative or an authorized person who wishes to examine or obtain a copy of part or all of a medical record shall submit to the health care provider (including pharmacists) a written request signed by the patient, personal representative, or authorized person dated not more than one year before the date on which it is submitted.

The request shall indicate whether the copy is to be sent to the requestor, physician or chiropractor, or held for the requestor at the office of the health care provider. Within a reasonable time after receiving a request that meets the requirements of this division and includes sufficient information to identify the record requested, a health care provider that has the patient's medical records shall permit the patient to examine the record during regular business hours without charge or, on request, shall provide a copy of the record in accordance with section 3701.741 of the Revised Code, etc.

The health care provider shall take reasonable steps to establish the identity of the person making the request to examine or obtain a copy of the patient's record.

If a health care provider fails to furnish a medical record as required by division (B) of this section, the patient, personal representative, or authorized person who requested the record may bring a civil action to enforce the patient's right of access to the record.

## **4729-5-29 Confidentiality of patient records in respect to pharmacy services.**

Effective: 01/01/2009

**(A) Records relating to the practice of pharmacy, the administration of drugs, or any patient specific drug transaction are not a public record.** A person having custody of, or access to, such records shall not divulge the contents thereof, or provide a copy thereof, to anyone except:

Parties listed in 1-8, and 9 are entitled to requested information on demand. However, many such requests require careful consideration by the pharmacist.

- (1) The patient for whom the prescription or medication order was issued.
- (2) The prescriber who issued the prescription or medication order.

OAC 4729-5-24(D) The information on a prescription is the property of the patient (OAC 4729-5-24(D)). In this sense it is confidential. If, for instance, the requesting prescriber no longer treats the patient it is reasonable to determine the need of the request before complying. It might be necessary to comply only after discussing the request with the patient.

- (3) Certified/licensed health care personnel who are responsible for the care of the patient.

The pharmacist might consider whether a specific health care provider has a "need to know". For example, does a physical therapist have a real need to know the prescription history of the patient? The same is true for a number of other health care practitioners. Such questions can usually be clarified by discussing the requests with the patient. As a safeguard the pharmacist

might request a signed release from the patient and a faxed or mailed request from the health care provider.

(4) A member, inspector, agent, or investigator of the state board of pharmacy or any federal, state, county, or municipal officer whose duty is to enforce the laws of this state or the United States relating to drugs and who is engaged in a specific investigation involving a designated person or drug.

(5) An agent of the state medical board when enforcing Chapters 4730 and 4731 of the Revised Code.

(6) An agency of government charged with the responsibility of providing medical care for the patient upon a written request by an authorized representative of the agency requesting such information.

Individuals represented by 4-6 above usually have specific reasons for requesting information. There is no problem in asking the individual to explain the request, and there is no problem in calling the agency sponsoring the request. Additionally, the State Board of Pharmacy may be able to provide guidance concerning the appropriateness of any request.

(7) An agent of a medical insurance company who provides prescription insurance coverage to the patient upon authorization and proof of insurance by the patient or proof of payment by the insurance company for those medications whose information is requested.

Note that the agent has no right to request information concerning medications the insurance company did not pay for. The pharmacist will want be careful to restrict any information provided to only that which is specifically requested. For example, if the patient has a medication for which he or she consistently pays for out-of-pocket this information should not be provided.

(8) An agent who contracts with the pharmacy as a “business associate” in accordance with the regulations promulgated by the secretary of the United States department of health and human services pursuant to the federal standards for privacy of individually identifiable health information.

The real question is just who is a business associate? It is such a broad term that it might even include the technician who services the computers and can access PHI. The term is so broad that the pharmacist might want to determine just who, and under what circumstances, certain individuals even casually associated with the pharmacy might have access to PHI. It would be prudent to have written and signed agreements with such individuals concerning the need to protect PHI.

(9) An agent of the state board of nursing when enforcing Chapter 4723 of the Revised Code.

Similar to previous discussions, The agent should certainly be able to describe the need for information and any questions can be clarified by contacting the state board of nursing.

(10) Any person, other than those listed in paragraphs (A)(1) to (A)(8) of this rule, only when the patient has given consent for such disclosure in writing, except where a patient requiring

medication is unable to deliver a written consent to the necessary disclosure. Any consent must be signed by the patient and dated. Any consent for disclosure is valid until rescinded by the patient. In an emergency, the pharmacist may disclose the prescription information when, in the professional judgment of the pharmacist, it is deemed to be in the best interest of the patient. A pharmacist making an oral disclosure in an emergency situation must prepare a written memorandum showing the patient's name, the date and time the disclosure was made, the nature of the emergency, and the names of the individuals by whom and to whom the information was disclosed.

For the most part this is straight forward. There are at least three questions that should be asked of those requesting information:

**“Who are you?”**

**“What is your relationship with the patient?”**

**“Why do you need this information?”**

**And in the event of an emergency it is appropriate to inquire about the nature of the emergency.**

Based on these questions the pharmacist will know how to fulfill the request responsibly. Remember that any such requests should be well documented.

(B) Testimonial privilege is not waived for any communication between a physician, a pharmacist, and a patient section [2317.02](#) of the Revised Code.

This is actually stating that the physician's need to be confidential is not waived by communication between the patient and pharmacist. For example, if a patient discusses his or her prescriptions or therapy with the pharmacist, such communication does not waive the privilege so that the physician can testify regarding his or her treatment of the patient. No Ohio court, on the other hand, has concluded that communication between patient and pharmacist are encompassed by the physician-patient privilege.

Pharmacists under both state and federal laws are now required to counsel patients in virtually all practice settings. It seems unreasonable that such communication are not granted privileged status.

(C) Records relating to the practice of pharmacy, the administration of drugs, or any patient specific drug transaction which may be required as evidence of a violation shall be released to a member, inspector, agent, or investigator of the state board of pharmacy or any state, county, or municipal officer whose duty is to enforce the laws of this state or the United States relating to drugs and who is engaged in a specific investigation involving a designated person or drug upon his request. Such person shall furnish a receipt to the person having legal custody of the records. If the record is a prescription, the receipt shall list the following information:

(1) Prescription identification number; or, if an order for medication, the name of the patient;

- (2) The drugs prescribed;
- (3) Quantity of drugs prescribed and dispensed;
- (4) Name of the prescriber;
- (5) Date, name of agency, and signature of person removing the records.

(D) All such records, including consents, memoranda of emergency disclosures, and written requests pursuant to paragraph (A)(9) of this rule, shall be kept on file at the pharmacy for a period of three years in a readily retrievable manner.

## Public and Medical Records Once Again

That all records covered by 4729-5-29 are medical records is clarified by the following definition: A medical record is, "*Any document or combination of documents, except births, deaths, and the fact of admission to or discharge from a hospital, that pertains to the medical history, diagnosis, prognosis, or medical condition of the patient and that is generated and maintained in the process of medical treatment*".

A careful reading of this definition is suggested. The only part of a patient's hospital stay that may not be considered confidential (**public**) is the fact that he or she was admitted and discharged from a particular hospital. Everything else except an acknowledgment of birth and death (**usually always public**) is to be considered confidential and treated as such.

A very important matter is that **no one can request medical records on the pretense that they have become public records** no matter how many times, or to whom, the records have been transferred or transmitted electronically or otherwise. This might arise as an important issue, for instance, upon the death of a patient. A court should probably decide whether such records become "public". It is unlikely the professional would be able to do so.

In respect to prescriptions a request for information must conform to the requirements of OAC 4729-5-29. Certified/ licensed health care personnel should be taken to refer only to those health professionals involved in the care of the patient with what the pharmacist would reasonably consider a "need to know". As mentioned earlier, for instance, there would be little reason to discuss the prescription history of a patient with his or her physical therapist. Unless the pharmacist is responding to an emergency there is usually time to consider the "need to know" issue.

**An example might help:**

Say a pharmacist receives a call from a nurse who represents a third-party plan to which the patient belongs and requests by fax a record of all prescriptions dispensed for the patient during a specified period of time. The pharmacist knows that participation in the plan by patients allow the transfer of such information between health care providers servicing the plan. In fact, this information is routinely transferred to the provider during adjudication. However, on examination, you notice that the patient routinely pays cash for certain medications even though his third-party plan would pay for them if asked. The pharmacist would have a difficult time answering the "need to know" issue in this example without first talking to the patient. The pharmacist might request a written release from the patient before providing information to the third-party representative for the medications which the patient, apparently, prefers that the third-party plan not know about.

### **Confidentiality of non-prescription information**

With the advent of "pharmaceutical care" pharmacists are collecting far more sensitive information from patients than that related to the dispensing process. State laws and board of pharmacy rules do not directly address this information in respect to pharmacy practice. It seems, however, that it would be considered privileged information under HIPAA. That does not mean, however, that there are no laws or applicable rules that can provide guidance to the community pharmacist on this important issue. The State Board of Pharmacy is one resource.

### **Philosophical Basis for Confidentiality**

Aside from Law we cannot turn to ethics generally. We can also turn to literature for guidance. Beauchamp and Childress ( Principles of Biomedical Ethics, 4th ed., 1994, Oxford University Press ) reason that one can imagine a society that by consensus does not recognize any obligations of confidentiality. They state, therefore, that one must argue in favor of confidentiality between physician and patient, and do so three different ways:

**Consequentialist Arguments:** patients who cannot trust their physicians to conceal certain information might be reluctant to disclose full and forthright information to a physician that might be essential to therapy. This argument may be convincing, but there is still a question of the rule's scope and weight. What, for instance, is the obligation to confidentiality in the case where a patient reveals the intent to harm himself or another person, and the clinician has reason to know or suspect that the threat is real? In certain legal cases [Tarasoff v. Regents of the University of California, 17 Cal.3d 425 (1976)] the majority has held that "confidentiality" should be breached if necessary to prevent injury to innocent parties.

**Arguments from autonomy and privacy rights:**

Even when the consequences of revealing confidential information cannot be known by the health professional the act nevertheless breaches the patient's right to both autonomy and privacy. Breaching such rights may subject the patient to possible legal jeopardy, loss of friends and lovers, emotional devastation, discrimination, loss of employment, and the like. Common-law, some statutory law, and some constitutional arguments feed the interest and debate in this argument, especially in respect to the issue of privacy, but it remains a moral rather than a legal thesis.

### **Fidelity-based arguments:**

Fidelity in general is taken to refer to the expectation of strict observance of promises, duties, etc. Sometimes the expectations in respect to the observance of confidentiality or privacy rights on the part of the patient are unrealistic. It is probably the responsibility of the professional to clarify these unrealistic expectations as they occur, or as the professional realizes them.

### **Overriding Confidentiality:**

Beauchamp and Childress acknowledge that none of these arguments can support absolute rules of confidentiality. And in doing so they feel the need to explain when obligations of confidentiality can be validly overridden by more compelling obligations. Health care professionals have a right to disclose confidential information in circumstances in which a person is not, all things considered, entitled to the confidence.

Sometimes such confidences seem obvious or are actually defined by law: expressing an intent to murder someone, revealing child abuse, having certain communicable diseases. On the other hand, there are many situations that arise which are not so obvious or well defined. These situations provoke a dilemma with which the professional must deal. Beauchamp and Childress suggest a risk assessment chart such as the following:

Magnitude of Harm		
	Major	Minor
Probability of Harm	High	2
	Low	4

One can see that as an objective evaluation of the situation approaches 4 the likelihood of having to breach confidentiality is lessened. However, it is not always easy to assess either the magnitude of harm or the probability of harm. It may be that the professional will want to establish a relationship with an attorney, other professionals, or professional organizations to help resolve difficult dilemmas. Such relationships can usually be queried without revealing the identity of an individual.

### **Covenantal Relationship**

The 1994 American Pharmaceutical Association Code of Ethics recognizes a covenantal relationship between pharmacist and patient that paves the way for pharmaceutical care: a Pharmacist respects the covenantal relationship between the patient and pharmacist. By explanation this means considering the patient-pharmacist relationship as a covenant in which the pharmacist has moral obligations in response to the gift of trust received from society (Ethical Responsibilities in Pharmacy Practice, Buerki and Vottero, 1994, American Institute of the History of Pharmacy). In return for this gift, pharmacists promise to help individuals achieve optimum benefit from their medications, to be committed to their welfare, and to maintain their trust. This is much like the covenantal relationship that is assumed to exist in the physician-patient relationship. Trust, for instance, must address the issues of fidelity, truthfulness, respect for autonomy, and confidentiality.

### **Summary:**

There are few Ohio laws or board of pharmacy rules that directly address the confidentiality of information exchanged between patients and pharmacists except that which pertains to an individual prescription or the prescription history of individuals. There is good reason to hope that no laws will be necessary to clarify the new covenantal relationship that is developing between pharmacists and patients. It would be desirable that a professional code of ethics lays the groundwork for resolving dilemmas in this area, and that an ever developing standard of care would provide insight to satisfactory resolution to such dilemmas. There should never arise, for instance, the question of whether a patient enrolled in a methadone treatment program should be considered confidential information (ORC 3793.13). Nor should a law be necessary to indicate that communications by a person seeking aid in good faith for alcoholism or drug dependence are confidential (ORC 3793.12). Pharmacists should also understand, without applicable laws, that their patient records constitute a personal information center and, as such, contained confidential information as defined by law [ ORC 1347.01(E) (F) ].

The author suggests that pharmacists accept and promote the covenantal relationship between themselves and patients. The pharmacist should then stay abreast with literature on pharmacy practice and the practice of other professions that have covenantal relationships with patients. The covenantal relationship should not vary much between health care professions, since to a great extent then relationship expresses the perceptions patients have of just what the relationship ought to be. If a court or board rules correctly that a covenantal relationship has been inappropriately breached by a representative of one profession, it is likely that practitioners representing other professions would likewise be acting inappropriately.

Finally, it is important to understand that under ORC 1347 there are penalties for wrongful disclosure of personal information. **This is one reason why all pharmacy employees must be trained concerning the inappropriateness of disclosure of personal information.**

### **1347.10. Liability for wrongful disclosure; limitation of action**

(A) A person who is harmed by the use of personal information that relates to him and that is maintained in a personal information system may recover damages in civil action from any person who directly and proximately caused the harm by doing any of the following:

(1) Intentionally maintaining personal information that he knows, or has reason to know, is inaccurate, irrelevant, no longer timely, or incomplete and may result in such harm;

(2) Intentionally using or disclosing the personal information in a manner prohibited by law;

(3) Intentionally supplying personal information for storage in, or using or disclosing personal information maintained in, a personal information system, that he knows, or has reason to know, is false;

(4) Intentionally denying to the person the right to inspect and dispute the personal information at a time when inspection or correction might have prevented the harm. An action under this division shall be brought within two years after the cause of action accrued or within six months after the wrongdoing is discovered, whichever is later; provided that no action shall be brought later than six years after the cause of action accrued. The cause of action accrues at the time that the wrongdoing occurs.

(B) Any person who, or any state or local agency that, violates or proposes to violate any provision of this chapter may be enjoined by any court of competent jurisdiction. The court may issue an order or enter a judgment that is necessary to ensure compliance with the applicable provisions of this chapter or to prevent the use of any practice that violates this chapter. An action for an injunction may be prosecuted by the person who is the subject of the violation, by the attorney general, or by any prosecuting attorney.

**Last thought:**

Most professionals inherently understand the need for patient confidentiality. This is not necessarily true of the people who are employed by professionals. It is important to remind pharmacists, therefore, that they are individually responsible to take steps to encourage and even insist on patient confidentiality in their work environment.

Employees should be routinely reminded of and instructed in the concept of confidentiality and its application. Any breach in patient confidentiality on the part of an employee should be dealt with severely. Quite simply, the employee should be discharged if at all possible. Lastly, confidentiality is such an important part of the covenantal relationship being developed between pharmacists and patients that a pharmacist should not continue to work in an environment that does not respect or foster patient confidentiality.

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There is only one best answer for each question. Please complete the answer sheet and mail along with the appropriate administrative fee to: Adherence, Inc., 9023 Shadetree Dr., Cincinnati, Ohio 45242

Special note: A grade of **75%** is require for CE credit. One retake without an additional fee is allowed.

1. Arguments involving the confidentiality of non-prescription related information about a patient are fully discussed in Ohio pharmacy laws or rules.

- a. true
- b. false

2. The pharmacist should consider the reference to certified/licensed health care personnel in OAC 4729-5-29 as universal in respect to sharing confidential patient information.

- a. true
- b. false

3. The pharmacist should rely only on him/herself to accurately assess risk to the patient if confidentiality may have to be breached.

- a. true
- b. false

4. A covenantal relationship is expressed in the APhA code of ethics between patients and pharmacists.

- a. true
- b. false

5. Records of dispensing of drugs are considered public records.

- a. true
- b. false

6. Board of Pharmacy investigators are allowed to view records of the dispensing of drugs for any patient.

- a. true
- b. false

7. An appropriate release form signed and dated by the patient should be retained for:

- a. 6 months
- b. 1 year
- c. 3 years
- d. 5 years

8.. Though some may view birth records as medical records, unlike prescription records, they are generally also considered public records.

- a. true
- b. false

9. Basic ethical principles include all except

- a. autonomy
- b. beneficence
- c. gratuity
- d. fidelity

10. A written request for medical information made by a patient must be written and signed no more than three months of presentation.

- a. true
- b. false

11. In a medical setting a medical record transmitted numerous times to various practitioners or departments becomes, in essence, a public record as defined by law.

- a. true
- b. false

12. Veracity does not have the same importance as the ethical principles of fidelity, autonomy and justice.

- a. true
- b. false



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