"**CHAPTER 622**
DOCUMENTARY EVIDENCE

Note

As to procedural statutes superseded by the rules of court, see note preceding Title 32.

"**PART I. GENERAL PROVISIONS--REPEALED**

§§622-1 to 622-5 REPEALED. L 1980, c 164, §5.

"**PART II. DOCUMENTARY EVIDENCE OF A PUBLIC NATURE; CORPORATE RECORDS--REPEALED**

§§622-11 to 622-23 REPEALED. L 1980, c 164, §6.

"**PART III. FEDERAL STATUTES CONCERNING MISSING PERSONS; EFFECT OF--REPEALED**

§§622-31 to 622-33 REPEALED. L 1980, c 164, §7.

"**PART IV. PROBATE, PEDIGREE, TITLE**

§§622-41 and 622-42 REPEALED. L 1980, c 164, §8.

" **§622-43 Decree of distribution, prima facie evidence of what.** When upon the trial of any cause in any court of the State it becomes necessary to show the devolution of the title to land any former owner of which died intestate, a decree or order of distribution duly entered by a court having jurisdiction in probate of the estate of any such deceased owner may be received in evidence, and, when so received, shall constitute prima facie proof of the descent of the title to the person or persons named as distributee or distributees in the order or decree, provided that the order or decree was so entered not less than ten years prior to the date upon which the cause was commenced. [L 1923, c 169, §1; RL 1925, §2609; RL 1935, §3849; RL 1945, §9900; RL 1955, §224-24; HRS §622-43]

Case Notes

Cited: 45 H. 521, 536, 371 P.2d 379 (1962); 49 H. 273, 295, 296, 414 P.2d 925 (1966).

" **§§622-44 and 622-45 REPEALED.** L 1972, c 104, §2(r).

"PART V. MEDICAL RECORDS

§622-51 Definitions. As used in this part:

"Health care data" means information submitted for outcomes, trends, or cost analysis, and research or informed policy and decision making relating to health care costs, mortality, morbidity, and treatment outcomes including but not limited to the:

(1) Date of admission and date of discharge;
(2) Patient discharge status;
(3) Principal and secondary diagnoses;
(4) Principal and secondary procedures;
(5) Total charge segregated by service, procedures, facility, drugs, and medical supplies used; and
(6) Total payment reimbursed to the health care professional or provider.

"Medical facility" means a hospital operated by a public entity, a hospital licensed under chapter 321, the office of a medical group practice, a licensed physician's office, or any other type of facility where medical records relating to the care or treatment of a patient are kept.

"Medical records" mean records of patients kept by a medical facility.

"Officer" means a public officer, but does not include a person before whom a deposition is being taken. [L 1971, c 139, pt of §1; am L 1972, c 104, §2(s); am L 1995, c 190, §3]

" **§622-52 Subpoena duces tecum for medical records, compliance.** (a) Whenever a subpoena duces tecum is served upon the custodian of medical records or other qualified witness from a medical facility, in an action or other proceeding on a claim for personal injuries in which the custodian or the custodian's employer is neither a party to the action or proceeding nor is it alleged that the claim arose at the medical facility, and such subpoena requires the production in court, or before an officer, board, commission, or tribunal, of all or any part of the medical records of a patient who is or has been cared for or treated at the medical facility, it shall be sufficient compliance therewith if the custodian or other qualified witness within five days after receipt of such subpoena, delivers by registered or certified mail or by messenger a true and correct copy (which may be by any method described in rule 1001(4), Hawaii rules of evidence) of all the medical records described

in such subpoena to the clerk of the court or the clerk's deputy authorized to issue it, together with the affidavit described in section 622-53.

(b) The copy of the medical records shall be separately enclosed in an inner envelope or wrapper, sealed, with the title and number of the action, name of the custodian or other qualified witness, and date of the subpoena clearly inscribed thereon; the sealed envelope or wrapper shall then be enclosed in an outer envelope or wrapper, sealed, and directed as follows:

(1) If the subpoena directs attendance in court, to the clerk of such court or the clerk's deputy authorized to issue it, at the courthouse.

(2) In other cases, to the officer, board, commission, or tribunal conducting the hearing, at the place designated in the subpoena.

(c) The copy of the medical records shall remain sealed and shall be opened only at the time of trial, or other hearing, upon the direction of the judge, officer, board, commission, or tribunal conducting the proceeding, in the presence of all parties who have appeared in person or by counsel at such trial, or hearing, unless the parties or counsel in the proceeding otherwise agree, or unless the sealed envelope or wrapper is returned to the custodian or other qualified witness who is to appear personally. Copies of medical records which are not introduced in evidence or required as part of the record shall be returned by registered or certified mail or by messenger to the person or entity from whom received. If the copies of the medical records are introduced in evidence or are required as part of the record, they shall be returned by registered or certified mail or messenger to the person or entity from whom received as soon as their use is no longer needed, after the trial, or other hearing. [L 1971, c 139, pt of §1; am L 1972, c 104, §2(t), (u); gen ch 1985; am L 1987, c 283, §60]

Note

The amendments to this section by L 1999, c 87, §4 and L 2000, c 91, §3 effective July 1, 2001, by L Sp 2000 2d, c 1 were repealed by L 2001, c 244 on June 30, 2001.

" **§622-53 Affidavit accompanying medical records.** (a) The medical records shall be accompanied by the affidavit of the custodian or other qualified witness, stating in substance each of the following:

(1) That the affiant is the duly authorized custodian of the medical records and has authority to certify the medical records;
(2) That the copy is a true copy of all the medical records described in the subpoena; and
(3) That the medical records were prepared by the personnel of the medical facility, staff physicians, or persons acting under the control of either, in the regular course of business at or near the time of the act, condition, or event.

(b) The affidavit shall be notarized by a notary public, who may be the custodian of the medical records; except where the custodian or the custodian's employer is a party to the cause of action or the medical facility is the place where the cause of action is alleged to have arisen and for which the subpoena duces tecum is being served.

(c) If none of the medical records described in the subpoena, or only a part thereof, are available, the custodian shall so state in the affidavit, and deliver the affidavit and such medical records as are available in the manner provided in section 622-52. [L 1971, c 139, pt of §1; am L 1972, c 104, §2(v); gen ch 1985]

Revision Note

Pursuant to §23G-15, in:
(1) Subsection (a)(1), punctuation changed; and
(2) Subsection (a)(2), punctuation changed and "and" added after ending punctuation.

" **§§622-54 and 622-55 REPEALED.** L 1980, c 164, §9.

" **§622-56 Fees; service of more than one subpoena.** (a) All copies of medical records requested under this part shall be paid for by the person, board, commission, or tribunal requesting such records. The cost shall be based on the actual cost of preparation.

(b) This part shall not be deemed to require the tender of more than one witness or mileage fee required, unless there is an agreement to the contrary.

(c) If more than one subpoena duces tecum is served upon the custodian or other qualified witness from a medical facility and the personal attendance of that person is required, the witness shall be deemed to be the witness of the party serving

the first subpoena. [L 1971, c 139, pt of §1; am L 1972, c 104, §2(w); am L 1987, c 283, §61]

" **§622-57 Availability of medical records.** (a) If a patient of a health care provider as defined in section 671-1, requests copies of the patient's medical records, the copies shall be made available to the patient unless, in the opinion of the health care provider, it would be detrimental to the health of the patient to obtain the records. If the health care provider is of the opinion that release of the records to the patient would be detrimental to the health of the patient, the health care provider shall advise the patient that copies of the records will be made available to the patient's attorney upon presentation of a proper authorization signed by the patient.

(b) If an attorney for a patient asks a health care provider for copies of the patient's medical records and presents a proper authorization from the patient for the release of the information, complete and accurate copies of the records shall be given to the attorney within a reasonable time not to exceed ten working days.

(c) In the case of a deceased person, a personal representative of the deceased person's estate may obtain copies of or may authorize the health care provider to release copies of the deceased person's medical records upon presentation of proper documentation showing the personal representative's authority.

If no personal representative has been appointed, the deceased person's next of kin in order of superseding priority, without court order, may obtain copies of or may authorize the health care provider to release copies of the deceased person's medical records, except as otherwise provided in this subsection and subsections (d) and (e). A deceased person's next of kin possesses superseding priority when all kin ranked higher in the order listed in the definition of "deceased person's next of kin" are deceased or incapacitated. When there are multiple persons at the same level of superseding priority, all such persons shall be entitled to request and obtain the records. The person claiming to be next of kin of a deceased person and requesting the deceased person's medical records shall submit to the medical provider from whom the records are requested, an affidavit attesting to status as next of kin with superseding priority. The medical provider may rely upon the affidavit, and in so doing, shall be immune to any claims relating to release of the medical records.

(d) Notwithstanding applicable state confidentiality laws governing the following types of specially protected health

information, a health care provider may honor, in whole or in part, a request by the deceased person's next of kin for release of medical records if the medical records of the deceased person contain references pertaining to any of the following types of specially protected health information:

(1) HIV infection, AIDS, or AIDS-related complex;

(2) Diagnosis or treatment of a mental illness; or

(3) Participation in a substance abuse treatment program.

(e) A health care provider shall refuse a request by the deceased person's next of kin for release of medical records if the deceased person had previously indicated to the medical provider in writing that the person did not wish to have medical records released to next of kin.

(f) Notwithstanding subsections (c) through (e), any medical records of a deceased person may be produced pursuant to a court order specifically compelling release.

(g) Reasonable costs incurred by a health care provider in making copies of medical records shall be borne by the requesting person.

(h) For the purposes of this section:

"Deceased person's next of kin" means a person with the following relationship to the deceased person:

(1) The spouse or reciprocal beneficiary;

(2) An adult child;

(3) Either parent;

(4) An adult sibling;

(5) A grandparent; and

(6) A guardian at the time of death.

"Personal representative" shall have the meaning provided in section 560:1-201. [L 1976, c 219, §15; am L 1984, c 150, §1; am L 2004, c 192, §1]

" **§622-58 Retention of medical records.** (a) Medical records may be computerized or minified by the use of microfilm or any other similar photographic process; provided that the method used creates an unalterable record. The health care provider shall retain medical records in the original or reproduced form for a minimum of seven years after the last data entry except in the case of minors whose records shall be retained during the period of minority plus seven years after the minor reaches the age of majority.

(b) Records exempt from the retention requirement are: public health mass screening records; pupils' health records and related school health room records; preschool screening program records; communicable disease reports; and mass testing epidemiological projects and studies records, including

consents; topical fluoride application consents; psychological test booklets; laboratory copies of reports, pharmacy copies of prescriptions, patient medication profiles, hospital nutritionists' special diet orders, and similar records retained separately from the medical record but duplicated within it; public health nurses' case records that do not contain any physician's direct notations; social workers' case records; and diagnostic or evaluative studies for the department of education or other state agencies.

(c) X-ray films, electro-encephalogram tracings, and similar imaging records shall be retained for at least seven years, after which they may be presented to the patient or destroyed; provided that interpretations or separate reports of x-ray films, electro-encephalogram tracings, and similar imaging records shall be subject to subsection (e).

(d) Medical records may be destroyed after the seven-year retention period or after minification, in a manner that will preserve the confidentiality of the information in the record; provided that the health care provider retains basic information from each record destroyed. Basic information from the records of a physician or surgeon shall include the patient's name and birthdate, a list of dated diagnoses and intrusive treatments, and a record of all drugs prescribed or given. Basic information from the records of a health care facility, as defined in section 323D-2, shall include the patient's name and birthdate, dates of admission and discharge, names of attending physicians, final diagnosis, major procedures performed, operative reports, pathology reports, and discharge summaries.

(e) The health care provider, or the health care provider's successor, shall be liable for the preservation of basic information from the medical record for twenty-five years after the last entry, except in the case of minors, whose records shall be retained during the period of minority plus twenty-five years after the minor reaches the age of majority. If the health care provider is succeeded by another entity, the burden of compliance with this section shall rest with the successor. Before a provider ceases operations, the provider shall make immediate arrangements, subject to the approval of the department of health, for the retention and preservation of the medical records in keeping with the intent of this section.

(f) For the purposes of this section, the term "health care provider" means as defined in section 671-1. [L 1984, c 150, §2; am L 1986, c 176, §1; am L 1988, c 80, §1]

" **[§622-59] Health care data discovery.** Where health care data submitted to either a public or private organization for

the purpose of aggregate treatment outcomes, trends, or cost analysis, or public reporting, that identifies or reasonably could be used to identify specific physicians, health care professionals, or individual patients, that portion of the data shall not be subject to discovery or admission into evidence in any civil or administrative proceeding involving the organization. Information, documents, or records made in the regular course of business by a hospital or other provider of health care are not to be construed as immune from discovery or use in any civil or administrative proceeding merely because they were presented to an organization for aggregate analysis. [L 1995, c 190, §2]