Examples of Sharable Information Between a Patient's Providers:

Current WI Mental Health Law vs. Federal Law

- Wisconsin law generally requires written consent to disclose mental health records, but does permit certain discrete information to be disclosed to treating providers without consent (the items in peach below).
- HIPAA requires consent to disclose psychotherapy notes, but does permit the disclosure of non-psychotherapy notes and certain other specific items that may be in a psychotherapy note (the items in purple below) without consent.
- Also pursuant to HIPAA, a patient at any time may request that their health care provider limit the disclosure of information to another treating provider, and if the patient and health care provider agree to the restriction, the health care provider must adhere to that agreement.
- The table below compares the list of information that may be shared without consent between a treating mental health provider and other providers under Wisconsin law with examples of information that can be shared without consent under Federal HIPAA law. **Bolded** items in the table identify items that are different from the items that may be disclosed without consent under current Wisconsin law.
- In addition, the information in blue lists information that must be in "transitions of care summaries" created by a health care providers' EHR by 2014 pursuant to new Federal Regulations.

Key: Citations for the items listed below	
	Wisconsin Statute: s. 51.30(4)(b)8g. (Act 108)
	HIPAA: 45 CFR 164.501. Items specifically excluded from HIPAA's "psychotherapy note" treatment disclosure restrictions. **While HIPAA requires consent to disclose psychotherapy notes, HIPAA does permit the disclosure of these items without consent**.
	Current Federal Meaningful Use Regulation: Federal Register Vol. 77, No. 171. Items that at a minimum must be included in "transitions of care summaries" created by health care providers' EHR by 2014.

Current Wisconsin Law	**Federal HIPAA Law**
The following information may be disclosed **without consent** under current Wisconsin law.	The following is a list of examples of information that can be disclosed **without consent** under Federal HIPAA law and that are discussed in the context of other state or federal laws. (Note that some are redundant):
The individual's name, address, and date of birth;	The individual's name, address, and date of birth;
The name of the individual's provider of services for mental illness, developmental disability, alcoholism, or drug dependence;	The name of the individual's provider of services for mental illness, developmental disability, alcoholism, or drug dependence;
The date of any of those services provided;	The date of any of those services provided;
The individual's medications	The individual's medications
The individual's allergies,	The individual's allergies,
The individual's diagnosis,	The individual's diagnosis,

The individual's diagnostic test of biological parameters, but not the results of psychological or neuropsychological testing.	The individual's diagnostic of biological parameters, but not the results of psychological or neuropsychological testing.
The individual's symptoms.	The individual's symptoms.
Other relevant demographic information.	Other relevant demographic information.
	Medication prescription and **medication monitoring notes**,
	Counseling session start and stop times,
	The modalities and frequencies of treatment furnished,
	Results of clinical tests
	Any **summary** of an individual's diagnosis:
	Any **summary** of an individual's **functional status**,
	Any **summary** of an individual's **treatment plan**,
	Any **summary** of an individual's symptoms
	Any **summary** of an individual's **prognosis**
	Any **summary** of an individual's **progress to date**.
	Patient name
	Referring or transitioning provider's name and office contact information
	Procedures
	Encounter diagnosis
	Immunizations
	Laboratory test results
	Vital signs
	Smoking status
	Functional status, including activities of daily living, cognitive and disability status
	Demographic information
	Preferred language
	A care plan that defines care management actions for the patient's conditions, problems or issues and that includes the problem, goal, and any instructions that the provider has given to the patient.
	Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
	Discharge instructions
	Reason for referral
	Problem list, including historical problems and not just diagnoses
	Medication list
	Medication allergy list