Date of Hearing: June 21, 2022

ASSEMBLY COMMITTEE ON PRIVACY AND CONSUMER PROTECTION
Jesse Gabriel, Chair
SB 1184 (Cortese) – As Amended May 5, 2022

SENATE VOTE: 27-9

SUBJECT: Confidentiality of Medical Information Act: school-linked services coordinators

SUMMARY: This bill would amend the Confidentiality of Medical Information Act (CMIA) to permit a provider of health care or a health care service plan to disclose medical information to a school-linked services coordinator, as defined, pursuant to a written authorization between the provider and the patient or client that complies with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, **this bill would**:

1) Authorize a provider of health care or a health care service plan to disclose medical information to a school-linked services coordinator pursuant to a written authorization between the health provider and the patient or client that complies with HIPAA.

2) Defines "school-linked services coordinator" to mean an individual located on a school campus or under contract by a county behavioral health provider agency for the treatment and health care operations and referrals of students and their families that holds any of the following:

   - A services credential with a specialization in pupil personnel services, as specified.
   - A services credential with a specialization in health authorizing service as a school nurse, as specified.
   - A license to engage in the practice of marriage and family therapy, as specified.
   - A license to engage in the practice of educational psychology, as specified.
   - A license to engage in the practice of professional clinical counseling, as specified.

3) Make technical, non-substantive amendments to CMIA.

EXISTING LAW:

1) Under federal law, provides, pursuant to HIPAA, that, except as otherwise permitted or required by HIPAA, a covered entity may not use or disclose protected health information, as defined, without a valid authorization, as specified (45 C.F.R. Sec. 164.508(a)(1)); and requires that a valid authorization be written in plain language and include at least the following elements:

   - A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.

- The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.
- The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure.
- A description of each purpose of the requested use or disclosure.
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure.
- Signature of the individual and date.
- A statement of the individual's right to revoke the authorization in writing, as specified.
- A statement of the ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, as specified.
- A statement of the potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by HIPAA. (45 C.F.R. Sec. 164.508(c).)

2) Defines "covered entity," for purposes of 1), above, to mean a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by HIPAA. (45 C.F.R. Sec. 160.103.)

3) Defines "protected health information," for purposes of 1), above, to mean individually identifiable information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium, excluding education records covered by the Family Educational Rights and Privacy Act (FERPA), employment records held by a covered entity in its role as employer, and records regarding a person who has been deceased for more than 50 years. (*Id.*)

4) Pursuant to CMIA, prohibits a provider of health care, health care service plan, or contractor from disclosing medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining authorization, as specified, except as provided. (Civ. Code Sec. 56.10(a).)

5) Permits a provider of health care or a health care service plan to disclose medical information without first obtaining authorization under specified circumstances, including, among others, emergency situations, disease management programs, for provider licensing and accreditation purposes, for bona fide research purposes, and for purposes of administering a health care service plan. (Civ. Code Sec. 56.10(c).)

6) Prohibits a provider of health care, health care service plan, contractor, or corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using medical information for a purpose not necessary to provide health care services to the patient, except to the extent expressly authorized by a patient, enrollee, or subscriber, or as otherwise provided in CMIA. (Civ. Code Sec. 56.10(d).)

7) Requires any person or entity that wishes to obtain medical information that is not explicitly authorized to do so pursuant to 5), above, to obtain a valid authorization for the release of the information that meets the following specifications:

   - Is handwritten by the person who signs it or is in a typeface no smaller than 14-point type.

   - Is clearly separate from any other language present on the same page and is executed by a signature which serves no other purpose than to execute the authorization.

   - Is signed and dated by one of the following: the patient, including a minor if the authorization is for the release of medical information obtained in the course of furnishing services to which the minor could lawfully have consented; the legal representative of the patient, if the patient is a minor or an incompetent; the spouse of the patient or the person financially responsible for the patient, where medical information is being sought for the sole purpose of processing an application for health insurance or enrollment in a nonprofit hospital plan, a health care service plan, or an employee benefit plan; or the beneficiary or personal representative of a deceased patient.

   - States the specific uses and limitations on the types of medical information to be disclosed.

   - States the name or functions of the provider of health care, health care service plan, pharmaceutical company, or contractor that may disclose the medical information.

   - States the name or functions of the persons or entities authorized to receive the medical information.

   - States the specific uses and limitations on the use of the medical information by the persons or entities authorized to receive the medical information.

   - States a specific date after which the provider of health care, health care service plan, pharmaceutical company, or contractor is no longer authorized to disclose the medical information.

   - Advises the person signing the authorization of the right to receive a copy of the authorization. (Civ. Code Sec. 56.11.)

8) Prohibits a recipient of medical information pursuant to an authorization as provided by 7), above, or pursuant to a permissible purposes provided in 5), above, may not further disclose that medical information except in accordance with a new authorization that meets specified requirements, or as specifically required or permitted by other provisions of law. (Civ. Code Sec. 56.13.)

9) Requires a provider of health care, health care service plan, or contractor that discloses medical information pursuant to the required authorizations to communicate to the person or entity to which it discloses the medical information any limitations in the authorization regarding the use of the medical information; and provides that a person that has attempted in good faith to comply with this provision shall not be liable for any unauthorized use of the

medical information by the person or entity to which the medical information was disclosed. (Civ. Code Sec. 56.14.)

10) Defines "medical information" for the above purposes to mean any individually identifiable information, in electronic or physical form, in possession of or dervied from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment; and defines "individually identifiable" to mean that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, email address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual. (Civ. Code Sec. 56.05(i).)

FISCAL EFFECT: None. This bill has been keyed non-fiscal by the Legislative Counsel.

COMMENTS:

1) **Purpose of this bill**: This bill seeks to improve student access to behavioral health services by facilitating the sharing of medical information with dedicated support personnel on school-sites in order to mitigate the worsening youth mental health crisis in this state and across the country. This bill is sponsored by GENup.

2) **Author's statement**: According to the author:

> Between 2007 and 2014, the suicide rate for children ages 10 to 14 more than doubled. Suicide is now the second leading cause of death for individuals between the ages of 10 and 24. COVID-19 has only exacerbated these issues, as we're seeing a steep rise in calls to youth crisis lines as well as mental-health related emergency room visits for those between 5-17 years of age.
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> Perceived barriers around information sharing during the behavioral health referral process decrease the likelihood of "closing the referral loop" when services are delivered by health care providers independent of a school system. While the Education Code (Section 49602) states that protected health information shared during discussions with educational psychotherapists, other health care providers, or the school nurse, may be disclosed for the sole purpose of referring the pupil for treatment, the Civil Code needs clarification on what information can be shared to school-based health providers.
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> A report published by the Santa Clara County Office of Education, titled "*The Efficacy of Implementing a School-Based Approach to Student Wellness*," demonstrated that students are 10 to 21 times more likely to receive behavioral health services when they are provided on a school campus. SB 1184 would define under the California Civil Code a "School-Linked Services" coordinator as those individuals or entities, including licensed educational psychologists, located on a school campus or under contract by a behavioral health provider for treatment and health care operations, and ensure that these "School-Linked Services" coordinators can disclose medical information when authorized for the purposes of referral or treatment.

3) **Nationwide youth mental health crisis continues to worsen**: Over the past several years, research has reliably demonstrated that the United States is in the grips of a deepening crisis

of mental health among its youth. On February 8, 2022 United States Surgeon General Vivek Murthy testified before the United States Senate Committee on Finance regarding the crisis of deteriorating mental health among the nation's youth, which he dubbed a "crisis of loneliness and hopelessness."[1] In 2021, Murthy published an advisory detailing the state of this crisis and recommending certain actions to attempt to curb the devastating effects of mental illness on today's youth. According to the Surgeon General's advisory:

> Even before the COVID-19 pandemic, mental health challenges were the leading cause of disability and poor life outcomes in young people, with up to 1 in 5 children ages 3 to 17 in the US with a reported mental, emotional, developmental, or behavioral disorder. In 2016, of the 7.7 million children with treatable mental health disorders, about half did not receive treatment.
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> Unfortunately, in recent years, national surveys of youth have shown major increases in certain mental health symptoms, including depressive symptoms and suicidal ideation. From 2009 to 2019, the proportion of high school students reporting persistent feelings of sadness and hopelessness increased by 40%; the share seriously considering attempting suicide increased by 36%; and the share creating a suicide plan increased by 44%. Between 2011 and 2015, youth psychiatric visits to emergency departments for depression, anxiety, and behavioral challenges increased by 28%. Between 2007 and 2018, suicide rates among youth ages 10-24 in the US increased by 57%. Early estimates from the National Center for Health Statistics suggest there were tragically more than 6,600 deaths by suicide among the 10-24 age group in 2020. […]
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> Since the pandemic began, rates of psychological distress among young people, including symptoms of anxiety, depression, and other mental health disorders, have increased. Recent research covering 80,000 youth globally found that depressive and anxiety symptoms doubled during the pandemic, with 25% of youth experiencing depressive symptoms and 20% experiencing anxiety symptoms. Negative emotions or behaviors such as impulsivity and irritability – associated with conditions such as ADHD – appear to have moderately increased. Early clinical data are also concerning: In early 2021, emergency department visits in the United States for suspected suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to the same time period in early 2019.[2]

This worsening mental health crisis has likely been exacerbated by a shortage of accessible behavioral healthcare. A recent study published in *The Annals of Family Medicine* estimated that more than 85% of primary-care practices have difficulty obtaining help with evidence-based elements of pediatric behavioral healthcare. As that article explains, "[w]hen used appropriately, psychotropic drugs, evidence-based psychotherapy, and family-based

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[1] Vivek H. Murthy, Testimony before United States Senate Committee on Finance, Feb. 8, 2022.
[2] Vivek H. Murthy, "Protecting Youth Mental Health: The U.S. Surgeon General's Advisory," *Surgeon General of the United States*, 2021, https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf [as of Jun. 19, 2022].

treatments are cornerstones of effective treatment but are challenging to deliver broadly given the ongoing national shortage of child behavioral health professionals."[3]

The American Academy of Child and Adolescent Psychiatry estimates that the country needs 47 child psychiatrists per 100,000 children. A 2019 study published in the journal *Pediatrics* estimated that, as of 2016, that figure was less than 10.[4] This problem is particularly acute in California, and especially among already socioeconomically disadvantaged communities. As a 2019 article published by the University of Southern California's Center for Health Journalism described:

> In California, nearly one in 13 kids suffers with a mental disorder severe enough to disrupt daily living. California has fewer than 1,135 child and adolescent psychiatrists to serve almost 10 million children and teens younger than 18 years. This mismatch means many kids do not have access to care.
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> The dearth of mental health providers is especially problematic in areas of the state that are poor, rural or have mostly immigrant populations. In a community, as the rate of poverty increases, so does the rate of mental illness. But the number of licensed mental health professionals decreases. For example, in Los Angeles County 18 percent of people live in poverty and there are about 20 psychiatrists per 100,000 people. In comparison, the wealthier counties of San Francisco and Marin have poverty rates below 10 percent. But they have the highest rates of psychiatrists in the state, at 76 and 70 per 100,000 people, respectively.[5]

This shortage, and these disparities, have likely only worsened since then. This bill seeks to address the youth mental health crisis by eliminating perceived barriers in the sharing of medical information between health care providers and school-linked personnel responsible for providing or referring care.

4) School-linked Services Initiative: This bill appears to respond to the remarkable success of the so-called "School-Linked Services" program in Santa Clara County. According to the County of Santa Clara Behavioral Health Services Department**:**

> School Linked Services (SLS) provides students and families with school based coordinated services to improve health and wellbeing of families through a community participatory approach. School Linked Services (SLS) Coordinators, located at the school district or a school site, develop partnerships with schools, public agencies and community based organizations in Santa Clara County to improve protective factors, e.g., family relationships, decrease ris-factors, e.g., behavioral and emotional problems,

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[3] A. Chien, et al., "Difficulty Obtaining Behavioral Health Services for Children: A National Survey of Multiphysician Practices," *The Annals of Family Medicine*¸ Jan. 2022, 20 (1) 42-50; DOI: https://doi.org/10.1370/afm.2759, https://www.annfammed.org/content/20/1/42 [as of Jun. 19, 2022].
[4] David Axelson, "Beyond A Bigger Workforce: Addressing the Shortage of Child and Adolescent Psychiatrists," *Pediatrics Nationwide*, Apr. 10, 2020, https://pediatricsnationwide.org/2020/04/10/beyond-a-bigger-workforce-addressing-the-shortage-of-child-and-adolescent-psychiatrists/ [as of Jun. 19, 2022].
[5] ChrisAnna Mink, "There's a huge shortage of mental health providers for kids who need help," *USC Center for Health Journalism*, May 6, 2019, https://centerforhealthjournalism.org/2019/04/22/there-s-huge-shortage-mental-health-providers-kids-who-need-help [as of Jun. 19, 2022].

enhance service accessibility and resource linkage, and to support children's success in school and in life.[6]

As the author explains:

> Envisioned and pioneered by Senator Dave Cortese, the "School-Linked Services" program in Santa Clara County connects students and families to county mental health counseling, case management, and public health services on district and school site campuses through "School-Linked Services Coordinators" and has grown to a $40 million-a-year program serving about 200 schools across 15 school districts in Santa Clara County.

Research by the Santa Clara County Office of Education indicates that students are 10 to 21 times more likely to receive behavioral health services when they are provided on a school campus. In the School-Linked Services program's Fiscal Year 2020 end-of year survey, Santa Clara County reported that roughly three out of every four families surveyed reported the program helped them learn more about the services and supports available in their community, as well as their health and wellbeing. In addition, 67% of families reported that the program improved their ability to find resources for their child, 65% reported that the program helped them advocate for their child, and 76% reported that the program increased their child's academic success. In a survey of staff participating in the program, 83% of those surveyed responded "agree" or "strongly agree" that the model has improved school-family-community partnerships, and staff generally indicated significant benefits including connecting diverse community partners in lasting relationships and streamlining referral processes to save families and staff time and resources.

This bill appears intended to facilitate the establishment of similar programs beyond Santa Clara County, and to improve the efficiency of these programs in providing and connecting students and families with essential services.

5) **Medical privacy laws**: Federal and state medical privacy laws regulate the sharing of health information by health care providers. HIPAA, enacted in 1996, guarantees privacy protection for individuals with regards to protected health information. (Pub.L. 104–191, 110 Stat. 1936.) Generally, protected health information is any information held by a covered entity which concerns health status, provision of health care, or payment for health care that can be connected to an individual. HIPAA privacy regulations require health care providers and organizations to develop and follow procedures that ensure the confidentiality and security of protected health information when it is transferred, received, handled, or shared. HIPAA further requires reasonable efforts when using, disclosing, or requesting protected health information, to limit disclosure of that information to the minimum amount necessary to accomplish the intended purpose.

   In the case of student medical information, some additional federal privacy protections are provided pursuant to the Family Educational Rights and Privacy Act (FERPA), which protects the privacy of student education records. (20 U.S.C. Sec. 1232g; 34 C.F.R. Part 99.)

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[6] *School Linked Services Initiative*, County of Santa Clara Behavioral Health Services, https://bhsd.sccgov.org/information-resources/children-youth-and-family/school-linked-services-initiative [as of Jun. 19, 2022].

As U.S. Department of Health and Human Services' and the U.S. Department of Education's "Joint Guidance on the Application of the *Family Educational Rights and Privacy Act (FERPA)* And the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* To Student Health Records," December 2019 Update explains:

> FERPA [citation] is a Federal law that protects the privacy of students' "education records." FERPA affords parents certain rights with respect to their children's education records maintained by educational agencies and institutions […]. These include […] the right to provide consent for the disclosure of personally identifiable information (PII) from these records, unless an exception to consent applies. […]
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> An educational agency or institution subject to FERPA may not disclose education records, or PII from education records, of a student without the prior written consent of a parent or the student if the student is an "eligible student," unless an exception applies. […] For example, educational agencies and institutions can disclose PII From a student's education records, including health and medical information, to teachers and other school officials within the school, without prior written consent, if these school officials have been determined to have "legitimate educational interests" in the education records […].
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> Under FERPA, "treatment records," as they are commonly called, are excluded from the definition of "education records." […] Assuming certain conditions are satisfied, treatment records may include, for instance, a student's health or medical records that a college's psychologist maintains solely in connection with providing treatment to a student (including health care professionals who are not part of, nor acting on behalf of, the educational agency or institution (e.g., third-party health care providers)), and a physician or other appropriate professional of the student's choice. [] For all other disclosures of an eligible student's treatment records, an educational agency or institution must obtain the student's prior written consent or satisfy one of the exceptions to FERPA's general written consent requirement, as the records would no longer qualify as "treatment records" (and thereby be excluded from the definition of "education records") and, instead, become subject to all other FERPA requirements.[7]

California's CMIA also protects medical information and restricts its disclosure by health care providers, and health care service plans, as specified. (Civ. Code Sec. 56, et seq.) CMIA prohibits a provider of health care, health care service plan, contractor, or corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using medical information for a purpose not necessary to provide health care services to the patient, unless expressly authorized by the patient or otherwise provided by CMIA. (Civ. Code Sec. 56.10(d).) CMIA also prohibits a provider of health care, health care service plan, or contractor from disclosing the medical information of a patient without first obtaining authorization from the patient or the patient's designated representative (Civ. Code Sec. 56.10(a)), but specifies certain circumstances under which medical information can be disclosed without authorization. These include if disclosure is compelled by a court order or otherwise specifically required by law, and, among others, emergency situations, disease management programs, for provider licensing and accreditation purposes, for bona

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[7] U.S. Dept. of Health and Human Services & U.S. Department of Education, "Joint Guidance on the Application of the *Family Educational Rights and Privacy Act (FERPA)* And the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* To Student Health Records," Dec. 2019 Update.

fide research purposes, and for purposes of administering a health care service plan. (Civ. Code Sec. 56.10(b) and (c).)

This bill would amend CMIA to explicitly add to the list of permissible disclosures of medical information the sharing of medical information between health care providers and school-linked services coordinators, as defined.

6) **Bill would explicitly permit specified disclosure of medical information to a school-linked services coordinator, which may already be permissible under existing law**: This bill would add to the list of permissible disclosures of medical information by a provider of health care or a health care service plan under CMIA that the information may be disclosed to a school-linked services coordinator pursuant to a written authorization between the "health provider" and the patient or client that complies with HIPAA. The bill would define "school-linked services coordinator" to mean "an individual located on a school campus or under contract by a county behavioral health provider agency for the treatment and health care operations and referrals of students and their families that holds any of the following, as specified: a services credential with a specialization in pupil personnel services; a services credential with a specialization in health authorizing service as a school nurse; a license to engage in the practice of marriage and family therapy; a license to engage in the practice of educational psychology; or a license to engage in the practice of professional clinical counseling.

Due to the dearth of pediatric behavioral health resources available and the worsening mental health crisis among youth, measures to improve access to treatment resources within the course of their daily activities are arguably necessary. Studies have consistently demonstrated that increasing the availability of mental health services at school-based health centers produces remarkable improvements in student mental health.[8] As such, the bill identifies a particularly critical issue, and seeks to resolve it by nominally removing barriers to evidence-based solutions.

The sponsors of the bill, GENup, contend:

> We must work to improve the way we deliver behavioral health support to our student community, whether it is through partnerships between counties and local school systems or school-site wellness centers, so that we can meet the mental health needs of our students.
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> By defining in California law a ""School-Linked Services Coordinator" as those individuals or entities, who serve as licensed educational psychologists, located on a school campus or under contract by a county behavioral health provider, and ensuring that these "School-Linked Services" can better refer both students and families to mental health treatment and care, SB 1184 would improve the ways we holistically serve our children and student community.

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[8] *See*, e.g., MJ Paschall & M Bersamin, "School-based mental health services, suicide risk and substance use among at-risk adolescents in Oregon," *Preventative Medicine*, Jan. 2018, 106:209-214, DOI: 10.1016/j.ypmed.2017.11.004, https://pubmed.ncbi.nlm.nih.gov/29126919/ [as of Jun. 19, 2022].

In support of the bill, the California School Nurses Organization lauds the author's inclusion of credentialed school nurses in the definition of "school-linked services coordinator":

> School nurses are uniquely qualified to serve in the role of "school linked services coordinator". We provide assessment, counseling and education to students and their parents regarding school health issues but also interact with their individual health care providers. This level of expertise provides important and accurate health information and case management services for both physical and mental health issues, while assuring better access to critical services.

Opponents of the bill, however, caution that including an explicit exemption from the authorization requirements of CMIA for sharing medical information with school-linked services coordinators may weaken privacy protections for this highly sensitive information. The Electronic Frontier Foundation, in opposition to the bill, argues:

> The Confidentiality of Medical Information Act rightly limits access to medical information except in particular cases for particular people. We would also like more information on how this law interacts with the federal Family Education Rights and Privacy Act, which already provides for sharing of information with "appropriate" officials in the case of health and safety emergencies, as well as more details on how compliance with the Health Information Portability and Accountability Act (HIPAA) will be operationalized in this context.

Children's Health Defense – California Chapter adds in opposition:

> The California Chapter of the Children's Health Defense strongly opposes SB 1184 because it is a violation of privacy and sets a dangerous precedent for as-of-yet undefined position of "*school-linked services coordinators*" and the state government to supersede individual and family rights to privacy. No one should have access to student's [*sic.*] private medical history or files without prior, formal consent given by that child's parents and/or guardians. In granting additional powers to an organization which does not yet exist "school-linked services coordinator," for an indefinite time and/or indefinitely, we are endangering our right to privacy and freedoms as guaranteed by the Constitution and the Law.

Staff notes that this bill would not permit disclosure of medical information to a school-linked services coordinator without "a written authorization between the health provider and the patient or client that complies with the federal Health Insurance Portability and Accountability Act of 1996." While this may allay some concerns with respect to the privacy of a patient's medical information, it is not entirely clear whether this bill would have the practical effect of increasing access to mental health services on school campuses. Pursuant to CMIA, a provider of health care, health care service plan, or contractor is permitted to disclose medical information regarding a patient so long as they first retain an authorization that meets prescribed specifications. (Civ. Code Secs. 56.10(a) and 56.11.)

This bill would add disclosure to a school-linked services coordinator to a subdivision enumerating circumstances under which a provider of health care or a health care service plan may disclose medical information without explicit authorization. But because the bill would also provide in the specified circumstances that such disclosure is only permissible "pursuant to a written authorization between the health provider and the patient or client that

complies with [HIPAA]," in effect, this would likely mean that disclosure to a school-linked services coordinator is subject to the authorization requirements under HIPAA rather than the authorization requirements under CMIA. Because the two sets of authorization requirements are substantively similar, it seems unlikely that the bill would meaningfully facilitate information sharing between providers and school-linked service coordinators, as avenues for such sharing are already available under existing law. Instead, by requiring compliance with HIPAA authorization requirements rather than CMIA authorization requirements, the bill could further complicate procedures for information sharing in the specified circumstance, necessitating a complex assessment of the interaction between state and federal requirements for the sharing of information.

Particular quirks of the language of the bill may also result in less clarity as to precisely what authorization is necessary to request sharing of information from a provider, and from whom. The bill's substantive provision refers to "written authorization between the *health provider* and the patient or client," but while "provider of health care" is a defined term in CMIA, "health provider" is not. Much of CMIA also allows, in certain circumstances, for the parent or designated representative of the patient to provide authorization on behalf of the patient. Since this language refers only to written authorization between the "health provider" and the "patient or client," it is not clear whether others that could generally provide such authorization under CMIA can do so in this circumstance.

Additionally, utilizing the HIPAA authorization requirements may lead to confusion for some patients, since, while CMIA prohibits a recipient of medical information pursuant to an authorization from further disclose that medical information except in accordance with a new authorization that meets specified requirements, or as specifically required or permitted by other provisions of law (Civ. Code Sec. 56.13), HIPAA authorization requires a statement of the potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by HIPAA. (45 C.F.R. Sec. 164.508(c).) In the context of this sharing, that statement could be generally misleading, obscuring the specific laws applicable to the sharing of information between the provider and the school-linked services coordinator.

As a result of this, the bill may not produce a meaningful practical effect on the ease with which medical information can be shared between providers of health care and school-linked services coordinators, arguably to the benefit of patient privacy. That said, the author of the bill indicates that "*perceived barriers* around information sharing during the behavioral health referral process decrease the likelihood of 'closing the referral loop' when services are delivered by health care providers independent of a school system." If the author's intent is to provide explicit authority in order to eliminate perceived barriers rather than actual administrative barriers, this bill seems likely accomplish that end, but may do so at the expense of clarity with respect to compliance. Given the dire state of youth mental health and the substantial evidence supporting school-linked services as an avenue for enhancing access to treatment, the benefit of reducing perceived barriers to such services is arguably worth that risk.

7) **Double referral**: This bill was double-referred to the Assembly Health Committee, where it will be heard should it pass out of this committee. While Assembly Health is the committee of first-referral on this bill, the bill is being heard in this Committee first to accommodate logistical constraints.

8) Related legislation: AB 2089 (Bauer-Kahan) would include "mental health application information" within the definition of "medical information" in CMIA and provide that a business that offers a mental health app to consumers is a provider of health care pursuant to CMIA.

9) Prior legislation: AB 998 (Lackey, 2021) would have amended CMIA to allow for disclosure of mental health records by a county correctional facility, county medical facility, state correctional facility, or state hospital, as provided. This bill died in the Senate appropriations Committee

AB 1184 (Chiu, Ch. 190, Stats. 2021) revised and recast certain provisions in CMIA to require a health care service plan or health insurer to accommodate requests for confidential communications of medical information regardless of whether there is a situation involving sensitive services or a situation in which disclosure would endanger the individual.

AB 1252 (Chau, 2021) would have revised CMIA to deem a business that offers personal health record software or hardware to a consumer, as specified, for purposes of allowing the individual to manage their information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be a "provider of health care" subject to the requirements of CMIA. This bill died on the Assembly Inactive File.

SB 41 (Umberg, Ch. 596, Stats. 2021) established the Genetic Information Privacy Act, providing additional protections for genetic data collected by direct-to-consumer genetic testing companies by regulating its collection, use, maintenance, and disclosure.

SB 1443 (Galgiani, 2016) would have amended CMIA to allow disclosure of information between county and state correctional facilities to ensure the continuity of health care for inmates being transferred. This bill died in the Senate Appropriations Committee.

AB 1297 (Pérez, Ch. 341, Stats. 2013) facilitated the sharing of information between coroners and organ procurement organizations regarding cases in which an anatomical gift may be available from a person whose demise is imminent and that person's body will be subject to a death investigation by the coroner.

REGISTERED SUPPORT / OPPOSITION:

Support

GENup (Generation Up) (sponsor)
California Association of School Counselors
California School Nurses Organization
National Alliance on Mental Illness, Santa Clara County

Opposition

Catholic Families 4 Freedom CA
Children's Health Defense – California Chapter
Electronic Frontier Foundation
Nuremberg 2.0 Ltd.
Protection of the Educational Rights of Kids

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