

Council of State and Territorial Epidemiologists

Leaders in Applied Public Health Epidemiology

An Assessment of Legal Issues Concerning Public Health Disclosures Pursuant to Proposed Rulemaking Re: the Family Education Rights and Privacy Act (FERPA)

Comments from the Council of State and Territorial Epidemiologists (CSTE) to: Proposed Rulemaking Regarding the Family Education Rights and Privacy Act (FERPA), Issued by the Office of Planning, Evaluation, and Policy Development, U.S. Department of Education¹

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I. Introduction

¹ Issued electronically via Federal eRulemaking Portal: Go to <http://www.regulations.gov> . Under Search Documents go to Optional Step 2 and select Department of Education from the agency drop-down menu; then click Submit. In the Docket ID column, select ED-2008-OPEPD-0002 to add or view public comments and to view supporting and related materials available electronically. MAIL TO: LeRoy S. Rooker, U.S. Department of Education, 400 Maryland Avenue, SW., Room 6W243, Washington, DC 20202-5920.

On March 24, 2008, the U.S. Department of Education (ED) proposed new administrative regulations to supplement its existing interpretation of the Family Education Rights and Privacy Act (FERPA). These proposed regulations have been introduced at least partly in response to the tragic shootings on the Virginia Tech campus in April of 2007 and two reports that pointed to certain privacy protections as having a chilling effect on education authorities who might otherwise have warned health and safety authorities about the shooter's mental health problems.²

As drafted, the regulations (which ED has published in the Federal Register for public comment until May 8, 2008) will affect public health authorities' ability to access identifiable health information contained in school-based records in two major ways. First, among other suggested changes, the proposed regulations would secure ED's existing policy limiting the ability of state and local educational agencies to designate state or local public health authorities as "authorized representatives" for the purposes of granting public health authorities access to identifiable student health records without informed consent. Second, the proposed regulations would broaden ED's interpretation of FERPA's "health and safety" exception to potentially allow public health authorities greater access to identifiable student health records than they have been allowed under ED's current interpretation of this exception.

While the expansion of the existing interpretation of the "health and safety" exception may potentially allow some additional sharing of identifiable student health data between educational and public health authorities, ED's proposed regulations collectively fail to recognize the strong, national need for enhanced data exchanges to protect the health of children, adolescents, and others. ED's interpretation of FERPA will continue to restrict many beneficial data exchanges that public health authorities need to fulfill their duty to protect communal health. In consultation with the Council of State and Territorial Epidemiologists (CSTE), this memo:

- (1) analyzes the existing need for exchanges of identifiable public health data between educational and public health authorities;
- (2) briefly discusses the underlying background of FERPA related to the sharing of public health data;
- (3) explains the changes and public health impact of ED's proposed administrative regulations concerning the:
 - a. "authorized representatives" exception to FERPA; and
 - b. "health and safety" exception to FERPA; and
- (4) discusses options to address the existing limitations of the proposed regulations on data sharing practices between educational and public health authorities in the interests of protecting the public's health.

² U.S. Department of Health and Human Services, Report to the President on Issues Raised by the Virginia Tech Tragedy (June 13, 2007), available at <http://www.hhs.gov/vtreport.pdf>; Virginia Tech Review Panel, Mass Shootings at Virginia Tech (August 2007) (report to the Governor of Virginia), available at <http://www.governor.virginia.gov/TempContent/techPanelReport-docs/FullReport.pdf>.

II. The Need for Public Health Access to School-based Health Records

Access to school health data is essential to the ability of state and local health authorities to protect the public's health. State and local public health authorities rely on identifiable health data to detect, assess, and respond to a host of public health challenges, including those concerning children, adolescents, and others in school settings. Access to identifiable health information available in school records allows public health authorities to (1) identify specific health needs of children, adolescents, and others in the population, (2) track short- and long-term health outcomes among various groups, (3) develop and target health promotion and disease prevention programs, (4) engage public health interventions or investigations, and (5) evaluate the effectiveness of public health programs and interventions.

Specifically, access to identifiable school health data allows public health authorities to identify and study trends in chronic and environmental diseases among children and adolescents, enabling a better understanding of health threats such as childhood diseases (e.g., chickenpox), autism, developmental disabilities, obesity, and asthma.³ Information from school records also allows public health authorities to detect emerging threats to health such as outbreaks of staph or methicillin-resistant *Staphylococcus aureus* (MRSA) infections, measles, or pertussis. Recently, MRSA has received considerable media attention when the antibiotic-resistant strain of bacteria was identified as a potentially deadly problem in schools.⁴

Identifiable health data in education records also allow health officials to identify, evaluate, and track the effects of environmental exposures, such as exposure to lead or other potentially toxic substances.⁵ One program in Massachusetts, for example, sought to track developmental disabilities in children to investigate a possible link to polychlorinated biphenyl (PCB) contaminant data for a particular area.⁶ Health information available through schools is also essential to monitoring levels of immunization coverage to prevent outbreaks of preventable infectious diseases. Recently, for example, the Centers for Disease Control and Prevention (CDC) reported outbreaks of measles among children in several jurisdictions.⁷

The acquisition of identifiable health data by state and local public health authorities through schools or other sources (e.g., health care providers) is authorized under existing state

3 Association of State and Territorial Health Officials, Tracking childhood asthma with school data in three states: case study. 2006. Available at <http://www.astho.org/pubs/TrackingChildhoodAsthmawithSchoolDataFeb.2006-final.pdf>. Accessed January 20, 2008.

4 Hu W & Kershaw S, Dead student had infection, officials say. *New York Times*. Oct. 26, 2007. Available at <http://www.nytimes.com/2007/10/26/nyregion/26infect.html?pagewanted=print>. Accessed January 20, 2008.

5 Sathyanarayana S, Beaudet N, Omri K & Karr C. Predicting children's blood lead levels from exposure to school drinking water in Seattle, Washington, USA. *Ambulatory Pediatrics*. 2006;6:288-292.

6 Elaine T. Krueger, Impact of FERPA on Childhood Developmental Disabilities Tracking: One State's Experience. Available at <http://www.cdc.gov/nceh/tracking/webinars/mar05/krueger.pdf> (March 28, 2005).

7 CDC, Measles outbreak in the United States: public health preparedness, control and response in healthcare settings and the community (April 2, 2008). Available at <http://www2a.cdc.gov/HAN/ArchiveSys/ViewMsgV.asp?AlertNum=00273> (April 2, 2008).

and local laws. All states' laws not only authorize public health authorities to collect these identifiable data, they also mandate that health care workers and others report specific conditions to public health authorities.⁸ While public health laws generally require the reporting of various diseases or conditions, additional laws in many states require specific reporting of identifiable health information contained in education records. For example, state child protection laws, such as those in Michigan,⁹ typically require school officials to report evidence of abuse or neglect as well as pregnancy or sexually transmitted diseases among children below a certain age.

In sum, public health access to identifiable health information in student health records is an essential component of the protection of child and adolescent health in the United States that is supported, even required, by existing state public health reporting laws. The dilemma, as discussed below and espoused by several national public health associations including CSTE,¹⁰ the Association of State and Territorial Health Officials (ASTHO),¹¹ and the American Public Health Association (APHA),¹² is that privacy protections governing student educational records within FERPA, and as interpreted by ED, effectively limit the disclosure of identifiable health data between educational and public health authorities.

III. A Brief Overview of FERPA Privacy Protections

The Family Educational Rights and Privacy Act of 1974 (FERPA)¹³ was enacted by Congress to provide public school students and their parents/guardians with (1) greater access to their educational records; and (2) some ability to control the use and disclosure of identifiable information, including health data, contained in those records. FERPA protects the privacy of student educational records by generally requiring advance written consent from the student or parent/guardian for the disclosure of identifiable information from school records to non-educational authorities. FERPA is administered and enforced by ED's Family Policy Compliance Office (FPCO), which is authorized to revoke federal education funding for state and local educational institutions that violate the Act.

FERPA defines "education records" broadly as "records, files, documents, and other materials which – (i) contain information directly related to a student; and (ii) are maintained by

8 Hodge, JG. Health information privacy and public health. *Journal of Law, Medicine, and Ethics* 2004; 31: 4: 663-671.

9 Mich. Comp. Laws § 722.623 (mandating reporting of abuse or neglect or of pregnancy or STI in children under 12 years old); Mich. Comp. Laws § 333.5131(5)(f) (stating that records relating to HIV/AIDS are not confidential if required to be reported under child protection laws).

10 Council of State and Territorial Epidemiologists. CSTE position statement 06-CD-01: Public health access to student health information. 2006.

11 Association of State and Territorial Health Officials, Tracking childhood asthma with school data in three states: case study. 2006. Available at <http://www.astho.org/pubs/TrackingChildhoodAsthmawithSchoolDataFeb.2006-final.pdf>. Accessed January 20, 2008.

12 American Public Health Association. Promoting school information sharing for public health purposes. 2007.

13 20 U.S.C. 1232g.

an educational agency or institution or by a person acting for such agency or institution.”¹⁴ Identifiable health information maintained by state or local educational institutions is part of a student’s education record, and is thus subject to FERPA’s privacy protections. Institutions such as state and local boards of education, local elementary and secondary schools, institutes of higher education (e.g., universities, colleges), as well as their personnel (e.g., school nurses, physicians, teachers, administrative staff), are required to adhere to FERPA privacy protections in how they handle student education records.

Like other federal privacy standards, notably the HIPAA Privacy Rule,¹⁵ FERPA exempts numerous types of identifiable data from its general “anti-disclosure” provision, allowing some disclosures without specific informed consent.¹⁶ Relevant examples of these exceptions in FERPA pertaining to public health disclosures are discussed below. Collectively, however, these exceptions in FERPA do not provide the sort of access to identifiable health data provided to public health authorities via the HIPAA Privacy Rule. The Privacy Rule specifically authorizes covered entities (i.e., health care providers, insurers, and data clearinghouses) to disclose identifiable health data to public health authorities for public health purposes without individual written authorization.¹⁷ FERPA does not include a broad exception for disclosures of identifiable health data to state and local public health authorities for public health purposes.

In addition, the HIPAA Privacy Rule specifically exempts education records covered by FERPA.^{18,19} In a February 2004 opinion letter addressing access to student immunization records in Alabama, ED’s FPCO stated that “student immunization records that are maintained by an educational agency or institution subject to FERPA that directly relate to a student or students are considered to be education records under FERPA and are not subject to the HIPAA Privacy Rule.”²⁰ As a result, the only way that state and local public health authorities may gain broad access to student health data in education records is either by:

- (1) obtaining advance, written informed consent from students or their parents/guardians (which is impractical in many cases); or
- (2) by acquiring non-identifiable health data (which lacks utility for most public health purposes).

The application of FERPA’s privacy protections to restrict public health authorities from accessing student health data through education records is thus inconsistent with national health

14 20 U.S.C. 1232g (a)(4).

15 45 C.F.R. 160.100 *et seq.*

16 Hodge, JG. Health information privacy and public health. *Journal of Law, Medicine, and Ethics* 2004; 31: 4: 663-671.

17 CDC, HIPAA Privacy Rule and Public Health: Guidance from CDC and the U.S. Department of Health and Human Services, available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/m2e411a1.htm>.

18 CDC, HIPAA Privacy Rule and Public Health: Guidance from CDC and the U.S. Department of Health and Human Services, available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/m2e411a1.htm>.

19 Letter from LeRoy S. Rooker, Director, Family Compliance Policy Office, U.S. Department of Education, to Martha Holloway, State School Nurse Consultant, Alabama Department of Education, dated February 25, 2004.

20 *Id.*

information privacy regulations that routinely allow disclosures of identifiable health data to public health authorities without specific, informed consent.

Despite this national inconsistency among existing privacy laws governing health data, state and local educational and public health authorities are often bound by FERPA. As a federal law, which preempts inconsistent or conflicting state or local laws pursuant to the which the Supremacy Clause of the U.S. Constitution, FERPA supersedes existing state laws that require reporting of notifiable diseases or other health conditions from educational authorities to public health authorities. Potential modern, federalism-based arguments may be raised to allege that Congress' completely overstepped its legislative authority in enacting strong privacy protections via FERPA that supplant traditional state-based public health reporting laws. Notwithstanding these arguments, FERPA's privacy protections may effectively be viewed as trumping state reporting requirements concerning state and local educational authorities. This is because state reporting laws that require educational authorities or their personnel to report identifiable health data to public health authorities without informed consent conflict with FERPA's requirement that such disclosures only be made with consent.

Previously, however, subsection (b)(1)(E) of FERPA created an exception for disclosures to "State and local officials or authorities to whom such information is specifically required to be reported or disclosed pursuant to State statute adopted prior to November 19, 1974." This language effectively "grandfathered" in existing state public health reporting requirements that pre-dated the enactment of FERPA, providing a route to data sharing between education and public health authorities to protect communal health. In 1994, however, as part of an amendment to FERPA, Congress eliminated this broad provision, substituting an exception that limited to disclosures pertaining solely to the juvenile justice system.²¹

FERPA does include a number of limited statutory exceptions that allow disclosures of identifiable student data without informed consent. This includes an exception for "treatment records," which is strictly limited to records made or maintained by health care professionals and used only in connection with the direct provision of treatment (and not public health services or benefits) to students.²² Most identifiable information that public health authorities seek does not fall under the treatment records exception. For example, in November 2004, ED's FPCO issued an interpretation letter addressing a conflict between FERPA and New Mexico Health Department regulations that required mandatory reporting of a variety of health conditions to the New Mexico Department of Health and immediate reporting of certain communicable diseases

21 Specifically, (b)(1)(E) now allows for disclosure to "State and local officials or authorities to whom such information is specifically allowed to be reported or disclosed pursuant to State statute adopted -- (i) before November 19, 1974, if the allowed reporting or disclosure concerns the juvenile justice system and such system's ability to effectively serve the student whose records are released, or (ii) after November 19, 1974, if -- (I) the allowed reporting or disclosure concerns the juvenile justice system and such system's ability to effectively serve, prior to adjudication, the student whose records are released; and (II) the officials and authorities to whom such information is disclosed certify in writing to the educational agency or institution that the information will not be disclosed to any other party except as provided under State law without the prior written consent of the parent of the student."

22 20 U.S.C. 1232g (a)(4)(B)(iv).

to the Office of Epidemiology (discussed further below). FPCO explained that student treatment records “are excluded from the definition of “education records” under FERPA only if they are made, maintained, and used only in connection with the student’s treatment and not disclosed to anyone other than individuals providing treatment to the student.”²³ To the extent that state or local public health authorities are not providing medical treatment to students, access to the students’ health data under this exception is restricted.

IV. Proposed Changes to the “Authorized Representatives” Exception

FERPA also includes an existing exception allowing access to education records by “authorized representatives.” Specifically, this exception allows non-consensual disclosures of identifiable student information to authorized representatives of “(A) the Comptroller General of the United States, (B) the Secretary [of Education], (C) an administrative head of an education agency or (D) State educational authorities.”²⁴ FERPA notes that access pursuant to this exception is limited to those instances as “may be necessary in connection with the audit and evaluation of Federally-supported education program, or in connection with the enforcement of the Federal legal requirements which relate to such programs.”²⁵ Except when the collection of identifiable student information is “specifically authorized by Federal law,” any data gathered pursuant to this exception shall be protected in a manner so as to not identify students or their parents by persons other than authorized representatives. In addition, identifiable data shall be destroyed when no longer needed for the original purposes of disclosure.²⁶

For several years, ED and CDC executed memoranda of understanding (MOUs) to support limited access to identifiable data (e.g., immunization records) for public health purposes by designating public health authorities as “authorized representatives” of educational authorities pursuant to this exception. For example, a prior MOU designated CDC as an “authorized representative” of ED, granting CDC and its partners limited access to health data in educational records in five Georgia counties so CDC could conduct its Metropolitan Atlanta Developmental Disabilities Surveillance Project.²⁷ In addition to the model monitoring program in Georgia, CDC supported autism spectrum disorder monitoring programs in seventeen states, some of which sought similar MOUs with their state departments of education.

In 2003, however, the ability to execute MOUs between education and public health authorities to share data pursuant to this exception ended. In a 2003 policy memo, Deputy Secretary of Education William D. Hansen interpreted the “authorized representative” exception

23 Letter from LeRoy S. Rooker, Director, Family Compliance Policy Office, U.S. Department of Education, to Melanie P. Baise, Associate University Counsel, The University of New Mexico, dated November 29, 2004.

24 20 U.S.C. §1232g(b)(3).

25 *Id.*

26 *Id.*

27 Testimony of the Centers for Disease Control and Prevention (CDC) on HIPAA Privacy Rule and the Family Educational Rights and Privacy Act Impact on Public Health Practice, National Committee on Vital Health Statistics (NCVHS) Subcommittee on Privacy and Confidentiality, February 19, 2004, available at <http://www.ncvhs.hhs.gov/040219p1.pdf> (last visited April 30, 2008).

narrowly.²⁸ Rescinding ED’s previously expansive interpretation, Deputy Secretary Hansen opined that the “authorized representative” exception was limited to employees, appointed officials, and contractors of state educational authorities by arguing that the “authorized representatives” of a state educational authority must be under the “direct control” of that authority. This “direct control” requirement superseded prior, longstanding guidance from ED, which had interpreted this exception to allow agreements between educational institutions and other arms of federal or state governments to designate non-education representatives, such as public health authorities, as “authorized representatives.”

In a series of interpretation letters issued in 2004 and 2005, FPCO applied Deputy Secretary Hansen’s narrow interpretation of the “authorized representative” exception to limit access to school health records for public health purposes. In February 2004, FPCO advised that the California Department of Education could not enter into a MOU with the state’s Department of Health Services to disclose identifiable health information from education records as part of an autism and developmental disability surveillance program.²⁹ Later the same month, FPCO opined that a similar MOU between the Pennsylvania Department of Education (PDE) and local CDC grantees to allow access to school health records to track developmental disabilities and autism also violated FERPA.³⁰ Acknowledging its awareness of other cases involving state education agencies using MOUs to designate state health departments as “authorized representatives,” FPCO stated that “information disclosed to PDE... may not be redisclosed in personally identifiable form, intentionally or otherwise, to anyone other than authorized representatives of PDE and must be destroyed when no longer needed for the audit or evaluation purpose for which it was collected.”

To date, this narrow interpretation of a “direct control” requirement pursuant to FERPA’s “authorized representatives” exception has been espoused solely through ED internal memos and opinion letters from FPCO. Though influential in setting federal policy, internal memos and agency opinion letters concerning interpretations of federal statutes are granted little deference by courts under U.S. Supreme Court jurisprudence.³¹ ED’s recently proposed changes to its FERPA administrative regulations would, however, incorporate the “direct control” requirement into the regulations.³² This legal change would impact the deference that courts would be required to grant to ED’s narrow opinion regarding the meaning of FERPA’s “authorized representative” exception. If the “direct control” requirement is incorporated directly into the administrative regulations as proposed, it would be entitled to greater deference under the U.S. Supreme Court’s decision in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*,³³ which requires a reviewing court to affirm any reasonable statutory interpretation offered by an

28 Memo from William D. Hansen, Deputy Secretary of Education, to Chief State School Officers, et al., dated January 30, 2003.

29 Letter from LeRoy S. Rooker, Director, Family Compliance Policy Office, U.S. Department of Education, to Dr. Allan M. Lloyd-Jones, Special Education Consultant, California Department of Education, dated February 18, 2004.

30 Letter from LeRoy S. Rooker, Director, Family Compliance Policy Office, U.S. Department of Education, to Amy C. Foerster, Assistant Counsel, Pennsylvania Department of Education, dated February 25, 2004.

31 See, e.g., *Skidmore v. Swift & Co.* 323 U.S. 134 (1944).

32 See 73 Fed. Reg. 15574, 15578 (March 24, 2008).

33 467 U.S. 837 (1984).

agency through administrative regulation.³⁴

As a result, public health authorities would likely be significantly thwarted in any present or future attempt to gain access to identifiable student health data as an “authorized representative” of state or local educational agencies, despite the fact that (1) Congress has not specifically foreclosed this possibility based on its broad language concerning the “authorized representative” exception in FERPA; and (2) less than five years ago, ED permitted the type of limited data sharing between public health and educational authorities via an MOU under the same language in FERPA as presently exists. The “authorized representative” exception of FERPA can and should be interpreted in such a way that limited data exchanges for public health purposes may be made without informed consent pursuant to executed MOUs between educational and public health authorities.

V. Proposed Changes to the “Health and Safety” Exception

FERPA also includes a statutory exception for non-consensual disclosures made “in connection with an emergency,” to “appropriate persons if the knowledge of such information is necessary to protect the health or safety of the student or other persons.”³⁵ This “health and safety” exception may permit limited disclosures of student health data from educational authorities to public health authorities (and others) to protect the health or safety of students or others in exigent circumstances. Congress does not provide explicit definitions in FERPA of what constitutes an “emergency,” or what may be included in protecting the “health or safety of students or other persons,” leaving these facts to further interpretation.

However, ED’s existing FERPA administrative regulations indicate that this exception should be strictly construed.³⁶ Following its own strict construction mandate, ED’s FPCO has examined specific requests to share student health data without informed consent for health or safety emergencies on a “case by case” basis. Though FPCO’s opinions vary, it has generally determined such non-consensual disclosures to public health authorities or others are only authorized in response to “a *specific situation* that presents *imminent danger* to students or other members of the community, or that requires an *immediate need* for information in order to avert or diffuse serious threats to the safety or health of a student or other individuals.”³⁷

In a November 2004 opinion letter addressing New Mexico’s mandatory reporting requirements, FPCO provided its most comprehensive discussion of its existing interpretation of the “health and safety” exception with respect to public health surveillance practices.³⁸ Requesting FPCO’s guidance and interpretation, the University of New Mexico’s (UNM) general counsel explained New Mexico’s statutory public health reporting laws:

³⁴ See *U.S. v. Mead Corp.*, 533 U.S. 218 (2001).

³⁵ 20 U.S.C. §1232g(b)(1)(I).

³⁶ 34 C.F.R. 99.36(c).

³⁷ Letter from LeRoy S. Rooker, Director, Family Compliance Policy Office, U.S. Department of Education, to Melanie P. Baise, Associate University Counsel, The University of New Mexico, dated November 29, 2004

³⁸ *Id.*

Regulations issued by the New Mexico Department of Health for “Control of Disease and Conditions of Public Health Significance” impose mandatory reporting requirements for “notifiable conditions,” which include both “communicable diseases” and “conditions of public health significance.” 7 NMAC 4.3.7 J. “Communicable disease” means “an illness caused by infectious agents or their toxic products which may be transmitted to a susceptible host.” “Condition of public health significance” means “a condition dangerous to public health or safety.” 7 NMAC 4.3.7 D & E.

Certain communicable diseases require immediate reporting on an “emergency basis.” These include vaccine preventable diseases, such as measles, mumps, haemophilus influenzae, invasive infections, rubella, tetanus, etc., and other diseases such as anthrax, botulism, cholera, E.coli infections, Hantavirus, rabies, smallpox, tuberculosis, yellow fever, as well as suspected food and waterborne illnesses and those suspected to be caused by release of biologic or chemical agents. 7 NMAC 4.3.12 A. “Routine” (i.e., non-emergency) reporting is required for various infectious diseases, including but not limited to Colorado tick fever, encephalitis, hepatitis, Legionnaires’ disease, Lyme disease, malaria, Reye syndrome, toxic shock syndrome, etc.; sexually transmitted diseases, such as chlamydia, gonorrhea, syphilis, HIV, and AIDS; birth defects; and health conditions related to environmental exposures and certain injuries, such as asbestosis, firearm injuries, lead blood levels, pesticide-related illness, silicosis, spinal cord injuries, traumatic brain injuries, and other environmentally-induced health conditions. 7 NMAC 4.3.12 B.

Against this legal backdrop, FPCO considered UNM’s request for guidance as to what non-consensual disclosures its school nurses and health care workers may make under FERPA’s “health and safety” exception to state public health authorities pursuant to state public health reporting requirements. FPCO attempted to distinguish between “emergency” reporting (which may authorize disclosures without informed consent) and “routine” reporting (which would not):

The New Mexico Department of Health has made a reasonable determination, by regulation, which specific, communicable diseases require immediate reporting on an “emergency” basis. 7 NMAC 4.3.12(A). [FPCO] will not substitute its judgment for what constitutes a true threat or emergency unless the determination appears manifestly unreasonable or irrational. We find that the State reporting requirement for communicable diseases satisfies the FERPA requirement for a case-by-case determination that a specific situation, i.e., an identified communicable disease, presents an imminent danger or threat to students or other members of the community, that the release is narrowly tailored to meet the emergency, and that reports are made to appropriate authorities within the health department. Therefore, the University may disclose personally identifiable information from education records, without written consent, to meet these State

health reporting requirements.

We cannot come to the same conclusion with respect to the “routine” or non-emergency reporting that is required by regulation for other notifiable conditions, including the infectious diseases, injuries, environmental exposures, sexually transmitted diseases, HIV/AIDS, cancer, and birth defects specified in 7NMAC 4.3.12 B, as well as reports to the New Mexico Tumor Registry required under 7 NMAC 4.3.10. Indeed, in these cases, the State Department of Health has determined that the specified disease or condition *does not* constitute an imminent danger or threat or that emergency reporting or other action is necessary to address the concern. Consequently, the University may not disclose information from a student’s education records to meet these “routine” health reporting requirements unless it has made a specific, case-by-case determination that a health or safety emergency exists, as described above, or the student provides prior written consent for the disclosure³⁹

FPCO’s existing interpretation that certain, reportable communicable diseases in New Mexico likely fall under FERPA’s “health and safety” exception, while routinely-reported notifiable conditions would not, is subject to considerable criticism among the public health community. At its core, FPCO provides no meaningful bases for educational and public health authorities to determine what types of public health disclosures may be allowed via the exception because there is no definitional criteria offered to assess what FPCO believes constitutes an “imminent danger” or threat to the community.⁴⁰ FPCO’s guidance results in a fallacious conclusion that diseases like measles, mumps, and tetanus may be reported immediately to public health authorities by educational authorities because they fit the “health and safety” exception, whereas serious conditions like encephalitis, malaria, toxic shock syndrome, syphilis, HIV/ AIDS, lead blood levels, and firearm and traumatic brain injuries do not. However, only through the routine, ongoing reporting of these latter conditions may serious outbreaks or emergency conditions be detected and averted.

Furthermore, by deferring to the New Mexico legislature and Department of Health to determine when “a health or safety emergency exists” before allowing non-consensual disclosures for “routine” reportable conditions, FPCO essentially provides an incentive for any public health authority to formally declare every health condition as “reportable on an emergency basis.” Such declaration would help ensure that public health authorities may access relevant, identifiable data in the possession of educational authorities. Absent such declaration, FPCO effectively precludes access to the types of identifiable data in student education records that are essential for public health authorities to detect, monitor, or prevent emergencies.

Perhaps in recognition of these and other problems in its existing interpretive guidance, ED’s recently proposed regulations would alter the Department’s interpretation of the “health

³⁹ *Id.*

⁴⁰ *Id.*

and safety” exception in ways that might allow for greater public health access to health information contained in school records. ED’s proposed regulations would eliminate the provisions requiring strict construction of the “health and safety” exception which has constrained FPCO’s previous, limited interpretations.

Furthermore, ED proposes that in making a determination under the “health and safety” exception, “an educational agency or institution may take into account the totality of the circumstances pertaining to a threat to the safety or health of a student or other individuals.”⁴¹ Upon finding an “*articulable and significant*” threat to the health or safety of a student or other individuals, educational authorities may disclose information from education records to “any person whose knowledge of the information is necessary to protect the health and safety of the student or other individuals,”⁴² including public health authorities.

This new “articulable and significant threat” standard is considerably more lenient than the existing standard articulated in the FPCO’s current requirement of “a *specific situation* that presents *imminent danger* to students or other members of the community, or that requires an *immediate need* for information in order to avert or diffuse serious threats to the safety or health of a student or other individuals.”⁴³ Arguably, *any* health condition covered by state or local mandatory reporting laws may pose an “articulable and significant threat” to the health or safety of students or others, and thus allow non-consensual disclosures from educational authorities to public health authorities.

Importantly, the proposed regulations also state that ED will defer to the determination of the educational authority as to the presence of an articulable and significant threat, so long as there is a rational basis for the determination based on available information.⁴⁴ This more flexible approach offers the opportunity for educational authorities to share identifiable student health data with public health authorities more extensively. By offering a less strict “articulable and significant threat” standard for these disclosures, and explicitly granting deference to state and local educational authorities, the possibility of sharing student health data with public health authorities is opened.

Yet, problems remain. First, determining what constitutes an “articulable and significant threat” is at best amorphous. State and local educational authorities will assuredly differ in their interpretations nationally (or even within a specific state) of what disclosures fall under this standard, leading to varying and conflicting examples of allowable data disclosures to public health authorities. Second, deferring to state and local educational authorities in their determination as to what constitutes this sort of threat is beneficial, but fails to expressly authorize these authorities to rely on the judgment of state or local public health authorities. ED’s deference clause should permit educational authorities to defer to state and local public

41 73 Fed. Reg. at 15589.

42 *Id.*

43 Letter from LeRoy S. Rooker, Director, Family Compliance Policy Office, U.S. Department of Education, to Melanie P. Baise, Associate University Counsel, The University of New Mexico, dated November 29, 2004

44 *Id.*

health authorities as to what constitutes an “articulable and significant threat.” Public health authorities are knowledgeable and well-positioned to determine the health and safety threats facing children and adolescents in their jurisdictions. Educational authorities should defer to public health authorities’ expertise and judgment in these matters, which in turn may reflect state or local laws. While ED’s proposed regulations presumably would allow such deference, this should be expressly stated to warrant a higher degree of confidence that neither ED nor the courts will interfere with reasonable state and local determinations regarding health and safety threats.

Third, while these proposed changes would, on their face, broaden the discretion of states in determining what sorts of reportable conditions would justify non-consensual disclosures under FERPA’s “health and safety” exception, ED’s comments accompanying the proposed regulations echo the more narrow interpretation of FPCO’s prior opinions. The comments specifically note that “the ‘health and safety’ exception does not allow disclosures on a routine, non-emergency basis.”⁴⁵ Through this language, ED seems to express its intention to continue to follow FPCO’s prior designation between “routine” and “emergency” disclosures. This designation may effectively deny public health access to information regarding “routinely” reported conditions even though these conditions may present “articulable and significant threats.” This language should be excised from the proposed regulations. It is a distinction without meaning in public health contexts.

VI. Conclusion

While it is not entirely clear how these new regulations might be applied, there are direct public health implications. The incorporation of the “direct control” requirement under the “authorized representative” exception to FERPA further confirms that MOUs previously executed between educational authorities and public health authorities will no longer be an option for furthering data exchanges to protect the public’s health. This restrictive interpretation is inconsistent with the specific language of FERPA and Congressional intent, and should be reconsidered by ED.

Proposed changes to ED’s interpretation of FERPA’s “health and safety” exception may offer educational and public health authorities additional opportunities to share identifiable student health data to protect student health and the health of the community. Yet, this expanded, more lenient interpretation of this exception fails to allow public health authorities adequate access to all of the information they need to fulfill their duty to protect the public’s health. Ultimately, a legislative amendment to FERPA to incorporate an explicit public health exception would better serve the individual and communal health needs of students and populations nationally.

⁴⁵ *Id.*