Article 5.

Hospital Licensure Act.

Part 1. Article Title and Definitions.

§ 131E-75. Title; purpose.

(a) This Article shall be known as the "Hospital Licensure Act."

(b) The purpose of this article is to establish hospital licensing requirements which promote public health, safety and welfare and to provide for the development, establishment and enforcement of basic standards for the care and treatment of patients in hospitals. (1947, c. 933, s. 6; 1983, c. 775, s. 1.)

§ 131E-76. Definitions.

As used in this article, unless otherwise specified:

(1) "Commission" means the North Carolina Medical Care Commission.

(1a) "Critical access hospital" means a hospital which has been designated as a critical access hospital by the North Carolina Department of Health and Human Services, Office of Research, Demonstrations and Rural Health Development. To be designated as a critical access hospital under this subdivision, the hospital must be certified as a critical access hospital pursuant to 42 CFR Part 485 Subpart F. The North Carolina Department of Health and Human Services, Office of Research, Demonstrations, and Rural Health Development may designate a hospital located in a Metropolitan Statistical Area as a rural hospital for the purposes of the critical access hospital program if the hospital is located in a county with twenty-five percent (25%) or more rural residents as defined by the most recent United States decennial census.

(1b) Reserved for future codification purposes.

(1c) Division of Health Service Regulation. – The Division of Health Service Regulation within the Department of Health and Human Services.

(1d) Reserved for future codification purposes.

(1e) "Gastrointestinal endoscopy room" means a room used for the performance of procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes.

(2) "Governing body" means the Board of Trustees, Board of Directors, partnership, corporation, association, person or group of persons who maintain and control the hospital. The governing body may or may not be the owner of the properties in which the hospital services are provided.

(3) "Hospital" means any facility (i) that has an organized medical staff and is designed, used, and operated to provide health care, diagnostic and therapeutic services, and continuous nursing care primarily to inpatients where such care and services are rendered under the supervision and direction of physicians licensed under Chapter 90 of the General Statutes, Article 1, to two or more persons over a period in excess of 24 hours or (ii) designated by the Centers for Medicare and Medicaid Services as a rural emergency hospital as defined under 42 C.F.R. § 485.502 or under section 125 of Division CC of the Consolidated Appropriations Act of 2021, Public Law 116-260. The term includes facilities

for the diagnosis and treatment of disorders within the scope of specific health specialties. The term does not include any of the following:

a. Private mental facilities licensed under Article 2 of Chapter 122C of the General Statutes.
b. Nursing homes licensed under G.S. 131E-102.
c. Adult care homes licensed under Part 1 of Article 1 of Chapter 131D of the General Statutes.
d. Any outpatient department including a portion of a hospital operated as an outpatient department, on or off of the hospital's main campus, that is operated under the hospital's control or ownership and is classified as Business Occupancy by the Life Safety Code of the National Fire Protection Association as referenced under 42 C.F.R. § 482.41. Provided, however, if the Business Occupancy outpatient location is to be operated within 30 feet of any hospital facility, or any portion thereof, which is classified as Health Care Occupancy or Ambulatory Health Care Occupancy under the Life Safety Code of the National Fire Protection Association, the hospital shall provide plans and specifications to the Department for review and approval as required for hospital construction or renovations in a manner described by the Department.

(4) "Infirmary" means a unit of a school, or similar educational institution, which has the primary purpose to provide limited short-term health and nursing services to its students.

(5) "Medical review committee" means any of the following committees formed for the purpose of evaluating the quality, cost of, or necessity for hospitalization or health care, including medical staff credentialing:

a. A committee of a state or local professional society.
b. A committee of a medical staff of a hospital.
c. A committee of a hospital or hospital system, if created by the governing board or medical staff of the hospital or system or operating under written procedures adopted by the governing board or medical staff of the hospital or system.
d. A committee of a peer review corporation or organization.

(6) Renumbered.

(6a) "Operating room" means a room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room.

(7) "Rural hospital network" means an alliance of members that shall include at least one critical access hospital and one other hospital. To qualify as a rural hospital network, the critical access hospital must submit a comprehensive, written memorandum of understanding to the Department of Health and Human Services, Office of Research, Demonstrations and Rural Health Development, for the Department's approval. The memorandum of understanding must include provisions for patient referral and transfer, a plan for network-wide emergency services, and a plan for sharing patient information and services between hospital members including medical staff credentialing, risk

management, quality assurance, and peer review. (1947, c. 933, s. 6; 1949, c. 920, s. 1; 1955, c. 369; 1961, c. 51, s. 1; 1973, c. 476, s. 152; 1983, c. 775, s. 1; 1985, c. 589, s. 41; 1993, c. 321, s. 245; 1995, c. 535, s. 20; 1997-443, s. 11A.118(a); 2004-149, ss. 1.1, 2.4; 2004-199, s. 49; 2005-346, ss. 1, 2; 2009-462, s. 4(j); 2009-487, s. 4(a); 2023-134, s. 9F.11(a); 2024-1, s. 3.2(a); 2025-27, s. 3.3(a).)

Part 2. Hospital Licensure.

§ 131E-77. Licensure requirement.

(a) No person or governmental unit shall establish or operate a hospital in this state without a license. An infirmary is not required to obtain a license under this Part.

(b) The Commission shall prescribe by rule that any licensee or prospective applicant seeking to make specified types of alteration or addition to its facilities or to construct new facilities shall submit plans and specifications before commencement to the Department for preliminary inspection and approval or recommendations with respect to compliance with the applicable rules under this Part.

(c) An applicant for licensing under this Part shall provide information related to hospital operations as requested by the Department. The required information shall be submitted by the applicant on forms provided by the Department and established by rule.

(d) Upon receipt of an application for a license, the Department shall issue a license if it finds that the applicant complies with the provisions of this Article and the rules of the Commission. The Department shall renew each license in accordance with the rules of the Commission. The Department shall charge the applicant a nonrefundable annual base license fee plus a nonrefundable annual per-bed fee as follows:

Facility Type	**Number of Beds**	**Base Fee**	**Per-Bed Fee**
General Acute Hospitals:	1-49 beds	$250.00	$17.50
	50-99 beds	$350.00	$17.50
	100-199 beds	$450.00	$17.50
	200-399 beds	$550.00	$17.50
	400-699 beds	$750.00	$17.50
	700+ beds	$950.00	$17.50
Other Hospitals:		$500.00	$17.50

(e) The Department shall issue the license to the operator of the hospital who shall not transfer or assign it except with the written approval of the Department. The license shall designate the number and types of inpatient beds, the number of operating rooms, and the number of gastrointestinal endoscopy rooms.

(e1) Any license issued by the Department shall include only facilities (i) operated by the hospital within a single county and (ii) operated by the hospital in an immediately adjoining county; provided, however, that facilities operated by a hospital in an immediately adjoining county shall only be included within the same hospital license if the applicant hospital demonstrates all of the following to the satisfaction of the Department:

(1) There was previously only one hospital licensed by the Department providing inpatient services in the immediately adjoining county.

(2) The licensed hospital in the immediately adjoining county described in subdivision (1) of this subsection closed or otherwise ceased providing hospital

services to patients no more than three years prior to the date the applicant hospital first applied to license a facility in such immediately adjoining county.

If the Department approves a hospital's initial request to include within its hospital license a facility in an immediately adjoining county, then any other hospital services thereafter developed and operated by the applicant in such immediately adjoining county in accordance with applicable law may also be included within and covered by the license issued to the applicant by the Department.

(f) The operator shall post the license on the licensed premises in an area accessible to the public. (1947, c. 933, s. 6; 1949, c. 920, ss. 3, 4; 1963, c. 66; 1973, c. 476, s. 152; c. 1090, s. 1; 1975, c. 718, s. 2; 1983, c. 775, s. 1; 2003-284, s. 34.2(a); 2005-276, s. 41.2(b); 2005-346, s. 3; 2009-451, s. 10.76(e); 2011-145, s. 18.10(c); 2011-391, s. 42.1; 2016-94, s. 12G.3(a); 2017-57, s. 11G.2(a).)

§ 131E-78. Adverse action on a license.

(a) The Department shall have the authority to deny, suspend, revoke, annul, withdraw, recall, cancel, or amend a license in any case when it finds a substantial failure to comply with the provisions of this Part or any rule promulgated under this Part.

(b) Repealed by Session Laws 2007-444, s. 1, effective August 23, 2007.

(b1) The Secretary may suspend the admission of any new patients to specific areas of a hospital or suspend specific services of a hospital licensed under this Article where the conditions of the hospital constitute a substantial failure to comply with the provisions of this Part or any rule adopted under this Part and are dangerous to the health or safety of the patients. When the Secretary suspends admissions or specific services, the suspension shall be limited to the smallest possible components of the hospital. The Department shall provide consultation to assist the hospital in correcting the conditions that led to the suspension in order that the suspension can be lifted at the earliest possible time after the Secretary is satisfied that conditions or circumstances merit removal of the suspension. In determining whether to suspend admissions or services under this subsection, the Secretary shall consider the following factors:

(1) The character and degree of impact of the conditions at the hospital on the health and safety of its patients.

(2) The character and degree of impact that the proposed suspension of admissions or services would have on the functionality of the hospital and the availability of services necessary to the community or to current patients of the hospital.

(3) Whether all other reasonable means for correcting the problem have been exhausted and no less restrictive alternative to suspension of admissions or service exists.

(c) Repealed by Session Laws 2007-444, s. 1, effective August 23, 2007.

(c1) A hospital may contest any adverse action on its license under this section in accordance with Chapter 150B of the General Statutes. (1947, c. 933, s. 6; 1973, c. 476, s. 152; c. 1090, s. 1; 1981, c. 614, ss. 16, 17; 1983, c. 775, s. 1; 1987, c. 827, s. 1; 2007-444, s. 1.)

§ 131E-78.1: Reserved for future codification purposes.

§ 131E-78.2: Reserved for future codification purposes.

§ 131E-78.3. Rural emergency hospital.

(a) A hospital licensed under this Article shall notify the Department and the board of commissioners of the county where the hospital is located if the owner, operator, or governing body of the hospital applies for federal designation as a rural emergency hospital.

(b) Before operating as a rural emergency hospital, the owner, operator, or governing body of the hospital shall comply with each of the following:

(1) Submit a plan to the board of commissioners of the county where the hospital is located that includes an assessment of the current and future health care needs of the county and how the rural emergency hospital will support those needs.

(2) Conduct a public hearing at a location within the county. The owner, operator, or governing body of the hospital shall give notice, in writing, to the board of commissioners in that county and by publication in one or more newspapers of general circulation in the affected area describing the intent to convert to a rural emergency hospital. Publication of notice shall be given at least 15 days before the public hearing is held. All interested persons shall be heard at the public hearing.

(c) The conversion of a critical access hospital or acute care hospital to a rural emergency hospital is not subject to certificate of need review under Article 9 of this Chapter. (2023-134, s. 9F.11(b).)

§ 131E-78.4. Hospital standards for surgical smoke evacuation.

(a) Definitions. – The following definitions apply in this section:

(1) Smoke evacuation/filtering system. – Stand-alone, portable equipment that effectively captures, filters, and eliminates surgical smoke at the site of origin before the smoke makes contact with the eyes or respiratory tracts of occupants in the room. This equipment is not required to be interconnected to the hospital surgical ventilation or medical gas system.

(2) Surgical smoke. – The gaseous by-product produced by energy-generating devices, including surgical plume, smoke plume, bio-aerosols, laser-generated airborne contaminants, or lung-damaging dust.

(b) [Requirement. –] Each hospital licensed under this Part shall adopt and implement policies that require the use of a smoke evacuation/filtering system during any surgical procedure that is likely to generate surgical smoke.

(c) Adverse Action. – The Department of Health and Human Services may take adverse action against a hospital under G.S. 131E-78 for a violation of this section. (2025-37, s. 8(a).)

§ 131E-78.5. Stroke center designation.

(a) The Department shall designate hospitals that meet the criteria set forth in this section as an Acute Stroke Ready Hospital, Primary Stroke Center, Thrombectomy-Capable Stroke Center, or Comprehensive Stroke Center. A hospital shall apply to the Department for recognition of such designation and shall demonstrate to the satisfaction of the Department that the hospital meets the applicable criteria set forth in this section.

(a1) The Department shall recognize as many certified acute care hospitals as Acute Stroke Ready Hospitals as apply and are certified as an Acute Stroke Ready Hospital by the American Heart Association, the Joint Commission, or other Department-approved certifying body that is a nationally recognized guidelines-based organization that provides Acute Stroke Ready Hospital certification for stroke care, provided that each applicant continues to maintain its certification.

(a2) The Department shall recognize as many certified acute care hospitals as Primary Stroke Centers as apply and are certified as a Primary Stroke Center by the American Heart Association, the Joint Commission, or other Department-approved certifying body that is a nationally recognized guidelines-based organization that provides Primary Stroke Center Hospital certification for stroke care, provided that each applicant continues to maintain its certification. Further, the Department may recognize those Primary Stroke Centers that offer mechanical endovascular therapies but have not been certified as Thrombectomy-Capable Stroke Centers as "Primary Stroke Centers with endovascular services."

(a3) The Department shall recognize as many certified acute care hospitals as Thrombectomy-Capable Stroke Centers as apply and are certified as a Thrombectomy-Capable Stroke Center by the American Heart Association, the Joint Commission, or other Department-approved certifying body that is a nationally recognized guidelines-based organization that provides Thrombectomy-Capable Stroke Center Hospital certification for stroke care, provided that each applicant continues to maintain its certification.

(a4) The Department shall recognize as many certified acute care hospitals as Comprehensive Stroke Centers as apply and are certified as a Comprehensive Stroke Center by the American Heart Association, the Joint Commission, or other Department-approved certifying body that is a nationally recognized guidelines-based organization that provides Comprehensive Stroke Center Hospital certification for stroke care, provided that each applicant continues to maintain its certification.

(a5) A hospital that is certified by the Joint Commission or other nationally recognized accrediting body that requires conformance to best practices for stroke care in order to be identified as a stroke center shall report the following information to the Department within 90 days of receiving that certification:

(1) The name of the accrediting organization issuing certification to the hospital.
(2) The date of certification.
(3) The level of certification.
(4) The date of renewal of the certification.
(5) The name and phone number of the primary contact person at the hospital who is responsible for obtaining certification.

(b) Each hospital designated as an Acute Stroke Ready Hospital, Primary Stroke Center, Thrombectomy-Capable Stroke Center, or a Comprehensive Stroke Center pursuant to this section shall make efforts to coordinate the provision of appropriate acute stroke care with other hospitals licensed in this State through a formal written agreement. The agreement shall, at a minimum, address (i) transportation of acute stroke patients to hospitals designated as stroke centers and (ii) acceptance by hospitals designated as stroke centers of acute stroke patients initially treated at hospitals that are not capable of providing appropriate stroke care.

(c) The Department shall maintain within the Division of Health Service Regulation, Office of Emergency Services, a list of the hospitals designated as an Acute Stroke Ready Hospital, Primary Stroke Center, Thrombectomy-Capable Stroke Center, or a Comprehensive Stroke Center in accordance with this section and post the list on the Department's website. Annually on June 1, the Department shall transmit this list to the medical director of each licensed emergency medical services provider in this State.

(d) A hospital licensed under this Article shall not advertise or hold itself out to the public as an Acute Stroke Ready Hospital, Primary Stroke Center, Thrombectomy-Capable Stroke Center, or a Comprehensive Stroke Center unless certified as a stroke center by the Joint

Commission or other nationally recognized accrediting body that requires conformance to best practices for stroke care in order to be identified as a designated stroke center.

(e) Nothing in this section shall be construed to do any of the following:

(1) Establish a standard of medical practice for stroke patients.

(2) Restrict in any way the authority of any hospital to provide services authorized under its hospital license.

(f) The Department may adopt rules to implement the provisions of this section. (2013-44, s. 1; 2023-137, s. 30; 2025-25, s. 29(5).)

§ 131E-79. Rules and enforcement.

(a) The Commission shall promulgate rules necessary to implement this Article.

(b) The Department shall enforce this Article and the rules of the Commission. (1947, c. 933, s. 6; 1973, c. 476, s. 152; 1983, c. 775, s. 1.)

§ 131E-79.1. Counseling patients regarding prescriptions.

(a) Any hospital or other health care facility licensed pursuant to this Chapter or Chapter 122C of the General Statutes, health maintenance organization, local health department, community health center, medical office, or facility operated by a health care provider licensed under Chapter 90 of the General Statutes, providing patient counseling by a physician, a registered nurse, or any other appropriately trained health care professional shall be deemed in compliance with the rules adopted by the North Carolina Board of Pharmacy regarding patient counseling.

(b) As used in this section, "patient counseling" means the effective communication of information to the patient or representative in order to improve therapeutic outcomes by maximizing proper use of prescription medications and devices. (1993, c. 529, s. 7.7.)

§ 131E-79.2. Educating parents of newborns regarding pertussis disease.

(a) Each hospital licensed under this Article shall provide to the parents of newborns delivered at the hospital free, medically accurate educational information about pertussis disease and the availability of the tetanus-diphtheria and pertussis (Tdap) vaccine to protect against pertussis disease. The hospital shall provide this educational information to parents during the postpartum period and prior to the mother's discharge from the hospital. As used in this section, "postpartum period" means the period of time between the mother's admittance to the hospital for delivery of the newborn child through the first few hours after childbirth.

(b) The educational information provided to parents pursuant to this section shall include, at a minimum, the most current recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices regarding the use of tetanus-toxoid-diphtheria-acellular pertussis (Tdap) vaccine to reduce the burden of pertussis in infants.

(c) Nothing in this section shall be construed to require a hospital to provide or pay for any vaccination against pertussis disease. (2013-161, s. 1.)

§ 131E-79.3. Hospital patient visitation, civil penalty.

(a) Each hospital licensed under this Article shall permit patients to receive visitors to the fullest extent permitted under any applicable rules, regulations, or guidelines adopted by either the Centers for Medicare and Medicaid Services or the Centers for Disease Control and Prevention or any federal law.

(b) In the event the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, or any other federal agency finds a hospital has violated any rule, regulation, guidance, or federal law relating to a patient's visitation rights, the Department may issue a warning to the hospital about the violation and give the hospital not more than 24 hours to allow visitation. If visitation is not allowed after the 24-hour warning period, the Department shall impose a civil penalty in an amount not less than five hundred dollars ($500.00) for each instance on each day the hospital was found to have a violation. This civil penalty shall be in addition to any fine or civil penalty that the Centers for Medicare and Medicaid Services or other federal agency may choose to impose.

(c) Notwithstanding the provisions of subsection (b) of this section, in the event that circumstances require the complete closure of a hospital to visitors, the hospital shall use its best efforts to develop alternate visitation protocols that would allow visitation to the greatest extent safely possible. If those alternate protocols are found by the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, or any other federal agency to violate any rule, regulation, guidance, or federal law relating to a patient's visitation rights, the Department may impose a civil penalty in an amount not less than five hundred dollars ($500.00) for each instance on each day the hospital was found to have a violation. This civil penalty shall be in addition to any fine or civil penalty that the Centers for Medicare and Medicaid Services or other federal agency may choose to impose.

(d) Each hospital shall provide notice of the patient visitation rights in this act to patients and, when possible, family members of patients. The required notice shall also include the contact information for the agency or individuals tasked with investigating violations of hospital patient visitation.

(e) Subject to, and to the fullest extent permitted by, any rules, regulations, or guidelines adopted by either the Centers for Medicare and Medicaid Services or the Centers for Disease Control and Prevention or any federal law, each hospital shall allow compassionate care visits. A hospital may require compassionate care visitors to submit to health screenings necessary to prevent the spread of infectious diseases, and, notwithstanding anything to the contrary in this section, a hospital may restrict a compassionate care visitor who does not pass a health screening requirement or who has tested positive for an infectious disease. A hospital may require compassionate care visitors to adhere to infection control procedures, including wearing personal protective equipment. Compassionate care situations that require visits include, but are not limited to, the following:

(1) End-of-life situations.
(2) A patient who was living with his or her family before recently being admitted to the facility is struggling with the change in environment and lack of physical family support.
(3) A patient who is grieving after a friend or family member recently passed away.
(4) A patient who needs cueing and encouragement with eating or drinking, previously provided by family or caregivers, is experiencing weight loss or dehydration.
(5) A patient, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently when the patient had rarely cried in the past.

(f) The Commission shall adopt rules necessary to require each hospital to have written policies and procedures for visitation. (2021-171, s. 2; 2021-181, s. 2(a).)

§ 131E-80. Inspections.

(a) The Department shall make or cause to be made inspections as it may deem necessary. Any hospital licensed under this Part shall at all times be subject to inspections by the Department according to the rules of the Commission. Except as provided under G.S. 131E-77(b) of this Part, after the hospital's initial licensing, any location included or added to the hospital's accreditation through an accrediting body approved pursuant to section 1865(a) of the Social Security Act, shall be deemed to be part of the hospital's license; provided, however, that all locations may be subject to inspections which the Department deems necessary to validate compliance with the requirements set forth in this Part.

(b) The Department may delegate to any state officer or agency the authority to inspect hospitals. The Department may revoke this delegated authority at its discretion and make its own inspections.

(c) Authorized representatives of the Department shall have at all times the right of proper entry upon any and all parts of the premises of any place in which entry is necessary to carry out the provisions of this Part or the rules adopted by the Commission; and it shall be unlawful for any person to resist a proper entry by such authorized representative upon any premises other than a private dwelling. However, no representative shall, by this entry onto the premises, endanger the health or well being of any patient being treated in the hospital.

(d) To enable the Department to determine compliance with this Part and the rules promulgated under the authority of this Part and to investigate complaints made against a hospital licensed under this Part, while maintaining the confidentiality of the complainant, the Department shall have the authority to review any writing or other record in any recording medium which pertains to the admission, discharge, medication, treatment, medical condition, or history of persons who are or have been patients of the hospital licensed under this Part and the personnel records of those individuals employed by the licensed hospital. The examinations of these records is permitted notwithstanding the provisions of G.S. 8-53, "Communications between physician and patient," or any other provision of law relating to the confidentiality of communications between physician and patient. Proceedings of medical review committees are exempt from the provisions of this section. The hospital, its employees, and any person interviewed during these inspections shall be immune from liability for damages resulting from the disclosure of any information to the Department. Any confidential or privileged information received from review of records or interviews shall be kept confidential by the Department and not disclosed without written authorization of the patient, employee or legal representative, or unless disclosure is ordered by a court of competent jurisdiction. The Department shall institute appropriate policies and procedures to ensure that this information shall not be disclosed without authorization or court order. The Department shall not disclose the name of anyone who has furnished information concerning a hospital without the consent of that person. Any officer, administrator, or employee of the Department who willfully discloses confidential or privileged information without appropriate authorization or court order shall be guilty of a Class 3 misdemeanor and upon conviction shall only be fined in the discretion of the court but not in excess of five hundred dollars ($500.00). Neither the names of persons furnishing information nor any confidential or privileged information obtained from records or interviews shall be considered "public records" within the meaning of G.S. 132-1, "Public Records" defined.

(e) Information received by the Commission and the Department through filed reports, license applications, or inspections that are required or authorized by the provisions of this Part,

may be disclosed publicly except where this disclosure would violate the confidential relationship existing between physician and patient. However, no such public disclosure shall identify the patient involved without permission of the patient or court order. (1947, c. 933, s. 6; 1973, c. 476, s. 152; c. 1090, s. 1; 1981, c. 586, s. 3; 1983, c. 775, s. 1; 1993, c. 539, s. 957; 1994, Ex. Sess., c. 24, s. 14(c); 2009-487, s. 4(b).)

§ 131E-81. Penalties.

(a) Any person establishing, conducting, managing, or operating any hospital without a license is guilty of a Class 3 misdemeanor, and upon conviction is only liable for a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction is a separate offense.

(b) Except as otherwise provided in this Part, any person that willfully violates any provision of this Part, willfully fails to perform any act required by this Part, or willfully performs any act prohibited by this Part is guilty of a Class 1 misdemeanor. (1947, c. 933, s. 6; 1983, c. 775, s. 1; 1993, c. 539, s. 958; 1994, Ex. Sess., c. 24, s. 14(c); 2021-84, s. 10.)

§ 131E-82. Injunction.

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may, in the manner provided by law, maintain an action in the name of the State for injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, management or operation of a hospital without a license.

(b) If any person shall hinder the proper performance of duty of the Secretary or a representative in carrying out the provisions of this Part, the Secretary may institute an action in the superior court of the county in which the hindrance occurred for injunctive relief against the continued hindrance, irrespective of all other remedies at law.

(c) Actions under this section shall be in accordance with Article 37 of Chapter 1 of the General Statutes, and Rule 65 of the Rules of Civil Procedure. (1947, c. 933, s. 6; 1973, c. 476, s. 152; 1983, c. 775, s. 1.)

§ 131E-83. Temporary change of hospital bed capacity.

A hospital may temporarily increase its bed capacity by up to ten percent (10%) over its licensed bed capacity by utilizing observation beds for hospital inpatients if the hospital notifies and obtains the approval of the Division of Health Service Regulation. For purposes of this section, "temporarily" means not longer than 60 consecutive days. (2001-410, s. 1; 2007-182, s. 1.)

§ 131E-84. Waiver of rules and increase in bed capacity during an emergency.

(a) The Division of Health Service Regulation may temporarily waive, during disasters or emergencies declared in accordance with Article 1A of Chapter 166A of the General Statutes, any rules of the Commission pertaining to a hospital to the extent necessary to allow the hospital to provide temporary shelter and temporary services requested by the emergency management agency. The Division may identify, in advance of a declared disaster or emergency, rules that may be waived, and the extent to which the rules may be waived, upon a declaration of disaster or emergency in accordance with Article 1A of Chapter 166A of the General Statutes. The Division may also waive rules under this subsection during a declared disaster or emergency upon the request of an emergency management agency and may rescind the waiver if, after investigation, the Division determines the waiver poses an unreasonable risk to the health, safety, or welfare of any of

the persons occupying the hospital. The emergency management agency requesting temporary shelter or temporary services shall notify the Division within 72 hours of the time the preapproved waivers are deemed by the emergency management agency to apply.

(a1) In the event of a declaration of a state of emergency by the Governor in accordance with Article 1A of Chapter 166A of the General Statutes, a declaration of a national emergency by the President of the United States, a declaration of a public health emergency by the Secretary of the United States Department of Health and Human Services; or to the extent necessary to allow for consistency with any temporary waiver or modification issued by the Secretary of the United States Department of Health and Human Services or the Centers for Medicare and Medicaid Services under section 1135 or 1812(f) of the Social Security Act; or when the Division of Health Service Regulation determines the existence of an emergency that poses a risk to the health or safety of patients, the Division of Health Service Regulation may do either or both of the following:

(1) Temporarily waive any rules of the Commission pertaining to hospitals.

(2) Notwithstanding G.S. 131E-183, allow a hospital to temporarily increase its bed capacity.

(a2) Notwithstanding any other provision of this section or the General Statutes, in the event the Secretary of the United States Department of Health and Human Services or the Centers for Medicare and Medicaid Services issues a temporary waiver or modification under section 1135 or 1812(f) of the Social Security Act, the corresponding rule or portion of a rule adopted by the Commission pertaining to hospitals is automatically modified or waived to the extent necessary to allow for consistency with the federal waiver or modification and shall continue in place at least until the federal waiver or modification has expired. Nothing in this subsection shall be construed as preventing the Division of Health Service Regulation from further waiving or modifying any rules of the Commission.

(b) As used in this section, "emergency management agency" is as defined in G.S. 166A-19.3. (2007-444, s. 2; 2012-12, s. 2(t); 2022-74, s. 9E.2(c); 2025-18, s. 5.)

§ 131E-84.05. Patient visitation by clergy, including during declared disasters or emergencies.

Notwithstanding G.S. 131E-84, Chapter 166A of the General Statutes, or any other provision of law to the contrary, each hospital licensed under this Article shall allow a clergy member to visit any patient admitted to the hospital who requests or consents to be visited by a clergy member during the patient's hospital stay, including a hospital stay that occurs during a declared disaster or emergency. A hospital may require a visiting clergy member to submit to health screenings necessary to prevent the spread of infectious diseases, and, notwithstanding anything to the contrary in this section, a hospital may restrict a visiting clergy member who does not pass a health screening requirement or who has tested positive for an infectious disease. A hospital may require a visiting clergy member to adhere to infection control procedures, including wearing personal protective equipment, as long as the infection control procedures do not interfere with the religious beliefs of the patient or the visiting clergy member. (2021-156, s. 1.)

§ 131E-84.1. Human trafficking public awareness sign.

Each hospital licensed under this Article shall prominently display in its emergency room or emergency department in a place that is clearly conspicuous and visible to employees and the public a public awareness sign created and provided by the North Carolina Human Trafficking

Commission that contains the National Human Trafficking Resource hotline information. (2017-57, s. 17.4(d); 2017-197, s. 5.8.)

Part 3. Hospital Privileges.

§ 131E-85. Hospital privileges and procedures.

(a) The granting or denial of privileges to practice in hospitals to physicians licensed under Chapter 90 of the General Statutes, Article 1, dentists, optometrists, and podiatrists and the scope and delineation of such privileges shall be determined by the governing body of the hospital on a non-discriminatory basis. Such determinations shall be based upon the applicant's education, training, experience, demonstrated competence and ability, and judgment and character of the applicant, and the reasonable objectives and regulations of the hospital, including, but not limited to appropriate utilization of hospital facilities, in which privileges are sought. Nothing in this Part shall be deemed to mandate hospitals to grant or deny to any such individuals or others privileges to practice in hospitals, or to offer or provide any type of care.

(b) The procedures to be followed by a licensed hospital in considering applications of dentists, optometrists, and podiatrists for privileges to practice in such hospitals shall be similar to those applicable to applications of physicians licensed under Chapter 90 of the General Statutes, Article 1. Such procedures shall be available upon request.

(c) In addition to the granting or denial of privileges, the governing body of each hospital may suspend, revoke, or modify privileges.

(d) All applicants or individuals who have privileges shall comply with all applicable medical staff bylaws, rules and regulations, including the policies and procedures governing the qualifications of applicants and the scope and delineation of privileges.

(e) The Department shall not issue or renew a license under this Article unless the applicant has demonstrated that the procedures followed in determining hospital privileges are in accordance with this Part and rules of the Department. (1981, c. 659, s. 10; 1983, c. 775, s. 1; 1987, c. 859, s. 18; 1989, c. 446; 1997-75, s. 2.)

§ 131E-86. Limited privileges.

(a) It shall be unlawful for an individual who is not licensed under Chapter 90 of the General Statutes, Article 1, to admit a patient to a hospital without written proof in accordance with the policy of the governing body of the hospital that a physician licensed under Chapter 90 of the General Statutes, Article 1, who is a member of the medical staff will be responsible for the performance of a basic medical appraisal and for the medical needs of the patient. The governing body of a hospital may waive this requirement for a dentist licensed under Chapter 90 of the General Statutes, Article 2, to the extent authorized by this statute, who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the American Dental Association.

(b) The governing body of each hospital shall not grant privileges that exceed the scope of a license. (1983, c. 775, s. 1.)

§ 131E-87. Reports of disciplinary action; immunity from liability.

The chief administrative officer of each licensed hospital in the State shall report to the appropriate occupational licensing board the details, as prescribed by the board, of any revocation, suspension, limitation, or voluntary reduction of privileges of a health care provider to practice in that hospital. Each hospital shall also report to the board its medical staff resignations. Reports

concerning physician privileges and resignations shall be made in accordance with G.S. 90-14.13. Any person making a report required by this section shall be immune from any resulting criminal prosecution or civil liability unless the person knew the report was false or acted in reckless disregard of whether the report was false. (1983, c. 775, s. 1; 1987, c. 859, s. 16; 2006-144, s. 9.)

Part 3A. Hospital Violence Protection Act.

§ 131E-88. Law enforcement officers required in emergency departments.

(a) As used in this Part, "law enforcement officer" means (i) a sworn law enforcement officer, (ii) a special police officer, as defined in subsection (b) of G.S. 74E-6, or (iii) a campus police officer, in accordance with Chapter 74G of the General Statutes, who is duly authorized to carry a concealed weapon.

(b) Each hospital licensed under this Article that has an emergency department shall conduct a security risk assessment and develop and implement a security plan with protocols to ensure that at least one law enforcement officer is present at all times, except when temporarily required to leave in connection with the discharge of their duties, in the emergency department or on the same campus as the emergency department, unless subsection (c) of this section applies. The security plan required by this section shall include all of the following components:

(1) Training for law enforcement officers employed or contracted by the hospital that is appropriate for the populations served by the emergency department.

(2) Training for law enforcement officers employed or contracted by the hospital that is based on a trauma-informed approach to identifying and safely addressing situations involving patients, family members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance use disorder or who are experiencing a mental health crisis.

(3) Safety protocols based on all of the following:

a. Standards established by a nationally recognized organization that has experience educating and certifying professionals involved in managing and directing security and safety programs in healthcare facilities. The Department of Health and Human Services shall solicit names of nationally recognized organizations from the North Carolina Sheriffs' Association, the North Carolina Association of Chiefs of Police, the North Carolina Emergency Management Association, and the North Carolina Healthcare Association.

b. The results of a security risk assessment of the emergency department.

c. Risks for the emergency department identified in consultation with the emergency department's medical director and nurse leadership, law enforcement officers employed or contracted by the hospital, and a local law enforcement representative. These identified risks shall take into consideration the hospital's trauma level designation, overall patient volume, volume of psychiatric and forensic patients, incidents of violence against staff and level of injuries sustained from such violence, and prevalence of crime in the community.

(4) Safety protocols that include the presence of at least one law enforcement officer in the emergency department, or on the same campus as the emergency department, at all times, unless an exemption is approved under subsection (c) of this section.

(5) Training requirements for law enforcement officers employed or contracted by the hospital in the potential use of and response to weapons, defensive tactics, de-escalation techniques, appropriate patient intervention activities, crisis intervention, and trauma-informed approaches.

(b1) Each hospital licensed under this Article that has an emergency department may submit a summary report of its security risk assessment to the Department of Health and Human Services by October 1, 2024. The submitted report must include the following:

(1) The process for the development of the security risk assessment, including the types of professionals who participated in the development of the security risk assessment.
(2) The actions recommended by the security risk assessment.
(3) The physical modifications recommended by the security risk assessment.
(4) The proposed budget and time line for the implementation of the security plan required by subsection (b) of this section.
(5) Any barriers to fully implement the security risk assessment findings and, if applicable, any barriers to the required presence of a law enforcement officer, and the hospital's planned efforts to overcome these barriers by June 1, 2025.

Subsection (b) of this section shall not apply until June 1, 2025, to a hospital licensed under this Article that has an emergency department who acts in compliance with this subsection.

(c) A hospital is not required to have at least one law enforcement officer present in the emergency department or on the hospital campus at all times if the hospital in good faith determines that a different level of security is necessary and appropriate for any of its emergency departments based upon findings in the security risk assessment required under sub-subdivision (b)(3)b. of this section. A hospital that determines that a different level of security is necessary and appropriate shall include the basis for that determination in its security risk assessment, and the security plan must include the following:

(1) The signature of the county sheriff.
(2) The signature of the municipal police chief, if applicable.
(3) The approval and signature of the county emergency management director.

(d) Every hospital with an emergency department shall provide appropriate hospital workplace violence prevention program training, education, and resources to staff, practitioners, and non-law enforcement officer security personnel.

(e) The Department of Health and Human Services shall have access to all security plans for hospitals with an emergency department. The Department of Health and Human Services shall maintain a list of those hospitals with a security plan developed in accordance with this section and a list of those hospitals who submitted a security risk assessment in accordance with subsection (b1) of this section.

(f) The following are not public records as defined by Chapter 132 of the General Statutes:

(1) A hospital security risk assessment, regardless of who has custody of the security risk assessment.
(2) A hospital security plan, regardless of who has custody of the security plan. (2023-129, s. 8.1(a); 2024-34, s. 11(a).)

§ 131E-88.2. Reports.

(a) Annually by February 28, each hospital shall report to the Division of Health Service Regulation, in a manner and format requested by the Department, the following data for the prior

federal fiscal year ending September 30: (i) the number of assaults occurring in the hospital or on hospital grounds that required the involvement of law enforcement, whether the assaults involved hospital personnel, and how those assaults were pursued by the hospital and processed by the judicial system, (ii) the number and impact of incidences where patient behavioral health and substance use issues resulted in violence in the hospital and the number that occurred specifically in the emergency department, and (iii) the number of workplace violence incidences occurring at the hospital that were reported as required by accrediting agencies, the Occupational Safety and Health Administration, and other entities.

(b) The Department shall compile the information required by subsection (a) of this section and shall share that data with the North Carolina Sheriffs' Association, the North Carolina Association of Chiefs of Police, and the North Carolina Emergency Management Association. The Department shall request these organizations examine the data and make recommendations to the Department to decrease the incidences of violence in hospitals and to decrease assaults on hospital personnel.

(c) The Department shall compile the information required by subsections (a) and (b) of this section and report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services annually by May 1. (2023-129, s. 8.1(a); 2025-27, s. 3.3(b).)

§ 131E-88.3. (Effective October 1, 2024 until October 30, 2030 – see editor's note for effective date and expiration) Report by the Administrative Office of the Courts.

(a) Annually by September 1, the Administrative Office of the Courts shall report to the Department of Health and Human Services, Division of Health Service Regulation, the number of persons charged and convicted during the preceding calendar year of a crime under G.S. 14-34.6.

(b) The Department shall include the information provided in subsection (a) of this section in the report required by G.S. 131E-88.2(c). (2023-129, s. 8.1(b).)

§ 131E-89. Reserved for future codification purposes.

Part 4. Discharge from Hospital.

§ 131E-90. Authority of administrator; refusal to leave after discharge.

The case of a patient who refuses or fails to leave the hospital upon discharge by the attending physician shall be reviewed by two physicians licensed to practice medicine in this State, one of whom may be the attending physician. If in the opinion of the physicians, the patient should be discharged as cured or as no longer needing treatment or for the reason that treatment cannot benefit the patient's case or for other good and sufficient reasons, the patient's refusal to leave shall constitute a trespass. The patient shall be guilty of a Class 3 misdemeanor. (1965, c. 258; 1983, c. 775, s. 1; 1993, c. 539, s. 959; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 131E-91. Fair billing and collections practices for hospitals and ambulatory surgical facilities.

(a) All hospitals and ambulatory surgical facilities licensed pursuant to this Chapter shall, upon request of the patient, present an itemized list of charges to all discharged patients detailing in language comprehensible to an ordinary layperson the specific nature of the charges or expenses incurred by the patient. Patient bills that are not itemized shall include notification to the patient of the right to request, free of charge, an itemized bill. A patient may request an itemized list of

charges at any time within three years after the date of discharge or so long as the hospital or ambulatory surgical facility, a collections agency, or another assignee of the hospital or ambulatory surgical facility asserts the patient has an obligation to pay the bill. Each hospital and ambulatory surgical facility shall establish a method for patients to inquire about or dispute a bill.

(b) If a patient has overpaid the amount due to the hospital or ambulatory surgical facility, whether as the result of insurance coverage, patient error, health care facility billing error, or other cause, and the overpayment is not in dispute or on appeal, the hospital or ambulatory surgical facility shall provide the patient with a refund within 45 days of receiving notice of the overpayment.

(c) A hospital or ambulatory surgical facility shall not bill insured patients for charges that would have been covered by their insurance had the hospital or ambulatory surgical facility submitted the claim or other information required to process the claim within the allotted time requirements of the insurer.

(d) Hospitals and ambulatory surgical facilities shall abide by the following reasonable collections practices:

(1) A hospital or ambulatory surgical facility shall not refer a patient's unpaid bill to a collections agency, entity, or other assignee during the pendency of a patient's application for charity care or financial assistance under the hospital's or ambulatory surgical facility's charity care or financial assistance policies.

(2) A hospital or ambulatory surgical facility shall provide a patient with a written notice that the patient's bill will be subject to collections activity at least 30 days prior to the referral being made.

(3) A hospital or ambulatory surgical facility that contracts with a collections agency, entity, or other assignee shall require the collections agency, entity, or other assignee to inform the patient of the hospital's or ambulatory surgical facility's charity care and financial assistance policies when engaging in collections activity.

(4) A hospital or ambulatory surgical facility shall require a collections agency, entity, or other assignee to obtain the written consent of the hospital or ambulatory surgical facility prior to the collections agency, entity, or other assignee filing a lawsuit to collect the debt.

(5) For debts arising from the provision of care by a hospital or ambulatory surgical center, the doctrine of necessaries as it existed at common law shall apply equally to both spouses, except where they are permanently living separate and apart, but shall in no event create any liability between the spouses as to each other. No lien arising out of a judgment for a debt owed a hospital or ambulatory surgical facility under this section shall attach to the judgment debtors' principal residence, or, if the land upon which the principal residence is located is greater than five acres, then no lien shall attach to the judgment debtors' principal residence and the surrounding five acres, held by them as tenants by the entireties or that was held by them as tenants by the entireties prior to the death of either spouse where the tenancy terminated as a result of the death of either spouse.

(6) For debts arising from the provision of care by a hospital or ambulatory surgical center to a minor, there shall be no execution on or otherwise forced sale of the principal residence of the custodial parent or parents for a judgment obtained

for the outstanding debt until such time as the minor is either no longer residing with the custodial parent or parents or until the minor reaches the age of majority, whichever occurs first.

(7) A hospital or ambulatory surgical facility shall have policies to prevent collections of debts related to expenses that cannot be charged to a patient pursuant to G.S. 143B-1200.

(e) The Commission shall adopt rules to ensure that this section is properly implemented. The Department shall not issue or renew a license under this Article unless the applicant has demonstrated that the requirements of this subsection are being met. (1991, c. 310, s. 1; 2013-382, s. 13.1; 2013-393, s. 2; 2022-50, s. 2(b).)

§ 131E-92. Reserved for future codification purposes.

§ 131E-93. Reserved for future codification purposes.

§ 131E-94. Reserved for future codification purposes.

Part 5. Medical Review Committee.

§ 131E-95. Medical review committee.

(a) A member of a duly appointed medical review committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement or proceeding undertaken, made, or performed within the scope of the functions of the committee.

(b) The proceedings of a medical review committee, the records and materials it produces and the materials it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, " 'Public records' defined", and shall not be subject to discovery or introduction into evidence in any civil action against a hospital, an ambulatory surgical facility licensed under Chapter 131E of the General Statutes, or a provider of professional health services which results from matters which are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee or a person who testifies before the committee may testify in a civil action but cannot be asked about the person's testimony before the committee or any opinions formed as a result of the committee hearings.

(c) Information that is confidential and is not subject to discovery or use in civil actions under this section may be released to a professional standards review organization that performs any accreditation or certification including the Joint Commission on Accreditation of Healthcare Organizations, or to a patient safety organization or its designated contractors. Information released under this subsection shall be limited to that which is reasonably necessary and relevant to the standards review organization's determination to grant or continue accreditation or

certification, or the patient safety organization's or its contractors' analysis of patient safety and health care quality. Information released under this subsection retains its confidentiality and is not subject to discovery or use in any civil actions as provided under this section, and the standards review or patient safety organization shall keep the information confidential subject to this section, except as necessary to carry out the organization's patient safety, accreditation, or certification activities. For the purposes of this section, "patient safety organization" means an entity that collects and analyzes patient safety or health care quality data of providers for the purpose of improving patient safety and the quality of health care delivery and includes, but is not limited to, an entity formed pursuant to Public Law No. 109-41. (1973, c. 1111; 1981, c. 725; 1983, c. 775, s. 1; 1999-222, s. 2; 2002-179, s. 19; 2004-149, s. 2.5; 2006-144, s. 3.2.)

Part 6. Risk Management.

§ 131E-96. Risk management programs.

(a) Each hospital shall develop and maintain a risk management program which is designed to identify, analyze, evaluate, and manage risks of injury to patients, visitors, employees, and property through loss reduction and prevention techniques and quality assurance activities, as prescribed in rules promulgated by the Commission.

(b) The Department shall not issue or renew a license under this Article unless the applicant is in compliance with this section. (1987, c. 859, s. 17.)

Part 7. Confidential Information.

§ 131E-97. Confidentiality of patient information.

(a) Medical records compiled and maintained by health care facilities in connection with the admission, treatment, and discharge of individual patients are not public records as defined by Chapter 132 of the General Statutes.

(b) Charges, accounts, credit histories, and other personal financial records compiled and maintained by health care facilities in connection with the admission, treatment, and discharge of individual patients are not public records as defined by Chapter 132 of the General Statutes. (1993 (Reg. Sess., 1994), c. 570, s. 10.)

§ 131E-97.1. Confidentiality of personnel information.

(a) Except as provided in subsection (b) of this section, the personnel files of employees or former employees, and the files of applicants for employment maintained by a public hospital as defined in G.S. 159-39 or maintained by a hospital that has been sold or conveyed pursuant to G.S. 131E-8 are not public records as defined by Chapter 132 of the General Statutes.

(b) Repealed by Session Laws, 1997-517, s. 3.

(c) Information regarding the qualifications, competence, performance, character, fitness, or conditions of appointment of an independent contractor who provides health care services under a contract with a public hospital as defined in G.S. 159-39, or with a hospital which has been sold or conveyed pursuant to G.S. 131E-8, is not a public record as defined by Chapter 132 of the General Statutes. Information regarding a hearing or investigation of a complaint, charge, or grievance by or against an independent contractor who provides health care services under a contract with a public hospital as defined in G.S. 159-39 or with a hospital which has been sold or conveyed pursuant to G.S. 131E-8, is not a public record as defined by Chapter 132 of the General Statutes. Final action making an appointment or discharge or removal by a public hospital having final authority for the appointment or discharge or removal shall be taken in an open meeting,

unless otherwise exempted by law. The following information with respect to each independent contractor of health care services of a public hospital, as defined by G.S. 159-39, is a matter of public record: name; age; date of original contract; beginning and ending dates; position title; position descriptions; and total compensation of current and former positions; and the date of the most recent promotion, demotion, transfer, suspension, separation, or other change in position classification. (1993 (Reg. Sess., 1994), c. 570, s. 10; 1995, c. 99, s. 1; c. 509, s. 135.2(q); 1997-517, s. 3.)

§ 131E-97.2. Confidentiality of credentialing information.

Information acquired by a public hospital, as defined in G.S. 159-39, a hospital that has been sold or conveyed pursuant to G.S. 131E-8, a State-owned or State-operated hospital, or by persons acting for or on behalf of a hospital, in connection with the credentialing and peer review of persons having or applying for privileges to practice in the hospital is confidential and is not a public record under Chapter 132 of the General Statutes; provided that information otherwise available to the public shall not become confidential merely because it was acquired by the hospital or by persons acting for or on behalf of the hospital. (1993 (Reg. Sess., 1994), c. 570, s. 10; 1995, c. 509, s. 135.2(r).)

§ 131E-97.3. Confidentiality of competitive health care information.

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of hospitals and public hospital authorities. Competitive health care information does not include any of the information hospitals and ambulatory surgical facilities are required to report under G.S. 131E-214.12. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of a public hospital or public hospital authority, as defined in G.S. 159-39, shall be a public record unless otherwise exempted by law, or the contract contains competitive health care information, the determination of which shall be as provided in subsection (b) of this section.

(b) If a public hospital or public hospital authority is requested to disclose any contract which the hospital or hospital authority believes in good faith contains or constitutes competitive health care information, the hospital or hospital authority may either redact the portions of the contract believed to constitute competitive health care information prior to disclosure, or if the entire contract constitutes competitive health care information, refuse disclosure of the contract. The person requesting disclosure of the contract may institute an action pursuant to G.S. 132-9 to compel disclosure of the contract or any redacted portion thereof. In any action brought under this subsection, the issue for decision by the court shall be whether the contract, or portions of the contract withheld, constitutes competitive health care information, and in making its determination, the court shall be guided by the procedures and standards applicable to protective orders requested under Rule 26(c)(7) of the Rules of Civil Procedure. For the purposes of this section, competitive health care information includes, but is not limited to, contracts entered into by or on behalf of a public hospital or public hospital authority to purchase a medical practice. Before rendering a decision, the court shall review the contract in camera and hear arguments from the parties. If the court finds that the contract constitutes or contains competitive health care information, the court may either deny disclosure or may make such other appropriate orders as are permitted under Rule 26(c) of the Rules of Civil Procedure.

(c) Nothing in this section shall be deemed to prevent an elected public body, in closed session, which has responsibility for the hospital, the Attorney General, or the State Auditor from having access to this confidential information. The disclosure to any public entity does not affect the confidentiality of the information. Members of the public entity shall have a duty not to further disclose the confidential information. (1993 (Reg. Sess., 1994), c. 570, s. 10; 2001-516, s. 5; 2007-508, s. 8.5; 2013-382, s. 10.4.)

§ 131E-98. Inmate medical records.

Notwithstanding any other provision of law, a hospital does not breach patient confidentiality by providing the Division of Prisons of the Department of Adult Correction with the medical records of inmates who receive medical treatment at the hospital while in the custody of the Division. A hospital complying with a request from the Division of Prisons of the Department of Adult Correction or its agent for a copy of the medical records of an inmate who received medical services while in custody shall be immune from liability in any civil action for the release of the inmate's medical record. (1993, c. 321, s. 178(b); 2011-145, s. 19.1(h); 2017-186, s. 2(wwwww); 2021-180, s. 19C.9(p).)

§ 131E-99. Confidentiality of health care contracts.

Except for the information a hospital or an ambulatory surgical facility is required to report under G.S. 131E-214.12, the financial terms and other competitive health care information directly related to the financial terms in a health care services contract between a hospital or a medical school and a managed care organization, insurance company, employer, or other payer is confidential and not a public record under Chapter 132 of the General Statutes. Nothing in this section shall prevent an elected public body which has responsibility for the hospital or medical school from having access to this confidential information in a closed session. The disclosure to a public body does not affect the confidentiality of the information. Members of the public body shall have a duty not to further disclose the confidential information. (1995 (Reg. Sess., 1996), c. 713, s. 2; 1997-123, ss. 1, 2; 2013-382, s. 10.5.)