RE: HIPAA and Mental Health Record

Federal Rules: 45 CFR 164.508(a)(2); 164.512(a); 164.502(a)(2)(ii); 164.512(d); 164.512(g)(1); 164.512(j)(1)(i)

Generally, the Privacy Rule applies uniformly to all protected health information without regard to the type of information. However, one of the exceptions to this general rule is for psychotherapy notes. Psychotherapy notes documents or analyzes the conversations during counseling sessions with a mental health provider. **Psychotherapy notes do NOT include any information about medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, or results of clinical tests; nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. They also do not include any information that is maintained in a patient's medical record.**

The general rule with respect to psychotherapy notes is that a covered entity must obtain a separate patient authorization prior to the disclosure of psychotherapy notes for any reason, including a disclosure for treatment purposes to another health care provider. The mental health provider does NOT need a separate patient authorization to carry out the following treatment, payment, or health care operations:

- Use by the originator of the psychotherapy notes for treatment;
- Use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family, or individual counseling; or
- Use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual.

A separate patient authorization is also not necessary if the disclosure is required by law (a mandate such as a court order, warrant, subpoena, etc.)

There are additional exceptions concerning business associates, health oversight activities, and emergency situations. These can be provided by request.

Maryland §4-307

In Maryland, psychotherapy notes are referred to as "personal notes." A "personal note" is information that is the work product and personal property of a mental health provider and not discoverable or admissible as evidence in any criminal, civil, or administrative action**. The medical record does not include a mental health provider's personal note if the mental health provider**:

- Keeps the personal note in the mental health provider's sole possession for the provider's own personal use;
- Maintains the personal note separate from the recipient's medical records; and
- Does not disclose the personal note to any other person except

- The mental health provider's supervising health care provider that maintains the confidentiality of the personal note;
- A consulting health care provider that maintains the confidentiality of the personal note; or
- An attorney of the health care provider that maintains the confidentiality of the personal.

Like with psychotherapy notes, personal notes do not include information concerning the patient's diagnosis, treatment plan, symptoms, prognosis, or progress notes.

A personal note shall be considered part of the medical record if the mental health care provider discloses a personal note to a person other than:

- The provider's supervising health care provider;
- A consulting health care provider;
- An attorney of the health care provider; or
- A recipient who has initiated an action of malpractice, an intentional tort, or professional negligence.

These rules do NOT prohibit the disclosure, discovery or admissibility of a personal note in an action of malpractice, intentional tort, or professional negligence.

Disclosure of Mental Health Record

Normal disclosure rules apply <u>in addition to</u> the following rules concerning mental health records specifically.

Duty not to Redisclose

If an individual given access to a medical record that relates to mental health services signs an acknowledgement of the duty not to redisclose, **this acknowledgment cannot be construed to prevent the disclosure for rate review, auditing, health planning, licensure, approval, or accreditation of a facility by governmental or professional standard setting entities.**

Without Authorization of Person in Interest

When a medical record (developed during mental health services) is disclosed without the authorization of a person in interest, **<u>only the information in the record relevant to the purpose for disclosure may be released.</u>**

A healthcare provider may disclose a medical record **without the authorization** of a person in interest in the certain circumstances. Below are **SOME** of those circumstances. **Additional rules apply and can be provided upon request.**

- In the event of an involuntary commitment;

- A cause of action against a mental health care provider (as provided in §5-609 of Courts and Judicial Proceedings Article;
- To a law enforcement agency concerning an involuntary commitment;
- To a medical/mental health director of a juvenile or adult dentition or correctional facility or another inpatient provider of mental health services in connection with the transfer of a patient from an inpatient provider;
- To the State designated protection and advocacy system for mentally ill individuals;
- To another health care provider or legal counsel to the other health care provider prior to and in connection with or for use in a commitment proceeding;
- In accordance with a court order, other than a compulsory process compelling disclosure, or as otherwise provided by law; and
- **In accordance with a subpoena for medical records on specific patients.**

Again, <u>additional rules apply</u> in these circumstances. Please be sure to <u>comply with ALL rules</u> regarding disclosures of medical records.