Section 6 Compliance Policies Subject 6.2 Privacy and Disclosure **Policy 6.2.8 Use and Disclosure of Psychotherapy Notes and Physician Process Notes**	05/12/03-Originated 08/01/13-Reviewed w/ changes -Reviewed w/o changes 09/05/13 -Effective Compliance Office -Author

Use and Disclosure of Psychotherapy Notes and Physician Process Notes

Definitions

Psychotherapy Notes*:* Notes (*i.e.*, process notes) that capture the therapist's impressions about the patient containing details of the conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. Psychotherapy notes can also be recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session. Psychotherapy notes are kept separate from the rest of the individual's medical record. These notes typically exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms and progress to date.

Unit Medical Record (UMR): The official UTMB legal medical record maintained by the Department of Health Information Management (HIM) that contains UTMB's original/official patient care information.

The UMR is designed to contain the written interpretations of all significant clinical information gathered for a given patient, whether as an inpatient, outpatient, or emergency care patient. The entire patient's medical record is in paper or electronic form under one hospital number. UMR's have a permanent retention schedule.

Case Management Records (CMR): A medical record maintained by a specific physician or department that only includes copies of original patient care information already included in the UMR. Commonly referred to as "shadow records," CMRs should never contain original medical records.

Policy

Process notes are considered records to be maintained by the provider who created them and may not be disclosed to the patient. If individual providers decide to create and maintain process notes, they must ensure these notes are maintained in a separate location from other records,

Policy, continued

including Case Management Records, and must be secured from unauthorized access at all times. Since these records are a separate and distinct record series and are convenience copies they must be managed in accordance with the records retention schedule and may be destroyed after their usefulness expires in accordance with IHOP Policy 6.2.10 *Physical Protections/Safeguards for Protected Health Information (PHI).*

Violation of this policy may result in disciplinary action up to and including termination for employees; a termination of employment relationship in the case of contractors or consultants; or suspension or expulsion in the case of a student. Additionally, individuals may be subject to loss of access privileges and civil and/or criminal prosecution**.**

When Authorization is Not Required

All disclosures of process notes **must be approved** by HIM.

UTMB may only use and disclose process notes in the following situations or pursuant to a patient authorization. An authorization for the use of disclosure of process notes may not be combined with another authorization except for one that relates to the use and disclosure of process notes.

An authorization is not required:

1. For use by the originator for treatment;
2. For use in educational programs including residency or graduate training programs where students and trainees learn to practice counseling;
3. To defend a legal action brought by the patient; For use by the Department of Health and Human Services in determining compliance with the privacy rule;
4. As otherwise required by law in accordance with IHOP 6.2.16 *Permitted Uses and Disclosure of PHI in Special Situations*;
5. For use by a health oversight agency for a lawful purpose related to oversight of a psychotherapist;
6. For use by a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law; or,
7. For use by law enforcement in instances of permissible disclosure related to a serious or imminent threat to the health

When Authorization is Not Required, continued

or safety of a person or the public in accordance with IHOP 6.2.16 *Permitted Uses and Disclosure of PHI in Special Situations.*

Requests for the Release of Process Notes or Psychotherapy Notes

Patient's Access to Process Notes and Psychotherapy Notes
A patient does not have the right to inspect or obtain a copy of process notes, so providers may deny the release of process notes if, in their professional judgment, the provider believes releasing the information will be detrimental to the patient.

Patient Requests for Process Notes or Psychotherapy Notes

1. Request to HIM. Providers must direct requestors of process notes to the Department of Health Information Management (HIM). The request for process notes will be made on a standard patient authorization; however, the authorization must be a stand-alone authorization and may not be combined with an authorization for any other PHI.

2. Compilation of Information. Once HIM receives an authorization for the use and disclosure of process notes, HIM will attempt to gather the information from all of the patient's providers and ask each provider to approve of the release of information.

3. Records Unavailable. Records may be unavailable for the following reasons:
   a. Provider has disposed of the process note because the record's usefulness expired, HIM will inform the patient that the document no longer exists
   b. Provider does not create or maintain process notes, the requestor will be notified that no such documents are maintained by the provider.
   c. Provider denies the release of the process note because the provider believes the disclosure of the information would harm the patient; HIM will inform the patient the provider has denied the request.

Requests for the Release of Process Notes or Psychotherapy Notes, continued

Third Party Requests for Process Notes

All third party requestors of process notes must either obtain the patient's authorization for disclosing the process notes or provide HIM with legal justification for the disclosure. Any subpoena for process notes must follow the HIPAA requirements for permitted disclosures for administrative and judicial purposes. See *IHOP Policy #6.2.1, Use & Disclosure of PHI base on Patient Authorization* and *IHOP Policy # 6.2.16, Use & Disclosure of PHI in Special Situations.*.

HIM is responsible for processing the request and account for all disclosures as required by the accounting of disclosure policy. See *IHOP Policy #6.2.28, Accounting of Disclosures of PHI*.

References

45 C.F.R. §164.502(a)(2)(ii) Uses and disclosures of protected health information: general rules.
45 C.F.R. §164.508 Uses and disclosures for which an authorization is required.
42 C.F.R. §164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required.
45 C.F.R § 164.524 Access of individuals to protected health information.