

Right of Access to Psychotherapy notes - clarifying the mental health clinician's responsibility in the United States

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Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) applies to most, if not all, providers of mental health services - and it is within the HIPAA privacy rule that obligates mental health clinicians to provide timely access to protected health information (PHI). Recent efforts have bolstered such advocacy, as when the Office of Civil Rights (OCR) announced an initiative in 2019 to enforce ensuring patients access to their health records. While there shouldn't be any surprises about that – what about psychotherapy notes? Those notes contain some of the most delicate and protected information about a person- and are crucial in treatment. Such documentation includes the subjective thoughts and impressions of a therapist. Are clinicians supposed to turn those over as well at the behest of a patient or client without regard to the potential impact such information may have on their psyche? The answer - it depends and varies (in some cases, tremendously) by state.

HIPAA's mandates pertaining to records as part of the official 'designated record set' do NOT include psychotherapy notes. The Department of Health and Human Services explained in the comments to the regulations distinguishing psychotherapy notes from the patient's medical chart that psychotherapy notes are intended to only be a point of reference for the therapist, not documentation to communicate clinical data to other clinicians: "...*the rationale for pro-*

viding special protection for psychotherapy notes is not only that they contain particularly sensitive information, but also that they are the personal notes of the therapist, intended to help him or her recall the therapy discussion and are of little or no use to others not involved in the therapy. Information in these notes is not intended to communicate to, or even be seen by, persons other than the therapist. In addition to maintaining the confidentiality of psychotherapy notes, there are ethical, legal, and clinical matters that would give providers pause to consider before providing patients access to their psychotherapy notes.

Right of Access - Clinical and Ethical Considerations

The ethical duty of a physician is to maintain confidentiality dates as far back as the Hippocratic tradition. The legal concept of privilege is afforded to the recipient of treatment - and accordingly is their right to have their confidential information protected. Confidentiality is the duty of the physician to protect patient confidences. At the same time, mental health professionals are increasingly called upon to perform diverse tasks which test the limits of confidentiality and an individual privilege to such: analyze the suitability of individuals for child custody, to determine individual risk of harm to self/others, to establish the terms of reference for criminal guilt, to warn possible victims of the threat intended or implied that may bring harm to them - such roles and responsibilities often concern patients of potential ‘punishment’ and potentially reduce the likelihood of disclosing pertinent sensitive information.

Right of Access - Law

There is a misconception among many that HIPAA applies to all health information in the United States. In fact, privacy obligations only attach to health data when being held by an individual or entity that has a duty (physicians, most often) under an applicable law. Further, the same type of data may have different privacy obligations attached to it when held or created in different contexts. For example, information related to history and physical health could be subject to the Family Education Rights and Privacy Act (FERPA) if the treatment occurred at an educational institution, Part 2 - if treatment related to substance use disorder treatment, or HIPAA - if done during an annual exam at a patient’s primary care provider. The United States utilizes a dual federalism system of governance, which means that the power of governance is divided between the federal and state governments. The Supremacy Clause of the United States Constitution dictates the general rule that federal law is the “law of the land” and preempts any contradictory state laws. However, Congress can deviate from this general rule and defer to contradictory state laws by including provisions in statutes stating as much.

They do so intentionally in deferring to state laws in matters pertaining to right of access - such that greater privacy rights are granted to an individual receiving treatment. Thus, providers must consider federal and their state's law in determining what their exact requirements are in maintaining clinical documentation and providing access thereto. *Accordingly, if state law provides a right of access to the psychotherapy notes, they may not be withheld pursuant to the exception to the right of access for psychotherapy notes under HIPAA.*

If state law does not allow a provider to withhold psychotherapy notes pursuant to a right of access request and there is an ethical or clinical reason why it would be beneficial to withhold them, providing written summaries in lieu of the actual psychotherapy notes may be a good alternative. While normally under HIPAA, written summaries of medical records may only be provided instead of the actual records if the patient agrees in advance of the production²⁴. However, because there is no right of access to the psychotherapy notes under HIPAA, patient consent would not be required if state law does not require consent.

Navigating the clinical reality

All other information pertaining to intimate details of a patient's life (contents typical of process notes) should be kept separately for a practitioner's use only in psychotherapy notes. Integrating this information in one's practice may, at the very least, prepare them for the potential scenario in which there is a perceived conflict/risk associated with release of one's therapy process notes to a patient or third-party. In many scenarios the law accommodates clinical circumstances that pertain to providing access to psychotherapy records (see table 1). Clinical circumstances (aka the psychological wellbeing and health of the patient) are given high importance by the law, appropriately, over other areas of concern. As referred to above and in table, there are clinical circumstances where harm or providing access outweighs right to access- demonstrating such carefully through careful documentation is critical to avoid misinterpretation by the legal system. *Here are some potential factors to consider in a potential exception to right of access: the presence of characterological disturbance; relative acuity of symptoms and associated safety risk of harm to self/others; the current therapeutic alliance with practitioner and how it may be impacted by receipt of therapy notes; potential ways in which notes may be utilized (i.e., litigation) and how that may impact the patient's treatment trajectory.* As table 1 illustrates, there are no two states that are exactly alike in their definition of specific circumstances in which access can be directly or indirectly denied.

Conclusion

An individual's right to access therapy notes is a matter that is handled with meticulous attention by the spheres of medicine, ethics, and both federal and state law. While federal guidance is provided for in the HIPAA and other federal healthcare privacy laws, each state can set alternative standards and exceptions. Further complicating the matter, clinicians are not typically provided education on how to handle these sensitive matters. Proactive awareness of the guiding forces and applicability of local state regulation will assist clinicians navigate the medical-legal challenges associated with access to psychotherapy notes while providing the highest quality of clinical care.

References

1. Berner ES, Detmer DE, Simborg D. Will the wave finally break? A brief view of the adoption of electronic medical records in the United States. *Journal of the American Medical Informatics Association*. 2005;12(1):3-7.
2. Miller RH, Sim I. Physicians' use of electronic medical records: barriers and solutions. *Health affairs*. 2004;23(2):116-26.
3. Burde H. The HITECH act: an overview. *AMA Journal of Ethics*. 2011;13(3):172-5.
4. Baker A. *Crossing the quality chasm: a new health system for the 21st century*: British Medical Journal Publishing Group; 2001.
5. Nazi KM, Hogan TP, McInnes DK, Woods SS, Graham G. Evaluating patient access to Electronic Health Records: results from a survey of veterans. *Medical Care*. 2013:S52-S6.
6. Delbanco T, Walker J, Bell SK, Darer JD, Elmore JG, Farag N, et al. Inviting patients to read their doctors' notes: a quasi-experimental study and a look ahead. *Annals of internal medicine*. 2012;157(7):461-70.
7. Ross SE, Lin C-T. The effects of promoting patient access to medical records: a review. *Journal of the American Medical Informatics Association*. 2003;10(2):129-38.
8. Beard L, Schein R, Morra D, Wilson K, Keelan J. The challenges in making electronic health records accessible to patients. *Journal of the American Medical Informatics Association*. 2012;19(1):116-20.
9. Peacock S, Reddy A, Leveille SG, Walker J, Payne TH, Oster NV, et al. Patient portals and personal health information online: perception, access, and use by US adults. *Journal of the American Medical Informatics Association*. 2017;24(e1):e173-e7.

| State | Exception to access: | Statute/Notes:

| New York | Provider may deny access to all or part of the information and may grant access to a prepared summary of the information if, after consideration of all the attendant facts and circumstances, the provider determines that the request to review all or a part of the patient information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right of access to the information (18(3)(d)(i)). | PHL § 18 (3)(d)(i)

| California | The health care provider may decline to permit inspection or provide copies of psychotherapy notes to a patient if the health care provider determines there is a “substantial risk of significant adverse or detrimental consequences to the patient in seeing or receiving” such psychotherapy notes. | H&SC § 123115(b)

| Texas | The professional may deny access to any portion of a record if the professional determines that release of that portion would be harmful to the patient's physical, mental, or emotional health. | Sec. 611.0045 (Right to mental health record)

| Massachusetts | A psychotherapist may prohibit access to that portion of the mental health record generated by psychotherapist if the psychotherapist believes that access to those specific records would “adversely affect the patient's well-being”. If a psychotherapist limits access, he, or she must provide the individual with a summary of the psychotherapy records. | ‘Your rights regarding access to mental health records in Massachusetts’ (prepared by mental health legal advisors committee February 2010)

| Florida | Patients shall have reasonable access to their clinical records unless such access is determined by the patient's physician to be harmful to the patient. | Title XXIX, Chapter 394.461

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