



Harris County Hospital District

POLICY AND REGULATIONS MANUAL HIPAA ADMINISTRATIVE POLICY

Use and Disclosure of
Psychotherapy Notes

Policy No: 3.11.301
Page Number: 1 of 9

Effective Date: 041403
Board Motion No:

**TITLE: USE AND DISCLOSURE OF PSYCHOTHERAPY
NOTES**

PURPOSE:

It is the purpose of this policy to provide guidance to Harris County Hospital District (HCHD) on the Use and Disclosure of Psychotherapy Notes for Treatment, Payment, or Healthcare Operations.

This policy supports HCHD's HIPAA policy and may require development of department specific procedures.

[Key Words: Authorization, Psychotherapy Notes, Designated Record Set (DRS)]

POLICY STATEMENT:

Harris County Hospital District (HCHD) desires to ensure that Psychotherapy Notes are Used and disclosed in accordance with applicable Federal and state laws by maintaining a separate file for them from the patients' Designated Record Set (DRS).

POLICY ELABORATION:

I. DEFINITIONS

- A. Authorization - is a signed written document that allows Use and Disclosure of PHI for purposes other than Treatment, Payment, or Healthcare Operations.
- B. Designated record set - means a group of records maintained by or for the facility that is:
 - (1) The medical and billing records about patients,
 - (2) The enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan, or



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(3) Used, in whole or part, by or for the facility to make decisions about patients.

For purposes of this definition, the term “record” means any item, collection or grouping of information that includes PHI and is maintained, collected, Used or disseminated by or for the facility; the term “record” includes (a) patient information originated by another healthcare provider and used by the facility to make decisions about the patient, and (b) tracings, photographs, videotapes, digital and other images that may be recorded to document care of the patient.

- C. Psychotherapy Notes - are notes recorded (in any medium) by a mental health professional that document or analyze the contents of conversation during a private, group, joint, or family counseling session and that are separated from the rest of the patient's medical record. Psychotherapy Notes exclude the following: 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 diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

II. **USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES WITHOUT AUTHORIZATION**

- A. Harris County Hospital District may Use and disclose Psychotherapy Notes for Treatment, Payment or Health Care Operations in the following situations **without** a patient's Authorization:
1. Use by the originator of the notes for Treatment;
 2. Use or Disclosure by HCHD for its own training programs in which students, trainees, or practitioners



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in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or

3. Use or Disclosure by HCHD to defend itself in a legal action or other proceeding brought by the individual;
4. Use or Disclosure required by the Secretary of the Department of Health and Human Services (DHHS) to investigate or determine HCHD's compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulations;
5. Use or Disclosure required by law and is limited to the relevant requirements of such law;
6. Disclosure to a health oversight agency for activities with respect to the oversight of the originator of the Psychotherapy Notes;
7. Disclosure to coroners and medical examiners for the purpose of identifying a deceased individual, determining a cause of death, or other duties as authorized by law; or
8. In a belief (in good faith by HCHD) that the Disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

- B. The individual's **Authorization** is required for the Use or Disclosure of Psychotherapy Notes situations **not** listed above.



**III. USE AND DISCLOSURE OF PSYCHOTHERAPY
NOTES WITH A PATIENT'S AUTHORIZATION**

- A. The form entitled "Authorization for Use and Disclosure of Protected Health Information" (Attachment A) will be used to obtain written Authorization from individuals for Use or Disclosure of Psychotherapy Notes to carry out Treatment, Payment or Health Care Operations in situations not listed in Section II. A., Use and Disclosure of Psychotherapy Notes Without Authorization, above.
- B. An Authorization for a use or disclosure of psychotherapy notes may only be combined with another Authorization for a use and disclosure of psychotherapy notes, and may not be combined with Authorizations for the Use or Disclosure of other PHI. If the selection entitled Psychotherapy Notes on the Authorization form is checked, no other selection may be checked on the same form. All other selections must be indicated on a separate Authorization.
- C. HCHD must obtain an Authorization for Disclosure of Psychotherapy Notes to family and others involved in the individual's care.
- D. Harris County Hospital District may not condition Treatment or Payment on whether the Authorization for Use and Disclosure of Psychotherapy Notes is signed by the individual.
- E. The Authorization must include the following to be considered valid.



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1. Description of the information to be Used or Disclosed that identifies the information in a specific and meaningful fashion;
2. Name or other specific identification of the person(s), or class of persons, authorized to make the requested Use or Disclosure;
3. Name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested Use or Disclosure;
4. Description of each purpose of the requested Use or Disclosure. The statement “at the request of the individual” is a sufficient description of the purpose when an individual initiates the Authorization and does not, or elects not to, provide a statement of the purpose.
5. Expiration date or an expiration event that relates to the individual or the purpose of the Use or Disclosure. The statement “end of the research study,” “none,” or similar language is sufficient if the Authorization is for a Use or Disclosure of PHI for research, including the creation and maintenance of a research database or research repository. See– Use and Disclosure of PHI for Research;
6. Statement that the individual has the right to revoke the Authorization in writing, except to the extent that HCHD has taken action in reliance thereon; or to the extent that the information in this section F. is included in the Notice of Privacy Practices, a reference to HCHD’s Notice;
7. Statement that HCHD may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the Authorization;
8. Statement that information used or disclosed pursuant to the Authorization may be subject to re-



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- Disclosure by the recipient and no longer protected by the HIPAA regulations; and
9. Signed and dated by the individual; if the Authorization is signed by a personal representative of the individual, a description of the representative's authority to act for the individual.
- F. A copy of the signed Authorization must be given to the individual if the Authorization is requested by the Covered Entity.
- G. In addition to the above core elements and required statements the Authorization must be written in plain language.
- H. The Authorization is defective and therefore invalid and may not be acted upon if:
1. The expiration date has passed or the expiration event is known by HCHD to have occurred;
 2. The Authorization has not been filled out completely, with respect to the required elements listed in section F. above;
 3. The Authorization is known by HCHD to have been revoked;
 4. The Authorization for Use and Disclosure of psychotherapy notes is combined with an Authorization for any other PHI; or
 5. Any material information in the Authorization is known by HCHD to be false.
- I. If an invalid Authorization is received, HCHD will identify why it is invalid and return it to the requestor for completion.



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- J. If the Authorization is valid and approved, HCHD will comply with the terms of the Authorization. If the patient requests, HCHD will provide/Disclose an informational summary of the Psychotherapy Notes to the patient.
- K. An individual's Authorization for Use or Disclosure of PHI to carry out Treatment, Payment, or Health Care Operations must be maintained for six (6) years from its last effective date or longer per the HCHD Record Retention Policy.
- L. Transition Provisions: HCHD may Use or disclose PHI, i.e. Psychotherapy Notes, that it created or received prior to April 14, 2003 pursuant to an Authorization or other express legal permission obtained from the individual, provided that the Authorization or other express legal permission specifically permits such Use and Disclosure and, there is no agreed to restriction in effect.

IV. RESPONSIBILITIES

- A. The health care providers are responsible for requesting and obtaining an individual's written Authorization for Use or Disclosure of PHI for treatment, payment or health care operations on the Authorization for Use and Disclosure of Protected Health Information (See Attachment A).
- B. The patient or personal representative may also authorize the Use and Disclosure of Psychotherapy Notes for other than treatment, payment or health care operations by completing the Authorization for Use and Disclosure of Protected Health Information (Attachment A).

V. SPECIAL CONSIDERATIONS



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- A. Individual Refuses Authorization – HCHD may *not* refuse to treat the individual who refuses to sign the Authorization for Release of Psychotherapy Notes.
- B. For further instructions related to Authorizations for Use and Disclosure of PHI, see Policy 3.11.300, Authorization for Use and Disclosure of Protected Health Information for Purposes Other Than Treatment, Payment and Health Care Operations.
- C. Revoking of Authorization – The patient has the right to revoke an Authorization, see Policy 3.11.300, Authorization for Use and Disclosure of Protected Health Information for Purposes Other Than Treatment, Payment and Health Care Operations.

REFERENCES/BIBLIOGRAPHY:

- Policy 3.11.000, HCHD HIPAA Policy
- Policy 3.11.300, Authorization for Use and Disclosure of Protected Health Information for Purposes Other Than Treatment, Payment and Health Care Operations

OFFICE OF PRIMARY RESPONSIBILITY:

Office of Privacy Administration.

REVISION HISTORY:

Version 1.0 created 04/14/03.

Record revisions below:

Effective Date	Version	Approved by:

Harris County Hospital District

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION (Please Print)

Hospital Card Number:			
Patient Name:	Social Security No.	Date of Birth	Phone No.
Address	City	State	Zip Code

I, _____, authorize Harris County Hospital District to disclose and provide photocopies of the health-care information indicated below from my medical record to the following party:

Name of person(s) or company to receive information Phone Number

Street Address City State Zip Code

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

- | | | | |
|--------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Admission Sheet | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Clinic Visit |
| <input type="checkbox"/> Autopsy | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Footprints | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Radiology Report (X-Ray, MRI, Ultrasound, etc) | _____ |
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Entire Record Excluding Nurses Notes | <input type="checkbox"/> Emergency Room Sheet | _____ |
| <input type="checkbox"/> Itemized Bill | <input type="checkbox"/> Lab / Slides | <input type="checkbox"/> Radiology Film (MRI, chest X-Ray, etc.) | |
| <input type="checkbox"/> Complete Billing Record | <input type="checkbox"/> Block/Specimens | <input type="checkbox"/> Psychotherapy Notes (If this box is checked, no other box may be checked) | |

Purpose of Request/Disclosure

- Treatment or Consultation At the request of the Patient Billing or claims payment Requested for Government Benefit
- Other, (specify) _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my information requested above contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, HIV, Aids, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. Check One: Yes No

Re-Disclosure

I understand the information disclosed by this authorization may be subjected to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act 1996. This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

This authorization will expire on the following event or date _____ or 180 days from the date of signature. I understand that this authorization may be revoked by the person giving the authorization by written and dated notice to Harris County Hospital District, except to the extent that disclosure of information has been made prior to receipt of the revocation by Harris County Hospital District.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under **Purpose of Request**. I can inspect or copy the protected health information to be used or disclosed.

Signature of Patient Date Signed

Authority to Sign if not patient _____

Identity of Requestor Verified via: Photo ID Matching Signature Other, specify _____