“Psychotherapy Notes” And “Psychotherapy Records”

written by Richard Leslie | May 24, 2016

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… A reader has asked me to “write a column discussing the difference between psychotherapy RECORDS and psychotherapy NOTES addressing the issue of privilege, subpoenas, confidentiality, content etc….”

The request necessarily involves a discussion about HIPAA regulations and about state law (in this article, California law). The term “psychotherapy notes” is defined in federal regulations (the Privacy Rule) implementing HIPAA, which generally deal with the privacy and confidentiality concerns of the patient. These two terms are not defined in California law, although California law does make reference to the federal regulation defining “psychotherapy notes.” The term “psychotherapy records” is generally understood to mean the mental health treatment records that a psychotherapist creates and maintains with respect to his or her patients or clients.

“Psychotherapy notes” means notes recorded in any medium (e.g., on paper or electronically) by a health care provider who is a mental health professional documenting or analyzing the content of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical (includes mental health) record. This is the definition in the federal regulation, and it is significant to those mental health providers who are “covered entities” (also referred to herein as “covered providers”). If not a covered provider under HIPAA, then the mental health practitioner will usually be governed by state law.

While the term “psychotherapy records” is not defined in the federal regulations implementing HIPAA (the Privacy Rule) or in California law, it is generally understood to mean, among other things, those records kept by a mental health practitioner which include such matters as counseling session dates, including start and stop times, the modalities and frequencies of treatment furnished, and any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date (in other words, the general treatment record). The federal regulations provide an added degree of protection to “psychotherapy notes,” generally requiring the practitioner to obtain a written and signed authorization from the patient before releasing these “notes” to an insurer. Under HIPAA regulations, psychotherapy records (the treatment records) can be released by the covered provider to the insurer without the patient’s written authorization. The patient is informed of this exception to privacy and confidentiality by the covered provider in the required Notice of Privacy Practices form that is given to the patient.

Another interesting aspect of “psychotherapy notes” under HIPAA is that when the patient demands to

inspect his or her records, the mental health practitioner (covered provider) is not required to produce the “psychotherapy notes” for inspection by the patient. It must be remembered that these notes must be kept separate from the rest of the patient’s treatment records. If they are not, then it would likely mean that the patient would be entitled to inspection of all.

With respect to privilege and subpoenas, HIPAA regulations (the Privacy Rule) provide, in part, that before the covered entity responds to the subpoena, it must either receive a court order to release the records, or it must receive a written authorization from the patient to release the records, or it must receive documentation that reasonable efforts were made to notify the patient about the legal proceeding, providing the patient with an opportunity to raise an objection (re: the subpoena) to the court. This may be similar to state law requirements, which will usually be applicable to those who are not covered providers. Reference to the psychotherapist-patient privilege statutes of the state will become necessary. In California, the therapist is duty bound to assert the privilege on behalf of the patient when served with a subpoena for treatment records. The patient and the patient’s attorney will usually be contacted to ascertain whether they are claiming the privilege or waiving it. Usually, the practitioner will take his or her “marching orders” from the attorney for the patient. It is always important to make sure that the patient and the patient’s attorney are on the same page before releasing records pursuant to a subpoena.

Sometimes, patients are unaware of the times when the psychotherapist-patient privilege is waived by the actions of the patient or by the operation of law. When records are subpoenaed, and assuming that the privilege has been waived, the “other side” will generally be entitled to all of the records, including those that would be considered “psychotherapy notes” under the federal regulation mentioned above. The distinction between psychotherapy records and psychotherapy notes is therefore generally not of significance in state litigation. However, a state may treat this aspect of the law somewhat differently. For example, a state may have amended its laws to include provisions that mirror the HIPAA Privacy Rule provisions, including those related to “psychotherapy notes.” In most states, the patient’s attorney may seek a protective order, where the records, or certain portions of the records, may be protected from discovery – such as where the probative value of the evidence is outweighed by its prejudicial effect.