

**Texas Tech University Health Sciences Center
HIPAA Privacy Policies**

Using and Disclosing PHI	Policy 3.2
Psychotherapy Notes	Effective Date: July 20, 2010
References: 45 CFR 164.508 and 45 CFR 164.512 ; Texas Health and Safety Code, Chapter 611 ; Texas Attorney General's Pre-emption Analysis	

Policy Statement

Psychotherapy notes shall be maintained separately from other portions of the patient's medical record and shall only be used or disclosed as allowed by law and this policy.

Scope and Distribution

This policy applies to all health care clinics, research or educational activities or areas owned, operated and/or provided by Texas Tech University Health Sciences Center (TTUHSC). It does not apply to inmates seen or treated by TTUHSC providers.

Definitions

1. "Psychotherapy notes" mean notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private individual, group, joint, or family counseling session that are separated from the rest of the individual's medical record. The following ARE NOT Psychotherapy notes:
 - a. Medication prescription and monitoring;
 - b. Start and stop times of counseling sessions;
 - c. Modalities and frequencies of treatment furnished;
 - d. Results of clinical tests; and
 - e. Any summary of the following items:
 - 1) Diagnosis,
 - 2) Functional status,
 - 3) Treatment plan,
 - 4) Symptoms,
 - 5) Prognosis, and
 - 6) Progress to date.
2. "Mental health professional" means any person authorized to practice medicine in any state or nation and any person licensed or certified by the State of Texas to diagnose, evaluate, or treat any mental or emotional condition or disorder.

Procedure

1. Maintenance of Psychotherapy Notes
 - a. *Separate File.* Psychotherapy notes shall be maintained separate from the patient's general medical record. In the electronic health record (EHR) it is sufficient if psychotherapy notes are maintained in a separate folder that is only

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accessible by the mental health professional that created the note, designated medical records staff or for use allowed under paragraph 2c.

- b. *Information Placed in the Medical Record.* The following information, which is not considered psychotherapy notes, may be placed in the patient's regular medical record for audits, program evaluations, research, and/or payment purposes:
- Medication prescription and monitoring;
 - Start and stop times of counseling sessions;
 - 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.

2. Use or Disclosure of Psychotherapy Notes

- a. *HIPAA Authorization for Psychotherapy Notes Required.* Except as otherwise allowed by law and this policy, a separate HIPAA Authorization specifically limited to use or disclosure of psychotherapy notes must be obtained from the patient or his/her legal representative before psychotherapy notes can be used or disclosed.

The HIPAA Authorization for Release of Psychotherapy Notes SHALL NOT be combined with any other HIPAA Authorization or consent form.

- b. *Location of TTUHSC Approved HIPAA Authorization for Psychotherapy Notes Forms.* All HIPAA Authorization for Psychotherapy Note forms required under this policy shall be prepared, reviewed and updated by the Institutional Privacy Officer. HIPAA Authorization forms can be accessed by going to the HIPAA website (<http://www.ttuhscc.edu/hipaa/>) and from the left navigation menu selecting "HIPAA Approved Forms" and then the appropriate campus.
- c. *HIPAA Authorization Not Required.* A HIPAA Authorization **IS NOT** required for **TTUHSC to carry out its own LIMITED treatment, payment or health care operations** in the following circumstances:
- 1) For use by the originator of the psychotherapy notes for treatment;
 - 2) For use or disclosure in TTUHSC training programs in which students, trainees, or practitioners in mental health learn, under supervision, to practice or improve their counseling skills;
 - 3) To defend a legal action brought by the patient against TTUHSC or its employed mental health professionals;
 - 4) To the Department of Health and Human Services to determine compliance with the privacy rule; and
 - 5) As otherwise required or allowed by law for the following purposes:

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- To a government authority, to report information about an individual who is a suspected victim of abuse, neglect or domestic violence;
 - During the course of any judicial or administrative proceeding in response to an order;
 - During the course of any judicial or administrative proceeding in response to a subpoena, discovery request or other lawful process only if there is evidence that written notice has been provided to the patient and no objections were filed; and
 - For limited law enforcement purposes as outlined at [45 CFR 164.512\(f\)](#)
- 6) To a health oversight agency for oversight of the provider who created the notes;
- 7) To a coroner or medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties as authorized by law; or
- 8) To medical or law enforcement personnel reasonably able to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, or prevent or lessen the probability of immediate mental or emotional injury to the patient.

d. *Patient Right to Access and Denial of Access.*

Under Texas law, a patient has the right to access his or her own psychotherapy notes, which may be denied as outlined in paragraph 2) below.

- 1) Right to Access. The patient must provide a written and signed HIPAA Authorization for Psychotherapy Notes. Any patient request to access his or her own psychotherapy notes must be reviewed by the mental health professional that created the psychotherapy notes and who shall either approve or deny the request to access the psychotherapy notes.
- 2) Denial of Access. Access to psychotherapy notes may be denied if the mental health professional determines that release of the psychotherapy notes is reasonably likely to endanger the life or physical safety of the patient or another person. If access is denied, the mental health professional shall:
- Provide the patient with a signed and dated written statement that states access to the psychotherapy notes would likely endanger the life or physical safety of the patient or another person, which shall also be included in the patient's record. The statement must specify the portion of the record to which access is denied, the reason for denial and the duration of the denial.
 - Re-determine the necessity for the denial each time a request for access to the denied portion of the patient's record is made.

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Approval Authority

Questions regarding this policy may be addressed to the Regional Privacy Officer ([Amarillo](#), [El Paso](#), [Permian Basin](#)), the [Institutional Privacy Officer](#), or the [Institutional Compliance Officer](#).

Responsibility and Revisions

This policy may be amended or terminated at any time to address changes in law or processes at TTUHSC.