USE AND DISCLOSURE OF MENTAL HEALTH RECORDS

Policy Number: [Enter]  
Effective Date: [Enter]

I. Policy:

A. Purpose

This policy establishes guidelines to be followed by [Organization]’s workforce when using or disclosing Mental Health Records, including Psychotherapy Notes.

B. Policy Implementation—General Rule

[Organization] must obtain patient consent prior to disclosing Mental Health Records, unless an exception to the consent requirement under Minnesota law applies. Workforce should refer to policy [enter], Consent to Use and Disclose Health Information under Minnesota Law, for more information about disclosures under Minnesota law and these exceptions.

Although disclosure of Mental Health Records is generally permitted with patient consent, special rules do apply to certain types of records (e.g., Psychotherapy Notes) and certain disclosure scenarios (e.g., disclosure to law enforcement). Many of these special rules are set forth in this policy.

The terms “Mental Health Records” and “Psychotherapy Notes” have different meanings. “Mental Health Records” is not defined under Minnesota Law. It is a broad term that refers to information, whether oral or recorded, that relates to the past, present, or future mental health or condition of an individual. Minnesota has specific rules that apply to the disclosure of Mental Health Records in certain circumstances. Several examples of these circumstances are described in this Policy (Sections E-G).

In contrast, “Psychotherapy Notes” has a very specific definition under HIPAA and means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a 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 record. “Psychotherapy Notes” excludes 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 terms: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

C. Use or Disclosure of Psychotherapy Notes
[Organization] must obtain HIPAA authorization for any use or disclosure of Psychotherapy Notes. As described in Section B, the term “Psychotherapy Notes” is specifically defined under HIPAA.

However, authorization is not required for the following Uses and Disclosures of Psychotherapy Notes:

1. Use by the originator of the Psychotherapy Notes for treatment;
2. Use or disclosure by [Organization] for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family or individual counseling;
3. Use or disclosure by [Organization] to defend itself in a legal action or other proceeding brought by the individual;
4. Use or disclosure that is required by the Secretary to investigate or determine [Organization]’s compliance with the HIPAA Privacy Rule;
5. Use or disclosure that is Required by Law;
6. Use or disclosure by [Organization] for health oversight activities to health oversight agencies with respect to the oversight of the originator;
7. Use or disclosure about decedents to 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
8. Use or disclosure to avert a serious threat to health or safety pursuant to 45 C.F.R. § 164.512(j)(1)(i).

For information regarding the content of the authorization and other information about HIPAA authorization forms, refer to policy number [Enter], Authorization for Use and Disclosure of PHI.

Minnesota Law. Minnesota law generally requires patient consent prior to disclosing Health Records, which includes Psychotherapy Notes. In situations where [Organization] is not required to obtain HIPAA authorization for the disclosure of Psychotherapy Notes, [Organization] must nonetheless address Minnesota law by either obtaining patient consent permitting the disclosure or meeting an exception to the consent requirement. If [Organization] obtains HIPAA authorization for the release of Psychotherapy Notes, this consent requirement is satisfied. However, the consent requirement is not satisfied when the disclosure scenario falls within an exception to the authorization requirement under HIPAA unless the basis for disclosure without authorization also qualifies as basis for a permitted disclosure without consent in Minnesota.

For more information on consent requirements under Minnesota law, refer to policy [enter], Consent to Use and Disclose Health Information Under Minnesota Law.
D. Use and Disclosure of Substance Use Disorder Records

If an individual’s Mental Health Record contains substance use disorder information subject to 42 C.F.R. Part 2 (the federal Confidentiality of Substance Use Disorder Patient Records regulations), [Organization] must comply with the stricter Part 2 requirements for this information. Specifically, [Organization] may not use or disclose any information about an individual unless such individual has consented in writing on a form that meets the requirements of Part 2, or unless another limited exception applies. A Part 2 consent form is different from an authorization under the HIPAA Regulations—thus, [Organization] and its workforce must be sure to use the appropriate form.

Additional information can be found in policy number [Enter], Disclosures of Substance Use Disorder Patient Records.

E. Communicating with a Patient’s Family, Friends, or Other Persons who are Involved in the Patient’s Care

As described in Section 1.B, Mental Health Records are subject to the same requirements related to consent as other types of Health Records. Minnesota law establishes several specific rules related to additional categories of disclosures of Mental Health Records, however. For example:

1. General Rule

Regardless of the general requirement under Minnesota Law to obtain consent for disclosing Health Records, when providing mental health care and treatment, [Organization] may disclose certain types of information to the patient’s family member or other caretaker who requests the information when the following requirements are met:

1. The request is in writing;
2. The family member or other person lives with, provides care for, or is directly involved in monitoring the treatment of the patient;
3. The involvement of the family member or caretaker is verified by [Organization] or a person other than the person requesting the information, and is documented in the patient’s medical record;
4. Before the disclosure, [Organization] informs the patient, in writing, of:
   a. The request;
   b. The name of the person requesting the information;
   c. The reason for the request; and
   d. The specific information being requested
5. The patient agrees to the disclosure, does not object to the disclosure, or is unable to consent or object, and the patient’s decision or inability to make a decision is documented in their medical record; and

6. The disclosure is necessary to assist in the provision of care or monitoring of the patient’s treatment.

The information that may be disclosed under this exception is limited to:

1. Diagnosis;
2. Admission to or discharge from treatment;
3. The name and dosage of the medications prescribed;
4. Side effects of the medication;
5. Consequences of failure of the patient to take the prescribed medication; and
6. A summary of the discharge plan.

However, if [Organization] reasonably determines that providing the above information would be detrimental to the physical or mental health of the individual whose information is to be disclosed, or is likely to cause the individual to inflict self-harm or harm to another, [Organization] must not disclose the information.

**HIPAA.** HIPAA allows providers to communicate with a patient’s family members, friends, or other caretakers in certain circumstances. Specifically, if the patient is present and has capacity to make health care decisions, HIPAA permits a provider to disclose information to caretakers if the provider: (1) gives the patient the opportunity to object to the disclosure (and the patient does not object); (2) reasonably infers from the circumstances, based on professional judgment, that the patient does not object; or (3) the patient agrees to the disclosure.

If the patient is not present or is incapacitated, HIPAA permits providers to share information with caretakers if the provider determines, based on professional judgment, that sharing the information is in the best interests of the patient. In this scenario, the provider may only disclose information that is directly relevant to the caretaker’s involvement with the patient’s care or payment for care.

However, the HIPAA rules described above are limited by the Minnesota law requirements, described in Section E(1), on the disclosure of Mental Health Records. Consequently, [Organization] and its workforce must comply with Minnesota law prior to disclosing Mental Health Records to a patient’s caretaker.

2. **Written Request of a Spouse, Parent, Child or Sibling**

Upon the written request of a spouse, parent, child, or sibling of an individual being evaluated for or diagnosed with mental illness, [Organization] must ask the individual
whether he/she wishes to authorize the spouse, parent, child, or sibling to receive information regarding the individual’s current or proposed course of treatment.

If the individual so authorizes, the provider will communicate to the designated individual the person’s current and proposed course of treatment. Such consent is valid for one year or for a period specified in the consent or for a different period provided by law.

F. Emergency Situations

1. Mental Health Records

[Organization] may disclose Mental Health Records without obtaining prior consent from the patient, or complying with rules set forth in Section E above, if the situation satisfies the “emergency exception” under Minnesota law. The “emergency exception” permits disclosure without patient consent if:

   a. The patient is experiencing a medical emergency; and
   b. [Organization] is unable to obtain the patient’s consent to disclosure due to:
      a. The patient’s condition; or
      b. The nature of the medical emergency.

If these elements are satisfied, [Organization] and its staff may disclose Mental Health Records without patient consent. However, if these elements are not satisfied [Organization] must obtain patient consent or fall within a different exception to the consent requirement under Minnesota law. For more information on consent requirements under Minnesota law, refer to policy [enter], Consent to Use and Disclose Health Information Under Minnesota Law.

2. Psychotherapy Notes

[Organization] may disclose Psychotherapy Notes in an emergency situation if:

   a. [Organization] obtains HIPAA authorization; or
   b. The disclosure falls within an exception to the HIPAA authorization requirement for psychotherapy notes and:
      i. The scenario qualifies as an “emergency exception” under Minnesota law, as set forth above in Section I.F.1;
      ii. The disclosure qualifies as a disclosure for which there is specific authorization in law pursuant to Minn. Stat. § 144.293, subd. 2(2); or

Exceptions to the HIPAA authorization requirement are set forth in Section I.C. The exception set forth in Section I.C.8 is particularly relevant in the context of an emergency (use or disclosure to avert a serious threat to health or safety pursuant to 45 C.F.R. § 164.512(j)(1)(i)). Under this authorization exception, [Organization] may disclose
Psychotherapy Notes without obtaining HIPAA authorization if [Organization], in good faith, believes that the use or disclosure:

i. Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

ii. Is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

G. Disclosures to law enforcement

[Organization] must disclose Mental Health Records to a law enforcement agency if the law enforcement agency provides the name of the patient and communicates that:

1. The patient is currently involved in an emergency interaction with the law enforcement agency; and

2. The disclosure is necessary to protect the health or safety of the patient or another person.

If these requirements are satisfied, [Organization] must disclose the Mental Health Records. However, the disclosure must be limited to the minimum necessary for law enforcement to respond to the emergency.

If a disclosure is made the law enforcement agency is required to maintain a record that describes who made the request, the fact that [Organization] provided the information, and the patient’s name. The health records will remain private data on individuals under the Minnesota Data Practices Act and cannot be used by law enforcement for any other purpose.

Substance Use Disorder Records. Special rules apply disclosures of substance use disorder records to law enforcement. Workforce should consult with the compliance officer/privacy officer/other designee prior to disclosing substance use disorder records to law enforcement.

II. Procedure:

Prior to disclosing Mental Health Records, [Organization] staff should do the following:

A. Determine what types of records are involved: (1) general Mental Health Records; (2) Psychotherapy Notes; and/or (3) substance use disorder records. Follow the procedures for each set forth below.

B. General Mental Health Records (without Psychotherapy Notes or substance use disorder records)

1. Obtain patient consent to the disclosure (or confirm whether existing consent addresses the disclosure);
a. Consent must be in writing, signed, and dated;

b. Make a copy of the consent form for the patient’s chart/file

2. If patient consent cannot be obtained, determine whether the situation falls within an exception to the consent requirement;

   a. If the situation does fall within an exception to the consent requirement, disclosure is permitted.

   b. If the situation does not fall within an exception to the consent requirement, staff must not disclose the records.

C. Psychotherapy Notes

   1. Authorization:

      a. Complete [Organization]’s template Authorization Form assuring that all blanks are completed;

      b. Review the form and rationale for use and disclosure of PHI with the patient;

      c. Request that the patient sign and date the form; and

      d. Make a copy of the completed and signed form for the patient’s chart/file; or

      e. If presented with a different authorization form from the requesting authority, verify that the form is valid and place in the patient’s chart/file.

   2. Exception to Authorization: determine whether provider qualifies for an exception as outlined in Section I.C of this policy and the Privacy Rule.

D. Substance Use Disorder Records

   1. Obtain the patient’s consent to disclosure that satisfies Part 2 requirements;

      a. Make a copy of the consent form for the patient’s chart/file

   2. If Part 2 patient consent cannot be obtained, determine whether the situation falls within an exception to the Part 2 consent requirement;

      a. If the situation does fall within an exception to the Part 2 consent requirement, disclosure is permitted.

      3. If the situation does not fall within an exception to the Part 2 consent requirement, staff must not disclose the records.

B. Follow the procedures set forth in this policy for any unique disclosure scenarios.
C. If a disclosure is made:

1. Make copies only of the information identified to be used or disclosed and agreed upon by the patient on their authorization/consent form;

2. Document the disclosure in the patient’s record and/or on the [Organization] Accounting for Disclosure of PHI.

3. Provide the information to the requesting individual in a non-digital mode, i.e. fax or mail.