Social Workers and Psychotherapy Notes

Introduction

To the extent that previously there was uncertainty within the mental health professions as to the acceptability of creating a set of private notes separate from the primary clinical record, this has largely been dispelled by the "psychotherapy notes" provisions of the Health Insurance Portability and Accessibility Act of 1996 Medical Privacy Regulations (known as the HIPAA Privacy Rule) (*U.S. Department of Health and Human Services (DHHS),* 2002).

Although social workers and other health care practitioners are increasingly well-informed about HIPAA Privacy Rule requirements, many are unaware of the implications of keeping (or not keeping) separate psychotherapy notes, while others may be confused. This Legal Issue of the Month article seeks to inform social workers as to the current understanding of the federal definition of psychotherapy notes and their usage in practice.

Psychotherapy Notes Defined

What's in the Psychotherapy Notes File?

The HIPAA Privacy Rule recognizes the unique characteristics of "psychotherapy notes" and defines them as notes that are:

- Recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session; *and*
- Separated from the rest of the individual's medical or clinical record (*DHHS,* § 164.501).

Thus, any additional privacy protection that may be available to clients' psychotherapy notes depends on whether the notes are maintained separately from the rest of the clinical file. This has been interpreted to mean in a separate file (paper or electronic), rather than a sub-section of a file. The underlying rationale is that the notes are intended primarily for use by the direct treating clinician. Access to the notes should be limited to the primary clinician.

What's in the Primary Client File or Medical Record?

Under the Privacy Rule, the definition of "psychotherapy notes" does not include session start and stop times, modalities and frequency of treatment, medication monitoring, clinical tests, or summaries of diagnosis, prognosis, treatment plan, or progress (*DHHS*, § 164.501).

If a social work practice decides to maintain separate psychotherapy notes, all of the excluded material listed above would be maintained in the primary client file or "medical record," while the psychotherapy notes would be kept elsewhere. Thus, the primary client chart would include, as applicable:

- Medication prescription and monitoring;
- Counseling sessions start and stop times;
- The modalities and frequencies of treatment furnished;
- Results of clinical tests;

- Any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date;
- Intake information;
- Billing information;
- Formal evaluations;
- Notes of collateral contacts; and
- Records obtained from other providers.

The above information would be considered the "medical record" for HIPAA purposes and subject to disclosure with a general consent or authorization to release information, as required by the *NASW Code of Ethics.* A sample HIPAA authorization form is available for members on the NASW Web site at www.socialworkers.org/hipaa

Are Psychotherapy Notes Mandated by HIPAA?

No, the Privacy Rule does not require practitioners to maintain any notes that are separated from the main record. Although separating the notes provides additional privacy protection in the event of a request for disclosure by a third party, it is not a HIPAA violation to maintain a single, integrated file of notes and records for clients. It is important, however, for social workers to understand the implications for client privacy when making decisions about how to maintain clinical notes and records. As to the professional responsibility for clinical social workers to take session notes, that issue is addressed elsewhere.

Additional Privacy Protection for Psychotherapy Notes

Under the Privacy Rule, in order for separately maintained psychotherapy notes to be released, the client must sign a separate authorization form. This means clients will be more aware as to when such a specific request has been made, and clinicians can provide clients an opportunity to consider whether or not they wish to sign a separate authorization for release of psychotherapy notes. Thus, if a clinician receives a request for "all records" or the "complete medical record," along with a signed authorization, this is not sufficient to release separately maintained psychotherapy notes. A separate signed authorization, specific to the psychotherapy notes is required. This provides additional protection from routine disclosure of the notes to third parties, such as insurers.

Health plans and clinicians may not require clients to sign an authorization to release psychotherapy notes as a condition of providing treatment or coverage for treatment (*DHHS,* §164.508(b)(4)).

Also, keeping separate notes may provide some additional privacy protection for minor clients, in the event of a request for access by parents, although this subject requires further study. There is no federal right for patients to access separately maintained psychotherapy notes (*DHHS,*§ 164.524 (a)(1)(i)) . Because parents act under HIPAA as the representatives for their children in exercising privacy rights, denying access to separately maintained psychotherapy notes would not violate HIPAA. The requirements for parental access to separately maintained psychotherapy notes under state law and how state law interacts with HIPAA in that situation is less clear.

Exceptions to HIPAA Protection

Under the Privacy Rule, psychotherapy notes are protected from release to business associates and law enforcement officials, as well as the client. However, HIPAA permits release without a client's consent in certain circumstances:

- When needed to defend a lawsuit against the therapist by the individual who is the subject of the notes (*DHHS,* § 164.508 (a)(2)(i)(C));
- To HHS when required for enforcement of the Privacy Rule (*DHHS,* § 164.508 (a)(2)(ii));
- When required by law (*DHHS,* § 164.512(a));
- When needed for oversight of the provider who created the notes (*DHHS,* § 164.512(d));
- To a coroner or medical examiner (*DHHS,* § 164.512(g)(1));
- When needed to avert a serious and imminent threat to health or safety (*DHHS*, § 164.512(j)(1)(i)).

It is important for social workers to understand that in the event they receive a subpoena for client notes and records they must take steps to protect the client's confidentiality. However, in the event a court orders disclosure of a client's clinical information, it may include disclosure of the psychotherapy notes, even if they are separately maintained.

The Influence of *Jaffee v. Redmond*

The U.S. Supreme Court's *Jaffee* decision was a significant factor in creating special protections for psychotherapy notes in the Privacy Rule. When promulgating the Privacy Rule, DHHS noted the particular intrusion of privacy "when records reveal details about a person's mental state, such as during treatment for mental health" and went on to reference *Jaffee* and the Supreme Court's recognition that "all fifty states have adopted some form of the psychotherapist–patient privilege" (65 Fed.Reg. at 82,464). Responding to public comments about the regulations, DHHS explained,

[W]e have provided additional protections for psychotherapy notes because of *Jaffee v. Redmond* and the unique role of this type of information. . . . As we have defined them, psychotherapy notes are primarily of use to the mental health professional who wrote them, maintained separately from the medical record, and not involved in the documentation necessary to carry out treatment, payment, or health care operations (65 Fed.Reg. at 82,652).

Analysis and Conclusions

The Federal recognition of a special status for psychotherapy notes is significant because the HIPAA regulations are far reaching, create a single Federal definition and standards, provide penalties for violations, and create special protections for "psychotherapy notes." The new Federal definition is also clearer and more specific than most state definitions issued to date.

Although the Privacy Rule does not mandate whether clinicians should maintain psychotherapy notes, it provides a mechanism for increased confidentiality of client information if notes are separated from the primary client file or "medical record." Thus, if feasible, having HIPAA psychotherapy note protections available will facilitate the social worker's ability to meet HIPAA and other privacy standards.

References

U.S. Department of Health and Human Services (DHHS). (2002, August 14). *Standards for privacy of individually identifiable health information: Final rule.* 45 CFR Parts 160 and 164. *Federal Register* 67, no. 157. (Regulation Text, Unofficial Version, December 28, 2000 as amended: May 31, 2002, August 14, 2002, February 20, 2003, and April 17, 2003) [Online]. Retrieved from http://www.hhs.gov/ocr/combinedregtext.pdf on May 30, 2006.

65 Fed.Reg. 82,462 (2000).

Resources

Jaffee v. Redmond, 518 U.S. 1 (1996).

Polowy, C. I., Morgan, S. & Gilbertson, J. (2005). *Social workers and subpoenas*. National Association of Social Workers. Washington, DC: NASW Legal Defense Fund Law Note Series.

Polowy, C. I. & Morgan, S. (2001). *Social workers and clinical notes*. National Association of Social Workers. Washington, DC: NASW Legal Defense Fund Law Note Series.

Polowy, C. I. & Gorenberg, C. (1997). *Client confidentiality and privileged communications*. National Association of Social Workers. Washington, DC: NASW Legal Defense Fund Law Note Series.