

**Webinar Title: Best Practices for Managing Risks Associated with Records Requests**

**Date/Time: Wednesday, September 17, 2025 at 1pm ET**

**Moderator:** Hello, and welcome to today's webinar, Best Practices for Managing Risks Associated with Records Requests. This topical webinar is paid for by American Professional Agency, the sole, authorized, and preferred provider of professional liability insurance for APA members. Some important points before we get started. Allison Funicelli and Cara Staus, two of today's presenters, have a working relationship with Allied World, underwriter for the American Professional Agency. As such, they have both a financial and intellectual interest in the webinar content.

The purpose of this presentation is to provide a balanced view for managing risks associated with a request for records. APA does not endorse any products or services. The content was created by the risk management experts at Allied World and does not reflect the views of APA or its editorial staff. Email [advertising@apa.org](mailto:advertising@apa.org) to learn more. The information in this topical webinar will be from a risk management perspective and not from a clinical perspective. This presentation does not constitute and should not be relied upon as legal or clinical advice and should not be used as a substitute for obtaining personal legal or clinical advice and consultation prior to making decisions.

Next, this program does not offer CE. However, we will email everyone watching live today a certificate of attendance. Certificates will only be issued to those who watch for a minimum of 45 minutes. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. During our time together, you will be on mute. You can communicate with us using the Q&A box located on your webinar screen. The Q&A is enabled for attendee interaction with submitted questions. Attendees can view all submitted questions and upvote those they find important.

This helps the presenters identify questions that many attendees want answered. A link to the presentation slides will be posted in the chat box of your webinar screen. If you miss them, don't worry. We will email them to you with the recording. Now, let me introduce our presenters. First, Allison Funicelli. She is Assistant Vice President, Risk Management Group, AWAC Services Company, a member company of Allied World. Cara H. Staus, who also is an Assistant Vice President, Risk Management Group, AWAC Services Company, a member of Allied World. Welcome, Allison and Cara.

**Allison Funicelli:** Thank you, everyone. We're going to be talking about release of protected health information. That will be the focus of our presentation today. What are the objectives? We're going to be identifying the risks associated with releasing protected health information. We'll go over some common scenarios and requests for records and how to handle them. We'll explain HIPAA and the Right to Access, including privacy and confidentiality. We'll apply risk management best practices when releasing protected health information and releasing health records.

Next slide, please. Let's talk about some key definitions here, just so we make sure we're all on the same page. The protected health information, or PHI, or EPHI, if it's in an electronic format, that's basically the identifiable information that identifies the health information tied to a specific person. We want to do what we can to protect a person's protected health information. The designated record set. There is a legal definition of that.

Basically, the designated record set is a group of records maintained for a particular patient that includes their progress notes and treatment records, what we consider the meat of the medical records, billing records, and then any other health information that the provider relies on when they're providing care and treatment to a patient. That may also include, if you get records from, say, their previously treating therapist, or, say, their psychiatrist, or PCP, and you rely on the information provided and you incorporate it into your records, those would be deemed now part of the designated record set.

If we use the term EHI, that just means we're talking about electronic version of the health information. Then, if we use EHR or EMR, we're referring to the electronic health record or electronic medical record versus paper records. Then we'll be talking about state privacy laws. State privacy laws may be more restrictive than the federal laws. We always advise that you follow whatever is the most restrictive laws that apply to the situation. Then we're going to talk a little bit about confidentiality and privacy, and privilege. Confidentiality is where you, as a provider, have the duty to protect the information of a patient, their protected health information.

It's agreement that you have with your patient. You share with me privileged information, private information, and I will agree to keep it confidential. Privacy is the information that the patient has that they control. They can control who releases their information. Then privilege is a legal term, and that has to do with the legal protection against disclosure of confidential information, not having an unauthorized release of it. Some more definitions we have here. Oh, sorry. Next slide. Minimum necessary. You're going to hear Cara and I use that term throughout the presentation.

What minimum necessary means is the minimum necessary information required to disclose for the circumstances. We'll talk about minimally disclosing to certain types of people, especially when it's outside the patient's consent. We'll be talking about really just focusing on what's being asked, focusing on the ask, and only releasing that information. Payment treatment operations. That's a term you may hear that's used under HIPAA. For example, health insurers or healthcare facilities, they control payment treatment operations. Under HIPAA, information can be shared under those categories without specific patient consent, so that you can get paid, you can contact a health insurer, especially if you're in network.

A covered entity is somebody that is required to comply with HIPAA. Most healthcare professionals are considered covered entities and must comply with that law. A business associate is somebody who is not typically a medical professional, usually another third party that does work on behalf of a covered entity. It's always important that you get a business associate agreement from those third parties that you contract with that may have access to protected health information. That would

include your telehealth company, whatever that platform is, if you use an EMR, if you use a collections or billing company, et cetera.

The HITECH Act that was created, again, to deal with HIPAA and privacy and protected information from a technology standpoint, it was really directed for the EHR and EMRs. Then the 21st Century Cures Act was enacted in 2016. It prohibits the practices that interfere with patient access. Remember, patients can control their records. They technically are the owners of the records. You are the custodian of the records. We can't unreasonably, and we'll get into more detail, withhold information. The 21st Century Cures Act has details about no information blocking the patient from accessing it, except under certain circumstances.

Then they define information-blocking actors are those folks who are in the process of or are basically blocking the information. Cara? Oh, sorry. I apologize. Next slide. [laughs] What components make up a complete record? The record, as I talked about already, is it includes the health record, the progress notes, billing records, records related to communications with health insurers, health plans, case management records. Then any other records that are used to make decisions about the patient, those are basically deemed part of the complete medical record. I'm sorry. Next slide, Cara.

**Cara Staus:** Thanks, Allison. Psychotherapy notes versus the health record. As we prepared this presentation today, there's certain, as Allison mentioned, terms you're going to hear us talk about. It's important to discuss these elements of the health record. Designated record set terminology. Psychotherapy notes, obviously, in the practice of psychology, are often used. They are typically defined as your observations, any hypotheses, your thoughts, or feelings related to the therapy session, and are kept separate from the health record and billing records.

By keeping separate, it affords a greater protection under HIPAA in most situations. Separate and distinct. If you are using an electronic version, if it is on a different tab, clearly label that these were psychotherapy notes, or in paper, a separate folder in how you are filing and recording records. We say it has an added protection under the federal statute to where it doesn't have to be disclosed under certain circumstances. However, it's important to note that your state statute may have the ability for a patient to access and request those psychotherapy notes.

You'll hear Allison and I throughout the presentation really focus on the federal and state statutes. It's very important that you are familiar with those statutes because there is no one uniformity. As Allison said, the state that has more restrictive guidelines is the one you need to follow versus HIPAA federal standards. Again, if you have sensitive information that you're keeping on file, it's probably best served to put it in that psychotherapy notes and keep it separate from that progress note. Again, for example, if you are providing therapy and someone discloses potential infidelity, how are you capturing that? Should it belong in the regular process note?

That could be viewed and accessed with other individuals. You could certainly document and say that the individual is having concerns about the relationship with their significant other, and then in your separate observations, keep separate in the psychotherapy notes. For your progress notes, health record, it's called a lot of things. Some people call them process notes. The items that typically are in there is

obviously your dates of service, evaluation test results, what is their status, their treatment plan, diagnosis, prognosis, what is your modality and frequency of treatment appointments, therapies, any symptoms, summary of progress.

Keep in mind this last bullet of other communications, email, voicemail, texts, and referrals. If anything is related to the care, the therapy of the individual, that needs to be incorporated into the health record. If somebody does request their record, if you have email communications or texts, it needs to be captured in that because that is considered part of the actual record. Next slide, please. Who may consent to the release of this protected health information? Obviously, the patient. Under Right to Access, the patient has the right to access their record in accordance with right to access under HIPAA.

The parents of a minor. It's important to recognize that married parents may ask for records, divorced or legally separated. It's important to point out that just because parents are divorced or separated, and the child may be living with one parent, and that parent is bringing them to appointments or participating in the therapy, doesn't mean the other parent doesn't have a right to access their health record. That's an important distinction because a lot of times you may not have interaction with this other parent, or there may be other factors. Be sure that you obtain a copy of that custody agreement that clearly delineates who has the right to consent and the right to access that health information.

A legal guardian or the guardian ad litem. Again, in contentious situations, there may be a court-appointed individual that may have a right to access the notes that you are providing through therapy. Be aware of the age of consent in your state. Minors have the ability to consent, I think as young as 12 in one state in the US. Be familiar with that. If you are a member of PSYPACT and utilizing your PSYPACT abilities, be aware of the consent and regulations in the states in which your patients are located. Conservators, power of attorneys, and healthcare representatives.

Again, if there is a conservator, guardian, someone that has guardianship over an individual, make sure that you obtain the legal document that states that that individual is the one responsible for making decisions. A power of attorney or healthcare representative, keep in mind that those documents could consent to the release. However, if the individual has the ability to consent on their own, they may also say to you, "No, I don't want it to go to this person," or "Yes, I do." Again, reference what the patient is consenting to, but also any legal documents that support their access.

Then, an executor, administrator of the estate. A lot of times, following death, the courts, the probate courts, will identify and name a person to handle the administrative affairs. It might be called something else in your state. Those are just some of the common terms. Again, HIPAA does follow in death. Those individuals, if appointed by the court, will act as if they were the patient. They would have the right to access information if the court deems them the responsible party.

Next slide, please. What should you include in an authorization? It's important to always have an authorization that you're giving your patients in your practice for releasing information. It's something that you should have readily available, and as part of the start of care, probably talk about who can you release information to. It

should include what information is to be disclosed. A lot of templates out there. You can certainly find templates that include access to mental health records. Obviously, that's important in the treatment of psychology. Substance abuse is another checkoff. Maybe billing records is another item to check off.

Again, what information are they looking to access? The individual authorized to make the disclosure. We just talked about who is authorized to access the information. Then you would be the one disclosing the records. Who's the recipient? If they want it sent to an attorney or a third party, make sure that they're clearly stating who that individual is and providing the mechanism of how you should send that record. Then purpose of disclosure, there's an asterisk there, and the reason for that is that the patient does not have to provide you with a reason why they want the records. Under HIPAA, they have a right.

Although some individuals might say, "It's for disability, it's for a legal matter, I was in a car accident," they don't have to. You cannot withhold access to records simply because they haven't provided you with the purpose and the use of that record. Have dates of expiration for that authorization. Some people might have an open-ended or they might limit it to one year of access that you're allowed to share information. Then any statements on your form regarding the ability for the patient to revoke their consent, and also make them aware that once the records leave your possession, there may be redisclosure, meaning somebody else, if it's going to a third party, might send it off.

Again, you're responsible for the records while they're in your possession as the keeper and custodian of the record. Once they leave your possession, they're the patient or that third party's responsibility. Next slide. Record-keeping. Obviously, record-keeping is a huge portion of your job through documentation in the health record. It's important to refer to your professional and state regulatory guidelines for record-keeping, such as documentation, what you should be documenting, and how long you should be documenting. State statutes. Each state has statutes for record retention, so be aware of that.

If your state is silent, then it is recommended that you look into HIPAA. HIPAA is a six-year. However, if you are accepting forms of Medicare or Medicaid, there's a 10-year retention guideline. Always err on the side of caution if your state is silenced and you are accepting insurance. Make sure you're referencing those guidelines so that you are retaining records appropriately. Also, know that there is distinctions for record retention for minors, a lot of times to the age of majority, and then additional years beyond. HIPAA does have requirements for an accounting of disclosures.

Really, what that accounting of disclosure is, is anytime you're releasing the record to a third party outside the normal treatment payment and operations under HIPAA. If you did get a request from a disability provider, keep an accounting of that, that I gave the record to. It is simple as you could use an Excel spreadsheet or document in the record that you released the record. Again, keep track of that. That is part of the record and your responsibilities under HIPAA. Be aware that there are HIPAA-compliant processes for destroying records.

How you destroy them, whether it's a cross-shredder or a strip-shredder or burning records, there are HIPAA-compliant processes for destroying records. Then

destruction log. Keep a log when you destroy records due to statute of limitations in your state. Make sure you're keeping a log of when you destroyed the record. In the event you get asked for a record beyond the retention period, you have something to go and fall back on on the date you actually destroyed the record. Next slide, Allison.

**Allison:** As Cara was just talking about the requirements for releasing information, do you have a release form that specifically says for the release of mental health information? Sometimes somebody may be in a car accident, as we mentioned before. The attorney has their client come in and sign 10 forms. Then they themselves, the attorney, will fill in who they send them to, all the different providers. It may just be a general release of medical records. We always recommend that it says specifically for the release of mental health information.

Now, it may be a general form, and they check off a box that says mental health, and that would suffice. You also can ask your patient to sign your release form as well, if you feel more comfortable doing that. Consider adding language about release of information in your general consent forms. Who can you release information to? Under what circumstances? How your process works for your practice? If you're going to be charging, it's always good. Think also about the No Surprises Act. What are your fees? It's always good to disclose all that stuff up front.

Were the records reviewed directly with the patient? It may be routine records, and the patient might say, "Go ahead and release them." If there's something in there that you have a concern that might get released, you may want to have a conversation with the patient so that they're aware of what's in the documentation that they're consenting to be disclosed to a third party. Will the releasing of the records create harm to patient or others? We get calls from time to time on our helpline where "My patient's not going to like what I wrote. I don't want to give them the records."

We can't withhold records because they're not going to like what we write or what diagnosis we're given. The only way you can really block outside of some other situations, which we'll get to later, if a patient themselves wants to see their records, they're entitled to that unless there's more likely than not physical harm will come to them or others. When in doubt, you're not sure if you should release records or withhold records as well, ask a practice attorney. It's good for providers to have a healthcare lawyer that they have a relationship with that's licensed in their state, that they can ask legal questions that apply to them in their specific state.

If you practice in multiple states, you might need to have multiple attorneys or a law firm that has attorneys that are located in multiple states, specifically working in healthcare. Ask your risk professionals. Your malpractice carrier should have a risk management department you can consult. If you work at a facility, there's usually somebody that wears a risk management hat or a general counsel that you can ask these questions to, so we make sure we're in compliance. Then certainly, we want to confirm where the records are going to be sent and how we're going to send them.

Next slide. What about permitted disclosures without authorization? We had talked a little bit before about treatment payment and healthcare operations. Generally, if you get a request for records from a patient's health insurer that they want records, generally, under HIPAA, you're allowed to release them. Again, keep in mind, what is

the ask? Only give them that, and can the ask be pared down? Especially, some of these health insurers have third-party companies that they're using, and they may just say, "Give us the records. You've been treating somebody for five years."

They don't need five years of records. Do they only need the last couple of visits, or would a treatment summary suffice? If you just go ahead and release a summary, I just want to prevent you from wasting your time if you do that, thinking that they'll accept that. I would just ask upfront because if you go through the task of summarizing records and then it turns out that's not going to suffice, we might try to avoid that. Again, what are they asking for? You can tell the health insurer, "There is some super-sensitive information that was shared with me. I'm not going to disclose that information."

Most of the time, that's fine. They're not really trying to get into the nitty-gritty of someone's therapy. They're trying to get the information they're required under their own laws and statutes that they have to follow for proper auditing. Again, you may be permitted to disclose without authorization because there might be a certain law or statute, or regulation, or there's a court order. If you receive a court order or you think there's a law that is allowing you to submit records to somebody without the patient's permission, again, we always recommend that you consult an attorney. It's the best way to go.

If you do get court orders or subpoenas, and we'll talk a little bit about what's the difference of those two, it's always good to talk to your malpractice carrier or your facility if you work for an organization about what the process is and if they have services that are available to help you to respond. You may be required to disclose information under mandatory reporting, you're mandatory reporters. It's required in all states that you mandatory report child abuse or child neglect. Then, depending on the state you're in, you may have mandatory reporting obligations for certain things that may affect adults, or you may have a duty to warn situation.

Again, duty to warn varies from state to state. Does it fall under that category, and if so, again, providing that minimum necessary information. For law enforcement purposes, same thing. If law enforcement's coming to you because they're investigating a crime or they're investigating the death of your patient, there may be certain circumstances that you can decline to give information to law enforcement, and then other information where they're trying to protect patient safety. Again, you would give them what they need under those circumstances, and just the minimum of what they need.

With all these folks, including I'll talk about medical examiners too, but you could take a pause. If someone's pressuring you to do something immediately, you could say, "Let me do some research and I'll get back to you." Then you can go consult somebody. Don't feel that you immediately have to respond. Take that breath, take that pause, and get some advice before you do what you're going to do. Then, medical examiners generally have the right to receive information that they need to determine cause of death. Again, what are they asking for? If you're treating somebody for 5 years, 10 years, they don't need all that. Usually, ask them what they need.

If they're trying to determine if someone may have completed suicide, they usually only need the past certain number of visits. Next slide. Can you charge for copies of records? Generally, yes, you can. Every state has different rules. Some are very specific. This is how much you can charge per page, how much you can charge to search for the records. Then other ones are-- They'll say reasonable. What's reasonable? I would limit it to a dollar a page if you're printing something out. Some states are very specific as to what you can charge for releasing electronic records in an electronic format.

Some say you can't charge. You can if it's paper because there's a task that's involved with printing it out the paper or mailing it, whatever. There are fees involved with that. If you're transferring from an EMR to an electronic, hopefully HIPAA-compliant way, to the patient or the person they're authorizing you to release their records to, some states say it's the same as paper. Some say not. Again, you need to investigate that if you don't know the answer to that. It's usually pretty easy to search on the internet, but if, again, you're not sure, that's something you could ask a risk professional.

You cannot withhold records because patients still owe you money for treatment. You cannot withhold records if someone has an inability to pay the fee to duplicate the records. You have to release those records. Then, if they have a bill now because you're charging them, say, \$10 for those records, and they're not paying the bill, you release the records, and then you would determine whether or not what process you want to follow, just like as if they didn't pay their bill for treatment. Are you going to send them to collections? Are you going to waive it? Whatever you decide to do. Again, you can't withhold it for those reasons. Next slide.

**Cara:** Now we're going to take a look at some common scenarios. This is where I think a lot of your questions will be answered. We'll try to get through some of these quicker than others because we've got a lot on the agenda. Next slide, please. Scenario number one. You've been providing therapy to a patient for 4 years, with a gap in therapy of 15 months. Recently, the patient has been upset with the lack of progress made in therapy, and they ask you for a copy of their health record. You tell the patient it is your policy to only provide a summary of care. Is this allowed under HIPAA and Right to Access?

Next slide. In addressing summaries, while a summary is a good start, you could offer a summary. However, if the patient says, "No, I would like my complete record," then under the privacy rules, as we started early on, HIPAA requires you as a covered entity to provide the patient or their designated representative access to their protected health information. We talked about on slide seven that designated record set and what should be included in your release for authorization. What exactly are they looking for? The entire record, including billing notes. Make sure that you clarify that so that you're only providing them with what they actually want.

It's important to comply with your state statute for the timeline to produce the copy of the record. Each state has timelines in place. Some may be as few as 15 days, 12 days. Again, a lot of this we wish we had uniformity across the states, but we don't. It is important to be familiar with your state statutes and the time that you have to produce that record once the individual requests it. We touched upon those

psychotherapy notes. Again, your state is going to dictate whether or not those are included as part of the record and if the patient wants those notes as well.

Allison mentioned, too, the record request can be denied if there's reasonably likely that to cause physical harm to the patient or another individual. Again, that's something that you might want to get further counsel on and speak to a risk professional or a practice attorney in your state to determine what, if anything, needs to be excluded. It may not be the entire record that you withhold, but maybe portions of it you could redact. Again, there are very few circumstances where records can be denied. It's also important to note if it's a custody situation. If your state allows for that determination by the healthcare provider to withhold the records as well. Again, take pause and make sure that you're getting further counsel on whether or not you can restrict access to the record. Next slide, Allison.

**Allison:** Our next scenario. Your adult patient told you that they were involved in a motor vehicle accident, and they are suing the driver who caused the accident. They have not shared any other information with you. You receive a call from the patient's attorney requesting you to release the record and include a statement attesting to the records. Attesting usually means that you are attesting to that you have given them the complete information they've asked for. How do you respond to this request?

Next slide. If you have an attorney request for records, advise the attorney that you're unable to provide any information without a HIPAA-compliant release of information, again, for mental health records that's signed by the person that they represent. Once the document is received, again, confirm with the patient that they want the record released. I've had conversations with providers that say the patient changes their mind, so then they revoke that consent. You'd have to tell the attorney, "My patient has revoked their consent." Then, unless they reinstate it, they're not going to get the information.

Again, review the patient record and discuss with the patient any concerns about the release. I did happen to glance over and look at some of the questions coming in. One question was, "What do you do when the provider has left?" If the practice is the keeper of the records, not the provider, so the provider leaves the group practice and the practice they were working for keeps the records, you would have to come up with a policy and procedure in that practice as to who's now the person that's best to talk to this patient about what may be contained in the record and how to handle the record request.

Advise the patient once the record is released, you can't control where it goes. You give it to their attorney, and then whatever their attorney is going to choose to do with it is between your patient and the attorney. You can't control what happens after that. Then again, confirm where and how the record is to be released. Is it to be faxed, mailed, et cetera? Hopefully, it's done in a HIPAA-compliant manner. Next slide. We have scenario three involving subpoenas. You receive a subpoena from the attorney of a minor who you are treating, who is in the process of a contentious divorce.

You're concerned that the parents may use the child's therapy records to challenge custody. You want to be sure that the child is protected and feel safe that they can

confide in you and share information in therapy. What is a subpoena, and do I need to comply with the request? Next slide, please. A subpoena is a document basically trying to legally demand you to do something that's usually served by an attorney. A court order is something that usually a judge will serve. If an attorney is serving you with a subpoena for records, again, ask a healthcare attorney on how to respond to it because maybe you don't have to comply with it.

There are all sorts of rules and regulations about when you do or don't have to comply with a subpoena, or you may have a subset of what you have to provide, or contact your malpractice carrier. Your claim department should hopefully have a service that they provide on responding. Get a copy of the custody agreement. You should always have that upfront when you're treating children of divorced or legally separated parents, or if they get divorced or legally separated during the course of your treatment, get that document, because that document was approved by a court that says what each parent has as far as rights, what they can or can't access, what they can or can't do.

As Cara mentioned earlier, just because a child lives primarily with one parent doesn't mean the other parent doesn't have rights and access to information. You want to comply with that custody agreement. Again, considerations for safety of the minor. If you think more likely than not harm may come to that minor, you would release what you can and deal with what you can't release, and then disclose, "Unless I'm under a subpoena or a court order, I can't release any additional information." Then again, you get that document, you get an attorney or somebody to assist you with complying with that.

Usually, both parents are required to release information. If the document says that both parents have that right, then you should really get both parents' consent before you release information. If it says one parent controls who gets information, that would be the parent that has the consent. Then sometimes there's a tiebreaker. When the two parents don't agree, sometimes it could be the therapist, sometimes it could be the pediatrician, it could be a court, sometimes one of the two parents gets to actually be the ultimate decision-maker. Next slide.

**Cara:** We're going to talk about-- Recently, your office was contacted by the spouse of one of your former patients to let you know they unfortunately passed away. They are requesting a copy of the patient's records and need it as soon as possible. You offer condolences and want to share information about the last encounter with the patient, but pause because you remember the patient mentioned they may be separating from their spouse. What happens to patient records after death?

Next slide. HIPAA still applies. HIPAA follows in death, indefinitely. It's important to know that just because someone passed away, and you may want to offer condolences or talk about it because that person is grieving, especially if it's unexpected, you have a duty to protect the privacy and confidentiality of those records, even in death. Some considerations are: did you have permission to speak to the person requesting the record prior to death? Were they involved? You may have met with them. The patient may have allowed for certain disclosures to that individual, or it may just have strictly been an emergency contact only.

You would reference the record first and then determine whether or not the person contacting you has the legal right to the record. Have they been appointed? We talked about in a couple of prior slides, have they been named? Did the court appoint them as the person responsible for the decedent's estate? It's a difficult time, a lot of times, and so it's balancing wanting to be supportive of that family member who's recently lost a loved one, but also protecting the privacy and confidentiality. Just simply say, "I would really love to honor this request, but this is what I need before I can disclose anything to you."

You can't even disclose a lot of times whether or not you were their therapist or the last time you saw them. Again, take that pause, ask them. It may take some time for them to get that document. The other thing to point out is, again, referring to state statutes, I believe it's Illinois might have a provision that allows an individual, so a spouse, to have access to those records. There are exceptions to this, as daunting as it must seem and feel. First, ask for that request from the court, and then secondly, look at your state statute as I indicated below.

Does it allow access to next of kin without a court appointment? Some states have done that for ease and access because there could be some delays. Keep that in mind when receiving those requests. Next slide. I did see a question regarding couples. Scenario five is you're treating a couple for couples therapy. What is the best way to handle requests for records when treating a couple? I think the best thing that we can recommend, and this goes for really all scenarios, not just couples, is at the start of care, at that initial encounter, is discuss how information will be shared and be released.

It's important, especially when dealing with minors and also in couples. A lot of times, from a billing standpoint, you may be documenting under one individual as part of the couple, because their insurance, it's only going to be billed under one individual, even though you're treating couples. I think you suggest that even though that record may be under one individual's name, if the purpose of your therapy is for couples, and that's how you're documenting, that's how you're proceeding with the therapy, both of those individuals need to understand that before you can release the records, they're both going to have to consent.

Even though the record might be under one person, if, again, it's for couples, make sure you are clear at the start that you will not be releasing information unless both can agree. This does come into play. A lot of situations go down the wrong path, and it becomes contentious. You want to make sure that you are clear and not releasing records when you don't have that consent. Next slide, I'm talking about it. We talk about releasing any part of it. If there's a disagreement, consider redacting significant portions of the record. There might be disagreements with releasing of information, and then you can redact.

The best-case scenario with handling couples' records is having that couple's consent at the start and then again confirming it if you do receive a request for information. You may need a court order. If both parties can't agree to release that information, if the court mandates you to release the record, that might be the way you ultimately have to go if it is a legal matter to where they're involved in divorce or it's related to custody. Sometimes, from a custody standpoint, the evaluators want to

see the couple's therapy. Again, consent is what is needed from both individuals. Next slide.

**Allison:** We have scenario six here. You recently provided a copy of the health record to a patient who doesn't like what you wrote in the record and is requesting you make a change to the diagnosis and other related information. How do you respond? Next slide, please. Patients have the right to request an amendment to their record. Doesn't mean they're going to get their way. They just have the right to. Again, you have to comply with those state and federal statutes. The first thing is the patient needs to put in writing specifically what they want amended.

The next thing is that you have to decide as the provider which way you're going to go. You can accept the amendment, say, "I noticed something in there on one of these visits. It doesn't seem like me you were talking about." You go back and you look and you say, "Oh, shoot. I must have documented that in the wrong patient's chart." We're not going to delete documentation, but we're going to put a new note in today, date and time today, saying and refer back to that note of what you're changing or what was incorrectly entered into the record.

You can deny the request for the amendment. You stand by your documentation. Just because they don't like it doesn't mean you're going to change it. You just tell the patient, "I have to respectfully stay with the documentation I put in my chart. However, you have the right, patient, to write what your disagreement is, and it will become a permanent part of your chart. Anytime you authorize me to release your records, it will become part of the records, and it will be released with your records." It shows in there what they disagree with, and you keep your documentation as is.

Then there could be a partial acceptance. Some things you agree that you would change, and some things you don't. Again, we don't want to ever go backwards and alter documentation. We want to put in a new note that talks about what we're amending or what our change is to the-- Just refer to that note that you're basically changing. A written response must be provided to the patient within 60 days of when they request that you make the amendment, whichever route you're going to go, yes, no, whatever.

Then your response has to include the reason for the denial, advise the patient. As I said, they can put a reply of their disagreement into their chart. That becomes part of the chart. Again, you have to give them the information that they have the right if they feel that their rights are being impinged to file a complaint with the Department of Health and Human Services Office for Civil Rights. Next slide.

**Cara:** Moving on into you've received a request from an insurance company or a vendor for insurer to request records. Are these requests valid? Next slide. Yes, these requests are valid. A lot of times, they come under risk adjustment audits. We've seen questions that come in for that, as well as it is a provision under the Affordable Care Act. That's one way that the risk adjustments can come in. We need to understand what the requests are and the consequences for not responding. Keep in mind these third-party requests from insurance auditors, you might be a panel provider. You have a contract with them.

Under HIPAA and payment treatment and operations, there's an expectation of that contract that you will provide records. Understand that we talked about the minimum necessary. You can certainly look at the request, respond to it, and say, "What's the minimum necessary for me to respond to this request in order to protect the privacy of those records?" Also, understand consequences. I say consequences of not responding. You may be denied reimbursement for that. You may also be asked to refund money if the insurer has paid you for these, and they are auditing a certain code or looking at a certain subset of records for your practice.

Make sure that you're aware of what the request is for and potential impacts. It's important to note that while people, of course, are very protective of their health information, keep in mind if they have insurance, the insurance company is getting that information in order to pay for claims. Although it may not be to the level and extent of detail, they're getting CPT coding that's going to show potential diagnoses and what you're seeing them for. Again, you can always speak to your patient about releasing the information, but bear in mind that if you are a paneled, contracted provider, there may be some obligations that you have as being part of that in-network provider.

Patient authorization and minimum necessary, we talked about. Next slide. You've received a request for a minor patient's records from a parent who is in the midst of a contentious custody battle. Should I release the records? What if the guardian ad litem is appointed by the court as part of the custody case? Should I share information with that guardian? Next slide. Custody, we talked about this. Age of consent. First thing is, what's the age of consent of that individual in your state? Do they have the ability to consent? I believe there was a question in the chat that talked about does consent just mean consent for treatment, or does it encompass many other pieces of your treatment with the individual.

Again, you're going to refer to your state statute about what exactly that minor can consent to, and is it the records as well. A lot of states it is. The consent, it may be just limited to a few outpatient sessions. You really have to be familiar with your state statute when you are treating and dealing with minors. Is there a custody agreement stating which parents and legal guardians are entitled? Again, get a copy of that agreement. The court took time to establish who has the right to access the information. Don't just take one parent's word that they are the ones that make all the decisions, because a lot of times they're not.

The custody agreement lays out who can access the information. Will the minor's records cause potential harm? Can a summary? Again, these are all questions that you really need to consider given the dynamics. Try not to insert yourself in the middle of that parental dispute. Allison and I were on a webinar from our professional association earlier today with an attorney presenting on a topic such as this. Don't get involved where you don't need to. It's easy to want to, I say, take sides when you're dealing with one parent or the other and you've been working with the family, but it's always best to defer to that custody agreement.

If both parents have access and legal rights to it, if one parent asks for the record, share it with the other parent because you want to be transparent and not show a deference to one parent or the other when dealing with records. One thing I will mention, because I believe this was another comment, was how do you deal with

minors or adolescents and confidentiality? You don't want to break down that therapeutic alliance because it is mental health, and you want to be able to have that privacy and that trust with these minors.

At the start of care, have that conversation so that the parents and the child understand that there may be certain circumstances where you have to disclose, such as mandatory reporting, but have that discussion upfront so that in the event there is a request for records down the road, you're not at a crossroads with, what should I send or not send? Because again, ultimately, if the state statute allows the parent to have access to the record, then they have the right to access the record unless it's going to fall under the harm exception.

Then, that guardian ad litem, request the court document that states that this person has the right to access the information. Again, there's no reason you should be intimidated by the courts or anything like that. Just verify and confirm that that person has access to the information. Next slide.

**Allison:** Then quickly, our last scenario is, I received a request for protected health information from the Child Protective Services in follow-up to filing a mandatory reporting obligation. What information can I provide? Next slide. Again, under HIPAA, as a mandatory reporter, you have to give them necessary information for CPS to start their investigation. Usually, you fill out a form, you put in the information. If they want records, again, you can ask CPS, is there a statute that says that they have the right to that information? What is the minimum necessary information they need?

You can push back a little bit. We want to make sure we comply with the law, but we have a right to understand what it is that allows them to have access to that information. Again, if CPS or law enforcement is asking for information, you don't have to answer immediately. You open up your email, you open up a letter, whatever you see it, take a breath, talk to your attorney or talk to a risk management professional before you respond. Next slide. Now we're going to sum up what we talked about. We want to always obtain HIPAA-compliant signed release of information form, specifically for the release of mental health information.

When we're releasing records of a minor, we want to obtain that parent or guardian consent, and again, as we've talked about, refer to the custody agreement if it's the parent asking. Maintain those psychotherapy or process notes separate from the record. They enjoy greater protections under the law. Consider minimum necessary provision, as we talked about. Emails, texts, and phone messages are considered part of the record.

Texting really should be limited to just using text and canceling, confirming appointments. Really, you should dissuade your patients from getting into detailed conversations through texting because we don't always know who we're texting with, and it's more difficult to make sure it gets into that medical record since it's a part of that. Hopefully, everybody's using HIPAA-compliant software. Next slide.

**Cara:** Never release the original record. Always make copies. You follow appropriate steps when addressing a patient's request to amend the record. Allison talked about that. There's great information and resources out there under HIPAA and

amendments that can help you comply with federal and state retention guidelines. Always refer to them and follow the one that is most restrictive if your state is more restrictive. When destroying records, use that HIPAA-compliant method. As always, with every situation, those state and federal statutes are going to give you guidance as important as they are in so many parts of the practice.

Next slide. In summary, a patient does have the right to request a review or obtain a copy of their health record. A timely acknowledgement and response is always required. Refer to HIPAA and the individual's Right to Access because you don't want to have a complaint filed against you to the Department of Health and Human Services and the Office of Civil Rights for restricting access to a health record. When in doubt, consult with a practice attorney for healthcare practice or risk management professional as part of your malpractice insurer for any information regarding that. I think we have a few minutes for questions. I did answer a couple in the chat. Allison, do you want to tackle one?

**Allison:** Sure. There's one question here that asks, "How do providers navigate the differences in the rules and regulations if you're practicing under PSYPACT, because every state's got all these different rules?" If you're practicing under PSYPACT, you are required to understand all the state rules and regulations for those states. If PSYPACT says you can practice in 30 states, if you don't have an ability to keep track of what goes on in 30 states, you may want to limit the number of states that you feel you can comfortably handle so that you are in compliance in state and federal guidelines. We can't use PSYPACT as a reason to not be familiar with what we need to do to be in compliance.

**Cara:** All right. Someone typed that you've never used a biller before, and you're starting to use one for an insurance issue. Do I need to communicate to those patients, if at all? I think, again, incorporating your practices policies, they don't need to know operationally how you are handling business, but make sure that you have that business associate agreement in place with that third party biller for you because what that does is that protects you and the patient because that business associate agreement is certifying that that billing organization complies and upholds the HIPAA standards.

You could put a general notice out to be transparent and communicate, but you don't need to obtain any separate consent or authorization if you are using that third-party biller.

**Allison:** We have another question here about if you're releasing records, and we had recommended that you keep a log of who's getting the information and what you're releasing. The question is, can it simply just be a note in the chart? It's really a good idea if you create a little spreadsheet or a little document that you could keep in the record that lists the date that the records were requested, the date they were released, what specifically was released, and to whom you released them to.

You might want to put in there how you released them. It would be September 17th, 2025, released Cara's records to her attorney, Joe Schmo, and it was a complete record. It was a subset, whatever it is. Just a basic log. It doesn't have to be a big note. Just even a simple grid of what you fill in in each of those categories, just so you'll know who, what went to.

**Cara:** Another question is about the risks of sharing mental health records going to a school, and can a summary suffice? Your duty is to explain the confidentiality and privacy in that record to the individuals, and just say, "This is what I would recommend." If ultimately they want the record sent, then you send the records.

You can certainly advocate for that treatment summary and say, "This is what I would recommend. I can certainly offer the treatment summary," just so that the individuals are aware, because once those records leave, again, your possession, you can't protect the confidentiality. What's the minimum necessary that's needed so that you're communicating the appropriate information to the entity that is requesting the information?

**Allison:** I'd like to just say one thing because I know we have to let our folks at the APA wrap up. Someone did ask a clarifying question about what I just said about PSYPACT, and I guess they were looking more for what do you do when there's a discrepancy between the provider's state laws and the patient's. The law goes that the patient's state dictates the standard of care and what you have to do.

I would follow the rules and regulations of the state where the patient is located because that's where all the requirements come from. Again, you can always ask your own personal attorney if you have a question like that, but the laws usually are dictated by where the patient is located. Thank you, everybody.

**Cara:** I'll just say one last quick one was regarding about closing down a practice. You still are required to have records be accessible for your state statute for how long you need to retain records. It's either you retain them, have a business retain them. If you have a colleague, again, you need to have contingency planning for when you close your practice, and your state statute probably has information and guidance. Thank you.

**Moderator:** Thank you so much for joining us, Allison and Cara. Thank you to all our listeners for your participation. We'd also like to thank the American Professional Agency for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. As soon as the webinar has ended, a short survey will appear on your screen. Please take the survey and give us your feedback. We thank you for your attention and hope you have a great day.

**[00:58:07] [END OF AUDIO]**