Psychotherapy Notes/Records

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… In a prior Avoiding Liability Bulletin (June, 2005 - Volume No.2), under the topic of “HIPAA – Patient Access to Records,” the definition of “psychotherapy notes” was included, since under HIPAA regulations “covered providers” are permitted to deny access to their “psychotherapy notes” when patients demand a copy of all treatment records.

Excluded from the definition of “psychotherapy notes” are: documentation of counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, medication prescription and monitoring, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date. These excluded items essentially constitute the typical content of “psychotherapy records.” Under HIPAA regulations, patients are generally to be informed in the Notice of Privacy Practices that psychotherapy records (but not “psychotherapy notes,” unless pursuant to a valid authorization form signed by the patient) will be released to insurers for purposes of payment, without the patient’s signed authorization.

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