The Duty to Record: Ethical, Legal, and Professional Considerations for Florida Psychologists

Introduction

The American Psychological Association Practice Directorate has provided an excellent online presentation about electronic healthcare records (EHRs) and the basic terminology related to EHRs; the presentation dispels common myths about EHR systems and provides detail about their meaningful use in integrated health care settings.¹

The Division 31 and 42 EHR working group's² primary goal was to create a series of State specific templates that would work well for psychologists as they transition into the use of EHRs, particularly in integrated health care settings where shared information is clinically essential and specific laws or regulations may dictate at least some of what is included in those records. To achieve this goal, we conducted a review of the laws related to record keeping, and the relevant and recent literature (particularly the last decade) regarding EHRs, including variations across states. Further, we consulted with key psychologists that have been using EHRs on a day to day basis, who have developed experience establishing polices and processes within their own institutions and practices. They have effectively used this developing technology to improve clinical care while protecting patient rights. They have found that the EHR enables collaborating professionals within the integrated health care settings to understand the behavioral risk factors that exist in each case and to be kept informed about the health behavior changes that occur with psychological service interventions (HRSA, 2012).³

In order to digest the laws accurately, we examined the annotated codes and regulations available on Westlaw and Lexis for the 50 states and the District of Columbia with reference to several relevant state-by-state surveys retrieved from Lexis

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and Westlaw.\textsuperscript{4} Our research answered the following questions for each jurisdiction: (a) Do record keeping duties created by statutes or administrative rules exist? (b) Have court rulings created a common-law duty or interpreted the statutes or administrative rules? (c) What are the contents of the record that are mandated by law? (d) Are there laws related to the maintenance and security of records? (e) What are the laws related to retention of records? (f) What are the consequences of violating specific duties?

Readers should view the narrative summary of their jurisdiction’s law as a starting point for interpreting how to meet the law within their own jurisdiction as they construct their electronic records. As laws can change, please check the law with your state associations to see if more current interpretations for meeting the record keeping duties. Many state professional associations have ethics committees that can be consulted as part of their benefits. In addition, your association can refer psychologists for individual consultation to lawyers specializing in legal practices focused on \textit{mental health practice}. The professional liability carriers also provide free legal and professional consultation.

Florida specific templates for the types and contents of the record are provided based upon a review of your jurisdiction’s law. The digest of your jurisdiction’s law should be read if you intend to use the templates.

\textbf{State Specific Template for contents of a record}

Florida law calls for an intake and evaluation note, and progress notes. The contents of the two templates for these documents comply with the law digested below. We also believe that a termination note will likely reduce exposure to arguments about continued duty of care, and reduce the risk of responsibility in a duty to protect/warn jurisdiction.\textsuperscript{5}

Because the documents permit hovering over the underline fields with a cursor to select an option or permit filling in the shaded text boxes, they cannot be inserted into this document. Please access each of the documents on this website, separately.

Our group also suggests that users of the templates consider how “behavior

\textsuperscript{4} 50 State Surveys, Legislation & Regulations, Psychologists & Mental Health Facilities (Lexis March 2012); Lexis Nexis 50 State Comparative Legislation / Regulations, Medical Records (Lexis June 2011); 50 State Statutory Surveys: Healthcare Records and Recordkeeping (Thomson Reuters/ West October 2011).

may be shaped by culture, the groups to which one belongs, and cultural stereotypes."\(^6\) Whenever “Eurocentric therapeutic and interventions models”\(^7\) may impair the consideration of multicultural factors among the integrated health care team members, we urge that psychologists note the factors within the appropriate template fields.

**Statute or Rule**

Florida law sets forth specific record-keeping guidelines for psychologists at Chapter 64B19-19 of its Administrative Code.\(^8\) In addition, various other Florida laws set forth below address recordkeeping by psychologists who work in certain settings or health care providers generally.\(^9\) Neither the Florida Statutes nor the Administrative Code adopt the American Psychological Association’s Ethical Principles of Psychologists and Code of Conduct (“APA Code of Ethics”) explicitly. The law, however, implies that Florida psychologists are subject to the Code of Ethics and its recordkeeping provisions.\(^10\)

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\(^7\) *Id.* at p. 45.


\(^9\) For instance, Florida psychologists involved in performance in court-ordered child custody evaluation and family law proceedings are required (FLA. STAT. § 64B19-18.007) to adhere to the “APA Guidelines for Child Custody Evaluations in Divorce Proceedings,” American Psychologist (Dec. 2010), at 863, available at [http://www.apa.org/practice/guidelines/child-custody.pdf](http://www.apa.org/practice/guidelines/child-custody.pdf) (last accessed Oct. 10, 2012) and the APA “Specialty Guidelines for Forensic Psychologists.” In addition, the content of records maintained by psychologists who work in certain hospitals are specified by the law: See, FLA. STAT. § 395.3015 (Patient records; form and content) for each hospital operated by the agency (Agency for Health Care Administration-- FLA. STAT. § 395.0022) or by the Department of Corrections; See, FLA. STAT. § 395.302 (Patient records; penalties for alteration); FLA. STAT. § 395.3025 (Patient and personnel records; copies; examination).

\(^10\) For example, see FLA. ADMIN. CODE § 64B19-18.008 that requires the certifying bodies to adopt the APA Code of Ethics:

- Board Approval of Specialty Certifying Bodies.
  - To obtain Board approval as a certifying body, eligible to grant formal recognition declaring a licensed psychologist to be a “certified psychology specialist,” “board-certified psychology specialist,” or a “psychology diplomat,” pursuant to Section 490.0149, F.S., an applicant shall file a petition demonstrating that it:
    - . . .(3) Has established standards for specialized practice of psychology and adopts the American Psychological Association (APA) “Ethical Principles of Psychologists and Code of Conduct,” effective June 1, 2003, to guide the practice of its members. The code is incorporated by reference and available for inspection at the Board office as well as at: www.apa.org/ethics/code2002.html...
**Common Law**

The Florida Third District Court of Appeals explicitly rejected *Tarasoff* in 1991, finding that the state’s statutes permitted MHPs to warn but imposed no duty.\(^{11}\) In 1998, Florida’s First District Court of Appeal found that a psychiatrist who treated and released a patient who killed his father did have a duty to warn the teenager’s parents that the child was dangerous, because the psychiatrist knew or should have known of his patient’s deteriorating condition, but that duty was based on the clinician’s particular fiduciary relationship to the parents: in addition to being parents of the teenaged client, they were also under the psychiatrist’s care.\(^{12}\) It does appear that a duty to protect is likely to be found for the MHP who is treating patients who are hospitalized and under the control of professional.

*Annotation to Florida Statutes § 490.003 (Definitions Section under “Psychological Services”)*

- Neuropsychologist was competent to testify as an expert with regard to temporal stages of organic brain development as reflected in and through behavioral and functional conditions and evaluations, in medical malpractice action arising from child who was born with cerebral palsy due to oxygen deprivation; witness specialized in clinical and forensic neuropsychology devoted to study of brain function and behavior, area of expertise included both educational and practical involvement with how human brain works, how brain functions, and how brain development and function relates to human behavior, and witness reviewed the medical records and was involved in child’s clinical examination.\(^{13}\)

*Citing Reference to Florida Administrative Code Section 64B19-19.0025 (re: Standards for Records.)*

- The evidence establishes that by violating Florida Administrative Code Rule 64B-19.0025(1), the Respondent also violated Subsection 490.009(1)(w), Florida Statutes (2006). The Respondent's documentation of his consultation with the patient failed to meet the minimal standards for recordkeeping applicable to this case.\(^{14}\)

**Contents of the record are mandated by law**

The following provision governs the content of records maintained by licensed


\(^{13}\) *Grenitz v. Tomlian*, 858 So.2d 999 (2003), rehearing denied.

Standards for Records

To serve and protect users of psychological services, psychologists' records must meet minimum requirements for chronicling and documenting the services performed by the psychologist, documenting informed consent and recording financial transactions.

(1) Records for chronicling and documenting psychologists' services must include the following: basic identification data such as name, address, telephone number, age and sex; presenting symptoms or requests for services; dates of service and types of services provided. Additionally, as applicable, these records must include: test data (previous and current); history including relevant medical data and medication, especially current; what transpired during the service sessions; significant actions by the psychologist, service user, and service payer; psychologist's indications suggesting possible sensitive matters like threats; progress notes; copies of correspondence related to assessment or services provided; and notes concerning relevant psychologist's conversation with persons significant to the service user.

(2) Written informed consent must be obtained concerning all aspects of services including assessment and therapy.

(3) A provisionally licensed psychologist must include on the informed consent form the fact that the provisional licensee is working under the supervision of a licensed psychologist as required by Section 490.0051, F.S. The informed consent form must identify the supervising psychologist.

(4) Records shall also contain data relating to financial transactions between the psychologist and service user, including fees assessed and collected.

(5) Entries in the records must be made within ten (10) days following each consultation or rendition of service. Entries that are made after the date of service should indicate the date the entries are made, as well as the date of service.

In addition, the Health Insurance Portability and Accountability Act (HIPAA) would apply to Florida psychological records. A HIPAA notice of privacy practices.

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that delineates the psychologist’s scope of and limitations of confidentiality works in tandem with the disclosure document provided to the patient during the informed consent process specified by Florida law. Mandatory disclosures could occur and should be identified to the patient as part of the informed consent process:

- Mandatory duty to report child abuse or neglect;\(^{18}\)
- Mandatory duty to report suspected abuse, neglect, or financial exploitation of an vulnerable adult.\(^{19}\)

**Maintenance and Security of Records**

The following provisions govern the maintenance and security of records by psychologists:

**Psychologist and school psychologist records**\(^{20}\)

Each psychologist and school psychologist who provides services as defined in this chapter shall maintain records. The board or, in the case of a school psychologist, the department may adopt rules defining the minimum requirements for such records, including content, length of time such records shall be maintained, and transfer of such records or of a summary of such records, or both, to a subsequent treating practitioner or other individual with the written consent of the client or clients.

**Confidentiality**\(^{21}\)

(1) One of the primary obligations of psychologists is to respect the confidentiality of information entrusted to them by service users. Psychologists may disclose that information only with the written consent of the service user. The only exceptions to this general rule occur in those situations when nondisclosure on the part of the psychologist would violate the law. If there are limits to the maintenance of confidentiality, however, the licensed psychologist shall inform the service user of those limitations. For instance, licensed

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\(^{18}\) FLA. STAT. § 39.201.

\(^{19}\) FLA. STAT. § 415.1034.

\(^{20}\) FLA. STAT. § 490.0148.

\(^{21}\) FLA. ADMIN. CODE § 64B19-19.006.
psychologists in hospital, subacute or nursing home settings should inform service users when the service user's clinical records will contain psychological information which may be available to others without the service user's written consent. Similar limitations on confidentiality may present themselves in educational, industrial, military or third-party payment situations, and in each of the circumstances mentioned herein or in each similar circumstance, the licensed psychologist must obtain a written statement from the service user which acknowledges the psychologist's advice in those regards. This rule is particularly applicable to supervisory situations wherein the supervised individual will be sharing confidential information with the supervising psychologist. In that situation, it is incumbent upon the licensed psychologist to secure the written acknowledgement of the service user regarding that breach of confidentiality.

(2) In cases where an evaluation is performed upon a person by a psychologist for use by a third party, the psychologist must explain to the person being evaluated the limits of confidentiality in that specific situation, document that such information was explained and understood by the person being evaluated, and obtain written informed consent to all aspects of the testing and evaluative procedures.

(3) This rule recognizes that minors and legally incapacitated individuals cannot give informed consent under the law. Psychologists, nonetheless, owe a duty of confidentiality to minor and legally incapacitated service users consistent with the duty imposed by paragraph (1). This does not mean that the psychologist may not impart the psychologist's own evaluation, assessment, analysis, diagnosis, or recommendations regarding the minor or legally incapacitated individual to the service user's guardian or to any court of law.

(4) The licensed psychologist shall maintain the confidentiality of all psychological records in the licensed psychologist's possession or under the licensed psychologist's control except as otherwise provided by law or pursuant to written and signed authorization of a service user specifically requesting or authorizing release or disclosure of the service user's psychological records.

(5) The licensed psychologist shall also ensure that no person working for the psychologist, whether as an employee, an independent contractor, or a volunteer violates the confidentiality of the service user.

In addition, the Florida Mental Health Act contains the following provision:
Clinical records; confidentiality

(1) A clinical record shall be maintained for each patient. The record shall include data pertaining to admission and such other information as may be required under rules of the department. A clinical record is confidential and exempt from the provisions of s. 119.07(1). Unless waived by express and informed consent, by the patient or the patient’s guardian or guardian advocate or, if the patient is deceased, by the patient’s personal representative or the family member who stands next in line of intestate succession, the confidential status of the clinical record shall not be lost by either authorized or unauthorized disclosure to any person, organization, or agency.

(2) The clinical record shall be released when:

(a) The patient or the patient's guardian authorizes the release. The guardian or guardian advocate shall be provided access to the appropriate clinical records of the patient. The patient or the patient's guardian or guardian advocate may authorize the release of information and clinical records to appropriate persons to ensure the continuity of the patient's health care or mental health care.

(b) The patient is represented by counsel and the records are needed by the patient's counsel for adequate representation.

(c) The court orders such release. In determining whether there is good cause for disclosure, the court shall weigh the need for the information to be disclosed against the possible harm of disclosure to the person to whom such information pertains.

(d) The patient is committed to, or is to be returned to, the Department of Corrections from the Department of Children and Family Services, and the Department of Corrections requests such records. These records shall be furnished without charge to the Department of Corrections.

(3) Information from the clinical record may be released in the following circumstances:

(a) When a patient has declared an intention to harm other persons. When such declaration has been made, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient.

(b) When the administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, an aftercare treatment provider, or an employee or agent of the

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22 FLA. STAT. § 394.4615.
23 “Department” means the Department of Children and Family Services. FLA. STAT. § 394.455(8).
For the purpose of determining whether a person meets the criteria for involuntary outpatient placement or for preparing the proposed treatment plan pursuant to s. 394.4655, the clinical record may be released to the state attorney, the public defender or the patient's private legal counsel, the court, and to the appropriate mental health professionals, including the service provider identified in s. 394.4655(6)(b) 2., in accordance with state and federal law.

(4) Information from clinical records may be used for statistical and research purposes if the information is abstracted in such a way as to protect the identity of individuals.

(5) Information from clinical records may be used by the Agency for Health Care Administration, the department, and the Florida advocacy councils for the purpose of monitoring facility activity and complaints concerning facilities.

(6) Clinical records relating to a Medicaid recipient shall be furnished to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request.

(7) Any person, agency, or entity receiving information pursuant to this section shall maintain such information as confidential and exempt from the provisions of s. 119.07(1).

(8) Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to this section is not subject to civil or criminal liability for such release.

(9) Nothing in this section is intended to prohibit the parent or next of kin of a person who is held in or treated under a mental health facility or program from requesting and receiving information limited to a summary of that person's treatment plan and current physical and mental condition. Release of such information shall be in accordance with the code of ethics of the profession involved.

(10) Patients shall have reasonable access to their clinical records, unless such access is determined by the patient's physician to be harmful to the patient. If the patient's right to inspect his or her clinical record is restricted by the facility, written notice of such restriction shall be given to the patient and the patient's
guardian, guardian advocate, attorney, and representative. In addition, the restriction shall be recorded in the clinical record, together with the reasons for it. The restriction of a patient's right to inspect his or her clinical record shall expire after 7 days but may be renewed, after review, for subsequent 7-day periods.

(11) Any person who fraudulently alters, defaces, or falsifies the clinical record of any person receiving mental health services in a facility subject to this part, or causes or procures any of these offenses to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Further, the following provisions apply to all “health care practitioners”:

Ownership and control of patient records; report or copies of records to be furnished

(1) As used in this section, the term “records owner” means any health care practitioner who generates a medical record after making a physical or mental examination of, or administering treatment or dispensing legend drugs to, any person; any health care practitioner to whom records are transferred by a previous records owner; or any health care practitioner's employer, including, but not limited to, group practices and staff-model health maintenance organizations, provided the employment contract or agreement between the employer and the health care practitioner designates the employer as the records owner…

…(3) As used in this section, the term “records custodian” means any person or entity that:
   (a) Maintains documents that are authorized in subsection (2); or
   (b) Obtains medical records from a records owner.

(4) Any health care practitioner's employer who is a records owner and any records custodian shall maintain records or documents as provided under the confidentiality and disclosure requirements of this section.

(5) This section does not apply to facilities licensed under chapter 395.

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24 Licensed psychologists are “health care practitioners as defined by the code because they are licensed pursuant to chapter 490. See FLA. STAT. § 456.001(4) (“Health care practitioner’ means any person licensed under . . . chapter 490.”).
25 FLA. STAT. § 456.057.
(6) …when a patient's psychiatric, chapter 490 psychological, or chapter 491 psychotherapeutic records are requested by the patient or the patient's legal representative, the health care practitioner may provide a report of examination and treatment in lieu of copies of records. Upon a patient's written request, complete copies of the patient's psychiatric records shall be provided directly to a subsequent treating psychiatrist. The furnishing of such report or copies shall not be conditioned upon payment of a fee for services rendered.

(7)(a) Except as otherwise provided in this section and in s. 440.13(4)(c), such records may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient or the patient's legal representative or other health care practitioners and providers involved in the care or treatment of the patient, except upon written authorization of the patient. However, such records may be furnished without written authorization under the following circumstances:

1. To any person, firm, or corporation that has procured or furnished such examination or treatment with the patient's consent.
2. When compulsory physical examination is made pursuant to Rule 1.360, Florida Rules of Civil Procedure, in which case copies of the medical records shall be furnished to both the defendant and the plaintiff.
3. In any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the patient or the patient's legal representative by the party seeking such records.
4. For statistical and scientific research, provided the information is abstracted in such a way as to protect the identity of the patient or provided written permission is received from the patient or the patient's legal representative.
5. To a regional poison control center for purposes of treating a poison episode under evaluation, case management of poison cases, or compliance with data collection and reporting requirements of s. 395.1027 and the professional organization that certifies poison control centers in accordance with federal law.

(b) Absent a specific written release or authorization permitting utilization of patient information for solicitation or marketing the sale of goods or services, any use of that information for those purposes is prohibited.

(8) Except in a medical negligence action or administrative proceeding when a health care practitioner or provider is or reasonably expects to be named as a
defendant, information disclosed to a health care practitioner by a patient in the course of the care and treatment of such patient is confidential and may be disclosed only to other health care practitioners and providers involved in the care or treatment of the patient, or if permitted by written authorization from the patient or compelled by subpoena at a deposition, evidentiary hearing, or trial for which proper notice has been given.

(9)(a) 1. The department may obtain patient records pursuant to a subpoena without written authorization from the patient if the department and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has excessively or inappropriately prescribed any controlled substance specified in chapter 893 in violation of this chapter or any professional practice act or that a health care practitioner has practiced his or her profession below that level of care, skill, and treatment required as defined by this chapter or any professional practice act and also find that appropriate, reasonable attempts were made to obtain a patient release. Notwithstanding the foregoing, the department need not attempt to obtain a patient release when investigating an offense involving the inappropriate prescribing, overprescribing, or diversion of controlled substances and the offense involves a pain-management clinic. The department may obtain patient records without patient authorization or subpoena from any pain-management clinic required to be licensed if the department has probable cause to believe that a violation of any provision of s. 458.3265 or s. 459.0137 is occurring or has occurred and reasonably believes that obtaining such authorization is not feasible due to the volume of the dispensing and prescribing activity involving controlled substances and that obtaining patient authorization or the issuance of a subpoena would jeopardize the investigation.

2. The department may obtain patient records and insurance information pursuant to a subpoena without written authorization from the patient if the department and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has provided inadequate medical care based on termination of insurance and also find that appropriate, reasonable attempts were made to obtain a patient release.

3. The department may obtain patient records, billing records, insurance information, provider contracts, and all attachments thereto pursuant to a subpoena without written authorization from the patient if the
department and probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has submitted a claim, statement, or bill using a billing code that would result in payment greater in amount than would be paid using a billing code that accurately describes the services performed, requested payment for services that were not performed by that health care practitioner, used information derived from a written report of an automobile accident generated pursuant to chapter 316 to solicit or obtain patients personally or through an agent regardless of whether the information is derived directly from the report or a summary of that report or from another person, solicited patients fraudulently, received a kickback as defined in s. 456.054, violated the patient brokering provisions of s. 817.505, or presented or caused to be presented a false or fraudulent insurance claim within the meaning of s. 817.234(1)(a), and also find that, within the meaning of s. 817.234(1)(a), patient authorization cannot be obtained because the patient cannot be located or is deceased, incapacitated, or suspected of being a participant in the fraud or scheme, and if the subpoena is issued for specific and relevant records.

4. Notwithstanding subparagraphs 1.-3., when the department investigates a professional liability claim or undertakes action pursuant to s. 456.049 or s. 627.912, the department may obtain patient records pursuant to a subpoena without written authorization from the patient if the patient refuses to cooperate or if the department attempts to obtain a patient release and the failure to obtain the patient records would be detrimental to the investigation.

(b) Patient records, billing records, insurance information, provider contracts, and all attachments thereto obtained by the department pursuant to this subsection shall be used solely for the purpose of the department and the appropriate regulatory board in disciplinary proceedings. This section does not limit the assertion of the psychotherapist-patient privilege under s. 90.503 in regard to records of treatment for mental or nervous disorders by a medical practitioner licensed pursuant to chapter 458 or chapter 459 who has primarily diagnosed and treated mental and nervous disorders for a period of not less than 3 years, inclusive of psychiatric residency. However, the health care practitioner shall release records of treatment for medical conditions even if the health care practitioner has also treated the patient for mental or nervous disorders. If the department has found reasonable cause under this section and the psychotherapist-patient privilege is asserted, the department may petition
the circuit court for an in camera review of the records by expert medical practitioners appointed by the court to determine if the records or any part thereof are protected under the psychotherapist-patient privilege.

(10)(a) All patient records obtained by the department and any other documents maintained by the department which identify the patient by name are confidential and exempt from s. 119.07(1) and shall be used solely for the purpose of the department and the appropriate regulatory board in its investigation, prosecution, and appeal of disciplinary proceedings. The records shall not be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department or the appropriate board.

(b) Notwithstanding paragraph (a), all patient records obtained by the department and any other documents maintained by the department which relate to a current or former Medicaid recipient shall be provided to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request.

(11) All records owners shall develop and implement policies, standards, and procedures to protect the confidentiality and security of the medical record. Employees of records owners shall be trained in these policies, standards, and procedures.

(12) Records owners are responsible for maintaining a record of all disclosures of information contained in the medical record to a third party, including the purpose of the disclosure request. The record of disclosure may be maintained in the medical record. The third party to whom information is disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient’s legal representative.

(13) Notwithstanding the provisions of s. 456.058, records owners shall place an advertisement in the local newspaper or notify patients, in writing, when they are terminating practice, retiring, or relocating, and no longer available to patients, and offer patients the opportunity to obtain a copy of their medical record.

(14) Notwithstanding the provisions of s. 456.058, records owners shall notify the appropriate board office when they are terminating practice, retiring, or
relocating, and no longer available to patients, specifying who the new records owner is and where medical records can be found.

(15) Whenever a records owner has turned records over to a new records owner, the new records owner shall be responsible for providing a copy of the complete medical record, upon written request, of the patient or the patient's legal representative.

(16) Licensees in violation of the provisions of this section shall be disciplined by the appropriate licensing authority.

(17) The Attorney General is authorized to enforce the provisions of this section for records owners not otherwise licensed by the state, through injunctive relief and fines not to exceed $5,000 per violation.

(18) A health care practitioner or records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section shall charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when there is no board.

(19) Nothing in this section shall be construed to limit health care practitioner consultations, as necessary.

(20) A records owner shall release to a health care practitioner who, as an employee of the records owner, previously provided treatment to a patient, those records that the health care practitioner actually created or generated when the health care practitioner treated the patient. Records released pursuant to this subsection shall be released only upon written request of the health care practitioner and shall be limited to the notes, plans of care, and orders and summaries that were actually generated by the health care practitioner requesting the record.

(21) The board, or department when there is no board, may temporarily or permanently appoint a person or entity as a custodian of medical records in the event of the death of a practitioner, the mental or physical incapacitation of the practitioner, or the abandonment of medical records by a practitioner. The custodian appointed shall comply with all provisions of this section, including the release of patient records.

HIPAA also enables the patient to inspect and obtain Protected Health
Information (PHI) records, including Psychotherapy Notes created by the psychologist, as long as those records are maintained.\(^{26}\) In addition, patients have a right to amend any part of the record;\(^{27}\) Under this section, a denial of the proposed amendment can occur if the record was not created by the psychologist (unless the patient provides a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment) or if the record is accurate and complete (other subsections are not discussed as they are unlikely to arise for psychologists). Release and transfer of PHI records cannot be conditioned on payment or other conditions (such as enrollment in the health plan that employs the psychologist).\(^{28}\) Finally, patients may obtain an accounting as to who has accessed the PHI and the details about each disclosure.\(^{29}\)

HIPAA establishes privacy protections for all transmissions of PHI records, and requires specific patient authorizations (with a right of revocation) to transfer PHI records to third parties.\(^{30}\) Concrete security standards are established for all electronic healthcare information (45 CFR 160).

**Retention of Records**

The following provisions govern the retention of records by Florida psychologists:

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**Retention of Records**\(^{31}\)

1. Licensed psychologists shall maintain psychological records for each service user and shall record information concerning consultations and/or services rendered by the psychologist to the service user within a reasonable time following that consultation or the rendition of that service.

2. Except as provided in subsection (4) of this rule, the licensed psychologist shall maintain full and total responsibility for and control of all psychological records relating to users of the licensee's psychological services and of the users of the psychological services rendered by any person under the supervision of the licensed psychologist.

3. Except as provided in subsection (4) of this rule, complete psychological records shall be retained by the licensed psychologist for a minimum of 3 years.

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\(^{26}\) 45 CFR 164.524.  
\(^{27}\) 45 CFR 164.526 (a).  
\(^{28}\) 45 CFR 164.508 (b)(4).  
\(^{29}\) 45 CFR 164.528.  
\(^{30}\) 45 CFR 164.508.  
\(^{31}\) FLA. ADMIN. CODE § 64B19-19.003.
after (a) the completion of planned services or (b) the date of last contact with the user, whichever event occurs later in time. Thereafter, either the complete psychological records or a summary of those psychological records shall be retained for an additional 4 years.

(4) A licensed psychologist is not required to retain psychological records if the psychologist's patients were assigned to the psychologist by a business entity which agrees to maintain and retain the confidentiality of the psychological records consistent with Rule 64B19-19.005, Rule 64B19-19.006, F.A.C., and subsections (2) and (3) of this rule.

Disposition of records of deceased practitioners or practitioners relocating or terminating practice

Each board created under the provisions of chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, part I of chapter 464, chapter 465, chapter 466, part I of chapter 484, chapter 486, chapter 490, or chapter 491, and the department under the provisions of chapter 462, shall provide by rule for the disposition, under that chapter, of the medical records or records of a psychological nature of practitioners which are in existence at the time the practitioner dies, terminates practice, or relocates and is no longer available to patients and which records pertain to the practitioner's patients. The rules shall provide that the records be retained for at least 2 years after the practitioner's death, termination of practice, or relocation. In the case of the death of the practitioner, the rules shall provide for the disposition of such records by the estate of the practitioner.

Disposition of Records Upon Termination or Relocation of Psychological Practice

(1) When a licensed psychologist terminates practice or relocates practice and is no longer available to service users in the practice area, the licensed psychologist shall provide notice of such termination or relocation of practice. The licensed psychologist shall cause such notice to be published in the newspaper of greatest circulation in the county from which the licensed psychologist is relocating or, in the case of termination of practice, in each county where the licensed psychologist has practiced. Such notice shall be published weekly for four (4) consecutive weeks. The notice shall contain the date of termination or relocation of practice and an address at which the psychological records of the service users may be obtained by them, their legal representatives, or licensed...
mental health professionals designated by service users in writing, to receive the service user's records.

(2) The executor, administrator, personal representative or survivor of a deceased licensed psychologist shall ensure the retention of psychological records in existence upon the death of the psychologist for a period of at least two (2) years and two (2) months from the date of the licensed psychologist’s death. Within 1 month of the licensed psychologist's death, the executor, administrator, personal representative or survivor of the deceased licensed psychologist shall cause notice to be published in the newspaper of greatest general circulation in each county where the licensed psychologist practiced. Such notice shall be published weekly for four (4) consecutive weeks and shall advise of the licensed psychologist's death. Such notice shall also state the address from which service users, their legal representative, or licensed mental health professionals designated by the service user in writing, may obtain the service user's psychological records. A copy of such notice shall be mailed to the administrative office of the Board of Psychology. At the conclusion of 24 months from the date of the licensed psychologist's death, the executor, administrator, personal representative or survivor shall cause a notice to be published in the newspaper of greatest circulation in each county where the deceased psychologist practiced. Such notice shall advise that the psychological records still in the possession or under the control of the executor, administrator, personal representative or survivor will be destroyed on a date specified which may not be any sooner than 1 month from the last day of the last week of the publication of the notice. Such notice shall also be published once a week for four (4) consecutive weeks. Thereafter, on the date specified in the notice, the executor, administrator, personal representative or survivor shall destroy unclaimed psychological records.

Violations of the specific duty

The following specific duties are identified in the portions of the Florida Statutes and Administrative Code governing the licensing of psychologists:

Discipline

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

…(h) Failing to perform any statutory or legal obligation placed upon a person licensed under this chapter.

34 FLA. STAT. § 490.009.
(i) Willfully making or filing a false report or record; failing to file a report or record required by state or federal law; willfully impeding or obstructing the filing of a report or record; or inducing another person to make or file a false report or record or to impede or obstruct the filing of a report or record. Such report or record includes only a report or record which requires the signature of a person licensed under this chapter.

...(n) Failing to make available to a patient or client, upon written request, copies of test results, reports, or documents in the possession or under the control of the licensee which have been prepared for and paid for by the patient or client.

(o) Failing to respond within 30 days to a written communication from the department concerning any investigation by the department or to make available any relevant records with respect to any investigation about the licensee's conduct or background.

...(r) Failing to meet the minimum standards of performance in professional activities when measured against generally prevailing peer performance, including the undertaking of activities for which the licensee is not qualified by training or experience.

...(t) Violating a rule relating to the regulation of the profession or a lawful order of the department previously entered in a disciplinary hearing.

(u) Failing to maintain in confidence a communication made by a patient or client in the context of such services, except as provided in s. 490.0147.