

The Duty to Record: Ethical, Legal, and Professional Considerations for Maine 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 policies 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

¹ Electronic Health Records: A Primer (retrieved Nov. 29, 2012 at <http://www.apapracticecentral.org/update/2012/11-29/electronic-records.aspx>.

² Christina Luini, JD, M.L.I.S.; Dinelia Rosa, PhD; Mary Karapetian Alvord, PhD; Vanessa K. Jensen, PsyD; Jeffrey N. Younggren, PhD; G. Andrew H. Benjamin, JD, PhD, ABPP. The working group, came together to discharge the obligations of the CODAPAR grant that we wrote and received: <http://www.apadivisions.org/division-31/news-events/grant-funding.aspx>.

³ Preparing the Interprofessional Workforce to Address Health Behavior Change. (retrieved Nov. 11, 2012 at http://www.hrsa.gov/advisorycommittees/bhpradvisory/acicbl/Reports/acicbl_tenth_report_final.pdf).

and Westlaw.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 *mental health practice*. The professional liability carriers also provide free legal and professional consultation.

Maine 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.

State Specific Template for contents of a record

Maine law suggests the need 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 believe that a termination note will likely reduce exposure to arguments about continued duty of care and recommend that psychologists use this template, too.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

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).

⁵ Benjamin, G. A. H., Kent, L., & Sirikantraporn, S. (2009). Duty to protect statutes. In J. L. Werth, E.R. Welfel, & G. A. H. Benjamin (Eds.), *The duty to protect: Ethical, legal, and professional responsibilities of mental health professionals* (pp. 9 – 28). Washington, DC: APA Press. doi:10.1037/11866-002.

Guidelines do not substitute for laws of each state and provincial jurisdiction. Such guidelines should not be used as a substitute for obtaining personal legal advice and consultation before making decisions regarding EHRs. Because statutory, administrative, and common law can change quickly, readers are well advised to seek legal advice about current laws and rules in their jurisdiction.

into this document.⁶ Please access each of the documents on this website, separately.

Our group also suggests that users of the templates consider how “behavior may be shaped by culture, the groups to which one belongs, and cultural stereotypes.”⁷ Whenever “Eurocentric therapeutic and interventions models”⁸ 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. In light of the World Health Organization’s demonstrated commitment to the formulation of a diagnostic system that moves beyond biological causation and integrates the contributions of psychological, cultural, and social factors, and APA’s participation in the development of the *International Classification of Functioning, Disability and Health* (World Health Organization, 2010), our group recommends using ICD-10 whenever diagnoses are being made.⁹ The EHR templates permit drop down diagnoses using the ICD-10 functional diagnoses.

Statute or Rule

The Department Of Professional And Financial Regulation, State Board of Examiners of Psychologists in Maine has incorporated by reference the standards of the American Psychological Association and Association of State and Provincial Psychology Boards.¹⁰

⁶ Please use the most recent version of WORD to access the full capabilities of the EHR templates.

⁷ American Psychological Association. (2002). *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (pp.17-24; p. 11). Washington, DC: Authors (<http://www.apa.org/pi/oema/resources/policy/multicultural-guideline.pdf> (last accessed August 1, 2012).

⁸ *Id.* at p. 45.

⁹ See ICD-10 at <http://apps.who.int/classifications/icd10/browse/2010/en> (last accessed August 1, 2012); The APA Policy and Planning Board recognized how psychology could move forward by turning to a diagnostic system that was based on the concept of functional impairments (APA Policy and Planning Board, (2005). APA 2020: A perfect vision for psychology: 2004 five-year report of the policy and planning board. *American Psychologist*, 60, 512-522, 518. (See, <http://www.apa.org/about/governance/bdcmte/five-year-report.pdf> ; and APA has helped fund the creation of the 10th edition in 2008. See, <http://www.apa.org/about/governance/council/08aug-crminutes.aspx> (last accessed August 1, 2012)).

¹⁰ 02-415 ME. CODE R. Ch. 9 § 1; see also Me. Rev. Stat. Ann. tit. 32, § 3816 (requiring the Board to adopt rules establishing a code of ethics in keeping with those standards established by the American Psychological Association). See, Ethical Principles of Psychologists and Code of Conduct (American Psychological Association 2002), copies available from American Psychological Association Order Department, 750 First Street, NE, Washington, D.C. 20002-4242, (202) 336-5510--www.apa.org/ethics; Code of Conduct (Association of State and Provincial Psychology Boards 2005), copies available from Association of State and Provincial Psychology Boards, P.O.

Common Law

Relevant annotation to Me. Rev. Stat. tit. 32, § 3837-A (re: Denial or refusal to renew license; disciplinary action)

- Substantial evidence supported Board of Examiners of Psychologists' findings that psychologist violated the code of conduct of psychologists and that these violations constituted negligence for purposes of statute providing that Board may refuse to issue or renew psychologist's license on ground of negligence; psychologist abandoned her patient and failed to create and maintain records regarding her treatment of patient, and she failed to properly discuss the nature and anticipated course of therapy with the patient.¹¹

Contents of the record are mandated by law

Maine has incorporated by reference the standards of the American Psychological Association and Association of State and Provincial Psychology Boards and the following standards regulate the content of psychological records kept by Maine psychologists.¹² In addition, the Health Insurance Portability and Accountability Act (HIPAA)¹³ would apply to Maine psychological records.

3.10 Informed Consent¹⁴

(a) When psychologists ...provide assessment, therapy, counseling or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons... (See also Standards [9.03, Informed Consent in Assessments](#); and [10.01, Informed Consent to Therapy](#).)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests,

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<http://www.asppb.org/publications/model/conduct.aspx>.

¹¹ *Seider v. Board of Examiners of Psychologists* (2000) Me., 754 A.2d 986.

¹² 02 -415 ME. CODE R. Ch. 9 § 1.

¹³ HIPAA, U.S. Government Printing Office Electronic Code Of Federal Regulations website at: [Subpart C--SECURITY STANDARDS FOR THE PROTECTION OF ELECTRONIC PROTECTED HEALTH INFORMATION](#) ; [Subpart E--PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION](#) (last accessed Aug. 1, 2012).

¹⁴ 02- 415 ME. CODE R. Ch. 9 § 1.

Guidelines do not substitute for laws of each state and provincial jurisdiction. Such guidelines should not be used as a substitute for obtaining personal legal advice and consultation before making decisions regarding EHRs. Because statutory, administrative, and common law can change quickly, readers are well advised to seek legal advice about current laws and rules in their jurisdiction.

and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards [9.03, Informed Consent in Assessments](#); and [10.01, Informed Consent to Therapy](#).)

A HIPAA notice of privacy practices¹⁵ 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 Standards 3.10, 9.03, and 10.01.¹⁶ Maine mandatory reporting duties must be disclosed to meet this standard:

- Duty to report abuse or neglect of a child under age 18;¹⁷
- Duty to report an incapacitated or dependent adult who has been or is at substantial risk of abuse, neglect or exploitation.¹⁸

The following standards set forth in the APA Code of Ethics create specific record keeping obligations for Maine psychologists:

4.04 Minimizing Intrusions on Privacy¹⁹

(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

¹⁵ 45 CFR 164.502 (a)(1)(ii) & 45 CFR 164.506 (c); HIPAA, U.S. Government Printing Office Electronic Code Of Federal Regulations website at: [Subpart E--PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION](#) (last accessed Aug. 1, 2012).

¹⁶ See, ME. R. EVID. 503 - Rule 503 that delineates laws about Psychologist --Patient Privilege; See, [Seider v. Board of Examiners of Psychologists \(2000\) Me., 762 A.2d 551](#), the scope of the patient-psychologist privilege is limited to confidential communications.

¹⁷ ME. REV. STAT. ANN. TIT. 22, § 4011-A.

¹⁸ ME. REV. STAT. ANN. TIT. 22, § 3477(1)-(4).

¹⁹ 02-415 ME. CODE R. Ch. 9 § 1.

Standard 4.04(a) suggests that psychologists focus the documentation in a manner that is very protective of their client's privacy rights.

The rules promulgated by the State Board of Examiners of Psychologists set forth the following requirements for the content of records maintained by licensed psychologists:²⁰

- A. The name of the client and other identifying information;
- B. The presenting problem(s) or purpose or diagnosis;
- C. The fee arrangement;
- D. The date and substance of each billed or service-count contractor service;
- E. Any test results or other evaluative results obtained and any basic test data from which they were derived;
- F. Notation and results of formal consults with other providers;
- G. A copy of all test or other evaluative reports prepared as part of the professional relationship; and
- H. Any releases executed by the client.

Other APA Ethical Standards that apply to Maine records include the following:

6.06 Accuracy in Reports to Payors and Funding Sources²¹

In their reports to payors for services ...psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided ...the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards [4.01, Maintaining Confidentiality](#); [4.04, Minimizing Intrusions on Privacy](#); and [4.05, Disclosures](#).)

9.01 Bases for Assessments²²

(a) Psychologists base the opinions contained in their recommendations, reports and diagnostic or evaluative statements,...on information and techniques sufficient to substantiate their findings. (See also Standard [2.04, Bases for Scientific and Professional Judgments](#).)

(b) Except as noted in [9.01c](#), psychologists provide opinions of the

²⁰ 02-415 ME. CODE R. Ch. 9 § 2(1).

²¹ 02-415 ME. CODE R. Ch. 9 § 1.

²² *Id.*

psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards [2.01, Boundaries of Competence](#), and [9.06, Interpreting Assessment Results](#).)

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.02 Use of Assessments²³

(a) Psychologists administer, adapt, score, interpret or use assessment techniques, interviews, tests or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques...

9.10 Explaining Assessment Results²⁴

Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative...

In light of Maine law and APA Standards 6.06, 9.01, 9.02, and 9.10 psychologists in Maine would use an intake and evaluation note, progress note, and termination templates.

Maintenance and Security of Records

Under APA Code of Ethics Standard 4.01 - Maintaining Confidentiality,²⁵ “[p]sychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*

institutional rules or professional or scientific relationship.” (See also Standard [2.05, Delegation of Work to Others](#).) This standard supports the record keeping standards:

6. Record Keeping and Fees²⁶

6.01 Documentation of Professional ...Maintenance of Records

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard [4.01, Maintaining Confidentiality](#).)

HIPAA permits sharing protected health information (PHI) with other health care professionals who are engaged in the evaluation and treatment of the same patient.²⁷ It also enables the patient to inspect and obtain PHI records created by the psychologist as long as those records are maintained.²⁸ In addition, patients have a right to amend any part of the record;²⁹ 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). Finally, patients may obtain an accounting as to who has accessed the PHI and the details about each disclosure.³⁰

²⁶ *Id*; *See*, the laws that focus upon institutional or inpatient record keeping duties: Maine Regulations, 14. Department of Human Services—General, 193. Office of Adult Mental Health, Chapter 1. Rights of Recipients of Mental Health Services, *includes*: 14-193 ME. CODE R. Ch. 1, § IX (Confidentiality And Access To Records); ME. REV. STAT. TIT. 22, § 1711. Patient access to hospital medical records; ME. REV. STAT. tit. 22, § 1711-B Patient access to treatment records; health care practitioners; ME. REV. STAT. tit. 22, § 1711-C Confidentiality of health care information.

²⁷ 45 CFR 164.520; HIPAA, U.S. Government Printing Office Electronic Code Of Federal Regulations website at: [Subpart E--PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION](#) (last accessed Aug. 1, 2012).

²⁸ 45 CFR 164.524.

²⁹ 45 CFR 164.526 (a).

³⁰ 45 CFR 164.528.

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional...³¹

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards [4.01, Maintaining Confidentiality](#), and [6.01, Documentation of Professional and Scientific Work and Maintenance of Records](#).)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards [3.12, Interruption of Psychological Services](#), and [10.09, Interruption of Therapy](#).)

Additionally, APA Code of Ethics Standard 6.02(b) requires the use coding or other techniques to avoid the inclusion of personal identifiers when confidential patient information is entered into databases or systems of records that are available to persons whose access has not been consented to by the patient.³²

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.³³ Concrete security standards are established for all electronic healthcare information (45 CFR 160).

6.03 Withholding Records for Nonpayment³⁴

Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

Release and transfer of PHI records cannot be conditioned on payment or other

³¹ 02 -415 ME. CODE R. Ch. 9 § 1.

³² *Id.*

³³ 45 CFR 164.508.

³⁴ 02- 415 ME. CODE R. Ch. 9 § 1.

conditions (such as enrollment in the health plan that employs the psychologist).³⁵

Retention of records

Psychologists shall retain full client records for at least 7 years following the date of last contact with the client, and shall retain a treatment summary for at least 15 years following the date of last contact.³⁶ In addition, in the case of clients who were minors on the date of last contact, full records must be retained until at least 3 years after the client has attained the age of majority, and the treatment summary must be retained until at least 15 years after the client has attained the age of majority.³⁷

Violations of the specific duties

Grounds for discipline include violation of any provision of a APA Code of Ethics or a practice standard adopted in Chapter 9 of the Board's rules.³⁸ In the event of any conflict or inconsistency between a APA Code of Ethics, the provisions of the following govern:³⁹

Negligence or incompetence in the practice of psychology (and record keeping) includes, but is not limited to:⁴⁰

- A. Knowingly, recklessly or negligently causing physical or emotional harm to a client;
- B. Engaging in conduct which evidences a lack of knowledge or ability to apply principles or skills to carry out the practice of psychology;
- C. Practicing psychology in such a manner as to endanger the welfare of a client; and
- D. Functioning outside of one's professional competence established by education, training and experience.

The practice of fraud or deceit in connection with services rendered as a psychologist ...includes, but is not limited to:⁴¹

- A. Committing or aiding another to commit fraud;

³⁵ 45 CFR 164.508 (b)(4).

³⁶ 02-415 ME. CODE R. Ch. 9 § 2(2).

³⁷ *Id.*

³⁸ 02-415 ME. CODE R. Ch. 9 § 1 & § 2.

³⁹ 02-415 ME. CODE R. Ch. 10 § 2(1)

⁴⁰ 02-415 ME. CODE R. Ch. 10 § 2(5).

⁴¹ 02-415, ME. CODE R. Ch. 10 § 2(6).

- B. Falsifying client records; and
- C. Deceit or corruption in billing, payment or insurance reimbursement procedures.

Disclosing a client's health care information in violation of 22 Maine Revised Statutes Annotated (MRSA) §1711-C constitutes a ground for discipline.⁴²

Confidentiality of health information; disclosure. An individual's health care information is confidential and may not be disclosed other than to the individual by the health care practitioner or facility except as provided [below];

...3. Written authorization to disclose. A health care practitioner or facility may disclose health care information pursuant to a written authorization signed by an individual for the specific purpose stated in the authorization. A written authorization to disclose health care information must be retained with the individual's health care information. A written authorization to disclose is valid whether it is in an original, facsimile or electronic form. A written authorization to disclose must contain the following elements:

- A. The name and signature of the individual and the date of signature. If the authorization is in electronic form, a unique identifier of the individual and the date the individual authenticated the electronic authorization must be stated in place of the individual's signature and date of signature;
- B. The types of persons authorized to disclose health care information and the nature of the health care information to be disclosed;
- C. The identity or description of the 3rd party to whom the information is to be disclosed;
- D. The specific purpose or purposes of the disclosure and whether any subsequent disclosures may be made pursuant to the same authorization. An authorization to disclose health care information related to substance abuse treatment or care subject to the requirements of 42 United States Code, Section 290dd-2 (Supplement 1998) is governed by the provisions of that law;
- E. The duration of the authorization;
- F. A statement that the individual may refuse authorization to disclose all or some health care information but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences;

⁴² 02-415 ME. CODE R. Ch. 10 § 2(7).

G. A statement that the authorization may be revoked at any time by the individual by executing a written revocation, subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation, instructions on how to revoke an authorization and a statement that revocation may be the basis for denial of health benefits or other insurance coverage or benefits; and

H. A statement that the individual is entitled to a copy of the authorization form.

3-A. Oral authorization to disclose. When it is not practical to obtain written authorization under subsection 3 from an individual or person acting pursuant to subsection 3-B or when a person chooses to give oral authorization to disclose, a health care practitioner or facility may disclose health care information pursuant to oral authorization. A health care practitioner or facility shall record with the individual's health care information receipt of oral authorization to disclose, including the name of the authorizing person, the date, the information and purposes for which disclosure is authorized and the identity or description of the 3rd party to whom the information is to be disclosed.

3-B. Authorization to disclose provided by a 3rd party. When an individual or an authorized representative is unable to provide authorization to disclose under subsection 3 or 3-A, a health care practitioner or facility may disclose health care information pursuant to authorization to disclose that meets the requirements of subsection 3 or 3-A given by a 3rd party listed in this subsection. A health care practitioner or facility may determine not to obtain authorization from a person listed in this subsection when the practitioner or facility determines it would not be in the best interest of the individual to do so. In making this decision, the health care practitioner or facility shall respect the safety of the individual and shall consider any indicators, suspicion or substantiation of abuse. Persons who may authorize disclosure under this subsection include:

- A. The spouse of the individual;
- B. A parent of the individual;
- C. An adult who is a child, grandchild or sibling of the individual;
- D. An adult who is an aunt, uncle, niece or nephew of the individual, related by blood or adoption;
- E. An adult related to the individual, by blood or adoption, who is familiar with the individual's personal values; and

F. An adult who has exhibited special concern for the individual and who is familiar with the individual's personal values.

4. Duration of authorization to disclose. An authorization to disclose may not extend longer than 30 months, except that the duration of an authorization for the purposes of insurance coverage under Title 24, 24-A or 39-A is governed by the provisions of Title 24, 24-A or 39-A, respectively.

5. Revocation of authorization to disclose. A person who may authorize disclosure may revoke authorization to disclose at any time, subject to the rights of any person who acted in reliance on the authorization prior to receiving notice of revocation. A written revocation of authorization must be signed and dated. If the revocation is in electronic form, a unique identifier of the individual and the date the individual authenticated the electronic authorization must be stated in place of the individual's signature and date of signature. A health care practitioner or facility shall record receipt of oral revocation of authorization, including the name of the person revoking authorization and the date. A revocation of authorization must be retained with the authorization and the individual's health care information.

6. Disclosure without authorization to disclose. A health care practitioner or facility may disclose, or when required by law must disclose, health care information without authorization to disclose under the circumstances stated in this subsection or as provided in subsection 11. Disclosure may be made without authorization as follows:

A. To another health care practitioner or facility for diagnosis, treatment or care of individuals or to complete the responsibilities of a health care practitioner or facility that provided diagnosis, treatment or care of individuals, as provided in this paragraph.

(1) For a disclosure within the office, practice or organizational affiliate of the health care practitioner or facility, no authorization is required.

(2) For a disclosure outside of the office, practice or organizational affiliate of the health care practitioner or facility, authorization is not required, except that in nonemergency circumstances authorization is required for health care information derived from mental health services provided by:

...(b) A psychologist licensed under the provisions of Title 32, chapter 56.

...B. To an agent, employee, independent contractor or successor in interest of the health care practitioner or facility including a state-designated statewide

health information exchange that makes health care information available electronically to health care practitioners and facilities or to a member of a quality assurance, utilization review or peer review team to the extent necessary to carry out the usual and customary activities relating to the delivery of health care and for the practitioner's or facility's lawful purposes in diagnosing, treating or caring for individuals, including billing and collection, risk management, quality assurance, utilization review and peer review. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales;

C. To a family or household member unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B;

D. To appropriate persons when a health care practitioner or facility that is providing or has provided diagnosis, treatment or care to the individual has determined, based on reasonable professional judgment, that the individual poses a direct threat of imminent harm to the health or safety of any individual. A disclosure pursuant to this paragraph must protect the confidentiality of the health care information consistent with sound professional judgment;

E. To federal, state or local governmental entities in order to protect the public health and welfare when reporting is required or authorized by law, to report a suspected crime against the health care practitioner or facility or to report information that the health care facility's officials or health care practitioner in good faith believes constitutes evidence of criminal conduct that occurred on the premises of the health care facility or health care practitioner;

F-1. As directed by order of a court or as authorized or required by statute;

F-2. To a governmental entity pursuant to a lawful subpoena requesting health care information to which the governmental entity is entitled according to statute or rules of court;

G. To a person when necessary to conduct scientific research approved by an institutional review board...

H. To a person engaged in the assessment, evaluation or investigation of the provision of or payment for health care or the practices of a health care practitioner or facility or to an agent, employee or contractor of such a person, pursuant to statutory or professional standards or requirements. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales;

I. To a person engaged in the regulation, accreditation, licensure or certification of a health care practitioner or facility or to an agent, employee or contractor of such a person, pursuant to standards or requirements for regulation, accreditation, licensure or certification;

J. To a person engaged in the review of the provision of health care by a health care practitioner or facility or payment for such health care under Title 24, 24-A or 39-A or under a public program for the payment of health care or professional liability insurance for a health care practitioner or facility or to an agent, employee or contractor of such a person;

K. To attorneys for the health care practitioner or facility that is disclosing the health care information or to a person as required in the context of legal proceedings or in disclosure to a court or governmental entity, as determined by the practitioner or facility to be required for the practitioner's or facility's own legal representation;

L. To a person outside the office of the health care practitioner or facility engaged in payment activities, including but not limited to submission to payors for the purposes of billing, payment, claims management, medical data processing, determination of coverage or adjudication of health benefit or subrogation claims, review of health care services with respect to coverage or justification of charges or other administrative services. Payment activities also include but are not limited to:

- (1) Activities necessary to determine responsibility for coverage;
- (2) Activities undertaken to obtain payment for health care provided to an individual; and
- (3) Quality assessment and utilization review activities, including precertification and preauthorization of services and operations or services audits relating to diagnosis, treatment or care rendered to individuals by the health care practitioner or facility and covered by a health plan or other payor;

...N. To a person when disclosure is needed to set or confirm the date and time of an appointment or test or to make arrangements for the individual to receive those services...

P. To a person representing emergency services, health care and relief agencies, corrections facilities or a branch of federal or state military forces, of brief confirmation of general health status;

Q. To a member of the clergy, of information about the presence of an individual in a health care facility, including the person's room number, place of residence and religious affiliation unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B;

R. To a member of the media who asks a health care facility about an individual by name, of brief confirmation of general health status unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; and

S. To a member of the public who asks a health care facility about an individual by name, of the room number of the individual and brief confirmation of general health status unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B;

...8. Prohibited disclosure. A health care practitioner, facility or state-designated statewide health information exchange may not disclose health care information for the purpose of marketing or sales without written or oral authorization for the disclosure.

9. Disclosures of corrections or clarifications to health care information. A health care practitioner or facility shall provide to a 3rd party a copy of an addition submitted by an individual to the individual's health care information if:

A. The health care practitioner or facility provided a copy of the original health care record to the 3rd party on or after February 1, 2000;

B. The correction or clarification was submitted by the individual pursuant to section 1711 or 1711-B and relates to diagnosis, treatment or care;

C. The individual requests that a copy be sent to the 3rd party and provides an authorization that meets the requirements of subsection 3, 3-A or 3-B; and

D. If requested by the health care practitioner or facility, the individual pays to the health care practitioner or facility all reasonable costs requested by that practitioner or facility.

10. Requirements for disclosures. Except as otherwise provided by law, disclosures of health care information pursuant to this section are subject to the professional judgment of the health care practitioner and to the following requirements.

A. A health care practitioner or facility that discloses health care

information pursuant to subsection 3, 3-A or 3-B may not disclose information in excess of the information requested in the authorization.

B. A health care practitioner or facility that discloses health care information pursuant to subsections 3, 3-A, 3-B or 6 may not disclose information in excess of the information reasonably required for the purpose for which it is disclosed.

C. If a health care practitioner or facility believes that release of health care information to the individual would be detrimental to the health of the individual, the health care practitioner or facility shall advise the individual and make copies of the records available to the individual's authorized representative upon receipt of a written authorization.

D. If a health care practitioner or facility discloses partial or incomplete health care information, as compared to the request or directive to disclose under subsection 3, 3-A, 3-B or 6, the disclosure must expressly indicate that the information disclosed is partial or incomplete;

...12. Minors. If a minor has consented to health care in accordance with the laws of this State, authorization to disclose health care information pursuant to this section must be given by the minor unless otherwise provided by law.

13. Enforcement. This section may be enforced within 2 years of the date a disclosure in violation of this section was or should reasonably have been discovered.

A. When the Attorney General has reason to believe that a person has intentionally violated a provision of this section, the Attorney General may bring an action to enjoin unlawful disclosure of health care information.

B. An individual who is aggrieved by conduct in violation of this section may bring a civil action against a person who has intentionally unlawfully disclosed health care information in the Superior Court in the county in which the individual resides or the disclosure occurred. The action may seek to enjoin unlawful disclosure and may seek costs and a forfeiture or penalty under paragraph C. An applicant for injunctive relief under this paragraph may not be required to give security as a condition of the issuance of the injunction.

C. A person who intentionally violates this section is subject to a civil penalty not to exceed \$5,000, payable to the State, plus costs. If a court finds that intentional violations of this section have occurred after due notice of the violating conduct with sufficient frequency to constitute a general business practice, the person is subject to a civil penalty not to exceed \$10,000 for health

care practitioners and \$50,000 for health care facilities, payable to the State. A civil penalty under this subsection is recoverable in a civil action.

D. Nothing in this section may be construed to prohibit a person aggrieved by conduct in violation of this section from pursuing all available common law remedies, including but not limited to an action based on negligence.

14. Waiver prohibited. Any agreement to waive the provisions of this section is against public policy and void.

15. Immunity. A cause of action in the nature of defamation, invasion of privacy or negligence does not arise against any person for disclosing health care information in accordance with this section. This section provides no immunity for disclosing information with malice or willful intent to injure any person.

Also, refusing to release records or charging excessive fees can lead to disciplinary charges:⁴³

A. Refusal to release treatment records as required by 22 MRSA §1711-B constitutes a ground for discipline. 22 MRSA §1711-B includes delineates the following laws:

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

...B. "Treatment records" means all records relating to a patient's diagnosis, treatment and care, ...performed by a health care practitioner.

2. Access. Upon written authorization executed in accordance with section 1711-C, subsection 3, a health care practitioner shall release copies of all treatment records of a patient or a narrative containing all relevant information in the treatment records to the patient. The health care practitioner may exclude from the copies of treatment records released any personal notes that are not directly related to the patient's past or future treatment and any information related to a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration. The copies or narrative must be released to the designated person within a reasonable time.

⁴³ 02-415 ME. CODE R. Ch. 10 § 2(8).

If the practitioner believes that release of the records to the patient is detrimental to the health of the patient, the practitioner shall advise the patient that copies of the treatment records or a narrative containing all relevant information in the treatment records will be made available to the patient's authorized representative upon presentation of a written authorization signed by the patient. The copies or narrative must be released to the authorized representative within a reasonable time.

Except as provided in subsection 3, release of a patient's treatment records to a person other than the patient is governed by section 1711-C.

3. Person receiving the records. Except as otherwise provided in this section, the copies or narrative specified in subsection 2 must be released to:

A. The person who is the subject of the treatment record, if that person is 18 years of age or older and mentally competent;

B. The parent, guardian ad litem or legal guardian of the person who is the subject of the record if the person is a minor, or the legal guardian if the person who is the subject of the record is mentally incompetent;

C. The designee of a durable health care power of attorney executed by the person who is the subject of the record, at such time as the power of attorney is in effect; or

D. The agent, guardian or surrogate pursuant to the Uniform Health-care Decisions Act.

3-A. Corrections and clarifications of treatment records. A patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem may submit to a health care practitioner health care information that corrects or clarifies the patient's treatment record, which must be retained with the treatment record by the health care practitioner. If the health care practitioner adds to the treatment record a statement in response to the submitted correction or clarification, the health care practitioner shall provide a copy to the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem.

4. Minors. This section does not affect the right of minors to have their treatment records treated confidentially pursuant to the provisions of, chapter 260.

...8. Violation. A person who willfully violates this section commits a civil violation for which a forfeiture of not more than \$25 may be adjudged. Each day that the treatment records or narrative is not released after the reasonable time specified in subsection 2 constitutes a separate violation, up to a maximum forfeiture of \$100.

B. Charging excessive fees for treatment records in violation of 17 MRSA §1711-A constitutes a ground for discipline. 22 MRSA §1711-B states that:

...the charge for copies may not exceed \$10 for the first page and 35cents for each additional page.