TMA Office of the General Counsel

Release of Medical Records

June 2010

Patient Access and Consent to the Release of Medical Records

Physicians have the right of ownership in the physical pieces of paper or the physical hard drive that contain the records physicians develop when treating their patients in their office practice. However, patients generally have a right to access that information or receive copies. This whitepaper addresses several common issues that arise with medical records release.

Requirements for a Written Consent to Release Medical Records

According to the Texas Medical Practice Act (MPA), a release for medical records to patients or to persons designated by patients must satisfy the following requirements. (NOTE: a physician may release records to other physicians or those working with physicians for treatment without a written consent form1). There are exceptions discussed later in this document that permit disclosure without a signed form.

1. **Written request.** Consent for release of medical records must be in writing.2 Oral requests for release of records are not binding.

2. **Signed by proper consenting party.** The consent may be signed by the patient (if an adult)3 or by the patient's parents (if a minor)4 or guardian (if the patient is adjudicated incompetent)5 or a personal representative (if the patient is deceased)6 or an attorney ad litem appointed for the patient.7

3. **Requirements for validity.** To be valid, the consent must contain the following three elements:
   a) the billing records, medical records, or other information to be covered by the release;8
   b) the reasons or purposes for the release;9 and

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1 TEX. OCC. CODE §159.004(a)(7).
2 TEX. OCC. CODE §159.005.
3 TEX. OCC. CODE §159.005(a)(1).
4 TEX. OCC. CODE §159.005(a)(2).
5 TEX. OCC. CODE §159.005(a)(3).
6 TEX. OCC. CODE §159.005(a)(5).
7 TEX. OCC. CODE §159.005(a)(4).
8 TEX. OCC. CODE §159.005(b)(1).
9 TEX. OCC. CODE §159.005(b)(2).
c) the person to whom the information is to be released.  

4. **Reasons for release.** Records need not be released if the person signing the consent form will not give the reasons or purposes for the release. However, the MPA does not provide an exception to release if the physician or practice dislikes or disapproves of the purpose of release. Simply, there is no wrong reason for requesting copies of medical or billing records.

5. **To whom released.** A patient has the right to have copies of medical records released to any person or entity designated by the patient to receive the records. The only clear exception to disclosure is in those circumstances where the physician determines that access to the information would be harmful to the physical, mental, or emotional health of the patient.  

**HIPAA Authorizations and Texas Consent to Release**

Under the Health Insurance Portability and Accountability Act (HIPAA) oral requests for access or copies are binding unless patients are informed that requests must be in writing. For that reason, some practices place a statement in their notice of privacy practices that requests for access or copies of medical or billing records must be in writing.

Fortunately, HIPAA requirements for authorizations are extremely compatible with Texas law. All of the elements for a Texas consent form (listed above) also apply to a HIPAA release. Just as in Texas, HIPAA requires a patient to state the purpose of the release on the form. The federal government expressly states that “at the request of the individual” is a sufficient reason and – just as with Texas forms – there is nothing in the regulation that provides for an exception if the practice dislikes the reason for the request for records. Importantly, HIPAA authorizations include a few additional elements other than those under Texas law. First, A HIPAA authorization must also have an expiration event or date. Second, HIPAA has some mandatory disclosures that must be in the authorization form. Those disclosures are intended to place the patient on notice of the following:

- The individual’s right to revoke the authorization in writing, and either:
  - Any exceptions to the right to revoke (such as when the practice releases information in reliance on the executed authorization) and a description of how the individual may revoke the authorization (writing sent to the practice or any other method the practice may choose); or
  - If any of those exceptions are mentioned in the Notice of Privacy Practices (NPP), a reference to the NPP must be in the authorization.

- A statement on whether the practice is able or unable to condition treatment or payment on the execution of an authorization.  

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10 TEX. OCC. CODE §159.005(b)(3).
11 TEX. OCC. CODE §159.006(a).
12 45 CFR §164.524(b).
13 45 CFR §164.508(c)(1)(iv).
14 45 CFR §164.508(c)(1)(v).
15 45 CFR §164.508(c)(2)(i).
16 (Generally, a physician practice may
NOT condition treatment on the execution of an authorization. An example of an exception to that general rule is research conducted through an Institutional Review Board.

- The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by HIPAA.\(^\text{17}\)

**Originals or copies**

Patients are not entitled to the *original* medical records. They are entitled to receive copies, narratives or a summary of their records (or to have them sent to the person of their choosing).\(^\text{18}\) The original records - all of them - are the tangible personal property of the physician or the practice owners.\(^\text{19}\) Also, the Texas Medical Board requires a licensed physician to maintain records for seven years from the last date of treatment, when the patient is an adult, or for seven years from the last date of treatment or until the patient is 21 years old (whichever is later) if the patient is a minor.\(^\text{20}\) Keeping the originals in the physician’s possession aids the physician in complying with this regulation.

**Medium by Which Information is Provided**

Under Texas law, copies may be released on paper or using any other appropriate medium (e.g., microfiche, microfilm, computer disk or other electronic storage medium), so long as both the physician and the patient (or person/entity who is to receive the records) agree on the medium.\(^\text{21}\) However, if the physician is a HIPAA “covered entity”\(^\text{22}\) that uses or maintains an electronic health record for an individual, then the patient has a right to obtain a copy of the information from the physician in an electronic format.\(^\text{23}\) Additionally, if the patient chooses, he or she may direct the physician to transmit the electronic copy directly to a designated entity or person, provided that the choice is “clear, conspicuous and specific.”\(^\text{24}\)

**Copies or a Summary**

If a patient requests his or her records, under Texas law, the physician is free to provide either copies or a summary or narrative of those records.\(^\text{25}\) In other words, even if a patient insists on copies, the physician is free to provide a summary over the patient’s objections. Texas is one of the few states which still permits physicians to choose the form in which records are to be released. If the physician must comply with the HIPAA privacy standards, then the choice of copies versus summary, even in Texas, is now the patient’s choice.\(^\text{26}\)

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\(^\text{16}\) 45 CFR §164.508(c)(2)(ii).
\(^\text{17}\) 45 CFR §164.508(c)(2)(iii).
\(^\text{18}\) TEX. OCC. CODE §159.006(a).
\(^\text{19}\) For more information on medical record ownership, see: *Who Owns What, Texas Medicine*, February 2008, p. 7; available from the TMA Knowledge Center.
\(^\text{20}\) 22 TEX. ADMIN. CODE §165.1(b).
\(^\text{21}\) TEX. OCC. CODE §159.007.
\(^\text{22}\) For more information on who is a “covered entity,” see CMS materials at the following link: [http://www.cms.gov/HIPAAGenInfo/06_AreYouACoveredEntity.asp](http://www.cms.gov/HIPAAGenInfo/06_AreYouACoveredEntity.asp)
\(^\text{23}\) Health Information Technology for Economic and Clinical Health Act (“HITECH”) §13405(e)(1). Note that HITECH §13405(e)(2) also limits the copy fees in such situations to the labor cost incurred in responding to the request. Specifically, HITECH provides that “… any fee that the covered entity may impose for providing such individual with a copy of such information (or a summary or explanation of such information) if such copy (or summary or explanation) is in an electronic form shall not be greater than the entity’s labor costs in responding to the request for the copy (or summary or explanation).
\(^\text{24}\) HITECH §13405(e)(1).
\(^\text{25}\) TEX. OCC. CODE §159.006(a).
\(^\text{26}\) 45 CFR §164.524(c)(2)(ii).
The situation is different however, if a subsequent treating or consulting physician is requesting copies of the records. If a consulting or subsequent treating physician submits a written request for copies of the patient’s records, then the physician must provide copies and not a summary or narrative. 27

**Records Created by Other Physicians**

It is not uncommon for a medical record to contain records and information created by another physician. The Medical Practice Act contains a provision that requires disclosure of information in the possession of the physician that was created by another. Simply, the law states that in response to a request for records, the physician “shall” disclose records “including records received from a physician or other health care provider involved in the care or treatment of the patient.” 28 There is no exception in the Act for those documents that may be stamped “Do Not Copy or Forward” or “Not for Re-release.”

**Medical Records and Minors**

As mentioned above, a valid written consent for disclosure for minors must be signed by the parent to be valid (unless a court has emancipated the minor or the minor is married). 29 The Medical Practice Act provisions are very absolute as to the actions that take place once a physician receives a written request from a parent. It says, “a physician who receives a written consent for release of information … shall furnish copies of the requested billing or medical records.” 30 There is no discretion other than in those narrow set of circumstances where the physician believes the disclosure is harmful to the physical, mental, or emotional health of the patient (more information is provided later in this document). 31

As it may regard divorced parents, the law does not generally place any additional limitations on either parent’s access to medical information. 32 The Texas Family Code describes typical court orders to address custody and the authority of one parent versus another. However, these are guidelines and are not binding on a judge. The Family Code states, “Unless limited by court order, a parent appointed as a conservator of a child has at all times the right … of access to medical, dental, psychological, and educational records of the child….” 33 This means if a practice has any question about a particular parent’s right to access medical records or consent to release medical records, the answer will lie within that particular parent’s court order. Incidentally, a conservator can be either a managing conservator (the modern term for custodial parent) or possessory conservator (the modern term for non-custodial parent) – meaning the provision above generally applies to both parents.

**Fees for Copies**

The permissible fee for copies of medical records can vary depending upon the type of coverage (such as workers’ compensation) and there are exceptions to the ability to charge at all. TMA has a whitepaper entitled “Fees for Copies of Medical Records” should you need information on this topic. The whitepaper includes references to the TMB rules on time frames and maximum fees for copying medical records.

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27 TEX. OCC. CODE §159.006(c).
28 TEX. OCC. CODE §159.006(a).
29 TEX. FAM. CODE § 1.104.
30 TEX. OCC. CODE §159.006(a).
31 Id.
32 TEX. FAM. CODE, Chapter 153.
33 TEX. FAM. CODE §153.073. (emphasis added).
Withholding Copies of Records for Failure to Pay Copy Fee

Generally, the regulations permit physicians to retain records until payment of a copy fee is received (keep in mind there are exceptions, discussed below). However, to appropriately withhold copies for failure to include payment of the copy fee, a physician is required to send the requesting party written correspondence of the need for payment within ten calendar days of receiving the request. Failure to send the letter impairs the practice’s ability to withhold the records. The TMB further requires that the “10-day” letter be made part of the patient’s billing record.\textsuperscript{34} \textbf{It is important to note that if the records are requested by a physician licensed in the U.S. or Canada for the purposes of providing emergency or acute medical care to the patient the records cannot be withheld.}\textsuperscript{35}

The HIPAA privacy regulations do not, by their own terms, expressly permit withholding of records for failure to pay the copy fee. However, the regulation and the government comments implicitly permit this practice. Consider the following government discussion:

\begin{quote}
The inclusion of a fee for copying is not intended to impede the ability of individuals to copy their records. Rather, it is intended to reduce the burden on covered entities. If the cost is excessively high, some individuals will not be able to obtain a copy. We encourage covered entities to limit the fee for copying so that it is within reach of all individuals.\textsuperscript{36}
\end{quote}

One would not expect that the agency adopting the regulations would be concerned about high fees preventing access to records unless covered entities are permitted to withhold for failure to pay.

A physician may not charge a fee for copies (and therefore may not withhold the copies) where the records are requested:

(1) by a licensed Texas health care provider or any American or Canadian licensed physician for acute or emergency medical care;\textsuperscript{37} or

(2) to support an application (or an appeal) for disability or other benefits or assistance under:
   a. Aid to Families with Dependent Children;
   b. Medicaid;
   c. Medicare;
   d. Supplemental Security Income; and
   e. Federal Old-Age and Survivors Insurance.\textsuperscript{38}

Where the requestor attempts to avoid fees under number (2), above, the law states:

\begin{quote}
A person . . . that requests a record under this section \textbf{shall include with the request a statement or document from the department or agency} that administers the issuance of the assistance or benefits that confirms the application or appeal.\textsuperscript{39}
\end{quote}

\textsuperscript{34} See 22 TEx. ADMIN. CODE §165.2(g). “A copy of the letter regarding the need for payment shall be made part of the patient’s medical and/or billing record as appropriate.”
\textsuperscript{35} 22 TEx. ADMIN. CODE §165.2(f).
\textsuperscript{36} 65 Fed. Reg. 82557. (Emphasis Added).
\textsuperscript{37} 22 TEx. ADMIN. CODE §165.2(f).
\textsuperscript{38} TEx. HEALTH & SAFETY CODE §161.202(a).
\textsuperscript{39} TEx. HEALTH & SAFETY CODE §161.202(c).
The fee is only waived when the patient or his attorney requests the records and includes a statement or document from the agency; it does not apply when a state or federal agency requests the records.\(^{40}\)

A physician is not required to provide more than one complete record requested for supplementary security income or federal old-age and survivors’ insurance benefits without charge.\(^{41}\) If additional material is added to the patient or former patient’s record, on request of the patient, the physician shall supplement the record provided for supplementary security income or federal old-age and survivors insurance without charge.\(^{42}\) Similarly, the law does not appear to permit charging for copies of supplemental records to support applications under the other mentioned programs.\(^{43}\)

**What constitutes a medical record?**

The Medical Practice Act takes a functional approach to defining a medical record by stating that the “term ‘medical record’ means all records relating to the history, diagnosis, treatment or prognosis of a patient.”\(^{44}\) In order to maintain an “adequate medical record,” the TMB requires that the record be “complete, contemporaneous and legible.”\(^{45}\) Additionally, the following standards must be met:

- The documentation of each patient encounter should include:
  - (A) reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
  - (B) an assessment, clinical impression, or diagnosis;
  - (C) plan for care (including discharge plan if appropriate); and
  - (D) the date and legible identity of the observer.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- The rationale for and results of diagnostic and other ancillary services should be included in the medical record.
- The patient’s progress, including response to treatment, change in diagnosis, and patient’s non-compliance should be documented.
- Relevant risk factors should be identified.
- The written plan for care should include when appropriate:
  - treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
  - any referrals and consultations;
  - patient/family education; and,
  - specific instructions for follow up.


\(^{42}\) Id.

\(^{43}\) Id.

\(^{44}\) Tex. Occ. Code §151.002(a)(9).

• Any written consents for treatment or surgery requested from the patient/family by the physician.
• Billing codes, including CPT and ICD-9-CM codes, reported on health insurance claim forms or billing statements should be supported by the documentation in the medical record.
• Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.
• Records received from another physician or health care provider involved in the care or treatment of the patient shall be maintained as part of the patient's medical records.
• The board acknowledges that the nature and amount of physician work and documentation varies by type of services, place of service and the patient's status. These requirements may be modified to account for these variable circumstances in providing medical care.\textsuperscript{46}

\textit{Time limit to respond}

When a physician receives a proper written request for release of records and a reasonable copy fee, he or she has 15 business days to respond.\textsuperscript{47} HIPAA privacy provides for a greater response time, but since the Texas provision is more stringent (i.e., it is the shorter period) HIPAA covered entities must respond in 15 days as well.\textsuperscript{48} If, for some reason, it is determined that the request for release will not be honored (as described below), the physician must within those 15 days:

\begin{itemize}
  \item[a)] furnish the patient a written statement, signed and dated, stating the reason for denial; and
  \item[b)] how the patient can file a complaint with the federal Department of Health and Human Services (if the physician is subject to HIPAA) and the Texas Medical Board (for issues addressing withholding information under HIPAA, see the section entitled “Grounds for Refusing Release under HIPAA Regulations”); and
  \item[c)] place a copy of the written denial in the medical record and/or billing record as appropriate.\textsuperscript{49}
\end{itemize}

\textit{Conditions Under Which a Physician May Refuse a Request for Release Under Texas Law}

\textbf{(1) Request not accompanied by copy fee}

As stated earlier, if the physician receives a valid consent to release that is not accompanied by payment of the copy fee he may withhold the copies (until payment is received) provided a “10-day” letter is sent notifying the requesting party of the need for

\textsuperscript{46} Id.
\textsuperscript{47} TEX. OCC. CODE §159.006(d).
\textsuperscript{48} 45 CFR §164.524(b)(2).
\textsuperscript{49} TEX. OCC. CODE §159.006(e) and 22 TEX. ADMIN. CODE §165.2(c).
A copy of the letter must be made part of the patient’s medical record and/or billing records as appropriate.\(^{51}\)

**2) Other grounds**

A physician may also refuse to release copies or a summary if the physician determines that access to the information would be harmful to the physical, mental, or emotional health of the patient.\(^{52}\)

Additionally, Texas law permits the physician to “delete [from the copy of a medical record, not from the original medical record] confidential information about another patient or family member of the patient who has not consented to the release.”\(^{53}\) One situation in which this provision may apply is when the physician accidentally grabs the wrong chart and inputs the wrong patient’s information into the medical record.

In this situation, physicians must be careful with regard to: (1) properly documenting the error and (2) properly releasing the medical information.

As the TMA and TMLT publication “Medical Records: Your Rapid Route to Answers” states:

> Be truthful about charting mistakes. For instance, if halfway into documentation during a hectic afternoon, you realize that you grabbed the wrong chart, this is easy to rectify. Just draw one line through the mistaken entry; write “error,” your initials, and date; and move on.

> The rule of thumb is to make sure anyone can read all of your mistakes. Do not use whiteout or obliterate your mistake in any other way, as this often creates an impression of guilt, embarrassment, or a true cover-up. If the jury members can read your mistake, they will understand it. They have made mistakes, too. Remember that this is not about embarrassment; it is about your integrity in front of the jury.\(^{54}\)

The Texas Medical Board also requires that “any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation … be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.”\(^{55}\)

After correctly noting any error in the medical record, the physician should adhere to applicable state and federal law (e.g., HIPAA if the physician is a HIPAA covered entity) in order to prevent the improper release of any confidential patient information (both of the wrong patient and the correctly-charted patient).

As aforementioned, under Texas law “the physician may delete [from the copy of the released medical record, not from the original medical record] confidential information

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\(^{50}\) 22 TEx. ADMIN. CODE § 165.2(g).

\(^{51}\) Id.

\(^{52}\) TEX. OCC. CODE §159.006(a) and 22 TEx. ADMIN. CODE §165.2(a).

\(^{53}\) TEX. OCC. CODE §159.006(b) and 22 TEx. ADMIN. CODE §165.2(a).


\(^{55}\) 22 TEx. ADMIN. CODE §165.1(a)(9).
about another patient or a family member of the patient who has not consented to the release.\textsuperscript{56}

Section 165.2 of the Texas Medical Board Rules reiterates this point:

(a) Release of Records Pursuant to Written Request. As required by the Medical Practice Act, §159.006, a physician shall furnish copies of medical and/or billing records requested or a summary or narrative of the records pursuant to a written release of the information as provided by the Medical Practice Act, §159.005, except if the physician determines that access to the information would be harmful to the physical, mental, or emotional health of the patient. \textit{The physician may delete confidential information about another patient or family member of the patient who has not consented to the release.} If by the nature of the physician's practice, the physician transmits health information in electronic form, the physician may be subject to the Health Insurance Portability and Accountability Act (HIPAA) 45 C.F.R. Parts 160-164. Unless otherwise provided under HIPAA, physicians subject to HIPAA must permit the patient or an authorized representative access to inspect medical and/or billing records and may not provide summaries in lieu of actual copies unless the patient authorizes the summary and related charges.\textsuperscript{57}

If the physician denies a request for copies of a medical record or a summary, in whole or in part, the physician must furnish the patient with a written statement, signed and dated, within 15 business days of receipt of the request, stating the reason for the denial, and how the patient can file a complaint with the federal Department of Health and Human Services (if the physician is subject to HIPAA) and the Texas Medical Board.\textsuperscript{58} A copy of the statement denying the request shall be placed in the patient’s medical and/or billing records as appropriate.\textsuperscript{59} \textbf{If a physician is considered a covered entity under HIPAA, then particular attention should be brought to the next section.}

\textbf{Grounds for Refusing Release under HIPAA Regulations}

Even though patients are granted the privilege of access to information under HIPAA, physicians are provided with a limited ability to refuse such access. There are two classes of exceptions to the access right: (1) those for which the physician’s decision is unreviewable and (2) those for which review of the decision must be provided.\textsuperscript{60} Only that information for which an exception applies may be withheld, all other information must be disclosed to the patient.\textsuperscript{61} In other words, one can “black out” or redact the withheld information and provide the rest.

A physician may refuse patient access to or to provide copies of medical records without review if the records are psychotherapy notes, compiled in anticipation of litigation, subject to the Clinical Laboratory Improvements Amendments of 1988, or obtained from someone under a promise of confidentiality.\textsuperscript{62} In these cases, the physician’s decision is

\textsuperscript{56} TEX. OCC. CODE §159.006(b).
\textsuperscript{57} 22 TEX. ADMIN. CODE §165.2(a). (emphasis added).
\textsuperscript{58} TEX. OCC. CODE §159.006(e) and 22 TEX. ADMIN. CODE §165.2(c).
\textsuperscript{59} 22 TEX. ADMIN. CODE §165.2(c).
\textsuperscript{60} 45 CFR §164.524(d).
\textsuperscript{61} 45 CFR §164.524(d)(1).
\textsuperscript{62} 45 CFR §164.524(a)(1) and (2). The primary purpose of medical records is to provide a tool for the delivery of health care. Although records are often used in medical liability defense, it would be improper to \textit{generally} state they are created
A decision to deny access must be communicated in writing. That written denial must provide certain basic information such as why the denial was made, how a complaint can be filed with the federal government and Texas Medical Board, and be in plain language.  

A physician may refuse patient access to “protected health information” with review if in his judgment access to that information would be reasonably likely to endanger the life or physical safety of the patient or another person; 2) if the record makes reference to another person and access to that information is reasonably likely to cause substantial harm to that person; or 3) if the request is made by a personal representative and the physician believes access to that information is reasonably likely to cause substantial harm.  

When the patient requests it, a review of the decision by a licensed health care professional (who is designated by the physician covered entity to act as a reviewing official and who was not involved with the original decision) must take place. Should the reviewer affirm the original decision, the patient may be refused access to the records. Otherwise the patient must be allowed access to the information or copies of the medical record.  

It is important to note that the HIPAA requirement for review is by a licensed health care professional and, therefore, a person other than a physician may review the decision.  

Billing Records  

A physician does not need to provide copies of billing records unless specifically requested to do so. However, if an appropriate request is made, then the practice must disclose as the MPA applies to medical and billing records.  

Unauthorized Disclosure or Refusal to Disclose  

A patient aggrieved by the "unauthorized disclosure" of confidential information may seek an injunction and civil damages under state law. No relief is stated for a physician's seemingly unjustified refusal to comply with a valid release. However at least one appellate court in another state has upheld the award of punitive damages assessed against a physician because he allegedly caused a patient severe emotional distress by refusing to provide copies of her medical records. Additionally the TMB could consider the physician's lack of response to a patient's valid request to be a violation of the MPA and trigger disciplinary proceedings.  

Under HIPAA, the federal Department of Health and Human Services is authorized to impose civil monetary penalties on physicians for violations of the privacy law and regulations. In the recently-passed Health Information Technology for Clinical and Economic Health (“HITECH”) Act, the civil monetary penalty ranges were significantly increased and tiered. Previously, the maximum civil monetary penalty was $100 per
violation per day, with a total annual maximum of $25,000 for the identical type of violation. For violations occurring on or after February 18, 2009, the maximum for identical violations has been increased to $1.5 million per calendar year. Additionally, the four tiers of penalties are now as follows:

- Not less than $100 or more than $50,000 for each violation—For a violation in which it is established that the covered entity did not know and, by exercising reasonable diligence, would not have known that the covered entity violated such a provision;
- Not less than $1,000 or more than $50,000 for each violation—For a violation in which it is established that the violation was due to reasonable cause and not to willful neglect;
- Not less than $10,000 or more than $50,000 for each violation—For a violation in which it is established that the violation was due to willful neglect and was corrected during the 30-day period beginning on the first date the covered entity liable for the penalty knew, or by exercising reasonable diligence, would have known that the violation occurred;
- Not less than $50,000 for each violation—For a violation in which it is established that the violation was due to willful neglect and was not corrected during the 30-day period beginning on the first date the covered entity liable for the penalty knew, or by exercising reasonable diligence, would have known the violation occurred.

In addition to HHS enforcement, HITECH authorizes state Attorney Generals to bring civil actions in district court on behalf of residents of the relevant state to enjoin HIPAA violations or to obtain damages on behalf of the residents of the state. The amount of damages provided for under HITECH is the number of violations multiplied by up to $100. The maximum amount of damages that may be imposed on a person for identical violations during a calendar year is $25,000. Additionally, a court may award costs of the action and reasonable attorneys’ fees to the state if the state’s action is successful.

Finally, it is important to note that criminal penalties may be imposed if a person knowingly obtains or discloses individually identifiable health information in violation of HIPAA.

**Unpaid Balances; Withholding for Past Due Accounts is Prohibited**

Medical records may not be withheld from the patient, the patient’s authorized representative, or the patient’s designated recipient for such records based on a past due account for medical care or treatment previously rendered to the patient. Although a practice is permitted to withhold copies for lack of payment of the copy fee, the TMB has prohibited practices from utilizing requests for copies as a method of collecting on overdue accounts. Therefore, where a patient has a past due account for treatment previously rendered to the patient and that patient pays for the copies, the records must be

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74 45 CFR §160.404(b)(2).
75 Id.; see 45 CFR §160.408 for factors considered in determining the amount of a civil monetary penalty; see 45 CFR §160.410 for affirmative defenses; see 45 CFR §160.412 for waiver.
76 HITECH §13410(e).
77 Id.
78 Id.
79 Id.
80 42 USC §1320d-6.
81 22 TEX. ADMIN. CODE §165.2(h).
provided to the patient. The TMB actively enforces this particular provision. Consider the following summary (with the physician’s name omitted) that appeared in a Texas Medical Board Newsletter:

P, M.D., Texas

On August 26, 2005, the Board and Dr. P entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Dr. P failed to timely provide one patient properly requested medical records while under the misunderstanding that records can be withheld because of an outstanding bill.

It is possible that, in addition to the TMB penalty, the physician paid defense costs associated with hiring legal counsel. Also, the physician must now report on credentialing forms that he has been the subject of a complaint and penalty by the Texas Medical Board.

The TMB rule is in line with an opinion of the AMA Council on Ethical and Judicial Affairs, which provides that "medical reports should not be withheld because of an unpaid balance for medical services" as well as TMA's ethics position that it is unethical for a physician to refuse or to delay improperly in responding to a valid request for transfer of a former patient's medical records because of an unpaid bill. The physician's first responsibility is the care and welfare of the patient. Other alternatives are available for the collection of fees.

**Mental Health Records**

Chapter 611 of the Texas Health and Safety Code governs the release of information concerning a patient’s treatment for any mental or emotional disorder, including alcoholism or drug addiction. (This mental health, alcoholism, and drug addiction information is hereinafter referred to as “confidential information”). Just as the Medical Practice Act specifically states the conditions under which a physician may release medical records, Chapter 611 indicates the circumstances under which a “professional” may release confidential information. A “professional” includes, a psychiatrist, psychologist, certified social worker, chemical dependency counselor, etc.

**Consent to Release**

A professional must release confidential information to a person who has the written consent of the patient, a parent if the patient is a minor, a guardian if the patient has been adjudicated as incompetent to manage the patient’s personal affairs, or a personal representative if the patient is deceased. Professionals are to delete confidential information in the record about another person who has not consented to the release. But a professional may not delete information relating to the patient that another person has provided, the identity of the person responsible for that information, or the identity of any person responsible for the patient's confinement.

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82 22 T. EX. ADMIN. CODE §165.2(h).
83 Texas Medical Board Bulletin, Volume 3, No. 1 (Fall 2005), emphasis added.
85 TEX. HEALTH & SAFETY CODE § 611.004(a)(4)-(a)(5) and §611.0045.
86 TEX. HEALTH & SAFETY CODE §611.0045(g).
87 Id.
Grounds for Refusing Release Under Texas Law for Mental Health

However, Texas law states a professional may deny access to any portion of the patient’s record if the professional believes that release of that portion would be harmful to the patient’s mental, physical, or emotional health (for HIPAA covered entities, please see below). When denying a patient access to a portion of the record, a professional must provide the patient a signed and dated written reason for the denial, and file a copy in the mental health record. This is similar to the requirement in the Medical Practice Act discussed above, but with the following extra provisions: the statement must specify the portion of the record to which access is denied, the reason for the denial and the duration of the denial. This requirement is not preempted by federal HIPAA regulations, so these extra steps will apply even to professionals who are considered HIPAA covered entities. The professional who denies access to a portion of a mental health record shall re-determine the necessity for the denial at each time a request for the denied portion is made. If a subsequent request results in a subsequent denial, the same procedure must be followed.

Even if a professional denies a patient access to a portion of a mental health record, the professional must allow another professional who is treating the patient for a related condition to examine and copy the patient’s record.

HIPAA Preempts Portion of Texas Health & Safety Code

Professionals who must comply with HIPAA (i.e., those physicians who are covered entities) cannot withhold mental health records where the information would be merely harmful. Texas Senate Bill 1136, passed in 2003, directed the Attorney General to review all Texas laws that address confidentiality and report on whether the federal HIPAA privacy regulations preempt Texas law. That report concluded that HIPAA standards for withholding records are more stringent than Texas law and that the standard professionals should use is, if in the opinion of the professional, the disclosure is “reasonably likely to endanger the life or physical safety of the individual or another person.”

Revocation of Consent for Release of Mental Health Records

A patient or a patient’s legally-authorized representative may revoke a consent for disclosure at any time. A revocation is valid only if it is written, dated, and signed by the patient or legally-authorized representative.

Summary or Copies

If a patient or other authorized person requests a summary of confidential information, the professional must provide the summary.

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88 TEX. HEALTH & SAFETY CODE §611.0045(b).
89 TEX. HEALTH & SAFETY CODE §611.0045(c).
90 Id.
92 TEX. HEALTH & SAFETY CODE §611.0045(d).
93 Id.
94 TEX. HEALTH & SAFETY CODE §611.0045(e).
96 TEX. HEALTH & SAFETY CODE § 611.007(a).  But see TEX. HEALTH & SAFETY CODE § 611.007(b) stating that “a patient may not revoke a disclosure that is required for purposes of making payment to the professional for mental health care services provided to the patient.”
97 TEX. HEALTH & SAFETY CODE § 611.007(a).
98 TEX. HEALTH & SAFETY CODE § 611.0045(h).
Time to Respond for Mental Health Records Release

On receipt of a written request from a patient to examine or copy his/her records, a professional must, no later than the 15th day after receiving the request, make the records available for examination during regular business hours and provide a copy if requested. If the records cannot be found or do not exist, then within the 15 days, the professional must inform the patient that the records cannot be produced.

"Super-confidential" information

In addition to mental health records, there are certain types of medical information that require a specific signed consent-for-release form before it can be released to anyone for any purpose. If your medical chart contains information of this nature (from whatever source), you should not release it to anyone - another physician, insurance company, attorney or otherwise - without explicit written authorization from the patient.

Two federal statutes mandate confidentiality of the identity, diagnosis, prognosis, or treatment of any patient for drug or alcohol abuse in a program or activity that is conducted, regulated, or assisted by the federal government. However, the patient may give written consent to release information. Release is permitted without the patient's consent to:

- medical personnel in a bona fide emergency;
- qualified persons conducting program audits or evaluations if individual patients are not identified; and
- persons authorized by an appropriate court order based on "good cause" shown. The federal requirements override state law when a conflict occurs.

In the case of alcohol and drug abuse treatment information which is generated by a federally supported program, it may be necessary for the party seeking the information to obtain a special type of court order.

AIDS/HIV Test Information

The test results for AIDS infection, HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS are confidential and may not be released except as Texas law allows. The fact that such a test was conducted is also deemed confidential. Please note, the initial diagnosis of HIV infection is a reportable condition. Visit this website for information on reporting: http://www.dshs.state.tx.us/hivstd/healthcare/reporting.shtm

Under the law test results may be released to:

- the Texas Department of State Health Services;
- a local health authority if reporting is required under the Act;

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99 TEX. HEALTH & SAFETY CODE § 611.008.
100 Id.
101 42 USC §290dd-2; 42 CFR Subchapter A part 2 - Confidentiality of alcohol and drug abuse patient records.
103 TEX. HEALTH & SAFETY CODE §81.103
104 Id.
• the Centers for Disease Control of the United State Public Health Services if reporting is required by federal law or regulation;

• the physician or other person authorized by law who ordered the test;

• a physician nurse or other health care personnel who have a legitimate need to know the test result in order to provide for their protection and to provide for the patient's health and welfare;

• the person tested or a person legally authorized to consent to the test on the person's behalf;

• the spouse of the person tested if the person tests positive for AIDS infection, HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS; and

• when the person is a defendant in a criminal case and required to be tested by the Texas Code of Criminal Procedure the HIV test result may be released to the victim of a sexual assault or aggravated sexual assault allegedly committed by the person tested.\textsuperscript{105}

The person tested (or a person legally authorized to consent to the test on the person's behalf) may also:

• voluntarily release or disclose that person's test results to persons or entities other than those provided by the law; or

• authorize the release or disclosure of that person's test results to persons or entities other than those provided by the law.\textsuperscript{106}

This authorization must be in writing and be signed by the person tested (or a person legally authorized to consent to the test on the person's behalf) and state the persons or entities (or classification of persons or entities) to whom the test results may be released or disclosed.

If a report of an HIV test result is used for statistical summary purposes only, the person or entity releasing or disclosing the test result may disclose or release the information without the written consent of the person tested only after any information that could identify the person is removed from the report.

A blood bank may report the name of a donor with a positive HIV test result or other possible infectious disease to other blood banks; however the blood bank may not disclose the infectious disease that the donor has or is suspected of having. A blood bank may report HIV test results to the hospitals where the blood was transfused, to the physician who transfused the infected blood, and to the recipient of the blood. A blood bank may also report HIV test results for statistical purposes. A blood bank making a report as provided by this subsection is not considered to have breached a confidence arising out of any confidential relationship.\textsuperscript{107}

The law does not prohibit an employee of a health care facility from viewing HIV test results while performing the employee's duties if the employee's job requires the employee to deal with permanent medical records and the employee learns of test results

\textsuperscript{105} Id.

\textsuperscript{106} Id.

\textsuperscript{107} Id.
during reasonable health care facility practices. HIV test results which are viewed in such circumstances are also confidential.

**Special Rules for Records of Workers’ Compensation Patients**

A consulting doctor, referred by the primary treating doctor, shall submit a narrative medical report to the carrier, and the injured employee or the injured employee's representative, within seven days of the examination. If treatment continues, subsequent reports must be submitted 60 days and 120 days after treatment begins.

The treating physician shall also forward copies of medical records to a physician that is examining the claimant under a medical examination order when requested to do so within seven days. No written consent to release medical records is required in this situation.

A treating physician shall ensure that any required records and analyses (if any) are mailed to the designated doctor conducting a “designated doctor examination” no later than the fifth working day prior to the date of the examination. The designated doctor is entitled to copies without patient consent.

If the workers’ compensation patient changes doctors, the subsequent treating doctor is required to contact the previous treating physician and request transfer of records. The disclosing physician must “immediately forward” the records on request.

**Release Without Consent Under the Medical Practice Act**

The Medical Practice Act contains a number of exceptions to confidentiality which allow release of information and medical records without the necessity of having a signed consent from the patient. Sometimes the law demands disclosure. For example, physicians are required to report treatment of gunshot wounds, suspected child and elder abuse, and positive HIV tests. This mandatory reporting is permitted under the Medical Practice Act, which permits physicians to release medical records and information to a governmental agency, if the disclosure is required or authorized by law. Federal HIPAA regulations also permit disclosure to public health authorities and health care oversight agencies under mandatory reporting laws. On other occasions, a physician’s release of medical records and information is permissive, not mandatory. A physician may release medical records to the following, without the consent of the patient:

- medical or law enforcement personnel, if the physician determines that there is a probability of:
  - imminent physical injury to the patient, the physician, or another person; or
  - immediate mental or emotional injury to the patient;
- qualified personnel for research or for a management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify a patient in any report of the research, audit, or evaluation or otherwise disclose identity in any manner;

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108 28 TEX. ADMIN. CODE §42.35.
109 28 TEX. ADMIN. CODE §42.40.
110 28 TEX. ADMIN. CODE §42.60(b)(5).
111 28 TEX. ADMIN. CODE §126.7 (i).
112 Id.
113 28 TEX. ADMIN. CODE §42.65.
those parts of the medical records reflecting charges and specific services provided if necessary in the collection of fees for medical services provided by a physician, professional association, or other entity qualified to provide or arrange for medical services;

a person, corporation, or governmental agency involved in the payment or collection of fees for medical services provided by a physician;

another physician or other personnel acting under the direction of the physician who participate in the diagnosis, evaluation, or treatment of the patient;

an official legislative inquiry regarding state hospitals or state schools, if:

- information or a record that identifies a patient or client is not released for any purpose unless proper consent to the release is given by the patient; and

- only records created by the state hospital or school or its employees are included; or

- health care personnel of a penal or other custodial institution in which the patient is detained if the disclosure is for the sole purpose of providing health care to the patient.  

Access by the Texas Medical Board

Texas laws specifically authorize physicians to provide records of a patient's condition or treatment by a physician to the TMB. A physician who fails to comply with an appropriate request from the TMB (which can be in the form of a subpoena) can constitute grounds for cancellation, revocation, suspension, or probation of the physician's license. That does not mean the medical records are public records as the MPA requires the TMB to protect the information and maintain its confidentiality.

Insurer Access to Medical Records

A third party payor such as an insurance company which contracts with the patient to reimburse or pay for some or all of the services provided requires medical information for the limited purpose of making a decision on coverage and payment. The Medical Practice Act contains limited exceptions to confidentiality that allows physicians to release such information without a written consent for each insurance claim.

Insurance companies and other third party payors have a fiduciary duty to patient claimants to request only the information that is necessary to properly process claims for benefits. Further, insurance companies have a duty to use this information only for the purpose of processing the claim and for no other purpose unless the patient has given express written consent to do otherwise. The Medical Practice Act contains exceptions to physician-patient confidentiality for billing records. Any other use of this information

114 TEX. OCC. CODE §159.004.
115 TEX. OCC. CODE §160.009(a).
116 TEX. OCC. CODE §160.009(b).
117 TEX. OCC. CODE §159.004.
may violate the fiduciary duty the insurance company owes the patient and may implicate several HIPAA privacy provisions with which health insurance carriers must comply.\textsuperscript{118}

Third party telephone utilization involves the release and discussion of patient medical information. The procedures and criteria used by reviewers and the evaluation of their review staff vary greatly. Physicians and other office staff spend an increasing amount of time dealing with telephone utilization review. In response the TMA House of Delegates has approved a protocol for responding to private third party telephone review. The protocol recommends that before providing confidential information physicians should obtain from the caller (a) their name or identification number and the organization they work for (b) the name of the insurance company they work for and (c) the full name of the patient and their group or certificate number. Physicians should not provide confidential medical information unless this information is provided. Furthermore, physicians should provide only that information directly related to the need for hospital admission or continued stay and should not give sensitive information that is not germane to the admission.

Additionally, HIPAA privacy regulations generally permit disclosures of the minimum necessary to insurers for payment as well as operations, such as quality reviews.\textsuperscript{119} There are, however, limited exceptions to the general permissive-disclosure provisions.\textsuperscript{120} Some of these exceptions stem from situations in which a patient requests a restriction on a use or disclosure of his or her protected health information.

HIPAA permits individuals to request that the physician covered entity restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, and health care operations.\textsuperscript{121} If the physician agrees to such a restriction, then the physician is generally\textsuperscript{122} prohibited from using or disclosing the information in violation of the restriction (unless, for example, the individual who requested the restriction is in need of emergency treatment, then the physician may disclose the information to a health care provider to provide treatment to the individual).\textsuperscript{123}

Notably, a physician covered entity is not generally required to agree to a requested restriction.\textsuperscript{124} There is, however, an important exception under which a physician MUST comply with a requested restriction. Specifically, under the recently-passed HITECH Act, a physician covered entity is prohibited from disclosing protected health information if the patient requests that the physician restrict the disclosure and (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the physician involved has been paid out of pocket in full.\textsuperscript{125}

\textbf{AMA Policy}

E-7.02 Records of Physicians: Information and Patients

\begin{itemize}
\item \textsuperscript{118} Wilcox, Donald P., \textit{Release of Medical Information to Patients and Insurance Companies}. Tex Med 76:69-70 (March 1980).
\item \textsuperscript{119} 45 CFR§§164.502(b) and 164.506.
\item \textsuperscript{120} See 45 CFR§§ 164.506 and 164.522.
\item \textsuperscript{121} 45 CFR 164.522(a)(1)(i).
\item \textsuperscript{122} Note that there are exceptions under which an agreed-to restriction is not effective (e.g., to prevent a disclosure to the Secretary of the Department of Health and Human Services). See 45 CFR §164.522(a)(1)(v) for more information.
\item \textsuperscript{123} 45 CFR 164.522(a)(1)(ii). Note that if restricted protected health information is disclosed to a health care provider for emergency treatment then the physician covered entity must request that such health care provider not further use or disclose the information. See 45 CFR 164.522(a)(1)(iv).
\item \textsuperscript{124} 45 CFR 164.522(a)(1)(iii).
\item \textsuperscript{125} HITECH §13405(a).
\end{itemize}
Notes made in treating a patient are primarily for the physician’s own use and constitute his or her personal property. However, on request of the patient, a physician should provide a copy or a summary of the record to the patient or to another physician, an attorney, or other person designated by the patient. Most states have enacted statutes that authorize patient access to medical records. These statutes vary in scope and mechanism for permitting patients to review or copy medical records. Access to mental health records, particularly, may be limited by statute or regulation. A physician should become familiar with the applicable laws, rules, or regulations on patient access to medical records. The record is a confidential document involving the patient-physician relationship and should not be communicated to a third party without the patient’s prior written consent, unless required by law or to protect the welfare of the individual or the community. Medical reports should not be withheld because of an unpaid bill for medical services. Physicians may charge a reasonable fee for copying medical records. (IV)

Issued prior to April 1977; Updated June 1994.

E-8.082 Withholding Information from Patients

The practice of withholding pertinent medical information from patients in the belief that disclosure is medically contraindicated is known as "therapeutic privilege." It creates a conflict between the physician’s obligations to promote patients’ welfare and respect for their autonomy by communicating truthfully. Therapeutic privilege does not refer to withholding medical information in emergency situations, or reporting medical errors (see E-8.08, "Informed Consent," and E-8.121, "Ethical Responsibility to Study and Prevent Error and Harm").

Withholding medical information from patients without their knowledge or consent is ethically unacceptable. Physicians should encourage patients to specify their preferences regarding communication of their medical information, preferably before the information becomes available. Moreover, physicians should honor patient requests not to be informed of certain medical information or to convey the information to a designated proxy, provided these requests appear to genuinely represent the patient’s own wishes.

All information need not be communicated to the patient immediately or all at once; physicians should assess the amount of information a patient is capable of receiving at a given time, delaying the remainder to a later, more suitable time, and should tailor disclosure to meet patients' needs and expectations in light of their preferences.

Physicians may consider delaying disclosure only if early communication is clearly contraindicated. Physicians should continue to monitor the patient carefully and offer complete disclosure when the patient is able to decide whether or not to receive this information. This should be done according to a definite plan, so that disclosure is not permanently delayed. Consultation with patients’ families, colleagues, or an ethics committee may help in assessing the balance of benefits and harms associated with delayed disclosure. In all circumstances, physicians should communicate with patients sensitively and respectfully. (I, III, V, VIII) Issued November 2006 based on the report "Withholding Information from Patients (Therapeutic Privilege)," adopted June 2006.

**TMA Policy**

PATIENT RECORDS.
AUTHORIZATION FOR RELEASE. Physicians face both an ethical and a legal responsibility to safeguard patient communications and information in patients' medical records. Such information is confidential and privileged and may not be released except under circumstances outlined in the Medical Practice Act of Texas. Patient authorizations for release of confidential information should be in writing, signed by the patient or someone legally authorized to act on his/her behalf, and should specify the following: (1) the records which are to be covered by the release, (2) the reasons or purposes for the release, and (3) the person to whom the information is to be released.

Reporting of cases to cancer and other registries is not unethical if done in conformity with the Medical Practice Act.

DELINQUENT ACCOUNTS. It is unethical for a physician to refuse or to delay improperly in responding to a valid request for transfer of a former patient's medical records because of an unpaid bill. The physician's first responsibility is the care and welfare of the patient. Other alternatives are available for the collection of fees.

SALE OF. It is both legal and ethical to sell a medical practice and patient records so long as the sale of records contains provisions to insure that the purchaser agrees to make records of any patients treated by the selling physician available to subsequent physicians, or to other persons the patients designate. All active patients should be notified that their physician is selling his/her practice to another physician who will retain custody of their records, or forward them to other physicians upon proper authorization. Because Texas law contains no applicable exceptions to patient confidentiality in practice sale situations which allow medical records or other confidential material to be disclosed to non-physicians without patient consent, medical records are not considered "assets" of a physician's medical practice that can be sold to a non-physician. Thus, to be ethical the sale must be consummated with a physician, duly licensed to practice, and in good standing. Where non-physicians are or will be involved in the management of a medical practice or other organization to which medical records will be sold or transferred, physicians must take appropriate action to ensure that such non-physicians: (a) will not use or disclose the information for any other purposes; and (b) will take appropriate steps to protect the information.

PAYMENT FOR COMPLETION OF MEDICAL CHARTS. Physicians routinely maintain medical records in the course of their office and hospital practices. Timely completion of such charts is advisable from both the standpoints of liability protection and compliance with hospital medical staff bylaws. In addition, the completion of medical charts is traditionally regarded as part of the service rendered to the patient, and not a separate procedure for which payment is asked or expected.

The payment for completion of medical charts, from any source, is improper because it is an inducement to do that which good medical practice routinely requires of physicians, and may constitute an inducement to refer patients to a facility for reasons other than the quality of the services rendered in that facility.

PAYOR INTERFERENCE WITH CONFIDENTIALITY. Physicians have both ethical and legal obligations to safeguard the confidentiality of patient information within the bounds of the law. Third party payors, including government agencies involved in the payment of fees for medical care, have the right to receive accurate information in order to pay claims. However, physicians should not release confidential information to payors in excess of the need to pay claims without the patient’s written consent. Under no circumstances should a physician allow representatives of third party payors or government agencies to be present in any capacity at a time and place where patients are
examined or treated. This is a clear violation of the confidentiality of the patient-physician relationship. Such presence is inherently coercive because it may cause the patient not to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. Such problems cannot be cured by a purported consent executed by the patient, as such consent would not be free and voluntary.

**NOTICE:** This information is provided as a commentary on legal issues and is not intended to provide advice on any specific legal matter. This information should NOT be considered legal advice and receipt of it does not create an attorney-client relationship. This is not a substitute for the advice of an attorney. The Office of the General Counsel of the Texas Medical Association provides this information with the express understanding that 1) no attorney-client relationship exists, 2) neither TMA nor its attorneys are engaged in providing legal advice and 3) that the information is of a general character. Although TMA has attempted to present materials that are accurate and useful, some material may be outdated and TMA shall not be liable to anyone for any inaccuracy, error or omission, regardless of cause, or for any damages resulting therefrom. Any legal forms are only provided for the use of physicians in consultation with their attorneys. You should not rely on this information when dealing with personal legal matters; rather legal advice from retained legal counsel should be sought.