

Maintenance and Disclosure of Mental Health Records in the Primary Care Clinic Setting

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Introduction

Patient records documenting certain mental health and substance abuse services are protected under special confidentiality rules set out in both federal and state law. This article provides a basic overview of the complicated array of federal and California laws pertaining to the following:

- 1) the general rule for disclosure of mental health records;
- 2) applicability of privacy laws to primary care clinics;
- 3) maintenance of licensed primary care clinic patient health records;
- 4) the general rules for use and disclosure of patient records documenting mental health and substance abuse services; and
- 5) patient access to mental health records.

The federal rules regarding confidentiality of all protected health information are found in regulations to implement the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").¹ Health care providers subject to HIPAA are required to keep confidential all protected health information, whether in paper, oral or electronic form. Although HIPAA generally does not distinguish between mental health records and other forms of personal health information, it does provide enhanced protections for psychotherapy notes, as discussed herein.

In addition, the confidentiality of alcohol and substance abuse patient records are also protected under federal law.² Substance abuse programs subject to the Substance Abuse and Mental Health Services Administration (SAMHSA) rules for confidentiality of records must comply with both HIPAA and the SAMHSA rules unless there is a conflict between them. However, the HIPAA regulations are fairly parallel to the SAMHSA regulations.³ For this reason, even though, it is possible that a primary care clinic could be subject to the SAMHSA regulations and not HIPAA, this memorandum will not discuss the SAMHSA regulations in detail. (Readers who are interested in a more detailed discussion can review the document referenced in endnote 3, herein.)

California has several privacy laws and regulations that limit use and disclosure of mental health records. The most relevant of these to the day- to- day operations of an outpatient clinic include the Confidentiality of Medical Information Act (CMIA),⁴ Lanterman-Petris-Short Act (LPS Act)⁵ and the Patient Access to Health Records Act (PAHRA).⁶ These will be discussed in relation to the HIPAA provisions in some detail below. There are several other California statutes that also govern release of medical records in administrative, civil and criminal proceedings. These will not be discussed in this article.

It is important to note that HIPAA generally preempts state law unless provisions in state laws governing privacy, use and disclosure are more stringent.⁷

Health care providers that are covered under HIPAA are required to comply with HIPAA and, if subject to the particular state law, the more stringent provisions of state law. This article points out the differences between the federal and state laws where relevant. This article does not provide a full preemption analysis as to which state laws provide greater privacy protections to patients than HIPAA.⁸

Clinics May Be Subject to Stiff Penalties for Violation

Disclosure of mental health and substance abuse treatment records may only be made when acting in accordance with this complicated assortment of state and federal laws. From a legal standpoint, the general rule is to not disclose patient mental health records unless explicitly permitted by law, and then only in compliance with the specific requirements of the law. While this article provides some general guidelines for maintenance and disclosure of mental health and substance abuse records, it is advisable for a primary care clinic that is unsure of its obligation when it receives a request for mental health records to seek legal counsel.

Clarity about the rules is especially important because there may be potential civil liability, administrative fines, and/or criminal and civil penalties for violating HIPAA privacy rules and the CMIA. For example, HIPAA provides for fines of up to \$25,000 and criminal penalties of up to ten years in prison for violation of the privacy rules.

A clinic that unlawfully uses or discloses a patient's medical records, including mental health records in violation of the CMIA, may be liable for economic loss or personal injury, compensatory damages, punitive damages, and attorneys fees and costs.⁹ This applies whether the use or disclosure is negligent or intentional. In addition to the possibility of facing a lawsuit brought by a patient, a licensing or certifying board may assess an administrative fine or civil penalty against a clinic that violates CMIA whether or not the patient suffers any damages as a result of the use or disclosure.¹⁰ The penalties under California law are in addition to any other available remedy, therefore a clinic is subject to both state and federal penalties for violation of the privacy laws.

The LPS Act which regulates mental health evaluation and treatment in California also provides for significant civil damages for negligent or intentional disclosure of mental health records. A person may bring an action against an individual who has intentionally or negligently released confidential mental health and substance abuse treatment records in violation of the LPS Act. Damages for intentional disclosure may be for the greater of \$10,000 or three times the amount of the actual damages sustained by the patient plus court costs and reasonable attorney's fees. Damages for negligent disclosure may be for both \$1000, if actual damages are suffered, and the amount of actual damages suffered by the patient plus court costs and reasonable attorney's fees. A person may also enjoin the disclosure of mental health and substance abuse records.¹¹

Further, there are potential criminal penalties for violating SAMHSA regulations relating to confidentiality of alcohol and substance abuse patient records.¹² Any person who is found to have violated any provision of the statute or regulations relating to confidentiality of patient records for alcohol abuse and alcoholism programs is subject to a fine under the federal sentencing guidelines.¹³

In summary, because the privacy and disclosure rules are complicated and the penalties for inadvertent disclosure potential significant, the best policy for an individual clinic provider is to seek the advice of counsel on a case-by-case basis when in doubt about the clinic's and patient's respective rights and responsibilities.

Primary Care Clinics Are Subject to Patient Privacy Protection Laws

HIPAA governs the use and disclosure of individually identifiable health information and applies to "covered entities." The definition of "covered entity" includes a health care provider who transmit health information in electronic form in connection with a HIPAA standard transaction.¹⁴ If a primary care clinic transmits claims for services or any other type of HIPAA standard transaction electronically, the primary care clinic is a covered entity under HIPAA. A clinic that does not transmit electronic health information in connection with a standard HIPAA transaction is not covered entity and is not required to comply with HIPAA. Nevertheless, the clinic may be subject to state laws governing the use and/or disclosure of medical information.

The CMIA is meant to protect patient privacy and confidentiality by governing the uses and disclosures of various types of medical information. Providers of health care may not disclose individually identifiable medical information unless the disclosure is specifically authorized by the CMIA, other state and federal laws, or by the patient according to the requirements of the CMIA.¹⁵ "Providers of health care" include licensed primary care clinics, health care professionals licensed under Division 2 of the Business & Professions Code, and licensed health facilities. Outpatient clinics of licensed health facilities are also subject to CMIA.¹⁶

The federal alcohol and substance abuse patient records confidentiality rules apply to "programs." "Program" means:

1) an individual or entity, other than a general medical care facility that holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or

2) a general medical facility that has: a) an identified unit that holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment or b) medical personnel or other staff whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers.¹⁷

The substance abuse regulations apply only to programs that receive "federal assistance." An alcohol abuse or drug abuse program is federally-assisted if:

"(1) It is conducted in whole or in part, whether directly or by contract or otherwise by any department or agency of the United States, except the Veterans' Administration and the Armed Forces;

(2) It is being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States including but not limited to: (i) Certification of provider status under the Medicare program; (ii) Authorization to conduct methadone maintenance treatment or (iii) Registration to dispense a substance under the Controlled Substances Act to the extent the controlled substance is used in the treatment of alcohol or drug abuse;

(3) It is supported by funds provided by any department or agency of the United States by being: (i) a recipient of Federal financial assistance in any form, including financial assistance which does not directly pay for the alcohol or drug abuse diagnosis, treatment, or referral activities; or (ii) conducted by a State or local government unit which, through general or special revenue sharing or other forms of assistance, receives Federal funds which could be (but are not necessarily) spent for the alcohol or drug abuse program [emphasis added]; or

(4) It is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program or through the granting of tax exempt status to the program.”¹⁸

The substance abuse regulations would apply to any primary care clinic or outpatient clinic run by the county health department that receives federal funds to provide alcohol or drug abuse diagnosis, treatment or referral for treatment. This would include a Section 330 health center that is funded to provide substance abuse treatment services within the health center’s federal scope of project.

The LPS Act requirements are intended to protect the civil rights of persons with serious mental illness and chronic alcoholism and drug abuse. The LPS Act provisions apply when a person is involuntarily detained for evaluation or hospitalized for mental illness. The LPS Act also provides strict confidentiality protection to information and records obtained in the course of providing services to patients who are treated on a voluntary basis in specified institutional and outpatient settings, including private clinics that are conducted for, or include a department for, the care and treatment of persons who are mentally disordered. This would include community mental health services programs funded by the Bronzan-McCorquodale Act.¹⁹ Primary care clinics that have a mental health services department and/or receive community mental health services funding are subject to the confidentiality provisions in the LPS Act.

Most importantly, the disclosure of health information remains protected under the LPS Act when included in the records of providers who are not explicitly subject to the LPS Act. Therefore, a primary care clinic that has received such records from another provider is subject to the LPS Act.

Access to Primary Care Clinic Patient Records and Confidentiality.

Information contained in the patient health records maintained by a primary care clinic is required to be confidential and are disclosed only to “authorized persons” in accordance with federal, state and local laws. The primary care clinic regulations do not specifically define who are “authorized persons” for the purpose of disclosure.²⁰ Subsequently enacted federal and state laws define those boundaries.

California statute requires access to electronically stored patient records to be made available to the Division of Licensing and Certification staff promptly, upon request.²¹ However, this does not mean that state agencies, such as Licensing and Certification and the Medi-Cal program must be given unfettered access to all patient records. Primary care clinics must comply with HIPAA and CMIA, and other laws and regulations regarding privacy of health records, as applicable, and as generally discussed in this article.

Other Federal Requirements for Confidentiality of Patient Records Applicable to Federally Qualified Health Centers

The federal regulations specifically provide for confidentiality of information obtained by health center staff on recipients of health center services. Such information may not be divulged without the consent of the health center patient except as required by law, or as necessary to provide service to the individual or to provide for medical audits by the Secretary or his designee with appropriate safeguards for confidentiality of patient records.²²

In addition, the conditions for participation in Medi-Cal and Medicare generally require compliance with federal and state law and confidentiality of patient health records. Specifically, as a condition of coverage in Medicare, a federally qualified health center must protect patient health record information. Health centers must maintain the confidentiality of record information; provide safeguards against loss, destruction or unauthorized use; and implement written policies and procedures governing the use and removal of records from the health center and the conditions for release of information. The patient's written consent is required for release of information not authorized to be released without such consent.²³ However, health centers may not release patient's protected health information except as permitted under HIPAA and more stringent state law.²⁴

Requirements for Maintenance of Patient Health Records by Primary Care Clinics

The primary care clinics licensing regulations found in Title 22 Cal. Code Regs. §§ 75001 through 75083 set out the minimum requirements for maintenance of patient health records by licensed primary care clinic. These regulations, adopted in the early 1980's are obsolete in that they do not address subsequent changes in federal or state law regarding patient privacy or the use of electronic medical records.

Although not expressly required by the clinic licensing statute, the primary care clinic regulations require clinics to establish, implement and maintain written

administrative policies and procedures governing patient health records which are developed with the assistance of a person skilled in record maintenance and preservation. These policies and procedures are required to be updated at least annually and revised as necessary.²⁵ HIPAA also requires a covered entity to adopt policies and procedures for of protected health information consistent with federal law.²⁶ In addition, the California statutes governing patient access to health records require health care providers, including primary care clinics, to adopt policies and establish procedures for the uniform transmittal of X-rays and other patient records.²⁷

No Explicit Requirement for a Unified Medical Record

There is nothing in California law to explicitly require a unified medical record in which medical and mental health and/or substance abuse treatment records are consolidated, or to maintain separate mental health records.²⁸ Each licensed primary care clinic is required to establish and maintain a patient health records service which is systematically organized to provide “a complete accurate correlated, and current health records” for each patient which is filed in a centrally located area.²⁹ While the primary care clinic regulations appear to require the components of each patient’s health record to be interconnected, there is no explicit requirement that a patient’s mental health records must be fully integrated into each patient’s clinic record.

Because the special confidentiality requirements for sensitive medical information, such as mental health records, are complicated, it is advisable to maintain mental health records in a distinct part of each patient’s medical record to avoid inadvertent disclosure or the necessity to review the entire patient record each time patient records are requested.

Further, psychotherapy notes that are separate from the individual’s medical records are afforded special protections under HIPAA. The HIPAA regulations explicitly define “psychotherapy notes” as notes recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. However, medication prescription and monitoring, consulting session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms prognosis or progress to date are excluded from the definition of “psychotherapy notes.”³⁰ Therefore, psychotherapy notes must be separated from the individual’s medical record to be subject to special protection under HIPAA. The rules for disclosure of, and patient access to, psychotherapy notes are further discussed below.

Patient Health Records in Paper Form

California’s primary care clinic licensing regulations require that patient health record be permanent, either typewritten or legibly written in ink and kept on all patients accepted for treatment.³¹ These requirements are obsolete *only* to the extent that they do not address the creation and maintenance of electronic medical records. As to electronic medical records, existing regulatory requirements pertaining to primary care clinics for

the access, use, disclosure, confidentiality, retention of record contents, and maintenance of health information in patient records by health care providers remains in effect.³²

However, if the clinic utilizes an electronic recordkeeping system only, the requirements in the primary care clinic licensing regulations pertaining to patient health records are superseded by the requirements for electronic recordkeeping applicable to licensed clinics pursuant to Cal. Health & Safety Code § 123149. Section 123149 does not apply if hard copy versions of the patient records are retained.³³

Requirements for Maintaining and Storing Patient Health Records

Patient health records are required to be stored so as to be protected against loss, destruction or unauthorized use.³⁴ This would apply to both paper and electronic records.³⁵ All records, either originals or accurate reproductions thereof, are required to be maintained in such forms as to be legible and readily available upon the request of the attending physician, the clinic or any authorized officer, agent or employee of either, or any other person authorized by law to make such request.³⁶

The patient health record must be on the property of the facility and must be maintained for the benefit of the patient, health care team and clinic. It must not be removed from the clinic, except for storage purposes after termination of services.³⁷ Patient health records are required to be filed in an easily accessible manner in the clinic. Storage of records shall provide for prompt retrieval when needed for continuity of care.

The prior approval of the Department of Public Health, the clinic licensing agency, is required for storage of inactive health records away from the facility premises except as provided in Cal. Health & Safety Code § 1218.2.³⁸ Section 1218.2 allows two or more primary care clinics that are operated by a single nonprofit corporation to consolidate certain of their administrative functions. This includes the offsite storage of patient medical records that have been inactive for at least three years without first obtaining the approval of the Department. All records must be stored within the State of California

The primary care clinic licensing regulations require that personnel, space, equipment and supplies in the health record services to be located to facilitate immediate retrieval of health information. The regulations also require a person working in the clinic to be responsible for the direction and supervision of the health record service to ensure that all patient records are accurately documented, completed, indexed and filed in the unit system.³⁹ A clinic must arrange to preserve patient health records the clinic ceases operation or there is a change of ownership.⁴⁰

Additional Requirements for Maintaining Electronic Medical Records

Cal. Health & Safety Code §123149 allows a primary care clinic that utilizes electronic record keeping only to destroy original hard copies of patient records once the record has been electronically stored.⁴¹ Nonetheless, primary care clinics must maintain original copies of patient records that cannot be electronically stored.⁴² Original paper copies of patient records that can not be stored electronically must be maintained

according to the regulations in Title 22 Cal. Code of Regs. §§ 75049, 75054, and 75055 as discussed herein.

Primary care clinics must ensure the safety and integrity of all electronic media used to store patient records by employing an offsite backup storage system, an image mechanism that is able to copy signature documents, and a mechanism to ensure that once a record is input, it is unalterable.⁴³ A primary care clinic that chooses to utilize an electronic recordkeeping system is required to develop and implement policies and procedures to include safeguards for confidentiality and unauthorized access to electronically stored patient health records, authentication by electronic signature keys, and systems maintenance.⁴⁴

Content of Patient Medical Records

The exact content of the medical record is not specifically addressed by the primary care clinic regulations. Patient health records must: 1) be current; 2) be kept in detail consistent with good medical and professional practice and 3) describe the services provided to each patient. All entries in the patient medical record must be dated and be authenticated with the name, professional title, and classification of the person making the entry.⁴⁵ The regulations also require certain content in the patient “admission records.” A clinic is required to complete an admission record for each patient that shall include: 1) name, (2) current address; 3) age and date of birth, 4) sex; 5) date service began; 6) last date of services; and 7) consent for treatment authorizations.⁴⁶ In addition, all primary care clinics that are either licensed under Section 1204 of the Health Safety Code or exempt from licensure under Section 1206, must include a patient's principal spoken language on the patient's health records.⁴⁷

There are no California regulations explicitly applicable to primary care clinics regarding the quality of medical records. There is no explicit requirement in California law requiring psychotherapists to write detailed notes of patient visits. However, record keeping of psychotherapists and other providing mental health services should be consistent with standards of practice for the provider.

There is no clear and broadly applicable definition of “medical record” in the Medi-Cal statute and implementing regulations. Generally for payment purposes in Medi-Cal, the patient record must fully disclose the type and extent of services provided and be made at or near the time at which the services is rendered. The records that are required to be kept as a condition of payment must include “all medical records, services reports, and orders prescribing treatment plans.”⁴⁸ While the hospital regulations do describe the minimum content of a patient health record,⁴⁹ these requirements are not applicable to primary care clinics. There is no specific guidance in the Medi-Cal Provider Manuals pertaining to the content of medical records.

The federal regulations require certain conditions of coverage for federally qualified health centers participating as Medicare suppliers. Among these is a requirement to maintain patient health records. For each patient receiving health care services, the health center must maintain a record that includes, as applicable:

- 1)) identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;
- 2) reports of physical examinations, diagnostic and laboratory test results, and consultative findings;
- 3) all physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the patient's progress; and
- 4) signature of the physician or other health care professional.⁵⁰

In summary, a separate medical record should be kept for each patient. The contents of the medical record must conform to the minimum requirements set out in the primary care clinic licensing and Medi-Cal. In addition, other payors may have certain contractual requirements for the content of patient records. The actual content of each notation of patient care should be consistent with the standards of practice applicable to the individual provider who is providing the care and clinic policies and procedures.

Retaining Patient Records

All health records of discharged patients must be completed and filed within thirty (30) days after termination of each episode of treatment and such records must be kept for a minimum of seven (7) years. There is an exception for minors whose records must be kept at least until one (1) year after the minor has reached the age of eighteen (18), but in no case less than seven (7) years.⁵¹ This applies to both paper and electronic records.⁵² In addition, for purposes of coverage in Medicare, federal regulations require that federal qualified health centers retain medical records for six (6) years unless state law requires a longer period.⁵³ Therefore, patient records should be kept for a minimum of seven (7) years.

If a primary care clinic ceases operations is it obligated to preserve the patient medical records for a minimum of seven (7) years following the discharge of the patient (except that the records of each unemancipated minor must be kept at least one year after the minor has reached the age of 18 years, and in any case, not less than seven (7) years). The licensing agency or any person injured as a result of a clinic's abandonment of health records may bring a court action for the amount of damage suffered.⁵⁴ A primary care clinic is required to notify in writing the Division of Licensing and Certification within forty-eight (48) hours whenever patient health records are defaced or destroyed before termination of the required retention period.⁵⁵

Summary of Special Rules for Disclosure of Mental Health and Substance Abuse Records To Third Parties

The release of a patient's medical information to third parties is governed by both federal law and California law. The federal regulations for security and privacy of individually identifiable health information generally preempt state law unless the state law is more stringent.

HIPAA Requirements. Under HIPAA, a provider must obtain written authorization from the patient for use or disclosure of psychotherapy note except under very limited circumstances.⁵⁶ "Psychotherapy notes" are explicitly defined in the HIPAA privacy regulations as discussed above. The requirement for written authorization does not apply to parts of the mental health records that are not defined as psychotherapy notes. However, the more stringent California law requires written authorization for release of any patient mental health records unless an exception applies.

Under HIPAA, written authorization is not required when the psychotherapy notes are:

- Used for treatment purposes by the person who wrote the note;
- Used or disclosed by the covered entity for its own training programs in which students, trainees or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family or individual counseling;
- Used or disclosed by the covered entity to defend itself in a legal action or other proceeding brought by the patient;
- Disclosed to the patient, as required, when requested;
- Disclosed to the Department of Health & Human Services, as required, to investigate or determine the covered entity's compliance with the HIPAA privacy rules;
- Required to be disclosed by law under 45 Code of Fed. Regs 164.512(a) and the use and disclosure complies with and is limited to the relevant requirements of the law (i.e. disclosure for judicial or administrative proceedings)
- Disclosed for oversight of the originator of the psychotherapy note;
- Disclosed to coroners or medical examiners for the purpose of identifying the deceased, determining cause of death or other duties authorized by law; or
- Used or disclosed as necessary to prevent or lesson a serious and imminent threat to the health or safety of a person.

HIPAA requires a separate patient authorization for the disclosure of psychotherapy notes. A written authorization for psychotherapy notes may not be combined with a written authorization for other types of protected health information.⁵⁷

CMIA Requirements. The CMIA prohibits a provider of health care from releasing medical information about a patient except as authorized by law.⁵⁸ As discussed above, a clinic must obtain the patient's written authorization to release psychotherapy notes as required by HIPAA.

The CMIA contains an important requirement relating to outpatient treatment by community psychotherapists. This generally applies to persons or entities not subject to the LPS Act. The CMIA prohibits a provider of health care, including a primary care clinic, from releasing medical information specifically relating to the patient's participation in outpatient treatment with a psychotherapist.⁵⁹ This is so even if the person would be otherwise authorized to receive the information. The information may not be disclosed unless the person or entity requesting the information submits to the patient *and* to the clinic a written request, signed by the person requesting the information or an authorized agent of the entity requesting the information.

The request must include all of the following:

- The specific information relating to a patient's participation in outpatient treatment with a psychotherapist being requested and its specific intended use or uses;
- The length of time during which the information will be kept before being destroyed or disposed of;
- A statement that the information will not be used for any purpose other than its intended use; and
- A statement that the person or entity requesting the information will destroy the information and all copies in the person's or entity's possession or control, will cause it to be destroyed, or will return the information and all copies of it before or immediately after the length of time specified for which the record has expired.⁶⁰

There are two exceptions to the above requirement. There is an exception for disclosure of information as authorized to providers of health care, health care service plans, contractors, or other health care professionals or facilities for purposes of diagnosis and treatment of the patient.⁶¹ The requirement for a written request also does not apply to the disclosure or use of medical information by a law enforcement agency or a regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes, unless the disclosure is otherwise prohibited by law.⁶²

LPS Act Requirements. The LPS Act applies to disclosures of mental health information created at certain mental health treatment facilities, clinics and mental health community providers to third parties, as discussed herein above.⁶³ In light of HIPAA, the requirements of the LPS Act are not entirely clear.

The LPS Act does not expressly define the information covered by the confidentiality provision. The LPS Act refers to “all information and records” obtained in the course of providing mental health services under the specified provisions of law.⁶⁴ It is reasonable for a provider to assume that this is consistent with the definition of “health information” under HIPAA.⁶⁵ The LPS Act permits disclosure of information and records obtained in the course of providing mental health services *only* to those circumstances specifically enumerated in the statute.⁶⁶

Both HIPAA and the LPS Act allow disclosure of information by a provider without the consent of the patient for treatment and payment purposes. However, the consent of the patient, or his or her guardian or conservator must be obtained before information or records may be disclosed “by a professional person employed by a facility to a professional person not employed by the facility who does not have the medical or psychological responsibility for the patient's care.”⁶⁷

Generally, a provider subject to the LPS Act is required to obtain a signed consent from the patient for each separate use and disclosure of information when the patient is required to consent. The consent must specify the use, the information to be released, the name of the agency or individual to whom information is to be released, and the name of the responsible individual who has authorization to release information specified. Any use of the consent form is required to be noted in the patient file and a copy of the signed consent is required to be given to the patient.⁶⁸ A primary care clinic that is subject to the LPS Act is advised to use a HIPAA-compliant standard authorization for use and disclosure for protected health information for this purpose.

In addition, when any disclosure of information or records is made as authorized by the provisions of Section 11878 or 11879 of the Health and Safety Code, or subdivision (a) or (d) of Section 5328, Sections 5328.1, 5328.3, or 5328.4 of the Welfare & Institutions Code, the physician in charge of the patient or the professional person in charge of the facility shall promptly cause to be entered into the patient's medical record: 1) the date and circumstances under which such disclosure was made; 2) the names and relationships to the patient if any, of persons or agencies to whom such disclosure was made; and 3) the specific information disclosed.⁶⁹ Where the LPS Act requires a disclosure not specifically authorized by HIPAA, the disclosure may be made under the general authority permitted under HIPAA to disclose as required by law.

Confidentiality of Alcohol and Drug Abuse Patient Records. Generally, a program subject to the federal regulations may not use or disclose any patient information unless the patient has consented in writing or unless a very limited exception applies.⁷⁰ Both the substance abuse regulations and the HIPAA privacy rules permits certain uses and disclosures for treatment, payment and health care operations, as well as certain other disclosures without the patient prior written authorization. However, unless a provider can point to a particular exception to the general rule, the provider is advised to seek the patient’s written consent before disclosing substance abuse records.

Patient Access to Mental Health Records

Patients have the right to access their medical records under both the California law⁷¹ and the HIPAA regulations⁷² subject to specific requirements. Both HIPAA and California law limit the right of access to mental health records. Except for access to mental health records, California law generally provides a patient greater access to his or her own medical records than HIPAA. It is beyond the scope of this article to provide a comprehensive review of the laws regarding patient access to medical records.

Primary care clinics as well as specified individual providers are subject to the California statute governing access to patient medical records.⁷³ Clinics that are covered entities for purposes of HIPAA are subject to the HIPAA regulations. A clinic that does not transmit electronic health information in connection with a standard HIPAA transaction is not a covered entity under HIPAA and is not subject to the HIPAA requirements. Nevertheless, the clinic would be subject to California requirements for patient access to medical records.

For health care providers that are subject to both HIPAA and the California law, the federal law and state law must be read together to determine how to comply with the access provisions. Some provisions in the HIPAA regulation preempt state law; some requirements in the California law are more stringent than HIPAA and, therefore, prevail. This sets forth the general requirements primary care clinics must follow to provide or deny a patient (or a patient representative) access to his or her mental health records.

Under California law, a clinic is generally not liable to the patient or any other person for any consequences that result from disclosure of records to the patient as required by the California statute.⁷⁴ The federal regulation appears to be silent on provider liability as to patient access.

HIPAA does not allow a patient unfettered access to review and copy “psychotherapy notes,” as specifically defined in the HIPAA regulations.⁷⁵ HIPAA allows a covered entity to deny an individual access to his or her psychotherapy notes without providing the individual an opportunity for review of the denial.⁷⁶

HIPAA also permits the denial of access to other medical record information under limited circumstances. A covered entity may deny a patient access, subject to review for grounds for denial, if a licensed health care professional has determined, in the exercise of his or her professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.⁷⁷ Under HIPAA, a covered entity may deny a patient access to his or her mental health records, that do not included separately-maintained “psychotherapy notes,” under this standard if the provider meets certain requirements, as set forth below.

While HIPAA distinguishes between “psychotherapy notes” (kept separate from other parts of the medical records), subject to special protection, California law includes psychotherapy notes within the definition of mental health records.⁷⁸ California law does

allow, with limited exception, a patient to have access to his or her psychotherapy notes. As a consequence of this inconsistency between the federal and state law, health care providers subject to the California patient access law, must follow different requirements for denying a patient access to his or her separately-maintained psychotherapy notes than for other mental health records.

Grounds For Denial. When psychotherapy notes are not separately maintained or do not otherwise meet the HIPAA definition of psychotherapy notes, the HIPAA standard, requiring physical harm, applies in order for a provider to deny patient access to mental health records. However, because the state standard for denial of mental health records (which includes psychotherapy notes) is more stringent, the state standard (requiring either physical or psychological harm) for denial of mental health records applies to separately maintained psychotherapy notes. The specific process for denying access is described in more detail below.

Patient Written Request. California law requires that a patient's or patient representative's request to inspect or copy his or her medical record be in writing. A patient or patient representative must make written requests both to inspect the record and/or to be provided with a copy of the record. The written request must be made with specificity.⁷⁹ The request to inspect and/or copy may be made in a single document.

HIPAA does not require a written request but specifies that a covered entity may require an individual to make request in writing if the covered entity informs individuals of such a requirement.⁸⁰ This notice should be provided in the clinic's Notice of Privacy Practice required to be provided to patients by the HIPAA regulations.

Time for Responding to Patient Request. California law is more stringent than HIPAA regarding the time for response to a patient's request for access. A primary care clinic is required to permit the inspection of the patient's record inspection by the patient or patient's representative during business hours within five (5) working days after receipt of the written request.⁸¹ A clinic is required to provide a copy of all or a portion of the patient records that the patient or patient's representative has requested to inspect within 15 days after receiving the written request.⁸²

If a patient requests or agrees to a provider's summary of the records (discussed below), the summary must be provided to the patient within ten (10) working days from the date of the patient's written request to inspect and/or copy the record. If the record is voluminous or the patient was discharged from a licensed health facility within 10 days of make the request to inspect his or her record, the clinic is required to notify the patient the patient of the date that the summary will be completed and delivered to the patient. In no case may this be more than 30 days from the date of the patient's request.⁸³

What May Be Inspected. Patient records means records in any form or medium maintained by, or in the custody or control of, a health care provider relating to the health history, diagnosis, or condition of a patient, or relating to treatment provided

or proposed to be provided to the patient. "Patient records" includes only records pertaining to the patient requesting the records or whose representative requests the records. "Patient records" does not include information given in confidence to a health care provider by a person other than another health care provider or the patient, and that material may be removed from any records prior to inspection or copying under Section 123110 or 123115. "Patient records" does not include information contained in aggregate form, such as indices, registers, or logs.⁸⁴

Who May Inspect. The following persons are legally allowed to access to inspect their patient records upon written request:

- 1) any adult patient of a health care provider;
- 2) any minor patient authorized by law to consent to medical treatment; and
- 3) any patient representative.

A patient who is a minor is entitled to inspect patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent.⁸⁵ A "patient's representative" means any of the following: 1) a parent or guardian of a minor who is a patient; 2) the guardian or conservator of the person of an adult patient; 3) an individual designated in a power of attorney for health care to make a health care decision for the patient, or 4) an estate beneficiary or personal representative, such as the administrator or the executor of the estate of a deceased patient.⁸⁶

California Rules Regarding Access by The Representative of a Minor. The representative of a minor is not entitled to inspect or obtain copies of the minor's patient records under certain circumstances. A representative may not have access to a minor's patient record if 1) the minor has a right of inspection of his or her own patient record pertaining to health care of a type for which the minor is lawfully authorized to consent or 2) the health care provider makes a good faith determination that the representative's access to the minor's patient record would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being.⁸⁷

Effective January 1, 2008, a special law regarding minor's mental health records was added.⁸⁸ A provider of health care may disclose medical information to a county social worker, a probation officer, or any other person who is legally authorized to have custody or care of a minor for the purpose of coordinating health care services and medical treatment provided to the minor.⁸⁹ If a provider of health care determines that the disclosure of medical information concerning the diagnosis and treatment of a mental health condition of a minor is reasonably necessary for the purpose of assisting in coordinating the treatment and care of the minor, that information may be disclosed to a county social worker, probation officer, or any other person who is legally authorized to have custody or care of the minor. The information may not be further disclosed by the recipient unless the disclosure is for the purpose of coordinating mental health services and treatment of the minor and the disclosure is authorized by law.⁹⁰ However, for the

purpose of the new law, "medical information" *does not* include psychotherapy notes as defined in the HIPAA regulations.⁹¹

Identity Verification. A primary care clinic may require reasonable verification of identity prior to permitting inspection or copying of patient records, provided this is not used oppressively or discriminatorily to frustrate or delay compliance with patient access.⁹² HIPAA requires a covered entity to verify the identity of a person requesting protected health information and the authority of any such person to have access to protected health information under this subpart, if the identity or any such authority of such person is not known to the covered entity.⁹³ If the patient or authority requesting patient records, including the patient representative, is known to the clinic, identity verification is not required under federal or state law.

Fees to Patients. HIPAA allows providers to charge a reasonable fee based on cost for providing copies of medical records, including the cost of supplies and labor, postage if the information is mailed to the patient.⁹⁴ California law prescribes the fees. A clinic may charge a fee of up to twenty-five cents per page (or fifty cents per page if copied from microfilm).⁹⁵ While California law would permit a fee for clerical costs to make the record available, this type of fee is not allowed to be billed to the patient under HIPAA. Fees for clerical costs may be billed to others such as health care providers and insurance companies. If the patient consents to the preparation of a summary of the record in lieu of copying of the entire record, as discussed below, the provider may charge a reasonable fee for actual time and cost for the preparation of the summary.⁹⁶ In addition, all reasonable costs, not exceeding actual costs, incurred by the clinic in providing copies of X-rays and tracings may be charged to the patient or representative requesting the copies.⁹⁷

One Free Copy for Administrative Hearing. A patient or patient representative is entitled to one copy of the relevant portion of the patient's record free of charge per written request and proof that the records are needed to support an appeal regarding eligibility for Medi-Cal, SSID and SSI/SSP unless the patient is represented by a private attorney who is paying for the costs related to the patient's appeal.⁹⁸ Nonetheless, if the patient's eligibility appeal is successful, the clinic may bill the patient for the copies provided.⁹⁹ The clinic must transmit copies of the record for the purposes of an appeal within 30 days after receiving the written request.¹⁰⁰ This does not require the provider to allow the patient access to mental health records if the provider determines that this is not in the best interest of the patient as discussed below.

Summary Instead of Copy of the Patient Records Permitted at The Patient's Election. HIPAA gives a patient the choice to elect to receive a summary of his or her protected health information. California law allows the provider to make this election. Therefore, a provider that is subject to both HIPAA and the California patient access to record law may provide a summary in lieu of the entire record only if the patient agrees in advance a written summary and any related fees.¹⁰¹

Rules for Preparing A Summary of the Patient Record. Upon the consent of the patient, a clinic may choose to prepare a written summary of the patient record in lieu of access to the entire record. To expedite the summary of the patient record, the provider is permitted to confer with the patient to attempt to clarify the patient's purpose and goal in obtaining his or her record. If the patient requests information about only certain injuries, illnesses, or episodes, the clinic is permitted to prepare the summary only for those certain injuries, illnesses, or episodes. The clinic may not elect to prepare of summary of X-rays and tracings in lieu of inspection and/or copying of the record.¹⁰²

The summary must contain for each injury, illness, or episode any information included in the record relative to the following:

- 1) Chief complaint or complaints including pertinent history.
- 2) Findings from consultations and referrals to other health care providers.
- 3) Diagnosis, where determined.
- 4) Treatment plan and regimen including medications prescribed.
- 5) Progress of the treatment.
- 6) Prognosis including significant continuing problems or conditions.
- 7) Pertinent reports of diagnostic procedures and tests and all discharge summaries.
- 8) Objective findings from the most recent physical examination, such as blood pressure, weight, and actual values from routine laboratory tests.
- 9) A list of all current medications prescribed, including dosage, and any sensitivities or allergies to medications recorded by the provider.¹⁰³

The clinic may charge a “reasonable fee” for the preparation of the summary based on actual time spent in preparation of the summary at the lowest possible cost.¹⁰⁴ Although the statute does not address the issue, it follows that if a summary is prepared in lieu of copying records for an administrative appeal involving a public benefit program, the patient may not be charged a fee for preparation of the summary.

Standard for Denial of Access of HIPAA-Defined Psychotherapy Notes. The more restrictive California law must be followed. A provider may refuse a patient access to his or her HIPAA-defined psychotherapy notes if the health care provider determines that there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient.

Standard for Denial of Access of Other Mental Health Records. A provider must apply the HIPAA standard for denying a patient access to mental health records other than HIPAA-defined psychotherapy notes. The standard is met when, in the exercise of the professional judgment of a licensed health professional, the access requested by the patient is reasonably likely to endanger the life or physical safety of the patient.

Requirements For Denial of Access. If a primary care clinic refuses to permit inspection or provide copies of mental health records to a patient or a patient's representative, the provider must meet several conditions as follows:¹⁰⁵

1) Create Record of Request and Refusal to Permit Inspection or Copying.

If the request is to the clinic or an individual provider employed by or contracting with the clinic, the clinic is required to make a written record noting the date of the request and explaining the clinic's reason for refusing to permit inspection or provide copies of the records. The written record must include a description of the specific adverse or detrimental consequences to the patient anticipated by the clinic and must be included with the mental health records requested. The clinic may rely on the opinion of an individual clinic provider in making this determination.

2) Permit Inspection by Certain Health Care Providers.

The primary care clinic is required to permit inspection by, or provide copies of the mental health records to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist (MFT), or licensed clinical social worker, designated by written authorization of the patient. A clinic may not permit inspection or release records to MFT intern except under the direction and supervision of a licensed MFT who signs a receipt for the records prior to the records being provided.

3) Inform the Patient of the Refusal to Permit Access.

The clinic is required to inform the patient of his or her right to require the clinic to permit inspection by, or provide copies to another provider, as specified above, designated by written authorization of the patient. The statute does not require that the patient must be informed in writing but it is advisable to do so and include a copy of the letter to the patient in the patient's mental health records. The statute does not provide a specific time limit in which the information about refusing access to mental health records must be provided to the patient. In light of this, a timeframe consistent with the time by which a provider must make the records available should be reasonable to satisfy this requirement. Therefore, the clinic is advised to inform the patient about the refusal to permit access within fifteen days of receiving the request.

4) Record the Patient's Request for a Designated Provider to Review Records.

The clinic is to "indicate" in the mental health records of the patient whether he or she provided a written authorization designating another health provider to review and/or copy records. Including a copy of the written request from the patient in the patient's mental health records would be sufficient as an affirmative indication of the patient's request. The statute does not require a specific time frame within which the clinic must indicate that the patient did not follow through with the request.

Penalty for Unwarranted Denial of Access. The state statute provides a right of action to any patient or representative who is "aggrieved" by denial of access to his or her medical records. The aggrieved party may sue to enforce access. The court may award damages, including costs and reasonable attorney fees to the prevailing party.¹⁰⁶ In addition, a primary care clinic that is found to have willfully violated a patient's right to access medical records is guilty of an infraction punishable by a fine of not more than one hundred dollars (\$100). In addition, the state agency that issued the clinic's license is required to consider a violation as grounds for disciplinary action with respect to the licensure, including suspension or revocation of the license or certificate.¹⁰⁷

Patient Access to Substance Abuse Records. In addition, a clinic is not required to permit inspection or provide copies of alcohol and drug abuse records if prohibited by Section 408 of the federal Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255) or Section 333 of the federal Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (Public Law 91-616), or by regulations adopted pursuant to these federal laws. To the extent that these federal laws do not prohibit disclosure of the records, access to substance abuse records is governed by the California law.¹⁰⁸ Because the definition of mental health records, as described above, includes substance abuse records, under California law a clinic may refuse a patient permission to access the records in the same manner required for refusal to permit access to mental health records.

Conclusion

The requirement for use and disclosure of mental health records involve a complicated assortment of federal and state laws. Primary care clinics are advised to seek legal counsel on a case-by-case basis, and according to the facts and circumstances of each case, when in doubt about their rights and responsibilities relative to disclosing patient records. Adopting a general policy for non-disclosure unless the patient consents in writing is the most conservative course of action. However, this may be unnecessary or even impossible in some circumstances. To avoid the possibility of inadvertent unlawful disclosure of mental health records, a primary care clinic is advised to maintain mental health records in a distinct part of the patient record.

Disclaimer: *This article is meant to provide a basic summary of the most applicable legal requirements pertaining to primary care clinics for informational purposes only and is not to be used as a definitive treatise on the subject of patient mental health records or as a substitute for the advice of legal counsel. This article does not provide a full analysis of HIPAA privacy rules or the California laws regarding confidentiality of patient medical information.*

Endnotes

¹ 45 Code of Fed. Regs. parts 160 and 164.

² 42 U.S. Code § 290dd-2 and 42 Code Fed. Regs. part 2.

³ <http://www.hipaa.samhsa.gov/Part2ComparisonCleared.htm>

⁴ Cal. Civil Code, § 56, et. seq.

⁵ Cal. Welfare & Institutions Code § 5000, et. seq.

⁶ Cal. Health & Safety Code § 123100, et. seq.

⁷ 45 Code of Fed. Regs. § 160.203

⁸ A fairly complete preemption analysis can be found in *Mental Health Law: A Handbook on Laws Governing Mental Health Treatment*, 2nd Ed. 2004 published by the California Healthcare Association.

⁹ Cal. Civil Code § 56.104 and 56.35.

¹⁰ Cal. Civil Code § 56.36(c). A provider may be liable for up to \$2,500. per violation for negligent use or disclosure and up to \$25,000. per violation done knowingly and willfully. The penalties for licensed health care professionals are set out in Cal. Civ. Code § 56.36(c)(2)(B).

¹¹ Cal. Welfare & Institutions Code § 5330.

¹² See 42 Code Fed. Regs., part 2, § 2.3(b)(3).

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- ¹³ 42 U.S. Code § 290dd-2(f). *Also see* 42 Code Fed. Regs., part 2, § 2.4 which states that the fine is not more than \$500 for the first offense, and not more than \$5,000 in the case of each subsequent offense.
- ¹⁴ 45 Code. Fed. Regs. § 164.104(a)(3).
- ¹⁵ Cal. Civ. Code § 56.10.
- ¹⁶ Cal. Civil Code § 56.05(j).
- ¹⁷ 42 Code Fed. Regs. part 2, § 2.11.
- ¹⁸ 42 Code Fed. Regs. part 2, § 2.12(b).
- ¹⁹ Cal. Welfare & Institutions Code § 5328.
- ²⁰ Title 22 Cal. Code Regs. §75055(b).
- ²¹ Cal. Health & Safety Code § 123149(e).
- ²² 42 Code of Fed. Regs. § 51c.110
- ²³ 42Code of Fed. Regs. § 491.10(b).
- ²⁴ 45 Code Fed. Regs. § 164.500.
- ²⁵ Title 22 Cal. Code. Regs. § 75049 subdivisions (a) and (b)(3).
- ²⁶ 45 Code Fed. Regs. §165.530
- ²⁷ Cal. Health & Safety Code § 123110 (h).
- ²⁸ The requirements for coverage of mental health benefits under Medi-Cal and for the Mental Health Plans are found in the Medi-Cal Manual and Welfare & Institutions Codes §§ 5775-5781 and §§ 14021, et. seq. There are no Medi-Cal regulations that specifically require a primary care provider to maintain separate mental health records.
- ²⁹ Title 22 Cal. Code Regs. § 75054(a).
- ³⁰ 45 Code of Fed. Regs. § 164.501.
- ³¹ Title 22 Cal. Code of Regs. §75055(a).
- ³² Cal. Health & Safety Code § 123149 (h).
- ³³ Cal. Health & Safety Code § 123149(a).
- ³⁴ Title 22 Cal. Code Regs. § 75055(g).
- ³⁵ Cal. Health & Safety Code §123149(h).
- ³⁶ Title 22 Cal. Code Regs. § 75055(a).
- ³⁷ Title 22 Cal. Code Regs. § 75055(i).
- ³⁸ *See* Health & Safety Code § 1218.2 which supersedes Title 22 Cal. Code Regs. § 75055(h) pertaining to offsite storage of records.
- ³⁹ Title 22 Cal. Code. Regs. § 75054 subdivisions (b) and (c).
- ⁴⁰ Title 22 Cal. Code Regs. § 75055, subdivisions (c) and (e).
- ⁴¹ Cal. Health & Safety Code § 123149(c).
- ⁴² Cal. Health & Safety Code § 123149(f).
- ⁴³ Cal. Health & Safety Code § 123149(b).
- ⁴⁴ Cal. Health & Safety Code § 123149(g).
- ⁴⁵ Title 22 Cal. Code Regs. § 75055(f).
- ⁴⁶ Title 22 Cal. Code Regs. § 75056.
- ⁴⁷ Cal. Health & Safety Code § 123147(a).
- ⁴⁸ Title 22 Cal. Code Regs. §51476.
- ⁴⁹ Title 22 Cal. Code Regs. § 70749.
- ⁵⁰ 42 Code of Fed. Regs. § Sec. 491.10(a)(3).
- ⁵¹ Title 22 Cal Code Regs. §75055(a).
- ⁵² Cal. Health & Safety Code § 123149(h).
- ⁵³ 42 Code of Fed. Regs. § Sec. 491.10(c).
- ⁵⁴ Cal. Health & Safety Code § 123145.
- ⁵⁵ Title 22 Cal Code Regs. § 75055(d).
- ⁵⁶ 45 Code of Fed. Regs. § 164.508(a)(2).
- ⁵⁷ 45 Code of Fed. Regs. § 164.508(b)(3)(ii).
- ⁵⁸ Cal. Civil Code § 56.10.
- ⁵⁹ For purposes of this section, "psychotherapist" means a person who is both a "psychotherapist" as defined in Section 1010 of the Evidence Code and a "provider of health care" as defined in

subdivision (i) of Section 56.05. See Cal. Civil Code § 54.104(c). “Provider of health care” is actually defined in Cal. Civil Code § 56.05(j). This includes psychiatrists, advanced practice nurses, licensed clinical social workers, clinical psychologists, marriage and family therapists and others.

⁶⁰ Cal. Civil Code § 56.104.

⁶¹ Cal. Civil Code § 56.104 (a).

⁶² Cal. Civil Code § 56.104(d).

⁶³ Cal. Welfare & Institutions Code § 5328 *et seq.*

⁶⁴ Cal. Welfare & Institutions Code § 5328.

⁶⁵ 45 Code of Fed. Regs. § 160.103 states: “ Health information means any information, whether oral or recorded in any form or medium, that: (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.”

⁶⁶ See Cal. Welfare & Institutions Code §§ 5328-5328.9

⁶⁷ Cal. Welfare & Institutions Code § 5328(a).

⁶⁸ Cal. Welfare & Institutions Code § 5328.7.

⁶⁹ Cal. Welfare & Institutions Code § 5328.6.

⁷⁰ 42 Code of Fed. Regs. § §2.13 and 2.33.

⁷¹ Cal. Health & Safety Code, commencing with § 123100.

⁷² 45 Code of Fed. Regs. § 164.524.

⁷³ Cal. Health & Safety Code §123105(a)(2). The statute also applies to hospitals and other licensed health care facilities and individual health care providers, including physicians, podiatrists, dentists, psychologists, optometrists, chiropractors, marriage and family therapists, clinic social workers, and physical therapists.

⁷⁴ Cal. Health & Safety Code §123110(h)

⁷⁵ 45 Code Fed. Regs. § 164.524(a)(1)(i). The HIPAA regulations explicitly define “psychotherapy notes” as notes recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. However, medication prescription and monitoring, consulting session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms prognosis or progress to date are excluded from the definition of “psychotherapy notes.” See 45 Code of Fed. Regs. § 164.501.

⁷⁶ 45 Code Fed. Regs. § 164.524(a)(2)(i).

⁷⁷ 45 Code Fed. Regs. § 164.524(a)(3).

⁷⁸ Cal. Health & Safety Code §123105(a). For the purpose of California’s patient records access law, "mental health records" means patient records, or discrete portions thereof, specifically relating to evaluation or treatment of a mental disorder. "Mental health records" includes, but is not limited to, all alcohol and drug abuse records. See Cal. Health & Safety Code §123105(a). "Alcohol and drug abuse records" means patient records specifically relating to evaluation and treatment of alcoholism or drug abuse. See Cal. Health & Safety Code §123105(f).

⁷⁹ Cal. Health & Safety Code § 123110.

⁸⁰ 45 Code of Fed. Regs. § 164.524(b).

⁸¹ Cal. Health & Safety Code § 123110(a).

⁸² Cal. Health & Safety Code § 123110(b).

⁸³ Cal. Health & Safety Code § 123130 (a).

⁸⁴ Cal. Health & Safety Code §123105 (d).

⁸⁵ Cal. Health & Safety Code §123110(a).

⁸⁶ Cal. Health & Safety Code §123105(e).

⁸⁷ Cal. Health & Safety Code §123115(a).

⁸⁸ See State 2007, ch.552 (AB 1687).

⁸⁹ Cal. Civ. Code § 56.103(a).

⁹⁰ Cal. Civ. Code § 56.103(e)(1).

⁹¹ Cal. Civ. Code § 56.103(e)(2).

⁹² Cal. Health & Safety Code §123110(g).

⁹³ 45 Code Fed. Regs. § 164.514(h)(1).

⁹⁴ 45 Code Fed. Regs. § 164.524(c)(4).

⁹⁵ Cal. Health & Safety Code §123110(b).

⁹⁶ Cal. Health & Safety Code § §123110 and 123130(e)-(f); 45 Code of Fed. Regs. § 164.524(c)(4).

⁹⁷ Cal. Health & Safety Code §123110(c).

⁹⁸ Cal. Health & Safety Code §123110(d).

⁹⁹ Cal. Health & Safety Code §123110(e).

¹⁰⁰ Cal. Health & Safety Code §123110(f).

¹⁰¹ 45 Code of Fed. Regs. § 164.524(c)(2)(ii) and Cal. Health & Safety Code §123130.

¹⁰² Cal. Health & Safety Code § 123130(e).

¹⁰³ Cal. Health & Safety Code § 123130 (b).

¹⁰⁴ Cal. Health & Safety Code § 123130 (f).

¹⁰⁵ *See* Cal. Health & Safety Code § 123115(b).

¹⁰⁶ Cal. Health & Safety Code § 123120.

¹⁰⁷ Cal. Health & Safety Code § 123110(i).

¹⁰⁸ *See* Cal. Health & Safety Code § 123125(a).