ACCESSING CLINICAL RECORDS

WHAT IS A CLINICAL RECORD?

A clinical record refers to any information regarding the examination or treatment of an individual who is receiving services or has received services from a provider under the jurisdiction of the Office of Mental Health (OMH), the Office for People With Developmental Disabilities (OPWDD) or the Office of Alcoholism and Substance Abuse Services (OASAS). Mental Hygiene Law § 33.16(a)(1).

Under Mental Hygiene Law § 33.13, these facilities have a duty to keep sufficient records of a patient's treatment. New York law holds such facilities to a high standard of confidentiality with regard to these records. They are not public records, and will not be released without the consent of the patient, unless they fit within an excepted category.

DO I HAVE A RIGHT TO ACCESS MY CLINICAL RECORDS?

Yes. Under Federal and New York law, a patient/client about whom clinical records are maintained by a facility (i.e. psychiatric hospital, psychiatric ward, mental health clinic) has the right to access his or her own clinical records.

However, a provider may deny access to all or part of their medical records and give them a prepared summary of the record instead, if the provider believes that the information can reasonably be expected to cause "substantial and identifiable harm" to the patient/client or another person.

It is important that you carefully review any insurance documents prior to signing any agreement.

WHO ELSE CAN ASK FOR MY CLINICAL RECORDS?

Because of the personal and sensitive nature of mental hygiene records, the confidentiality of this information is strictly protected. But the law permits certain persons, known as qualified persons, to access these records and documents. A qualified person includes an individual receiving services, his or her legal guardian, or a parent, spouse or adult child who has authority to provide consent for care and treatment. Mental Hygiene Law §§ 33.16(a)(6) and 33.16(b)(4).

ARE THERE RESTRICTIONS ON A QUALIFIED PERSON'S RIGHT TO OBTAIN RECORDS AND DOCUMENTS?

Yes. There are four restrictions on a qualified person's right to obtain records and documents:

1. Access to certain records and documents may be limited if the information is expected to be harmful to the individual receiving services or others;

2. Agency regulations may limit access in situations where, for example, the person requesting records and documents is alleged to have abused the individual receiving services, or where the individual receiving services is a capable adult who objects to the release of records and documents to another qualified person;

3. Federal confidentiality provisions applicable to programs operated or certified by the Office of Alcoholism and Substance Abuse Services require consent of the person receiving services for the release of any records regarding that individual's care and treatment (42 CFR Part 2); and

4. Other Federal laws, including the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") may, in some cases, impose additional restrictions on the availability of records and documents sought under Article 33.

CAN CLINICAL RECORDS BE OBTAINED THROUGH THE FREEDOM OF INFORMATION LAW (FOIL)?

While the general public may also request certain records from a governmental or "public" agency under the New York Freedom of Information Law (FOIL), FOIL is not the appropriate way to seek information about an individual's care and treatment. Under FOIL, personally identifying information, as well as other information deemed confidential and protected from disclosure under other statutes, such as Article 33 of the Mental Hygiene Law, cannot be released in response to a FOIL request.

How Do I Obtain My Clinical Records?

Requests for clinical records should be made to the director of the facility that maintains your records or the person who handles clinical record requests. Requests for clinical records must be made in writing. The written request should specify what information is sought as well as the dates the patient was admitted to the facility, the length of the patient's stay and the patient's social security number.

In addition, clinical records can be requested at any time.

When Will the Clinical Records be provided?

If you request to see the record in person, and there are no objections to the access of the record, the provider must provide an opportunity for you to go to the facility or other designated location and read the clinical record within ten days of receipt of the request. Mental Hygiene Law § 33.16(b)(5). If copies are requested, they must be provided within 10 to 14 days, or a reasonable time, and a reasonable charge, not to exceed $0.75/page, can be imposed for inspections and copies. Mental Hygiene Law § 33.16(b)(5), (6).

A facility can charge more than 75 cents per page for x-rays and for the cost of mailing records. Patients who cannot afford the cost of copies are still entitled to their clinical records.

Will the Whole Record be Provided?

Clinical records may be redacted or edited to withhold or delete information determined by the facility to be harmful to the subject of the clinical record or others. Mental Hygiene Law § 33.16(c).

What Can I Do if the Facility Denies Access to My Clinical Record?

Mental Hygiene Law § 33.16(c)(4) creates a Clinical Record Access Review Committee (Committee) in OMH, OPWDD and OASAS. The Committees must consist of three to five members, appointed by the appropriate commissioners. The review process works as follows:

1. A provider must notify you of its decision in reply to a records access request.

2. If the decision is to deny access to the records, in whole or in part, the provider must notify you of its decision, and it must inform you of your right to obtain a review of the

denial, free of charge, by the Committee. This notice must explain how you can request a review by the Committee.

3. If you request a review, the provider must send the clinical record to the Committee within ten days, explaining the specific reasons for denying access to the record.

4. The Committee will conduct a review of the entire clinical record, and will offer you or other involved parties the opportunity to be heard. The Committee will issue a decision promptly, based on its assessment of whether the risk of harm in releasing the information sought outweighs your right of access. The Committee may decide to affirm the denial in whole or in part, or may decide to expand access. The Committee's determination is binding on the provider.

5. If the Committee denies any part of the request for access, it must notify you of your right to seek judicial review. Within 30 days of the receipt of that decision, you may commence a special proceeding in New York State Supreme Court for a review of the provider's decision. The Court will conduct a review of the record, give parties an opportunity to be heard, and issue its ruling. The Court may order the provider to make the record available to you for inspection and copying. (Note: in OASAS-operated or certified programs, Federal confidentiality requirements take precedence over New York State law and the courts will abide by the stricter rules on access published by the United States Department of Health and Human Services).

WHAT CAN BE DONE IF THE CLINICAL RECORD IS INACCURATE?

If you believe there is a factual mistake in the clinic record, you may write a short statement disagreeing with parts of the record and it will become a permanent part of the clinical record.

Disability Rights New York Contact Information

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