Recent court decision puts independent contractor arrangements under the microscope

For years, the Independent Contractor (1099) staffing arrangement has been a cornerstone of operational efficiency for many group psychology practices, celebrated for offering flexibility and reduced administrative overhead. This landscape, however, is shifting.

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If you are a practicing psychologist working as an "independent contractor"—or you employ contractors in your practice—a recent federal court ruling has made it harder for organizations to classify workers as independent contractors. This decision reinforces a critical federal standard: what matters is not the label on the paperwork or contract but the reality of the job.

Breaking down the decision: *Galarza v. One Call Claims, LLC*

In October 2025, the 11th Circuit Court of Appeals decided *Galarza v. One Call Claims, LLC*, a case that reinforces the federal government's tough stance on worker classification. The court's central message was unambiguous: the relationship between a worker and a company is determined by the "economic reality"—not the "label" the parties use in a contract. The ultimate inquiry is whether the worker is economically dependent on the hiring practice.

The case involved three insurance adjusters who had signed contracts explicitly labeling them as "independent contractors." Despite this agreement,

the court found the workers functioned more like employees in nearly every meaningful way. They worked full time for nearly 2 years, had their schedules controlled by the companies, were required to get approval before settling claims, and couldn't work for other insurers during their engagement.

The court emphasized: "we care about reality, not possibility" and "the relationship is not determined by the 'label' the parties use." In other words, what matters isn't what your contract says—it's how the working relationship actually functions day to day.

The 11th Circuit, applying the Fair Labor Standards Act's (FLSA) "economic reality test," examined six key factors to determine whether the workers were truly independent contractors or employees in disguise. Based on that test, the court concluded that five of the six factors overwhelmingly favored classifying the workers as employees, not independent contractors, citing the overwhelming evidence of economic dependence.

Why this matters for psychologists

While this case involved insurance adjusters, the legal principles apply to all professions, including psychologists, under the FLSA, which is the primary federal law establishing minimum wage, overtime pay, and employee standards. The decision signals that federal courts are taking a much harder look at contractor classifications. For psychologists, this could mean that arrangements you thought were "independent contractor" relationships might actually be viewed as employment relationships under federal law.

National reinforcement

The principles affirmed in the *Galarza* ruling are not isolated. On July 17, 2025, the U.S. Court of Appeals for the Fourth Circuit upheld a $9.3 million judgment against a medical staffing company for misclassifying health care professionals. In that case, the Fourth Circuit also applied the six-factor economic realities test and found that five of the six factors favored employee status. This consistency across circuits serves as a warning to health care practices about the risks of misclassifying health care professionals as independent contractors. These decisions show the skepticism regarding independent contractor classifications where there is significant control, fixed compensation, and economic dependence. For psychology practices, this reinforces the importance of carefully structuring independent contractor relationships to minimize control factors and ensure genuine entrepreneurial opportunity for contract psychologists.

The ruling is a direct challenge to the common operational structure of many group practices. The court's reasoning clarifies why the typical 1099 arrangement for a clinician—involving significant control, fixed compensation, and economic dependence—may likely fail the test.

The six-factor test

Based on these court cases, the six-factor economic reality test is the federal standard used to determine the "economic reality" of the working relationship. An arrangement is at high risk of being reclassified as an employee instead of an independent contractor if multiple factors point toward the worker being economically dependent on the organization. Here is a breakdown of what

each factor means to help you determine if your current arrangement meets the federal standard:

1. **Control over work**. Does the organization control the schedule, methods, and daily tasks of the worker? Red flags signaling employee status often include set hours, required meetings, productivity monitoring, and detailed supervision beyond clinical consultation.
2. **Opportunity for profit or loss.** Can the worker actually increase earnings through business decisions, or are they paid a fixed rate? Employee status red flags include non-negotiable rates, lacking the ability to upsell additional services or negotiate fees to generate a profit, and having income tied solely to hours worked rather than managerial or investment initiative.
3. **Investment in equipment**. Who provides the tools needed for work? Red flags for employee status include situations where the organization provides the critical infrastructure, such as office space, computers, electronic health record systems, and assessment materials, demonstrating minimal entrepreneurial investment by the psychologist.
4. **Special skills.** Do the workers' professional credentials support independence? For psychologists, a license helps support independent contractor status but only if the psychologist actually exercises independent professional judgment.
5. **Permanency.** Is this a long-term, ongoing relationship or project-based work? Red flags signaling employee status include indefinite arrangements (contracts without a specific

end date), exclusive relationships (prohibiting work for other organizations), and working full-time for one organization over an extended period.

6. **Integral to business**. Is the work being done central to the organization's main operations? Red flags signaling employee status include providing direct patient care as the organization's primary service and revenue stream, thereby making the worker's services essential and integral to daily operations of the practice.

Essential actions for practices and practitioners

What independent contractors should do now

Psychologists who work as independent contractors should consider auditing their current arrangements using the six-factor economic reality test. If a majority of factors point toward employee status, it may be wise to raise the issue with the organization or seek legal counsel. The court emphasized that "no one factor dominates, and even the sum of factors should be rejected if they do not reflect the economic reality," but having multiple factors align creates a compelling case.

For those who want to maintain contractor status, it's important to demonstrate genuine business independence—such as maintaining your own business infrastructure and equipment, working with multiple practices or organizations when possible, exercising real control over your methods and schedule, and creating opportunities for profit or loss through business decisions.

Also, consider reviewing contracts carefully; while the contract language does not determine a contractor's actual status, agreements that claim independence but impose employee-like conditions are a warning sign. Finally, consider the trade-offs: employee status offers protections like overtime pay, benefits eligibility, and unemployment insurance, while contractor status provides greater autonomy but fewer safeguards.

What practice owners should do now

Psychologists who own their own practice and currently use 1099 contracts should immediately audit all contractor relationships using the six-factor economic reality test to ensure compliance. If any arrangement fails the test, it should either be restructured to provide genuine independence or the worker should be reclassified as an employee. Policies should be updated to align with legal requirements for true independent contractor relationships, reducing risk of misclassification. Finally, given the complexity and potential liability, seeking guidance from an employment counsel familiar with your state's laws would be important.

Compliance is urgent to avoid penalties

While the courts are tightening the screws on misclassification, efforts to modernize independent contractor laws remain stalled in Congress. Both practice owners and contractors should pay attention to these legislative efforts, such as proposed Senate Package (S.2210) and House Bills (H.R. 1319 and H.R. 1320), which aim to provide clarity for millions of independent workers and more flexibility to employers who use 1099s. If passed, these bills could provide a clearer, more

predictable standard for classification that favors the contractor arrangement or allows for benefits without triggering employee status. **However, since judicial precedent like *Galarza* and the stricter federal FLSA standards are the only active legal guides at this point, compliance is urgent now to avoid significant penalties.**

APA will continue to monitor any significant changes to independent contractor classifications and standards, including any updates on these pending bills.

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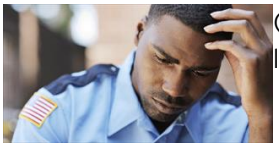

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Trends in Ethical Complaints Leading to Professional Counseling Licensing Boards Disciplinary Actions

Tyler Wilkinson, Dannielle Smith, and Ramona Wimberly

This article presents findings of a content analysis of the types of ethical violations that led to disciplinary actions (*N* = 936) across state counseling licensing boards for professional counselors during the time frame of 2010 to 2014. The most frequent types of ethical violations included failure to acquire the appropriate amount of continuing education, dual relationships (sexual and nonsexual), and misrepresentation of credentials. Implications of the findings and future research needs are discussed.

Keywords: ethical issues, legal issues, counseling ethics, professional issues, content analysis

Experts in counseling ethics have indicated that the ability to practice ethically, to abide by the code of ethics, and to appropriately apply models of ethical decision making are critical issues for professional counselors (Herlihy & Dufrene, 2011). State legislators establish licensing laws that serve as a minimum set of standards for each state in the areas of education, examination, and experience (American Counseling Association [ACA], 2016). Licensing boards monitor the legal and ethical practice of counseling and serve as an entity to act upon consumer ethical complaints (ACA, 2016; Mascari & Webber, 2013).

Currently, all 50 states, Washington, DC, and Puerto Rico have laws and licensing boards that oversee professional counseling (ACA, 2016). This is a relatively recent phenomenon, with California being the last state to approve licensing laws for counselors in 2009 (ACA, 2016) after Virginia led the charge in 1976 (Mascari & Webber, 2013). Ethical issues are consistently changing and can be complex (Herlihy & Dufrene, 2011). Neukrug, Milliken, and Walden (2001) argued that understanding the types of ethical violations that get reported and acted upon by counseling licensing boards is helpful for the training and practice of counseling professionals. Researchers have made some attempts to explore counseling boards and their ethical trends, although many of the studies are now 10 to 30 years old. The purpose of this study is to address this gap by comprehensively exploring current trends in the ethical violations that result in disciplinary actions across the licensing boards of all 50 states and Washington, DC.

In 1987, an initial survey (Herlihy, Healy, Cook, & Hudson, 1987) was sent to seven state counseling boards in which a representative of each board was mailed a survey with a Likert-type scale. A follow-up to that study was conducted 5 years later (Neukrug, Healy, & Herlihy, 1992) in which 22 counseling boards replied to the mailed surveys. In both studies, the board representative was asked to note the frequency of complaints and actions in nine categories since the time the licensing of counselors was established. Both studies found that the two most common complaints to the licensing board were practicing without a license or inaccurate representation of credentials (27%) and having a sexual relationship with a client (20%).

More recently, Neukrug et al. (2001) surveyed 45 state counseling credentialing boards in 1999. The term *credentialing* was used because during that time not every state board provided a license for professional counselors. Of the 45 surveyed, 30 licensing boards reported data for complaints received during the previous year. The researchers used a mixed-method design to analyze the data and found that the most frequently reported complaints were for nonsexual dual relationship (24%), incompetence in the facilitation of a counseling relationship (17%), practicing without a license or other misrepresentation of qualifications (8%), and having a sexual relationship with a client (7%). Additionally, the researchers placed 337 (33%) of the complaints in a category noted as *other*, which included violations such as a felony or misdemeanor conviction (<2%) and drug abuse

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(1%). Neukrug et al. (2001) also noted that there were inconsistencies in the types of violations reported across state boards.

Not all complaints to licensing boards result in disciplinary actions. These early studies indicated that licensing boards had only formally investigated and subsequently acted upon approximately 10% to 34% of all complaints received since the inception of the counseling board (Herlihy et al., 1987; Neukrug et al., 1992, 2001). These studies did not further assess the data to determine the nature of the complaints that tended to result in formal investigations and subsequent disciplinary actions.

Boland-Prom, Johnson, and Gunaganti (2015) conducted a study of the types of ethical complaints that resulted in disciplinary actions in the field of social work. These researchers found that during the 2000–2009 period, the most frequent ethical complaints with resulting sanctions included dual relationships (22.32%), failing to obtain or comply with continuing education (CE) requirements (19.68%), and issues with keeping records (5.25%). The category of dual relationships included both sexual (9.59%) and nonsexual (12.73%) complaints.

These studies (Boland-Prom et al., 2015; Herlihy et al., 1987; Neukrug et al., 1992, 2001) indicate that dual relationships (both sexual and nonsexual) are consistently one of the most frequent reasons the public files complaints that may result in disciplinary actions. Dual relationships with clients is a topic that is often given considerable focus in counselor training curricula and counseling textbooks (e.g., Herlihy & Corey, 2015a; Wheeler & Bertram, 2015), with some counseling ethics books devoted entirely to the topic (Herlihy & Corey, 2015b). Liability claims related to dual relationships, specifically sexual relationships, are reported as one of the most common and costly types of ethical infractions (Healthcare Providers Service Organization [HPSO], 2014; Wheeler & Bertram, 2015). A report from HPSO (2014) regarding liability claims of counselors ($N = 1{,}043$) from 2003 to 2012 indicated that inappropriate sexual relationships with clients (39.7%) are the most frequent allegation against counselors that results in payment. These liability claims resulted in total indemnity payments during this time of approximately $2.2 million.

These previous studies (Boland-Prom et al., 2015; Herlihy et al., 1987; Neukrug et al., 1992, 2001) provide an understanding of overall ethical trends; however, they all have some limitations. The earliest surveys (Herlihy et al., 1987; Neukrug et al., 1992) included nine categories of ethical complaints, which created a forced choice for the respondents. When Boland-Prom et al. (2015) used qualitative coding to describe ethical complaints and sanctions within social work, the result was 34 distinct categories. Also, the existing studies analyzing counseling board trends (Herlihy et al., 1987; Neukrug et al., 1992, 2001) have only assessed the nature of ethical complaints in general. These studies have found that approximately 10% to 34% of complaints receive a full investigation with resulting disciplinary actions; however, it is unclear from these studies which types of complaints tend to result in disciplinary actions. The most recent study of counseling boards (Neukrug et al., 2001) assessed 45 state boards' complaints during a 1-year period; however, at the time that study was published, not all states and Washington, DC had enacted licensing laws for professional counselors (ACA, 2016). The purpose of our study is to provide an understanding of current trends in the ethical complaints that result in disciplinary actions across all state licensing boards. Because the existing literature has explored ethical complaints broadly and not those violations that lead to disciplinary actions specifically (Herlihy et al., 1987; Neukrug et al., 1992, 2001), we decided to analyze only the ethical complaints that subsequently led to disciplinary actions. Results regarding the type and frequency of the various ethical infractions are provided. Additionally, implications for ethical understanding and application for counselors are discussed (Neukrug et al., 2001).

Method

We conducted a content analysis (Schreier, 2012; Stemler, 2001) of the collected data using a priori and emerging codes (Creswell, 2007; Hays & Singh, 2012) to guide the development of categories from the data (Webber, Kitzinger, Runte, Smith, & Mascari, 2017). Content analysis is a qualitative research method that is used to systematically analyze large amounts of text (Schreier, 2012; Webber et al., 2017). This type of qualitative analysis is appropriate for this study because we were analyzing archival textual data from counseling licensing boards (Schreier, 2012; Stemler, 2001). Researchers in counseling have used this research methodology to explore textual data in the profession (e.g., Evans, 2013; Shin et al., 2017; Webber et al., 2017). This study was approved by the institutional review board at the authors' university.

Data Collection

We obtained data regarding the nature of the complaints that resulted in disciplinary actions from professional counselor licensing boards in all 50 states and Washington, DC from 2010 to 2014. Many states have multiple tiers of licensure (ACA, 2016), and the requirements needed throughout the licensure process vary across states; as such, we limited the data collected to only complaints about counselors who had a license to practice counseling independently in their respective states at the time of the infraction. We only focused on those individuals who had the highest level of licensing as indicated by the titles provided in ACA's (2016) *Licensing Requirements for Professional Counselors: A State-by-State Report*.

Because states use different language to title counselors (e.g., LPC, LMHC, LCPC), we will use the term *professional counselor* to mean any counselor who can practice independently in their state.

We were only interested in those ethical violations and complaints that resulted in disciplinary actions during the time period of 2010 to 2014. We chose this time frame because we wanted to analyze the most recent trends of licensing boards from the time all states recognized counseling licensure (ACA, 2016; Mascari & Webber, 2013). At the time of data collection, we identified 2014 as the most recent year that licensing boards would have had time to review complaints and provide subsequent disciplinary actions. We used several methods to obtain the disciplinary action records. Many state licensing boards post data on acted-upon violations and the nature of the infraction on their website. We sent emails and letters to the states' licensing board offices and/or the states' Freedom of Information offices for states that did not post this information online. Some states (n = 15) required us to submit a Freedom of Information Act request letter to obtain the data. Many states sent copies of the individuals' consent agreement and sanction orders that provided detailed accounts of the ethical violations and the resulting consequences. The nature of most of the data we collected, written decrees of the violations and the actions, required us to reach out to each licensing board individually to obtain these existing documents. The representatives of these boards took various amounts of time to respond to our requests for information. In total, it took approximately 14 months to obtain our final data set before we analyzed it.

We were only interested in capturing the nature of the violations that led to complaints and disciplinary actions with state licensing boards. No identifying information of the individuals who had complaints acted upon was recorded or collected. Most of the data received did not include identifying information.

Role of Researchers

We each identify as professional counselors; as such, we have received formal training on the *ACA Code of Ethics* (ACA, 2014) and abide by this code in the practice of professional counseling. The first author works as a counselor educator and has a limited private practice as a licensed professional counselors in his state of residency. Among other subjects, he teaches course work on counseling ethics. The second and third author are both doctoral students pursuing a degree in counselor education and supervision. They are licensed as a professional counselor and an associate professional counselor in their state of residency, respectively.

Our interest in this study is situated in a broader interest in the development of professional standards for counselors pursuing licensure in their respective states. Given the various discussions occurring at the national and state levels regarding professional counseling standards and credentialing, we are interested in better understanding to what extent the public is reporting concerns to licensing boards and which infractions result in licensing board disciplinary actions. Our assumptions going into the study are being influenced by current texts on ethics in counseling (ACA, 2014; Herlihy & Corey, 2015a) and recent studies on trends in violations of ethical standards (Neukrug et al., 2001; Wheeler & Bertram, 2015).

Trustworthiness

We made intentional efforts to maximize the trustworthiness of this study (Hays & Singh, 2012). We did this by using the following recommended strategies: field notes, persistent observation, triangulation of investigators, and simultaneous data collection and analysis (Hays & Singh, 2012).

Field notes. We met before collecting any data to discuss our assumptions, biases, and prior experiences with the topic of this study. We met approximately every other week during the data collection and analysis period to create a reflexive process to discuss emerging themes of the study and to address any assumptions made from reading the detailed complaint narratives. Field notes (Schwandt, 2007) were collected in a journal at every meeting, which allowed us to track discussions, emerging ideas, and thoughts as they developed throughout the study.

Persistent observation. This type of strategy attempts to establish trustworthiness through seeking out depth of data (Hays & Singh, 2012) and to maintain prolonged engagement with the data (Creswell, 2007). We attempted to collect the entire narratives associated with the ethical infractions whenever possible. This allowed us to spend time gathering refined details associated with each case when this information was provided. We were then able to code the narrative of the complaint.

Triangulation of investigators. Triangulation is a means of checking the integrity of drawn inferences (Schwandt, 2007) by utilizing multiple sources (Creswell, 2007). We used triangulation of researchers to help minimize any potential distortions from any one author (Creswell, 2007; Hays & Singh, 2012). We divided an alphabetical list of the states in half. Each of the last two authors initially coded just one half of that list. After initial codes were established by the individuals, all three authors met every other week to review the collected data and the initial codes. During these meetings, we discussed the codes that best captured the complaint until interrater agreement and saturation occurred (Creswell, 2007).

Simultaneous data collection. Data from all 50 states' licensing boards were obtained at different rates. Some state licensing boards maintain websites that allow the public to review redacted complaints and disciplinary actions. This allowed us to obtain some data very quickly and begin analyzing them immediately. Other states required Freedom of

Information Act letters, which resulted in communication with the state licensing boards to specify the exact information we sought. Analyzing earlier data informed our understanding of the types of infractions occurring, which informed the ongoing data analysis.

Data Analysis

We developed an initial list of 11 a priori codes using information gained from previous studies on counseling ethical complaints (Boland-Prom et al., 2015; Neukrug et al., 2001), the *ACA Code of Ethics* (ACA, 2014), and other sources of information regarding disciplinary and liability actions (HPSO, 2014; Wheeler & Bertram, 2015). These codes guided an initial review of data from 27 states. After this initial review, we met regularly to discuss the findings and the need for emerging codes as well as to collapse or recode categories to best capture the data. Additionally, we discovered that many of the narratives of ethical infraction could be captured through multiple codes. Through interrater agreement and consensus, we discussed these cases to identify the single code that would best capture the overall essence of the infraction, for simplicity of analysis. We continued to do this until we agreed that saturation had occurred. We ended with a total of 24 different descriptive codes (see Table 1).

TABLE 1

Codes and Brief Descriptions

Code Name	Description
Alcohol-related legal arrest	An arrest as a result of alcohol use.
Billing fraud	Incidences involving improper billing practices.
Drug-related legal arrest	An arrest as a result of drug use other than alcohol.
Dual relationships (nonsexual)	Relationships with clients outside of therapy that do not involve sexual contact or sexual contact was not indicated in the documentation.
Failure to acquire continuing education credits	Failing to acquire required continuing education credit hours as required by the licensing board. This includes lying about number of hours accrued.
Failure to cooperate or fulfill board orders	Professional does not attempt to work with the board to address or comply with any complaints.
Failure to properly terminate or refer	Professional does not terminate or refer client when ethically appropriate (e.g., leaving a practice without notifying clients).
Failure to provide documentation	Professional does not provide or refuses to provide documentation of counseling or notes when requested by client or clients' authorized individuals (e.g., parents or courts).
Failure to report abuse or crisis	Failing to report abuse or a crisis as indicated by law for mandated reporters.
Failure to report prior legal charges	Failing to report any legal charge/disciplinary actions/complaints that the licensee acquired prior to being licensed in his or her current state.
Financial default	Failure to pay loans, taxes, child support, fees owed to the government.
Fraudulent documentation (improper notetaking)	Violations of notetaking and documentation, including failure to maintain notes, improper diagnosis, modifying preexisting notes, backdating notes, and/or fraudulent licensure documentation.
Impaired professional	Professional is engaging in practice while impaired (e.g., mental health, personal, or substance use) in which ability to do clinical work is affected.
Improper consent	Failing to receive consent from a client or client's parents/guardian (e.g., see a minor client without consent from the legal parent).
Improper evaluations	Professional engages in an evaluation (e.g., forensic, psychosexual) with the client, the client's family, or former clients OR provides results of an evaluation when an evaluation was not actually performed.
Improper supervisory practices	A violation of developed supervisory contracts/agreements and/or allowing for unlicensed work to occur.
Misrepresentation	Professional misrepresents self (e.g., training, credentials) to the public or professional is practicing on an expired/lapsed license.
Other	Any violation that does not fall into the aforementioned category or details were vague (e.g., the phrase "unprofessional conduct" was used, an individual was reported for watching illicit sexual content at work).
Other legal arrest	Any arrest as a result of anything not drug or alcohol related. Examples include theft, assault, breaking and entering, illegal gambling practices, sexual crimes, and fraud—specifically health care fraud.
Privacy breach	Any breach of clients' private data, including breaking confidentiality without consent or sharing data with others without proper consent.
Security breach	Any failure to properly secure client data, including leaving files in one's house or unsecured in a public space.
Sexual relationships with clients	Relationships with clients that involve sexual contact.
Sexual relationship with a client's family member(s)	Relationships with a client's family member(s) that involve sexual contact.
Working outside of scope	Any violation of the licensee working outside of his or her scope of practice. This includes areas without training, forging prescriptions, or areas not allowed according to state law (e.g., certain types of assessments).

Results

Data were obtained from 49 states and Washington, DC. Data were not received from Mississippi. During the time period of 2010 to 2014, a total of 936 complaints with resulting disciplinary actions were reported (see Table 2), ranging from 0 (Kentucky) to 75 (Illinois). The average number of complaints per state was 18.35, and the modal number of complaints across the states was 2. With approximately 139,749 (ACA, 2016) counselors fully licensed at their state's highest tier across all states and Washington, DC, this results in an approximate 0.67% rate of disciplinary actions for fully licensed counselors in these states.

Some of the provided data did not have information about the nature of the infraction that led to a disciplinary action; as such, the code *information not available* was removed when doing the final analysis. This code accounted for 89 (9.5%) of the original 936 items; the final content analysis was done on 847 licensing board complaints (see Table 3). The most commonly reported complaint with resulting action was counselors' failure to acquire the appropriate number of CE hours (n = 142; 16.8%). The next three items that were most reported were those of nonsexual dual relationships with clients (n = 106; 12.5%), sexual relationships with clients (n = 76; 9.0%), and misrepresenting oneself to the public (n = 57; 6.7%); however, if one combined both types of dual relationships (sexual and nonsexual), this larger category would represent the most acted-upon type of ethical violation (n = 182; 21.5%).

TABLE 2

Number of Reported Ethical Complaints Resulting in Disciplinary Actions Taken by States From 2010 to 2014

State	*n*
Alabama	12
Alaska	2
Arizona	50
Arkansas	6
California	1
Colorado	57
Connecticut	5
Delaware	2
District of Columbia	3
Florida	49
Georgia	4
Hawaii	2
Idaho	49
Illinois	75
Indiana	15
Iowa	14
Kansas	7
Kentucky	0
Louisiana	17
Maine	22
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Missouri	15
Montana	11
Nebraska	2
Nevada	2
New Hampshire	4
New Jersey	20
New Mexico	4
New York	6
North Carolina	30
North Dakota	1
Ohio	46
Oklahoma	22
Oregon	41
Pennsylvania	41
Rhode Island	2
South Carolina	4
South Dakota	5
Tennessee	23
Texas	74
Utah	11
Vermont	5
Virginia	29
Washington	30
West Virginia	8
Wisconsin	45
Wyoming	3

Note. N = 936. Data were not received from Mississippi.

TABLE 3

Type of Ethical Violation Acted on by State Licensing Boards

Type	*n*	%
Failure to acquire continuing education credits	142	16.8
Dual relationships (nonsexual)	106	12.5
Sexual relationships with clients	76	9.0
Misrepresentation of training/credentials to public	57	6.7
Other legal arrest	56	6.6
Document fraud/improper notetaking	54	6.4
Billing fraud	47	5.5
Impaired professional	34	4.0
Improper supervisory practices	34	4.0
Other	34	4.0
Failure to cooperate with board orders	27	3.2
Working outside one's scope of practice	26	3.1
Failure to report prior legal charges	21	2.5
Privacy breach	20	2.4
Financial default	17	2.0
Failure to provide documentation	17	2.0
Improper consent	17	2.0
Failure to report abuse/crisis (mandated reporting)	13	1.5
Security breach	11	1.3
Failure to properly terminate or refer	11	1.3
Improper use of evaluation practice	10	1.2
Alcohol-related legal arrest	9	1.1
Drug-related legal arrest	6	0.7
Sexual relationship with a client's family member(s)	2	0.2

Note. N = 847.

Discussion

The results of this study indicate that certain types of ethical violations result in disciplinary actions at rates similar to existing studies (Herlihy et al., 1987; Neukrug et al., 1992, 2001). The most frequently acted-upon category was in CE hour violations. This matches recent analysis of trends with social work boards (Boland-Prom, et al., 2015), in which failing to obtain the appropriate amount of CE hours was cited as one of the most frequently acted-upon ethical complaints. Most states require counselors to actively accrue CE hours during the licensure renewal period (ACA, 2016); as such, this may be the most frequently occurring infraction because licensing boards are more likely to actively seek out violators of this category by randomly auditing licensees.

If one considers the collapsed category of dual relationships, both sexual and nonsexual, it was the most frequently occurring ethical category with resulting disciplinary actions (21.5%). However, when separated out, nonsexual dual relationships (12.5%) and sexual relationships (9.0%) were the next two most frequently occurring ethical infractions. This matches other studies of ethical complaints (Herlihy et al., 1987; Neukrug et al., 1992, 2001) and ethical sanctions (Boland-Prom et al., 2015), which demonstrated that violations of dual relationships account for approximately 20% of all complaints. When compared with the data on counselor liability claims in which dual relationships account for approximately 40% of the allegations in these claims (Wheeler & Bertram, 2015), it appears that these types of ethical violations are also likely to result in a liability claim (HPSO, 2014). Counseling is an intimate endeavor, and engaging in relationships with clients outside of session has been one of the most frequent ethical complaints for decades (Herlihy et al., 1987; Neukrug et al., 1992, 2001). The clients who were involved in these dual relationships often remained for prolonged periods of time and did not file a complaint with the licensing board until the relationship ended.

The fourth most frequently occurring ethical complaint with a subsequent disciplinary action is misrepresentation of credentials (6.7%). This also follows with other studies (Herlihy et al., 1987; Neukrug et al., 1992, 2001) in which this was found to be a frequently occurring ethical complaint. Individuals were often sanctioned for misrepresenting their credentials to the public (e.g., claiming to be a doctor without the educational background) or practicing on a lapsed license.

Two of the most commonly occurring categories, CE infractions and misrepresentation to the public, seem to deal with the counselors' ability to maintain their professional license. The value of veracity is a core component of the *ACA Code of Ethics* (ACA, 2014), which has to do with one's ability to deal truthfully in the professional community. Violations of these two categories demonstrate the need for counselors to receive initial and ongoing training on the importance of dealing truthfully with the public and the licensing board.

The results of this study, overall, indicate a relatively low rate (0.67%) of ethical complaints that result in disciplinary actions when compared with the estimated total number of fully licensed counselors in the country (ACA, 2016). The results of this study follow trends from earlier studies on counseling credentialing boards regarding the types of violations being reported and acted upon (Herlihy et al., 1987; Neukrug et al., 1992, 2001). More recently, Boland-Prom et al. (2015) identified failing to obtain CE hours to be a common violation that resulted in sanctions for social workers. Similarly, the results of this study indicate that failing to obtain CE hours is one of the most frequently acted-upon infractions for counselors.

It should be noted that these results also demonstrate that a wide range of ethical complaints can result in disciplinary actions. It is important that counselors do not overlook the potential seriousness of these categories even though they do not occur at more frequent rates. Issues related to providing documentation, notetaking, billing practices, practicing while impaired, legal arrests, and failing to obtain consent are all important ethical categories that resulted in disciplinary actions. All ethical infractions, regardless of the frequency, affect the public, and the need for ethical practice for every practicing professional is important.

While analyzing the data, we found that states seem to investigate and act upon ethical categories at very different rates, with some states seemingly focusing on concerns specific to their respective state. For example, the category of financial default constituted 2% of the acted-upon complaints in this study. However, this category seemed to apply to individuals who defaulted on an educational loan and only occurred in two states. As the counseling profession looks to reduce disparity in licensing laws for counselors (Mascari & Webber, 2013), more research looking at the behaviors of licensing boards in making decisions to investigate and act upon claims is needed. Additionally, some of the narratives indicated that licensing boards have a difficult time determining if an individual pursuing licensure may have had an ethical violation in another state. Organizations like the American Association of State Counseling Boards (AASCB) exist to help bring together state licensing boards (Mascari & Webber, 2013); however, only 35 states have joined the organization. It has been reported that AASCB has created a National Credentials Registry (Glosoff & Schwarz-Whittaker, 2013); however, it does not appear to be in operation at the time of this writing (www.aascb.org/aws/AASCB/pt/sp/ncregistry). The results of this study demonstrate the need for a single clearinghouse or repository that can store and maintain ethical infractions across states.

Limitations and Recommendations for Future Research

We looked at ethical complaints with resulting disciplinary actions during the 2010–2014 time frame for counselors who are licensed for independent practice in their respective states. As such, the results only provide an overall look at trends of the types of ethical violations that result in a disciplinary action. More research is needed to look at the nature and consistency of the sanctions that state licensing boards render for various ethical complaints. Mascari and Webber (2006) have found that factors such as accreditation of the counseling program, length of time in practice, and the completion of a course in counseling ethics can affect the rate of ethical violations. We recommend future researchers look at rates of ethical complaints using various grouping variables (e.g., license status, years in the profession, age, type of work environment/practice).

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Using Holistic and Ethical Practices with Emotional Support Animal Requests

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ABSTRACT

Many professional counselors and the general public are enthusiastic and curious about the role of animals in mental health. In particular, professional counselors face a growing demand for professional consensus guidelines to ethically and appropriately respond to emotional support animal (ESA) documentation requests. In this article, the authors clarify helper animal taxonomy and discuss current literature, laws, policies, risks, and benefits relevant to making professional decisions surrounding the sensitive issue of ESAs in client wellness.

KEYWORDS

Emotional support animals; human-animal bond; animal assisted interventions; animal assisted therapy; professional ethics; professional counseling; best practices; creativity in counseling

Animals have been assisting human healers to promote health and wellness for centuries and possibly longer (Fine, 2015). However, the formal professionalization of the human-animal bond (HAB) is relatively new in comparison to other extant interventions in healthcare and human services. Currently, many mental health practitioners, medical care providers, and the general public are enthusiastic and curious about the role of HABs in human wellness, but, overall, there is much confusion and misunderstanding about the approach. Reflecting this general confusion among healthcare and human service providers, multiple authors (Boness et al., 2017; Bradley & Bennett, 2015; McNary, 2018) highlighted the need for more professional consensus guidelines to guide practitioners in making decisions about the HAB in clients' treatment plans, especially with regard to the sensitive issue of emotional support animals (ESAs). Professional counselors are taxed with understanding, synthesizing, and intentionally responding to the growing demand for animal involvement in human wellness. As the counseling profession moves toward consensus on this topic, we offer the following points of discussion related to clarifying helper animal taxonomy, describing provider considerations, and offering our perspectives on responding to ESA documentation requests.

Animals that partner with humans to fulfill helping roles are often broadly classified either as *companion animals* or *working animals*. The term *companion animal* refers to animals whose primary role is to provide companionship to an individual or family, rather than to fulfill a working role (American Society for the Prevention of Cruelty to Animals, 2019; Murphy, 2013). Alternatively, *working animals* are animals that fulfill a specific task or job in order to assist humans (Murphy, 2013). Some examples of working animals may include draft animals, herding dogs, military working dogs, rescue dogs, or flock guards.

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Although many *working animals* simultaneously offer companionship to their human partners, the term *companion animal* specifically describes an animal that is solely a personal pet (American Society for the Prevention of Cruelty to Animals, 2019). Within these broad classifications of companion and working animals, three particular taxonomies are most relevant to professional counselors and other allied healthcare professionals: *service animals, therapy animals, and ESAs*. To help clarify the roles and differences between these three kinds of helper animals, we describe current key concepts, definitions, and helper animal taxonomy below. Although all of these animals help people in a variety of ways, the laws, public access permissions, training and evaluation, and roles are very different for each category of helper animal listed. Gaining accurate and thorough understanding of relevant local and federal laws, personal and professional liability, and appropriate documentation are crucial for differentiating among helper animals (Boness et al., 2017).

Service animal/assistance animal

According to the Americans with Disabilities Act of 1990 (2011), a service/assistance animal is a dog that is individually trained to perform specific tasks of benefit to one individual person with a verifiable physical, psychiatric, intellectual, sensory, or other mental disability (U.S. Department of Justice, 2015). The term *service animal* and *assistance animals* are interchangeable in most instances, but in the scope of this article, we will use the term *service animals* to describe these examples. It is worthwhile to note that the only animal species currently recognized by the ADA as eligible to fulfill the role of service animals are dogs, and in select instances, miniature horses (Americans with Disabilities Act of 1990, 2011; U.S. Department of Justice, 2015). Some examples of service animals include guide dogs for the visually impaired, hearing assistance dogs for deaf persons, and psychiatric or medical alert animals, such as seizure detection dogs.

One of the key distinguishing features of a service animal, as defined by the U.S. Department of Justice (2015), is the performance of specific, often complex, and always highly *individualized* tasks that are directly related to an individual's diagnosed disability. For example, some service dogs are trained to lie under the individual's head during a seizure to prevent injuries from hard surfaces. Others may be trained to detect and alert an individual to an oncoming medical emergency or retrieve essential medication when the individual cannot do so themselves. Animals whose sole role in supporting the individual is to provide comfort or anxiety/stress relief without performing individualized and disability-specific tasks would *not* be considered a service animal, nor would protection or personal defense dogs (Assistance Dogs International, 2020; U.S. Department of Justice, 2015). Unlike therapy animals or ESAs, service animals are considered to be *working animals* rather than *companion animals* (American Veterinary Medical Association, 2017). As a result, the Americans with Disabilities Act of 1990 (2011) classifies service animals as medical equipment. Service animals most often have more advanced and intensive disability-specific, individual training than therapy or emotional support animals, as well as rigorous suitability evaluations (American Veterinary Medical Association, 2017; Assistance Dogs International, 2020). Further, most service animals are trained to ignore environmental distractions and are well prepared to appropriately cope with the stressors of accompanying individuals in a wide variety of public situations (Assistance Dogs

International, 2020). The average length of training involved in service animal preparation is at least two years, and the average cost associated with service animal preparation and placement is about 25,000 USD US Dollars (Ensminger & Thomas, 2013; Guide Dogs for the Blind, 2019).

Service animal access rights differ from those of therapy or emotional support animals, in that they are almost always allowed anywhere that the general public is allowed (American Veterinary Medical Association, 2017; U.S. Department of Justice, 2015). Service animals are the only helper animal classification with public access rights. Although it is illegal for anyone to ask for information about a person's diagnosis or disability, it is permissible to ask: (a) if the animal is a service animal required for a disability, (b) what specific tasks the animal is trained to perform, and/or (c) for proof of appropriate vaccinations (American Veterinary Medical Association, 2017). It is not legally permissible to ask for the animal to demonstrate the specific tasks, and service animals do not require proof or documentation beyond the handler's description of the specific tasks. Thus, vests, tags, identification cards, and other documents are *not* required for documentation/proof that the animal is a service animal (Americans with Disabilities Act of 1990, 2011; U.S. Department of Justice, 2015).

Therapy animal

A therapy animal is a *companion animal* that is specially trained, evaluated, and registered through a recognized therapy animal organization, such as Pet Partners. The animal itself represents half of the therapeutic team, while a specially trained and evaluated human handler constitutes the other half (Pet Partners, 2018). Together, the therapy animal and handler team engage others in therapeutic human-animal interactions and interventions (Chandler, 2017; Pet Partners, 2018; Stewart et al., 2013). One example of such an intervention might include guiding a client in using positive reinforcement to teach therapy dog tricks to help the client work on communications skills, empathy, and frustration tolerance. Thus, human handlers also require specialized training and evaluation for their ability to facilitate safe and mutually beneficial human-animal interactions, effectively process client-animal interactions into therapeutically meaningful experiences, and effectively respond to signs of stress or discomfort in their therapy animal partner (Chandler, 2017; Pet Partners, 2018; Stewart et al., 2016, 2013).

The animal's role of engaging others outside of the handler operates as a key distinguishing aspect of a therapy animal, as opposed to a service or emotional support animal (American Veterinary Medical Association, 2017; Assistance Dogs International, 2020). The therapy animal's involvement is intended to support the populations served by the handler, and not the handler themselves. Although empirical literature on animal-assisted interventions is still in development, support exists for the efficacy of competently implemented animal-assisted therapy in addressing a variety of mental health goals among diverse client populations (Chandler, 2017; Fine, 2015; Stewart et al., 2016). Although therapy animals must be trained to reliably perform basic obedience tasks and possess consistent and predictable manners and behavior in public, they do not need to perform specific tasks to assist clients. Therapy animals do not have public access rights without prior approval for a visit (Pet Partners, 2018). Unlike service animals, most therapy animal handlers must carry proof of their registration with a recognized therapy animal registration organization, such as Pet Partners, Intermountain Therapy Animals, or Therapy Dogs

International. It is both permissible and recommended to ask for such documentation of a team's registration credentials.

Emotional Support Animal (ESA)

An ESA is a *companion animal* (personal pet) that provides emotional comfort to a person with a verifiable mental health disability (American Veterinary Medical Association, 2017; U.S. Department of Justice, 2015). The most commonly designated ESAs are dogs and cats, but many other species of animal are sometimes designated, with the exclusion of venomous or wildlife species (American Veterinary Medical Association, 2017). ESAs are not service animals and do not have public access rights (U.S. Department of Justice, 2015). Unlike service animals, ESAs do not perform disability-specific tasks, nor do ESAs and their handlers require any formal training or suitability evaluation. The designation as an ESA is only relevant to those impacted by the Fair Housing Act of (1988) and, until late 2020, the Air Carrier Access Act of (1986). On December 2, 2020, the U.S. Department of Transportation revised the Air Carrier Access Act of 1986 to no longer include Emotional Support Animals. Thus, on commercial airlines, ESAs are subject to the same policies as other non-service animal pets (U.S. Department of Transportation, 2020). Appropriately documented ESAs have access to live with the owner in housing situations with no-pet policies. Outside of this specific housing context, ESAs are not permitted in places that are not normally designated as pet-friendly (Ensminger & Thomas, 2013; U.S. Department of Justice, 2015). Thus, ESAs are generally not permitted in schools, places of employment, restaurants, or shops/stores (American Veterinary Medical Association, 2017; Masinter, 2015). This stipulation often serves as a point of confusion for many clients who might seek an ESA designation for his/her pet in the hopes that this designation will allow them to take the pet to places where only service animals would be allowed. In such instances, psychoeducation about taxonomy, liability, access rights, and appropriate documentation can relate to effective client and public advocacy.

According the American Veterinary Medical Association (2017) and U.S. Department of Justice (2015), the only legitimate form of documentation for ESA designations is a formal letter, on professional letterhead, from a licensed or appropriately credentialed healthcare or human service professional. The letter must state that the animal's presence is necessary for the amelioration of a person's specific disability (American Veterinary Medical Association, 2017; Chandler, 2019; U.S. Department of Justice, 2015). Property managers or other professionals associated with housing may legally request or require this documentation before providing ESA access accommodations. In light of the prevalence of confusion about helper animal roles, designations, and documentation, providers and clients should be aware of trending predatory practices regarding ESA designation, as they have both financial and liability-related risks. A brief internet search for "ESA," "service animal," or "therapy animal" documentation reveals a plethora of fraudulent companies claiming that individuals may complete a questionnaire or pay a fee to receive cards, vests, and other documents that would legally designate a pet as an ESA or service animal. In order to best advocate for clients and animals, providers should inform their clients that all examples of these for-purchase documents are fraudulent, although companies claim that the ADA or DOJ legitimately recognizes their documentation (Chandler, 2019; U.S. Department of Justice, 2015).

Provider considerations

A thorough understanding of the differences and boundaries of the helper animal categories discussed above illustrates a crucial point for a provider's ability to synthesize accurate knowledge when responding to ESA requests, or when developing policies and programs related to helper animals. Such professional considerations include, but are not limited to, provider role and ethical conflicts, lack of human or animal training, client and public welfare, and animal advocacy (Boness et al., 2017; Herzog, 2016).

Ethical considerations

All healthcare and human service providers must consider the boundaries and expectations of their professional roles, and professional counselors must do so in ways that uphold the American Counseling Association American Counseling Association (2014). According to Boness et al. (2017), when a professional counselor or other healthcare provider writes a letter to endorse a client's ESA request, a conflict arises between the provider's clinical role and a forensic role. Technically, when assessing a client's need for an ESA, a professional counselor is serving in a forensic role. This discrepancy represents problematic concerns considering that ACA code E.13.c. clearly states that counselors do not perform forensic evaluations for current or past clients. However, as a client's wellness plan or course of treatment often include ESAs, best practices indicate that the counselor responsible for the client's overall treatment would be best positioned to understand the context surrounding the ESA's potential inclusion in a treatment plan, which complicates the topic of clinical and forensic role differentiation. When responding to client requests for an ESA, counselors should engage in an ethical decision-making process to consider the implications of this potential role conflict. As a result, we recommend that counselors create formal policies for balancing role confusion in this unique situation.

Additionally, the American Counseling Association (2014) code C.7.a. states that counselors use interventions with empirical support. Although many ESA owners self-report the animal as a beneficial component to their mental health, current empirical literature reveals no significant support for ESAs on owner depression or anxiety (Bradley & Bennett, 2015; Herzog, 2011, 2016). Some additional potential risks associated with ESA ownership may exacerbate existing mental health concerns and negatively impact animal welfare and public health, such as financial costs associated with pet ownership, the owner's ability to effectively care for the animal and address potential animal behavioral concerns, liability considerations that arise due to property damage or public interaction, legal consequences associated with an owner inadvertently claiming the animal as a service animal, and the inevitable reality of eventual pet loss (Herzog, 2011; Peacock et al., 2012). The paucity of empirical support for the efficacy of ESAs to effectively treat mental health diagnoses presents potential problems when justifying the risks involved with ESAs (Chur-Hansen et al., 2010).

Further, lack of awareness of ESA roles, laws, and implications among professional counselors poses potential conflicts with ACA ethical codes (American Counseling Association, 2014) C.2.a. and C.2.b., which state that counselors must operate only within their scope of competence, and that counselors will seek training and supervised experience in new specialty areas. Although ethical decision-making processes relevant to ESA

documentation does not require a counselor to be thoroughly trained in animal-assisted interventions (AAIs), such decisions do require a provider to be thoroughly and accurately informed about terminology, laws, legislation, policies, and potential concerns and considerations involved with the therapeutic applications of HAB. Not only must a counselor gain thorough and accurate information about such considerations, they must also integrate awareness of relevant cultural trends (i.e., public confusion about service vs. emotional support animals and the existence of predatory fraudulent documentation companies), client care considerations (i.e., if an ESA is an appropriate supplement to a treatment plan for the individual client, or may pose risk of harm), and awareness of a counselor's responsibility to provide psychoeducation about ESA policies, legislation, laws, and liabilities. Finally, professional counselors would benefit from considering their own professional liability implications when writing an ESA designation letter. One risk that some providers may encounter is the possibility of testifying if a client faces litigation related to the ESA's behavior in housing situations (Ensminger & Thomas, 2013; McNary, 2018). Cases where a client intentionally or inadvertently misrepresents the ESA as a service animal represent a violation of federal law (American Veterinary Medical Association, 2017). Further, providers must gain awareness that evaluating or attesting to any non-human animal's training, temperament, and suitability is outside of the scope of practice of a professional counselor entirely (Ensminger & Thomas, 2013). Although the ethical considerations described represent some specific codes and principles that apply to ESAs, they are not exhaustive, as other animal-specific considerations such as animal preparation and welfare often intersect with ethical codes in less concrete ways.

Training and evaluation considerations

Unlike service or therapy animals, emotional support animals and their handlers are not required to undergo any formal training, socialization, preparation, or evaluation for temperament, safety, or suitability (American Veterinary Medical Association, 2017; Chandler, 2019). Since service and therapy animal roles involve interaction with others in public contexts, formal training and evaluation of suitability and safety is necessary. In contrast, since the ESA's role is to provide emotional support or stress or anxiety relief as the owner's companion animal, no formal training or evaluation is actually necessary, as no formal training is required to have a pet in other circumstances (Ensminger & Thomas, 2013). Thus, the lack of formal training and evaluation for ESAs and their human handlers does not constitute an issue in and of itself. The potential for this lack of formal preparation to become problematic only arises in situations wherein an ESA owner and the ESA interact in public contexts (Herzog, 2018). This gap can occur when an ESA owner takes an animal into a public context where only a service animal would be allowed access (e.g., stores and shops, schools, places of employment), but also in housing situations where lack of animal training may create conflict with neighbors or property managers, or other situations where stressful conditions increase the likelihood for problematic behaviors in unsuitably prepared animals or unskilled handlers (Bergeron et al., 2002; Herzog, 2011). Such instances create potential concerns related to client distress and liability, public welfare, and animal welfare (American Veterinary Medical Association, 2017; Bergeron et al., 2002; Chandler, 2019).

Client and public welfare

As implied, public interaction with inadequately trained, socialized, evaluated, or supported animals significantly increases risk of public harm, as stressed animals are exponentially more likely to react unpredictably, disruptively, or aggressively (American Veterinary Medical Association, 2017; Bergeron et al., 2002; Chandler, 2019). Particularly relevant for handlers of canine ESAs is the sheer prevalence of dog bite instances, which comprise more than a third of insurance liability claims (Herzog, 2018). Examples of this type of risk relate to the number of airline reports of seemingly unprovoked ESA aggression toward other passengers (American Veterinary Medical Association, 2017; Chandler, 2019; Herzog, 2018) that prompted the 2020 revision of the Air Carrier Access Act of (1986) that now excludes ESAs. Clients should be aware that they are responsible for any liability and/or litigation related to the ESA, including property damage and/or personal injury or harm (American Veterinary Medical Association, 2017).

The risk of zoonoses is another important consideration relevant to ESA interactions with the public. Zoonoses are illnesses, infections, or diseases that are transmissible between humans and animals (Erdozain et al., 2015). Service and therapy animal caregivers must take specific precautions to reduce the risk of zoonoses, whereas ESAs handlers are not required to take such precautions. Zoonotic diseases impact 2.4 billion people every year, are responsible for 60% of worldwide human diseases (Wells, 2009), and up to 14% of diseases in the United States (Erdozain et al., 2015); thus, zoonoses prevention is much more than just an afterthought of responsible animal care. Additionally, handlers of all taxonomies of animals understanding of and compliance with health code policies and regulations relevant to an animal's presence is imperative (Ensminger & Thomas, 2013; Herzog, 2011, 2018).

The potential for ESAs in public settings that are only permissible for service animals to cause harm to service animals and/or the individual with a service animal is an often-unacknowledged social justice consideration. As discussed, most adequately prepared service animals spend years in training and reliably ignore people and other animals while attending to their handler. Since ESAs and their handlers lack such training and since the presence of other animals is highly distracting for most companion animals, there are instances where an ESA approached or behaved aggressively toward a service animal (American Veterinary Medical Association, 2017; Chandler, 2019). In some cases, this event causes such a disruption in the service animal's training that the service animal can no longer work for its handler as such (American Veterinary Medical Association, 2017; Chandler, 2019). Considering the independence and autonomy that service animals bring into the lives of their handlers, and the time and financial investments to acquire a service animal, such incidents are of devastating consequence to the individual requiring a service animal (American Veterinary Medical Association, 2017; Ensminger & Thomas, 2013). Professional counselors are trained to consider the wellbeing of clients and the public considering the principles of nonmaleficence and beneficence, and we encourage counselors to extend those principles to the sentient animals involved in HAB work (Low et al., 2012; McConnell & Fine, 2015).

Animal welfare and advocacy

Animal welfare and advocacy considerations arise when unevaluated and inadequately prepared animals encounter public situations (American Veterinary Medical Association,

2017). Multiple authors (Glenk, 2017; McConnell & Fine, 2015; McEwen & Wingfield, 2003) identified that interactions with unfamiliar people, places, and/or situations are highly stressful for most companion animals. As such, excessive accompaniment and handling by a person without adequate training in animal stress management and advocacy may create a harmful situation for the animal (Glenk, 2017; Serpell & Duffy, 2014).

Consequently, this situation contributes not only to undue stress for the animal, but it can also contribute to deficits in overall animal wellbeing and increase risks for stress-related health and behavioral complications. Mitigating this risk requires appropriate awareness of ESA access limitations and appropriate attention to the animal's care and welfare. Although all competent therapy animal handlers and some service animal caregivers must follow certain guidelines relevant to the animals' overall care and health (Stewart et al., 2016), no such guidelines exist for individuals with ESAs (Herzog, 2016, 2018). Below, we will discuss potential concrete steps and recommendations for documenting professional decisions relevant to ESAs in a client's treatment plan.

Recommendations

All human-animal interactions, including ESAs, carry certain unavoidable risks (Stewart et al., 2016). Ethically competent counselors thoughtfully consider the needs of the public, client, and animal welfare when providing an ESA documentation letter. In this article, we present considerations for counselors responding to ESA documentation requests and provide both information and context about the professional issues involved with ESAs in client care. Ethical decision-making strategies that include a thorough analysis of all potential risks and benefits support counselors when responding to an ESA documentation request. These are made on a case-by-case basis, given that professional counselors navigate prevention-oriented decisions when supporting or declining a client's request for an ESA documentation letter.

Decision to support an ESA designation

If, after careful consideration of the information and issues described above, the counselor assesses the client's request for ESA documentation to be potentially beneficial and appropriate to the client's needs and treatment plan, we recommend several steps to promote best practices. Such documentation recommendations serve three separate purposes: (1) formal documentation of an ESA designation (which is intended to be shared with interested third parties such as property managers), (2) client and counselor ESA contracts (which are intended to be confidential between the counselor and client), and (3) take home packets. In formal ESA designation letter documentation, we recommend the following components:

(a) Documentation expiration. It is helpful to specify for clarity that the documentation expires in one year per the U.S. Department of Justice (2015).
(b) Legislation and policies specific to ESAs and ESA owners.
(c) A clear statement that the counselor cannot assess or endorse the animal's training, behavior, or safety, and does not endorse public access for the ESA.

In contractual documentation that is intended to stay between the counselor and the client, we recommend the following components:

(a) Document a clear and direct link between the ESA and the client's treatment plan, including specifics as to how the HAB will be incorporated.
(b) A statement that the counselor's letter of support is contingent upon certain animal welfare conditions being met.
(c) A statement that the counselor reserves the right to revoke the endorsement if the animal is misrepresented or accompanies the owner in situations that are only accessible to a service animal (e.g., shops/stores, restaurants, schools, places of employment).

In a client take home packet, we recommend the following components:

(a) Clear and developmentally appropriate psychoeducation about all laws, policies, legislation, and risks relevant to ESAs.
(b) Clear and developmentally appropriate psychoeducation about local, state, and federal laws regarding all companion animals, including licensing and vaccination requirements, companion animal liability laws, and other ordinances relevant to companion animals.
(c) Resources and recommendations about animal care, training, and socialization, that may increase the likelihood of a positive pet ownership experience. We recommend the following, based on our own experience:
    (i) Brambell's Five Freedoms of Animal Welfare (Brambell, 1965)
    (ii) Assistance programs and/or reduced cost veterinary care, including veterinarians, vaccination and spay/neuter programs, training classes, behavior evaluations, and boarding/pet sitting options
    (iii) Information about accurate and scientifically grounded training methods and contact information for appropriately credentialed, rewards-based, non-aversive/punishment animal trainers

To further guide counselors in writing ESA documentation that supports counselor liability, client risks and expectations, and animal welfare, we included a sample ESA Documentation Letter in Appendix A and asample ESA Client and Counselor Contract in Appendix B.

Decision to decline an ESA designation

If, after careful consideration of the issues and implications associated with ESA designations, the counselor decides to decline the client's request for an ESA designation letter, we recommend responding to the client sensitively. We encourage counselors to respond to clients with empathy, psychoeducation, and viable alternatives as appropriate and to document this exchange. Often, clients do not realize the limitations involved with an ESA and mistakenly believe that ESAs have the same access rights as service animals. Many clients are also unaware of the risks involved for the animal as well as for their own personal liability. Thus, providing psychoeducation and a clear explanation of the rationale behind

a counselor's decision is crucial for the client's understanding as well as for professional advocacy surrounding the therapeutic application of the HAB.

After helping the client process their reaction to the counselor's decision to decline the ESA designation, counselors might choose to discuss more suitable alternatives for including the HAB into a client's treatment plan or wellness strategy. Examples of these alternatives will be described further in the next paragraph. Further, counselors may consider adopting formal policies regarding ESA designation letters to help solidify the rationale to decline such letters. To further guide counselors in documenting a decision to decline an ESA designation in a way that is supportive and wellness-oriented, we included a sample ESA Denial Letter in Appendix C.

Alternatives to ESA designations

Many clients seeking an ESA designation letter may do so because their relationships with companion animals are meaningful to them. Even without an ESA designation, skilled counselors have many options for including the client's relationships with animals into therapeutically meaningful interventions. These may occur both outside of sessions and during sessions.

Outside of sessions, a counselor may incorporate a client's relationship with his/her own pet into the client's wellness plan (without the animal present in sessions) by discussing relational learning that occurs between a client and a pet at home, or including an animal to help encourage other client wellness goals such as getting more exercise (going for walks, hikes, runs, etc. with the pet) or relational and socialization goals (attending a dog park, obedience classes, or other public pet-friendly locations with the pet). Clients for whom long-term pet ownership is currently inappropriate or impractical may choose to become involved with time-limited animal-related activities, such as volunteer work (i.e. zoos, animal shelters, etc.), pet sitting, or consider temporarily fostering an animal awaiting adoption. We encourage counselors to be aware of local volunteering opportunities and pet fostering programs.

In sessions, clients may still have options for the therapeutic application of the HAB without bringing their own pet to the counseling setting (which could pose risks for other clients or service animals). Professionally directed AAT is one option that counselors may integrate into counseling sessions and is empirically supported with a wide variety of presenting concerns in a diverse range of settings and populations (Chandler, 2017; Fine, 2015; Stewart et al., 2016). It is important to note that extensive formal training, preparation, and supervised experience is required for counselors wishing to implement AAT themselves, and that counselors providing AAT are expected to honor the American Counseling Association's *Animal-Assisted Therapy in Counseling Competencies* (Stewart et al., 2016).

Conclusions

The world of therapeutic human-animal interactions is complex, rapidly evolving, and often challenging to navigate. As the popularity and prevalence of animal involvement in human wellness continues to rise, professional counselors are called upon to learn current and accurate information about helper animal roles, and to consider best practices when

responding to client interest in the therapeutic application of the Human-Animal Bond. In doing so, professional counselors uphold their duty to provide ethical and competent services while fulfilling much needed client, community, and professional advocacy roles.

We wish to disclose our support and enthusiasm for the potential benefits associated with the informed and appropriate inclusion of service, therapy, and emotional support animals in client wellness. Likewise, we wish to challenge our colleagues to thoroughly and thoughtfully consider their role in preventing harm to humans and animals involved and in upholding professional ethics when considering HAB treatment options. We recognize the need for continued research and best practice literature and acknowledge the need for mutually beneficial interdisciplinary collaborations between mental health professionals, animal care professionals, and policymakers to expand upon the considerations and recommendations discussed in this article.

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Appendix A: sample ESA documentation letter

(Professional Letterhead Header)

Emotional support animal letter of documentation

Date of Issue: Date of Expiration:

To Whom It May Concern:

_____ is currently under my professional care and is diagnosed with a specific mental health disability that impacts his/her daily functioning. As such, _____ is entitled to protections as described by the Fair Housing Act of 1988, which posits that reasonable accommodations be made for _____.

One such accommodation that I recommend for the improvement of _____'s daily functioning is an Emotional Support Animal (ESA).

It is important to note that I cannot endorse this particular animal's behavior, temperament, suitability, or safety. Unlike service animals, ESAs **do not** have general public access rights. I do **not** condone or recommend that this ESA accompany _____ in public places, outside of those protected by the Fair Housing Act of 1988, which are not otherwise designated as pet friendly. Places **not protected** by the aforementioned acts of legislation include, but are not limited to: businesses, schools, places of employment, shops or stores, restaurants and other food venues, and event venues.

(Signature line with credentials and date)

Appendix B: sample client contract letter

(Professional letterhead heading)

Emotional support animal client contract

Date of Issue: Date of Expiration:

The purpose of this document is to serve as a contract between (Clinician Name & Credentials) and (Client Name) regarding (Clinician's Name & Credentials)'s provision of documentation supporting an Emotional Support Animal as a reasonable accommodation for (Client Name)'s specific mental health disability. (Client Name)'s relationship with the ESA will be incorporated into his/her treatment plan in the following ways:_____.

(Clinician Name & Credentials) agrees to support the accommodation of an ESA for (Client Name) under the following conditions:

- (Client Name) agrees to avoid misrepresenting his/her ESA as a Service or Therapy Animal.
- (Client Name) agrees to avoid ESA accompaniment in public contexts not protected by the Fair Housing Act of , including, but not limited to: businesses, schools, places of employment, stores or shops, restaurants, and event venues (unless the public context is otherwise designated as pet-friendly).
- (Client Name) agrees to comply with all local, state, and federal laws and ordinances relevant to all companion animals, including vaccinations and licensing.
- (Client Name) will reliably provide for the ESA's mental and physical wellbeing in the following ways:

o Provide adequate nutrition, exercise, grooming, and veterinary care.

o Avoid animal neglect and/or abuse by practicing rewards-based training methods and attending to Brambell's Five Freedoms (Brambell, 1965; see client take home packet).

o Provide (Clinician Name & Credentials) with documentation of an evaluation of the animal's overall state of health, from a licensed veterinarian, no less than twice per year.

If the above conditions are not sufficiently met or addressed, (Clinician Name & Credentials) reserves the right to withdraw support for an ESA accommodation before the expiration date.

(Client Signature and Date)(Clinician Signature and Date)

Appendix C: sample denial letter

(Professional letterhead header)

Emotional support animal evaluation decision

Date of Issue:

Dear (Client Name),

After discussing your specific presenting concerns and request for an Emotional Support Animal (ESA), (Clinician Name & Credentials) has evaluated an ESA accommodation is not an appropriate accommodation *at this time*, due to one or more of the following:

· Conflict with provider policy;
· ESA is not a reasonable accommodation in the client's present context;
· Client is seeking the animal to fulfill a role outside the scope of ESA access rights;
· Significant barriers exist for adequate animal care or animal ownership;
· Risks associated with ESA ownership outweigh potential benefits;
· Contraindication with recommended course of treatment.

Although (Clinician Name & Credentials) has deemed that an ESA is not medically necessary or appropriate for you at this time, (Clinician Name) appreciates the potential benefits that healthy human-animal interactions offer to many people. Thus, (Clinician Name & Credentials) poses the following alternative avenue(s) for experiencing human-animal bonding: (List recommended alternatives). (Clinician Name & Credentials) will perform a future reevaluation of ESA suitability if the above conditions are adequately addressed.

(Clinician Signature and Date)

1099 contractor

NYMHCA frequently receives questions about Limited Permit holders operating under a 1099 contract while they are attaining their hours for licensure. As the information below details, a counselor who does not hold a license to operate independently does not qualify as a 1099 employee. Limited Permit holders work **under the supervision** of a clinician and do not have autonomy over their work. At no point does NYMHCA endorse the hiring of a Limited Permit holder under a 1099 contract, which would imply that a Limited Permit holder is running their own business. Owning a private practice is strictly prohibited for Limited Permit holders.

If a practice argues that they've been doing it for a long time, or that everybody does it, or that legality doesn't matter it would be good to question if this practice is operating either legally or ethically. The IRS has posted the definition of an independent (1099) contractor here: https://www.irs.gov/businesses/small-businesses-self-employed/independent-contractor-defined

Here's what you need to know, based on information from the IRS and completepayrollsolutions.com:

A 1099 contractor, also known as an independent contractor or freelancer, is **a self-employed individual who works on a contract basis for a company or organization**. They are not considered employees and do not receive regular wages or salaries. Here are some key points about 1099 contractors:

- **Tax Reporting**: Companies that pay a 1099 contractor more than $600 in a year are required to issue a Form 1099-NEC to the contractor and report the payment to the IRS. The contractor is responsible for paying their own self-employment taxes.
- **Flexibility**: 1099 contractors have the freedom to choose their work schedules and projects, allowing them to work for multiple clients and select opportunities that align with their interests.
- **Control**: **Unlike employees, 1099 contractors enjoy a high degree of autonomy and control over their work.** They are responsible for their own workspace, tools, and insurance.
- **Benefits**: Companies do not provide benefits like health insurance or paid leave to 1099 contractors. Instead, these individuals must secure their own benefits.
- **Legal Considerations**: Contracts with 1099 contractors should be carefully drafted and reviewed by legal professionals to ensure compliance with regulations and to protect both parties in case of disputes.
- **Classification**: The distinction between an employee and a 1099 contractor is crucial for tax and labor law purposes. The IRS and the Department of Labor have different classification systems that may lead to different categorizations for the same worker.

- **Costs**: Businesses generally incur lower costs when hiring 1099 contractors compared to traditional employees, as they are not responsible for payroll taxes or employee benefits.
- **Regulations**: The use of 1099 contractors has been a subject of scrutiny and regulation, with ongoing discussions about the rights and protections for these workers.

The general rule is that an individual is an independent contractor if the person for whom the services are performed has the right to control or direct only the result of the work and not what will be done and how it will be done.

You are not an independent contractor if you perform services that can be controlled by an employer (what will be done and how it will be done). This applies even if you are given freedom of action. What matters is that the employer has the legal right to control the details of how the services are performed.

What are the penalties for misclassifying a 1099 contractor?

Proper classification is essential to determine how you'll pay a worker. If you get classification wrong, and call an individual a 1099 worker who is actually an employee, you could be liable for back employment taxes as well as substantial penalties, including:

- $50 for each W-2 that you didn't file
- A penalty of 3% of employee wages plus 40% of FICA taxes that weren't withheld and 100% of the matching FICA taxes you're responsible for
- A penalty of 0.5% of the unpaid tax liability per month up to 25% of the total tax liability

In addition to those penalties from the IRS, under the FLSA, you may be assessed penalties for unpaid overtime or minimum wage violations.

American Counseling Association

Competencies for Counseling

The Center for Counseling Practice, Policy, and Research | 703-823-9800 x324

Animal-Assisted Therapy in Counseling Competencies

Developed in collaboration with the Animal-Assisted Therapy in Mental Health Interest Network of the American Counseling Association

Based on the findings of a qualitative investigation of the knowledge, skills, and attitudes required of competent animal-assisted therapy practitioners

Authors

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Overview

Animal-assisted therapy (AAT) is defined as a goal-directed intervention, delivered by an appropriately credentialed health or human service professional, in which an animal is incorporated as an integral part of the clinical health care treatment process and utilized during counseling sessions (Pet Partners, n.d.). *Animal-assisted therapy in counseling* (AATC) is defined as the incorporation of specially trained and evaluated animals as therapeutic agents into the counseling process, whereby professional counselors use the human–animal bond as part of the treatment process (Chandler, 2012). AATC shares certain commonalities with AAT, such as the inclusion of a specially trained and evaluated therapy animal, an appropriately credentialed health or human services provider, and clearly defined goals for treatment; however, the application and delivery of AAT interventions vary greatly depending on the professional identity of the health or human service provider involved (e.g., physical therapist, nurse, physician, mental health professional). Thus, AATC represents an evolving subspecialty within the field of AAT, which is unique to mental health professionals, such as professional counselors, counseling psychologists, and clinical social workers (Stewart, Chang, & Rice, 2013).

When implemented with the appropriate education and training, AATC has the potential to affect the therapeutic experience of a diverse range of clients across a wide variety of settings in a highly positive manner (Chandler, 2012; Chandler, Portrie-Bethke, Barrio Minton, Fernando, & O'Callaghan, 2010; Fine, 2015). A number of benefits to the therapeutic process are associated with AATC, including facilitating and enhancing the therapeutic alliance (Chandler, 2012; Fine, 2015; Wesley, Minatrea, & Watson, 2009), decreasing the need for language in therapy (Fine, 2015), increasing client disclosure (Reichert, 1998), and providing pivotal therapeutic experiences for survivors of trauma (Reichert, 1998; Yorke, Adams, & Coady, 2008). AATC is growing in use and popularity, and the empirical support for its efficacy is steadily increasing (Stewart, Chang, & Jaynes, 2013). The intervention's broad and flexible applicability and positive impact on the therapeutic process make it an attractive and valuable treatment option for many professional counselors. Thus, the popularity and prevalence of this approach in the profession of counseling are likely to continue growing. If professional counselors are to provide this intervention ethically and effectively, specialized knowledge and training are necessary.

Background and Current Issues

In addition to demonstrating professional competencies in areas essential to general counseling, ethical professional counselors demonstrate competency in specialty areas (Myers, 1992). With regard to specialty areas, the ACA Code of Ethics (American Counseling Association [ACA], 2014) clearly states, "Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm" (Standard C.2.b.). AATC is an evolving field of specialized skills and competencies that allows professional counselors to incorporate specially trained animals into the counseling process. Together, the mental health professional and the therapy animal influence the therapeutic process in ways that are beyond the scope of traditional counselor–client helping relationships. However, there is currently no definition of counseling-specific competencies to guide practitioners in this specialty area.

To address this gap, we recruited experts in the area of AATC ($N = 20$) to participate in a grounded theory investigation of the knowledge, skills, and attitudes required of competent AATC providers (Stewart, 2014). The participants of this study represented a wide variety of mental health professional identities, practice settings, client populations, and choice of therapy animal species. All participants were invited to review and provide feedback on the themes and subthemes that we identified. On the basis of the themes and subthemes that emerged from the data, we constructed a theoretical framework that represents competencies in AATC.

Using this theoretical framework, we propose nine important competency areas for professional counselors using AATC. These competency areas are divided into three domains—knowledge, skills, and attitudes—in accordance with the competency framework (see Figure 1; Myers & Sweeney, 1990). Professional counselors practicing AATC are advised to be familiar with all areas in which the counselors are involved in their practice of AATC. These domains, competency areas, and supporting subthemes are represented in this document. This document is intended to address the clear call for such standards of competence by many researchers and experienced practitioners of AATC.

These competencies are intended to apply only to counselors who incorporate their own animals into the counseling sessions and therapy. The competencies are not intended to apply (a) when a counselor has a pet with whom the client is permitted to casually interact at the office; (b) when a counselor suggests that a client consider adopting an animal/pet for companionship; or (c) when a counselor authorizes or prescribes a service animal to her or his client, which should be covered under the existing ACA practice standards.

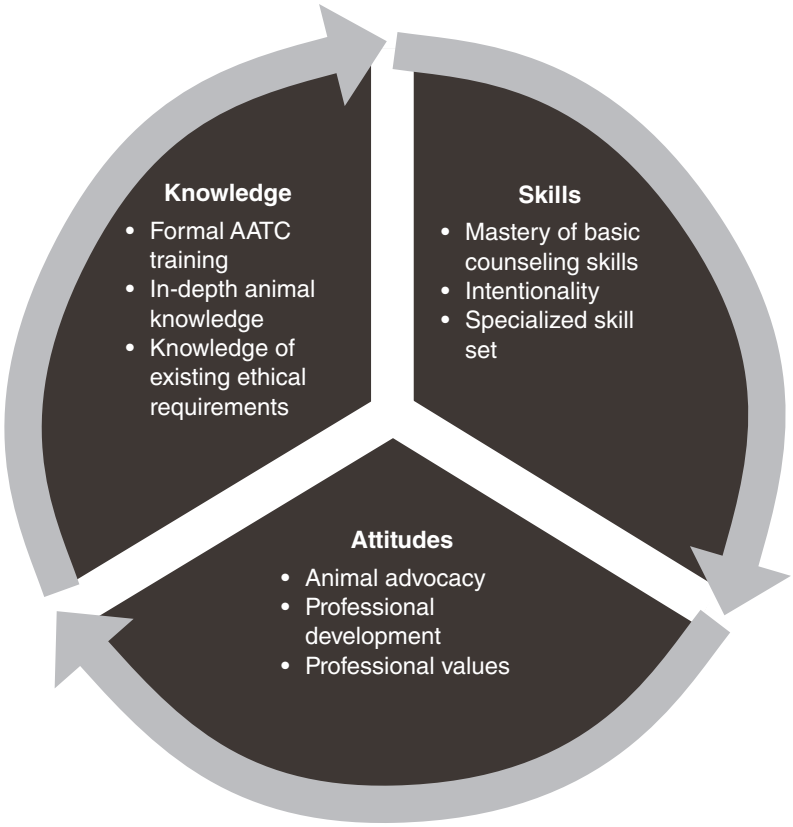

FIGURE 1

Animal-Assisted Therapy in Counseling (AATC) Competencies Framework

Note. Adapted from *Competencies in Animal Assisted Therapy in Counseling: A Qualitative Investigation of the Knowledge, Skills and Attitudes Required of Competent Animal Assisted Therapy Practitioners* (p. 66), by L. A. Stewart. Retrieved from: http://scholarworks.gsu.edu/cps_diss/100. Copyright 2014 by L. A. Stewart. Adapted with permission.

Animal-Assisted Therapy in Counseling (AATC) Competencies

A. Knowledge

1. Formal AATC training. Providers of AATC are expected to acquire AATC-specific training, assessment, and supervision, including:
    a. Successful completion of formal evaluative course work, to include:
        i. Evaluation of animal knowledge, including:
            1. Knowledge of how animals are incorporated in therapeutic settings
            2. Ability to work effectively as a team with a therapy animal
        ii. Evaluation of AATC knowledge, including:
            1. AATC professional identity
            2. History of AATC
            3. Literature and evidence-based practice of AATC
    b. Knowledge of AATC-specific counseling techniques and principles, including implications for specific presenting concerns and client populations
    c. Understanding of the relevant aspects of the human–animal bond, including:
        i. Physiological and neurological impact of human–animal interaction
        ii. Awareness that human–animal interaction can elicit unexpected vulnerability and disclosure in others
        iii. Impact of the human–animal bond on the therapeutic process, including advantages, limitations, and contraindications
    d. Participation in supervised professional practice, including:
        i. Applied experience under the supervision of an appropriately qualified AATC provider to supplement didactic knowledge
        ii. Feedback and assessment of AATC skills by a supervisor
2. In-depth animal knowledge. Providers of AATC are knowledgeable about their therapy animal on an individual, breed, and species level, including:
    a. Adequate, species-specific ethological knowledge about the selected therapy animal(s), including:
        i. Physiology, behavior, and history
        ii. Care and husbandry
        iii. Understandings that knowledge about one particular species is not necessarily generalizable to other species
        iv. Limitations on the utility of using animals and selecting specific animals in client situations
    b. Knowledge of the importance of animal training techniques, including:
        i. Ability to apply positive, noncoercive training methods
        ii. Ability to ensure that the animal is trained for the counseling environments and situations in which it is working
        iii. Ability to detect and, as necessary, arrange to facilitate the animal's socialization, desensitization, and comfort

c. Establishment and maintenance of a strong working relationship with the therapy animal(s), to include:
    i. Knowledge of triggers to stress
    ii. Ability to educate others about the animal's triggers
    iii. Ability to recognize and apply effective calming interventions to a stressed therapy animal

3. Knowledge of existing ethical requirements. Providers of AATC demonstrate integrated ethics. Thus, competent providers of AATC are aware of AATC-specific ethical considerations and are able to incorporate AATC practice within the ACA Code of Ethics, with actions that include:
    a. Ability to recognize and discuss the ethical implications of AATC, including:
        i. Assessing the suitability and amenability of each client to this type of counseling
        ii. Informing clients of the purpose of AATC
        iii. Discussing and addressing potential safety issues
        iv. Maintaining respect for the animal(s), the client(s), and the therapeutic process
        v. Being aware of the provider's personal biases, including the impact of the provider's emotional bond with the animal and its impact on the therapeutic process
    b. Ability to understand the social and cultural factors relevant to AATC and multicultural implications of AATC, including:
        i. Respecting the attitudes of others, particularly those concerned with the animal's presence
        ii. Understanding that human–animal interaction may hold different meanings across a variety of cultures
    c. Ability to maximize the potential for safe interactions between clients and animals, including:
        i. Infection prevention/control and consideration of other zoonotic agents
        ii. Considerations for allergies, phobias, past history of animal abuse, and past history of animal-related trauma
    d. Effective risk-management strategies and skills, including:
        i. Knowledge of liability issues related to AATC
        ii. Knowledge of legal issues associated with AATC
        iii. Inclusion of appropriate documentation procedures
        iv. Confirmation of personal and professional insurance coverage for AATC

B. Skills

1. Mastery of basic counseling skills. Competent providers of AATC demonstrate competency in general counseling skills prior to integrating AATC interventions. AATC is practiced only within the boundaries of a provider's professional scope of practice.
    a. Counselors are expected to effectively integrate AATC into their personal model of counseling.
    b. Counselors are expected to demonstrate counseling effectiveness without the integration of a therapy animal
    c. Counselors are expected to recognize that AATC is used to enhance the therapeutic process rather than as a stand-alone intervention

2. Intentionality. Competent providers of AATC demonstrate intentional incorporation of AATC into the counseling relationship, plan, and process. Providers are able to demonstrate:
    a. Knowledge that AATC is a skillful intervention and that AATC is:
        i. More than owning/loving animals
        ii. More than simply including an animal in the counseling setting
    b. Knowledge and integration of theory-based interventions, including:
        i. Ability to articulate the role of AATC within a provider's personal theoretical approach or personal model of counseling
        ii. Understanding of the goals of AATC interventions
        iii. Awareness of the validity of the AATC interventions being used
    c. Skillful selections and assessment of AATC intervention strategies, including:
        i. Selection of appropriate interventions and strategies for each client, in each session, based on treatment goals
        ii. Ability to assess the outcome of AATC interventions
3. Specialized skill set. Competent providers of AATC recognize that AATC is a specialty area with a learned and practiced skill set. Competent AATC providers demonstrate specialized skills and abilities that are appropriate to the specialty area of AATC, including:
    a. Ability to understand the experiential nature of AATC interventions and demonstrate skill in spontaneous situations
    b. Ability to attend to/care for the client(s) and therapy animal(s) simultaneously by demonstrating:
        i. Effective judgment when assessing the session's impact on the therapy animal(s)
        ii. Effective judgment when assessing the session's impact on the client(s)
        iii. Effective judgment when assessing the session's impact on volunteers/assistants/paraprofessionals (if applicable)
    c. Ability to assess, interpret, and utilize the animal's responses in a therapeutically meaningful way, including:
        i. Ability to link animal–client interactions to client behaviors, goals, or conceptualization
        ii. Willingness to allow natural client–animal interactions to occur
        iii. Ability to link unexpected events or interactions to client goals or presenting concerns
        iv. Ability to model appropriate, respectful, and empathetic animal care
    d. Ability to prevent and respond to animal stress, fatigue, and burnout
        i. Ability to immediately address unexpected animal stress and proactively plan stress-relief and stress-prevention strategies for the animal(s)
        ii. Ability to identify and respond to the animal's signals and body language, especially when the animal does not want to interact
        iii. Ability to provide for the animal's needs, both at the site and in general, including:
            1. Attending to the animal's access to water, a quiet rest/retreat area, and regular bathroom breaks
            2. Attending to the animal's overall wellness through appropriate provision of quality nutrition, exercise, grooming, and veterinary care

e. Ability to objectively assess an animal's suitability, strengths, and limitations despite the provider's potential emotional bond with or personal bias toward the animal
    i. Ability to identify and address personal biases toward the therapy animal(s), including:
        1. Awareness of transference/countertransference considerations related to AATC interventions
        2. Objective assessment of an animal's suitability for AATC in general
        3. Objective assessment of an animal's suitability for each AATC session on an individual basis
    ii. Ability to identify and address personal biases toward AATC interventions in general
f. Ability to attain and maintain compliance with applicable legal requirements for registration, care, and inoculation of the animals used for AATC

C. Attitudes

1. Animal advocacy. Competent providers of AATC prioritize their responsibility to animals involved in AATC and demonstrate that they are effective animal advocates by:
    a. Understanding that the animal(s) involved in AATC is (are) the provider's responsibility, including:
        i. Understanding how and why animal welfare and advocacy directly affect client safety
        ii. Understanding how and why animal welfare and advocacy are essential to the ethical practice of AATC
    b. Respecting animal rights and animal welfare, including:
        i. Recognizing that animals have a right to choose their level of participation in AATC
        ii. Recognizing the potential for animal exploitation, either accidentally or intentionally
2. Professional development. Competent providers of AATC continue the development of their AATC skills by:
    a. Active involvement in continuing education and engagement in professional development, including:
        i. Regular consultation and collaboration with other AATC providers
        ii. Regular consultation and collaboration with professional animal specialists
    b. Familiarity with existing and emerging AATC literature, including:
        i. Familiarity with current AATC language/terminology
        ii. Encouragement and support for the continued development of AATC literature
3. Professional values. Competent providers of AATC strive toward AATC-specific professional values, including:
    a. Demonstrating enthusiasm and passion for AATC
    b. Demonstrating flexibility, openness, and creativity
    c. Demonstrating a calm demeanor during unexpected events/situations
    d. Demonstrating empathy for humans and animals
    e. Demonstrating a willingness to embrace the experiential nature of AATC by being cognitively present and responsive to ever-changing situational factors

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THE HIPAA GUIDE
Healthcare Compliance

20 COMMON HIPAA MYTHS DEBUNKED

NOVEMBER 19, 2019 HIPAA GUIDE HIPAA ARTICLES

In this post we cover some of the many HIPAA myths that have been circulating on the internet and often get talked about. In a lot of cases, healthcare employees are guilty of believing these HIPAA myths, so it is about time that these myths were busted.

These HIPAA myths have often arisen as a result of misinterpretations of the complex HIPAA Rules. Over time, these myths have gained traction and many people mistakenly believe that HIPAA is overly restrictive and prevents healthcare employees from doing their jobs or stops patients from exercising their legitimate HIPAA rights.

20 Common HIPAA Myths Busted

Healthcare professionals cannot be expected to have an encyclopedic knowledge of HIPAA Rules, and it is not necessary for all the intricacies of HIPAA to be understood. It is if you are a HIPAA officer, but not of you are a physician or nurse as you just need to know enough to be able to do your job without violating HIPAA Rules.

The HIPAA myths listed below are relevant to all healthcare workers. If you believe any of the HIPAA myths listed here, you could actually be violating HIPAA!

So enough of the preamble, lets get on with busting some HIPAA myths! 20 to be precise!

HIPAA MYTH #1 – HIPAA Applies to All Healthcare Organizations

HIPAA applies to all healthcare organizations that conduct healthcare transactions electronically. These HIPAA-covered entities are healthcare providers, health plans, and healthcare clearinghouses. The latter convert data from one format to another. In the digital age, virtually all healthcare organizations are required to comply with HIPAA as at least some transactions are conducted electronically.

HIPAA MYTH #2 – Copies of Medical Records Can Only Be Provided to a Patient or the Patient's Caregiver

Copies of a patient's medical records can be provided to anyone who has been named a personal representative of a patient. That could be a spouse, family member, caregiver, lawyer, or any other individual that the patient nominates as his or her personal representative.

HIPAA MYTH #3 – HIPAA Prevents Healthcare Providers from Sharing Patient Information with Family Members

HIPAA does not prevent healthcare providers from sharing information about a patient with members of the patient's family. If the patient is present, information can be shared with friends and family members if the patient does not object. If the patient is incapacitated and, based on professional judgement, a healthcare employee believes the patient would not object to information being shared, it is permissible for information to be shared with family members, other relatives, or close personal friends of the patient. You should be aware that family members cannot be provided with a copy of a patient's health records unless the patient has authorized this in writing.

If a patient has made it clear that information should not be shared with their family, or a specific person, then the patient's wishes must be respected.

HIPAA MYTH #4 – Doctors are Prohibited from Emailing Patients

This is one of the most common HIPAA myths. Doctors and other healthcare professionals are permitted to send emails to patients. This myth may have arisen because many doctors do not want to email patients. It is also acceptable to send copies of patient health records via email, or to disclose healthcare information in emails. There is one caveat. Safeguards must be implemented to keep that information secure when it is transmitted over email. That means that emails must be encrypted.

If a patient requests a copy of their health information via email, and encryption for email is not available, healthcare providers must advise the patient of the risks associated with the transfer of information in that manner. If the patient accepts those risks, then it is perfectly acceptable to email the information without first encrypting it.

It is worth mentioning that care must be taken to ensure the email address is correct. If a patient's electronic protected health information is sent to an incorrect person, that would be an impermissible disclosure and a violation of HIPAA.

HIPAA MYTH #5 – HIPAA Prohibits the Use of Sign-in Sheets

Patient sign-in sheets are permitted under HIPAA, but the information on those sheets must be restricted. They should not include any health information. For

example, you should not include information about the reason for a visit, only the name, time, and provider name are acceptable.

HIPAA MYTH #6 – HIPAA Prohibits Family Members from Collecting a Patient's Prescription

Pharmacies are permitted to give a patient's prescription to a family member. Another individual can act on a patient's behalf and can collect medical supplies, prescriptions, and even medical images, test results and other information containing the patient's protected health information. A healthcare employee must use their professional judgement and determine that it is in the best interest of the patient.

HIPAA MYTH #7 – Patients' Health Information Cannot be Used for Marketing Purposes

HIPAA does prohibit the use of protected health information for marketing purposes, unless authorization is obtained from the patient in advance, but certain marketing activities are expressly permitted. For instance, health plans can send information to plan members about alternative treatments or health plan related products. Such correspondence is not considered to be marketing, even if the health plan is paid to encourage patients to use an alternative product or service.

HIPAA MYTH #8 – If a Patient Refuses a Notice of Privacy Practices, Healthcare Services Cannot be Provided

Healthcare providers must provide patients with their Notice of Privacy Practices, but patients do not have to accept the document, read it, or sign it. A healthcare provider must provide the NPP and make a good faith effort to obtain a signature to acknowledge that the patient has received the NPP. If a signature cannot be obtained, treatment can still be provided.

HIPAA MYTH #9 – HIPAA Makes Fundraising Impossible for Healthcare Providers

HIPAA does not prohibit fundraising and disclosures of a limited amount of information to business associates for the purpose of fundraising is permitted. Demographic information and dates of healthcare provision can be disclosed to an individual for the purpose of raising funds, provided that the disclosures are detailed in the Notice of Privacy Practices and the patient has not opted out. Any correspondence for fundraising purposes must include information about how patients can opt out of further fundraising initiatives.

HIPAA MYTH #10 – You Have the Right to Obtain a Copy of ALL your Health Information

Healthcare organizations must provide patients/plan members with a copy of their health information on request, but some information can be omitted. Notably, psychotherapy notes will not be provided to patients and information about a patient may be withheld if it is believed the disclosure could cause a patient harm. The latter tends to apply to mental health records.

Under HIPAA, healthcare organizations must provide all health information contained in a designated record set. That will typically include all information that is used to make decisions about individuals, such as medical records, billing information, and medical images, but it does not include *all* information on a

patient. For example, Information on patients that is only used for business purposes or for making business decisions will not be released.

HIPAA MYTH #11 – Doctors Cannot Send Medical Records to Another Healthcare Provider

Doctors can send medical records to other healthcare providers, and other entities, without patient consent. The HIPAA Privacy Rule permits disclosures for the purpose of treatment, payment, and healthcare operations without requiring consent from patients. That includes sending patient health records to other physicians for consultations and for referrals. Most other disclosures do require consent to be obtained in writing in advance. Notable exceptions are disclosures to family members, to law enforcement as part of investigations into criminal activity, to the Secretary of the HHS for the purpose of oversight investigations, and for public health activities.

HIPAA MYTH #12 – Healthcare Providers Cannot Sell Your Health information

This is not strictly true as your health information can be sold on, although before that happens it must be striped of all identifiers that tie that information to you personally. There are 18 identifiers that must first be removed. Your health information is then classed as de-identified health information, which is no longer covered by HIPAA Rules.

HIPAA MYTH #13 – Patients Cannot be Listed in a Hospital Directory Without Consent

The HIPAA Privacy Rule allows patients to be included in hospital directories without consent being provided, although a patient has the right to opt out. The information on the patient may include a name, location, and a general description of the patient's condition: Critical, serious, fair, good, and undetermined for instance. That information can be disclosed over the phone or in person to anyone who asks about the patient by name. That information can also be disclosed to members of the clergy, unless a patient has specifically objected to such disclosures.

HIPAA MYTH #14 – The Media Cannot be Notified About the Status of a Patient

Healthcare providers can disclose basic information about a patient to the media without violating HIPAA. That information should be restricted to directory information as detailed above, provided the patient has not objected or opted out from such disclosures. Again, this applies when a request is made about a patient and the patient's name is provided.

HIPAA MYTH #15 – Reporters that Publish Patient Information are Violating HIPAA

HIPAA Rules can only be violated by HIPAA-covered entities, business associates of HIPAA-covered entities, and subcontractors of those business associates. Newspapers, TV stations, and other media outlets are not HIPAA-covered entities or business associates, so their reporters cannot violate HIPAA Rules. If they obtain any patient information and publish the details, HIPAA Rules have not been violated by the reporter or media outlet, no matter where that information has come from. If a healthcare employee accesses medical records without

authorization and provides the information to a reporter, it is the healthcare employee that has violated HIPAA not the reporter.

HIPAA MYTH #16 – You Cannot be Called by Name in a Waiting Room

This is one of the most common HIPAA myths on internet forums. It is not a HIPAA violation to call a patient in a waiting room by name as no health information is being disclosed. However, it is not permitted to call a patient by name and also state a health condition or any other health information. Don't say, "Mrs Smith, please come to room 10 for your Chlamydia test"!

HIPAA MYTH #17 – All Health Information is Covered by HIPAA

This is not true. HIPAA only covers health information that is created, received, maintained, stored, or transmitted by a HIPAA-covered entity (healthcare provider, health plan, healthcare clearinghouse) or its business associates.

It is important to understand this in an age of health apps and wearable devices. Personal fitness trackers and other such devices and apps may collect similar or the same information as your doctor (blood pressure, heart rate, weight, etc.) but this information is not covered by HIPAA. The developer of a health app can use your data however they choose, provided they have told you about the uses and disclosures in their terms and conditions. The exception is when a device is provided by your healthcare provider. The manufacturer of the device would then be a business associate, and the data collected would be subject to HIPAA regulations.

HIPAA MYTH #18 – You Can Sue Your Healthcare Provider for a HIPAA Violation

If there is a data breach or your healthcare provider or health plan violates HIPAA, you cannot sue them for the HIPAA violation as there is no private cause of action in HIPAA. That does not leave you powerless. You have the right to report the violation to the Department of Health and Human Services' Office for Civil Rights (OCR) and OCR will investigate. If a HIPAA violation has occurred, OCR can take action and that may result in a financial penalty or, in certain cases, criminal penalties.

You may be able to sue a healthcare provider for a "HIPAA violation" under state laws, provided a state law has been violated. Many states have implemented "HIPAA-like" privacy, security, and breach notification laws.

HIPAA MYTH #19 – Healthcare Organizations are Often Fined for Data Breaches

Data breaches can lead to financial penalties for healthcare organizations, but the penalty is not usually given for the breach itself, but for the HIPAA violations that contributed to the cause of the breach. Data breaches are investigated by the HHS' Office for Civil Rights and, in the majority of cases, no action is taken or technical assistance is provided. OCR is well aware that not all data breaches can be prevented.

What OCR wants to establish, is whether reasonable and appropriate safeguards have been implemented and if HIPAA-compliant policies and procedures are in place and are being followed. If a breach occurs at a HIPAA-compliant covered entity, a financial penalty is unlikely to be issued.

HIPAA MYTH #20 – Healthcare Organizations Do Not Have to Send Health Records to Apps if Requested by Patients

Healthcare organizations are required to provide patients with a copy of their health information on request. This can be in paper form, but if an electronic copy is requested the information must be provided in electronic form if the healthcare organization has the technology to do so. If a patient wants their health information sent to a third-party app, a healthcare organization cannot refuse if the ePHI is readily producible in a format supported by the app. Refusal is generally only possible when the act of sending ePHI to the app poses a security risk to the healthcare organization. A healthcare organization is not responsible for further disclosures of ePHI once ePHI has been sent to an app.

HIPAA Preemption Analysis

The New York State Department of Health has issued an analysis of the New York statutes and regulations that pertain to confidentiality health information and whether the statutes and regulations are preempted by HIPAA. The summary is available on the NYSDOH website at www.health.state.ny.us. NYSDOH takes the position that the New York State Public Health Law ("PHL") is NOT PREEMPTED BY HIPAA and NYSDOH will continue to enforce the PHL unless otherwise indicated by the United States Department of Health and Human Services ("HHS"), NYSDOH, or the courts. In releasing its preemption analysis, NYSDOH cautioned that, ultimately, only the courts can resolve preemption issues.

NYSDOH issued a number of general statements.

1. Although HIPAA does not require a consent for treatment, payment and healthcare operations "(TPO)"and states that a consent for TPO activities is optional, state law consent requirements continue to apply. Education law section 6530(23) is not preempted by HIPAA. Education Law section 6530(23) provides that professional misconduct applicable to physicians includes "(r)evealing of personally identifiable facts, data, or information obtained in a professional capacity without the prior consent of the patient, except as authorized or required by law".

   For example, prior to HIPAA, for purposes of complying with state law confidentiality requirements, physicians would obtain a patient's written consent to make health information available to other health care providers for treatment purposes, or to make health information available to health care payors for payment purposes. NYSDOH states that these consent requirements continue as before. The fact that the HIPAA regulations were modified to remove the consent requirement for TPO activities did not preempt state law consent requirements. The "consent" required under New York is a more generalized consent and need not follow the specific consent elements previously included in the HIPAA Privacy Rule.

2. To the extent that State law provides greater privacy for health information or more complete record keeping, State law prevails.

3. When State law is more restrictive than HIPAA in providing a person access to his/her health information HIPAA prevails. When HIPAA provides the patient greater access and control over patient information than State law HIPAA prevails.

4. State laws that mandate reporting of health information such as disease, certain injuries, child abuse, birth, death or for the conduct of health surveillance and oversight are not affected by HIPAA.

5. Article 27-F of the PHL, which pertains to HIV and AIDS Related Information, is not affected by HIPAA. NYSDOH stated that the model HIV release form, which is

included in 10 N.Y.C.R.R. §63.11, will be amended in order to comply with HIPAA. The new form will appear in the regulations and on the NYSDOH website.

6. PHL 1805-m provides confidentiality to information collected by hospitals for quality assurance and credentialing purposes and incident reporting. The confidentiality provision prevails because information required under PHL 2805-j, 2905-k, and 2805-p are outside of the "designated record set" required to be maintained under HIPAA. (NOTE: Information maintained under PHL 2805-j, 2805-k, 2805-l, and 2805-m should not be placed in the medical record).

The most complex preemption issues related to Public Health Law section 17 and 18.

This memorandum will summarize some of the highlights of the NYSDOH analysis in a Question and Answer format.

Q. Is PHL §17 preempted to the extent that §17 requires a physician, upon the written request of a patient, to release and deliver copies of medical records regarding that patient to any other designated physician or hospital?

A. No. PHL §17 prevails. HIPAA allows a covered entity to disclose protected health information (PHI) to the extent such disclosure is required by law.

Q. Is PHL §17 preempted to the extent that section 17 provides "…[R]ecords concerning the treatment of an infant patient for venereal disease or the performance of an abortion operation upon such infant patient shall not be released or in any manner made available to the parent or guardian of an infant…".

A. No. HIPAA defers to state law on issues pertaining to parental access to records of minor patients.

Q. The HIPAA Privacy Rule at 164.524(a) provides that an individual has a right of access to inspect and obtain a copy of PHI about the individual in a designated record set, for as long as the PHI is maintained in the designated record set. An exception is made for psychotherapy notes as defined by §164.524(a)(i). Psychotherapy notes is defined by §164.501 as:

> "Psychotherapy notes means notes recorded (in any medium) by a health care provider who is 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. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date".

Under HIPAA, the individual does not have a right of access to "psychotherapy notes" as "psychotherapy notes" is defined by HIPAA.

PHL §18 requires patient information to be made available upon written request to certain individuals referred to as "qualified persons". Section 18 provides no exception for psychotherapy notes. Is there any HIPAA preemption?

A. No. For psychotherapy notes as defined by HIPAA, section 18 prevails because section 18 provides a right of access where HIPAA does not.

Q. PHL §18 allows a health care provider to deny access to the health care provider's "personal notes and observations". PHL §18(1)(f) defines "personal notes and observations" as "… a practitioner's speculations, impressions (other than tentative or actual diagnosis) and reminders, provided such data is maintained by a practitioner". Is the "personal notes and observations" exception under PHL §18 preempted by HIPAA?

A. Yes, according to NYSDOH. The HIPAA Privacy Rule does not include any exception for "personal notes and observations", so it is preempted under HIPAA. Accordingly, if a physician's personal notes and observations are included in the medical record, they are subject to the access requirements under §164.524 (If the records are psychotherapy notes as defined under HIPAA, there is no right of access under HIPAA. The individual could assert PHL §18 to seek access to psychotherapy notes that otherwise are not available under HIPAA but the personal notes exception would apply under §18).

[Comments: While NYSDOH takes the position that the "personal notes and observations" provision is preempted by HIPAA, it may be argued that certain types of "personal notes and observations" are outside of the purview of HIPAA.

HIPAA at 164.524 states that an individual has a right of access to inspect and obtain a copy of "protected health information" about the individual in a "designated record set", for so long as the protected health information is maintained in the designated record set.

Generally, the term "protected health information" is defined by HIPAA at §164.501 as "individually identifiable health information" maintained or transmitted in any form or medium. The term "individually identifiable health information" is defined as information that is a subset of "health information", including demographic information collected from an individual, and:

(1) "Is created or received by a health care provider, health plan, employer, 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; and

(i) That identifies the individual; or

(ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual."

The term "designated record set" is defined at 164.501 as:

(1) "A group of records maintained by or for a covered entity that is:

(i) The medical records and billing records about individuals maintained by or for covered health care provider;

(ii) The enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or

(iii) Used, in whole or in part, by or for the covered entity to make decisions about individuals.

(2) For the purpose of this paragraph, the term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity".

It might be argued that certain types of "personal notes and observations" do not come within HIPAA's definition of "protected health information" and "individually identifiable health information" and would not be subject to access by the individual under HIPAA. For example, a physician might write a reminder that the patient is "disruptive" in the physician's office in order to remind the physician's staff to take certain precautions when the patient visits. Assuming the physician is not treating or diagnosing the patient for the disruptive behavior, it might be argued that the personal note "the patient is disruptive" falls outside of HIPAA's individual access to protected health information provision at 164.524 because the information about the patient's disruptive behavior has no bearing to the "past, present, or future physical or mental health or condition" of the individual; has no bearing to the provision of health care to the individual; and no bearing to the "past, present, or future payment for the provision of health care" to the individual.

However, given the possibility that personal notes and observations of the physician may be subject to patient access under HIPAA, each medical practice should evaluate whether there is any benefit to include personal notes and observations that are irrelevant to treatment or diagnosis in the medical record].

Q. PHL §18(1)(e)(iii) provides that information maintained by a practitioner, concerning or relating to the prior examination or treatment of a subject received from another practitioner need not be disclosed to the individual provided such information may be requested by the individual directly from such other practitioner. Is this provision preempted by HIPAA?

A. Yes, There is no similar exception under HIPAA. HIPAA would prevail because it gives the individual greater access to information.

Q. PHL §18(1)(e) provides that a health care practitioner is not required to release information about diagnostic services (except mammography) performed at the request of another health care practitioner, if the information may be requested by the subject directly from the practitioner at whose request such diagnostic services were performed. There is no equivalent exception under HIPAA. Does HIPAA prevail?

A. Yes. HIPAA prevails.

Q. PHL §18(3) provides that a health care provider may deny access to all or a part of the information and may grant access to a prepared summary if the provider determines that the review of all or a part of the information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right of access to the information.

HIPAA at 164.524(a)(3)(i) provides where the PHI does not make reference to another person a licensed health professional may withhold access to the individual if the access requested is reasonably likely to endanger the life or physical safety of the individual or another person. Which standard prevails?

A. NYSDOH states that the HIPAA standard prevails. The HIPAA standard "endanger the life or physical safety" of the individual or another person is a more stringent standard than the PHL §18 standard "substantial" and "identifiable" harm.

Q. HIPAA provides at 164.524(a)(3)(ii) that where the PHI makes reference to another person, and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person, the licensed health professional may deny access. As stated above, PHL §18(3) provides that a health care provider may deny access to all or part of the information if the provider determines that the access would cause substantial and identifiable harm to the subject or other person which would outweigh the qualified person's right of access. Which standard person's prevails?

A. HIPAA prevails if the disclosure would cause substantial harm to the subject but not the other person, because the threshold for the harm to the subject in order for the exception to apply is "endanger the life or physical safety" of the individual. PHL §18 prevails if disclosure would cause substantial harm to the other person.

Q. HIPAA at 164.524(a)(3)(iii) provides that where the request for access is made by the individual's personal representative, and a licensed health care professional has determined, in the exercise of professional judgment, that disclosure is reasonably likely to cause substantial harm to the individual or another person, the licensed health care professional may deny the individual access. Which standard prevails?

A. Section 18 prevails because both HIPAA and PHL 18 have a "substantial harm" threshold.

[Comment The dichotomy is that HIPAA at 164.524(a)(3)(i) has the stricter "endanger the life or physical safety standard, but at 164.524(a)(3)(ii) and 164.524(a)(3)(iii) have the "substantial harm" standard. When the facts fall into the 164.524(a)(3)(i) situation, the stricter HIPAA "endanger the life or physical safety" preempts the PHL "substantial" harm standard. When the facts fall into the 164.524(a)(3)(ii) and 164.524(a)(3)(iii) situations, the "substantial" harm standard is the same as the PHL §18 "substantial" harm standard.

Q. PHL §18(3)(c) provides that if a minor subject is over the age of 12, the health care provider may notify the minor subject of a request by a qualified person to review his/her patient information, and if the minor objects to the disclosure, the provider may deny the request. Is PHL §18(3)(c) preempted?

A. No PHL §18(3)(c) prevails. HIPAA defers to state law regarding parental access to records of minor patients.

Q. PHL §18(3)(c) and §18(3)(d) provide that a health care provider may deny access to all or part of the information and may grant access to a prepared summary of the information if the provider determines that disclosure would have a detrimental effect on the provider's professional relationship with an infant, or on the care and treatment of the infant, or on the infant's relationship with his or her parents or guardian. Is this provision preempted by HIPAA?

A. No. HIPAA defers to state law regarding parental access to records of minors.

Q. Public Health Law section 18(2)(e) allows a health care provider to charge a "reasonable charge not to exceed costs and not to exceed 75 cents per page. Copies of records such as x-rays which cannot be photocopied is subject to "reasonable charge" requirement not to exceed costs. A provider may not impose a charge for copying an original mammogram when the original has been furnished to the patient. Copies of records cannot be denied solely because of inability to pay. HIPAA at 164.524(c)(4) permits a health care provider to impose a reasonable cost-based fee including (i) copying, includes costs of supplies and labor in copying, (ii) postage, (iii) preparing an explanation or summary of the PHI, if agreed by the individual. Which law prevails?

A. PHL law section 18 prevails because it is stricter.

Q. Public Health law section 18(2) provides that a health care provider must permit visual inspection within 10 days of a written request. The health care provider must furnish within a reasonable time a copy of any patient information requested which the person is authorized to inspect. In the event a health care provider does not have space available to permit the inspection of the patient information, the health care provider may, in the alternative, furnish a copy of the information within 10 days. HIPAA at 164.524(b)(2) and 164.524(c)(2) provides that a covered entity must act on a request for access within 30 days following the request. If the PHI is not maintained or accessible to the covered entity on site, the covered entity has 60 days to act on a request. HIPAA at

164.524(b)(2)(iii) provides an extension up to 30 days if the covered entity is unable to take action within the required time period. Which time period prevails, PHL §18 or HIPAA?

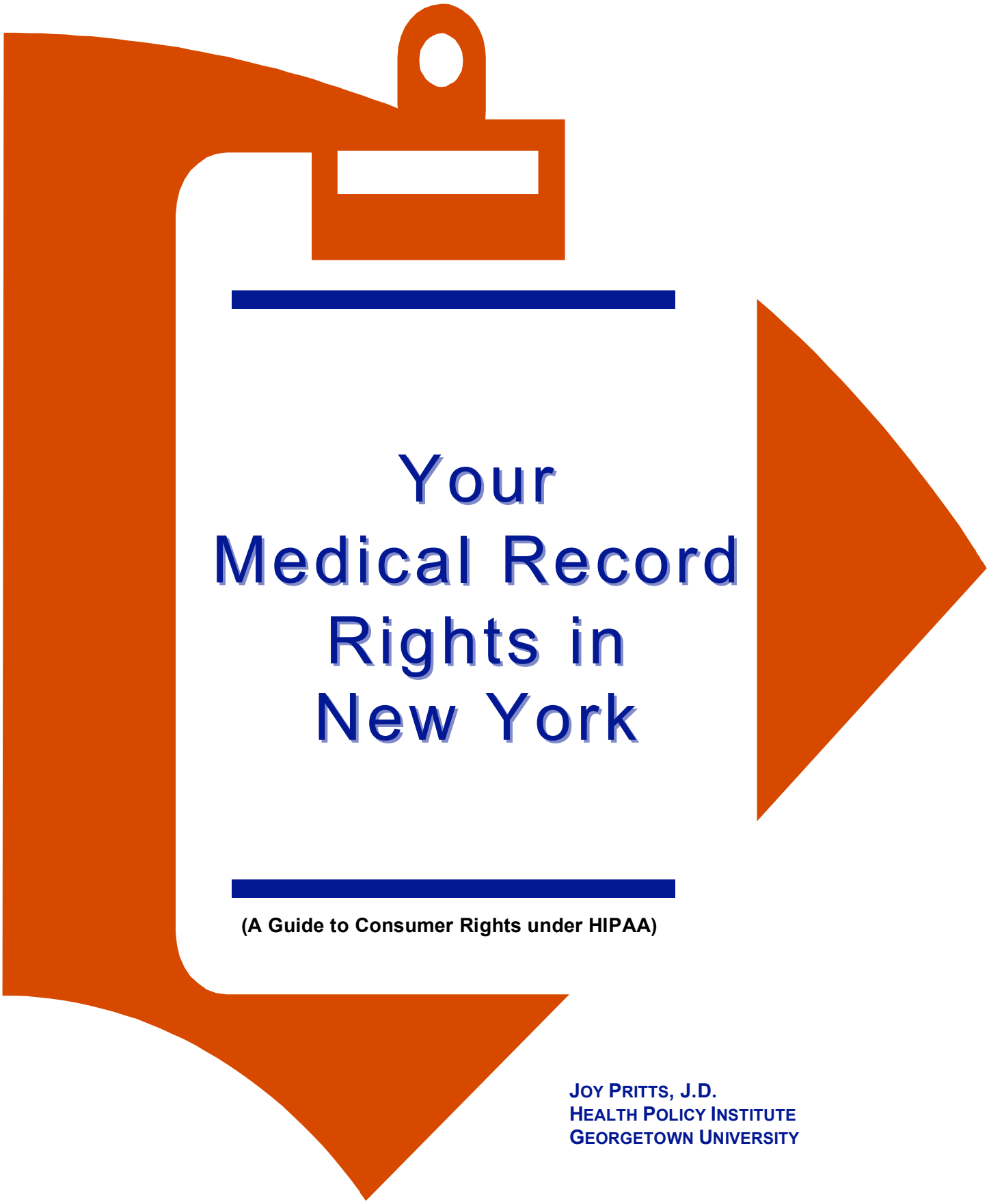
A. PHL §18(2) prevails because it is stricter.

Q. Under HIPAA at 164.524(d)(4) if a health care professional denies an individual access to protected health information, in whole or in part, and the individual requests a review of the denial, the health care professional must designate a licensed health care professional who was not directly involved in the denial to review the decision to deny access. Under Public Health Law section (18)(4) the New York State Department of Health appoints a medical record access review committee to hear appeals regarding the denial of access to patient information. In cases involving physicians, the Department of Health appoints licensed physicians from a list of nominees submitted by the Medical Society of the State of New York to hear the appeal. Is there a conflict between HIPAA and the PHL?

A. No. There is not conflict because it is possible to comply with both requirements. If individual seeks rights under HIPAA follow HIPAA procedure. If individual seeks rights under PHL §18, follow §18 procedure.

Q. Under HIPAA at 164.526 an individual has a right to request a covered entity to amend the protected health information. Where the request to make an amendment is denied the covered entity must permit the individual to submit to the covered entity a written statement disagreeing with the denial of all or part of the requested amendment and the basis of the disagreement. The covered entity may prepare a written rebuttal to the individual's statement of disagreement. Pursuant to PHL §18(8) a qualified person may challenge the accuracy of information maintained in the patient information and may require that a brief, written statement prepared by him or her concerning the challenged information be inserted into the patient information. This right, however, only applies to "factual statements" and Public Health Law section 18(8) expressly states that the qualified person's right to challenge the accuracy of information does <u>not</u> include the health care provider's observations, inferences or conclusions. Any conflict between HIPAA and PHL section 18(8)?

A. HIPAA prevails. Unlike PHL §18(8) which provides that the right to challenge accuracy of information does not include the health care provider's observations, inferences, or conclusions, HIPAA's rule giving the individual the right to request an amendment, and the right to submit a statement of disagreement does not include any similar limitation regarding the provider's observations, inferences or conclusions. HIPAA prevails because it gives the individual broader rights.



Your Medical Record Rights in New York

(A Guide to Consumer Rights under HIPAA)

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INTRODUCTION

Medical records are an important part of your health care. These records are a written history of your health condition and treatment. They are used by health care providers to treat you.

A federal law called the HIPAA Privacy Rule gives you the right to get and amend (correct) your medical record. HIPAA stands for the "Health Insurance Portability and Accountability Act." New York laws also give you rights in your medical record.

ABOUT THIS GUIDE

This guide describes how to get and amend (correct) medical records from New York doctors, hospitals and other health care providers that have to follow the HIPAA Privacy Rule. If you get your medical care in another state, different rules apply. You can read guides for other states at http://hpi.georgetown.edu/privacy/index.html.

This guide was designed so that you can read just the parts that interest you. For example, if you are interested in how much your provider can charge you for copying your medical record, you may want to focus on that part of the guide. We urge everyone to read "Who Is Covered by These Rules?" so that you can be sure the guide applies to your provider. Because we expect most people to read only parts of the guide, some basic information is repeated throughout the guide.

The rules explained in this guide only apply when you ask for your own record or when you ask for a record as a personal representative of someone else. They do not apply when you request that your health care provider give your record to someone else (such as another doctor or a lawyer).

This guide does not discuss mental health records or records about drug and substance abuse treatment. Section 6 of this guide lists some resources where you can find some information about your right to get and amend these types of records.

Words to Know

Some of the words in this guide have a special meaning. In this guide "health care provider" is used in this guide to refer to health care practitioners (including doctors, dentists, chiropractors, podiatrists, and others) and health care facilities (such as hospitals, hospices, and home care services). Section 5 explains these and other words that are helpful to know. These words are in ***boldface*** print the first time they appear in each section of the guide.

Rather than use the awkward phrases "he, she, or it" and "his, her, or its" this guide uses "they" and 'theirs" when referring to health care providers in a general way. Examples that use "he" or "she" are meant to refer to both genders.

DISCLAIMER

The author has made every attempt to assure that the information in this guide is accurate as of the date of publication. Many areas of the law can be interpreted more than one way. This guide has tried to interpret the law in a way that is consistent with protecting health care consumer rights. Others might interpret the law in another way. This guide is only a summary. The rights and procedures described in this guide can change depending on the circumstances. The information in this guide may not apply to your particular situation.

This guide should not be used as a substitute for legal or other expert professional advice. The author, Georgetown University, and the National Library of Medicine specifically disclaim any personal liability, loss, or risk incurred as a consequence of the use of any information in this guide.

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1. OVERVIEW

Both the ***HIPAA Privacy Rule*** and New York laws give you rights to your medical record. The HIPAA Privacy Rule sets standards that apply to records held by ***health care providers*** across the nation. New York law sets standards for records held by health care providers within the state. Generally, health care providers must follow *both* New York law and the HIPAA Privacy Rule. If a standard is different under the HIPAA Privacy Rule than it is under New York law, your health care provider must follow the law that is the most protective of your rights.

SUMMARY OF YOUR RIGHTS

In New York, you have the right to:

- ***See and get a copy of your medical record.***
  Your health care provider usually must let you *inspect* or *see* your medical record within ten (10) days of receiving your written request. Your health care provider generally must give you a copy of your medical record within 30 days after they receive your request.

  Your health care provider is allowed to charge you up to 75¢ per page for paper copies. They can also charge you for postage. Your provider *cannot* refuse to give you access to your medical record just because you are unable to pay for it.

- ***Correct your medical record by adding information to it.***
  You have the right to add information to your medical record to make it more complete or accurate. This right is often called the ***right to amend*** your record.

- ***File a complaint.***
  You have the right to file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services if you believe your health care provider has violated your right to see, get a copy of, or amend your medical record. You can also file a complaint with the state agency that regulates your health care provider.

- ***Sue in state court.***
  You have the right to file suit in New York State Court for violations of your rights under state law.

You can learn more about these rights in the following sections of this guide.

WHO HAS TO FOLLOW THESE LAWS?

Most New York health care providers must follow both the HIPAA Privacy Rule and state laws that give patients rights in their medical records. When this guide uses the phrase health care providers it includes both health care practitioners (such as doctors, dentists, and chiropractors) and health care facilities (such as hospitals).

There are some health care providers that do *not* have to follow the HIPAA Privacy Rule. The HIPAA Privacy Rule only covers health care providers that use computer technology to send health information for certain administrative or financial purposes (such as filing claims for insurance).

Example

Sometimes Ashley goes to a doctor at a free clinic for medical treatment. The doctor does not accept private insurance, Medicaid, or Medicare. The doctor does not file any insurance claims. Ashley's doctor probably does not have to follow the HIPAA Privacy Rule. This is because the doctor does not appear to send health information for the types of administrative or financial purposes that would make her a covered health care provider under the HIPAA Privacy Rule.

If you have questions about whether your health care provider must follow the federal HIPAA Privacy Rule, you can contact the Office for Civil Rights, U.S. Department of Health and Human Services (OCR), the agency that is in charge of enforcing the HIPAA Privacy Rule. Section 4 of this guide lists contact information for OCR.

Are nursing homes covered by HIPAA?

Yes. Most nursing homes are covered by the HIPAA Privacy Rule. They also have to follow other specific rules that cover nursing homes and long term care facilities. Because the rules for nursing homes are different than they are for other health care providers, they are not covered by this guide.

What happens if my provider does not have to follow HIPAA?

If your provider does not have to follow the HIPAA Privacy Rule, they still have to follow New York laws that give you rights to your medical record. Section 6 lists some resources that summarize these state laws.

This guide, however, only explains getting your medical record from New York providers who *have* to follow the HIPAA Privacy Rule.

WHAT RECORDS DO I HAVE THE RIGHT TO GET AND AMEND?

You have the right to see and get a copy of your medical record. You also have the right to correct your medical record by having information added to it to make it more complete or accurate. This right is called the ***right to amend*** your record. (This guide will call these rights the right to "get and amend.")

Your medical record includes such things as:

- Information that identifies you, such as your name and Social Security number.
- Information that you tell your doctor or health care provider, such as:
  - Your medical history.
  - How you feel at the time of your visit.
  - Your family health history.
- The results of your examination.
- Test results.
- Treatment received in a hospital.
- X-rays, records made by heart monitors, and similar items.
- Medicine prescribed.
- Other information about things that can affect your health or health care.

Who owns my medical record?

Under New York law, your health care provider owns the actual medical record. This means, for example, that if your provider maintains paper medical records, your provider has the right to keep the original record. You only have the right to see and get a copy of it.

My health care provider makes personal notes about patients. Do I have a right to get these notes?

Probably. You have the right to get a provider's personal notes about you if the notes are used to make decisions about you.

Example

Michael's doctor writes notes about her personal impressions of patients in their medical records. She uses these notes to help her treat her patients. For example, she wrote a note in Michael's medical record saying she suspects that he is exaggerating his complaints about his health and that his problems are "all in his head." If Michael requests his entire medical record, the doctor must let him see and get a copy of this note.

What happens if my medical record has information in it that came from a different health care provider?

Generally, if your provider has the medical information that you request, they must give it to you. You have the right to get the information no matter who originally put it in the record. Your right to amend this information may be limited though. For more information about how to amend information in your record you can read Section 3 of this guide.

Example

Dr. Green keeps a medical record on his patient Kayla. This record includes information about Dr. Green's treatment of Kayla. It also includes information about tests and treatment that she has received from other doctors. If Kayla requests her medical record from Dr. Green, she has the right to get the entire medical record, not just the part that is about Dr. Green's treatment of her.

Do I have the right to get and amend records about my mental health treatment?

Maybe. The rules for when you can get and amend your records about mental health treatment can be different. For example, psychotherapy notes are treated differently than other records under the HIPAA Privacy Rule. Because the rules for mental health records can be different they are not discussed in this guide. You can find some resources about your rights in these types of records in Section 6.

WHO HAS THE RIGHT TO GET AND AMEND MY MEDICAL RECORD?

You have the right to see and get a copy of medical records that are about you. You also have the right to correct medical records that are about you by having information added to them. (This guide calls these rights the right to "get and amend" your medical record.) If there is someone who acts as your ***personal representative***, they usually have the right to get and amend your record on your behalf. Generally, a personal representative is a person who has the right to make health care decisions on your behalf.

Do I have the right to get and amend my child's medical record?

Generally, yes. When you, as a parent, consent to treatment or care for your minor child you have right to get and amend the minor's medical record related to that treatment. You also have the right of access to a minor's medical record where they obtain emergency treatment without your consent.

In New York, you usually have these rights until your child turns 18. However, if your child is 12 or older and objects to your request, her provider may deny you access to her medical record.

As a parent, do I always have the right to get and amend my child's medical record?

No. A parent does not always have the right of access to a child's medical record. For example, parents do not have the right to get their minor child's medical record if a health care provider determines that providing a parent access would have a harmful effect on the care and treatment of the minor.

Some other situations where parents do not have the right of access to their child's medical records are discussed in the following questions and answers.

Who has the right to get and amend my child's medical record once she turns 18?

Once your child turns 18, she has the right to get and amend her own medical record. This right includes getting access to records that were created when she was younger. You usually no longer have the right to get and amend your child's medical record just because you are her parent.

I am under 18. Do I have the right to get and amend my medical record?

Generally, no. As a minor, you usually do not have the right to get and amend your own medical record. That right usually belongs to your parents.

However, there are situations when you may have the right of access to your own medical record. For example, if you are an emancipated minor under New York law, you have the right to get and amend your own medical record. In New York, you also have the right to access your medical record when, as a minor, you can legally consent to medical treatment without your parents' permission. This right is discussed in the next question and answer.

I am under 18, but I can legally consent to medical treatment without my parents' permission. Who has the right to get and amend medical records that are related to this treatment?

You do. Even though you are a minor, sometimes you can consent to medical treatment without the permission of your parents. For example, in New York a minor who is pregnant may give consent for medical, dental, health and hospital services relating to prenatal care. Similarly, a minor can get treated for sexually transmitted diseases without parental consent. When you consent to such treatment, you have the right to get and amend your medical record related to this treatment. In New York, your

parents generally do not have the right to get and amend information related to treatment for which they did not give consent.

Example

Jason is under 18 and is sexually active. At his annual exam Jason consents to an HIV test. He does not get his parents' permission for the test. Jason's mother later requests a copy of Jason's medical record. Jason's health care provider cannot give Jason's mother the part of his record about the HIV test unless Jason gives his written permission.

If you have questions or concerns about whether your parent will have access to your medical record you should talk to your health care provider.

My mother signed a form that names me as her health care proxy. Do I have the right to get and amend her medical records?

Yes. In New York, you can sign a health care proxy form that names someone you trust to make health care decisions for you if you lose the ability to make decisions yourself. This person is called your health care agent or proxy. If you are your mother's health care proxy, you generally have the right to get and amend her medical records that are relevant to making health care decisions on her behalf. You have these rights while the proxy is in effect.

Example

Maria's mother signed a form naming Maria her health care proxy in the event her mother is unable to make her own health care decisions. Maria's mother was in a bad accident and is not able to make decisions about her health care. Maria now has the right to make health care decisions on her mother's behalf. She also has the right to get and amend medical records that are relevant to making these decisions. For example, Maria has the right to see the records about her mother's current medical condition and treatment.

Maria is curious about the time her mother had a miscarriage. Maria wants to look at these old medical records. Maria does *not* have the right to get and amend these medical records because the records have nothing to do with her mother's current condition or treatment.

My father recently died. Do I have the right to get a copy of his medical record?

Maybe. In New York, you have the right to get and amend a deceased person's medical records if you are the personal representative (an executor or administrator) of their estate. If no personal representative has been appointed, you have the right to get and amend a deceased person's medical record if you are their surviving spouse or child. In some circumstances other relatives may have access rights to a deceased's medical records.

How Long Does My Provider Have to Keep My Medical Record?

Under New York law, many health care providers must keep medical records for a minimum period of time. For example, doctors in New York generally must keep medical records for at least six (6) years. Obstetrical records and records about minor patients must be kept at least six (6) years or until one year after the minor patient reaches 18, whichever is longer. Hospitals must keep their medical records at least six years from the date you are discharged. In practice, many health care providers keep their records longer.

You have a right to see, get a copy of, and amend your medical record for as long as your health care provider has it.

2. GETTING YOUR MEDICAL RECORD

SUMMARY

You have the right to see your medical record. You also have the right to get a copy of your medical record. These rights are often called the ***right of access*** to your medical record.

Usually, your health care provider must let you see your record within 10 days after they receive your written request.

Generally, your provider must give you a copy in the format that you request if they are able to do so.

You may have to pay a fee to get a copy of your record.

HOW DO I ASK FOR MY MEDICAL RECORD?

You should ask your provider about their specific procedures for getting your medical record. Often, your health care provider has a form for requesting your medical record. You should use this form if one is available. You should be able to find some information about getting your medical record in your provider's ***notice of privacy practices***.

Can my provider require me to put my request for my medical record in writing?

Yes. Your provider can require that you put your request in writing (such as by sending a letter, an e-mail, or a fax). Your provider must let you know that it has such a requirement.

What information should I include in my request for my medical record?

If your provider does not have a form for requesting your medical record, you should check to see what information your provider requires.

Generally, when you ask for your medical record, your request should include:

- Your name.
- Your address.
- Your telephone number.
- Your e-mail address.
- Your medical record number (if you know it) or your date of birth.

- A description of the information that you want to see or copy. This might include:
  - Dates of treatment.
  - Whether you want the entire record or just part of the record.
  - Medical condition for which you are asking information.
  - Specific test results.
  - Whether you want X-rays or records made by heart monitors or similar medical devices.
- Whether you want to see your medical record, want a copy of your record, or would like both.

Do I have to choose between seeing my medical record and getting a copy of it?

No. You have the right to do both.

Can my provider require that I include my Social Security number on my request for my medical record?

Yes. Because some health care providers use Social Security numbers as a way to identify medical records, they may need your Social Security number to locate your medical record. There is nothing in the HIPAA Privacy Rule or the Social Security Act that prohibits a private provider from engaging in this practice.

Will I have to show some proof of who I am in order to see or get a copy of my medical record?

Maybe. If your health care provider does not know you well, they are supposed to make sure you are the person who has the right of access to the medical record before they give it to you.

If you request someone else's medical record as their personal representative, you generally have to prove that you have the right to get their medical record. For example, if you ask for someone's medical record as their "health care proxy," you must give the provider a copy of the "health care proxy" form along with your request.

What Will Happen If My Request for My Medical Record is Accepted?

Your health care provider will inform you if they agree to give you your medical record. If you asked to *see* your records, your health care provider must arrange a convenient time and place for you to review the record. If you have requested a *copy* of your record, your health care provider must either send it to you or arrange for you to pick up a copy.

How Long Should It Take to Get My Medical Record?

Your provider must let you *inspect* or *see* your medical record within ten (10) days of your request. If you request a copy of your medical record, your provider must give you the copy within a reasonable time, usually within 30 days after they receive your request.

Can I Control Where the Copy of My Medical Record Is Sent?

Yes. You can ask your health care provider to send the copy of your medical record to your regular address (such as your home) or to another address (such as to your office or to a friend's house). As long as your request is reasonable, your provider must send your record to the place that you identify.

Can I Get a Paper, E-mail, or Fax Copy?

It depends. Generally, your health care provider must give you your medical record in the format that you request if it is not difficult to do so. For example, if you request a paper copy of your record, your provider generally must give you a paper copy.

Providers also must make sure that they send your records to you in a secure manner. Due to security concerns, many health care providers are reluctant to send copies of medical records by e-mail or fax.

Can I get a Summary or Explanation of My Medical Record?

It depends. You may want just a summary of your record. You may want your provider to explain some of the information in your record. Under the HIPAA Privacy Rule, your health care provider can give a summary or explanation of your medical record if you both agree *in advance*

- That it is all right for them to give you a summary or explanation, *and*
- To the fee, if any, they want to charge for writing the summary or explanation.

Your health care provider generally must give you the summary within 30 days from when you request the summary. If they are unable to produce the summary in this time they can get a 30 day extension.

Your provider can charge you a reasonable fee for the actual time they spend preparing the summary or explanation.

Example

Leon requests a summary of his medical record. The record does not currently contain a summary and the doctor does not have the time or staff to prepare one. Leon's doctor is not required to prepare a summary at Leon's request. But the doctor must let Leon see or get a copy of his medical record.

I received a copy of my medical record, but I can't understand it. Doesn't my provider have to give me a copy that is in plain language that I can understand?

No. Health care providers often use technical words or a type of medical shorthand. Providers are not required to translate this information for you or give you your medical record in a form that you can understand. If you cannot understand what is written in your medical record you can request an explanation of your record. However, your provider is not required to give you an explanation. Section 6 lists some resources that explain medical terms.

$ Will I Have To Pay for My Medical Record?

Maybe. Your health care provider can charge you up to 75¢ per page for paper copies of your medical record. You also can be charged for postage if you have the copy mailed to you.

Can I be charged if I just want to look at or read my medical record?

No. Although New York law permits a provider to charge you an "***inspection fee***" if you just want to look at your record, the HIPAA Privacy Rule does not. Because the HIPAA Privacy Rule is more protective of your rights in this area, your provider must follow the HIPAA Privacy Rule. Your provider cannot charge you an inspection fee.

Can I be charged for someone searching for my record or for processing my request?

No. You cannot be charged a fee for someone searching for and getting your record. Neither can you be charged for someone processing your request for your record. These fees are often called "retrieval" or "clerical" fees. They are not permitted.

Can I be charged for copies of X- rays and similar records?

Yes. Your health care provider may charge you a reasonable fee for copying x-rays and similar records. This fee must be based on the actual cost of making the copies. You can also be charged postage if you ask that the records be mailed to you.

What happens if I am unable to pay the copying fee?

Under New York law, you cannot be denied access to your medical record solely because you are unable to pay the copying fee.

Can I be charged if I want a copy of my medical record sent to another health care provider?

The procedures and fees for having a copy of your medical record sent to another health care provider may be different. Because these procedures and fees are not covered by the HIPAA Privacy Rule, they are not discussed in this guide.

CAN MY PROVIDER DENY MY REQUEST FOR MY MEDICAL RECORD?

Yes. Your health care provider can deny your request to see or get a copy of your medical record, but only in a few cases. For example, if your provider believes that letting you see your record might physically endanger you, they can deny your request for your record.

How will I know if my request for my medical record has been denied?

Your health care provider must tell you in writing (by letter, fax, or e-mail) if they deny your request for your medical record. They must tell you why your request was denied. They also must tell you if you have a right to have their decision reviewed and how you can file a complaint.

Can my health care provider deny my request for my medical record just because they think I might get upset if I read it?

No. Your health care provider cannot deny you access to your record because they think the information in the record might upset you or that it might cause you mental harm. However, they can deny your request if they believe you will become upset enough to physically harm yourself or someone else.

Can my health care provider deny my request for records related to my mental health treatment?

Records about mental health treatment may be treated differently from other types of medical records. This guide does not discuss mental health records. Section 6 lists some resources for information about mental health records.

Can my health care provider refuse to give me my medical record because I have not paid my medical bill?

No. Your provider cannot deny your request for your medical record because you have not paid your medical bill.

What happens if my provider doesn't have the medical record that I requested?

If your health care provider doesn't have the record that you requested, they don't have to locate it for you. But your provider must tell you where your medical record is kept if they know.

WHAT CAN I DO IF MY HEALTH CARE PROVIDER DENIES MY REQUEST FOR MY MEDICAL RECORD?

If your health care provider denies your request for your medical record because they believe that seeing it might physically endanger you or someone else, you have the right to have another health care provider review their decision.

At the time your provider denies your request for your record, they must tell you in writing if you have a right to obtain a review. Both New York law and the HIPAA Privacy Rule have procedures for obtaining a review when your request is denied due to potential harm.

New York Law

Under New York law, you may request a review by a medical record access review committee. Medical record access review committees are made up of three to five licensed health care professionals. For example, a committee of doctors reviews the decisions of doctors. The members of the committee are appointed by the Commissioner of Health.

The committee will review your provider's decision. The committee decides whether you should get access to your medical record. If the committee decides you should be given access to your record, your provider must let you see or get a copy of your medical record.

If the committee decides that you should *not* get access to your medical record, they must tell you that your request has been denied. They must also give you notice that you have the right to seek judicial review of their decision. To obtain judicial review, you must start a proceeding in New York Supreme Court within 30 days of receiving

the committee's notice. The judge will decide whether you get access to your medical record.

HIPAA Privacy Rule

You may request a review by another health care provider under the HIPAA Privacy Rule. If you request such a review, your provider must choose another licensed health care professional who was not involved in the original decision to review the denial of your request for your record. The reviewer will decide whether you can see or get a copy of your medical record. Your health care provider must follow the reviewer's decision. Your provider must tell you in writing (such as by a letter, fax or e-mail) the reviewer's decision.

3. AMENDING (CORRECTING) YOUR MEDICAL RECORD

SUMMARY

When you read your medical record you may find something that you believe is not accurate. You might believe that important information is missing. You have the right to amend your medical record by adding information to your record to make it more complete or accurate. This right is called the "***right to amend***" your medical record.

There are two ways you can amend your medical record:

- You can write a short statement and give it to your ***health care provider*** to add to your medical record under New York law *or*
- You can request that your health care provider amend your record under the HIPAA Privacy Rule.

You do not have the right under either law to have information removed from your record.

Which way should I choose to amend my record?

Both procedures have their advantages. Writing your own short statement is a simpler procedure. But some people feel that having your health care provider make the change makes your medical record more believable to others. Only you can decide which procedure is better for your purposes. Both procedures are discussed in the sections that follow.

HOW DO I ADD A WRITTEN STATEMENT TO MY MEDICAL RECORD UNDER NEW YORK LAW?

Under New York law, you have the right to challenge information in your medical record that you believe is inaccurate. The right only applies to factual statements. You do not have the right to challenge a provider's observations, inferences or conclusions.

You may give your health care provider a brief written statement about the challenged information. You should include a statement that you are challenging your medical record under New York law.

Your provider must make this statement a permanent part of your medical record. They must release it whenever the challenged information at issue is released.

How Do I Ask My Health Care Provider to Amend My Medical Record under the HIPAA Privacy Rule?

Before you ask your health care provider to amend your medical record, you should:

- Identify the part of your medical record that you think is inaccurate or incomplete.
- Identify the health care provider that created the information or that first put the information into your record.

You should ask your provider about their specific procedures for requesting an amendment to your medical record. You should be able to find some information about amending your medical record in your provider's ***notice of privacy practices***.

Can my health care provider require that I put my request to amend my record in writing?

Yes. Your health care provider is allowed to require that you put your request to amend your record in writing, such as by a letter, fax, or e-mail. They are also allowed to require that you give them a reason why you want to amend your record.

What information must be included in my request to amend my medical record?

If your provider does not have a form for requesting your medical record, you should check to see what information your provider requires.

Generally, when you ask for your medical record, your request to amend should include:

- Your name.
- Your address.
- Your telephone number.
- Your email address.
- Your medical record number (if you know it) or your date of birth.
- Dates related to the information (such as the date the treatment was given).
- The type of information you want to amend.
- A description of the information that you believe is inaccurate or incomplete.
- The information that you want them to add to your record.
- The reason why you want the information added.

Can my health care provider require that I include my Social Security number in my request to amend my medical record?

Yes. Because some health care providers use Social Security numbers as a way to identify medical records, they may need your Social Security number to locate your medical record so that they can amend it. There is nothing in the HIPAA Privacy Rule or the Social Security Act that prohibits a private provider from engaging in this practice.

Do I have the right to have information removed from my medical record?

No. You do not have the right to have information that is already in your record removed or altered. You only have the right to add more information.

I disagree with my health care provider's diagnosis. Can I make them change it?

No. The right to amend your record under HIPAA is not supposed to be a chance to dispute a diagnosis. It is meant to give you the chance to correct your record by adding information to it.

As a minor, do I have the right to request my provider amend my medical record under the HIPAA Privacy Rule?

Sometimes. As a minor, you usually do not have the right to amend your medical record. The right to amend (like the right of access) usually belongs to your parents.

However, if you are an emancipated minor, you have the right to amend your own medical record. Similarly, when minors legally consent to certain kinds of medical treatment they have the right to amend medical records related to that treatment.

What Happens if My Request to Amend My Record Under the HIPAA Privacy Rule Is Accepted?

If your health care provider agrees with your request to amend your medical record, they must add the new information to your record. They also must tell you in writing that your request to amend was accepted.

You might know people or organizations that should be told about the new information. You should give their names and contact information to your health care provider. Your provider must give the amended health information to the people and organizations you identify.

How long Should it Take to Amend My Medical Record under the HIPAA Privacy Rule?

Generally, within 60 days after they receive your request, your health care provider must either

- Add the information to your medical record as you requested *or*
- Deny your request in writing.

Can it ever take longer?

Yes. Under the HIPAA Privacy Rule, if your health care provider is unable to act within 60 days, they can get one 30-day extension to respond. In order to do this, they have to give you a written explanation for the delay and tell you the date they expect to respond. Even with an extension, they shouldn't take more than 90 days to respond to your request to amend your record.

When does the 60 day time period begin?

The 60 days does not start until your provider *receives* your request to amend your medical record. If you mailed your request, you should make sure you include some additional time for mail delivery when you count days for these deadlines.

CAN MY PROVIDER DENY MY REQUEST TO AMEND MY MEDICAL RECORD UNDER THE HIPAA PRIVACY RULE?

Yes. Under the HIPAA Privacy Rule, there are times when your health care provider can deny your request to amend your medical record. Generally, your provider can deny your request when:

- They determine your record is accurate or complete.
- They did not create the information that you want to amend.

If your health care provider denies your request to amend your record, they must let you know in writing (for example by sending you a letter, a fax or an e-mail). Your provider also must tell you why they denied your request.

The health care provider that created the information that I want to amend isn't around any more. What can I do?

You can ask your current provider to amend your information. You should explain to them in as much detail as possible that the health care provider who first created the information that you want to amend is no longer available to act on your request. If your explanation is reasonable, your current provider cannot deny your request on the grounds that they did not create the medical information that you want to amend.

Example

Brianna wants to amend information in her medical record that was originally put in her record by Dr. Smith. When he retired, Dr. Smith put a notice in the paper telling patients of his retirement. Brianna requests that Dr. Jones amend her medical record and shows him the notice of Dr. Smith's retirement. Dr. Jones cannot refuse to amend Brianna's record on the grounds that he didn't create the information she wants to amend.

WHAT CAN I DO UNDER THE HIPAA PRIVACY RULE IF MY PROVIDER DENIES MY REQUEST TO AMEND MY MEDICAL RECORD?

If your request to amend is denied, you have the right to give your health care provider a written statement that explains why you disagree with their decision. Your provider may reasonably limit the length of your statement. Your provider must make your statement part of your medical record. In the future, when your provider shares your medical information with others, your provider must also give them a copy of their denial of your request to amend along with a copy (or summary) of your statement of disagreement.

What if my health care provider disagrees with my statement of disagreement?

If your health care provider disagrees with your statement, they have the right to put a note in your record that says why they do not agree with you. They must give you a copy of this note. In the future, when your provider shares your medical information with others, they will include this note along with their original denial, and your statement of disagreement.

Do I have the right to have someone else review my health care provider's denial of my request to amend my records?

No. If your health care provider denies your request to amend your medical record you do not have the right to have someone else review that decision under the HIPAA Privacy Rule

4. ASKING QUESTIONS AND FILING COMPLAINTS

This guide is just a summary of your rights to see, get a copy of and amend your medical record. If you have more questions or would like to file a complaint you can contact the people and organizations listed below. You can also contact a lawyer if necessary.

WHO CAN ANSWER MY QUESTIONS ABOUT GETTING AND AMENDING MY MEDICAL RECORD?

There are a number of resources available to answer your questions about getting and amending your medical record.

Your health care provider

Your health care provider should be able to answer many of your questions about getting and amending your medical record. Your provider's ***notice of privacy practices*** must contain a general description of your right to see, get a copy of, and amend your medical record. The notice also must list the name (or title) and the telephone number of a contact person who should be able to answer your questions about getting and amending your medical record. In addition, some providers have Web sites that list information on how to see, get a copy of and amend your medical record.

Office for Civil Rights, United States Department of Health and Human Services

You may be able to get answers to your questions about your rights under the HIPAA Privacy Rule OCR, from the office for Civil Rights, U.S. Department of Health and Human Services (OCR), the federal agency in charge of enforcing the HIPAA Privacy Rule. OCR provides fact sheets for consumers and responses to frequently asked questions on its Website http://www.hhs.gov/ocr/hipaa/.

If you do not find your questions answered there you can call OCR at **1-866-627-7748**. This is a toll free number. OCR requests that you read their responses to frequently asked questions before you call this number.

WHAT CAN I DO IF I BELIEVE MY RIGHTS TO GET AND AMEND MY MEDICAL RECORDS HAVE BEEN VIOLATED?

Before taking any formal action, you should discuss problems and issues you have about getting and amending your medical record with your health care provider. It is possible that you may be able to resolve your issues informally. It is also likely that if you contact someone for assistance, they will ask whether you have tried to solve your problem informally. If you believe your rights have been violated and are unable to resolve your issues informally, there are a number of possible actions you can take.

You can file a complaint with your health care provider.

You have the right, under the HIPAA Privacy Rule, to file a complaint with your health care provider. Your health care provider's notice of privacy practices must describe how to file your complaint. If you file a complaint, your health care provider cannot threaten you or do anything else to get even with you.

You can file a complaint with the Office for Civil Rights, United States Department of Health and Human Services (OCR).

Complaints must be in writing. You can get detailed information about filing a complaint with OCR at http://www.hhs.gov/ocr/privacyhowtofile.htm.

You can call OCR toll free at **1-800-368-1019** if you need help filing a complaint or have a question about the complaint form. This is a toll free call.

If you file a complaint with OCR, your health care provider cannot threaten you or do anything else to get even with you.

You can file a complaint about a medical doctor with the New York State Department of Health, Office of Professional Medical Misconduct at:

New York State Department of Health
Office of Professional Medical Conduct
433 River Street, Suite 303
Troy, NY 12180-2299

Complaints must be in writing. You can obtain information about filing a complaint and download a complaint form at: http://www.health.state.ny.us/nysdoh/opmc/main.htm.

You can also call **1-800-663-6114** (toll free) to get a complaint form or if you have questions.

You can file a complaint about health care professionals other than medical doctors (such as dentists, chiropractors and podiatrists) with the New York State Education Department, office of Professional Discipline at:

1-800-442-8106 (complaint hotline)
conduct@mail.nysed.gov (e-mail)

You can write to or send a complaint form to:
State Education Department
Office of Professional Discipline
1 Park Avenue, 6th Floor
New York, NY 10016

You can also send a complaint form to a regional office. You can get more information about filing complaints, obtain a list of regional offices, and download a complaint form at: http://www.op.nysed.gov/opd.htm or http://www.op.nysed.gov/faq.htm#complain.

You can file a complaint against a hospital with the New York State Department of Health, Bureau of Hospital and Primary Care Services.

You can file a complaint against a hospital with the appropriate regional office of the New York State Department of Health.

You can obtain information about filing complaints, obtain a list of regional offices and download a complaint form at:
http://www.health.state.ny.us/nysdoh/consumer/director/hospcare.htm

Can I sue my health care provider for violating my right to get my medical record?

Under New York law, you have the right to sue in state court to get your medical record or for other violations of your state rights. If your provider denied your request because of potential harm, you must first request a review by a medical access review committee. If the review committee also denies your request for your record, you can bring an action in state court to get your record.

You do *not* have the right to sue your health care provider in federal district court (U.S. District Court) for violating your right to get and amend your medical record under the HIPAA Privacy Rule.

5. WORDS TO KNOW

Correct. This guide uses the word "correct" to mean adding information to your medical record to make it more accurate or complete.

Health Care Provider. This guide uses the term "health care provider" to refer to doctors, dentists, chiropractors (and other health care practitioners) and to hospitals and other health care facilities licensed in New York.

HIPAA Privacy Rule. A set of legal rules written by the United States Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These rules set national standards that give patients the right to see, copy, and amend their own health information. They also set standards protecting the privacy of health information. Health care providers (such as doctors and hospitals) and health plans (such as health insurers and Medicare) have to follow the HIPAA Privacy Rule. Others, such as employers, generally do not have to follow the HIPAA Privacy Rule.

HIPAA. Health Insurance Portability and Accountability Act of 1996. This federal law directed the United States Department of Health and Human Services to write rules protecting the privacy of health information. The federal law leaves in place state laws that have privacy protections that are equal to or greater than the federal law.

Inspection Fee. A fee imposed for the administrative costs associated with letting you look at (inspect) your medical record. This fee is prohibited under HIPAA.

Notice of Privacy Practices. A notice required under the HIPAA Privacy Rule that describes a person's right to get and correct (amend) their medical record. It also explains when a provider can use and disclose (share) health information. The notice must also give the name (or title) and telephone number of a contact person who should be able to answer questions about getting and amending medical records. A provider must give a privacy notice to a patient on their first visit and upon the patient's request.

Personal representative. This guide uses the term "personal representative" to refer to someone who has the legal right to make health care decisions on behalf of another person.

Right of Access. The right to see and get a copy of your medical record.

Right to Amend. The right to correct your health information by adding information to it. The right to amend does not mean a right to have information erased.

Right to Review. The right to have someone else review a health care provider's denial of a request for a medical record.

6. WHERE TO FIND MORE INFORMATION

This guide only discusses how to get and amend (correct) your medical records from health care providers who have to follow the HIPAA Privacy Rule. The guide mentions some related topics without discussing them in detail. Here are some resources where you can find information about these related topics.

Alcohol and Drug Treatment Records

Records related to alcohol and drug treatment may be subject to other privacy rules. You can get more information about these records at:
http://hipaa.samhsa.gov/Part2ComparisonCleared.htm

Medical Records in General

You can read general information on your medical record rights, the flow of medical information, and how to create a personal medical record at http://www.myphr.com/
a Website operated by the American Health Information Management Association, an association of professionals who manage medical records and information.

Medical Terms

You can find out the meaning of many medical terms and medical shorthand from the Medical Library Association's Website at:
http://www.mlanet.org/resources/consumr_index.html
Your library might also have books or brochures that explain medical terms.

Mental Health Treatment Records

For information about mental health rights and referral services in New York you can contact:
Advocacy Services Bureau
NYS Commission on Quality of Care
401 State Street
Schenectady, NY 12305-2397

(518) 388-2892 or 1-800-624-4143 (toll free)

The HIPAA Privacy Rule treats most mental health treatment records like other medical records. However, psychotherapy notes (as defined by the HIPAA Privacy Rule) are treated differently. You can find what types of records are included in psychotherapy notes and how these notes are treated in the *Summary of the Privacy Rule* written by the Office for Civil Rights, HHS at:
http://www.hhs.gov/ocr/hipaa/.

New York Medical Record Access Laws

Some health care providers do *not* have to follow the HIPAA Privacy Rule. These providers must still follow New York laws that give you the right to see and get a copy of your medical record. You can read New York Public Health Law, Section 18, the state law that gives you access to your medical records, on the New York State Legislature's Web site at http://public.leginfo.state.ny.us/menuf.cgi. Look under "Laws of New York," under "PBH," Article 1, Title 2, Section 18.

HIPAA Preemption Charts

- Also availiable in Adobe Acrobat Portable Document Format (PDF, 99KB, 13pg.)

October 15, 2002

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") gave the federal Department of Health and Human Services ("HHS") the authority to promulgate regulations containing standards with respect to the privacy of individually identifiable health information. HIPAA provided that such standards shall not supersede State law that imposes more stringent standards (P.L. 104-191, § 264(c)). HHS promulgated the federal standards, and they are now in Parts 160 and 164 of Title 45 of the Code of Federal Regulations (the "Privacy Rule").

Under the Supremacy Clause of the U.S. Constitution, federal law preempts State law when preemption is the clear and manifest purpose of Congress. In instances where the purpose of Congress is not clear, only the judicial branch of government can determine whether a federal law preempts a State law under the Supremacy Clause.

In enacting HIPAA, Congress clearly did not supersede State laws that impose more stringent standards with respect to the privacy of individually identifiable health information. Thus, the Department will continue to enforce such State laws that are within the Department's purview to enforce. The Department will enforce other State laws to the extent that the Privacy Rule does not preempt them. Under the provisions of the Privacy Rule, the Privacy Rule does not alter State laws that permit individuals greater rights of access to or amendment of their own individually identifiable health information (45 CFR § 160.202(More stringent)).

April 14, 2003, is the compliance date for most covered entities under the Privacy Rule. Unless the relevant federal or State laws or regulations are amended, the Department intends to enforce specified provisions of State law as outlined in the following charts.

10/15/02 rev

PHL § 17

HIPAA Privacy Rule	PHL § 17	Law That Will Prevail
A "covered entity" may generally disclose "protected health information" (PHI) to another covered entity for treatment, payment or health care operations without consent (164.506(a), 164.506(c)). A covered entity may use or disclose PHI without an authorization or opportunity to agree or object to the extent that	"Upon the written request . . . [of a patient, a provider] . . . must release and deliver . . . copies of all . . . medical records . . . regarding that patient to any other designated physician or hospital. . ." (PHL § 17).	PHL § 17 prevails, because disclosures under PHL § 17 are "required by law."

such use or disclosure is "required by law" (164.512(a), 164.501(Required by law)).		
"If, and to the extent, prohibited by an applicable provision of State . . . law, . . . a covered entity may not disclose, or provide access . . . to, protected health information about an unemancipated minor to a parent, guardian, or other person acting *in loco parentis*" (164.502(g)(3)(ii)(B)).	". . . [R]ecords concerning the treatment of an infant patient for venereal disease or the performance of an abortion operation upon such infant patient shall not be released or in any manner be made available to the parent or guardian of such infant. . ." (PHL § 17).	PHL § 17 prevails, because it is a provision of State law that prohibits a disclosure about an unemancipated minor to a parent, guardian, or other person acting *in loco parentis*. Also, PHL § 17 prevails, because HIPAA does not preempt State law that imposes privacy standards that are "more stringent than" the standards imposed under HIPAA (P.L. 104-191, § 264(c)(2)).

PHL § 18

HIPAA Privacy Rule	PHL § 18	Law That Will Prevail
General rule		
Applies to any "covered entity": health care provider, health plan or health care clearinghouse (unless the entity transmits no health information in electronic form in connection with a transaction covered by the HIPAA Regulations) (160.102)	Applies to any "health care provider" as defined in New York law (18(2), 18(1)(b), 18(1)(c), 18(1)(d))	HIPAA prevails for health plans, health care clearinghouses and individuals who are health care providers under HIPAA but are not health care practitioners under State law. The remainder of this chart is confined to the law for "health care providers" under State law.
Applies to all medical records and billing records and any other records used to make decisions about individuals (164.524(a), 164.501(Designated record set))	Applies to information concerning or relating to the examination, health assessment or treatment of an individual (18(2), 18(1)(e))	HIPAA prevails for billing records. The remainder of this chart is confined to "patient information" under State law.
Exceptions to the general rule (when access can be denied)		
No exception	Does not apply to clinical records (maintained or possessed by an OMH, OMRDD or OASAS facility) access to which is governed under Mental Hygiene Law §§ 22.03 and 33.16 (18(1)(e)(i))	The law for clinical records maintained or possessed by an OMH, OMRDD or OASAS facility is beyond the scope of this chart.
Does not apply to psychotherapy notes (164.524(a)(1)(i), 164.501(Psychotherapy notes)).	No exception	For psychotherapy notes as defined by HIPAA, PHL § 18 prevails.
No exception	Does not apply to practitioner's	For personal notes and observations

	personal notes and observations (18(1)(e)(ii))	other than psychotherapy notes as defined by HIPAA, HIPAA prevails
No exception	Does not apply to information maintained by a practitioner, concerning or relating to the prior examination or treatment of a subject received from another practitioner (18(1)(e)(iii))	HIPAA prevails
No exception	Does not apply to diagnostic services performed by a practitioner at the request of another practitioner (18(1)(e)(last sentence))	HIPAA prevails
Does not apply to PHI obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information (164.524(a)(2)(v))	Does not include data disclosed to a practitioner in confidence by other persons on the basis of an express condition that such data would never be disclosed (18(1)(e)(iv))	HIPAA prevails
PHI does not make reference to another person, and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person (164.524(a)(3)(i)), e.g., when an individual exhibits suicidal or homicidal tendencies. This exception is intended to apply where disclosure is reasonably likely to result in the individual committing suicide, murder, or other physical violence. Under this reason for denial, covered entities may not deny access on the basis of the sensitivity of the health information or the potential for causing emotional or psychological harm (65 Fed. Reg. 82,555).	Provider may deny access to all or part of the information and may grant access to a prepared summary of the information if, after consideration of all the attendant facts and circumstances, the provider determines that the request to review all or a part of the patient information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right of access to the information (18(3)(d)(i)).	HIPAA prevails
PHI makes reference to another person, and a licensed health care professional has determined, in the exercise of professional judgment,	Provider may deny access to all or part of the information and may grant access to a prepared summary of the information if, after	HIPAA prevails if disclosure would cause substantial harm to the subject but not to the other person. PHL § 18 prevails if disclosure

that disclosure is reasonably likely to cause substantial harm to such other person (164.524(a)(3)(ii)). Substantial harm means serious harm (65 Fed. Reg. 82,555) and may be substantial physical, emotional, or psychological harm (65 Fed. Reg. 82,556).	consideration of all the attendant facts and circumstances, the provider determines that the request to review all or a part of the patient information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right of access to the information (18(3)(d)(i)).	would cause substantial harm to the other person.
The request is made by the individual's personal representative, and a licensed health care professional has determined, in the exercise of professional judgment, that disclosure is reasonably likely to cause substantial harm to the individual or another person (164.524(a)(3)(iii)).	Provider may deny access to all or part of the information and may grant access to a prepared summary of the information if, after consideration of all the attendant facts and circumstances, the provider determines that the request to review all or a part of the patient information can reasonably be expected to cause substantial and identifiable harm to the subject or others which would outweigh the qualified person's right of access to the information (18(3)(d)(i)).	PHL § 18 prevails
Parental access to child's health information		
General rule is that parent has access (164.502(g)(1)).	General rule is that parent has access (18(2), 18(1)(g)).	No conflict
Parents have no right of access if minor can lawfully obtain health care service without the consent of a parent (164.502(g)(3)(i)). "If, and to the extent, permitted or required by an applicable provision of State . . . law, . . . a covered entity may disclose, or provide access . . . to, protected health information about an unemancipated minor to a parent, guardian, or other person acting *in loco parentis* (164.502(g)(3)(ii)(A)).	If a parent requests information concerning a child over 12 years old, the practitioner may notify the child and if the child objects to disclosure, may deny the request (18(3)(c)).	PHL § 18 prevails, because a covered entity may only disclose PHI to a parent to the extent permitted by State law. Also, HIPAA does not preempt State law that imposes privacy standards that are "more stringent than" the standards imposed under HIPAA (P.L. 104-191, § 264(c)(2)).
Parent has no right to access if the covered entity has a reasonable belief that the child has been or may be subjected to domestic violence, abuse or neglect by the parent or disclosure could endanger	Provider may deny access to all or part of the information and may grant access to a prepared summary of the information if, after consideration of all the attendant facts and circumstances, the	PHL § 18 prevails

the child and the covered entity, in the exercise of professional judgment, decides that disclosure is not in the best interest of the child (164.502(g)(5)).	provider determines that disclosure would have a detrimental effect on the provider's professional relationship with an infant, or on the care and treatment of the infant, or on the infant's relationship with his or her parents (18(3)(d)(i), 18(2)(c)).	
Fees		
Covered entity may impose a reasonable, cost-based fee (164.524(c)(4)).	The provider may impose a reasonable charge, not to exceed costs and not to exceed 75¢ per page, but the release of records cannot be denied solely because of inability to pay (18(2)(e)).	PHL § 18 prevails
Procedure		
Covered entity must provide the individual with access to the PHI in the form or format requested by the individual, if it is readily producible in such form or format, in a timely manner (30 or 60 days, with a possible 30 day extension) (164.524(c)(2), 164.524(b)(2)).	Provider must permit visual inspection within 10 days and furnish a copy within a reasonable time if the provider has space available to permit visual inspection, or must provide a copy within 10 days if the provider does not have space available to permit visual inspection (18(2)(a), (d), (g)).	PHL § 18 prevails
A licensed health care professional must be designated by the provider as a reviewing official to make a final determination (164.524(d)(4)).	A medical record access review committee appointed by the commissioner of the Department of Health (DOH) reviews appeals of denials of access (18(4)).	No conflict, because it is possible to comply with both the State and federal requirements. The reviewing official reviews HIPAA issues, and the medical record access review committee reviews PHL § 18 issues.
Individuals have a right to have a covered entity amend inaccurate or incomplete PHI about themselves created by a health care provider. Where a request to amend is denied, individuals may submit into the medical record a written statement of disagreement and the provider may submit a written rebuttal to such statement (164.526).	Individual may challenge the accuracy of information and may require that a brief written statement prepared by the individual concerning the challenged information be inserted into the medical record (18(8)).	HIPAA prevails

PHL § 206(1)(j)

HIPAA Privacy Rule	PHL § 206(1)(j)	Law That Will Prevail
Generally, a covered entity may not disclose PHI for research purposes without an authorization (164.508). A covered entity may disclose PHI without authorization to the extent that such use or disclosure is to a public health authority for public health activities (164.512(b)), to a health oversight authority for health oversight activities (164.512(d)) or if an IRB has waived the requirement to get an authorization, applying the specific criteria in 164.512(i). A covered entity must provide an accounting of a § 206(1)(j) disclosure if the subject did not authorize the disclosure and requests an accounting (164.528). PHI may only be disclosed in a manner consistent with a covered entity's Notice of Privacy Practices (164.502(i)). If disclosure is not pursuant to an authorization, covered entities must limit PHI disclosed for research to that which is reasonably considered to be the "minimum necessary" to accomplish the research (164.514(d)(3)(ii)). However, the covered entity may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for section 206(1)(j) research if DOH represents that the information DOH is requesting is the minimum necessary to do the research (164.514(d)(3)(iii)). PHI that is de-identified under HIPAA is no longer PHI and is no longer subject to HIPAA (164.514(a), (b), (c)). A covered	The Commissioner of DOH shall cause to be made scientific studies and research, and in conducting such studies and research, the commissioner is authorized to collect information, and such information shall be kept confidential and shall be used solely for the purposes of medical or scientific research or the improvement of the quality of medical care through the conduction of medical audits (PHL § 206(1)(j)).	Covered entities may disclose PHI to DOH under PHL § 206(1)(j): (1) if the subject authorizes the disclosure under HIPAA; or (2) if an IRB has waived the requirement to get authorization, applying the specific criteria in HIPAA. (A covered entity may disclose PHI to DOH without authorization for public health or health oversight activities, but such activities would not generally be considered PHL § 206(1)(j) research.) In addition, the disclosure must be: (1) accounted for by the provider if not authorized by the subject; (2) consistent with the provider's Notice of Privacy Practices; and (3) the minimum necessary to accomplish the research if not authorized by the subject. DOH could be asked to represent that the requested disclosure is the minimum necessary. Also, covered entities may disclose information that has been de-identified under HIPAA. Alternatively, a covered entity may disclose a "limited data set" to DOH for research purposes if DOH executes a "data use agreement."

entity may disclose a "limited data set" to DOH for research purposes if DOH executes a "data use agreement" (164.514(e)).		

PHL § 2782

HIPAA Privacy Rule	PHL § 2782	Law That Will Prevail
"If, and to the extent, permitted or required by an applicable provision of State . . . law, . . . a covered entity may disclose, or provide access . . . to, protected health information about an unemancipated minor to a parent, guardian, or other person acting *in loco parentis*" (164.502(g)(3)(ii)(A)).	"No person who obtains confidential HIV related information in the course of providing any health or social service or pursuant to a release of confidential HIV related information may disclose or be compelled to disclose such information, except to . . . an authorized agency in connection with foster care or adoption of a child" (PHL § 2782(1)(h)).	HIPAA does not preempt PHL § 2782(1)(h), but HIPAA may require an authorization to disclose confidential HIV related information to an authorized agency in connection with foster care or adoption of a child, if the agency is not a "person acting *in loco parentis*."
A covered entity may use or disclose PHI without an authorization or opportunity to agree or object to the extent that such use or disclosure is "required by law" (164.512(a), 164.501(Required by law)) or if the disclosure is "for a law enforcement purpose to a law enforcement official . . . [i]n compliance with and as limited by the relevant requirements of . . . [a]n administrative request. . ." (164.512(f)(1)(ii)).	"No person who obtains confidential HIV related information in the course of providing any health or social service or pursuant to a release of confidential HIV related information may disclose or be compelled to disclose such information, except to . . . an employee or agent of the division of parole . . . [or] an employee or agent of the division of probation and correctional alternatives or any local probation department . . . [or] an employee or agent of the commission of correction" (PHL § 2782(1)(l), (m), (o)).	HIPAA does not preempt PHL § 2782(1)(l), (m) or (o). Nor would HIPAA require an authorization to disclose confidential HIV related information under these provisions, because such disclosures may be required by law or are for law enforcement purposes to law enforcement officials in compliance with and as limited by the relevant requirements of an administrative request.
Generally, a covered entity must treat a "personal representative" of a person who is the subject of PHI as though the personal representative were the person (164.502(g)).	Generally, a parent, legally appointed guardian or committee exercises rights on behalf of a child, ward or incapacitated person (e.g., PHL § 18(2)(b), (c)).	Preemption of Mental Hygiene Law Article 81 and Surrogate's Court Procedure Act Articles 17 and 17-A is beyond the scope of this chart. This row of this chart is merely intended to preface the analysis of preemption of PHL § 2782(4) below.

If under applicable law a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative with respect to PHI relevant to such personal representation (164.502(g)(2)). A covered entity may not disclose PHI about an unemancipated minor to a parent, guardian, or other person acting *in loco parentis* to the extent that an applicable provision of State or other law, including applicable case law, prohibits such disclosure (164.502(g)(3)(ii)(B)). A covered entity may elect not to treat a person as the personal representative of an individual if: (i) The covered entity has a reasonable belief that: (A) The individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or (B) Treating such person as the personal representative could endanger the individual; and (ii) The covered entity, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual's personal representative (164.502(g)(5)).	"A physician may disclose confidential HIV related information pertaining to a protected individual to a person (known to the physician) authorized pursuant to law to consent to health care for a protected individual when the physician reasonably believes that: (1) disclosure is medically necessary in order to provide timely care and treatment for the protected individual; and (2) after appropriate counseling as to the need for such disclosure, the protected individual will not inform a person authorized by law to consent to health care; provided, however, that the physician shall not make such disclosure if, in the judgment of the physician: (A) the disclosure would not be in the best interest of the protected individual; or (B) the protected individual is authorized pursuant to law to consent to such care and treatment" (PHL § 2782(4)(e) [emphasis supplied]).	PHL § 2782(4)(e) prevails. A physician shall not disclose confidential HIV related information to a parent or guardian of a protected individual, if in the judgment of the physician, the disclosure would not be in the best interest of the protected individual, because HIPAA does not preempt State law that imposes privacy standards that are "more stringent than" the standards imposed under HIPAA (P.L. 104-191, § 264(c)(2)). Also, a physician shall not disclose confidential HIV related information to a parent or guardian of a minor who is a protected individual, if in the judgment of the physician, the disclosure would not be in the best interest of the protected individual, because State law prohibits such disclosure. There is no conflict between HIPAA and State law with respect to a disclosure of confidential HIV related information to a personal representative of a protected individual in abuse, neglect or endangerment situations, where, in the judgment of the physician, the disclosure would not be in the best interest of the protected individual.

PHL § 2805-m

HIPAA Privacy Rule	PHL § 2805-m	Law That Will Prevail
The HIPAA right of access to PHI applies to all medical records and billing records and any other records used to make decisions about individuals (164.524(a),	Information required to be collected and maintained under PHL §§ 2805-j, 2805-k and reports required to be submitted under PHL § 2805-l and any incident reporting	PHL § 2805-m prevails. None of the information that must be kept confidential under PHL § 2805-m is part of an individual's designated record set under HIPAA, because

164.501(Designated record set)). Individual means the person who is the subject of PHI (164.501(Individual)).	requirements imposed upon diagnostic and treatment centers shall be kept confidential and shall not be released except to DOH or under PHL § 2805-k(4).	such information is not used to make decisions about the subject of the PHI.

PHL § 4410

HIPAA Privacy Rule	PHL § 4410(2)	Law That Will Prevail
A covered entity may use and disclose PHI for treatment, payment, or health care operations without consent (164.502(a)(1)(ii), 164.506). A covered entity may obtain consent of the individual to use or disclose PHI to carry out treatment, payment, or health care operations (164.506(b)(1)). Except in an emergency treatment situation, a provider must make a good faith effort to obtain a written acknowledgment of receipt of the provider's Notice of Privacy Practices, and if not obtained, document its good faith efforts to obtain such acknowledgment and the reason why the acknowledgment was not obtained (164.520(c)(2)(ii)).	"Unless the patient waives the right of confidentiality, a health maintenance organization or its comprehensive health services plan shall not be allowed to disclose any information which was acquired by such organization or plan in the course of the rendering to a patient of professional services by a person authorized to practice medicine, registered professional nursing, licensed practical nursing, or dentistry, and which was necessary to acquire to enable such person to act in that capacity, except as may be otherwise required by law. A non-participating provider shall provide an enrollee's organization with such patient information as is reasonably required by the organization to administer its plan. In making such disclosure a provider shall comply with the provisions of subdivision six of section eighteen of this chapter concerning the disclosure of patient information to third parties provided, however, that with respect to a protected individual as defined in subdivision six of section twenty-seven hundred eighty of this chapter, disclosure shall be made only pursuant to an enrollee's written authorization and shall otherwise be consistent with the requirements of such section and rules and regulations promulgated	Health maintenance organizations must comply with both HIPAA and State law.

	pursuant thereto" (PHL § 4410(2)).	

Civil Rights Law § 79-l

HIPAA Privacy Rule	Civil Rights Law § 79-l	Law That Will Prevail
A "covered entity" may generally disclose PHI to another covered entity for treatment, payment or health care operations without consent (164.502(a)(1)(ii), 164.506(a), 164.506(c)). A covered entity generally must have authorization to disclose PHI for other purposes (164.508). To be valid, an authorization must contain specified elements and comply with specified requirements (164.508(c)).	No person shall perform a genetic test on a biological sample taken from an individual without the prior written informed consent of such individual consisting of eight specific elements (Civil Rights Law § 79-l(2)).	Disclosures of genetic test information for treatment, payment or health care operations need only be in compliance with Civil Rights Law § 79-l. If not for treatment, payment or health care operations, a HIPAA-compliant authorization is also required.

Education Law § 6530(23)

HIPAA Privacy Rule	Education Law § 6530(23)	Law That Will Prevail
A covered entity may use and disclose PHI for treatment, payment, or health care operations without consent (164.502(a)(1)(ii), 164.506). A covered entity may obtain consent of the individual to use or disclose PHI to carry out treatment, payment, or health care operations (164.506(b)(1)). Except in an emergency treatment situation, a provider must make a good faith effort to obtain a written acknowledgment of receipt of the provider's Notice of Privacy Practices, and if not obtained, document its good faith efforts to obtain such acknowledgment and the reason why the acknowledgment was not obtained (164.520(c)(2)(ii)).	The following is professional misconduct for a physician, physician's assistant or a specialist's assistant: "Revealing of personally identifiable facts, data, or information obtained in a professional capacity without the prior consent of the patient, except as authorized or required by law."	Physicians, physician's assistants and specialist's assistants must comply with both HIPAA and State law.