

Access to Mental Hygiene Records in New York State:  
A Guide for Individuals Receiving Services  
and Other “Qualified Persons”  
“Jonathan’s Law”

Facilities and programs which provide services to individuals with disabilities are required to keep records about the care and treatment of the people they serve. To respect the dignity and rights of these individuals, the New York State Mental Hygiene Law (hereafter “MHL”) establishes basic rules of confidentiality and provides for access to records by individuals receiving services and persons legally authorized to speak on their behalf.

This pamphlet offers guidance for individuals receiving services, their families and other “qualified persons” interested in accessing records, in a question and answer format, together with references to the applicable provisions of the MHL.

What records are available?

Article 33 of the MHL provides access to three types of records: (1) clinical records, (2) incident reports and reports on actions taken, and (3) records and documents pertaining to allegations and investigations into abuse and mistreatment. All of these documents are available to qualified persons (See Who can ask for records? for an explanation of the term “qualified person”) with certain exceptions.

1. Clinical records include any information concerning or related to the examination or treatment of an individual who is receiving services or who has received services from a provider under the jurisdiction of the Office of Mental Health (OMH), the Office for Persons With Developmental Disabilities (OPWDD) or the Office of Alcoholism and Substance Abuse Services (OASAS) (MHL Section 33.16 (a) (1)). A qualified person may request that the provider permit him or her access to clinical records.

2. Incident reports and reports on actions taken are documents created by a provider following the occurrence or discovery of an event or situation concerning an individual who is receiving services, including any incident which affects the individual’s health or safety.

An incident report is created by the provider as an initial record of an incident very quickly after the incident occurs or is discovered. A qualified person who is notified of an incident may ask the provider, in writing, that he or she be given a copy of the incident report, and the provider must promptly comply with that request (MHL Section 33.23 (a)).

A report on actions taken is a report prepared by the provider relatively soon after the incident at issue to explain the actions immediately taken by the provider to address the incident. When a qualified person is notified of an incident concerning an individual who is receiving services, he or she will be provided with a report on actions taken within 10 days (MHL Section 33.23 (a)).

3. Records and documents pertaining to allegations and investigations into abuse and mistreatment include records or documents created and/or maintained by a provider under the jurisdiction of OMH, OPWDD or OASAS (including State-operated facilities) in response to an allegation of abuse or mistreatment. This will include an incident report and a report on actions taken and may also include an investigative report, which explains the steps taken by a provider to investigate alleged abuse or mistreatment and sets forth the conclusion of the investigation.

Records and documents pertaining to allegations and investigations into abuse and mistreatment may also include additional documents generated and/or compiled by OMH, OPWDD, OASAS, and/or the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD) if an investigation into the alleged abuse or mistreatment is conducted by any of these State agencies (MHL Section 33.25 (a)).

Who can ask for records?

Because of the personal and sensitive nature of mental hygiene records, the confidentiality of this information is strictly protected under Article 33 of the MHL. However, the law permits certain persons, known as “qualified persons,” to access these records and documents. A qualified person includes an individual receiving services, his or her legal guardian, or a parent, spouse or adult child who has authority to provide consent for care and treatment (MHL Sections 33.16 (a) (6) and 33.16 (b) (4)).

There are some restrictions on a qualified person’s right to obtain records and documents. For example:

1. Access to certain records and documents may be limited if the information is expected to be harmful to the individual receiving services or others (See What happens if the request for records is denied?);

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

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

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

While the general public may also request certain records from governmental or “public” agencies under the New York State Free-

dom of Information Law (FOIL), FOIL is not the appropriate way to seek information about an individual’s care and treatment. Under FOIL, personally identifying information, as well as other information deemed confidential and protected from disclosure under other statutes, such as Article 33 of the MHL, cannot be released in response to a FOIL request.

Who should the request for records be directed to?

Requests for clinical records should be sent to the provider serving the individual. Requests for clinical records must be made in writing.

Requests for records and documents pertaining to allegations and investigations into abuse and mistreatment should be sent to the provider which was serving the individual at the time the abuse or mistreatment is alleged to have taken place.

If OMH, OASAS or CQCAPD conducted an investigation, requests for records and documents pertaining to that investigation should be directed to the appropriate State agency:

NYS Office of Mental Health  
Office of Quality Management  
44 Holland Avenue  
Albany, NY 12229

NYS Office of Alcoholism and Substance Abuse Services  
Bureau of Standards Compliance  
1450 Western Avenue  
Albany, NY 12203

NYS Commission on Quality of Care and  
Advocacy for Persons with Disabilities  
Records Access Officer  
401 State Street  
Schenectady, NY 12305

If OPWDD conducted an investigation, requests for records and documents should be sent to the Director of the local Developmental Disabilities Services Office (DDSO) responsible for oversight of services in the region in which the abuse or mistreatment is alleged to have taken place.

Requests for records and documents pertaining to allegations and investigations into abuse and mistreatment must be made in writing.

When can records be requested?

Clinical records can be requested at any time.

Records and documents pertaining to allegations and investigations into abuse and mistreatment can be requested at any time for allegations of abuse or mistreatment which occurred or were discovered on or after May 5, 2007. Requests can also be made for records and documents pertaining to allegations of abuse or mistreatment which occurred or were discovered on or after January 1, 2003 if the request is made, in writing, on or before December 31, 2012.

### When will records be provided?

The provider must offer an opportunity for a qualified person to come to the facility or other designated location and read a clinical record within 10 days of receipt of the request (MHL Section 33.16 (b) (1)). If copies are requested, they must be provided within a reasonable time (MHL Section 33.16 (b) (5)), and a reasonable charge, not to exceed \$.75/page, can be imposed for inspections and copies (MHL Section 33.16 (b) (6)). If a request to review clinical records or obtain copies is denied, the denial can be appealed. (See What happens if the request for records is denied?)

Records and documents pertaining to allegations and investigations into abuse and mistreatment must be provided within 21 days of receipt of the request if an investigation has been concluded. If the investigation has not been concluded when the request is received, the records and documents must be provided within 21 days of the conclusion of the investigation (MHL Section 33.25 (a)).

### Will the whole record be provided?

Clinical records may be "redacted" or edited to withhold or delete information determined by the facility to be harmful to the subject of the clinical record or others (MHL Section 33.16 (c)). (See What happens if the request for records is denied?)

Records and documents pertaining to allegations and investigations into patient abuse and mistreatment will be redacted to delete the names and other personally identifying information of other individuals receiving services and employees unless such individuals authorize disclosure (MHL Section 33.25 (a)). The MHL requires that records and documents regarding allegations and investigations into abuse and mistreatment provided in response to a request from a "qualified person" not be shared with other people (MHL Section 33.25 (b)).

### Under what circumstances can a request for records be denied?

MHL Section 33.16 sets out rules for access to clinical records by individuals receiving services and other qualified persons. Generally, these individuals have a qualified right of access to the clinical record unless the treating practitioner primarily responsible for the care and treatment of the individual receiving services determines that the requested review of the clinical record can reasonably be expected to cause substantial and identifiable harm to the individual receiving services or others which outweighs the right of access (MHL Section 33.16 (c)).

### If a clinical determination is made to deny access to a clinical record, in whole or in part, what can the qualified person do?

MHL Section 33.16 (c) (4) creates a Clinical record Access Review Committee (Committee) in OMH, OPWDD and OASAS. The Committees must consist of three to five members, appointed by the appropriate commissioners. The review process works like this:

1. A provider must notify a qualified person of its decision in reply to a records access request.
2. If the decision is to deny access to the records, in whole or in part, the provider must notify the qualified person of its decision, and it must inform the qualified person of his/her right to obtain a review of the denial, free of charge, by the Committee. This notice must explain how a qualified person can request a review by the Committee.
3. If the qualified person requests a review, the provider must send the clinical record to the Committee within 10 days, explaining the specific reasons for denying access to the record.
4. The Committee will conduct a review of the entire clinical record, and will offer the qualified person and other involved parties an opportunity to be heard. The Committee will issue a decision promptly, based upon its assessment of whether the risk of harm in releasing the information sought outweighs the qualified person's right of access. The Committee may decide to affirm the denial in whole or in part, or may decide to expand access. The Committee determination is binding on the provider.
5. If the Committee denies any part of the request for access, it must notify the qualified person of his/her right to seek judicial review. Within 30 days of the receipt of that decision, the qualified person may commence a special proceeding in New York State Supreme Court for a review of the provider's decision. The Court will conduct a review of the record, give parties an opportunity to be heard, and issue its ruling. The Court may order the provider to make the record available to the qualified person for inspection or copying. (Note: in OASAS-operated or certified programs, Federal confidentiality requirements take precedence over New York State law and the courts will abide by the stricter rules on access published by the United States Department of Health and Human Services.)

For further information regarding access to mental hygiene records and documents, or for assistance in securing records and documents, please contact:

NYS Commission on Quality of Care and  
Advocacy for Persons with Disabilities  
401 State Street  
Schenectady, NY 12305  
1-800-624-4143 (toll-free, voice/TTY/Spanish)  
[www.cqc.ny.gov](http://www.cqc.ny.gov)

For more information about programs and services provided by OMH, OPWDD or OASAS, visit the State agency websites at:

[www.omh.ny.gov](http://www.omh.ny.gov)  
[www.opwdd.ny.gov](http://www.opwdd.ny.gov)  
[www.oasas.state.ny.us](http://www.oasas.state.ny.us)

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Includes

## "Jonathan's Law" Amendments



## NYS Commission on Quality of Care and Advocacy for Persons with Disabilities

**Andrew M. Cuomo, Governor**

**Roger Bearden, Chair**

**Bruce Blower and Pat Okoniewski  
Commission Members**