

Senate Bill No. 1415

Passed the Senate August 19, 2008

Secretary of the Senate

Passed the Assembly August 12, 2008

Chief Clerk of the Assembly

This bill was received by the Governor this _____ day
of _____, 2008, at _____ o'clock ____M.

Private Secretary of the Governor

CHAPTER _____

An act to add Section 123106 to the Health and Safety Code, relating to patient records.

LEGISLATIVE COUNSEL'S DIGEST

SB 1415, Kuehl. Patient records: maintenance and storage.

Existing law establishes procedures for providing access to various types of health care records, including patient records, as defined, by patients and persons having responsibility for decisions respecting the health care of others. Existing law gives health care providers, as defined, various responsibilities in connection with providing access to these records.

This bill would require certain health care providers who create patient records, at the time the initial patient record is created, to provide a statement to the patient, or the patient's representative, that sets forth the patient's rights, as specified, and the intended retention period for the records, as specified in applicable law or by the health care provider's retention policy. The bill would require the patient, or the patient's representative, to sign an acknowledgment of having received the statement described above, and would also require, if the patient, or the patient's representative, refuses to sign the acknowledgment, that this fact be included in the patient's record.

This bill would require certain health care providers that plan to destroy patient records earlier than the period specified in the statement, no fewer than 60 days before a patient's records are to be destroyed, to notify the patient that his or her records are scheduled to be destroyed, when they are scheduled to be destroyed, and set forth the patient's rights, as specified. The bill would require a health care provider to provide a patient with his or her original medical records that the provider plans to destroy earlier than the period specified in the statement if the patient makes a request for the records to the provider before the date of the proposed destruction of the records.

This bill would provide that the above provisions shall only apply to a health care provider, as defined, whose first visit with a patient occurs on or after January 1, 2009. It would also provide

that the above provisions shall not apply to a health care provider whose patient is a minor at the time the patient record is created.

This bill would provide for the issuance of citations and the assessment of administrative penalties for violation of the bill's requirements, as specified. The bill would exempt the patient records created by a psychiatrist, as defined, from the requirements of the bill.

The people of the State of California do enact as follows:

SECTION 1. Section 123106 is added to the Health and Safety Code, to read:

123106. (a) A health care provider described in paragraphs (4), (5), (6), (8), and (9) of subdivision (a) of Section 123105, who creates patient records, as defined in subdivision (d) of Section 123105, shall, at the time the initial patient record is created, provide a statement to the patient, or the patient's representative, that sets forth both of the following:

(1) The patient's rights under this chapter to inspect his or her medical records, obtain copies of his or her medical records, and to provide a written addendum, pursuant to Section 123111, with respect to any item or statement in the patient's records that the patient believes to be incomplete or incorrect.

(2) The intended retention period for the records, as specified in applicable law or by the health care provider's retention policy.

(b) The patient, or the patient's representative, shall sign an acknowledgment that he or she received the statement required pursuant to subdivision (a).

(c) Nothing in this section shall preclude the statement required pursuant to subdivision (a) from being included in another form or statement provided to the patient, or the patient's representative, at the time the initial patient record is created.

(d) If a patient, or the patient's representative, is provided a statement at the time that the initial patient record is created, and the patient, or the patient's representative, refuses to sign an acknowledgment that he or she received the statement, the patient's record shall indicate that the patient, or the patient's representative, refused to sign.

(e) If a health care provider to whom subdivision (a) applies plans to destroy patient records earlier than the period specified

in the statement, the health care provider shall, no fewer than 60 days before a patient's records are to be destroyed, notify the patient, via first-class mail, electronic mail, or both, to the patient's last known mailing or electronic mail address, or both. The notification shall inform the patient that his or her records are scheduled to be destroyed and the date of the proposed destruction of records. The notification shall also inform the patient of his or her rights under this chapter to inspect his or her medical records. A health care provider to whom subdivision (a) applies shall provide a patient with his or her original medical records that the provider plans to destroy earlier than the period specified in the statement required pursuant to subdivision (a) if the patient makes a request for the records to the health care provider before the date of the proposed destruction of the records. Nothing in this section shall be construed to reduce the length of record retention as otherwise required by law.

(f) A health care provider to whom subdivision (a) applies shall not be subject to this section for medical records that are created for a patient who is referred to the provider solely for a diagnostic evaluation, if the provider does not provide treatment to the patient and reports the results of the diagnostic evaluation to the patient's referring provider.

(g) This section shall only apply to a health care provider to whom subdivision (a) applies who creates an initial patient record for a patient whose first visit with the health care provider occurs on or after January 1, 2009.

(h) This section shall not apply to a health care provider to whom subdivision (a) applies whose patient is a minor at the time the patient record is created.

(i) A health care provider who violates this section may be cited and assessed an administrative penalty in accordance with Section 125.9 of the Business and Professions Code. No citation shall be issued and no penalty shall be assessed upon the first violation by a licensee of this section. Upon the second and each subsequent violation by a health care provider of this section, a citation may be issued and an administrative penalty may be assessed after appropriate notice and opportunity for hearings. Notwithstanding any other provision of law, the remedy described in this subdivision constitutes the exclusive remedy for a violation of this section.

However, nothing in this section affects other existing rights, duties, or remedies provided by law.

(j) The patient records created by a psychiatrist, including psychotherapy notes, as defined in Section 164.501 of Title 45 of the Code of Federal Regulations, are not subject to this section. For the purposes of this subdivision, “psychiatrist” means a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or pursuant to the Osteopathic Act, who devotes, or is reasonably believed by the patient to devote, a substantial portion of his or her time to the practice of psychiatry.

Approved _____, 2008

Governor