VSCSW

Ethics: How do you know you are doing the right thing?

Joseph G. Lynch LCSW, CSOTP

This workshop will explore Social Work Ethics in terms of placing Ethics into the overall context of Social Work practice. The chart below shows the context of Social Work practice. These areas will be explored examining the behaviors that Social Workers actually do that lead to ethics violation charges presented to the Virginia Board of Social Work, Malpractice claims and Professional Association complaints. Topics tool be examined include:

- Boundary crossings versus boundary violations
- Ethical decision making models
- Supreme court cases that establish Standards of Care for Social Workers regarding Privileged communication
- Slippery slope behaviors
- Ten Steps to manage Transference-Countertransference
- Typologies of Therapist Perpetrators
- Clinical Boundary Self Assessment tool for practitioners
- Elements of Malpractice

Goals and Objectives:

1) Place Social Work Ethics into context of Social Work Practice
2) Provide an Ethical Decision Making model
3) Explain Jaffee v. Redmond Supreme Court decision implications for Social Work Practice
4) Introduce Ten Steps to manage Transference and Countertransference
5) Introduce the Clinical Boundary Self Assessment tool
6) Demonstrate the four Elements of Malpractice
7) Identify sources of Standards of Care

Bio: Joseph G. Lynch LCSW, CSOTP

Joe is an LCSW with 37 years of clinical social work practice experience. He served on the Virginia Board of Social Work for ten years, chairing the Discipline Committee for nine years. Joe was adjunct faculty for the Social Work Program at James Madison University for 20 years teaching Social Work and the Law, Violence in Families and Working with Teenagers. Joe was instrumental in legislative efforts to accomplish vendorship for Social Workers, privileged communication for Social Workers, the Duty to Inform Statute to empower clients to file complaints against unethical practice by mental health professionals and establishment of the Certified Sex Offender Treatment Provider credential in Virginia.

Joe frequently presents educational programs on Ethics, Malpractice, Testifying in Court and other topics. Joe served on the State Human Rights Committee for the Department of Behavioral Health and Developmental Services. He has previously served on and chaired the Department of Health Professions, Health Practitioner Monitoring Program committee and many community Boards and Commissions in Harrisonburg. VSCSW awarded Joe with the first granting of the Lifetime achievement award in March 2011.He is a partner in private practice with Newman Avenue Associates in Harrisonburg VA.

Virginia Society for Clinical Social Work
Blue Ridge Chapter
March 15, 2013

SOCIAL WORK ETHICS:
How Do you Know if you are doing the right thing?

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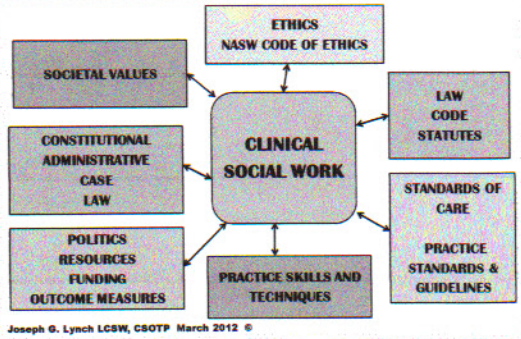
Ethical Issues in Providing Clinical Social Work: Context and Factors of Influence



Joseph G. Lynch LCSW, CSOTP March 2012 ©

ETHICS-DEFINITION

Ethics:
1. **The discipline dealing with what is good and bad and with moral duty and obligation.**
2. **A set of moral principles or values.**
3. **A theory or system of moral values.**
4. **The principals of conduct governing an individual or a group (professional)**
5. **Guiding philosophy**

By permission: From Merriam-Webster's Collegiate Dictionary, 2001.

ETHICS-PROFESSIONAL

Ronald K. Bullis defines professional ethics as "a system of norms." Professional ethics are ethical determinations and guidelines specifically determined by or specifically determined for a professional group. Professional norms can be operationalized by a code of ethics.

Leila O. Schroeder notes that one hallmark of a profession is a codified system of ethics. Unless the provisions of this or similar code are incorporated into state law, even if only by reference, their observance is voluntary, not mandatory

ETHICAL THEORIES

Metaethics- concerns the meaning of ethical terms or language and the derivation of ethical principles and guidelines- "Good" vs. "Bad."

Normative Ethics- attempts to apply ethical theories and principles to actual ethical dilemmas. Conflicting duties.

A. Deontological- certain actions are inherently right or wrong

B. Teleological- the rightness of any action is determined by the goodness of its consequences.

Teleological

1. Egoism- when faced with conflicting duties you should maximize your own good and enhance your own self interest.
2. Utilitarianism- when faced with conflicting duties your action is right if it promotes the maximum good.
   - Good- aggregative- that which promotes the greatest total or aggregate good.
   - Locus-aggregative- that which promotes the greatest good for the greatest number.
     - ACT: considers only individual case
     - RULE: considers case as precedent setting.

"The Theory of Morality" Alan Donagan (1977)

- When choosing among duties that may result in harm, one should do that which results in the least harm.
- "Minimization of Suffering"- (Popper 1966)
- "Negative Utilitarianism" (Smart & Williams 1973)
- Rank ordering of values and ethical duties. Judgment about what values or duties will take precedence over others

ETHICAL PRINCIPLES SCREEN

1. Principle of the protection of life
2. Principle of equality and inequality
3. Principle of autonomy and freedom
4. Principle of least harm
5. Principle of quality of life
6. Principle of privacy and confidentiality
7. Principle of truthfulness and full disclosure

CLIENTS ?

PINCUS AND MINAHAN OFFER A VIEW OF A "CLIENT SYSTEM"

"... WE TAKE THE VIEW... THAT THE CLIENT SYSTEM AS THE INDIVIDUAL, FAMILY, GROUP, ORGANIZATION, OR COMMUNITY THAT, IN ADDITION TO BEING THE EXPECTED BENEFICIARY OF SERVICE, IS A SYSTEM THAT ASK FOR HELP AND ENGAGES THE SERVICES OF A SOCIAL WORKER AS A CHANGE AGENT. AND WE ADD A THIRD DIMENSION TO OUR VIEW OF A CLIENT SYSTEM- THE IDEA THAT PEOPLE BECOME CLIENTS ONLY WHEN A WORKING AGREEMENT OR CONTRACT HAS BEEN ESTABLISHED BETWEEN THEM AND A CHANGE AGENT... WE CALL THE PEOPLE THE CHANGE AGENT NEEDS TO CHANGE OR INFLUENCE IN ORDER TO ACCOMPLISH HIS GOALS THE "TARGET SYSTEM."

SOCIAL WORK PRACTICE BY PINCUS AND MINAHAN, CHAPTER 3, "FOUR BASIC SYSTEMS IN SOCIAL WORK PRACTICE"

WHAT IS A FORMER CLIENT?

PRACTITIONERS HAVE DIFFERENT VIEWS ON THE DEFINITION OF AN EX-CLIENT OR FORMER CLIENT. WHEN WOULD YOU CONSIDER SOMEONE TO WHOM YOU HAVE PROVIDED SERVICES TO BE AN EX-CLIENT?

THE THREE CATEGORIES AND RESULTS ARE:

FORMER CLIENT IS DEFINED:	% AGREE
1. AT THE TIME SERVICES ARE TERMINATED	40.9 %
2. ONCE A CLIENT, ALWAYS A CLIENT	46.8 %
3. OTHER *	12.1 %

(*INDICATED VARIOUS TIME PERIODS RANGES FROM SIX MONTHS TO TEN YEARS)

Social Work, January 2002, Mattison, Jayaratne and Croxton

FIDUCIARY DUTY

A person having duty, created by his undertaking, to act primarily for another's benefit in matters connected with such undertaking. The term is derived from the Roman law, and means a person holding the character of a trustee, or a character analogous to that of a trustee, in respect to the trust and confidence involved in it and the scrupulous good faith and candor which it requires.

Black's Law Dictionary, St. Paul Minn., West Publishing Co. 1990

MALPRACTICE

1. A ***professional relationship existed*** between the social worker and client. Only thus does a social worker incur a legal duty of care.
2. There is a ***demonstrable standard of care*** and the social worker breached that standard.
3. The client suffered ***harm or injury***, which must be demonstrated and established.
4. The social workers breach of duty to practice within the standard of care was the ***proximate cause*** of the client's injury: that is, the injury was a reasonable foreseeable consequence of the breach.

Adapted from: Professional Liability and Risk Management, by Bruce E. Bennett, Brenda Bryant, Gary R. VandenBos, and Addison Greenwood, Copyright 1990 by the American

Standard of Care

"What an ordinary, reasonable, and prudent professional, with the same or similar training, would have done under the same or similar circumstances."

SOURCES OF STANDARDS OF CARE OR STANDARDS OF PRACTICE

1. State licensing laws and regulations that define Standards of Practice
2. National professional associations that publish Codes of Ethics and Standards
3. Professional literature dealing with the area of practice.
4. Expert witnesses who can testify as to the current Standard of Care as it applies to the facts of the cast before the court

STANDARD OF PROOF

- ❑ Preponderance of evidence
- ❑ Clear and convincing
- ❑ Beyond a reasonable doubt

Preponderance of evidence = 51%

As a standard of proof in civil cases, is evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not.

Black's Law Dictionary, St. Paul Minn., West Publishing Co. 1990

Clear and convincing = 75%

That proof which results in reasonable certainty of the truth of the ultimate fact in controversy. Proof which requires more than a preponderance of the evidence but less than proof beyond a reasonable doubt. Clear and convincing proof will be show where the truth of the facts asserted is highly probable.

Black's Law Dictionary, St. Paul Minn., West Publishing Co. 1990

Beyond a reasonable doubt = 99%

In evidence means fully satisfied, entirely convinced, satisfied to a moral certainty; and phrase is the equivalent of the words clear, precise and indubitable.

Black's Law Dictionary, St. Paul Minn., West Publishing Co. 1990

Frequency and Relative Cost of Malpractice Claims Filed Against Individual Social Worker: 1969 to 1990 (Reamer, F. 1995) Top Items

Malpractice Category	n 634	% of n	%$ Paid	Cost Index
1. Incorrect Treatment	118	18.61	19.22	103
2. Sexual Impropriety	**117**	**18.45**	41.34	**224**
3. Suicide of Patient	32	5.05	10.77	213
4. Failure to warn a third party	8	1.26	2.58	205
TOTAL	275	43.37	73.91	

Frequent Ethical Areas of Difficulty

1) Boundaries:
   A. Typology of Boundary Crossings,
      i. Emotional and Dependency Needs
      ii. Personal Benefit
      iii. Altruism,
      iv. Unavoidable / Unintended Circumstances
      v. Slippery Slope Behaviors
   B. Boundary Violations,
   C. Typologies of Therapist Sexual Boundary Violators
      i. Rule Out Risk approach
      ii. Psychodynamic approach
      iii. Sexual Addiction approach
2) Termination of Services
3) Supervision of Other Clinicians

1. Boundaries

1. BOUNDARIES

Boundaries are the limits that allow for a safe connection based on the client's needs. When these limits are altered, what is allowed in the relationship becomes ambiguous. Such ambiguity is often experienced as an intrusion into the sphere of safety. The pain from a violation is frequently delayed, and the violation itself may not be recognized or felt until harmful consequences emerge.

At Personal Risk, Boundary Violations in Professional-Client Relationships, by Marilyn R. Peterson, W.W. Norton and Company, New York (1992).

A. Typology of Boundary Crossings

- EMOTIONAL AND DEPENDENCY NEEDS
- PERSONAL BENEFIT
- ALTURISM
- UNAVOIDABLE & UNANTICIPATED CIRCUMSTANCES

Frederic G. Reamer Ph.D., Tangled Relationships: Managing Boundary Issues in the Human Services, New York, Columbia University Press, 2001

Altruism

- **Giving gifts to clients**- books, flowers, or cards.
- **Meeting clients in social or community settings**- weddings, graduations, AA, church and other events.
- **Offering client favors**.-rides, unscheduled informal follow up session, housing, informal counseling friend or neighbor and at work, supervising a former client.
- **Accommodating clients**- home phone number, calls while worker is on vacation, free services, "exceptions" to usual practice.
- **Self Disclosure**- to establish empathy, trust, or acceptance but may cause confusion and boundary crossing.

Frederic G. Reamer Ph.D., Tangled Relationships: Managing Boundary Issues in the Human Services, New York, Columbia University Press, 2001

UNAVOIDABLE & UNANTICIPATED CIRCUMSTANCES

- Geographic Proximity- rural settings
- Conflict of Interest- former client now your child's teacher.
- Professional Encounters- client is appointed to the board of directors of which you are a member.

Frederic G. Reamer Ph.D., Tangled Relationships: Managing Boundary Issues in the Human Services, New York, Columbia University Press, 2001

B. BOUNDARY VIOLATIONS

Boundary violation are acts that breach the core intent of the professional-client association. They happen when the professional exploits the relationship to meet personal needs rather then client needs. Changing the fundamental principle undoes the covenant, altering the ethos of care that obligates professionals ***to place client' concerns first***. In fact, all of the boundaries in a professional-client relationship exist in order to protect this core understanding.

At Personal Risk, Boundary Violations in Professional-Client Relationships, by Marilyn R. Peterson, W.W. Norton and Company, New York (1992) (page 74-75)

Typologies of Therapist Sexual Boundary Violators

i. Rule Out Risk Approach

1. **Uninformed/Naive**
2. **Healthy or Mildly Neurotic**
3. **Severely Neurotic and or Socially Isolated**
4. **Impulsive Character Disorders**.
5. **Sociopathic or Narcissistic Character Disorder**
6. **Psychotic or Borderline Personalities**

Gonsiorek, J. C. & Schoener, G. R. (1989). Assessment and development of rehabilitation plans for the therapist. In Gonsiorek, E. T., Hofstee, J. Luepker, T & Schoener, G. R., *In psychotherapists' sexual involvement with clients: intervention and prevention* (pp. 401 - 410). Minneapolis, MN: Walk-in Counseling Center.

ii. Psychodynamic Approach

- **Psychotic Disorders**
- **Predatory Psychopathy and Paraphilias**
- **Masochistic Surrender**
- **Lovesick**

iii. Sexual Addiction

Archetypal Categorization

1. The Naive Prince 7.9%
2. The Wounded Warrior 22.7%
3. The Self-serving Martyr 25.0%
4. The False Lover 19.3%
5. The Dark King 13.6%
6. The Madman 11.4%

(The Wounded Healer, Irons & Schneider (1999) p. 102

"SLIPPERY SLOPE" BEHAVIORS

- Therapy sessions becomes less clinical and more social.
- Patient is treated as "special" or confidant.
- Therapist self-disclosures occur, usually about current personal problems and sexual fantasies about the patient.
- Therapist begins touching patient, progressing to hugs & embraces.
- Extra-therapeutic contacts occur.
- Therapist and patient have drinks/dinner after sessions; dating begins.
- Therapist-patient sex begins

Simon 1995

Some discipline cases are not typical professional misconduct but administrative as listed below:

REVIEW OF
VIRGINIA BOARD OF SOCIAL WORK DISCIPLINE CASES
FROM 1992 TO 2011
THAT RESULTED IN A BOARD ORDER

Some discipline cases are not typical professional misconduct but administrative as listed below:

NUMBER OF CASES DEALING WITH LICENSURE RENEWAL PROBLEMS (Usually these had to do with licensees not completing the correct number of continuing education hours to renew license)	30
NUMBER OF CASES WITH INCOMPLETE DATA TO DETERMINE DISCIPLINE ISSUE	3

When just looking at differentiating the sexual misconduct cases from no sexual misconduct cases these are the numbers:

NUMBER OF CASES DEALING WITH MISMANAGEMENT OF COUNTERTRANSFERENCE INVOLVING SEXUAL MISCONDUCT	18
NUMBER OF CASES WITH NO SEXUAL MISCONDUCT: (includes 33 above)	70
TOTAL NUMBER OF DISCIPLINE CASES OF THE VIRGINIA BOARD OF SOCIAL WORK FROM 1992 TO 2011	88

ANALYSIS:

The license renewal cases are primarily an administrative matter and minor infraction. If you remove those 30 cases from the total and the 3 cases that had incomplete data then that leaves 55 cases that involve some type of professional misconduct. The highest frequency type of discipline case is the mismanagement of countertransference with 18. That means that **33% of the VBSW discipline cases are mismanagement of countertransference involving sexual misconduct type cases.**

2. Termination of Services Therapeutic Abandonment?

- Once a therapist contracts to provide care to a patient, the therapist is legally and ethically bound to continue with care until the treatment relationship ends:
  - By mutual consent of the therapist and patient
  - The therapist withdraws with proper notice
  - The therapist transfers care to another mental health provider
  - The therapist services are no longer needed

3. Supervisor Liability

- Vicarious Liability for Social Work Supervisors
- Known Higher Risk Areas of Liability for Supervisors
- Seven Step Process to Demonstrate Meeting a Procedural Standard of Care

ETHICAL DECISION-MAKING PROTOCOL

(SEE HANDOUT)

1. Identify the ethical issues, including the social work values and duties that conflict.
2. Identify the individuals, groups, and organizations that are likely to be affected by the ethical decision.
3. Tentatively identify all possible courses of action and the participants involved in each, along with possible benefits and risk for each.
4. Thoroughly examine the reasons in favor or and opposed to each possible course of action, considering relevant: ethical theories, principles, and guidelines, codes of ethics and legal principles, social work practice theory and principles, personal values (including religious, cultural, and ethnic values and political ideology).
5. Consult with colleagues, and appropriate experts (such as agency staff, supervisors, and agency administrators, attorneys, ethics scholars, and ethics committees)
6. Make decision and document the decision making process.
7. Monitor, evaluate and document the decision.

The Social Work Ethics Audit, A Risk Management Tool, By Fredric G. Reamer, NASW Press, Washington, D. C. 2001

TEN BASIC STEPS TO MANAGE COUNTERTRANSFERENCE

1. Regardless of your theoretical orientation, become educated about transference and countertransference.
2. Limit physical contact and self-disclosure with all clients.
3. If a client test boundaries, remind them of the importance of limits in the therapeutic process.
4. Any client request for personal information must be redirected by asking why such information is pertinent to the client's situation and therapeutic progress.
5. If you are aware of your own boundary crossing behaviors then contact a supervisor, trusted colleague or your own personal therapist to review the meaning of the behavior.
6. Conduct periodic behavioral self inventories of slippery slope behaviors.
7. If any of the slippery slope behaviors are present then contact a supervisor, trusted colleague or your own personal therapist to review the behaviors.
8. Beware that some diagnostic categories are higher risk for boundary violations, such as Borderline Personality Disorder and Dissociative Identity Disorder
9. If treating any client with a higher risk diagnosis and you are aware of any "exceptions" you have made to your usual practice then contact a supervisor, trusted colleague or your own personal therapist to review the exceptions.
10 If you are aware of any sexual attraction to any client contact a supervisor, trusted colleague or consultant to review the feeling of attraction and document in the client record your consultation.

Self Assessment
Clinical Boundary Questionnaire

(see handout)

A tool for self assessment of slippery slope behaviors. It could be used in supervision also. This tool helps to raise the issue of boundaries and management of any early warning sign of boundary crossings.

Clinical Social Work Association Code of Ethics

(see handout)

I. General responsibilities of Clinical Social Workers
II. Responsibility to Clients
III. Confidentiality
IV. Relationship with Colleagues
V. Fee Arrangements
VI. Responsibilities to the Community
VII. Research and Scholarly activities
VIII. Public Statements

"An Ethical LCSW Complies With The Law"

- There are exceptions when the law and an ethical principal conflict and the LCSW must decide which direction to follow.
- In order to comply with the law one must know the law. Remember two old adages:
  - "Ignorance of the law is no excuse"
  - "If it is not written down it did not happen"
- What is an LCSW to do? (Short of going to law school- not really sure that would help)

Code of Virginia & Federal Law/Regulation

Joe's Code of Virginia, Federal Law/Regulation "In A Box"

A collection of statutes that most frequently apply to issues of concern to LCSW's in day to day practice.

Addresses some of the following questions:

- Does the law offer client communication confidentiality? § 8.01-399
- Do LCSW's have "privileged communication" with clients? § 801-400.2
- Can I charge a fee for a request to produce a copy of records? § 8.01-413
- What are the criteria for involuntary commitment? § 16.1-345
- Does a parent of an under 18 year old have a right to a copy of the record? § 20-124.6

More Questions 1

- If the child is over 18, attending college, on the parent's health insurance and attending college, does the parent have a right to the record? § 32.1-127.1:03
- What do I do when I get a subpoena? §32.1-127.1:03
- What do I do when I get a Subpoena Duces Tecum? § 32.1-127.1:03
- Can I get paid for my time appearing in court? Virginia State Bar: Rules for Professional Conduct, Rule 3.4
- What if the attorney says I am just a "fact witness" not an "expert witness"? Virginia State Bar: Rules for Professional Conduct, Rule 3.4

More Questions 2

- What are the 5 things that the Virginia Duty to Warn statute require me to do if I determine that there is an imminent threat to an identifiable third party? OR a threat to property? § 54.1-2400.1
- When do I have an "affirmative duty" to take an action and when will taking an action remove me from any "immunity" protections? For Example: § 54.1-2400.1, § 54.1-2400.4, § 63.2-1509 and §32.1-127.1:03

What about HIPAA- Health Insurance Portability and Accountability Act?

Privacy Rule	Security Rule
The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used.	Administrative Safeguards
	Physical Safeguards
	Technical Safeguards

Virginia Society for Clinical Social Work
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January 20, 2012

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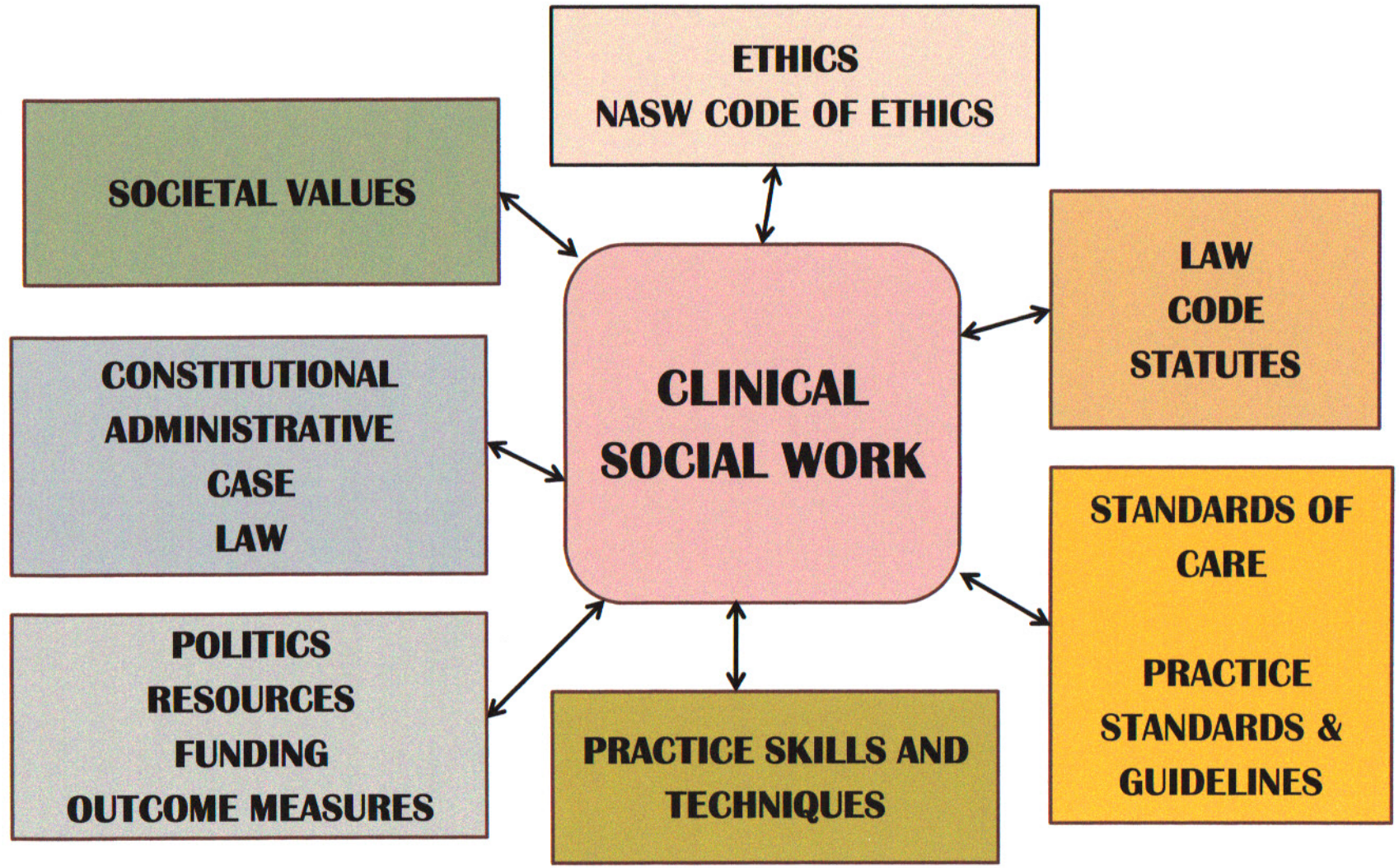

ETHICAL DECISION MAKING PROTOCOL

1. Identify the ethical issues, including the social work values and duties that conflict.

2. Identify the individuals, groups, and organizations that are likely to be affected by the ethical decision.

3. Tentatively identify all possible courses of action and the participants involved in each, along with possible benefits and risk for each.

4. Thoroughly examine the reasons in favor or and opposed to each possible course of action, considering relevant: ethical theories, principles, and guidelines, codes of ethics and legal principles, social work practice theory and principles, personal values (including religious, cultural, and ethnic values and political ideology).

5. Consult with colleagues, and appropriate experts (such as agency staff, supervisors, and agency administrators, attorneys, ethics scholars, and ethics committees)

6. Make decision and document the decision making process.

7. Monitor, evaluate and document the decision.

CLINICAL BOUNDARY QUESTIONNAIRE
SELF ASSESSMENT

	ANSWER THE FOLLOWING QUESTIONS ABOUT YOURSELF AND YOUR PRACTICE Rate as follows: 5= agree, 4=somewhat agree, 3= neither agree nor disagree 2= somewhat disagree,1= disagree	5	4	3	2	1
1	I am currently experiencing intimate relationship stress, separation or divorce.					
2	I do NOT routinely have clients call me by my first name and I do NOT routinely call clients by their first name but I have started to do this with a particular client.					
3	I have disclosed a client's problems to another client.					
4	I have revealed my personal problems in my life to clients.					
5	I have changed my seating arrangement with a client to now be side-by-side.					
6	I have made physical contact (other than a handshake) that is unique to a particular client.					
7	I have shared information about a client to others without a valid written authorization for release of that information.					
8	I have started scheduling a particular client for the end of the day.					
9	I have extended session length for a particular client.					
10	I have increased the number of sessions (on a weekly or monthly basis) for a particular client.					
11	I have stopped billing for sessions for a particular client even though I met at the office with that client.					
12	I am having serious questions about my sexual orientation.					
13	I am involved in providing treatment that includes physical touching of the client.					
14	If I answered "agree" or "somewhat agree" to Question #13, I **failed to** get written informed consent for this specific touching.					
15	I have engaged in behavior with a client that I would feel uncomfortable videotaping and showing to five mental health providers who do not know my work.					
16	I have had unintentional or unavoidable social contact with a client or former client.					
	FOR THE FOLLOWING QUESTIONS ANSWER "YES" OR "NO"	**YES**			**NO**	
17	I have allowed a client to barter for payment of fee for services.					
18	I have engaged in sexual contact with a client. (Sexual contact includes any touching of the client or the touching of you by the client on the breast or genitals. This includes touching under or over the client's clothing)					
19	I have engaged in sexual contact with a former client. (Sexual contact includes any touching of the client or the touching of you by the client o the breast or genitals. This includes touching under or over the clothing)					
20	I have verbally or in writing suggested to the client or former client that we engage in sexual contact?					
21	I have consumed alcohol and or drugs with a client or former client.					
22	I have engaged in a business, employment, or social relationship with a current client or former client. (business/employment includes lending or borrowing money to/from a client)					
23	I have terminated treatment with a client in order to begin a relationship outside of treatment.					
23	I have invited a client or former client to a social activity with me.					
24	I have lived in the same household with a client or former client.					

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CLINICAL BOUNDARY QUESTIONNAIRE
SELF ASSESSMENT

DESCRIPTION: The Clinical Boundary Questionnaire is an instrument designed to assess the degree to which appropriate boundaries are being maintained in the treatment relationship. Some of the questions are designed simply to raise awareness about the issue of boundaries in the treatment relationship. Some of the questions help identify workers that are on the "slippery slope" toward boundary violations and thus offer an opportunity for the individual therapist or supervisors to assist in preventing boundary violations. Other questions clearly identify that boundary violations have occurred and allow the individual therapist or supervisor to take appropriate action. Agencies can also use this as a tool to document their direct efforts to identify and to prevent boundary violations and thus manage agency vicarious liability exposure.

1. OPPORTUNITY FOR EDUCATION ABOUT BOUNDARIES:
If there are any scores in this area then use this as an opportunity for education about boundaries in the professional relationship.

If you answered "agree-5" or "somewhat agree -4" for one item #1-16.

2. POSSIBLE RISK FACTOR FOR BOUNDARY VIOLATION: If there are any scores in this area then a possible risk for boundary violation exist. The supervisor should explore with the worker the rational for changes in scheduling with a particular client. The behavior in question may be appropriate or it may be a beginning sign of the workers' counter transference issues that could impact case decisions. The worker may need to be sure they have adequate emotional support for themselves to deal with their current psychosocial stressors and the supervisor may need to monitor case assignment to avoid assigning cases that may risk mismanagement of counter transference by the worker.

If you answered "agree-5" or "somewhat agree-4" for more than 3 items #1-16

3. BOUNDARY VIOLATION HAS OCCURRED: If any scores in this area then a boundary violation has occurred and the supervisor must take appropriate actions to protect the client, deal with the worker, notify the agency of a possible liability for malpractice and conduct further investigation for this client and other client's safety.

If you answered "YES" to any item # 17-24

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CODE

OF

VIRGINIA

IMPORTANT STATUTES FOR LCSW'S

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§ 8.01-400.2. 3
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§ 8.01-413. 4
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§ 63.2-1509. 49
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§ 63.2-1605. 52
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Protection of aged or incapacitated adults; mandated and voluntary reporting.

§ 8.01-399

Communications between physicians and patients
(Supreme Court Rule 2:505 derived from this section).

A. Except at the request or with the consent of the patient, or as provided in this section, no duly licensed practitioner of any branch of the healing arts shall be permitted to testify in any civil action, respecting any information that he may have acquired in attending, examining or treating the patient in a professional capacity.

B. If the physical or mental condition of the patient is at issue in a civil action, the diagnoses, signs and symptoms, observations, evaluations, histories, or treatment plan of the practitioner, obtained or formulated as contemporaneously documented during the course of the practitioner's treatment, together with the facts communicated to, or otherwise learned by, such practitioner in connection with such attendance, examination or treatment shall be disclosed but only in discovery pursuant to the Rules of Court or through testimony at the trial of the action. In addition, disclosure may be ordered when a court, in the exercise of sound discretion, deems it necessary to the proper administration of justice. However, no order shall be entered compelling a party to sign a release for medical records from a health care provider unless the health care provider is not located in the Commonwealth or is a federal facility. If an order is issued pursuant to this section, it shall be restricted to the medical records that relate to the physical or mental conditions at issue in the case. No disclosure of diagnosis or treatment plan facts communicated to, or otherwise learned by, such practitioner shall occur if the court determines, upon the request of the patient, that such facts are not relevant to the subject matter involved in the pending action or do not appear to be reasonably calculated to lead to the discovery of admissible evidence. Only diagnosis offered to a reasonable degree of medical probability shall be admissible at trial.

C. This section shall not (i) be construed to repeal or otherwise affect the provisions of § 65.2-607 relating to privileged communications between physicians and surgeons and employees under the Workers' Compensation Act; (ii) apply to information communicated to any such practitioner in an effort unlawfully to procure a narcotic drug, or unlawfully to procure the administration of any such drug; or (iii) prohibit a duly licensed practitioner of the healing arts, or his agents, from disclosing information as required by state or federal law.

D. Neither a lawyer nor anyone acting on the lawyer's behalf shall obtain, in connection with pending or threatened litigation, information concerning a patient from a practitioner of any branch of the healing arts without the consent of the patient, except through discovery pursuant to the Rules of Supreme Court as herein provided. However, the prohibition of this subsection shall not apply to:

1. Communication between a lawyer retained to represent a practitioner of the healing arts, or that lawyer's agent, and that practitioner's employers, partners, agents, servants, employees, co-employees or others for whom, at law, the practitioner is or may be liable or who, at law, are or may be liable for the practitioner's acts or omissions;

2. Information about a patient provided to a lawyer or his agent by a practitioner of the healing arts employed by that lawyer to examine or evaluate the patient in accordance with Rule 4:10 of the Rules of Supreme Court; or

§ 8.01-400.2.

Communications between certain mental health professionals and clients.

Except at the request of or with the consent of the client, no licensed professional counselor, as defined in § 54.1-3500; licensed clinical social worker, as defined in § 54.1-3700; licensed psychologist, as defined in § 54.1-3600; or licensed marriage and family therapist, as defined in § 54.1-3500, shall be required in giving testimony as a witness in any civil action to disclose any information communicated to him in a confidential manner, properly entrusted to him in his professional capacity and necessary to enable him to discharge his professional or occupational services according to the usual course of his practice or discipline, wherein such person so communicating such information about himself or another is seeking professional counseling or treatment and advice relative to and growing out of the information so imparted; provided, however, that when the physical or mental condition of the client is at issue in such action, or when a court, in the exercise of sound discretion, deems such disclosure necessary to the proper administration of justice, no fact communicated to, or otherwise learned by, such practitioner in connection with such counseling, treatment or advice shall be privileged, and disclosure may be required. The privileges conferred by this section shall not extend to testimony in matters relating to child abuse and neglect nor serve to relieve any person from the reporting requirements set forth in § 63.2-1509.

(1982, c. 537; 2005, c. 110.)

§ 8.01-413.

Certain copies of health care provider's records or papers of patient admissible; right of patient, his attorney and authorized insurer to copies of such records or papers; subpoena; damages, costs and attorneys' fees.

A. In any case where the hospital, nursing facility, physician's, or other health care provider's original records or papers of any patient in a hospital or institution for the treatment of physical or mental illness are admissible or would be admissible as evidence, any typewritten copy, photograph, photostatted copy, or microphotograph or printout or other hard copy generated from computerized or other electronic storage, microfilm, or other photographic, mechanical, electronic or chemical storage process thereof shall be admissible as evidence in any court of this Commonwealth in like manner as the original, if the printout or hard copy or microphotograph or photograph is properly authenticated by the employees having authority to release or produce the original records.

Any hospital, nursing facility, physician, or other health care provider whose records or papers relating to any such patient are subpoenaed for production as provided by law may comply with the subpoena by a timely mailing to the clerk issuing the subpoena or in whose court the action is pending properly authenticated copies, photographs or microphotographs in lieu of the originals. The court whose clerk issued the subpoena or, in the case of an attorney-issued subpoena, in which the action is pending, may, after notice to such hospital, nursing facility, physician, or other health care provider, enter an order requiring production of the originals, if available, of any stored records or papers whose copies, photographs or microphotographs are not sufficiently legible.

Except as provided in subsection G, the party requesting the subpoena duces tecum or on whose behalf an attorney-issued subpoena duces tecum was issued shall be liable for the reasonable charges of the hospital, nursing facility, physician, or other health care provider for the service of maintaining, retrieving, reviewing, preparing, copying and mailing the items produced. Except for copies of X-ray photographs, however, such charges shall not exceed $0.50 for each page up to 50 pages and $0.25 a page thereafter for copies from paper or other hard copy generated from computerized or other electronic storage, or other photographic, mechanical, electronic, imaging or chemical storage process and $1 per page for copies from microfilm or other micrographic process, plus all postage and shipping costs and a search and handling fee not to exceed $10.

Upon request, a patient's account balance or itemized listing of charges maintained by a health care provider shall be supplied at no cost up to three times every twelve months to either the patient or the patient's attorney.

B. Copies of hospital, nursing facility, physician's, or other health care provider's records or papers shall be furnished within 15 days of receipt of such request to the patient, his attorney, his executor or administrator, or an authorized insurer upon such patient's, attorney's, executor's, administrator's, or authorized insurer's written request, which request shall comply with the requirements of subsection E of § 32.1-127.1:03.

However, copies of a patient's records shall not be furnished to such patient when the patient's treating physician or clinical psychologist, in the exercise of professional judgment, has made a part of the patient's records a written statement that in his opinion the furnishing to or review by the patient of such records would be reasonably likely to endanger the life or physical safety of the patient or another person, or that such health records make reference to a person, other than a health care provider, and the access requested would be reasonably likely to cause substantial harm to such referenced person. In any such case, if requested by the patient or his attorney or authorized insurer, such records shall be furnished within 15 days of the date of such request to the patient's attorney or authorized insurer, rather than to the patient.

If the records are not provided to the patient in accordance with this section, then, if requested by the patient, the hospital, nursing facility, physician, or other health care provider denying the request shall comply with the patient's request to either (i) provide a copy of the records to a physician or clinical psychologist of the patient's choice whose licensure, training, and experience, relative to the patient's condition, are at least equivalent to that of the treating physician or clinical psychologist upon whose opinion the denial is based, who shall, at the patient's expense, make a judgment as to whether to make the records available to the patient or (ii) designate a physician or clinical psychologist, whose licensure, training, and experience, relative to the patient's condition, are at least equivalent to that of the treating physician or clinical psychologist upon whose opinion the denial is based and who did not participate in the original decision to deny the patient's request for his records, who shall, at the expense of the provider denying access to the patient, review the records and make a judgment as to whether to make the records available to the patient. In either such event, the hospital, nursing facility, physician, or other health care provider denying the request shall comply with the judgment of the reviewing physician or clinical psychologist.

Except as provided in subsection G, a reasonable charge may be made by the hospital, nursing facility, physician or other health care provider maintaining the records for the cost of the services relating to the maintenance, retrieval, review, and preparation of the copies of the records. Except for copies of X-ray photographs, however, such charges shall not exceed $0.50 per page for up to 50 pages and $0.25 a page thereafter for copies from paper or other hard copy generated from computerized or other electronic storage, or other photographic, mechanical, electronic, imaging or chemical storage process and $1 per page for copies from microfilm or other micrographic process, a fee for search and handling, not to exceed $10, and all postage and shipping costs. Any hospital, nursing facility, physician, or other health care provider receiving such a request from a patient's attorney or authorized insurer shall require a writing signed by the patient confirming the attorney's or authorized insurer's authority to make the request and shall accept a photocopy, facsimile, or other copy of the original signed by the patient as if it were an original.

Upon request, a patient's account balance or itemized listing of charges maintained by a health care provider shall be supplied at no cost up to three times every twelve months to either the patient or the patient's attorney.

C. Upon the failure of any hospital, nursing facility, physician, or other health care provider to comply with any written request made in accordance with subsection B within the period of time

specified in that subsection and within the manner specified in subsections E and F of § 32.1-127.1:03, the patient, his attorney, his executor or administrator, or authorized insurer may cause a subpoena duces tecum to be issued. The subpoena may be issued (i) upon filing a request therefor with the clerk of the circuit court wherein any eventual suit would be required to be filed, and upon payment of the fees required by subdivision A 18 of § 17.1-275, and fees for service or (ii) by the patient's attorney in a pending civil case in accordance with § 8.01-407 without payment of the fees established in subdivision A 23 of § 17.1-275. A sheriff shall not be required to serve an attorney-issued subpoena that is not issued at least five business days prior to the date production of the record is desired. The subpoena shall be returnable within 20 days of proper service, directing the hospital, nursing facility, physician, or other health care provider to produce and furnish copies of the reports and papers to the clerk who shall then make the same available to the patient, his attorney or authorized insurer. If the court finds that a hospital, nursing facility, physician, or other health care provider willfully refused to comply with a written request made in accordance with subsection B, either by willfully or arbitrarily refusing or by imposing a charge in excess of the reasonable expense of making the copies and processing the request for records, the court may award damages for all expenses incurred by the patient or authorized insurer to obtain such copies, including court costs and reasonable attorney's fees.

D. The provisions of subsections A, B, and C hereof shall apply to any health care provider whose office is located within or without the Commonwealth if the records pertain to any patient who is a party to a cause of action in any court in the Commonwealth of Virginia, and shall apply only to requests made by the patient, his attorney, his executor or administrator, or any authorized insurer, in anticipation of litigation or in the course of litigation.

E. Health care provider, as used in this section, shall have the same meaning as provided in § 32.1-127.1:03 and shall also include an independent medical copy retrieval service contracted to provide the service of retrieving, reviewing, and preparing such copies for distribution.

F. Notwithstanding the authorization to admit as evidence patient records in the form of microphotographs, prescription dispensing records maintained in or on behalf of any pharmacy registered or permitted in Virginia shall only be stored in compliance with §§ 54.1-3410, 54.1-3411 and 54.1-3412.

G. The provisions of this section governing fees that may be charged by a health care provider whose records are subpoenaed or requested pursuant to this section shall not apply in the case of any request by a patient for his own records, which shall be governed by subsection J of § 32.1-127.1:03. This subsection shall not be construed to affect other provisions of state or federal statute, regulation or any case decision relating to charges by health care providers for copies of records requested by any person other than a patient when requesting his own records pursuant to subsection J of § 32.1-127.1:03.

(Code 1950, § 8-277.1; 1954, c. 329; 1976, c. 50; 1977, cc. 208, 617; 1981, c. 457; 1982, c. 378; 1990, cc. 99, 320; 1992, c. 696; 1994, cc. 390, 572; 1995, c. 586; 1997, c. 682; 1998, c. 470; 2000, cc. 813, 923; 2001, c. 567; 2002, cc. 463, 654; 2004, cc. 65, 335, 742, 1014; 2005, cc. 642, 697; 2009, c. 270.)

§ 16.1-345.

Involuntary commitment; criteria.

After observing the minor and considering (i) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the minor, (iii) any past mental health treatment of the minor, (iv) any qualified evaluator's report, (v) any medical records available, (vi) the preadmission screening report, and (vii) any other evidence that may have been admitted, the court shall order the involuntary commitment of the minor to a mental health facility for treatment for a period not to exceed 90 days if it finds, by clear and convincing evidence, that:

1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;

2. The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment; and

3. If the court finds that inpatient treatment is not the least restrictive treatment, the court shall consider entering an order for mandatory outpatient treatment pursuant to § 16.1-345.2.

Upon the expiration of an order for involuntary commitment, the minor shall be released unless he is involuntarily admitted by further petition and order of a court, which shall be for a period not to exceed 90 days from the date of the subsequent court order, or the minor or his parent rescinds the objection to inpatient treatment and consents to admission pursuant to § 16.1-338 or subsection D of § 16.1-339 or the minor is ordered to mandatory outpatient treatment pursuant to § 16.1-345.2.

A minor who has been hospitalized while properly detained by a juvenile and domestic relations district court shall be returned to the detention home, shelter care, or other facility approved by the Department of Juvenile Justice by the sheriff serving the jurisdiction where the minor was detained within 24 hours following completion of a period of inpatient treatment, unless the court having jurisdiction over the case orders that the minor be released from custody. However, such a minor shall not be eligible for mandatory outpatient treatment.

In conducting an evaluation of a minor who has been properly detained, if the evaluator finds, irrespective of the fact that the minor has been detained, that the minor meets the criteria for involuntary commitment in this section, the evaluator shall recommend that the minor meets the criteria for involuntary commitment.

If the parent or parents with whom the minor resides are not willing to approve the proposed commitment, the court shall order inpatient treatment only if it finds, in addition to the criteria specified in this section, that such treatment is necessary to protect the minor's life, health, safety, or normal development. If a special justice believes that issuance of a removal order or protective order may be in the child's best interest, the special justice shall report the matter to the local department of social services for the county or city where the minor resides.

§ 18.2-67.10.

General definitions.

As used in this article:

1. "Complaining witness" means the person alleged to have been subjected to rape, forcible sodomy, inanimate or animate object sexual penetration, marital sexual assault, aggravated sexual battery, or sexual battery.

2. "Intimate parts" means the genitalia, anus, groin, breast, or buttocks of any person.

3. "Mental incapacity" means that condition of the complaining witness existing at the time of an offense under this article which prevents the complaining witness from understanding the nature or consequences of the sexual act involved in such offense and about which the accused knew or should have known.

4. "Physical helplessness" means unconsciousness or any other condition existing at the time of an offense under this article which otherwise rendered the complaining witness physically unable to communicate an unwillingness to act and about which the accused knew or should have known.

5. The complaining witness's "prior sexual conduct" means any sexual conduct on the part of the complaining witness which took place before the conclusion of the trial, excluding the conduct involved in the offense alleged under this article.

6. "Sexual abuse" means an act committed with the intent to sexually molest, arouse, or gratify any person, where:

a. The accused intentionally touches the complaining witness's intimate parts or material directly covering such intimate parts;

b. The accused forces the complaining witness to touch the accused's, the witness's own, or another person's intimate parts or material directly covering such intimate parts;

c. If the complaining witness is under the age of 13, the accused causes or assists the complaining witness to touch the accused's, the witness's own, or another person's intimate parts or material directly covering such intimate parts; or

d. The accused forces another person to touch the complaining witness's intimate parts or material directly covering such intimate parts.

(1981, c. 397; 1987, c. 277; 1993, c. 549; 1994, c. 568; 2004, c. 741.)

Title 20 DOMESTIC RELATIONS
Chapter 6.1 Custody and Visitation Arrangements for Minor Children (20-124.1 thru 20-124.6)

§ 20-124.6. Access to minor's records.

A. Notwithstanding any other provision of law, neither parent, regardless of whether such parent has custody, shall be denied access to the academic or health records of that parent's minor child unless otherwise ordered by the court for good cause shown or pursuant to subsection B.

B. In the case of health records, access may also be denied if the minor's treating physician or the minor's treating clinical psychologist has made a part of the minor's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the requesting parent of such health records would be reasonably likely to cause substantial harm to the minor or another person. If a health care entity denies a parental request for access to, or copies of, a minor's health record, the health care entity denying the request shall comply with the provisions of subsection F of § 32.1-127.1:03. The minor or his parent, either or both, shall have the right to have the denial reviewed as specified in subsection F of § 32.1-127.1:03 to determine whether to make the minor's health record available to the requesting parent.

C. For the purposes of this section, the meaning of the term "health record" or the plural thereof and the term "health care entity" shall be as defined in subsection B of § 32.1-127.1:03.

(1994, c. 769; 2000, c. 485; 2005, cc. 181, 227.)

Title 54.1 Professions and Occupations
Chapter 24 General Provisions (54.1-2400 thru 54.1-2409.4)

§ 54.1-2400.4. Mental health service providers duty to inform; immunity; civil penalty.

A. Any mental health service provider, as defined in § 54.1-2400.1, shall, upon learning of evidence that indicates a reasonable probability that another mental health provider is or may be guilty of a violation of standards of conduct as defined in statute or regulation, advise his patient of his right to report such misconduct to the Department of Health Professions, hereinafter referred to as the "Department."

B. The mental health service provider shall provide relevant information to the patient, including, but not limited to, the Department's toll-free complaint hotline number for consumer complaints and written information, published by the Department of Health Professions, explaining how to file a report. The mental health service provider shall document in the patient's record the alleged misconduct, the category of licensure or certification, and approximate dates of treatment, if known, of the mental health service provider who will be the subject of the report, and the action taken by the mental health service provider to inform the patient of his right to file a complaint with the Department of Health Professions.

C. Any mental health service provider informing a patient of his right to file a complaint against a regulated person and providing the information required by this section shall be immune from any civil liability or criminal prosecution resulting therefrom unless such person acted in bad faith or with malicious intent.

D. Notwithstanding any other provision of law, any person required to inform a patient of his right to file a complaint against a regulated person pursuant to this section who fails to do so shall be subject to a civil penalty not to exceed $100.

(2000, c. 578.)

§ 32.1-127.1:03. Health records privacy.

A. There is hereby recognized an individual's right of privacy in the content of his health records. Health records are the property of the health care entity maintaining them, and, except when permitted or required by this section or by other provisions of state law, no health care entity, or other person working in a health care setting, may disclose an individual's health records.

Pursuant to this subsection:

1. Health care entities shall disclose health records to the individual who is the subject of the health record, except as provided in subsections E and F and subsection B of § 8.01-413.

2. Health records shall not be removed from the premises where they are maintained without the approval of the health care entity that maintains such health records, except in accordance with a court order or subpoena consistent with subsection C of § 8.01-413 or with this section or in accordance with the regulations relating to change of ownership of health records promulgated by a health regulatory board established in Title 54.1.

3. No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure. This redisclosure prohibition shall not, however, prevent (i) any health care entity that receives health records from another health care entity from making subsequent disclosures as permitted under this section and the federal Department of Health and Human Services regulations relating to privacy of the electronic transmission of data and protected health information promulgated by the United States Department of Health and Human Services as required by the Health Insurance Portability and Accountability Act (HIPAA)(42 U.S.C. § 1320d et seq.) or (ii) any health care entity from furnishing health records and aggregate or other data, from which individually identifying prescription information has been removed, encoded or encrypted, to qualified researchers, including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

4. Health care entities shall, upon the request of the individual who is the subject of the health record, disclose health records to other health care entities, in any available format of the requestor's choosing, as provided in subsection E.

B. As used in this section:

"Agent" means a person who has been appointed as an individual's agent under a power of attorney for health care or an advance directive under the Health Care Decisions Act (§ 54.1-2981 et seq.).

"Certification" means a written representation that is delivered by hand, by first-class mail, by overnight delivery service, or by facsimile if the sender obtains a facsimile-machine-generated confirmation reflecting that all facsimile pages were successfully transmitted.

"Guardian" means a court-appointed guardian of the person.

"Health care clearinghouse" means, consistent with the definition set out in 45 C.F.R. § 160.103, a public or private entity, such as a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions: (i) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or (ii) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

"Health care entity" means any health care provider, health plan or health care clearinghouse.

"Health care provider" means those entities listed in the definition of "health care provider" in § 8.01-581.1, except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered or permitted or who hold a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Health plan" means an individual or group plan that provides, or pays the cost of, medical care. "Health plan" shall include any entity included in such definition as set out in 45 C.F.R. § 160.103.

"Health record" means any written, printed or electronically recorded material maintained by a health care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health record" also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual.

"Health services" means, but shall not be limited to, examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind, as well as payment or reimbursement for any such services.

"Individual" means a patient who is receiving or has received health services from a health care entity.

"Individually identifying prescription information" means all prescriptions, drug orders or any other prescription information that specifically identifies an individual.

"Parent" means a biological, adoptive or foster parent.

"Psychotherapy notes" means comments, 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 with an individual or a group, joint, or family counseling session that are separated from the rest of the individual's health record. "Psychotherapy notes" shall not include annotations relating to medication and prescription monitoring, counseling session start and stop times, treatment modalities and frequencies, clinical test results, or any summary of any symptoms, diagnosis, prognosis, functional status, treatment plan, or the individual's progress to date.

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§ 65.2-604 and 65.2-607 of the Virginia Workers' Compensation Act;

2. Except where specifically provided herein, the health records of minors; or

3. The release of juvenile health records to a secure facility or a shelter care facility pursuant to § 16.1-248.3.

D. Health care entities may, and, when required by other provisions of state law, shall, disclose health records:

1. As set forth in subsection E, pursuant to the written authorization of (i) the individual or (ii) in the case of a minor, (a) his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § 54.1-2969 or (b) the minor himself, if he has consented to his own treatment pursuant to § 54.1-2969, or (iii) in emergency cases or situations where it is impractical to obtain an individual's written authorization, pursuant to the individual's oral authorization for a health care provider or health plan to discuss the individual's health records with a third party specified by the individual;

2. In compliance with a subpoena issued in accord with subsection H, pursuant to a search warrant or a grand jury subpoena, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § 8.01-413. Regardless of the manner by which health records relating to an individual are compelled to be disclosed pursuant to this subdivision, nothing in this subdivision shall be construed to prohibit any staff or employee of a health care entity from providing information about such individual to a law-enforcement officer in connection with such subpoena, search warrant, or court order;

3. In accord with subsection F of § 8.01-399 including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a health care entity or the health care entity's employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

4. In testimony in accordance with §§ 8.01-399 and 8.01-400.2;

5. In compliance with the provisions of § 8.01-413;

6. As required or authorized by law relating to public health activities, health oversight activities, serious threats to health or safety, or abuse, neglect or domestic violence, relating to contagious disease, public safety, and suspected child or adult abuse reporting requirements, including, but not limited to, those contained in §§ 32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-127.1:04, 32.1-276.5, 32.1-283, 32.1-283.1, 32.1-320, 37.2-710, 37.2-839, 53.1-40.10, 54.1-2400.6, 54.1-2400.7, 54.1-2403.3, 54.1-2506, 54.1-2966, 54.1-2966.1, 54.1-2967, 54.1-2968, 54.1-3408.2, 63.2-1509, and 63.2-1606;

7. Where necessary in connection with the care of the individual;

8. In connection with the health care entity's own health care operations or the health care operations of another health care entity, as specified in 45 C.F.R. § 164.501, or in the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§ 54.1-3410, 54.1-3411, and 54.1-3412;

9. When the individual has waived his right to the privacy of the health records;

10. When examination and evaluation of an individual are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such order;

11. (Effective until October 1, 2012) To the guardian ad litem and any attorney representing the respondent in the course of a guardianship proceeding of an adult patient who is the respondent in a proceeding under Chapter 10 (§ 37.2-1000 et seq.) of Title 37.2;

11. (Effective October 1, 2012) To the guardian ad litem and any attorney representing the respondent in the course of a guardianship proceeding of an adult patient who is the respondent in a proceeding under Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2;

12. To the guardian ad litem and any attorney appointed by the court to represent an individual who is or has been a patient who is the subject of a commitment proceeding under § 19.2-169.6, Article 5 (§ 37.2-814 et seq.) of Chapter 8 of Title 37.2, Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, or a judicial authorization for treatment proceeding pursuant to Chapter 11 (§ 37.2-1100 et seq.) of Title 37.2;

13. To a magistrate, the court, the evaluator or examiner required under Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1 or § 37.2-815, a community services board or behavioral health authority or a designee of a community services board or behavioral health authority, or a law-enforcement officer participating in any proceeding under Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, § 19.2-169.6, or Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 regarding the subject of the proceeding, and to any health care provider evaluating or providing services to the person who is the subject of the proceeding or monitoring the person's adherence to a treatment plan ordered under those provisions. Health records disclosed to a law-enforcement officer shall be limited to information necessary to protect the officer, the person, or the public from physical injury or to address the health care needs of the person. Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained;

14. To the attorney and/or guardian ad litem of a minor who represents such minor in any judicial or administrative proceeding, if the court or administrative hearing officer has entered an order granting the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the health care entity of such order;

15. With regard to the Court-Appointed Special Advocate (CASA) program, a minor's health records in accord with § 9.1-156;

16. To an agent appointed under an individual's power of attorney or to an agent or decision maker designated in an individual's advance directive for health care or for decisions on anatomical gifts and organ, tissue or eye donation or to any other person consistent with the provisions of the Health Care Decisions Act (§ 54.1-2981 et seq.);

17. To third-party payors and their agents for purposes of reimbursement;

18. As is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized governmental agency reviewing such application or reviewing benefits already provided or as necessary to the coordination of prevention and control of disease, injury, or disability and delivery of such health care benefits pursuant to § 32.1-127.1:04;

19. Upon the sale of a medical practice as provided in § 54.1-2405; or upon a change of ownership or closing of a pharmacy pursuant to regulations of the Board of Pharmacy;

20. In accord with subsection B of § 54.1-2400.1, to communicate an individual's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

21. Where necessary in connection with the implementation of a hospital's routine contact process for organ donation pursuant to subdivision B 4 of § 32.1-127;

22. In the case of substance abuse records, when permitted by and in conformity with requirements of federal law found in 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2;

23. In connection with the work of any entity established as set forth in § 8.01-581.16 to evaluate the adequacy or quality of professional services or the competency and qualifications for professional staff privileges;

24. If the health records are those of a deceased or mentally incapacitated individual to the personal representative or executor of the deceased individual or the legal guardian or committee of the incompetent or incapacitated individual or if there is no personal representative, executor, legal guardian or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased individual in order of blood relationship;

25. For the purpose of conducting record reviews of inpatient hospital deaths to promote identification of all potential organ, eye, and tissue donors in conformance with the requirements of applicable federal law and regulations, including 42 C.F.R. § 482.45, (i) to the health care provider's designated organ procurement organization certified by the United States Health Care Financing Administration and (ii) to any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks;

26. To the Office of the State Inspector General pursuant to Chapter 3.2 (§ 2.2-307 et seq.) of Title 2.2;

27. To an entity participating in the activities of a local health partnership authority established pursuant to Article 6.1 (§ 32.1-122.10:001 et seq.) of Chapter 4, pursuant to subdivision 1;

28. To law-enforcement officials by each licensed emergency medical services agency, (i) when the individual is the victim of a crime or (ii) when the individual has been arrested and has received emergency medical services or has refused emergency medical services and the health records consist of the prehospital patient care report required by § 32.1-116.1;

29. To law-enforcement officials, in response to their request, for the purpose of identifying or locating a suspect, fugitive, person required to register pursuant to § 9.1-901 of the Sex Offender and Crimes Against Minors Registry Act, material witness, or missing person, provided that only the following information may be disclosed: (i) name and address of the person, (ii) date and place of birth of the person, (iii) social security number of the person, (iv) blood type of the person, (v) date and time of treatment received by the person, (vi) date and time of death of the person, where applicable, (vii) description of distinguishing physical characteristics of the person, and (viii) type of injury sustained by the person;

30. To law-enforcement officials regarding the death of an individual for the purpose of alerting law enforcement of the death if the health care entity has a suspicion that such death may have resulted from criminal conduct;

31. To law-enforcement officials if the health care entity believes in good faith that the information disclosed constitutes evidence of a crime that occurred on its premises;

32. To the State Health Commissioner pursuant to § 32.1-48.015 when such records are those of a person or persons who are subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2;

33. To the Commissioner of the Department of Labor and Industry or his designee by each licensed emergency medical services agency when the records consist of the prehospital patient care report required by § 32.1-116.1 and the patient has suffered an injury or death on a work site while performing duties or tasks that are within the scope of his employment;

34. To notify a family member or personal representative of an individual who is the subject of a proceeding pursuant to Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1 or Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 of information that is directly relevant to such person's involvement with the individual's health care, which may include the individual's location and general condition, when the individual has the capacity to make health care decisions and (i) the individual has agreed to the notification, (ii) the individual has been provided an opportunity to object to the notification and does not express an objection, or (iii) the health care provider can, on the basis of his professional judgment, reasonably infer from the circumstances that the individual does not object to the notification. If the opportunity to agree or object to the notification cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the health care provider may notify a family member or personal representative of the individual of information that is directly relevant to such person's involvement with the individual's health care, which may include the individual's location and general condition if the health care provider, in the exercise of his professional judgment, determines that the notification is in the best interests of the individual. Such notification shall not be made if the provider has actual knowledge the family member or personal representative is currently prohibited by court order from contacting the individual;

35. To a threat assessment team established by a public institution of higher education pursuant to § 23-9.2:10 or by a private nonprofit institution of higher education when such records concern a student at the institution of higher education, including a student who is a minor; and

36. To a regional emergency medical services council pursuant to § 32.1-116.1, for purposes limited to monitoring and improving the quality of emergency medical services pursuant to § 32.1-111.3.

Notwithstanding the provisions of subdivisions 1 through 35, a health care entity shall obtain an individual's written authorization for any disclosure of psychotherapy notes, except when disclosure by the health care entity is (i) for its own training programs in which students, trainees, or practitioners in mental health are being taught under supervision to practice or to improve their skills in group, joint, family, or individual counseling; (ii) to defend itself or its employees or staff against any accusation of wrongful conduct; (iii) in the discharge of the duty, in accordance with subsection B of § 54.1-2400.1, to take precautions to protect third parties from violent behavior or other serious harm; (iv) required in the course of an investigation, audit, review, or proceeding regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity; or (v) otherwise required by law.

E. Health care records required to be disclosed pursuant to this section shall be made available electronically only to the extent and in the manner authorized by the federal Health Information Technology for Economic and Clinical Health Act (P.L. 111-5) and implementing regulations and the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.) and implementing

regulations. Notwithstanding any other provision to the contrary, a health care entity shall not be required to provide records in an electronic format requested if (i) the electronic format is not reasonably available without additional cost to the health care entity, (ii) the records would be subject to modification in the format requested, or (iii) the health care entity determines that the integrity of the records could be compromised in the electronic format requested. Requests for copies of or electronic access to health records shall (a) be in writing, dated and signed by the requester; (b) identify the nature of the information requested; and (c) include evidence of the authority of the requester to receive such copies or access such records, and identification of the person to whom the information is to be disclosed; and (d) specify whether the requester would like the records in electronic format, if available, or in paper format. The health care entity shall accept a photocopy, facsimile, or other copy of the original signed by the requestor as if it were an original. Within 15 days of receipt of a request for copies of or electronic access to health records, the health care entity shall do one of the following: (A) furnish such copies of or allow electronic access to the requested health records to any requester authorized to receive them in electronic format if so requested; (B) inform the requester if the information does not exist or cannot be found; (C) if the health care entity does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the health care entity who maintains the record; or (D) deny the request (1) under subsection F, (2) on the grounds that the requester has not established his authority to receive such health records or proof of his identity, or (3) as other provided by law. Procedures set forth in this section shall apply only to requests for health records not specifically governed by other provisions of state law.

F. Except as provided in subsection B of § 8.01-413, copies of or electronic access to an individual's health records shall not be furnished to such individual or anyone authorized to act on the individual's behalf when the individual's treating physician or the individual's treating clinical psychologist has made a part of the individual's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the individual of such health records would be reasonably likely to endanger the life or physical safety of the individual or another person, or that such health record makes reference to a person other than a health care provider and the access requested would be reasonably likely to cause substantial harm to such referenced person. If any health care entity denies a request for copies of or electronic access to health records based on such statement, the health care entity shall inform the individual of the individual's right to designate, in writing, at his own expense, another reviewing physician or clinical psychologist, whose licensure, training and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose opinion the denial is based. The designated reviewing physician or clinical psychologist shall make a judgment as to whether to make the health record available to the individual.

The health care entity denying the request shall also inform the individual of the individual's right to request in writing that such health care entity designate, at its own expense, a physician or clinical psychologist, whose licensure, training, and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose professional judgment the denial is based and who did not participate in the original decision to deny the health records, who shall make a judgment as to whether to make the health record available to the individual. The health care entity shall comply with the judgment of the reviewing physician or clinical psychologist. The health care entity shall permit copying and examination of the health record by such other physician or clinical psychologist designated by either the individual at his own expense or by the health care entity at its expense.

Any health record copied for review by any such designated physician or clinical psychologist shall be accompanied by a statement from the custodian of the health record that the individual's treating physician or clinical psychologist determined that the individual's review of his health record would be

reasonably likely to endanger the life or physical safety of the individual or would be reasonably likely to cause substantial harm to a person referenced in the health record who is not a health care provider.

Further, nothing herein shall be construed as giving, or interpreted to bestow the right to receive copies of, or otherwise obtain access to, psychotherapy notes to any individual or any person authorized to act on his behalf.

G. A written authorization to allow release of an individual's health records shall substantially include the following information:

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Individual's Name .....

Health Care Entity's Name .....

Person, Agency, or Health Care Entity to whom disclosure is to be made .....

Information or Health Records to be disclosed .....

Purpose of Disclosure or at the Request of the Individual .....

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by

law while solely in the possession of the health care entity.

This authorization expires on (date) or (event) .....

Signature of Individual or Individual's Legal Representative if Individual is Unable to Sign .....

Relationship or Authority of Legal Representative .....

Date of Signature .....

H. Pursuant to this subsection:

1. Unless excepted from these provisions in subdivision 9, no party to a civil, criminal or administrative action or proceeding shall request the issuance of a subpoena duces tecum for another party's health records or cause a subpoena duces tecum to be issued by an attorney unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the other party's counsel or to the other party if pro se, simultaneously with filing the request or issuance of the subpoena. No party to an action or proceeding shall request or cause the issuance of a subpoena duces tecum for the health records of a nonparty witness unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the nonparty witness simultaneously with filing the request or issuance of the attorney-issued subpoena.

No subpoena duces tecum for health records shall set a return date earlier than 15 days from the date of the subpoena except by order of a court or administrative agency for good cause shown. When a court or administrative agency directs that health records be disclosed pursuant to a subpoena duces tecum earlier than 15 days from the date of the subpoena, a copy of the order shall accompany the subpoena.

Any party requesting a subpoena duces tecum for health records or on whose behalf the subpoena duces tecum is being issued shall have the duty to determine whether the individual whose health records are being sought is pro se or a nonparty.

In instances where health records being subpoenaed are those of a pro se party or nonparty witness, the party requesting or issuing the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, or a copy of the subpoena in the case of an attorney-issued subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters:

NOTICE TO INDIVIDUAL

The attached document means that (insert name of party requesting or causing issuance of the subpoena) has either asked the court or administrative agency to issue a subpoena or a subpoena has been issued by the other party's attorney to your doctor, other health care providers (names of health care providers inserted here) or other health care entity (name of health care entity to be inserted here) requiring them to produce your health records. Your doctor, other health care provider or other health care entity is required to respond by providing a copy of your health records. If you believe your health records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court or the administrative agency to quash the subpoena. If you elect to file a motion to quash, such motion must be filed within 15 days of the date of the request or of the attorney-issued subpoena. You may contact the clerk's office or the administrative agency to determine the

requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, you must notify your doctor, other health care provider(s), or other health care entity, that you are filing the motion so that the health care provider or health care entity knows to send the health records to the clerk of court or administrative agency in a sealed envelope or package for safekeeping while your motion is decided.

2. Any party filing a request for a subpoena duces tecum or causing such a subpoena to be issued for an individual's health records shall include a Notice in the same part of the request in which the recipient of the subpoena duces tecum is directed where and when to return the health records. Such notice shall be in boldface capital letters and shall include the following language:

NOTICE TO HEALTH CARE ENTITIES

A COPY OF THIS SUBPOENA DUCES TECUM HAS BEEN PROVIDED TO THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED OR HIS COUNSEL. YOU OR THAT INDIVIDUAL HAS THE RIGHT TO FILE A MOTION TO QUASH (OBJECT TO) THE ATTACHED SUBPOENA. IF YOU ELECT TO FILE A MOTION TO QUASH, YOU MUST FILE THE MOTION WITHIN 15 DAYS OF THE DATE OF THIS SUBPOENA.

YOU MUST NOT RESPOND TO THIS SUBPOENA UNTIL YOU HAVE RECEIVED WRITTEN CERTIFICATION FROM THE PARTY ON WHOSE BEHALF THE SUBPOENA WAS ISSUED THAT THE TIME FOR FILING A MOTION TO QUASH HAS ELAPSED AND THAT:

NO MOTION TO QUASH WAS FILED; OR

ANY MOTION TO QUASH HAS BEEN RESOLVED BY THE COURT OR THE ADMINISTRATIVE AGENCY AND THE DISCLOSURES SOUGHT ARE CONSISTENT WITH SUCH RESOLUTION.

IF YOU RECEIVE NOTICE THAT THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED HAS FILED A MOTION TO QUASH THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, YOU MUST SEND THE HEALTH RECORDS ONLY TO THE CLERK OF THE COURT OR ADMINISTRATIVE AGENCY THAT ISSUED THE SUBPOENA OR IN WHICH THE ACTION IS PENDING AS SHOWN ON THE SUBPOENA USING THE FOLLOWING PROCEDURE:

PLACE THE HEALTH RECORDS IN A SEALED ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT OR ADMINISTRATIVE AGENCY WHICH STATES THAT CONFIDENTIAL HEALTH RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING A RULING ON THE MOTION TO QUASH THE SUBPOENA. THE SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT OR ADMINISTRATIVE AGENCY.

3. Upon receiving a valid subpoena duces tecum for health records, health care entities shall have the duty to respond to the subpoena in accordance with the provisions of subdivisions 4, 5, 6, 7, and 8.

4. Except to deliver to a clerk of the court or administrative agency subpoenaed health records in a sealed envelope as set forth, health care entities shall not respond to a subpoena duces tecum for such health records until they have received a certification as set forth in subdivision 5 or 8 from the party on whose behalf the subpoena duces tecum was issued.

If the health care entity has actual receipt of notice that a motion to quash the subpoena has been filed or if the health care entity files a motion to quash the subpoena for health records, then the health care entity shall produce the health records, in a securely sealed envelope, to the clerk of the court or administrative agency issuing the subpoena or in whose court or administrative agency the action is

pending. The court or administrative agency shall place the health records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge or administrative agency. In the event the court or administrative agency grants the motion to quash, the health records shall be returned to the health care entity in the same sealed envelope in which they were delivered to the court or administrative agency. In the event that a judge or administrative agency orders the sealed envelope to be opened to review the health records in camera, a copy of the order shall accompany any health records returned to the health care entity. The health records returned to the health care entity shall be in a securely sealed envelope.

5. If no motion to quash is filed within 15 days of the date of the request or of the attorney-issued subpoena, the party on whose behalf the subpoena was issued shall have the duty to certify to the subpoenaed health care entity that the time for filing a motion to quash has elapsed and that no motion to quash was filed. Any health care entity receiving such certification shall have the duty to comply with the subpoena duces tecum by returning the specified health records by either the return date on the subpoena or five days after receipt of the certification, whichever is later.

6. In the event that the individual whose health records are being sought files a motion to quash the subpoena, the court or administrative agency shall decide whether good cause has been shown by the discovering party to compel disclosure of the individual's health records over the individual's objections. In determining whether good cause has been shown, the court or administrative agency shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

7. Concurrent with the court or administrative agency's resolution of a motion to quash, if subpoenaed health records have been submitted by a health care entity to the court or administrative agency in a sealed envelope, the court or administrative agency shall: (i) upon determining that no submitted health records should be disclosed, return all submitted health records to the health care entity in a sealed envelope; (ii) upon determining that all submitted health records should be disclosed, provide all the submitted health records to the party on whose behalf the subpoena was issued; or (iii) upon determining that only a portion of the submitted health records should be disclosed, provide such portion to the party on whose behalf the subpoena was issued and return the remaining health records to the health care entity in a sealed envelope.

8. Following the court or administrative agency's resolution of a motion to quash, the party on whose behalf the subpoena duces tecum was issued shall have the duty to certify in writing to the subpoenaed health care entity a statement of one of the following:

a. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution; and, therefore, the health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will not be returned to the health care entity;

b. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution and that, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall comply with the subpoena duces tecum by returning the health records designated in the subpoena by the return date on the subpoena or five days after receipt of certification, whichever is later;

c. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution; therefore, no health records shall be disclosed and all health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will be returned to the health care entity;

d. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and that only limited disclosure has been authorized. The certification shall state that only the portion of the health records as set forth in the certification, consistent with the court or administrative agency's ruling, shall be disclosed. The certification shall also state that health records that were previously delivered to the court or administrative agency for which disclosure has been authorized will not be returned to the health care entity; however, all health records for which disclosure has not been authorized will be returned to the health care entity; or

e. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall return only those health records specified in the certification, consistent with the court or administrative agency's ruling, by the return date on the subpoena or five days after receipt of the certification, whichever is later.

A copy of the court or administrative agency's ruling shall accompany any certification made pursuant to this subdivision.

9. The provisions of this subsection have no application to subpoenas for health records requested under § 8.01-413, or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a health care entity's conduct.

The provisions of this subsection shall apply to subpoenas for the health records of both minors and adults.

Nothing in this subsection shall have any effect on the existing authority of a court or administrative agency to issue a protective order regarding health records, including, but not limited to, ordering the return of health records to a health care entity, after the period for filing a motion to quash has passed.

A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

I. Health care entities may testify about the health records of an individual in compliance with §§ 8.01-399 and 8.01-400.2.

J. If an individual requests a copy of his health record from a health care entity, the health care entity may impose a reasonable cost-based fee, which shall include only the cost of supplies for and labor of copying the requested information, postage when the individual requests that such information be mailed, and preparation of an explanation or summary of such information as agreed to by the individual. For the purposes of this section, "individual" shall subsume a person with authority to act on behalf of the individual who is the subject of the health record in making decisions related to his health care.

K. Nothing in this section shall prohibit a health care provider who prescribes or dispenses a controlled substance required to be reported to the Prescription Monitoring Program established pursuant to

§ 54.1-2400.1. Mental health service providers; duty to protect third parties; immunity.

A. As used in this section:

"Certified substance abuse counselor" means a person certified to provide substance abuse counseling in a state-approved public or private substance abuse program or facility.

"Client" or "patient" means any person who is voluntarily or involuntarily receiving mental health services or substance abuse services from any mental health service provider.

"Clinical psychologist" means a person who practices clinical psychology as defined in § 54.1-3600.

"Clinical social worker" means a person who practices social work as defined in § 54.1-3700.

"Licensed practical nurse" means a person licensed to practice practical nursing as defined in § 54.1-3000.

"Licensed substance abuse treatment practitioner" means any person licensed to engage in the practice of substance abuse treatment as defined in § 54.1-3500.

"Marriage and family therapist" means a person licensed to engage in the practice of marriage and family therapy as defined in § 54.1-3500.

"Mental health professional" means a person who by education and experience is professionally qualified and licensed in Virginia to provide counseling interventions designed to facilitate an individual's achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses which interfere with mental health and development.

"Mental health service provider" or "provider" refers to any of the following: (i) a person who provides professional services as a certified substance abuse counselor, clinical psychologist, clinical social worker, licensed substance abuse treatment practitioner, licensed practical nurse, marriage and family therapist, mental health professional, physician, professional counselor, psychologist, registered nurse, school psychologist, or social worker; (ii) a professional corporation, all of whose shareholders or members are so licensed; or (iii) a partnership, all of whose partners are so licensed.

"Professional counselor" means a person who practices counseling as defined in § 54.1-3500.

"Psychologist" means a person who practices psychology as defined in § 54.1-3600.

"Registered nurse" means a person licensed to practice professional nursing as defined in § 54.1-3000.

"School psychologist" means a person who practices school psychology as defined in § 54.1-3600.

"Social worker" means a person who practices social work as defined in § 54.1-3700.

B. A mental health service provider has a duty to take precautions to protect third parties from violent behavior or other serious harm only when the client has orally, in writing, or via sign language,

communicated to the provider a specific and immediate threat to cause serious bodily injury or death to an identified or readily identifiable person or persons, if the provider reasonably believes, or should believe according to the standards of his profession, that the client has the intent and ability to carry out that threat immediately or imminently. If the third party is a child, in addition to taking precautions to protect the child from the behaviors in the above types of threats, the provider also has a duty to take precautions to protect the child if the client threatens to engage in behaviors that would constitute physical abuse or sexual abuse as defined in § 18.2-67.10. The duty to protect does not attach unless the threat has been communicated to the provider by the threatening client while the provider is engaged in his professional duties.

C. The duty set forth in subsection B is discharged by a mental health service provider who takes one or more of the following actions:

1. Seeks involuntary admission of the client under Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1 or Chapter 8 (§ 37.2-800 et seq.) of Title 37.2.

2. Makes reasonable attempts to warn the potential victims or the parent or guardian of the potential victim if the potential victim is under the age of 18.

3. Makes reasonable efforts to notify a law-enforcement official having jurisdiction in the client's or potential victim's place of residence or place of work, or place of work of the parent or guardian if the potential victim is under age 18, or both.

4. Takes steps reasonably available to the provider to prevent the client from using physical violence or other means of harm to others until the appropriate law-enforcement agency can be summoned and takes custody of the client.

5. Provides therapy or counseling to the client or patient in the session in which the threat has been communicated until the mental health service provider reasonably believes that the client no longer has the intent or the ability to carry out the threat.

D. A mental health service provider shall not be held civilly liable to any person for:

1. Breaching confidentiality with the limited purpose of protecting third parties by communicating the threats described in subsection B made by his clients to potential third party victims or law-enforcement agencies or by taking any of the actions specified in subsection C.

2. Failing to predict, in the absence of a threat described in subsection B, that the client would cause the third party serious physical harm.

3. Failing to take precautions other than those enumerated in subsection C to protect a potential third party victim from the client's violent behavior.

(1994, c. 958; 1997, c. 901; 2005, c. 716; 2010, cc. 778, 825.)