HEALTH AND SAFETY CODE - HSC

DIVISION 106. PERSONAL HEALTH CARE (INCLUDING MATERNAL, CHILD, AND ADOLESCENT) [123100 - 125850] *(Division 106 added by Stats. 1995, Ch. 415, Sec. 8.)*

PART 1. GENERAL ADMINISTRATION [123100 - 123223] *(Part 1 added by Stats. 1995, Ch. 415, Sec. 8.)*

CHAPTER 1. Patient Access to Health Records [123100 - 123149.5] *(Chapter 1 added by Stats. 1995, Ch. 415, Sec. 8.)*

123100. The Legislature finds and declares that every person having ultimate responsibility for decisions respecting his or her own health care also possesses a concomitant right of access to complete information respecting his or her condition and care provided. Similarly, persons having responsibility for decisions respecting the health care of others should, in general, have access to information on the patient's condition and care. It is, therefore, the intent of the Legislature in enacting this chapter to establish procedures for providing access to health care records or summaries of those records by patients and by those persons having responsibility for decisions respecting the health care of others.

(Added by Stats. 1995, Ch. 415, Sec. 8. Effective January 1, 1996.)

123105. As used in this chapter:

(a) "Health care provider" means any of the following:

(1) A health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

(2) A clinic licensed pursuant to Chapter 1 (commencing with Section 1200) of Division 2.

(3) A home health agency licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2.

(4) A physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or pursuant to the Osteopathic Act.

(5) A podiatrist licensed pursuant to Article 22 (commencing with Section 2460) of Chapter 5 of Division 2 of the Business and Professions Code.

(6) A dentist licensed pursuant to Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code.

(7) A psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.

(8) An optometrist licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code.

(9) A chiropractor licensed pursuant to the Chiropractic Initiative Act.

(10) A marriage and family therapist licensed pursuant to Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.

(11) A clinical social worker licensed pursuant to Chapter 14 (commencing with Section 4990) of Division 2 of the Business and Professions Code.

(12) A physical therapist licensed pursuant to Chapter 5.7 (commencing with Section 2600) of Division 2 of the Business and Professions Code.

(13) An occupational therapist licensed pursuant to Chapter 5.6 (commencing with Section 2570).

(14) A professional clinical counselor licensed pursuant to Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code.

(15) A speech-language pathologist or audiologist licensed pursuant to Chapter 5.3 (commencing with Section 2530) of Division 2 of the Business and Professions Code.

(16) A physician assistant licensed pursuant to Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code.

(17) A nurse practitioner licensed pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.

(b) “Mental health records” means patient records, or discrete portions thereof, specifically relating to evaluation or treatment of a mental disorder. “Mental health records” includes, but is not limited to, all alcohol and drug abuse records.

(c) “Patient” means a patient or former patient of a health care provider.

(d) “Patient records” means records in any form or medium maintained by, or in the custody or control of, a health care provider relating to the health history, diagnosis, or condition of a patient, or relating to treatment provided or proposed to be provided to the patient. “Patient records” includes only records pertaining to the patient requesting the records or whose representative requests the records. “Patient records” does not include information given in confidence to a health care provider by a person other than another health care provider or the patient, and that material may be removed from any records prior to inspection or copying under Section 123110 or 123115. “Patient records” does not include information contained in aggregate form, such as indices, registers, or logs.

(e) “Patient’s representative,” “patient’s personal representative,” or “representative” means any of the following:

(1) A parent or guardian of a minor who is a patient.

(2) The guardian or conservator of the person of an adult patient.

(3) An agent as defined in Section 4607 of the Probate Code, to the extent necessary for the agent to fulfill the duties set forth in Division 4.7 (commencing with Section 4600) of the Probate Code.

(4) The beneficiary as defined in Section 24 of the Probate Code or personal representative as defined in Section 58 of the Probate Code, of a deceased patient.

(f) “Alcohol and drug abuse records” means patient records, or discrete portions thereof, specifically relating to evaluation and treatment of alcoholism or drug abuse.

(Amended by Stats. 2020, Ch. 101, Sec. 1. (AB 2520) Effective January 1, 2021.)

123110. (a) Notwithstanding Section 5328 of the Welfare and Institutions Code, and except as provided in Sections 123115 and 123120, any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient’s personal representative shall be entitled to inspect patient records upon presenting to the health care provider a request for those records and upon payment of reasonable costs, as specified in subdivision (j). However, a patient who is a minor shall be entitled to inspect patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent. A health care provider shall permit this inspection during business hours within five working days after receipt of the request. The inspection shall be conducted by the patient or patient’s personal representative requesting the inspection, who may be accompanied by one other person of their choosing.

(b) (1) Additionally, any patient or patient’s personal representative shall be entitled to a paper or electronic copy of all or any portion of the patient records that they have a right to inspect, upon presenting a request to the health care provider specifying the records to be copied, together with a fee to defray the costs of producing the copy or summary, as specified in subdivision (j). The health care provider shall ensure that the copies are transmitted within 15 days after receiving the request.

(2) The health care provider shall provide the patient or patient’s personal representative with a copy of the record in the form and format requested if it is readily producible in the requested form and format, or, if not, in a readable paper copy form or other form and format as agreed to by the health care provider and the patient or patient’s personal representative. If the requested patient records are maintained electronically and if the patient or patient’s personal representative requests an electronic copy of those records, the health care provider shall provide them in the electronic form and format requested if they are readily producible in that form and format, or, if not, in a readable electronic form and format as agreed to by the health care provider and the patient or patient’s personal representative.

(c) Copies of X-rays or tracings derived from electrocardiography, electroencephalography, or electromyography need not be provided to the patient or patient’s personal representative under this section, if the original X-rays or tracings are transmitted to

another health care provider upon written request of the patient or patient's personal representative and within 15 days after receipt of the request. The request shall specify the name and address of the health care provider to whom the records are to be delivered. All reasonable costs, not exceeding actual costs, incurred by a health care provider in providing copies pursuant to this subdivision may be charged to the patient or representative requesting the copies.

(d) (1) Notwithstanding any provision of this section, and except as provided in Sections 123115 and 123120, a patient, employee of a nonprofit legal services entity representing the patient, or the personal representative of a patient, is entitled to a copy, at no charge, of the relevant portion of the patient's records, upon presenting to the provider a written request, and proof that the records or supporting forms are needed to support a claim or appeal regarding eligibility for a public benefit program, a petition for U nonimmigrant status under the Victims of Trafficking and Violence Protection Act, or a self-petition for lawful permanent residency under the Violence Against Women Act. A public benefit program includes the Medi-Cal program, the In-Home Supportive Services Program, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, Social Security Disability Insurance benefits, Supplemental Security Income/State Supplementary Program for the Aged, Blind and Disabled (SSI/SSP) benefits, federal veterans service-connected compensation and nonservice connected pension disability benefits, CalFresh, the Cash Assistance Program for Aged, Blind, and Disabled Legal Immigrants, and a government-funded housing subsidy or tenant-based housing assistance program.

(2) Although a patient shall not be limited to a single request, the patient, employee of a nonprofit legal services entity representing the patient, or patient's personal representative shall be entitled to no more than one copy of any relevant portion of their record free of charge.

(3) This subdivision shall not apply to any patient who is represented by a private attorney who is paying for the costs related to the patient's claim or appeal, pending the outcome of that claim or appeal. For purposes of this subdivision, "private attorney" means any attorney not employed by a nonprofit legal services entity.

(e) If a patient, employee of a nonprofit legal services entity representing the patient, or the patient's personal representative requests a record pursuant to subdivision (d), the health care provider shall ensure that the copies are transmitted within 30 days after receiving the written request.

(f) This section shall not be construed to preclude a health care provider from requiring reasonable verification of identity prior to permitting inspection or copying of patient records, provided this requirement is not used oppressively or discriminatorily to frustrate or delay compliance with this section. This section does not supersede any rights that a patient or personal representative might otherwise have or exercise under Section 1158 of the Evidence Code or any other provision of law. This chapter does not require a health care provider to retain records longer than required by applicable statutes or administrative regulations.

(g) (1) This chapter shall not be construed to render a health care provider liable for the quality of their records or the copies provided in excess of existing law and regulations with respect to the quality of medical records. A health care provider shall not be liable to the patient or any other person for any consequences that result from disclosure of patient records as required by this chapter. A health care provider shall not discriminate against classes or categories of providers in the transmittal of X-rays or other patient records, or copies of these X-rays or records, to other providers as authorized by this section.

(2) Every health care provider shall adopt policies and establish procedures for the uniform transmittal of X-rays and other patient records that effectively prevent the discrimination described in this subdivision. A health care provider may establish reasonable conditions, including a reasonable deposit fee, to ensure the return of original X-rays transmitted to another health care provider, provided the conditions do not discriminate on the basis of, or in a manner related to, the license of the provider to which the X-rays are transmitted.

(h) Any health care provider described in paragraphs (4) to (10), inclusive, of subdivision (a) of Section 123105 who willfully violates this chapter is guilty of unprofessional conduct. Any health care provider described in paragraphs (1) to (3), inclusive, of subdivision (a) of Section 123105 that willfully violates this chapter is guilty of an infraction punishable by a fine of not more than one hundred dollars ($100). The state agency, board, or commission that issued the health care provider's professional or institutional license shall consider a violation as grounds for disciplinary action with respect to the licensure, including suspension or revocation of the license or certificate.

(i) This section prohibits a health care provider from withholding patient records or summaries of patient records because of an unpaid bill for health care services. Any health care provider who willfully withholds patient records or summaries of patient records because of an unpaid bill for health care services is subject to the sanctions specified in subdivision (h).

(j) (1) Except as provided in subdivision (d), a health care provider may impose a reasonable, cost-based fee for providing a paper or electronic copy or summary of patient records, provided the fee includes only the cost of the following:

(A) Labor for copying the patient records requested by the patient or patient's personal representative, whether in paper or electronic form.

(B) Supplies for creating the paper copy or electronic media if the patient or patient's personal representative requests that the electronic copy be provided on portable media.

(C) Postage, if the patient or patient's personal representative has requested the copy, or the summary or explanation, be mailed.

(D) Preparing an explanation or summary of the patient record, if agreed to by the patient or patient's personal representative.

(2) The fee from a health care provider shall not exceed twenty-five cents ($0.25) per page for paper copies or fifty cents ($0.50) per page for records that are copied from microfilm.

(Amended by Stats. 2023, Ch. 294, Sec. 31. (SB 815) Effective January 1, 2024.)

123111. (a) A patient who inspects his or her patient records pursuant to Section 123110 has the right to provide to the health care provider a written addendum with respect to any item or statement in his or her records that the patient believes to be incomplete or incorrect. The addendum shall be limited to 250 words per alleged incomplete or incorrect item in the patient's record and shall clearly indicate in writing that the patient requests the addendum to be made a part of his or her record.

(b) The health care provider shall attach the addendum to the patient's records and shall include that addendum if the health care provider makes a disclosure of the allegedly incomplete or incorrect portion of the patient's records to any third party.

(c) The receipt of information in a patient's addendum which contains defamatory or otherwise unlawful language, and the inclusion of this information in the patient's records, in accordance with subdivision (b), shall not, in and of itself, subject the health care provider to liability in any civil, criminal, administrative, or other proceeding.

(d) Subdivision (i) of Section 123110 and Section 123120 are applicable with respect to any violation of this section by a health care provider.

(Amended by Stats. 2018, Ch. 275, Sec. 1. (AB 2088) Effective January 1, 2019.)

123114. (a) A health care provider shall not charge a fee to a patient for filling out forms or providing information responsive to forms that support a claim or appeal regarding eligibility for a public benefit program.

(b) A health care provider shall provide information responsive to those portions of the form for which the health care provider has the information necessary to provide a medical opinion. If the health care provider does not have the information necessary to provide a medical opinion, the health care provider may inform the patient if an examination is necessary to obtain the information.

(c) If a health care provider conducts an examination pursuant to subdivision (b), the health care provider shall provide information responsive to those portions of the form for which the health care provider has a medical opinion.

(d) For the purposes of this section, a public benefit program includes the Medi-Cal program, the In-Home Supportive Services Program, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, Social Security Disability Insurance benefits, Supplemental Security Income/State Supplementary Program for the Aged, Blind and Disabled (SSI/SSP) benefits, federal veterans service-connected compensation and nonservice connected pension disability benefits, discharge of a federal student loan based on total and permanent disability, CalFresh, the Cash Assistance Program for Aged, Blind, and Disabled Legal Immigrants, and a government-funded housing subsidy or tenant-based housing assistance program.

(e) Notwithstanding any other law, a health care provider may honor a request to disclose a patient record or complete a public benefit form that contains the written or electronic signature of the patient or the patient's personal representative.

(Added by Stats. 2020, Ch. 101, Sec. 3. (AB 2520) Effective January 1, 2021.)

123115. (a) The representative of a minor shall not be entitled to inspect or obtain copies of the minor's patient records, including clinical notes, in any of the following circumstances:

(1) With respect to which the minor has a right of inspection under Section 123110.

(2) When the health care provider determines that access to the patient records requested by the representative would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being. The decision of the health care provider as to whether or not a minor's records are available for inspection or copying under this section shall not attach any liability to the provider, unless the decision is found to be in bad faith.

(3) When records relate to services described in Section 6924, 6925, 6926, 6927, 6928, 6929, or 6930 of the Family Code, or Section 121020 or 124260 of this code, when obtained by a patient who has the mental capacity to provide consent and is at or above the minimum age for consenting to the service specified in the respective section.

(b) When a health care provider determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient, the provider may decline to permit inspection or provide copies of the records to the patient, subject to the following conditions:

(1) The health care provider shall make a written record, to be included with the mental health records requested, noting the date of the request and explaining the health care provider's reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse or detrimental consequences to the patient that the provider anticipates would occur if inspection or copying were permitted.

(2) (A) The health care provider shall permit inspection by, or provide copies of the mental health records to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or licensed professional clinical counselor, designated by request of the patient.

(B) Any person registered as a marriage and family therapist intern, as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, may not inspect the patient's mental health records or obtain copies thereof, except pursuant to the direction or supervision of a licensed professional specified in subdivision (g) of Section 4980.03 of the Business and Professions Code. Prior to providing copies of mental health records to a registered marriage and family therapist intern, a receipt for those records shall be signed by the supervising licensed professional.

(C) Any person registered as a clinical counselor intern, as defined in Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, may not inspect the patient's mental health records or obtain copies thereof, except pursuant to the direction or supervision of a licensed professional specified in subdivision (h) of Section 4999.12 of the Business and Professions Code. Prior to providing copies of mental health records to a person registered as a clinical counselor intern, a receipt for those records shall be signed by the supervising licensed professional.

(D) A licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, licensed professional clinical counselor, registered marriage and family therapist intern, or person registered as a clinical counselor intern to whom the records are provided for inspection or copying shall not permit inspection or copying by the patient.

(3) The health care provider shall inform the patient of the provider's refusal to permit them to inspect or obtain copies of the requested records, and inform the patient of the right to require the provider to permit inspection by, or provide copies to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or licensed professional clinical counselor designated by written authorization of the patient.

(4) The health care provider shall indicate in the mental health records of the patient whether the request was made under paragraph (2).

(Amended by Stats. 2022, Ch. 888, Sec. 2. (SB 1419) Effective January 1, 2023.)

123116. (a) Notwithstanding Section 3025 of the Family Code, paragraph (2) of subdivision (c) of Section 56.11 of the Civil Code, or any other provision of law, a psychotherapist who knows that a minor has been removed from the physical custody of his or her parent or guardian pursuant to Article 6 (commencing with Section 300) to Article 10 (commencing with Section 360), inclusive, of Chapter 2 of Part 1 of Division 2 of the Welfare and Institutions Code shall not allow the parent or guardian to inspect or obtain copies of mental health records of the minor patient. This restriction shall not apply if the juvenile court has issued an order authorizing the parent or guardian to inspect or obtain copies of the mental health records of the minor patient after finding that such an order would not be detrimental to the minor patient.

(b) For purposes of this section, the following definitions apply:

(1) "Mental health records" means mental health records as defined by subdivision (b) of Section 123105.

(2) "Psychotherapist" means a provider of health care as defined in Section 1010 of the Evidence Code.

(c) When the juvenile court has issued an order authorizing the parent or guardian to inspect or obtain copies of the mental health records of a minor patient under the circumstances described in subdivision (a), the parent or guardian requesting to inspect or obtain copies of the mental health records of the minor patient shall present a copy of the court order to the psychotherapist and shall comply with subdivisions (a) and (b) of Section 123110 before the records may be accessed by the parent or guardian.

(d) Nothing in this section shall be construed to prevent or limit a psychotherapist's authority under subdivision (a) of Section 123115 to deny a parent's or guardian's written request to inspect or obtain copies of the minor patient's mental health records, notwithstanding the fact that the juvenile court has issued an order authorizing the parent or guardian to inspect or obtain copies of the minor patient's mental health records. Liability for a psychotherapist's decision not to allow the parent or guardian to inspect or obtain copies of records pursuant to the authority of subdivision (a) of Section 123115 shall be governed by that section.

(e) Nothing in this section shall be construed to impose upon a psychotherapist a duty to inquire or investigate whether a child has been removed from the physical custody of his or her parent or guardian pursuant to Article 6 (commencing with Section 300) to Article 10 (commencing with Section 360), inclusive, of Chapter 2 of Part 1 of Division 2 of the Welfare and Institutions Code when a

parent or guardian presents the minor's psychotherapist with a written request to inspect or obtain copies of the minor's mental health records.

(Added by Stats. 2012, Ch. 657, Sec. 2. (SB 1407) Effective January 1, 2013.)

123120. Any patient or representative aggrieved by a violation of Section 123110 may, in addition to any other remedy provided by law, bring an action against the health care provider to enforce the obligations prescribed by Section 123110. Any judgment rendered in the action may, in the discretion of the court, include an award of costs and reasonable attorney fees to the prevailing party.

(Added by Stats. 1995, Ch. 415, Sec. 8. Effective January 1, 1996.)

123125. (a) This chapter shall not require a health care provider to permit inspection or provide copies of alcohol and drug abuse records where, or in a manner, prohibited by Section 408 of the federal Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255) or Section 333 of the federal Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (Public Law 91-616), or by regulations adopted pursuant to these federal laws. Alcohol and drug abuse records subject to these federal laws shall also be subject to this chapter, to the extent that these federal laws do not prohibit disclosure of the records. All other alcohol and drug abuse records shall be fully subject to this chapter.

(b) This chapter shall not require a health care provider to permit inspection or provide copies of records or portions of records where or in a manner prohibited by existing law respecting the confidentiality of information regarding communicable disease carriers.

(Added by Stats. 1995, Ch. 415, Sec. 8. Effective January 1, 1996.)

123130. (a) A health care provider may prepare a summary of the record, according to the requirements of this section, for inspection and copying by a patient. If the health care provider chooses to prepare a summary of the record rather than allowing access to the entire record, he or she shall make the summary of the record available to the patient within 10 working days from the date of the patient's request. However, if more time is needed because the record is of extraordinary length or because the patient was discharged from a licensed health facility within the last 10 days, the health care provider shall notify the patient of this fact and the date that the summary will be completed, but in no case shall more than 30 days elapse between the request by the patient and the delivery of the summary. In preparing the summary of the record the health care provider shall not be obligated to include information that is not contained in the original record.

(b) A health care provider may confer with the patient in an attempt to clarify the patient's purpose and goal in obtaining his or her record. If as a consequence the patient requests information about only certain injuries, illnesses, or episodes, this subdivision shall not require the provider to prepare the summary required by this subdivision for other than the injuries, illnesses, or episodes so requested by the patient. The summary shall contain for each injury, illness, or episode any information included in the record relative to the following:

(1) Chief complaint or complaints including pertinent history.

(2) Findings from consultations and referrals to other health care providers.

(3) Diagnosis, where determined.

(4) Treatment plan and regimen including medications prescribed.

(5) Progress of the treatment.

(6) Prognosis including significant continuing problems or conditions.

(7) Pertinent reports of diagnostic procedures and tests and all discharge summaries.

(8) Objective findings from the most recent physical examination, such as blood pressure, weight, and actual values from routine laboratory tests.

(c) This section shall not be construed to require any medical records to be written or maintained in any manner not otherwise required by law.

(d) The summary shall contain a list of all current medications prescribed, including dosage, and any sensitivities or allergies to medications recorded by the provider.

(e) Subdivision (c) of Section 123110 shall be applicable whether or not the health care provider elects to prepare a summary of the record.

(f) The health care provider may charge no more than a reasonable fee based on actual time and cost for the preparation of the summary. The cost shall be based on a computation of the actual time spent preparing the summary for availability to the patient or the patient's representative. It is the intent of the Legislature that summaries of the records be made available at the lowest possible cost to the patient.

(Added by Stats. 1995, Ch. 415, Sec. 8. Effective January 1, 1996.)

123135. Except as otherwise provided by law, nothing in this chapter shall be construed to grant greater access to individual patient records by any person, firm, association, organization, partnership, business trust, company, corporation, or municipal or other public corporation, or government officer or agency. Therefore, this chapter does not do any of the following:

(a) Relieve employers of the requirements of the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

(b) Relieve any person subject to the Insurance Information and Privacy Protection Act (Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2 of Division 1 of the Insurance Code) from the requirements of that act.

(c) Relieve government agencies of the requirements of the Information Practices Act of 1977 (Title 1.8 (commencing with Section 1798) of Part 4 of Division 3 of the Civil Code).

(Added by Stats. 1995, Ch. 415, Sec. 8. Effective January 1, 1996.)

123140. The Information Practices Act of 1977 (Title 1.8 (commencing with Section 1798) of Part 4 of Division 3 of the Civil Code) shall prevail over this chapter with respect to records maintained by a state agency.

(Added by Stats. 1995, Ch. 415, Sec. 8. Effective January 1, 1996.)

123145. (a) Providers of health services that are licensed pursuant to Sections 1205, 1253, 1575 and 1726 have an obligation, if the licensee ceases operation, to preserve records for a minimum of seven years following discharge of the patient, except that the records of unemancipated minors shall be kept at least one year after the minor has reached the age of 18 years, and in any case, not less than seven years.

(b) The department or any person injured as a result of the licensee's abandonment of health records may bring an action in a proper court for the amount of damage suffered as a result thereof. In the event that the licensee is a corporation or partnership that is dissolved, the person injured may take action against that corporation's or partnership's principle officers of record at the time of dissolution.

(c) Abandoned means violating subdivision (a) and leaving patients treated by the licensee without access to medical information to which they are entitled pursuant to Section 123110.

(Added by Stats. 1995, Ch. 415, Sec. 8. Effective January 1, 1996.)

123147. (a) Except as provided in subdivision (b), all health facilities, as defined in Section 1250, and all primary care clinics that are either licensed under Section 1204 or exempt from licensure under Section 1206, shall include a patient's principal spoken language on the patient's health records.

(b) Any long-term health care facility, as defined in Section 1418, that already completes the minimum data set form as specified in Section 14110.15 of the Welfare and Institutions Code, including documentation of a patient's principal spoken language, shall be deemed to be in compliance with subdivision (a).

(Added by Stats. 2005, Ch. 313, Sec. 1. Effective January 1, 2006.)

123148. (a) Notwithstanding any other law, a health care professional at whose request a test is performed shall provide or arrange for the provision of the results of a test to the patient who is the subject of the test if so requested by the patient, in oral or written form. The results shall be disclosed in plain language and in oral or written form, except the results may be disclosed in electronic form if requested by the patient unless deemed inappropriate by the health care professional who requested the test. The telephone shall not be considered an electronic form of disclosing test results subject to the limits on electronic disclosure of test results for the purpose of this section.

(b) (1) Consent of the patient to receive their test results by internet posting or other electronic means shall be obtained in a manner consistent with the requirements of Section 56.10 or 56.11 of the Civil Code. In the event that a health care professional arranges for the provision of test results by internet posting or other electronic manner, the results shall be disclosed to a patient in a reasonable time period. Access to test results shall be restricted by the use of a secure personal identification number when the results are disclosed to a patient by internet posting or other electronic manner.

(2) Paragraph (1) shall not prohibit direct communication by internet posting or the use of other electronic means to disclose test results by a treating health care professional who ordered the test for their patient or by a health care professional acting on behalf of, or with the authorization of, the treating health care professional who ordered the test.

(c) When a patient requests access to their test results by internet posting, the health care professional shall advise the patient of any charges that may be assessed directly to the patient or insurer for the service and that the patient may call the health care professional for a more detailed explanation of the laboratory test results when delivered.

(d) The electronic disclosure of test results under this section shall be in accordance with any applicable federal law governing privacy and security of electronic personal health records. However, any state statute that governs privacy and security of electronic personal health records, shall apply to test results under this section and shall prevail over federal law if federal law permits.

(e) The test results to be reported to the patient pursuant to this section shall be recorded in the patient's medical record, and shall be reported to the patient within a reasonable time period after the test results are received by the health care professional who requested the test.

(f) Notwithstanding subdivision (a), unless the patient requests the disclosure, the health care professional deems this disclosure as an appropriate means, and a health care professional has first discussed in person, by telephone, or by any other means of oral communication, the test results with the patient, in compliance with any other applicable laws, none of the following test results and any other related results shall be disclosed to a patient by internet posting or other electronic means:

(1) (A) A positive HIV test, unless an HIV test subject is anonymously tested and the test result is posted on a secure internet website and can only be viewed with the use of a secure code that can access only a single set of test results and that is provided to the patient at the time of testing. The test result shall be posted only if there is no link to any information that identifies or refers to the subject of the test and the information required pursuant to subdivision (h) of Section 120990 is provided.

(B) Subparagraph (A) does not prevent the disclosure of HIV test results, including viral load and CD4 count test results, to a patient living with HIV by secure internet website or other electronic means if the patient has previously been informed about the results of a positive HIV test pursuant to the requirements of this section.

(2) Presence of antigens indicating a hepatitis infection.

(3) Abusing the use of drugs.

(4) Test results related to routinely processed tissues and imaging scans that reveal a new or recurrent malignancy.

(g) Patient identifiable test results and health information that have been provided under this section shall not be used for any commercial purpose without the consent of the patient, obtained in a manner consistent with the requirements of Section 56.11 of the Civil Code. In no event shall patient identifiable HIV-related test results and health information disclosed in this section be used in violation of subdivision (f) of Section 120980.

(h) A third party to whom test results are disclosed pursuant to this section shall be deemed a provider of administrative services, as that term is used in paragraph (3) of subdivision (c) of Section 56.10 of the Civil Code, and shall be subject to all limitations and penalties applicable to that section.

(i) A patient may not be required to pay a cost, or be charged a fee, for electing to receive their test results in a manner other than by internet posting or other electronic form.

(j) A patient or their physician may revoke consent provided under this section at any time and without penalty, except to the extent that action has been taken in reliance on that consent.

(k) As used in this section, "test" applies to both clinical laboratory tests and imaging scans, such as x-rays, magnetic resonance imaging, ultrasound, or other similar technologies.

(l) As used in this section, "internet posting" includes posting to an online patient portal.

(Amended by Stats. 2022, Ch. 888, Sec. 3. (SB 1419) Effective January 1, 2023.)

123149. (a) Providers of health services, licensed pursuant to Sections 1205, 1253, 1575, and 1726, that utilize electronic recordkeeping systems only, shall comply with the additional requirements of this section. These additional requirements do not apply to patient records if hard copy versions of the patient records are retained.

(b) Any use of electronic recordkeeping to store patient records shall ensure the safety and integrity of those records at least to the extent of hard copy records. All providers set forth in subdivision (a) shall ensure the safety and integrity of all electronic media used to store patient records by employing an offsite backup storage system, an image mechanism that is able to copy signature documents, and a mechanism to ensure that once a record is input, it is unalterable.

(c) Original hard copies of patient records may be destroyed once the record has been electronically stored.

(d) The printout of the computerized version shall be considered the original as defined in Section 255 of the Evidence Code for purposes of providing copies to patients, the Division of Licensing and Certification, and for introduction into evidence in accordance with Sections 1550 and 1551 of the Evidence Code, in administrative or court proceedings.

(e) Access to electronically stored patient records shall be made available to the Division of Licensing and Certification staff promptly, upon request.

(f) This section does not exempt licensed clinics, health facilities, adult day health care centers, and home health agencies from the requirement of maintaining original copies of patient records that cannot be electronically stored.

(g) Any health care provider subject to this section, choosing to utilize an electronic recordkeeping system, shall develop and implement policies and procedures to include safeguards for confidentiality and unauthorized access to electronically stored patient health records, authentication by electronic signature keys, and systems maintenance.

(h) Nothing contained in this chapter shall affect the existing regulatory requirements for the access, use, disclosure, confidentiality, retention of record contents, and maintenance of health information in patient records by health care providers.

(i) This chapter does not prohibit any provider of health care services from maintaining or retaining patient records electronically.

(Added by Stats. 1995, Ch. 415, Sec. 8. Effective January 1, 1996.)

123149.5. (a) It is the intent of the Legislature that all medical information transmitted during the delivery of health care via telehealth, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, become part of the patient's medical record maintained by the licensed health care provider.

(b) This section shall not be construed to limit or waive any of the requirements of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(Amended by Stats. 2012, Ch. 782, Sec. 8. (AB 1733) Effective January 1, 2013.)