

Proposed Amendments to Title 37.2 to Support Discharge Planning for Involuntarily Hospitalized Patients in Private Hospitals

Individuals who are involuntarily hospitalized under a temporary detention order (TDO) are experiencing a severe mental health crisis. Research has shown that a substantial number of these individuals are not in community-based mental health care at the time of their hospitalization (with some having never been in care and others having terminated care), and this lack of care in the community is often a factor in their experiencing crisis and needing involuntary inpatient care.

A substantial percentage of the individuals who are hospitalized under a TDO are able to achieve stability over the course of the 24 to 72 hours that pass before their involuntary commitment hearing, and at that hearing the special justice dismisses the involuntary commitment petitions filed in regard to them. As a result, they are immediately discharged. Often, their stay in the hospital is simply too short for hospital staff to develop a meaningful discharge plan for them to connect them to community-based services. As a result, they leave the hospital without the kinds of supports they need to maintain stability in the community. They remain at risk of experiencing another crisis and “cycling” back into involuntary inpatient care. The dangers are particularly high for individuals who are hospitalized for suicidal thoughts or actions, as research shows that they are at a dramatically higher risk to die by suicide during the six months following their inpatient hospitalization, *especially* if there is no follow-up contact.

In regard to individuals who are involuntarily committed to a state psychiatric facility, Sections 37.2-837 and 37.2-839 already require discharge planning services for those individuals, and for communication between the state hospitals and the local community services boards (CSBs) in developing and carrying out those discharge plans. When, for whatever reason, an involuntarily hospitalized patient declines to authorize the exchange of information between a state hospital and a local CSB to develop that patient’s discharge plan, Section 37.2-839 authorizes the hospital and CSB to make those exchanges (and for the CSB to communicate with local service providers for that patient) to ensure that supportive services are available for that person upon discharge from the hospital.

There are no similar specific provisions in the Virginia Code for communication between private hospitals and CSBs regarding community-based treatment plans for individuals who are involuntarily hospitalized there under a TDO or an involuntary commitment order, even though almost 80% of involuntarily hospitalized individuals are placed in private hospitals statewide. CSBs do not routinely provide discharge planning for individuals TDO’d or committed to private hospitals, as the CSBs normally are the community treatment providers for only a small percentage of the individuals who are involuntarily hospitalized.

However, for those individuals who were in CSB care prior to involuntary hospitalization, being able to meet with and develop a community plan of care with the CSB can be vitally important for the safe and stable return of these individuals to their

communities. In addition, some CSBs are starting to offer planning services to individuals who were not in treatment at the time of their involuntary hospitalization, with the goal of helping these individuals maintain stability following discharge and avoid “cycling” back into involuntary inpatient care.

Because Title 37.2 does not address communications between the CSBs and private hospitals in regard to these patients, there are often doubts about what the hospitals and CSBs can share about these patients under the federal HIPAA Privacy Rule and under state privacy laws in order to carry out effective planning for community based services. HIPAA clearly allows mental health service providers who have the same client to share information about that client for treatment and treatment planning purposes, without specific written authorization from the client. In addition, the federal government, through a variety of agencies, has supported, authorized and in some cases (under Medicare regulations in particular) required hospitals to develop and implement discharge plans that connect patients to community services. Finally, HIPAA, under 45 CFR 164.502(a), authorizes health care providers to disclose patient information when such disclosure is required by state law.

The attached proposed amendments to Virginia Code Sections 37.2-813, 37.2-838 and 37.2-839, would provide that, where a local CSB offers to provide planning for community based services to individuals who have been TDO'd or involuntarily committed to a private hospital, the hospital *shall* provide reasonable and timely access by CSB employees, agents or contractors, and upon request shall provide client information to these individuals, so that this planning can be offered and carried out. By requiring that this access and this information be provided, the amendments remove any ambiguities that hospitals might feel about whether they can, or should, provide such access or information. This in turn would enhance the ability of the CSBs to provide timely and appropriate service planning services for individuals in the hospital to facilitate their successful discharge and their transition back to life in the community.

Notably, the amendments also require the CSBs, when requested by the hospitals, to work with the hospitals on developing written protocols that would provide guidance on how such access and information would be provided.

These amendments, then, provide both the direction and authorization needed to improve the planning that is so important for an individual's successful transition from crisis back to life in the community.

§ 37.2-813. Release of person prior to commitment hearing for involuntary admission; *planning for community based services.*

- A. Prior to a hearing as authorized in §§ 37.2-814 through 37.2-819, the district court judge or special justice may release the person on his personal recognizance or bond set by the district court judge or special justice if it appears from all evidence readily available that the person does not meet the commitment criteria specified in subsection D of § 37.2-817.
- B. The director of any facility in which the person is detained may release the person prior to a hearing as authorized in §§ 37.2-814 through 37.2-819 if it appears, based on an evaluation conducted by the psychiatrist or clinical psychologist treating the person, that the person would not meet the commitment criteria specified in subsection D of § 37.2-817 if released.
- C. *Where a community services board or behavioral health authority offers planning services to individuals who have been placed in a mental health facility under a temporary detention order, the facility shall allow reasonable and timely access to such individuals by employees, agents or contractors designated by the community services board or behavioral health authority to help such individuals identify and participate in community based services following release. . Upon request by any such employee, agent or contractor, the facility shall provide information in its possession regarding such individuals that the board or authority employee, agent or contractor determines is needed to develop a plan for providing community based services.*
- D. *At the request of the facility or the community services board or behavioral health authority that offers planning services described in subsection C above, a written protocol shall be developed by the parties setting out agreed procedures for the facility to provide reasonable and timely access to individuals and to information in the facility's possession regarding such individuals. The right of access to individuals and information by board or authority employees, agents or contractors under subsection C shall not be dependent upon the completion of such a protocol.*

§ 37.2-838. Discharge of individuals from a licensed hospital.

- A. The person in charge of a licensed hospital may discharge any individual involuntarily admitted who is recovered or, if not recovered, whose discharge will not be detrimental to the public welfare or injurious to the individual, or who meets other criteria as specified in § 37.2-837.
- B. Prior to discharging any individual who has not executed an advance directive, the person in charge of a licensed hospital or his designee shall give to the individual a written explanation of the procedures for executing an advance directive in accordance with the Health Care Decisions Act (§ 54.1-2981 et seq.) and an advance directive form, which may be the form set forth in § 54.1-2984.
- C. The person in charge of the licensed hospital may refuse to discharge any individual involuntarily admitted, if, in his judgment, the discharge will be detrimental to the public welfare or injurious to the individual.
- D. The person in charge of a licensed hospital may grant a trial or home visit to an individual in accordance with regulations adopted by the Board.
- E. *Where discharge planning services are offered by a community services board or behavioral health authority for individuals who have been placed in a licensed hospital under an involuntary commitment order, the facility shall allow reasonable and timely access to such individuals by employees, agents or contractors designated by the community services board to provide such services, and shall coordinate hospital discharge planning with the designated board or authority employee, agent or contractor. Upon request by any such employee, agent or contractor, the facility shall promptly provide information in its possession regarding such individuals that the employee, agent or contractor determines is needed to develop the discharge plan.*
- F. *At the request of the hospital or the community services board or behavioral health authority that offers discharge planning services described in subsection E above, a written protocol shall be developed by the parties setting out agreed procedures for providing reasonable and timely access to individuals and to information regarding such individuals. The right of access to individuals and information by board or authority employees, agents or contractors under subsection E shall not be dependent upon the completion of such a protocol.*

§ 37.2-839. Exchange of information between community services boards or behavioral health authorities and state facilities *and private licensed hospitals.*

- A. Community services boards or behavioral health authorities and state facilities *and private licensed hospitals may shall*, when the individual has refused authorization, exchange the information required to prepare and implement a comprehensive individualized treatment plan, including a discharge plan as specified in subsection A of § 37.2-837 *or subsection E of § 37.2-838*. This section shall apply to all individuals receiving services from community services boards, behavioral health authorities, and state facilities, *and to those individuals in private licensed hospitals under an order of involuntary commitment entered pursuant to Section 37.2-817 for whom the local board or authority has offered to develop a discharge plan or to coordinate with the hospital in the development and execution of such a plan.*
- B. When an individual who is deemed suitable for discharge pursuant to subsection A of § 37.2-837 *or § 37.2-838* or his guardian or conservator refuses to authorize the release of information that is required to formulate and implement a discharge plan as specified in subsection A of § 37.2-837 *or subsection E of § 37.2-838*, then the community services board or behavioral health authority may release without authorization to those service providers and human service agencies identified in the discharge plan only the information needed to secure those services specified in the plan.
- C. The release of any other information about an individual receiving services to any agency or person not affiliated directly or by contract with community services boards, behavioral health authorities, ~~or~~ state facilities *or private licensed hospitals* shall be subject to all regulations adopted by the Board or by agencies of the United States government that govern confidentiality of patient information.
- D. *At the request of a state facility or private licensed hospital, or community services board or behavioral health authority, a written protocol setting out agreed procedures for exchanging information as authorized in subsection A above shall be developed between the cooperating entities. The right of timely access to such information by state facilities, private licensed hospitals, and community services boards and behavioral health authorities under subsection A above shall not be dependent upon the completion of such a protocol.*

Temporary Detention Orders for Medical Care: Enabling Magistrates to Act

Virginia Code Section 37.2-1104 enables physicians to seek an order authorizing the temporary detention (up to 24 hours) of a patient who appears incapable of giving informed consent to treatment (or incapable of communicating consent) due to a mental or physical condition and the “medical standard of care” calls for testing, observing or treating the patient within the next 24 hours “to prevent death or disability, or to treat an emergency medical condition that requires immediate action to avoid harm, injury or death”. Not surprisingly, the vast majority of requests for these “medical TDOs” come from hospital Emergency Department (ED) physicians who are trying to treat patients who are brought into the ED and need particular care but are found to be incapable of making an informed decision about such care.

These are often situations that require immediate action by the hospital ED staff, so that prompt review and authorization is often needed. Section 37.2-1104 requires the physicians to first seek a temporary TDO from “the court”. Only if the court is “unavailable” can a medical TDO be sought from a magistrate. There is no definition of what constitutes being “unavailable”.

Understandably, it can often take many hours, extending into a day or days, for a judge to be available to hear and act on a request for a medical TDO. Magistrates, while often busy, are open 24 hours a day, 7 days a week, and have far more flexibility than the courts to respond to emergency requests such as the request for a medical TDO.

Magistrates are already the sole judicial officers with the authority to enter TDOs for psychiatric hospitalization, and, as noted, Section 37.2-1104 already includes them as appropriate decision-makers for entering medical TDOs. Given the fact that the welfare of patients in a hospital ED may depend upon prompt action authorizing the temporary detention and care of a patient who is unable to give informed consent to needed treatment, a request is being made that Section 37.2-1104 be amended so that doctors can go directly to the magistrate for a medical TDO instead of having to first contact the local court and determine that the court is “unavailable”. This would improve the timeliness and the quality of care provided to patients in emergencies.

§ 37.2-1104. Temporary detention in hospital for testing, observation or treatment.

A. Upon the advice of a licensed physician who has attempted to obtain consent and upon a finding of probable cause to believe that an adult person within the court's jurisdiction is incapable of making an informed decision regarding treatment of a physical or mental condition or is incapable of communicating such a decision due to a physical or mental condition and that the medical standard of care calls for testing, observation, or treatment within the next 24 hours to prevent death or disability, or to treat an emergency medical condition that requires immediate action to avoid harm, injury, or death, the court or, ~~if the court is unavailable,~~ a magistrate serving the jurisdiction may issue an order authorizing temporary detention of the person by a hospital emergency room or other appropriate facility and authorizing such testing, observation, or treatment. The detention may not be for a period exceeding 24 hours, unless extended by the court as part of an order authorizing treatment under § 37.2-1101. If, before completion of authorized testing, observation, or treatment, the physician determines that a person subject to an order under this subsection has become capable of making and communicating an informed decision, the physician shall rely on the person's decision on whether to consent to further testing, observation, or treatment. If, before issuance of an order under this subsection or during its period of effectiveness, the physician learns of an objection by a member of the person's immediate family to the testing, observation, or treatment, he shall so notify the ~~court or~~ magistrate, who shall consider the objection in determining whether to issue, modify, or terminate the order.

B. A court or, ~~if the court is unavailable,~~ a magistrate serving the jurisdiction may issue an order authorizing temporary detention for testing, observation, or treatment for a person who is also the subject of an emergency custody order issued pursuant to § 37.2-808, if such person meets the criteria set forth in subsection A. In any case in which an order for temporary detention for testing, observation, or treatment is issued for a person who is also the subject of an emergency custody order pursuant to § 37.2-808, the hospital emergency room or other appropriate facility in which the person is detained for testing, observation, or treatment shall notify the nearest community services board when such testing, observation, or treatment is complete, and the designee of the community services board shall, as soon as is practicable and prior to the expiration of the order for temporary detention issued pursuant to subsection A, conduct an evaluation of the person to determine if he meets the criteria for temporary detention pursuant to § 37.2-809.

Ensuring that Needed Custody of a Person Held under an ECO is Maintained Until the TDO is Served: Amending Virginia Code Section 37.2-808(K)

Virginia Code Section 37.2-808(K) currently states that when a person is held in custody by a law enforcement officer under an emergency custody order (ECO) for mental health evaluation, the person “shall remain in custody” until a temporary detention order is “issued” by a magistrate, authorizing the person’s temporary psychiatric hospitalization. Virginia Code. There is often a period of time between the magistrate issuing the TDO and the law enforcement officer actually receiving it and serving it on the person for that person’s transport to the hospital. This is especially the case when the officer receiving and serving the TDO is a different officer than the one maintaining custody of the person under the ECO.

That fact has raised this concern among officers and others: what authority does an officer have to maintain custody of a person under an ECO *after* the TDO is issued but *before* the TDO is served? Officers have been especially concerned about their custodial authority when the 8-hour ECO time period runs out before the TDO order arrives to be served on the person to be transported. In some cases an hour or more can elapse between the time the TDO is issued and the time it is served, and Section 37.2-809(I) provides that the TDO can be served up to 24 hours after it is issued. Officers need the assurance that they have the authority to keep a person in custody until the TDO arrives.

To ensure the continuity of custody and care, the proposed amendment to Section 37.2-808(K) specifically provides that the person in custody under an ECO will remain in custody until the TDO is issued *and served* on the person, after which the person will remain in custody under the authority of the TDO. The amendment also specifies that if the ECO’s 8-hour limit is reached after the TDO is entered but before it is served, the person still remains in custody until service of the TDO, unless the TDO for any reason is rendered void.

This amendment will provide needed assurance to officers regarding their custodial authority during the transition from an ECO to a TDO.

§ 37.2-808. Emergency custody; issuance and execution of order.

A. Any magistrate shall issue, upon the sworn petition of any responsible person, treating physician, or upon his own motion, an emergency custody order when he has probable cause to believe that any person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment. Any emergency custody order entered pursuant to this section shall provide for the disclosure of medical records pursuant to § 37.2-804.2. This subsection shall not preclude any other disclosures as required or permitted by law.

When considering whether there is probable cause to issue an emergency custody order, the magistrate may, in addition to the petition, consider (1) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (2) any past actions of the person, (3) any past mental health treatment of the person, (4) any relevant hearsay evidence, (5) any medical records available, (6) any affidavits submitted, if the witness is unavailable and it so states in the affidavit, and (7) any other information available that the magistrate considers relevant to the determination of whether probable cause exists to issue an emergency custody order.

B. Any person for whom an emergency custody order is issued shall be taken into custody and transported to a convenient location to be evaluated to determine whether the person meets the criteria for temporary detention pursuant to § 37.2-809 and to assess the need for hospitalization or treatment. The evaluation shall be made by a person designated by the community services board who is skilled in the diagnosis and treatment of mental illness and who has completed a certification program approved by the Department.

C. The magistrate issuing an emergency custody order shall specify the primary law-enforcement agency and jurisdiction to execute the emergency custody order and provide transportation. However, the magistrate shall consider any request to authorize transportation by an alternative transportation provider in accordance with this section, whenever an alternative transportation provider is identified to the magistrate, which may be a person, facility, or agency, including a family member or friend of the person who is the subject of the order, a representative of the community services board, or other transportation provider with personnel trained to provide transportation in a safe manner, upon determining, following consideration of information provided by the petitioner; the community services board or its designee; the local law-enforcement agency, if any; the person's treating physician, if any; or other persons who are available and have knowledge of the person, and, when the magistrate deems appropriate, the proposed alternative transportation provider, either in person or via two-way electronic video and audio or telephone communication system, that the proposed alternative transportation

provider is available to provide transportation, willing to provide transportation, and able to provide transportation in a safe manner. When transportation is ordered to be provided by an alternative transportation provider, the magistrate shall order the specified primary law-enforcement agency to execute the order, to take the person into custody, and to transfer custody of the person to the alternative transportation provider identified in the order. In such cases, a copy of the emergency custody order shall accompany the person being transported pursuant to this section at all times and shall be delivered by the alternative transportation provider to the community services board or its designee responsible for conducting the evaluation. The community services board or its designee conducting the evaluation shall return a copy of the emergency custody order to the court designated by the magistrate as soon as is practicable. Delivery of an order to a law-enforcement officer or alternative transportation provider and return of an order to the court may be accomplished electronically or by facsimile.

Transportation under this section shall include transportation to a medical facility as may be necessary to obtain emergency medical evaluation or treatment that shall be conducted immediately in accordance with state and federal law. Transportation under this section shall include transportation to a medical facility for a medical evaluation if a physician at the hospital in which the person subject to the emergency custody order may be detained requires a medical evaluation prior to admission.

D. In specifying the primary law-enforcement agency and jurisdiction for purposes of this section, the magistrate shall order the primary law-enforcement agency from the jurisdiction served by the community services board that designated the person to perform the evaluation required in subsection B to execute the order and, in cases in which transportation is ordered to be provided by the primary law-enforcement agency, provide transportation. If the community services board serves more than one jurisdiction, the magistrate shall designate the primary law-enforcement agency from the particular jurisdiction within the community services board's service area where the person who is the subject of the emergency custody order was taken into custody or, if the person has not yet been taken into custody, the primary law-enforcement agency from the jurisdiction where the person is presently located to execute the order and provide transportation.

E. The law-enforcement agency or alternative transportation provider providing transportation pursuant to this section may transfer custody of the person to the facility or location to which the person is transported for the evaluation required in subsection B, G, or H if the facility or location (i) is licensed to provide the level of security necessary to protect both the person and others from harm, (ii) is actually capable of providing the level of security necessary to protect the person and others from harm, and (iii) in cases in which transportation is provided by a law-enforcement agency, has entered into an agreement or memorandum of understanding with the law-enforcement agency setting forth the terms and conditions under which it will accept a transfer of custody, provided, however, that the facility or location may not require the law-enforcement agency to pay any fees or costs for the transfer of custody.

F. A law-enforcement officer may lawfully go or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of executing an emergency custody order pursuant to this section.

G. A law-enforcement officer who, based upon his observation or the reliable reports of others, has probable cause to believe that a person meets the criteria for emergency custody as stated in this section may take that person into custody and transport that person to an appropriate location to assess the need for hospitalization or treatment without prior authorization. A law-enforcement officer who takes a person into custody pursuant to this subsection or subsection H may lawfully go or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of obtaining the assessment. Such evaluation shall be conducted immediately. The period of custody shall not exceed eight hours from the time the law-enforcement officer takes the person into custody.

H. A law-enforcement officer who is transporting a person who has voluntarily consented to be transported to a facility for the purpose of assessment or evaluation and who is beyond the territorial limits of the county, city, or town in which he serves may take such person into custody and transport him to an appropriate location to assess the need for hospitalization or treatment without prior authorization when the law-enforcement officer determines (i) that the person has revoked consent to be transported to a facility for the purpose of assessment or evaluation, and (ii) based upon his observations, that probable cause exists to believe that the person meets the criteria for emergency custody as stated in this section. The period of custody shall not exceed eight hours from the time the law-enforcement officer takes the person into custody.

I. Nothing herein shall preclude a law-enforcement officer or alternative transportation provider from obtaining emergency medical treatment or further medical evaluation at any time for a person in his custody as provided in this section.

J. A representative of the primary law-enforcement agency specified to execute an emergency custody order or a representative of the law-enforcement agency employing a law-enforcement officer who takes a person into custody pursuant to subsection G or H shall notify the community services board responsible for conducting the evaluation required in subsection B, G, or H as soon as practicable after execution of the emergency custody order or after the person has been taken into custody pursuant to subsection G or H.

K. The person shall remain in custody until (1) a temporary detention order is issued *and served upon the person, at which time the person shall remain in custody under the authority of the temporary detention order;* ~~or~~ (2) until the person is released; ~~or~~ (3) until the emergency custody order expires. An emergency custody order shall be valid for a period not to exceed eight hours from the time of execution; *provided, however, that if that eight hour limit is reached after a temporary detention order is entered but before it is served, the person shall remain in custody until the temporary detention order is served, unless the temporary detention order for any reason is rendered void.*

L. Nothing in this section shall preclude the issuance of an order for temporary detention for testing, observation, or treatment pursuant to § 37.2-1104 for a person who is also the subject of an emergency custody order issued pursuant to this section. In any case in which an order for temporary detention for testing, observation, or treatment is issued for a person who is also the subject of an emergency custody order, the person may be detained by a hospital emergency room or other appropriate facility for testing, observation, and treatment for a period not to exceed 24 hours, unless extended by the court as part of an order pursuant to § 37.2-1101, in accordance with subsection A of § 37.2-1104. Upon completion of testing, observation, or treatment pursuant to § 37.2-1104, the hospital emergency room or other appropriate facility in which the person is detained shall notify the nearest community services board, and the designee of the community services board shall, as soon as is practicable and prior to the expiration of the order for temporary detention issued pursuant to § 37.2-1104, conduct an evaluation of the person to determine if he meets the criteria for temporary detention pursuant to § 37.2-809.

M. Any person taken into emergency custody pursuant to this section shall be given a written summary of the emergency custody procedures and the statutory protections associated with those procedures.

N. If an emergency custody order is not executed within eight hours of its issuance, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if such office is not open, to any magistrate serving the jurisdiction of the issuing court.

O. In addition to the eight-hour period of emergency custody set forth in subsection G, H, or K, if the individual is detained in a state facility pursuant to subsection E of § 37.2-809, the state facility and an employee or designee of the community services board as defined in § 37.2-809 may, for an additional four hours, continue to attempt to identify an alternative facility that is able and willing to provide temporary detention and appropriate care to the individual.

P. Payments shall be made pursuant to § 37.2-804 to licensed health care providers for medical screening and assessment services provided to persons with mental illnesses while in emergency custody.

Q. No person who provides alternative transportation pursuant to this section shall be liable to the person being transported for any civil damages for ordinary negligence in acts or omissions that result from providing such alternative transportation.

Individuals in Mental Health Crisis Who Have Complex Medical Conditions: The Need to Change Current Law to Prevent Inappropriate Placements in State Psychiatric Facilities

In 2014, the General Assembly amended Section 37.2-809 of the Virginia Code to provide that, if an individual being held under an 8-hour Emergency Custody Order (ECO) due to a mental health crisis is found to meet the criteria for temporary psychiatric hospitalization under a Temporary Detention Order (TDO), and no private psychiatric facility can be identified to accept the person under the TDO, “the individual shall be detained in a state facility for the treatment of individuals with mental illness...”

Prior to the passage of this amendment, if the 8-hour ECO period terminated without a willing private or state hospital being found for placement of the person under a TDO, the person could no longer be kept in custody. Sometimes such individuals cooperated with crisis workers and remained in care until a hospital bed was found for them. On some occasions these individuals would leave, a phenomenon referred to as “streeting”, with the result that these individuals walked away from care while still in mental health crisis. The tragedy of Gus Deeds’ attack on his father and his subsequent suicide following his own “streeting” incident prompted this 2014 statutory change, sometimes referred to as the “placement of last resort” requirement, to ensure that a hospital placement would be available for all such individuals experiencing mental health crisis that required intervention through an ECO.

In the ensuing years, there has been a dramatic overall increase in Virginia in the number of individuals needing crisis mental health services, and in both the ECOs issued for their evaluation and in the TDOs issued for their temporary hospital care. While the total number of TDOs issued has stabilized overall in the last 2 years, the number of TDOs issued for placement in state hospitals under the “placement of last resort” requirement has continued to rise dramatically, with the result that the state hospitals have a patient census approaching 100%, far beyond the levels recommended for good patient care and safety. This is due to the fact that private hospitals are accepting fewer patients for TDO placements. The available evidence is that a key part of the reason for fewer private beds being available for TDO placements is that there continues to be a steady increase in *voluntary* private psychiatric hospitalizations, thereby making fewer beds available for involuntary care. In addition, some private beds are becoming unavailable, either temporarily or permanently, because of new hospital accreditation standards (especially those to reduce “ligature” risks with suicidal patients) and workforce coverage challenges. It also appears, by report from CSB crisis services staff, that the private hospitals almost always decline for TDO placement individuals who (1) are aggressive or have a history of aggression, (2) have ID/DD, (3) have dementia, or (4) have a history indicating that they will be difficult to discharge back in the community. As a result, the state psychiatric hospitals are receiving increasing numbers of individuals who present the greatest behavioral and placement challenges. Notably, private hospitals are still accepting approximately 80% of all TDO patients, but just four years ago they were accepting well over 90% of such patients. In those four years the number of TDO patients received by the state psychiatric hospitals has more than tripled.

The state hospitals are also receiving an increasing number of patients who have complex medical conditions; for example: severe burns requiring acute care, unstable seizure disorders, unstable fractures, acute respiratory distress, conditions requiring dialysis treatment, and high risk pregnancies. The state psychiatric hospitals, as well as “freestanding” private psychiatric hospitals, do not have the on-site capacity to treat these complex conditions. Patients in the state hospitals who have such conditions must be transported by hospital staff to other medical facilities for treatment, a process that requires staff to spend many hours simply escorting patients to and from off-site services. When patients experience medical emergencies with these conditions, hospital staff have limited capacity to respond to them; an ambulance must be called, and direct treatment by specialists is delayed while the patient (and state hospital staff) must wait for ambulance transport. Finally, many of these individuals are physically and medically fragile, so that they are very vulnerable to harm in a hospital ward setting that includes psychotic patients.

In short, the TDO placement of these individuals in state psychiatric hospitals and private freestanding psychiatric hospitals places these individuals at greater risk of harm due to their medical condition and degrades the capacity of the hospital staff to focus on the mental health treatment needs of the patients in the hospital. These facilities are not an appropriate placement for these individuals. The freestanding private hospitals can respond to this reality by declining to accept these patients under a TDO. The state hospitals do not have that option. Under the “placement of last resort” legislation, they are obligated to accept these patients when the private hospitals do not.

It is clear that these patients can best be served in a general hospital setting that includes a psychiatric unit. There is no question that these patients are very challenging, and that it requires both cross-training and coordination among hospital medical and psychiatric staff to properly address the complex needs of these patients. It is also likely that current insurance reimbursement does not even cover the costs of providing the care these patients need, thus increasing the reluctance of the private hospitals to accept them. All of the legitimate concerns of the general hospitals, however, pale against the challenges these patients pose to the state psychiatric hospitals, which have to take their patients off-site – often several miles off-site – to a different medical facility to obtain the medical treatment that a general hospital would have in the same building or complex where these patients would receive psychiatric care.

Private and public physicians throughout Virginia have recognized this reality. In the consensus document developed through the efforts of the state’s private and public hospitals, entitled *Criteria for Medical Assessment Prior to Admission to a Psychiatric Hospital, Inpatient Psychiatric or Crisis Stabilization Unit*, there is a chart entitled “Exclusion Criteria: Adult Admission to State Hospitals and Crisis Stabilization Units”. These are the patient conditions that doctors and hospitals statewide agree should *exclude* the patient’s admission to a state psychiatric hospital. There are additional conditions cited elsewhere, including high risk pregnancies, in which there should be a case-by-case determination of the state facility’s capacity to care for the patient. However, under

current Virginia law, state hospitals are required to accept patients who, by medical consensus, should be *excluded* from state hospitals, if no private hospital will accept that patient at the end of the 8-hour ECO period. This must not be allowed to continue, for the sake of these patients and for the sake of the state hospitals which are already taking on increasing numbers of the most difficult and challenging individuals experiencing mental health crisis. It is not too much to suggest that there is a moral obligation on the part of private hospitals with both medical and psychiatric capacity to take responsibility for the care of these individuals. The costs of doing so, and how those costs can be met, certainly are appropriate for discussion and action. However, such discussion should not delay providing relief to the state hospitals from what is an unjust burden, to them and to these patients.

To provide such relief, two versions of a new Virginia Code Section 37.2-809.2, entitled “Person with a complex medical condition”, have been drafted. The new section defines a “person with a complex medical condition” as one who has any of the conditions in the “exclusion” list in the *Criteria for Medical Assessment* document cited above, or any “comparable condition”. I have also added to the definition two conditions from the “case-by-case” consultation provision in the *Criteria for Medical Assessment* document: high risk pregnancy and inability to transfer or move independently, even with mechanical assistance”.

Both versions provide that, if a person with a complex medical condition is under an ECO and the 8-hour ECO period runs without a willing hospital being identified for TDO placement, a state facility is *not* required to accept the person if the facility’s medical director confirms that the facility does not have the staff or facilities to safely treat the person’s concurrent medical condition. It places the state facilities in the same position as the private facilities in being able to decline a patient they cannot properly treat.

One version of the new Section 37.2-809.2 ends with those provisions. The consequence is that, at the end of the 8-hour ECO, there is no order in place requiring the individual’s continuing placement in custody or the individual’s hospitalization.

The second version of the new section provides that, if a placement for such a person has not been found within the 8-hour ECO period, the ECO period shall be extended for an additional 24 hours. The law enforcement officer who has had custody of the person for the 8-hour ECO is released, unless the magistrate makes a specific finding that safety concerns require the officer’s presence. The Department of Behavioral Health and Developmental Services is authorized to offer psychiatric consultation services to the facility where the person is located if that facility is not part of a hospital with psychiatric consultation and care available.

If no placement can be found by hour 20 of that 24-hour ECO extension, the CSB evaluator must conduct another evaluation to determine whether the person continues to meet TDO criteria, and report to the magistrate. If the magistrate finds that the person meets TDO criteria, the magistrate must enter a TDO and identify the facility where the person is located as the person’s placement pending the involuntary commitment hearing.

(There may be objection that such a facility does not meet licensing or certification standards to be a TDO facility, but robust discussions with experts in the field did not produce any other solutions to the current problem.) The involuntary commitment hearing must be held within 48 hours of the entry of the TDO (with extensions for weekends, etc.).

The alternative version of Section 37.2-809.2 also specifically provides for the extension of the ECO period to enable the filing of a petition for judicial authorization of medical care under Section 37.2-1101. It's notable that some individuals have been TDO'd to a state hospital because they were refusing needed medical care (such as dialysis), with that refusal being a result of their distorted thinking due to their mental illness. In such a situation, the court or special justice could order the needed medical care, even over the person's objection, if the person was found to be incapable of making an informed decision about that care due to their mental illness. This would be an appropriate alternative to psychiatric hospitalization under a TDO, since the TDO only authorizes placement in a psychiatric facility and does not authorize the medical treatment that the person needs.

It appears that there may not be any way to meaningfully address the problems posed by these challenging patients until state facilities are given the same discretion as private facilities to decline these individuals because the facilities do not have the capacity to treat their complex medical needs. Given the other burdens that the state facilities have had to assume as private hospitals provide fewer beds for involuntary patients, state facilities should not remain the "placement of last resort" for individuals with complex medical needs. Private hospitals need to take responsibility for this small but challenging set of patients.

§ 37.2-809.2. Person with a complex medical condition

A. For purposes of this section, a “person with a complex medical condition” shall mean a person with one or more of the following or comparable conditions: severe burns requiring acute care; acute delirium; dementia as a primary diagnosis, in the absence of clinically significant psychiatric symptoms; acute head trauma/traumatic brain injury in the absence of a mental illness; unstable fractures, open or closed and joint dislocations in an acute condition; unstable seizure disorders; bowel obstruction requiring active treatment or medical observation; acute respiratory distress; acute drug intoxication, withdrawal, or presenting a high risk for complicated withdrawal, including delirium tremens; active gastrointestinal bleeding and/or active bleeding from other unknown sites; active tuberculosis and other diseases requiring isolation and/or treatment by intravenous antibiotics; a draining open wound requiring daily complex wound care; intravenous fluids or intravenous antibiotics; conditions requiring maintenance of the patient with ventilator or tracheostomy, or with oxygen supplying technologies beyond the normal capacity of the receiving hospital; chest or abdominal tubes or drains, including ostomies (unless the individual provides their own ostomy care); conditions requiring treatment with hemodialysis; conditions requiring peritoneal dialysis beyond the normal capacity of the receiving hospital; high risk pregnancy; inability to transfer or move independently, even with mechanical assistance.

B. In the case of a person with a complex medical condition who is in care under an emergency custody order and who has been found by the local community services board designee to meet the criteria for entry of a temporary detention order, but for whom a facility placement has not been found by the end of the 8 hour emergency custody order period, a state facility shall not be required to accept the person under a temporary detention order if the facility’s medical director certifies that the facility does not have the staff or facilities to safely treat the person’s concurrent complex medical condition. The Department may offer psychiatric consultation services to the facility where the person is located regarding management of the person’s psychiatric condition if the facility is not part of a hospital with psychiatric consultation and care available.

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B. In the case of a person with a complex medical condition who is in care under an emergency custody order and who has been found by the local community services board designee to meet the criteria for entry of a temporary detention order, but for whom a facility placement has not been found by the end of the 8 hour emergency custody order period, a state facility shall not be required to accept the person under a temporary detention order if the facility’s medical director certifies that the facility does not have the staff or facilities to safely treat the person’s concurrent complex medical condition. The Department may offer psychiatric consultation services to the facility where the person is located regarding management of the person’s psychiatric condition if the facility is not part of a hospital with psychiatric consultation and care available.

C. When a placement under a temporary detention order cannot be found in either a private or state facility for a person with a complex medical condition who is in care under an emergency custody order, and the emergency custody order period is about to expire, the magistrate shall extend the emergency custody order period for an additional 24 hours. Any law enforcement officer maintaining the custody of such a person during the original emergency custody order period shall be released from maintaining custody for the extended emergency custody order period; provided, however, that if the magistrate specifically finds, based upon information submitted, including information from the custodial law enforcement officer, that the safety of the person or others so requires, the magistrate may, as part of the extended emergency custody order, direct the officer to maintain custody of the person. The magistrate may terminate such directive at any time upon finding that that the officer is no longer needed.

D. If a petition is filed seeking judicial authorization for treatment of a person with a medically complex condition who is in care under an emergency custody order, the filing of such petition shall automatically extend the emergency custody order period until the completion of the hearing and entry of an order on such petition. Any law enforcement officer maintaining the custody of such a person during the original emergency custody order period shall be released from maintaining custody for the extended emergency custody order period in the event of such a petition.

E. If the person remains in custody under the extended emergency custody order entered pursuant to either subsection C or D above, and no hospital has accepted placement of the person at least 4 hours prior to the expiration of the extended emergency custody order period, the local community services board designee shall conduct an updated evaluation to determine whether the person continues to meet the criteria for entry of a temporary detention order and shall submit the findings of that evaluation to the magistrate prior to the termination of the extended emergency custody order period. If the magistrate finds that the person meets the criteria for entry of a temporary detention order, such order shall be entered and, if no willing receiving facility has been identified, the magistrate shall identify the hospital where the person is located as the facility for the person's temporary detention. The involuntary commitment hearing for such a person shall be held no later than 48 hours after entry of the temporary detention order, provided that if the 48 hour period terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the person may be detained under the temporary detention order until the close of business on the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed. The person may be released, pursuant to § 37.2-813, before the 48-hour period has run.

§ 37.2-809. Involuntary temporary detention; issuance and execution of order.

A. For the purposes of this section:

"Designee of the local community services board" means an examiner designated by the local community services board who (i) is skilled in the assessment and treatment of mental illness, (ii) has completed a certification program approved by the Department, (iii) is able to provide an independent examination of the person, (iv) is not related by blood or marriage to the person being evaluated, (v) has no financial interest in the admission or treatment of the person being evaluated, (vi) has no investment interest in the facility detaining or admitting the person under this article, and (vii) except for employees of state hospitals and of the U.S. Department of Veterans Affairs, is not employed by the facility.

"Employee" means an employee of the local community services board who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by the Department.

"Investment interest" means the ownership or holding of an equity or debt security, including shares of stock in a corporation, interests or units of a partnership, bonds, debentures, notes, or other equity or debt instruments.

B. A magistrate shall issue, upon the sworn petition of any responsible person, treating physician, or upon his own motion and only after an evaluation conducted in-person or by means of a two-way electronic video and audio communication system as authorized in § 37.2-804.1 by an employee or a designee of the local community services board to determine whether the person meets the criteria for temporary detention, a temporary detention order if it appears from all evidence readily available, including any recommendation from a physician or clinical psychologist treating the person, that the person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs; (ii) is in need of hospitalization or treatment; and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment. The magistrate shall also consider, if available, (a) information provided by the person who initiated emergency custody and (b) the recommendations of any treating or examining physician licensed in Virginia either verbally or in writing prior to rendering a decision. Any temporary detention order entered pursuant to this section shall provide for the disclosure of medical records pursuant to § 37.2-804.2. This subsection shall not preclude any other disclosures as required or permitted by law.

C. When considering whether there is probable cause to issue a temporary detention order, the magistrate may, in addition to the petition, consider (i) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (ii) any past actions of the person, (iii) any past mental health treatment of the person, (iv) any relevant hearsay evidence, (v) any medical records available, (vi) any affidavits submitted, if the witness is unavailable and it so states in the affidavit, and (vii) any other

information available that the magistrate considers relevant to the determination of whether probable cause exists to issue a temporary detention order.

D. A magistrate may issue a temporary detention order without an emergency custody order proceeding. A magistrate may issue a temporary detention order without a prior evaluation pursuant to subsection B if (i) the person has been personally examined within the previous 72 hours by an employee or a designee of the local community services board or (ii) there is a significant physical, psychological, or medical risk to the person or to others associated with conducting such evaluation.

E. An employee or a designee of the local community services board shall determine the facility of temporary detention in accordance with the provisions of § 37.2-809.1 for all individuals detained pursuant to this section. An employee or designee of the local community services board may change the facility of temporary detention and may designate an alternative facility for temporary detention at any point during the period of temporary detention if it is determined that the alternative facility is a more appropriate facility for temporary detention of the individual given the specific security, medical, or behavioral health needs of the person. In cases in which the facility of temporary detention is changed following transfer of custody to an initial facility of temporary custody, transportation of the individual to the alternative facility of temporary detention shall be provided in accordance with the provisions of § 37.2-810. The initial facility of temporary detention shall be identified on the preadmission screening report and indicated on the temporary detention order; however, if an employee or designee of the local community services board designates an alternative facility, that employee or designee shall provide written notice forthwith, on a form developed by the Executive Secretary of the Supreme Court of Virginia, to the clerk of the issuing court of the name and address of the alternative facility. Subject to the provisions of §§ 37.2-809.1 *and* 37.2-809.2, if a facility of temporary detention cannot be identified by the time of the expiration of the period of emergency custody pursuant to § 37.2-808, the individual shall be detained in a state facility for the treatment of individuals with mental illness and such facility shall be indicated on the temporary detention order. Except as provided in § 37.2-811 for inmates requiring hospitalization in accordance with subdivision A 2 of § 19.2-169.6, the person shall not be detained in a jail or other place of confinement for persons charged with criminal offenses and shall remain in the custody of law enforcement until the person is either detained within a secure facility or custody has been accepted by the appropriate personnel designated by either the initial facility of temporary detention identified in the temporary detention order or by the alternative facility of temporary detention designated by the employee or designee of the local community services board pursuant to this subsection. The person detained or in custody pursuant to this section shall be given a written summary of the temporary detention procedures and the statutory protections associated with those procedures.

F. Any facility caring for a person placed with it pursuant to a temporary detention order is authorized to provide emergency medical and psychiatric services within its capabilities when the facility determines that the services are in the best interests of the person within its care. The costs incurred as a result of the hearings and by the facility in

providing services during the period of temporary detention shall be paid and recovered pursuant to § 37.2-804. The maximum costs reimbursable by the Commonwealth pursuant to this section shall be established by the State Board of Medical Assistance Services based on reasonable criteria. The State Board of Medical Assistance Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary detention.

G. The employee or the designee of the local community services board who is conducting the evaluation pursuant to this section shall determine, prior to the issuance of the temporary detention order, the insurance status of the person. Where coverage by a third party payor exists, the facility seeking reimbursement under this section shall first seek reimbursement from the third party payor. The Commonwealth shall reimburse the facility only for the balance of costs remaining after the allowances covered by the third party payor have been received.

H. The duration of temporary detention shall be sufficient to allow for completion of the examination required by § 37.2-815, preparation of the preadmission screening report required by § 37.2-816, and initiation of mental health treatment to stabilize the person's psychiatric condition to avoid involuntary commitment where possible, but shall not exceed 72 hours prior to a hearing. If the 72-hour period herein specified terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the person may be detained, as herein provided, until the close of business on the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed. The person may be released, pursuant to § 37.2-813, before the 72-hour period herein specified has run.

I. If a temporary detention order is not executed within 24 hours of its issuance, or within a shorter period as is specified in the order, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if the office is not open, to any magistrate serving the jurisdiction of the issuing court. Subsequent orders may be issued upon the original petition within 96 hours after the petition is filed. However, a magistrate must again obtain the advice of an employee or a designee of the local community services board prior to issuing a subsequent order upon the original petition. Any petition for which no temporary detention order or other process in connection therewith is served on the subject of the petition within 96 hours after the petition is filed shall be void and shall be returned to the office of the clerk of the issuing court.

J. The Executive Secretary of the Supreme Court of Virginia shall establish and require that a magistrate, as provided by this section, be available seven days a week, 24 hours a day, for the purpose of performing the duties established by this section. Each community services board shall provide to each general district court and magistrate's office within its service area a list of its employees and designees who are available to perform the evaluations required herein.

K. For purposes of this section, a health care provider or designee of a local community services board or behavioral health authority shall not be required to encrypt any email

containing information or medical records provided to a magistrate unless there is reason to believe that a third party will attempt to intercept the email.

L. If the employee or designee of the community services board who is conducting the evaluation pursuant to this section recommends that the person should not be subject to a temporary detention order, such employee or designee shall (i) inform the petitioner, the person who initiated emergency custody if such person is present, and an onsite treating physician of his recommendation; (ii) promptly inform such person who initiated emergency custody that the community services board will facilitate communication between the person and the magistrate if the person disagrees with recommendations of the employee or designee of the community services board who conducted the evaluation and the person who initiated emergency custody so requests; and (iii) upon prompt request made by the person who initiated emergency custody, arrange for such person who initiated emergency custody to communicate with the magistrate as soon as is practicable and prior to the expiration of the period of emergency custody. The magistrate shall consider any information provided by the person who initiated emergency custody and any recommendations of the treating or examining physician and the employee or designee of the community services board who conducted the evaluation and consider such information and recommendations in accordance with subsection B in making his determination to issue a temporary detention order. The individual who is the subject of emergency custody shall remain in the custody of law enforcement or a designee of law enforcement and shall not be released from emergency custody until communication with the magistrate pursuant to this subsection has concluded and the magistrate has made a determination regarding issuance of a temporary detention order.

M. For purposes of this section, "person who initiated emergency custody" means any person who initiated the issuance of an emergency custody order pursuant to § 37.2-808 or a law-enforcement officer who takes a person into custody pursuant to subsection G of § 37.2-808.

§ 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 requester'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" includes 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" does 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;
3. The release of juvenile health records to a secure facility or a shelter care facility pursuant to § 16.1-248.3; or
4. The release of health records to a state correctional facility pursuant to § 53.1-40.10 or a local or regional correctional facility pursuant to § 53.1-133.03.

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 §§ 16.1-248.3, 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, **37.20813**, **37.2-838**, **37.2-839**, 53.1-40.10, 53.1-133.03, 54.1-2400.6, 54.1-2400.7, 54.1-2400.9, 54.1-2403.3, 54.1-2506, 54.1-2966, 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. 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 local school board pursuant to § 22.1-79.4, by a public institution of higher education pursuant to § 23.1-805, or by a private nonprofit institution of higher education; 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 requester as if it were an original. Within 30 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: (1) 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; (2) inform the requester if the information does not exist or cannot be found; (3) 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 (4) deny the request (A) under subsection F, (B) on the grounds that the requester has not established his authority to receive such health records or proof of his identity, or (C) as otherwise 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 Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 to a patient from disclosing information obtained from the Prescription Monitoring Program and contained in a patient's health care record to another health care provider when such disclosure is related to the care or treatment of the patient who is the subject of the record.