

GEORGIA PATIENT RECORDS LAWS

31-33-1.

As used in this chapter, the term:

(1) 'Patient' means any person who has received health care services from a provider.

(2) 'Provider' means all hospitals, including public, private, osteopathic, and tuberculosis hospitals; other special care units, including podiatric facilities, skilled nursing facilities, and kidney disease treatment centers, including freestanding hemodialysis units; intermediate care facilities; ambulatory surgical or obstetrical facilities; health maintenance organizations; and home health agencies. It shall also mean any person licensed to practice under Chapter 9, 11, 26, 34, 35, or 39 of Title 43.

(3) 'Record' means a patient's health record, including, but not limited to, evaluations, diagnoses, prognoses, laboratory reports, X-rays, prescriptions, and other technical information used in assessing the patient's condition, or the pertinent portion of the record relating to a specific condition or a summary of the record.

31-33-2.

(a)(1)(A) A provider having custody and control of any evaluation, diagnosis, prognosis, laboratory report, or biopsy slide in a patient's record shall retain such item for a period of not less than ten years from the date such item was created.

(B) The requirements of subparagraph (A) of this paragraph shall not apply to:

(i) An individual provider who has retired from or sold his or her professional practice if such provider has notified the patient of such retirement or sale and offered to provide such items in the patient's record or copies thereof to another provider of the patient's choice and, if the patient so requests, to the patient; or

(ii) A hospital which is an institution as defined in subparagraph (B) of paragraph (1) of Code Section 31-7-1, which shall retain patient records in accordance with rules and regulations for hospitals as issued by the department pursuant to Code Section 31-7-2.

(2) Upon written request from the patient or a person authorized to have access to the patient's record under a health care power of attorney for such patient, the provider having custody and control of the patient's record shall furnish a complete and current copy of that record, in accordance with the provisions of this Code section. If the patient is deceased, such request may be made by a person authorized immediately prior to the decedent's death to have access to the patient's record under a health care power of attorney for such patient; the executor, temporary executor, administrator, or temporary administrator for the decedent's estate; or any survivor, as defined by Code Sections 51-4-2, 51-4-4, and 51-4-5.

(b) Any record requested under subsection (a) of this Code section shall be furnished within a reasonable period of time to the patient, any other provider designated by the patient, any person authorized by paragraph (2) of subsection (a) of this Code section to request a patient's or deceased patient's medical

records, or any other person designated by the patient.

(c) If the provider reasonably determines that disclosure of the record to the patient will be detrimental to the physical or mental health of the patient, the provider may refuse to furnish the record; however, upon such refusal, the patient's record shall, upon written request by the patient, be furnished to any other provider designated by the patient.

(d) A provider shall not be required to release records in accordance with this Code section unless and until the requesting person has furnished the provider with a signed written authorization indicating that he or she is authorized to have access to the patient's records by paragraph (2) of subsection (a) of this Code section. Any provider shall be justified in relying upon such written authorization.

(e) Any provider or person who in good faith releases copies of medical records in accordance with this Code section shall not be found to have violated any criminal law or to be civilly liable to the patient, the deceased patient's estate, or to any other person.

31-33-3.

(a) The party requesting the patient's records shall be responsible to the provider for the costs of copying and mailing the patient's record. A charge of up to \$20.00 may be collected for search, retrieval, and other direct administrative costs related to compliance with the request under this chapter. A fee for certifying the medical records may also be charged not to exceed \$7.50 for each record certified. The actual cost of postage incurred in mailing the requested records may also be charged. In addition, copying costs for a record which is in paper form shall not exceed \$.75 per page for the first 20 pages of the patient's records which are copied; \$.65 per page for pages 21 through 100; and \$.50 for each page copied in excess of 100 pages. All of the fees allowed by this Code section may be adjusted annually in accordance with the medical component of the consumer price index. The Office of Planning and Budget shall be responsible for calculating this annual adjustment, which will become effective on July 1 of each year. To the extent the request for medical records includes portions of records which are not in paper form, including but not limited to radiology films, models, or fetal monitoring strips, the provider shall be entitled to recover the full reasonable cost of such reproduction. Payment of such costs may be required by the provider prior to the records being furnished. This subsection shall not apply to records requested in order to make or complete an application for a disability benefits program.

(b) The rights granted to a patient or other person under this chapter are in addition to any other rights such patient or person may have relating to access to a patient's records; however, nothing in this chapter shall be construed as granting to a patient or person any right of ownership in the records, as such records are owned by and are the property of the provider.

31-33-4.

The provisions of this chapter shall not apply to psychiatric, psychological, or other mental health records of a patient.

31-33-5.

Any provider releasing information in good faith pursuant to the provisions of this chapter shall not be civilly or criminally liable to the patient, guardian, parent, or any other person for such release.

31-33-6.

Nothing in this chapter shall be construed as destroying or diminishing the privileged or confidential nature of any communication now or hereafter recognized by law.

31-33-7.

(a) Notwithstanding the provisions of Code Section 31-33-4, if a law enforcement officer employed by a governmental entity is required to submit to a psychological or psychiatric examination for the purpose of assessing the law enforcement officer's fitness for duty, employment status, or assignment of duties, then, upon the written request of the law enforcement officer, the employer shall furnish to the law enforcement officer a complete copy of the evaluation or report.

(b) Any employer or health care provider furnishing or making a report or evaluation in good faith pursuant to the provisions of this Code section shall not be civilly or criminally liable to the law enforcement officer or any other person for furnishing or making such report or evaluation.

(c) If an employer reasonably determines that disclosure of the evaluation or report to the law enforcement officer will be detrimental to the mental health of the law enforcement officer, would present a risk of harm to other persons, would involve the disclosure of confidential information or would violate the privacy of a third party, then the employer may refuse to furnish the record of evaluation; provided, however, that upon such refusal the evaluation or report shall, upon written request by the law enforcement officer, be furnished by the employer to a psychiatrist or psychologist treating the law enforcement officer.