



RECORDS AND RECORD KEEPING

Record keeping has clinical, ethical, and legal purposes, and all recordings should be directed by a purpose. An important purpose for a record is to provide quality care by documenting the planful nature of an intervention and progress toward established goals. However, other ethical and legal purposes also affect the form and content of a record.

In agency based practice, information to be kept in records is determined by agency requirements and is consistent with the mission of the agency. In private practice settings, information kept in records is determined by the multiple purposes of a record. Be aware that as an individual practitioner you have ethical obligations to the standards of the profession, especially in reference to confidentiality.

The content of a record will vary by type of client, setting, and service approach. Consideration should be given to how the record will be used, and to who will have access to the record.

Content/documentation:

Records should be accurate, objective, and sufficient for their purposes. In some instances, the practitioner may want to provide evidence to support professional actions and demonstrate professional competence in their records. However, ethical mandates to protect client confidentiality and privacy rights should always be considered in making record entries.

Records should document the contractual relationship; any legal responsibilities, such as reports of abuse, duty to warn actions, court orders, etc.; and any supervision, consultation, or coordination of care. See *Disclosures for Informed Consent* and *Recommended Disclosures*, Colorado Chapter NASW Practice Standards Committee.

The types of services provided should be clearly identified. Dates of contact should be kept, and any contact locations other than the office should be noted.

The practitioner may want to consider documenting the therapeutic aspects of the relationship, including some elements of an assessment and intervention plan, and demonstrating progress. Clinical judgments and conclusions should be supported by the documentation. A termination note, including any steps taken by the practitioner regarding termination, is recommended.

Issues that a practitioner may want to document are high risk issues, such as suicidal or violent thoughts including an assessment of lethality and actions taken. Transference/countertransference discussions may be spelled out in a session note along with the practitioner assessment of the seriousness of the issue. In addition, any client generated documents, correspondence, greeting cards, etc should be kept in the record.

Notes of contacts with family, other individuals, or groups should be kept separate, in order to protect the rights to confidentiality of others.

The Clinician should always be judicious in their recording of client information. Information should be factual, accurate, objective, and necessary only for the purpose at hand. Avoid any unnecessary detail, and do not falsify information. The Clinician should never alter earlier notes and recordings, but they may review records and update new information pertinent to the intervention process.

Confidentiality and Security:

Confidentiality and protection of client privacy is a fundamental issue to be considered in all recordings. Ethical standards require that records be kept confidential, secure, and free from unauthorized access. However, unauthorized access to written material is always a possibility which suggests that entries should be the least amount necessary for the purposes of the record.

Because of the importance of client privacy, process recording is inappropriate in a client record and should be kept as a separate learning tool. To minimize the threat to personal privacy, entries into client records must be guarded by common sense, and should be the least amount of information needed to accomplish the purpose of the recording.

For ADAD licensed agencies, records are governed by 42CFR.

Records and information in records may not be released without the written consent of the client, unless it is required by law. Any released information should be marked Private and Confidential, and have a statement that the information may not be released to anyone else. Confidential information obtained from another professional should not be released by the practitioner. When a release of information is not in the best interest of the client, the practitioner is obligated to not release that information. In the event of Subpoenas or other legal requests for confidential information, the practitioner is obligated to assert the privileged communication granted to the client by the legal system.

See the *Disclosures for Informed Consent*, Colorado Chapter NASW Practice Standards Committee, document for a discussion of client competency in releasing information. If the practitioner has any reason to believe the client fails to understand or is impaired, the practitioner must proceed to protect the client's right to confidentiality.

Storage should be secure and not available to unauthorized access. This requires that records be locked or securely in your possession. Efforts should be made to keep records secure from damage by the elements or from being stolen.

Client Access:

Ethical Standards say that clients should be allowed “reasonable access” to their records if they request it, and CO statute 25-1-802 exempts practitioner from a legal duty to allow inspection or release of patient records to a patient in the absence of a subpoena or a court order. Access to mental health records is handled differently than access to other medical records, so it is recommended that mental health records be kept separate.

Because of the sensitive nature of the mental health record, release of the record to a client or others should be carefully monitored. Once a record is out of your hands, you have no control over the confidential information in it. It is not advisable to supply a photocopy of a record to the client. It is advisable to support the client who reads their record with a discussion about the content of the record and the client’s reactions to reading the record. Note that reasonable access does not require a practitioner to supply a physical copy. The practitioner must make a judgment about what is reasonable access for the individual client. Client access to records should be withheld only under unusual circumstances, such as when access to the information would pose a serious harm to the client.

The client has a right to have unauthorized access to records protected, and the practitioner has a duty to keep information conveyed within the professional relationship confidential. Information in records obtained from third parties should be treated as confidential and protected from unauthorized access by others including the client. Only authorized individuals should make entries into the client’s record.

The U.S. Supreme Court recently reviewed the psychotherapist-patient privilege communication in *Jaffee v. Redmond*. The Court held that the confidential communications between a licensed psychotherapist and patient during the course of diagnosis or treatment are privileged under the Federal Rules of Evidence. The Court further expressed the opinion that this privilege extends to the confidential communications made between a licensed practitioner and client in the course of psychotherapy.

Ownership:

The content of a record is the client’s, and the client must have reasonable access to the content. However, the practitioner or the agency is the physical custodian of the record, and has ethical and legal obligations to keep it safe from unauthorized access, as well as available to the client. For a discussion of the handling of records of minors see the section on record keeping contained in the Guidelines for Children in the Care of their Families.

Record disposal after termination, and retirement or death of the practitioner:

All clients have a right to access their records for up to 7 years. Minor clients have a right to access their records for up to 7 years after the client reaches majority. The Colorado Mental Health Practice Act requires that records be kept for at least 5 years, and that at least a summary record be kept for another 5 years. In the event that a practitioner retires or dies, record custody arrangements must be made so that the client's right to access, confidentiality, and privacy is protected. Whenever records are disposed of they should be destroyed by means such as shredding to protect confidentiality.

Computer storage and fax transmission:

Storage of records must be secure and free from unauthorized access. Computer and telecommunications technology require additional effort to protect records and transmission of confidential information. Client information entered on a computer should be password protected or encrypted. Fax transmittals should have a complete statement about the confidential nature of the information in the fax, and prohibitions against unauthorized access to the confidential information. Cellular phones may not be secure, and clients should be informed that exchange of information by cell phone may not be confidential. Extra efforts should be in place to protect confidentiality when using answering machines and e-mails.

Measures should be taken to protect against accidental loss of computer stored information. Regular backups and/or hard copies serve this function. Before disposing of a computer the hard drive should be purged.

Supervision and Consultation Records:

It is advisable for both the supervisor and the supervisee to keep confidential and secure records of the cases covered in the supervision. Any supervisory recommendations should be noted.

Managed Care Issues:

Contracts with managed care companies may give the company the right to review client records or even assert ownership of records by the company. These clauses should be carefully reviewed by the practitioner in light of existing ethical mandates to protect client confidentiality and privacy. Practitioner must inform clients of a potential conflict of interest and take every precaution to protect the privacy of the client. Record entries should always be limited to the purpose for the service, and any information revealed should be limited to the least amount necessary for the management of the case.

Subpoenas of Records

A subpoena for client records issued by an attorney in the name of the court requires an immediate response within the time frame of the subpoena. It is advisable to seek the professional help of an attorney.

After careful review of the subpoena, the practitioner should contact the client. If the client consents to the release of the information, a written release should be obtained from the client. No information should be discussed with the issuing attorney or with the client's attorney without the client's written consent. If the client does not consent to the release of information, the practitioner has an ethical responsibility to take some action to protect the client's private and confidential information.

*Actions to take include:

- Consult with an attorney.
- Write an objection to the subpoena and send it to the issuing attorney with a copy to the Court, stating the grounds for the objection.
- If the issuing attorney does not file a motion to compel, the practitioner may then file a motion for a protective order, and
- Request that the issuing court either quash or modify the subpoena. Acceptable reasons for quashing a subpoena are that it would require the recipient to travel more than 100 miles or across state lines, or that the subpoena requires disclosure of privileged communication made within a protected relationship (see *Jaffe v. Redman*).

*Information from Social Workers...*Practitioner and Subpoenas: Office of General Counsel Law Notes*, Carolyn I. Polowy, JD, NASW, January 1997.