Health, Department of

Community Program - Mental Health & Substance Abuse Program

Chapter 6: Records

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CHAPTER VI

CLINICAL RECORDS

Section 1. Written Clinical Records. The program shall maintain a written clinical record on each client. These records shall serve the dual purpose of providing information useful to program personnel and documentation necessary to satisfy the accountability requirements of authorized funding sources. Each record shall contain:

(a) Client identifying data that is recorded on the state MIS forms.

(b) A clinical assessment, including a diagnosis or diagnostic impression.

(c) Documentation that clients have been informed of their rights.

(d) A record of the consent of the client, or legally responsible other, for the client's treatment.

(e) A fee agreement signed by the client or legally responsible other.

(f) An individualized treatment plan based on the clinical assessment, including the services and strategies to be used to meet identified treatment goals.

(g) Periodic documentation of client progress in achieving treatment goals, including updates of individualized treatment plans as frequently as clinically indicated.

(h) A discharge summary written within 90 days of a client's last clinical contact containing a summary of pertinent case record information including referrals to other continuing care services.

(i) Dated and signed clinical entries, including the clinical degree or title of the staff member.

(j) Other pertinent documentation as applicable, including but not limited to medications prescribed by a physician affiliated with the program and written interpretation of testing.

(k) Clinical entries made in clinical records by persons who are not qualified to act as a primary therapist under these Standards must be countersigned by the clinical supervisor.

Section 2. Security of Records.

(a) Written policies shall govern the compilation, storage, accessibility, and disposal of client records. Client records shall be kept either in original form or in another acceptable form, such as but not limited to microfilm, microfiche, or optical disk storage, for a period of seven (7) years from the date of closure. If the record is part of an investigation or lawsuit or it is deemed clinically important not to destroy the record, the record shall be kept until all matters are resolved.

(b) Records and client data, including computerized information systems, shall be protected in a manner that provides confidentiality and security, including suitably locked and secured rooms and files,

and ability to retrieve information.

Section 3. Release of Information.

(a) A client or his or her legally responsible other may consent to the release of or request for confidential information concerning the client provided that written consent is given on a form containing the following information:

(i) The name of the program that is seeking to release or is requesting the information;

(ii) The name of the person, agency, or organization to which the information is to be released or from which the information is requested;

(iii) The name of the client;

(iv) The specific information to be released and the specific information requested;

(v) The purpose or need for the release or request;

(vi) The date or condition upon which consent will expire, reasonably related to the purpose of the request or release;

(vii) A statement that the consent may be revoked at any time except in instances where a particular action depends upon the consent remaining in effect;

(viii) The date the consent was signed; and

(ix) The signature of the client, or in the case of a person who is a minor or has been adjudicated by a court of law as incompetent, the signature of such person's parent or guardian.

(b) Releases or requests authorized by written consent must be accompanied by a notice prohibiting subsequent release.

(c) The client's consent shall be acquired in accordance with all applicable federal, state, and local laws, rules, and regulations.

(d) When information is released as the result of a signed consent, the actual date the information was requested or released and the signature of the staff member who released the information shall be made a part of the clinical record.

(e) In a life-threatening situation or when a person's condition or situation precludes the possibility of obtaining written consent, the program may release or request pertinent information without a signed consent.

(f) When information has been released or requested under emergency conditions, the responsible staff member shall enter all pertinent details of the transaction into the client's clinical record, including at a minimum the following items:

(i) The date the information was released or requested;

(ii) The person to whom the information was released or from whom requested;

(iii) The reason the information was released and/or the reason the information was requested;

(iv) The reason written consent could not be obtained; and

(v) The specific information released or requested.

(vi) The client shall be informed that the information was released or requested as soon as reasonable after the release of or request for information.

Section 4. Confidentiality of Client Information. The program shall protect the confidentiality of all information related to its clients and former clients.

(a) The program shall disclose no confidential information, including the fact that a person is or has been a client of the program, unless at least one of the following conditions prevails:

(i) The client or a legally responsible other consents in writing to the disclosure;

(ii) Exceptions allowed under 42 CFR, Part 2;

(iii) The disclosure is required by State law in reporting suspected child or adult abuse or neglect;

(iv) Pursuant to a court order, which meets the requirements of 42 CFR, Part 2;

(v) Disclosure which may be made in the course of site visits, audits, and program evaluation. Such reviewers shall sign a written oath of confidentiality; or

(vi) To the extent necessary to defend against a lawsuit initiated by or on behalf of a client.

(vii) When a client poses a threat of harm to self or others.

(b) The consent of the client or a legally responsible other shall be obtained in writing prior to billing third party payers and pursuing the payment of delinquent accounts.

(c) Other than proceedings under W.S. 25-10-122, clinical staff services provided to all courts, including, but not limited to, consultations, evaluations, or expert testimony shall require the consent in writing of the client or a legally responsible other or meet the requirements of a (iv) above.

(d) The Governing Board shall be excluded both as a joint body and as individual board members from any access to confidential client information except to the extent necessary to resolve a client initiated grievance.

(e) All staff members having access to clinical records shall be required to abide by these standards regarding confidentiality as well as all applicable federal, state, and local laws, rules, and regulations.