7200.4750 RECORD KEEPING.

Subpart 1. **Record-keeping requirements.** Providers shall maintain accurate and legible records of their services for each client. Records shall minimally contain:

A. client personal data;

B. an accurate chronological listing of all client visits, fees charged to the client or a third-party payer, and payments received;

C. documentation of services, including, where applicable:

(1) assessment methods, data, and reports;

(2) an initial treatment plan and any subsequent revisions;

(3) the name of the individual providing the services;

(4) case notes for each date of service, including any interventions;

(5) consultations with collateral sources;

(6) diagnoses or problem descriptions;

(7) documentation that informed consent for services was given, including written informed consent documents, where applicable;

(8) documentation of supervision or consultation received; and

(9) the name of the individual who is clinically responsible for the services provided;

D. copies of all correspondence relating to the client; and

E. copies of all client authorizations for release of information and any other documents pertaining to the client.

Subp. 2. **Duplicate records.** The provider need not maintain client records that duplicate those maintained by the agency, clinic, or other facility at which services are provided.

Subp. 3. **Records retention.** The provider shall retain a client's records for a minimum of eight years after the date of the provider's last professional service to the client, except as otherwise provided by law. If the client is a minor, the records retention period shall not commence until the client reaches the age of 18, except as otherwise provided by law.

Statutory Authority: *MS s 148.905; 148.98*

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