

**148F.15 RECORD KEEPING.**

Subdivision 1. **Record-keeping requirements.** Providers must maintain accurate and legible client records. Records must include, at a minimum:

- (1) an accurate chronological listing of all substantive contacts with the client;
- (2) documentation of services, including:
  - (i) assessment methods, data, and reports;
  - (ii) an initial treatment plan and any revisions to the plan;
  - (iii) the name of the individual providing services;
  - (iv) the name and credentials of the individual who is professionally responsible for the services provided;
  - (v) case notes for each date of service, including interventions;
  - (vi) consultations with collateral sources;
  - (vii) diagnoses or presenting problems; and
  - (viii) documentation that informed consent was obtained, including written informed consent documents;
- (3) copies of all correspondence relevant to the client;
- (4) a client personal data sheet;
- (5) copies of all client authorizations for release of information;
- (6) an accurate chronological listing of all fees charged, if any, to the client or a third-party payer; and
- (7) any other documents pertaining to the client.

Subd. 2. **Duplicate records.** If the client records containing the documentation required by subdivision 1 are maintained by the agency, clinic, or other facility where the provider renders services, the provider is not required to maintain duplicate records of client information.

Subd. 3. **Record retention.** The provider shall retain a client's record for a minimum of seven 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 record retention period does not begin until the client reaches the age of 18, except as otherwise provided by law.

**History:** 2012 c 197 art 2 s 31