

**245F.19 PATIENT RECORDS.**

Subdivision 1. **Patient records required.** A license holder must maintain a file of current patient records on the program premises where the treatment is provided. Each entry in each patient record must be signed and dated by the staff member making the entry. Patient records must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and section 254A.09; Code of Federal Regulations, title 42, sections 2.1 to 2.67; and title 45, parts 160 to 164.

Subd. 2. **Records retention.** A license holder must retain and store records as required by section 245A.041, subdivisions 3 and 4.

Subd. 3. **Contents of records.** Patient records must include the following:

- (1) documentation of the patient's presenting problem, any substance use screening, the most recent assessment, and any updates;
- (2) a stabilization plan and progress notes as required by section 245F.07, subdivisions 1 and 2;
- (3) a discharge summary as required by section 245F.07, subdivision 3;
- (4) an individual abuse prevention plan that complies with section 245A.65 and related rules;
- (5) documentation of referrals made; and
- (6) documentation of the monitoring and observations of the patient's medical needs.

**History:** 2015 c 71 art 3 s 19