2150.7535 RECORD KEEPING.

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

A. an accurate chronological listing of all contacts with the client;

B. 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 description;

(7) documentation that informed consent for services was obtained, including written informed consent documents, where required; and

(8) the name and credentials of the individual who is professionally responsible for the services provided;

C. copies of all correspondence relevant to the client;

D. a client personal data sheet;

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

F. an accurate chronological listing of all fees charged, if any, to the client or a third-party payer.

Subp. 2. **Duplicate records.** Although it is the responsibility of providers to document the information required in subpart 1, they need not maintain client records that duplicate those maintained by the agency, clinic, or other facility at which they provide services.

Subp. 3. **Records retention.** The provider shall retain a client's records 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 records retention period does not begin until the client reaches the age of 18, except as otherwise provided by law.

Statutory Authority: *MS s 148B.52*

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