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*