245G.09 CLIENT RECORDS.

Subdivision 1. **Client records required.** (a) A license holder must maintain a file of current and accurate client records on the premises where the treatment service is provided or coordinated. For services provided off site, client records must be available at the program and adhere to the same clinical and administrative policies and procedures as services provided on site. The content and format of client records must be uniform and entries in each record must be signed and dated by the staff member making the entry. Client records must be protected against loss, tampering, or unauthorized disclosure according to section 254A.09, chapter 13, and Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and title 45, parts 160 to 164.

(b) The program must have a policy and procedure that identifies how the program will track and record client attendance at treatment activities, including the date, duration, and nature of each treatment service provided to the client.

(c) The program must identify in the client record designation of an individual who is receiving services under section 254A.03, subdivision 3, including the start date and end date of services eligible under section 254A.03, subdivision 3.

Subd. 2. **Record retention.** The client records of a discharged client must be retained by a license holder for seven years. A license holder that ceases to provide treatment service must retain client records for seven years from the date of facility closure and must notify the commissioner of the location of the client records and the name of the individual responsible for maintaining the client's records.

Subd. 3. **Contents.** (a) Client records must contain the following:

(1) documentation that the client was given:

(i) information on client rights and responsibilities and grievance procedures on the day of service initiation;

(ii) information on tuberculosis and HIV within 72 hours of service initiation;

(iii) an orientation to the program abuse prevention plan required under section 245A.65, subdivision 2, paragraph (a), clause (4), within 24 hours of admission or, for clients who would benefit from a later orientation, 72 hours; and

(iv) opioid educational material according to section 245G.04, subdivision 3, on the day of service initiation;

(2) an initial services plan completed according to section 245G.04;

(3) a comprehensive assessment completed according to section 245G.05;

(4) an individual abuse prevention plan according to sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

(5) an individual treatment plan according to section 245G.06, subdivisions 1 and 1a;

(6) documentation of treatment services, significant events, appointments, concerns, and treatment plan reviews according to section 245G.06, subdivisions 2a, 2b, 3, and 3a; and

(7) a summary at the time of service termination according to section 245G.06, subdivision 4.

(b) For a client that transfers to another of the license holder's licensed treatment locations, the license holder is not required to complete new documents or orientation for the client, except that the client must receive an orientation to the new location's grievance procedure, program abuse prevention plan, and maltreatment of minor and vulnerable adults reporting procedures.

History: *1Sp2017 c 6 art 8 s 22; 1Sp2020 c 2 art 5 s 32; 2022 c 98 art 12 s 12; 2023 c 50 art 2 s 19; 2023 c 61 art 4 s 5; 2024 c 108 art 4 s 9; 2025 c 38 art 5 s 19*