Retention, Maintenance, Storage and Access of Client Records

Policy Statement

All records and files pertaining to client contact with OLH are maintained and stored so as to protect the confidentiality and the integrity of the file. Client files are managed and stored in a manner to be easily accessible for current use, future use of returning clients, professional consultation, sharing with authorized recipients, and client review. OLH provides authorized persons access to the client records that its staff have generated, maintained, and stored.

Rationale

The client record is essential for current and future care, and review of client progress. It must be in a form that is easily accessible for professionals and clients. Federal law (HIPAA), state law, professional ethics, and licensing bodies governing clinical practice, mandate that provisions must be made for maintaining confidentiality in the storage and disposal of records and follow an established record retention, retrieval, and disposal practice. These records are to be kept in a form that is legible and easily accessible for prompt use. These standards also require that a client and legal guardian have access to current and past records generated by OLH staff. As permitted by law, external authorized agents, including other health care practitioners, school personnel, child abuse/neglect investigators, properly executed court orders, and public health officials may access client records. The contractual arrangements of accreditors, funders and insurance payers may also access records for auditing purposes.

Adult clients, legal guardians of minors, and previous clients who were minors when they received services, but have since reached the age of majority, have the right to inspect and review records regarding their PHI and care, and an accounting of what has been shared or disclosed by OLH to other entities.

Protocols

Maintenance and Storage of Client Records:

- Active case records are stored in locked areas for access and viewing allowed only to those OLH employees who have a professional “need to know”.
- Confidentiality of client files and records will be maintained after discharge, and such records are secured against damage, theft and inadvertent viewing. Closed case records are stored in locked, water and fire proofed cabinets or areas, away from public viewing.
- Electronic records are stored and backed up, with technological safeguards in place as to who may access the record.
- The full record is kept, as mandated by law. Sections of the record may not be destroyed or altered once created as part of the client chart.
- Records are kept in an easily accessible form, and for 7 years after the termination of services, or 7 years past the age of majority for minor children who received services.
- OLH complies with 3rd party payers and health insurance contracts regarding length of time for record retention when these exceed state mandates.

Access to Closed and Active Client Records:

- Access to all client records is on a professional need-to-know basis for all OLH staff.
- OLH professionals or external agents may request client records by completing a properly executed Authorization to Use and Disclose Information form, signed by the client or legal guardian of the client. The Authorization form must comply with all requirements of the HIPAA.

    - The client has the right to revoke an Authorization, as long as the record has not yet been disseminated. The client or guardian completes and signs the Request to Revoke Authorization Form or provides any written and signed statement to this effect, and their wishes will be honored.
    - Clinicians may not release any confidential client information from a chart unless one of the conditions of authorized release is met (see chapter: "Policies and Practices Governing Privacy and Confidentiality").
- Handling of confidential clinical documents by non-clinicians
    - Non-clinical staff may NOT review, remove, disseminate, disclose to others, copy, or summarize any client documents.
    - Clinical documents, including but not limited to progress notes, evaluations, and assessment reports, may only be summarized, disclosed, removed, copied, and disseminated by the clinician who generated the document.
    - In his/her absence, these actions are at the discretion of the most recent clinician handling the case.
    - In the absence of a current clinician, these actions are at the discretion of the Director of Clinical Programs (DCP) or the Associate Director of Clinical Programs.
- The client or guardian of clinical services may request access to records, present or past, by completing the OLH Record Review Request form.
    - Upon receipt of a written request, the OLH staff who generated the record will review the record to determine if there is potentially harmful information to the client if disclosed or information that will violate the confidentiality rights of other parties beyond the person requesting access. The Director of Clinical Programs or Associate Director of Clinical Programs is consulted in such clinical decisions.
    - The client is offered an appointment to review the record in the agency, in the presence of their clinician within a private office setting.
    - In the event that the clinician who generated the record is no longer with OLH, then the Director of Clinical Programs or the Associate Director of Clinical Programs serves in the role of the original clinician regarding access to records.
    - In situations where the client requests a copy of their record or parts of their record, the agency may charge for copies made.
    - The client signs a Receipt of Confidential Documents form in order to receive the copy.
- OLH must supply legitimately requested information within 30 days of the request. If the record is off-site in archived storage, OLH must supply the record within 90 days.

Subpoena's and Court-Ordered Access to Records:
When an OLH staff member receives a subpoena or court order to release records, s/he contacts Polsinelli Attorneys and follows the steps as directed. Neither a subpoena nor a court order may be ignored by OLH staff.

Destruction of Client Records:
When allowed, records are "destroyed" by shredding. Only authorized OLH service providers may shred documents. Confidential client documents may not be shredded by staff outside of client service programs, volunteers, and guests of OLH.

Disposition of Client Records in Event of Agency Closure:
In the event of OLH closure, a written agreement with Evangelical Children's Home, outlining their responsibilities for archiving all OLH files for the appropriate length of time, is kept on record.