Cornerstone Behavioral Healthcare
Section 16. Records Management and Retention

A. Record Management Policy: Cornerstone Behavioral Healthcare (CBH) will have a written records management policy. It will include objective criteria to determine when it would be harmful to allow a client to access their record.

B. Record Maintenance: CBH will maintain clean, readable records in an orderly, accessible format in a secure and private space and will have a record retention policy that addresses archiving and destruction of records consistent with all applicable State and federal statutes.

C. Client Access to Client's Record: A client or the client's guardian or legal representative may access the client's record in accordance with this rule.

1. If serious harm is likely to result from a client's review of their record, CBH may deny or otherwise limit a client's access to part or all of the client's record.
2. CBH's decision to deny a client's access to their record will be based on objective criteria.
3. A professional staff person will review the client's record and may share information with the client only after the qualified professional signs CBH-approved statement that information determined to be harmful will be withheld from the client.
    a. CBH's administrator or designee will review the findings of a record review and approve or deny a client's access to his or her record.
    b. CBH will render a written decision, including the findings of fact, to deny a client's access to part or all of the client's record. The decision must be included in the client's record.

D. Client Record

1. Client record entries will be made only by authorized personnel and will be:
    a. Specific, factual, relevant, and legible;
    b. Updated from intake through discharge;
    c. Completed, signed with identifying credentials, and dated by the person who provided the service; and
    d. Periodically reviewed by supervisors, in accordance with the CBH's policy and professional licensure requirements.
2. CBH will establish policies that ensure legibility and integrity of entries to records, which, at a minimum, will include the following:
    a. The appropriate manner to make corrections to records and prohibit the deletion of prior record entries;
    b. The prohibition of back-dating entries;
    c. A provision for making late entries to records, which must include a statement identifying the entry as late;
    d. A requirement for an easily recognizable date for every record entry; and
    e. CBH utilizes electronic health records and will use electronic date stamps for all entries in the record.
3. CBH will maintain documentation in the client's record in chronological order. The client's record will minimally include the following information:
    a. Identifying data, including:
        i. Name,
        ii. Address,

iii. Telephone number, and
iv. Date of birth;

b. All treatment documents, including but not limited to:
   i. Assessments,
   ii. Service plans,
   iii. Progress notes,
   iv. Incident reports, and
   v. Discharge summary;
c. Essential legal information, including:
   i. Court records;
   ii. Documents of guardianship, legal custody, powers of attorney and similar documents; and
   iii. Medical or psychiatric care directives; and
d. Copies of all completed releases and authorizations, including but not limited to:
   i. Forms documenting consent to treat;
   ii. Forms authorizing release of the client's information; and
   iii. Forms acknowledging receipt of written notification of client rights and responsibilities; information about fees, if applicable; the organization's privacy practices; and other notifications required by this rule and applicable law.
e. Clients may add written statements to their client record.
   i. With the client's knowledge, CBH personnel may add a written follow-up response to the client's statement in the record; and
   ii. The client must be given the opportunity to review and comment on the CBH follow-up response.
f. CBH will place a written explanation in the client's record to explain the absence of any required information.

E. Employee Access to Client Records

1. Access to client records is dependent on job responsibilities. Access to records is based on need-to-know.
2. Access is controlled by Supervisors, IT and Medical Records.
3. Supervisors must request access for employees to the EHR system.
4. These requests are reviewed for the level of access requirements that are appropriate for the employee. The employees' division and program are used to determine what access they have in the EHR system. Employees are only given access to the clients required by their job function. Each employee is given a unique username and password to access the electronic record system. Employee access is tracked and auditable in the EHR. Clients are allowed to request a copy of access logs to their medical chart.
5. All employees with a conflict of interest with a client will be blocked from access to the client charts. Both employees and clients can request a conflict-of-interest block to a chart.
6. Access to any paper charts is controlled by the Medical Records Department. Staff must request a chart from medical records staff.

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04/21/2025
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Date

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