PROGRESS NOTES V. PROCESS NOTES

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What is a Client Entitled to?

At some point in every mental health professional's career a client will request a copy of his/her file or an attorney will subpoena the production of the client's file. Given a mental health professional's duty of confidentiality and to promote the welfare of the client, it is extremely important to know when to provide a client's file, what to provide from the file, and the steps to take when providing or objecting to a request for a client's file. This article is meant to provide clarification on these issues when a licensed, registered, and/or certified mental health professional in Colorado receives a request for a client's record.

Confidentiality:
The first step is to understand the parameters of confidential information. As a general rule, confidential information disclosed to a mental health professional, in the course of professional employment of the mental health professional, is considered privileged and **may not be disclosed** (emphasis added) without the consent of the client (C.R.S. §12-43-218(1) and C.R.S. §13-90-107 (1)(g)). Therefore, generally a licensed, registered, and/or certified mental health professional in the State of Colorado may not disclose anything he or she learns during the course of the therapeutic relationship without the client's consent.

Colorado courts have long recognized the psychologist-client privilege. This privilege extends to the documents and records that evolved from that privilege. C.R.C.P. 45(c)(2)(B). However, there are certain legal exceptions, which include but are not limited to: the disclosure of child abuse (C.R.S. §19-3-304), disclosure of abuse and/or exploitation of at-risk elders (C.R.S. §18-6.5-108), delinquency and criminal proceedings, or during an investigation by a Mental Health Regulatory Board. (C.R.S. §12-43-218).

A mental health professional may also make disclosures pursuant to a Court Order or with the Client's authorization and consent.

When to Provide a Client File/Record:
A mental health professional will usually encounter a request for a client file in two ways: 1) the request comes directly from the client; or 2) the request comes in the form of a subpoena. If a client requests his/her file, the client has given the mental health professional authorization to release the file **only** to the client. Any request for the file to be transferred to another professional must be accompanied by an "Authorization for Release of Information". If the file is only going to the client, prepare a "Client Records Request Form" that states what was included in the file, confirms that the client requested the file, and confirms the client was given the file.

If the request for a client file is the result of a subpoena, a mental health professional should only provide the client file under two circumstances: 1) if the subpoena was accompanied by an **Authorization for Release of Information**, signed by the client and in the case of groups[1], families, or couples, signed by all parties whose information is requested; or 2) the subpoena is accompanied by a court order requiring the production of the client file.

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[1] There are certain requirements when disclosing confidential information in group, family, or couples situations. The mental health professional cannot disclose information about any client who has not authorized disclosure.

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Under no other circumstances should a mental health professional release a client file.

What to Provide:
If a mental health professional must turn over the client's file, the next step is determining what to provide. The question is whether all or part of the client file must be provided in these instances – specifically, whether a mental health professional must release progress **and** process notes, just progress notes, or just a treatment summary. Unfortunately, this is not clearly defined under Colorado statutes, rules, regulations, or policies.

The Difference between Progress and Process Notes
Progress notes and process notes are known in the greater mental health lexicon, in general definition, as notes that describe treatment, diagnosis, testing and assessment (progress notes); and, notes that are used by the mental health professional that do not necessarily contain information directly relevant to the treatment of a client (process notes). For example, hypotheses, notes for consultations, questions, etc. would be considered "process notes"; whereas, SOAP or DAP notes would be considered "progress notes". Colorado law has not defined or delineated the difference between "process notes" and "progress notes."

The clearest definition of the difference between a "progress note" and "process note" comes from Federal Law under the HIPAA Rule, in particular 45 C.F.R. §164.501. HIPAA defines process notes, which it refers to as "psychotherapy notes" as:

A. Notes recorded in any medium
B. By a healthcare provider who is a mental health professional
    1. Documenting or Analyzing
        i. The contents of conversation during
            1. Private Counseling Session
            2. Group, Joint or Family Counseling Session
        ii. That are separated from the rest of the individual's medical record (Emphasis Added)

This type of note is considered to contain privileged information similar to attorney work-product that may only be released with the specific permission of the client – unless otherwise mandated by state law (http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html). It is important to recognize that these records MUST be kept separate from the client's file.

Per the HIPAA definition, psychotherapy notes or "process notes" do not include the following information:

A. Medication Prescription and Monitoring
B. Counseling session start and stop times
C. Modalities and Frequencies of Treatment Furnished
D. Results of Clinical Tests
E. Any Summary of the following items:
    1. Diagnosis
    2. Functional Status
    3. Treatment Plan

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4. Symptoms
5. Prognosis
6. Progress to Date

This list is consistent with the general definition of "progress notes". 45 C.F.R. § 164.501. The HIPAA definition of psychotherapy notes will be used as a directional point when comparing and contrasting the use of process and progress notes for Colorado mental health professionals in this article.

While Colorado law prohibits the disclosure of privileged information it does not discuss methods of documenting these confidential communications or the form these confidential communications should take. It is therefore necessary to turn to the Colorado Board Rules for mental health professionals for further clarification.

Each Mental Health Board has promulgated a rule that addresses what records are required to be kept (record retention); (Board Rule 16 for LPCs, LMFTs, Psychologists, and Social Workers; Colorado Board Rule 15 for Addiction Counselors; and Colorado Rule 13 for Registered Psychotherapists[2]). In general, most of the Board Rules are the same and require the following information to be contained in all client records[3]:

A. Name of treating therapist
B. Client's Identifying Data
    1. Name
    2. Address
    3. Telephone Number
    4. Name of person authorizing the mental health provider's services or treatment
C. Reasons(s) for the Psychotherapy services
D. Mandatory Disclosure Statement(s)
E. Dates of Services including; but not limited to,
    1. Date of each contact with client
    2. Date on which services began
    3. Date of last contact with client
F. Types of Service
G. Fees
H. Any release of information
I. A justification and description of;
    a. Assessment
    b. Diagnosis
    c. Therapy Treatment
    d. The record must be prepared in such a manner that allows a subsequent provider to yield a comprehensive conclusion as to what occurred.
J. Test Information
    a. Name of test

[2] Each individual Board rule is located at the end of this article. The specific board rules were found on the Department of Regulatory Agencies' website: www.**dora**.colorado.gov/professions

[3] Please refer to the specific Board Rule for your license, registration, and/or certification as the Board Rule may have additional specific requirements of information to be included in a client record.

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    b. Date administered
    c. Name(s) of the person(s) administering the test
K. A final closing statement (if services are over)

This list is similar to HIPAA's list of information that is excluded from the heightened protection of psychotherapy/process notes but that would be included in progress notes. The Colorado Board Rules do not provide exclusionary language similar to that of HIPAA's definition of "process notes." However, two arguments can be made that the exclusion would apply at the State level as well as the Federal level.

First, C.R.S. §12-43-218 (6) states *"This section does not apply to covered entities, their business associates, or health oversight agencies, as each is defined in the federal "Health Insurance Portability and Accountability Act of 1996", as amended by the federal "Health Information Technology for Economic and Clinical Health Act", and the respective implementing regulations."* What this appears to mean is that any mental health professional whose practice falls within the Mental Health Practice Act and who is also a covered entity per HIPAA's definition would have his or her record creation and confidentiality requirements fall within HIPAA's definitions rather than Colorado law. This would mean that any psychotherapy/process notes may be excluded from production due to a request by subpoena or a court order for a client's file.

Second, Board Rules 13, 15, and 16 do not specifically exclude types of information from their list of record requirements. Rather, the Rules define in great detail what, at minimum, must be included in a client's record. Therefore, any information not specifically listed in the Board Rules may not be considered part of the client's record, which would include "process notes". This additional information might also then be excluded from a request for production of a client file due to a subpoena or court order.

It is important to keep in mind that even under HIPAA a client can authorize the disclosure of psychotherapy notes/process notes and/or a Court can order the disclosure of such notes. Psychotherapy notes/process notes are also not immune from a court order or a client's authorization. Although these "process notes" may be kept separately from the rest of the client file and are considered privileged communications, these notes may be requested and a mental health professional can be required to produce them.

Therefore, in regard to mental health records maintained by professionals licensed, registered, and/or certified within the State of Colorado, progress notes must include all of the information listed in Board Rules 13, 15, and 16; as well as 45 C.F.R. §164.501. This documentation may be requested by subpoena and/or court order. In contrast, process notes are notes that are kept separately from the client's file and that do not include any of the information required by Board Rules 13, 15, and 16 or 45 C.F.R. §164.501. This documentation does not need to be produced in response to a general subpoena or a court order to produce a client's file without specific client authorization for the separately kept process notes, without meeting very specific exceptions to the confidentiality rule – for example, harm to self or others, child abuse or elder abuse, or without a Court Order specifying the production.

How to Provide the Client Record:
Mental health professionals must always promote the welfare of their client. This means, in some instances, it may be more appropriate to release a summary of the record rather than the actual record if the information contained in the file could be harmful to the client. However, there will be times when the client wants/requires the entire record. Depending on how the therapeutic relationship ended, if it ended,

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and the circumstances under which the request is made, a mental health professional should offer to review the client's file with the client prior to its release. This helps ensure that the client understands the contents of the file. A mental health professional should always discuss the risks involved when producing the client file. Specifically, that a mental health professional cannot control who the client allows access to his/her records once the file is provided. When in doubt about what information to provide, please contact a trained mental health attorney.

If the record request is made pursuant to a subpoena, contact an attorney. If a mental health professional receives a broad and general subpoena, in which the mental health professional **must** provide the client file[4], the mental health professional should identify what is included with the client's request and if anything has been withheld. For example, if the request and/or authorization do not specifically identify psychotherapy/process notes, the mental health professional should inform the client those documents have been withheld. This added step will inform the client that the mental health professional is in compliance with Colorado Board Rules but that additional documents have been withheld. In addition, there may be other circumstances in which the subpoena is deficient and not in compliance with other Colorado statutes and rules, such as the timing of the subpoena and/or the amount of information requested to be produced. It is also important to keep in mind that clients will not necessarily know mental health jargon to be able to differentiate between progress notes and process notes. Thus, if a client specifically asks for "all notes", that likely includes progress and process notes.

Summary

Since there is always a risk that a client may obtain or a Court may order access to the client file, it is important that the client record complies with Board Rules and that the contents of the file accurately reflect the therapeutic relationship. Reviewing the Board Rule(s) specific to your license(s), certification, and/ or registration, and implementing the requirements into your practice is critical to ensure compliance. When in doubt, contact a trained mental health attorney for further advice.

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[4] A Subpoena must be accompanied by the Client's Authorization and/or a Court Order requiring the Mental Health Professional to produce the file. See above section on "When to Provide the Client File/Record."

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Individual Board Rules

State Board of Licensed Professional Counselor Examiners
Rule 16(b): the record shall contain, as applicable to the mental health services rendered, the following information:

(1) Name of treating therapist;
(2) Client's identifying data to include name, address, telephone number, gender, date of birth, and if applicable the name of the parent or guardian. If the client is an organization, the name of the organization, telephone number and name of the principal authorizing the mental health provider's services or treatment;
(3) Reason(s) for the psychotherapy services;
(4) Mandatory disclosure statement(s);
(5) Dates of service including, but not limited to the date of each contact with client, the date on which services began, and the date of last contact with client;
(6) Types of service;
(7) Fees;
(8) Any release of information;
(9) The record shall justify and describe the assessment, diagnosis and therapy/treatment administered in a legible document. The records must be prepared in a manner that allows any subsequent provider to yield a comprehensive conclusion as to what occurred;
(10) Name of any test administered, each date on which the test was administered, and the name(s) of the person(s) administering the test;
(11) A final closing statement (if services are over).

State Board of Psychologist Examiners:
Rule 16(b) Record. A record shall contain, as applicable to the mental health services rendered, at least the following information:

(1) Name of the treating therapist;
(2) Client's identifying data to include name, address, telephone number, gender, date of birth, and if applicable the name of the parent or guardian. If the client is an organization, the name of the organization, telephone number and name of the principal authorizing the mental health provider's services or treatment;
(3) Reason for the psychology/psychotherapy services;
(4) Mandatory disclosure statement(s);
(5) Dates of service including, but not limited to the date of each contact with client, the date on which services began, and the date of last contact with client;
(6) Types of service;
(7) Fees;
(8) Any release of information;
(9) If any of the following have been written: assessment, plan for intervention, consultation, summary reports, and/or testing reports and supporting data. The records must be prepared in a manner that allows any subsequent provider to yield a comprehensive conclusion as to what occurred;
(10) Name of any test administered, each date on which the test was administered, and the name(s) of the person(s) administering the test;
(11) Information on each referral made to and each consultation with another therapist or other health care provider. This information shall include the date of referral or consultation, the name

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of the person to whom the client was referred, the name of the person with whom consultation was sought; the outcome (if known) of the referral, and the outcome (if known) of the consultation;
(12) Records of counseling, interview notes, correspondence, audio or visual recordings, electronic data storage, and other documents considered professional information for use in counseling; and
(13) A final closing statement (if services are over).

State Board of Licensed Marriage and Family Therapist Examiners
Rule 16(b): Every licensed marriage and family therapist shall create and shall maintain, as applicable to the mental health services rendered, a record for the primary client(s) containing the following information:
(1) Name of treating therapist;
(2) Client's identifying data to include name, address, telephone number, gender, date of birth, and if applicable the name of the parent or guardian. If the client is an organization, the name of the organization, telephone number and name of the principal authorizing the mental health provider's services or treatment;
(3) Reason(s) for the psychotherapy services;
(4) Mandatory disclosure statement(s);
(5) Dates of service including, but not limited to the date of each contact with client, the date on which services began, and the date of last contact with client;
(6) Types of service;
(7) Fees;
(8) Any release of information;
(9) The records must be prepared in a manner that allows any subsequent provider to yield a comprehensive conclusion as to what occurred;
(10) Name of any test administered, each date on which the test was administered, and the name(s) of the person(s) administering the test;
(11) Information on each referral made to and each consultation with another therapist or other health care provider. This information shall include the date of referral or consultation, the name of the person to whom the client was referred, the name of the person with whom consultation was sought; the outcome (if known) of the referral, and the outcome (if known) of the consultation;
(12) Records of counseling, interview notes, correspondence, audio or visual recordings, electronic data storage, and other documents considered professional information for use in counseling; and
(13) A final closing statement (if services are over), if applicable.

State Board of Social Work Examiners:
Rule 16(b): Every social worker shall create and shall maintain a record for each social work/psychotherapy client. Every social worker shall retain a record on each social work/psychotherapy client for a period of seven (7) years. A record shall contain, as applicable to the mental health services rendered, at least the following information:
(1) Name of treating therapist.
(2) Client's identifying data to include name, address, telephone number, gender, date of birth, and if applicable the name of the parent or guardian. If the client is an organization, the name of

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the organization, telephone number and name of the principal authorizing the mental health provider's services or treatment;
(3) Reason(s) for the psychotherapy services;
(4) Mandatory disclosure statement.
(5) Dates of service including, but not limited to the date of each contact with client, the date on which services began, and the date of last contact with client;
(6) Types of service;
(7) Fees;
(8) Any release of information;
(9) The records must be prepared in a manner that allows any subsequent provider to reasonably conclude what occurred;
(10) Name of any test administered, each date on which the test was administered, and the name(s) of the person(s) administering the test;
(11) Information on each referral made to and each consultation with another social worker or other health care provider. This information shall include the date of the referral or consultation, the name of the person to whom the client was referred, the name of the person with whom consultation was sought, the outcome (if known) of the referral, and the outcome (if known) of the consultation;
(12) A final closing statement (if services are over), if applicable.

State Board of Registered Psychotherapists
Rule 13(b) Every registered psychotherapist shall maintain, as applicable to the mental health services rendered, a record containing the following information:
(1) Name of treating therapist;
(2) Client's identifying data to include name, address, telephone number, gender, date of birth, and if applicable the name of the parent or guardian.
If the client is an organization, the name of the organization, telephone number and name of the principal authorizing the mental health provider's services or treatment;
(3) Reason(s) for the psychotherapy services;
(4) Mandatory disclosure statement(s);
(5) Dates of service including, but not limited to the date of each contact with client, the date on which services began, and the date of last contact with client;
(6) Types of service;
(7) Fees;
(8) Any release of information;
(9) The records must be legible and prepared in a manner that allows any subsequent provider to yield a comprehensive conclusion as to what occurred;
(10) Name of any test administered, each date on which the test was administered, and the name(s) of the person(s) administering the test;
(11) Information on each referral made to and each consultation with another therapist or other health care provider. This information shall include the date of referral or consultation, the name of the person to whom the client was referred, the name of the person with whom consultation was sought; the outcome (if known) of the referral, and theoutcome (if known) of the consultation;
(12) Adequate and reasonable case management records;

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(13) Records of counseling, interview notes, correspondence, audio or visual recordings, electronic data storage, and other documents considered professional information for use in counseling; and

(14) A final closing statement (if services are over), if applicable.

State Board of Addiction Counselors

Rule 15(b) Record. Every addiction counselor shall maintain, as applicable to the mental health services provided, a record containing the following information:

(1) Name of treating therapist;

(2) Client's identifying data to include name, address, telephone number, gender, date of birth, and if applicable the name of the parent or guardian. If the client is an organization, the name of the organization, telephone number and name of the principal authorizing the mental health provider's services or treatment;

(3) Reason(s) for the psychotherapy services;

(4) Mandatory disclosure statement(s);

(5) Dates of service including, but not limited to the date of each contact with client, the date on which services began, and the date of last contact with client;

(6) Types of service;

(7) Fees;

(8) Any release of information;

(9) The records must be legible and prepared in a manner that allows any subsequent provider to yield a comprehensive conclusion as to what occurred;

(10) Name of any test administered, each date on which the test was administered, and the name(s) of the person(s) administering the test;

(11) Information on each referral made to and each consultation with another therapist or other health care provider. This information shall include the date of referral or consultation, the name of the person to whom the client was referred, the name of the person with whom consultation was sought; the outcome (if known) of the referral, and the outcome (if known) of the consultation;

(12) Records of counseling, interview notes, correspondence, audio or visual recordings, electronic data storage, and other documents considered professional information for use in counseling; and

(13) A final closing statement (if services are over).

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