CLIENT RECORDS

Individual records are maintained for each client seen for complete diagnostic or therapy services in the Communication Disorders Clinic. Each record will contain a referral form, a background information form, a signed release of information form if appropriate, a signed consent for services form, HIPAA consent form, a financial form with fee notation if appropriate, a chronological log of client contact, pertinent test and interview data, evaluation reports, and individualized program reports and therapy summary reports if in treatment. All client documents are secured in the chart to prevent accidental loss or disclosure.

Other information, such as correspondence with referral agencies, is maintained as it occurs. Each client contact, by whatever means, and entry or distribution of pertinent documents is to be recorded on the Progress Note form or Staff Note form and signed by the recording person. Clients generally have the right to review and obtain copies of their charts and to request in writing amendments to the information in the chart.

Group records are maintained for screening services. These include preschool screenings, school hearing screenings, University speech prerequisites, and OSHA hearing testing for the University or other industries. These records include relevant data forms for the individuals served and an indication of recommendations (on individual forms or a group summary sheet).

Appalachian State University is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the individual identifiable health information relevant to a client is considered protected health information. In accordance with HIPAA, client records are confidential. They are not to be divulged to anyone other than personnel associated with the Communication Disorders Clinic unless a signed written release is in the chart. Such written releases are effective for one year from the date of signature, and may be revoked at any time by written directive from the client or responsible party.

CLIENT records are not to be taken out of the Clinic areas. Areas interpreted to be in the “Clinic” include the Professional Preparation room, professional staff offices, the Student Lounge, and the treatment rooms. If the student must leave the Clinic areas, the chart must be returned to the Clinic office. A chart must never be left unattended.

On occasion charts may be taken to off-campus meetings by the clinical educator responsible for the case. This would include educational planning conferences or home visits. The office staff should be notified in writing where the chart will be and who is responsible for it. This notation should be made in accordance with the accepted office check-out procedure.

Student clinicians may NOT work on reports at home. They should not remove any records, including test protocols, from the charts in the Clinic. They may work on reports only in designated clinical areas. When not placing the information in the client’s chart, printed pages containing protected health information should be shredded or placed in the designated box in the Professional Preparation room for shredding. Photocopying of information in client charts is not allowed.

Active client records are stored in the Clinic office (University Hall room 120) in a locking file cabinet. These records are for clients who are presently being served, or have a specified recall date. The records only are accessible by Communication Disorders Clinic personnel involved with a given client.
Inactive charts are stored in the back of the same locking file cabinet in a Clinic storage area for a period of three years. When there has been no contact with a client for three years, the chart is transferred to the University Archives (where it is held for an additional twelve years or until the client is 24 years of age, whichever is longer).

In order to ensure that charts are in order, it is suggested that clinical educators review each chart with the student clinician twice during the semester. The client charts also are reviewed by the Clinic Billing Specialist at the time of billing. All information should be in chronological order. A final check should be completed before the final conference and before issuing the final grade.