

5122-27-02 Individual client record requirements.

- (A) Each provider shall maintain a complete and adequate individual client record for each client.
- (B) An individual client record shall mean the account compiled by health and behavioral health care professionals of information pertaining to client health, addiction, and mental health; including, but not limited to, assessment of findings and diagnosis, treatment details, and progress notes.
- (C) Documentation of consent for treatment, refusal to consent, or withdrawal of consent, shall be kept in the individual client record.

Consent by minors shall be in accordance with sections [5122.04](#) and [3719.012](#) of the Revised Code.

- (D) A provider shall include documentation regarding:

- (1) Service fees;
- (2) The individual's, or individual's parent or guardian, responsibility for payment.

Responsibility for payment includes any portion not covered by insurance or other funding source.

- (E) Documentation to reflect that the client was given a copy of the following:

- (1) Service or program expectations of clients, if applicable. Examples include required attendance, or maintaining a sober environment, and consequences if client does not meet expectations.
- (2) Summary of the federal laws and regulations that indicate the confidentiality of client records are protected as required by 42 C.F.R. part B, paragraph 2.22, if applicable.

- (F) Each authorization for release of information form signed by the client.

- (G) If provided, documentation verifying the client's attendance at alcoholism and drug addiction client-education.

- (H) Providers shall maintain treatment records for at least seven years after a client has been discharged from a program or services are no longer provided, and prevention records for at least three years.

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