QUILLEN COLLEGE of MEDICINE
EAST TENNESSEE STATE UNIVERSITY

Policy Name: Counseling Center Clinical Records

Policy Replaces a Previous Policy (this includes change in policy name): ☐Yes/ ☒No If so, list name of previous policy (include policy number if different):
Policy Number (issued by the Office of Academic Affairs upon final approval): **ADMIN-0125-35**
Policy Owner (Individual, Department, or Committee/Chair: **Student Affairs – Dr. Deidre Pierce, MD, MHA, CPE, FACP; Dr. Jean Daniels, Ph.D.**
Committees, Departments, or Individuals Responsible for Implementation: **Student Affairs; Academic Affairs**
Original Approval Date and Who Approved by: **Policy Advisory Committee; Dr. Deidre Pierce, MD, MHA, CPE, FACP; Dr. Jean Daniels, Ph.D.**
Effective Date(s): January 9, 2025
Revision Date(s) (include a brief description) and Who Approved by (made by Policy Owner and/or Policy Advisory Committee):
Administrative Edits (briefly describe) by Staff and/or the Policy Advisory Committee (PAC) and Date (these revisions do not require voting/approval by the policy owner):
Exemption(s) to Policy (date, by what committee or individual, and brief description):
LCME Required Policy: ☒Yes/ ☐No **12.5 – Non-Involvement of Providers of Student Health Services in Student Assessment/Location of Student Health Records** *The health professionals who provide health services, including psychiatric/psychological counseling, to a medical student have no involvement in the academic assessment or promotion of the medical student receiving those services, excluding exceptional circumstances. A medical school ensures that medical student health records are maintained in accordance with legal requirements for security, privacy, confidentiality and accessibility.* If yes, please list the Element(s) Affiliated with this Policy (include Element number/name/statement):
All policies will be reviewed by the Policy Advisory Committee every three years unless an earlier review is identified. Date of Review: Revisions Made: ☐Yes/ ☐No If yes, list revisions made: Revisions Require Approval by Policy Owner: ☐Yes/ ☐No

Policy Statement: The Quillen College of Medicine (QCOM) is committed to offering and providing students with counseling and mental health services and maintaining confidentiality of mental health records in a manner consistent with federal standards including the protection and use of records that protect both the clinician, Counseling Center, and QCOM from liability issues.

Purpose of Policy:

The Counseling Center Clinical Records Policy serves to demonstrate how clinicians and staff members will maintain mental health records for each client documenting the services provided, ensuring that records are created and maintained in a manner consistent with state and federal law. All staff members are responsible for documenting their own counseling services rendered to a client. Client records are maintained by clinicians to document the client's progress through the course of therapy. Emergency session documentation is important for ensuring standards of care and in protecting the clinician and the Counseling Center from liability issues.

Scope of Policy (applies to): This policy applies to Medical Students (clients), Counseling Center staff, clinicians and QCOM faculty.

Policy Activities:

1) General Expectations of Record Management
    a) Client records are confidential and will not be released to anyone external to the Counseling Center without appropriate written consent from the client. Client records are stored in the electronic Titanium database, which is on a secure server and has password-protected access.
    b) Clinicians are not permitted to remove any portion of client files from the Counseling Center. Therapy records are the property of the ETSU Counseling Center.
    c) While working with client files, clinicians shall not leave confidential information in a place where unauthorized individuals could gain access.
    d) Front-office staff i.e., administrative assistants, GA's (General Assistants), APS (Academic Performance Scholarship) workers are not permitted to review confidential files maintained by the Counseling Center. However, front-office staff have limited access to files to complete administrative tasks.
    e) Staff members will refrain from reading the notes of clients with whom they are acquainted through a non-clinical relationship (e.g., classmates, acquaintances, etc.).
    f) Records are retained for at least seven (7) years, and up to ten (10) years in order to allow for clients to have their records forwarded to another mental health professional, to provide documentation (e.g., the course of therapy) in a court case where clients' records are court-ordered, to provide for continuity of care if clients return to the Counseling Center or documentation is needed for national clearance.
2) Counseling Center staff members are required to complete case notes within ten (10) calendar days of the appointment date. It is preferred that clinicians' complete notes within forty-eight (48) hours for Personal Counseling notes and five (5) days for First Session/Treatment Review Session notes from when the service was provided.
3) When written or verbal evidence of health or safety risks is presented, clinicians will document what risk was present and provide a follow up plan, including any information used in the assessment and/or safety plan, on the same day as the appointment.
        i) The Clinical Director is responsible for overseeing that any assigned staff member providing services to a client will maintain their files consistent with the Tennessee Statutes.

Documentation of Counseling Center Services

1) All clinical services provided by the Counseling Center staff will include concise clinical notes indicating the appointment was attended and relevant clinical information, Including, but not limited to:
    a) Prominent concerns/symptoms and any changes in functioning since last session.
    b) Assessment of risk, especially if present (e.g., CCAP scores, client disclosure of risk). If risk is not present, the note will also indicate this information (e.g., No suicidal ideation, no homicidal ideation, and no psychosis was identified or observed).
    c) Clinician interventions and client response, and other relevant information regarding the delivery of service to the client.

d) Any consultation about such cases will also be documented in client notes.

Closed/Termination or Inactive Files
Client files will be deemed closed if the following circumstances have been met:

1. A client fails to appear for or cancels three (3) consecutive appointments
2. A client cancels, no shows, or reschedules more than three (3) appointments within a 60-day time frame. Once this occurs, the client will receive an email from the Counseling Center indicating that their file has been closed.

Clients who are not engaged in ongoing care and have not had communication with a Counseling Center provider within the last 60 days are considered "Inactive". Exceptions to this policy include clients taking a therapy break between semesters with intent to resume services the following semester. Clients who have their file closed due to attendance issues may not be eligible to receive services in the future and will be required to meet with one of our administrators prior to re-initiating services.

When clients are no longer engaged in Personal Counseling at the Counseling Center, the counselor will complete a termination note for the client and deactivate the client's file based on the criteria noted above. If a planned termination occurs and/or the client and counselor mutually agree that termination is appropriate, this process will be completed immediately.

Third Party Contacts
Third party contacts are communication (written or verbal) regarding an existing client. Information regarding current clients will only be released if the client has a signed Release of Information form in the client file.

Third party contact about previous client: Staff will use clinical judgement in making a determination in how to respond when presented with information about a former Counseling Center client. Considerations include: time since last contact, history of Counseling Center services including risk, and the content of the information. If the disclosure involves risk, and the other factors are considered, the Counseling Center staff may follow up with former client to assess interest in services and to assess for safety.

Retention of Records

I. In accordance with State of Tennessee standards for the retention of mental health/psychology records, the Counseling Center will maintain a client record for ten (10) years from last clinical contact. The Clinical Director in coordination with the Director and the Counseling Center Administrative Assistant will comply with the Counseling Center's policy on the retention and disposal of public records procedures.
II. In certain instances, staff members may recommend retention of a record beyond the usual retention schedule. Reasons for retaining a record may include records containing information about suicide, homicide, "sensational" or highly publicized cases, cases over which there may have been litigation, or at the request of the client.

Data Breach Policy
The Counseling Center follows Federal guidelines in situations of a breach, specifically 45 CFR §§ 164.400-414 which provides guidelines for breach situations. A breach is "an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information." A breach of confidentiality occurs when sensitive information pertaining to and identifying a specific client is made without the written or verbal consent of the client and/or does not fall within one of the limitations of confidentiality as outlined in the Informed Consent. In the event of a breach of protected health information, notifications will be done consistent with requirements to the affected individuals, the Administrative Assistant, and in certain circumstances to the media.
When any Counseling Center staff members become aware of a potential breach of confidential information, the following steps will be followed:

I. Immediately Notify the Clinical Director and/or Director.
II. Contain and limit the exposure to prevent additional confidential information from becoming breached.
    a. Describe the breach.
    b. Identify impacted individual/client and specific confidential information breached.

c. May need photocopy of breach information. Store photocopies in a secure location.

III. The Clinical Director or Director may report the breach to ETSU Information Technology,
IV. Conduct a thorough investigation as soon as possible. Investigations will be conducted within 24 hours of the compromise.
V. Effected individuals will be notified within 30 days per standardized expectations of care. Coordination of notification may be overseen by the Clinical Director or Director and will depend on the specific nature of the breach, impact on therapeutic relationship and/or presenting concerns, and permission status for contacting clients. Notification may occur during a therapy session, over the phone, or via written correspondence.
VI. Documentation of the breach and any follow-up procedures (e.g., notifications) will be added to the client's file.

Record Requests and Releases of Information

Confidential information may not be released or discussed with anyone other than Center staff without a signed release of information form in the file of the client involved (except as required by law). The Authorization for Release of Information must be signed and dated by the client. A signed release must be obtained whenever confidential information is to be shared with a person or agency outside the Counseling Center, including University staff and faculty.

If additional information is needed, the entity requesting records may contact the Counseling Center and speak with the Director or Clinical Director.

Client files are the property of the Counseling Center, not the client. Records will only be released to mental health or healthcare professionals who require this information for coordination of care. Requests for release or review of records are treated in accordance with professional ethical guidelines. If a client asks to review a file, an attempt will be made to ascertain not only the motivation behind the request, but the potential impact on the client's welfare. If a counselor believes that access to the records would be harmful to the student's mental, physical, or emotional health, access may be denied to portions or even the whole file. Individuals interested in obtaining their own records should be scheduled for a consultation with the Clinical Director.

Records also may be released if court ordered.

Requests for records that are received from insurance companies, military personnel, or security clearance personnel such as Federal Bureau of Investigation (FBI), Central Intelligence Agency (CIA) will only be released to a licensed mental health professional, with written permission from the client. With written permission, we will release information that the student attended counseling and the number of sessions attended. We will not make recommendations regarding a client's suitability for service or security clearance.

Power of Attorney

If the Counseling Center receives a request of confidential information of a client, by a Power of Attorney (POA), then the Counseling Center Director or Clinical Director will review the clinical record first to determine whether the client can be contacted for verification that the claimant is the clients' POA. If the client cannot be contacted or confirm the POA, the Power of Attorney form will be sent to ETSU General Counsel for review and to determine validity as defined by the signature of the client, plus two (2) witnesses and a Notary seal. Once ETSU General Counsel approves such document, the person with Power of Attorney will be asked to complete a Release of Information and an Affidavit of Understanding which clarifies the information requested and purpose of the request. This will be obtained by Legal Counsel.

Letter Requests

Current and former clients may request documentation of services received at the ETSU Counseling Center. Documentation requests will not be considered for students who have attended less than five sessions at the Counseling Center

Due to the scope of services offered at the ETSU Counseling Center, documentation will not be provided for the following:

- Hormone Replacement Therapy
- Gender Affirmation Surgery
- Emotional Support Animals
- Financial Aid and other University-based appeals
- Fitness for Duty or other employment-based requests
- Mandated treatment / Court-ordered care
- Medical withdrawals from the University

All requests must undergo a formal evaluation process with the Counseling Center staff and must be endorsed by the client's counselor. Exceptions to the above restrictions will be considered on a case-by-case basis by the Counseling Center. Any documentation provided by the Counseling Center will be limited to objective information only and will not be considered a "letter of support".

Visit Verification Forms

Students may request a copy of their attendance history without their case undergoing review. Students must still sign a Release of Information (to themselves) prior to obtaining this information in writing.

A visit verification form is an official documentation that you received services on a particular date. This could be helpful to share with a professor who desires proof of services, especially for students who may have missed a class/exam to attend an emergency appointment. All clients are welcome to request a visit verification summary from the Counseling Center. Please note that these summaries do not include session content and do not come in a letter format.

Administrative Reviews/Approvals	**Date Approved**
University Compliance (if applicable)	
Policy Advisory Committee (includes three-year reviews)	January 9, 2025
Associate Dean for Accreditation Compliance (if applicable)	
Vice Dean for Academic Affairs	January 9, 2025

Policy Review and/or Revision Completed By *(if applicable)*	**Date Policy Reviewed and/or Approved (if applies to that department, committee, or group)**
Office of the Dean	
Office of Academic Affairs	January 9, 2025
Office of Student Affairs	January 9, 2025
Department of Medical Education	
Medical Student Education Committee	
Student Promotions Committee	
Faculty Advisory Council	
Administrative Council	
M1/M2 Course Directors	
M3/M4 Clerkship/Course Directors	

Student Groups/Organizations (describe):	
Other (describe):	

Final Policy Emailed to:	**Date of Email Notifications**
Medical Education Director for Posting on Educational Policies Website	1/21/2025
Policy Owner	1/21/2025
Admissions Office for Catalog (only new policies)	1/21/2025