Patient Records – Making Changes

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... Most state laws and applicable ethical standards of the various mental health professional associations dealing with medical or mental health records require that the practitioner keep, maintain, and destroy patient records in a manner that protects the privacy of the patient. With the movement toward the keeping of electronic medical records, the concerns for privacy are heightened. In addition to concerns about privacy, policy makers and others are interested in assuring the accuracy of the records. Accuracy of treatment records is critical to the proper and safe treatment of the patient and helps to avoid “medical errors.” Simply put, accuracy is necessary in order to ensure accountability to both the patient and the legal system.

There are times when changes may need to be made to the records. Perhaps the therapist has read the records and realizes that a mistaken entry was made. Perhaps the entry should be deleted, or perhaps an additional entry or clarification should be made. It is appropriate to correct a mistake or to make a change that is needed. When this is done, it should be clear who made the change to the record, when it was done (the date and time), why it was done, and the nature of the change. Electronic record systems should be compliant with these principles as well. There may be times when it is unwise to make any change to the records, such as after receipt of a subpoena. Even an innocent change can give the appearance of wrongdoing or unethical behavior. Consultation with a knowledgeable attorney would be wise, perhaps necessary, in such situations.

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