Belin-Blank Center
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Belin-Blank Center Assessment and Counseling Clinic
Record-Keeping Policy for Assessments

Per Iowa law, assessment files will be securely maintained at the Assessment and Counseling Clinic for each client until at least seven years after the client was last seen in the clinic or three years after a client has reached the age of 18, whichever occurs later.

The following will be maintained in client assessment records, either electronically or in paper form:

- All legal documentation of consent, including but not limited to:
  - Signature page of Service Agreement
  - HIPAA Acknowledgement
  - Authorization to Provide Assessment Services
  - Consent for Supervision (if applicable)
  - Authorization to Release or Obtain Information (if applicable)
  - Authorization to Release information to Insurance (if applicable)
- Background Information form
- Comprehensive Assessment Report
- Clinic Notes
- Score reports for all tests administered
- Protocols for all tests/subtests administered (unadministered portions of protocols will not be retained)
- Insurance information
- Billing/Payment records
- Documentation of communication with Child Protective Services (if applicable)
- Clinically/Legally relevant communication regarding the client (relevance will be determined by the psychologist and/or clinical supervisor(s))

The following will *not* be maintained in client assessment records, and will be destroyed via shredding or confidential recycling after the comprehensive assessment report has been finalized:

- Prior records from outside organizations (e.g., prior assessment reports, school records, work samples, documentation of educational plans, etc.)
- The examiner's notes from clinical interviews, behavioral observations, etc. (this information will be integrated into the comprehensive report)
- Email exchanges (unless deemed clinically/legally relevant to the case)
- Unadministered portions of assessment protocols
- Other extraneous information

In addition to client files, the clinic maintains an electronic database that is comprised of the information clients provide on the clinic's request for services form (e.g., demographic information, contact information, reason for requesting services, etc.). This database is stored on the same secure drive as the electronic client files.