Record Keeping and Retention

What a mental health practice needs to keep, for how long, and who is allowed to see it. One page, so it can go on the wall.

> **Fill this in for your own practice.** Retention periods come from your professional obligations, your jurisdiction and your indemnity insurer, and they differ for adults and children. The blanks below are deliberate. Complete them once, put the sheet where your team can see it, and review it annually.

The rules of thumb most Australian practices work to

RECORD	KEPT FOR	NOTE
Adult clinical records	_____ years from last contact	Seven years from the date of last entry is the common benchmark.
Records for a client seen as a child	Until age _____	Usually until they turn 25, which can be far longer than seven years.
Consent forms and addenda	_____	Kept as long as the clinical record they relate to.
Outcome measures and scoring sheets	_____	Part of the clinical record, not a loose attachment.
Supervision records	_____	Stored apart from client files. Often needed to evidence hours years later.
Session transcripts, where used	_____	Decide this deliberately. See the section below.
Financial and Medicare records	_____	Your accountant's answer, usually longer than you expect.

Transcripts deserve their own decision

A transcript is a verbatim account of a conversation, which makes it a different kind of record from an approved clinical note. Once the note is written, checked and saved, ask what the transcript is still for. Three defensible positions:

- **Delete once the note is approved.** The cleanest position. The note is the record; the transcript was working material.

- **Keep for a short, fixed window.** Useful if clinicians revisit drafts, or if a note may be amended within days. Write the window down and hold to it.
- **Keep for the life of the record.** Defensible, but understand that everything you keep is discoverable, and say so in your privacy policy.

Our practice's position: _____

Whatever you choose, tell clients. The consent form should match what actually happens.

Access

- Who can open a client file, and on what basis.
- Clinicians see their own clients. Broad access needs a reason.
- Administrative staff see what they need for booking and billing.
- Every unusual access should leave a trace you can look up later.

Client requests

- Clients can ask to see their record, and generally can.
- Respond within a reasonable period; a month is the usual expectation.
- Third party information and material that could cause serious harm may be withheld.
- Log every request and what you released.

When something goes wrong

- Write down what happened and when you learned of it, that day.
- Assess whether serious harm is likely.
- Notify the client and the regulator where required, and note the clock starts at awareness.
- Tell your indemnity insurer early rather than late.

Annual review, ten minutes

- [ ] Every clinician can state the retention period without looking it up.
- [ ] Departed staff no longer have access to any system holding client records.
- [ ] Consent forms on file match the wording currently in use.
- [ ] Your privacy policy describes what actually happens, including AI involvement.
- [ ] Someone other than the owner knows how to retrieve a record.
- [ ] Records for clients seen as children are flagged so they are not destroyed early.

This is general guidance, not legal advice, and retention obligations vary by profession, state and insurer. Confirm the figures for your own practice before relying on them. Ecko Health, v1.0, August 2026.