Vermont Psychiatric Care Hospital Procedure	
Recording Treatment Sessions	
New: X	Date: 5/5/2016

Purpose:

Qualified clinical staff at the Vermont Psychiatric Care Hospital (VPCH) may record individual or group treatment sessions or testing sessions for the purpose of providing staff supervision, reviewing the provision of care to patients, and for treatment purposes. This practice allows VPCH to provide the best possible care to patient through supervisory feedback and training of clinical staff members and authorized trainees.

Recordings of treatment sessions shall be done only with the consent of the patient. Recordings shall be used only for purposes as specified in this procedure, and recordings shall be stored securely by VPCH supervisory personnel until erased.

Procedure:

I. Treatment sessions may be recorded only for the purpose of supervision, for the evaluation of treatment focus and interventions, intern application of practice theory, demonstration of communication techniques, testing procedure fidelity, and to augment clinical treatment of a patient provided that:

A. The patient is informed that the session is being recorded and the patient consents to the recording. Consent to the recording shall be given verbally on the recording.

B. The recording device may not be concealed from the patient during the session.

C. The recording is maintained separate from the patient's medical record in the possession of the clinical supervisor. All recording format shall be kept in lockable files prior to erasure.

D. The recording shall be erased by the clinical supervisor following its use for the purposes described above.

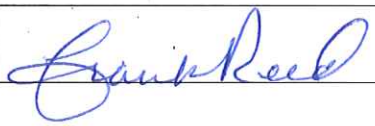
II. The HIPAA Privacy Rule does not give patients a right of access to inspect or obtain a copy of this recording if the above procedure is followed.

Guidance:

The recording must be kept separate from the patient's medical record for the recording to maintain status as "psychotherapy notes" under HIPAA.

"Psychotherapy notes," under HIPAA 45 CFR § 164.501 are defined as:

Notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. *Psychotherapy notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Approved by	**Signature**	**Date**
Frank Reed, Commissioner of DMH		11/29/16