KEEPING CURRENT

May 26, 2026

Maintaining Accurate and Complete Client Health Records: A Primer for Psychotherapists

By Lad Kucis

Founded in the 1920s, Gardiner Roberts LLP has grown to become a strategically placed mid-sized business law firm with a diverse client base which includes several of Canada's largest banks, public companies including mining, high tech and software companies, real estate enterprises, lenders and investors.

Lad Kucis
Partner
416.864.3114
lkucis@grllp.com

Maintaining client health records is a core responsibility of all psychotherapists in Ontario. Beyond documenting the details of each client interaction and supporting continuity of care, accurate and comprehensive recordkeeping is both a legal requirement and a professional obligation. A failure to meet these standards can result in significant regulatory, employment and financial consequences.

This article will outline the key recordkeeping requirements for psychotherapists and examine the potential repercussions of inadequate documentation.

Legal Sources

For psychotherapists, the obligation to maintain client health records flows from the following legal sources:

- The standards of practice established by the College of Psychotherapists of Ontario ("CRPO"), as set out section 5: Recordkeeping and Documentation of the *Professional Practice Standards*, including:
  - Standard 5.1: Clinical Records
  - Standard 5.2: Requests for Records
  - Standard 5.3: Issuing Accurate Documents
  - Standard 5.4: Appointment Records
  - Standard 5.5: Financial Records
- The Professional Misconduct Regulation (Ont. Reg. 317/12) under the *Psychotherapy Act, 2007*, which confirms that the following conduct constitutes professional misconduct:
  - Failing to keep written records in accordance with the standards of the profession;
  - Signing or issuing a document, in their professional capacity, that the psychotherapist knows or ought to know contains a false or misleading statement
  - Falsifying a record relating to the psychotherapist's practice
- Ontario's health sector privacy statute, the *Personal Health Information Protection Act, 2004* (PHIPA), which establishes a comprehensive framework as to how personal health information is to be collected, used, disclosed and protected.

Continued on page 2

Types of Records to Be Maintained

Psychotherapists are required to maintain the following types of records, which collectively form the client health record:

- *Clinical record*: as will be elaborated upon below, this record includes all documentation relating to the clinical care provided to the client
- *Appointment record*: documentation setting out the date, time and duration of each appointment, as well as cancelled or missed appointments
- *Financial record*: all documentation relating to financial issues, including the services provided, the cost of the services and the date and method of payment received (including receipts issued)

Clinical Record

As per Standard 5.1 of the *Professional Practice Standards*, psychotherapists are required to keep an accurate, complete and legible clinical record for each client, the contents of which are to be stored together.

The following are the key components of the clinical record:

- *Client Profile*: this document sets out the name and contact details of the client and any legally authorized representative, as well as information relating to the referral of the client
- *Assessment*: a record of any therapeutic assessment regarding the client
- *Progress Notes*: notes relating to each client appointment, including statements made by the client and the psychotherapist's observations, impressions and proposed plans
- *Client Contact*: a notation of all contact with the client, including letters, emails, text messages, etc.
- *Consultations and Referrals*: a record of every consultation that the psychotherapist receives from, or provides to, another health care provider, relating to the client
- *Mandatory Reports*: any report made in compliance with mandatory reporting requirement. In the context of a verbal report, a written summary of the report is to be prepared
- *Record of Conclusion*: this document summarizes the reasons for the end of the therapeutic relationship, a summary of the outcomes attained, a record of referrals and follow-up recommendations

Clinical records may be maintained in either hard copy or electronic format and each entry must clarify the name of the client or unique identifier, and the date and the name of the psychotherapist who made the entry. Changes to the clinical record must clearly identify the nature of the amendment, the date it was made, who made it, and the reason for the change, while ensuring that the original entry remains legible.

When more than one person (i.e. couple or family) attends therapy, the psychotherapist may maintain a single file, provided that the couple or family attend sessions in the same combination. If a member of the couple or family attends individually, a separate file should be maintained.

PHIPA Requirements

Psychotherapists are expected to comply with the requirements of PHIPA, irrespective of whether they are the health information custodian of the records (i.e. if they operate their own practice) or if they work in a setting where another person or entity is the health information custodian.

© 2016 Gardiner Roberts LLP

Under PHIPA, psychotherapists have specific obligations governing the collection, use, and disclosure of personal health information. Absent certain legal exceptions, a psychotherapist is prohibited from collecting, using or disclosing personal information unless consent is obtained from the client. In addition, a psychotherapist must only collect the minimum amount of information necessary to fulfill the purpose, and cannot collect, use or disclose personal health information if other non-identifying information would suffice.

Psychotherapists must also ensure that clients' rights related to their records are upheld. Clients have the right to request access to their records and request correction if they believe information is inaccurate or incomplete. Psychotherapists are responsible for responding to these requests within the timelines set out in PHIPA and for providing explanations when access is limited or corrections are refused. They must also clearly inform clients about how their records are maintained and the limits of confidentiality, typically as part of the informed consent process.

In addition, PHIPA requires psychotherapists to implement strong safeguards for the storage and security of records. This includes protecting paper and electronic files from unauthorized access, loss, or theft through appropriate physical, administrative and technological measures. Records must be retained for required minimum periods (i.e. 10 years since the last appointment, in the case of adult clients) and disposed of securely when no longer required.

In the event of a privacy breach involving client health records, psychotherapists must notify the client at the first reasonable opportunity, take steps to prevent future incidents and in certain prescribed cases, report the breach to the Information and Privacy Commissioner.

Evidentiary Importance of Client Health Record

In a legal proceeding, the client health record is often treated as the best evidence of what occurred at an appointment or over the course of the therapeutic relationship. Where progress notes or other components of the client health record are brief, incomplete or missing, it can be difficult, if not impossible, to accurately recall events or support the psychotherapist's account, including whether an appointment occurred. Deficient recordkeeping can therefore significantly weaken a psychotherapist's position in the context of a litigation matter, CRPO complaint or insurance audit.

Consequences of Inadequate Recordkeeping

A failure to maintain complete and accurate client health records can result in serious ramifications for a psychotherapist. Some of the key potential consequences include the following:

1. CRPO Complaints/Investigations

First and foremost, a failure to maintain appropriate client health records may result in a complaint or investigation by CRPO. As noted above, non-compliance with established recordkeeping standards constitutes professional misconduct.

Depending on the severity of the deficiency, such shortcomings may lead to a range of regulatory outcomes, including:

- A caution;
- An order to complete a Specified Continuing Education or Remediation Program (SCERP); or
- A suspension, which may only be imposed following a discipline hearing and a finding of professional misconduct.

In each case, the outcome is recorded as a permanent entry on the psychotherapist's public register, which is accessible through the CRPO website.

Importantly, psychotherapists should also be aware that recordkeeping deficiencies alone can give rise to the above sanctions, even in the absence of client harm or other forms of misconduct. Additionally, CRPO may initiate a separate investigation into recordkeeping practices where concerns are identified, even if the original complaint or investigation did not relate to recordkeeping.

2. Complaints to Information Privacy Commissioner

A psychotherapist who fails to safeguard personal health information or otherwise comply with the requirements of PHIPA may be subject to a complaint to the Information and Privacy Commissioner, which is the oversight body responsible for administering PHIPA.

The Information Privacy Commissioner can conduct a formal investigation and may issue orders against the psychotherapist to change or implement information practices, improve safeguards, grant access to, or correct personal health information, etc. The Information Privacy Commissioner also possesses the authority to issue administrative monetary penalties for serious or systemic PHIPA breaches.

3. Being De-Listed by Insurance Companies

Extended health insurers routinely audit client health records maintained by psychotherapists to confirm that billed services were in fact provided. Where documentation is inadequate, it may undermine the credibility of claims and raise broader concerns about a psychotherapist's administrative, billing and compliance practices.

If an insurer concludes that a billed service was not provided, or that a psychotherapist's recordkeeping practices fall below expected standards, it may de-list the psychotherapist. De-listing renders the psychotherapist's services permanently ineligible for reimbursement by that insurer, which can have massive financial consequences, particularly where a major insurer is involved. It is also imperative to keep in mind that it is extremely challenging to have an insurer reverse a de-listing decision, at any point in time.

Finally, insurers can also file a corresponding complaint with CRPO following a de-listing, further compounding the overall impact of the matter for the psychotherapist.

4. Workplace Consequences

Clinics, community health centres and other psychotherapist workplaces typically establish their own documentation standards and policies. A failure to comply with these requirements may result in employment consequences for a psychotherapist, including disciplinary action or termination of employment or contract.

Even where the clinical care provided is appropriate, inadequate recordkeeping may be viewed as a significant breach of employer expectations in the employment context.

Key Takeaways

The maintenance of complete and accurate client health records is not discretionary but is rather a fundamental legal and professional obligation. Appropriate recordkeeping serves several critical purposes, including:

- Supporting the delivery of high-quality client care
- Facilitating communication within the circle of care and assisting future care providers
- Demonstrating compliance with CRPO and PHIPA requirements
- Mitigating legal and regulatory risk

Psychotherapists are encouraged to regularly review recordkeeping standards issued by CRPO, as well as guidance published by the Information and Privacy Commissioner of Ontario, to ensure their documentation practices remain aligned with applicable legal, professional, and industry standards.

About the Author

Lad Kucis is certified by the Law Society of Ontario as a specialist in health law and provides advice and representation to psychotherapists in respect of all types of regulatory matters, including complaint and disciplinary matters before their regulatory colleges, and complaint reviews before the Health Professions Appeal and Review Board.

He can contacted at 416.864.3114 or at lkucis@grllp.com.

This article has been prepared for information purposes only and is not intended to be construed as legal advice.