Standards for Psychotherapy Notes Record Management in Healthcare Facilities

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Health Informatics and Smart Health Department

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ACKNOWLEDGMENT

The Health Informatics and Smart Health Department (HISHD) developed this Standard in collaboration with subject matter experts and would like to acknowledge and thank these health professionals for their dedication toward improving quality and safety of healthcare services in the Emirate of Dubai.

Dubai Health Authority

TABLE OF CONTENTS

INTRODUCTION

Dubai Health Authority (DHA) is mandated by Local Law No. (14) Of 2021 on amending the local Law No. (6) of 2018 concerning the Dubai Health Authority , to undertake several functions including but not limited to:

- Developing regulation, policy, standards, guidelines to improve quality and Data Subject/Patient safety and promote the growth and development of the health sector.
- Licensure and inspection of Healthcare Facilities as well as Health professionals and ensuring compliance to best Facility.
- Governing of health information, e-health and promoting innovation.
- Managing patient complaints and assuring patient and physician rights are upheld.

The “Standards for Psychotherapy Notes Record Management in Healthcare Facilities" aims to fulfil the following overarching Dubai Health Sector Strategy 2026:

- Pioneering Human-centered health system to promote trust, safety, quality and care for Patients and their families.
- Make Dubai a lighthouse for healthcare governance, integration and regulation.
- Leading global efforts to combat epidemics and infectious diseases and prepare for disasters.
- Become a global digital health hub.

EXECUTIVE SUMMARY

The purpose of this document is to assure the Psychotherapy Notes (PN) are managed as per requirements of Dubai Health Authority (DHA) for health information record management; and the retention of records is preserved properly while maintaining the integrity, security, privacy and accessibility of Data Subject/Patient data. The Standard has been developed to align with the evolving health information necessities and international best practices. This document should be read in conjunction with other Health Information Governance regulations released by DHA:

- Policy for Health Information Assets Management
- Policy for Health Information Sharing
- Health Data Quality Policy
- Health Data Classification Policy
- Policy for Health Data Protection and Confidentiality
- Incident Management and Breach Notification policy
- Subject of Care Rights
- Consent and Access Control
- Incident Management and Breach Notification Policy
- Data Management and Quality Policy (Primary and Secondary Use)
- Health Information Audit Policy
- Identity Management Policy
- Authentication and Authorization Policy

- Information Security Standards
- Interoperability and Data Exchange Standards
- Technical and Operational Standards
- Artificial Intelligence Policy

DEFINITIONS

Authentication: The process of reliable security identification of subjects by incorporating an identifier and its authenticator.

Authorization: The granting of rights, which includes the granting of access based on access rights.

Data Subject: A person who is the subject of protected health information.

Electronic Medical Record (also known as Electronic Health Record): A digital version of Data Subject/Patient's paper medical chart and personal information that contains a Patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, laboratory test results, etc. It conforms to nationally recognized interoperability standards and enables information to be used and shared over secure networks.

Facility: DHA licensed healthcare Facility that performs medical examinations on Patients, diagnosing their diseases, treating or nursing them, admitting them for convalescence, or assuming any activity related to treatment or to rehabilitation after treatment, whether it is owned or managed by natural or juridical persons. In this Standard the Facility also includes facilities that conduct "psychologic therapy," "mental health evaluations," and "psychological assessments".

Health Information Exchange: is the electronic transmission of health data and information among healthcare Facilities according to national guidelines. Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and Data

Subject/Patients to appropriately access and securely share a Data Subject/Patient's vital medical information electronically—improving the speed, quality, safety and cost of Patient care.

Mental Health Professionals: mental health professionals can provide psychological assessments and therapy, non-clinical interventions such as case management, crisis support, and psychoeducation. This includes, but is not limited to:

1) Clinical Psychologist
2) Psychiatrist
3) Psychiatric or Mental Health Nurse Practitioner
4) Nurse Psychotherapist
5) School Psychologist
6) Mental Health Counselor
7) Mental health social workers
8) Mental health occupational therapists
9) Licensed Professional Counselor
10) Certified Alcohol and Drug Abuse Counselor
11) Marital and Family Therapist

NABIDH: A health information exchange platform by the Dubai Health Authority that connects public and private Healthcare Facilities in Dubai to securely exchange health information.

Protected health information: also referred to as personal health information; include any of the 18 types of identifiers specified below:

• Name (Full name as per passport or Emirates ID)

• Address (All geographical identifiers)

• All elements of dates (other than years) related to an individual (including birth date, admission date, discharge date, date of death and exact age if over 89).

• Telephone numbers

• FAX number

• E-mail address

• Emirates Identification Number

• Medical record number

• Health insurance beneficiary numbers

• Bank Account number

• Driving license number

• Vehicle identifiers (including serial numbers and license plate numbers)

• Device identifiers or serial numbers

• Web Uniform Resource Locators (URLs)

• Internet Protocol (IP) address numbers

• Biometric identifiers, including finger, retinal and voice prints

• Full face photographic images and any comparable images

• Any other unique identifying number, characteristic, or code.

Psychotherapy Notes: refer to the personal notes recorded by a Mental Health Professional (MHP) during or after a private, group, counseling or psychotherapy session. These notes are specifically used to document or analyze the contents of the therapy session and are kept

separate from the Patient's medical record. Psychotherapy Notes are distinct from other types of medical records and are not used for billing, treatment planning, or other administrative purposes.

ABBREVIATIONS

CDA	:	Community Development Authority
DHA	:	Dubai Health Authority
EMR	:	Electronic Medical Record
HIE	:	Health Information Exchange
HISHD	:	Health Informatics and Smart health Department
ICT	:	Information and Communications Technology
MHP	:	Mental Health Professional
PHI	:	Protected Health Information
PN	:	Psychotherapy Notes
UAE	:	The United Arab Emirates

1. BACKGROUND

Dubai Health Authority (DHA) is mandated by Local Law (6) of 2018 Concerning Dubai Health Authority and Local Law No. (14) Of 2021 on amending the local Law No. (6) of 2018 concerning the Dubai Health Authority to undertake several functions including, but not limited to Developing regulation, policy, standards, guidelines to improve and promote the growth and development of the health sector in the Emirate of Dubai.

The "Standard for Psychotherapy Notes Record management in healthcare facilities" aims to fulfil health information requirements for Healthcare Facilities in management and retention of PN as per UAE laws and DHA regulations; in order to position Dubai as a global medical destination by introducing a value-based, comprehensive, integrated and high-quality service delivery system.

2. SCOPE

2.1. All Psychotherapy Notes (PN) being managed in Healthcare Facilities under jurisdiction of DHA. These PN can be created by DHA-licensed or Community Development Authority (CDA) – licensed mental health professionals.

3. PURPOSE

3.1. To ensure establishment of standardized process in managing Psychotherapy Notes in Healthcare Facilities in the Emirate of Dubai.

4. APPLICABILITY

4.1. All DHA Licensed Healthcare Facilities.

4.2. All licensed mental health professionals that provide psychotherapy services.

5. STANDARD ONE: BROAD DEFINITION OF PSYCHOTHERAPY NOTE

5.1. Psychotherapy Notes (PN) are anything which recorded by a Mental Health Professional (MHP) documenting or analyzing the contents of conversation during a private, group, or family counselling session.

5.2. Psychotherapy Notes are specifically used to document or analyse the contents of the therapy session.

5.3. Psychotherapy Notes are personal notes of the MHP that typically are not required or used for treatment, payment, or health care operations purposes, other than by the MHP who created the notes.

5.4. Psychotherapy Notes are kept separate from the rest of the Patient`s medical record.

5.5. Psychotherapy Notes are considered Protected Health Information (PHI).

5.6. Psychotherapy Notes are generally not accessible to Patients or parents.

5.7. Psychotherapy Notes can contain information (in any media) which has been created or gathered as a result of any aspect of the psychotherapy with Patients.

5.8. Psychotherapy Notes can includes:

5.8.1. Handwritten notes.

5.8.2. Computer typed and filed notes.

5.8.3. Impressions and Observations: The therapist's personal impressions about the Patient's behavior, emotions, or non-verbal cues during the session.

5.8.4. Subjective Insights: The therapist's thoughts, hypotheses, or reflections on what was discussed, including how the Patient's issues might relate to broader psychological theories or concepts.

5.8.5. Analysis of the Session: Notes on how the therapist is interpreting the Patient's responses and progress in therapy.

5.8.6. Details of the Session: Specific conversations, thoughts, or emotional exchanges between the Patient and therapist that may not be directly relevant to treatment planning but are useful for the therapist's understanding of the Patient.

5.8.7. Therapeutic Strategies: Ideas for potential future interventions or therapy directions that are still in the therapist's consideration phase.

5.8.8. Personal Reactions: The therapist's own emotional or cognitive reactions to the session, which may help guide future treatment but are not part of the Patient's clinical record.

5.8.9. Audio and visual recordings.

5.8.10. Proformas used in psychotherapy assessments.

5.8.11. Records made by the Data Subjects/Patient.

5.8.12. Work completed by Data Subjects/Patients during the course of assessments.

5.8.13. Creative work completed by the Data Subjects/Patient (e.g. artwork).

5.8.14. Electronic information including e-mails and mobile phone texts.

5.8.15. Communications between professionals and their Data Subjects/Patients.

5.8.16. Communications within and between teams and/or services caring for a Data Subject/Patient or Patients group.

6. **STANDARD TWO:** PSYCHOTHERAPY NOTES MANDATES

6.1. Psychotherapy Notes must be maintained separate from the medical record whether in digital or paper form.

6.2. Facilities are recommended to maintain their records (including PN) as electronic records (e.g. soft copy).

6.3. If PN are maintained in paper form, then they should be kept in separate file (Colored paper in the same chart is NOT considered separate).

6.4. The MHP should document who was present on the session, where it took place and as a minimum key points discussed and outcomes and action plans.

6.5. Records must demonstrate any risks identified and/or problems that have arisen and the action taken to rectify them.

6.6. Psychotherapy Notes must demonstrate a full description of the assessments made, and the care planned and provided, and actions taken to include information shared with other health professionals.

6.7. All entries in the PN must be made in either Arabic or English language.

6.8. Psychotherapy Notes should NOT contain:

6.8.1. Medication prescription and monitoring.

6.8.2. Modalities and frequency of treatment.

6.8.3. Results of clinical tests.

6.8.4. Any summary of diagnosis, functional status, the medication treatment plan, symptoms, prognosis, and progress to date.

6.9. It is recommended to write up PN on the same day or the day after the psychotherapy session.

7. **STANDARD THREE:** PSYCHOTHERAPY NOTES AS HARD COPY

If MHPs within the Facility prefer to record the PN as hard copy (e.g. paper based) then below aspects should be followed:

7.1. All PN should be documented on paper provided by the Facility (e.g. Clinical Notes sheets and Facility`s paperwork).

7.2. Handwriting must be legible and written in black ink to enable legible photocopying or scanning of documents if required.

7.3. No spaces should be left between lines or entries.

7.4. No abbreviations must be inserted.

7.5. The PN must be accurate and written in such a way that the meaning is clear.

7.6. The original PN should be kept intact (do not erase).

7.7. The original PN should be able to be read clearly.

7.8. Errors in PN must not be amended using white correction fluid, permanent marker, scribbling out or writing over the original entry.

7.9. In the event of an error being made, entries must be corrected by striking the error through with one line, and applying the author's initials, time, and date alongside the correction.

7.10. Records must never be falsified.

7.11. First entries on each page of the PN must include the name and signature of the person recording the information.

7.12. Abbreviations, jargon, meaningless phrases, or offensive statements must not be included in any PN.

7.13. All entries in the PN must be dated (date / month / year), timed accurately (e.g. time the entries), and signed with full name of the MHP included.

8. **STANDARD FOUR:** PSYCHOTHERAPY NOTE ARE CONSIDERED PART OF PATIENT RECORD

8.1. It is the intention of the DHA that there be a single electronic record for each person who uses health services.

8.2. Facility can impend software applications for PN managements. However, The software for capturing, storing, retrieving, viewing, and analysing PN should follow the DHA specified regulations, standards and requirements DHA Information Governance Regulations .

8.3. Compliance with the standards for the content of entries is obligatory whether paper or electronic records are being kept.

8.4. Psychotherapy Notes should not be shared with Health Information Exchange (HIE) such as Nabidh.

9. **STANDARD FIVE:** PSYCHOTHERAPY NOTES PROTECTION AND CONFIDENTIALITY

9.1. All the protection measures that apply to medical records also apply to PN Policy for Health Data Protection and Confidentiality.

9.2. The principles of health information confidentiality apply to both electronic (digital) and paper (hard copy) of PN as they do with other Data Subject/Patient records.

9.3. Facility must put the same protections in place for PN that they do for other medical records; to avoid accidental exposure of PHI.

9.4. Psychotherapy Notes should be protected from unauthorized access. For example, the notepad should be stored in a locked filing cabinet so that no one else can access them.

9.5. Facility must conduct a complete risk analysis to identify any potential gaps in security procedures — including training for staff.

9.6. Prior to the first assignment in a Facility, the MHP must obtain a log-in /password for relevant record systems.

9.7. Mental Health Professionals must use their own log-in details when accessing electronic records and must log-out when not in use.

9.8. Legal requirements and local policies regarding confidentiality of Patient records must be always followed.

9.9. In line with the Policy for Health Data Protection and Confidentiality , care records and information concerning Patients must not be left accessible, or in public places, and must not be unlawfully shared with anyone not directly involved in the Patient's care.

9.10. Mental Health Professionals have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium.

9.11. Psychotherapy Notes require high protection-most notably from third-party payers.

9.12. All MHPs are bound by the DHA standards and guidelines on confidentiality as part of their contractual relationship with the Facility, in addition to the codes of practice offered by the counselling professional bodies.

9.13. The Health Data Classification Policy considers mental health records and PN as sensitive records that should be flagged as such, and accessed only by treating physician or MHP.

9.14. All PN must be recorded properly and stored securely.

9.15. All MHPs are advised to maintain confidentiality and protect sensitive information obtained in consulting sessions.

9.16. If the Facility uses third-party vendors to store psychotherapy notes, they must ensure that these vendors have adequate security measures in place.

10. **STANDARD SIX:** PSYCHOTHERAPY NOTES MANAGEMENT AND RETENTION

10.1. The Dubai health Authority has standards for record keeping to which all staff groups, including MHPs, must adhere to Policy for Health Information Assets management.

10.2. All records including PN must compulsorily be retained according to the United Arab Emirates (UAE) laws UAE Federal Lao no. (2) of 2019 on Information and Communication Technology in the Health Field ICT Health Law and DHA regulations Policy for Health Information Assets Management .

10.3. Psychotherapy Notes are subject to the same standards for duration of archiving and retention as medical records Policy for Health Information Assets management. All PN should be kept at least 25 years after last Patient encounter.

10.4. It is recommended to link all Patient`s records (e.g. medical records and PN) in one official storage portal with having extra access control and security measures for PN.

10.5. Whether in soft or hard copies, PN must be kept separate from the Patient's medical record or progress notes.

10.6. Mental Health Professionals should maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (Policy for Health Data Protection and Confidentiality).

10.7. All PN should be stored in a secure, designated location. They should be protected from loss, damage, and unauthorized access.

10.8. Hard copy PN should be organized in a logical and systematic manner, making it easy to locate.

10.9. Audio and video recordings of counselling sessions and supervision sessions can be used for training or research only if the Patient has given signed consent and a copy of this consent is lodged in the file.

10.10. Secure storage and access to PN must be always considered.

10.11. Provision must be made for continuity of the Patient care; as when a MHP moves to another post the confidential materials arising from counselling work should be transferred to incoming post holder.

10.12. Certain forms of work such as pieces of art work, photographs Patients have brought in, letters or records they have written may be returned to the Patients and notification that this has been done made in the PN.

10.13. It is recommended for PN that were previously taken on paper to be digitized, and quality check must be done one them as per Policy for Health Information Assets Management. If digitized paper PN are not of good quality, then Facility must take precautions to safeguard them.

10.14. When PN reach their end of retention period (as per Federal Law No. (2) For the year 2019 On the Use of Information and Communications Technology and Policy for Health Information Assets Management); or they have been digitized and the paper PN needs to be destructed, the Facility must make sure that all precautions have been followed to avoid retrieving the sensitive data after disposal.

10.15. Facility can hire a third-party shredding service. If the Facility chooses a company for disposal of PN (after their retention time), then non-disclosure agreement should be signed by both parties.

10.16. Facilities may decide the timing of making a record inactive, however, it is preferable to follow the "five (5) year rule" where all records of a deceased/absent Data Subject/Patient are made inactive after five years as per Policy for Health Information Assets Management. Yet, all medical records including PN must remain accessible by the responsible healthcare provider as and when required.

10.17. Suitable archiving systems and processes have to be implemented to protect data integrity from unintended manipulation or deletion.

10.18. Regular backups should be made on soft copy of PN.

10.19. Appropriate quality checks should be in place to confirm that archived data (including metadata) are available, complete and readable.

10.20. Facilities must ensure, that the records are never destroyed or removed permanently before their retention timeline as per DHA requirements Policy for Health Information Assets Management.

10.21. Records written in the context of Facility employment are Facility property and do not belong to the person who wrote them. The MHP should handover work/PN that belongs to the Patient (materials they have produced for their work together whether writing, artistic creations, etc.) before leaving the Facility.

10.22. If the Facility is closing or the ownership is changing, then a custodian for all PN must be selected as per Policy for Health Information Assets Management .

11. STANDARD SEVEN: PSYCHOTHERAPY NOTES DISCLOSURE

11.1. Extra privacy protections should be applied by MHP to PN. This is different than protection applicable to general mental health records, or the overall Patient medical record. Mental health records are considered to fall within PHI and are part of the medical health record, which are covered by general authorizations for disclosure of Patient health records. But PN are notes created by the MHP for their own use.

11.2. There are a few exceptions for which PN may be disclosed to a person other than the person who created the notes:

11.2.1. For the investigation or defense of legal claims; or court orders.

11.2.2. Disclosure of PN for certain oversight activities authorized by federal law.

11.2.3. To assist police investigation.

11.2.4. For the investigation including complaints to the Regulator (DHA) against the Facility or its employees.

11.2.5. For the purposes of therapists defending themselves in court.

11.2.6. Professional consultations with other therapists/clinical psychiatrists/ healthcare professionals, to provide needed specialized services.

11.2.7. Disclosure of PN for avoidance of a serious and imminent threat to the Patient.

11.2.8. Emergency situations where sharing information is vital to the Patient's well-being.

11.2.9. For notifying appropriate parties if public health and safety is threatened.

11.2.10. Use in supervision or training of MHPs, ensuring confidentiality.

11.3. When disclosing PN, due to permitted reasons, the MHP should document the reason for the disclosure, the specific information disclosed, and the person the PN disclosed to.

11.4. Though the privacy rule does afford Patients the right to access and inspect their health records, PN are treated differently: Patients do not have the right to obtain a copy of their PN. And when a MHP denies a Patient access to these notes, the denial isn't subject to a review process, as it is with other records.

11.5. Mental Health Professionals should not withhold records under their control that are requested and needed for a Patient emergency treatment solely because payment has not been received.

11.6. Mental Health Professionals should not disclose in their writings, lectures, research or other public media, confidential, personally identifiable information concerning their Patient or other recipients of their services that they obtained during the course of their work.

11.7. All MHPs should be familiar with the latest directives with regard to minors.

11.8. All MHPs should be familiar with the latest directives with regard to vulnerable adults.

12. **STANDARD EIGHT:** PSYCHOTHERAPY NOTES CONSULTATIONS WITH COLLEAGUES

12.1. Mental Health Professionals must not disclose confidential information that reasonably could lead to the identification of a Data Subject/Patient or research

participant unless they have obtained the prior consent of the Patient or the disclosure cannot be avoided due to mandate of care being given to the Patient.

12.2. Mental Health Professionals must disclose information only to the extent necessary to achieve the purposes of the consultation.

12.3. If there is a professional responsibility to inform others involved in a person's care of psychologic consultation conducted, then it should include:

12.3.1. When the consultation has occurred.

12.3.2. What work has been done.

12.3.3. What work is intended and when (therapy plan).

12.4. Mental Health Professionals should recall that the "minimum necessary" requirement mandates them to restrict the disclosure of confidential information to the minimum amount of information needed; and that PN are granted more protection with regard to disclosures.

12.5. Mental Health Professionals may, upon request, share information like a diagnosis or Patient's progress to a psychiatrist also treating the Patient.

13. **STANDARD TEN:** GAINING CONSENT FOR PSYCHOTHERAPY NOTES

13.1. All MHPs should obtain Data Subject/Patient consent before recording the voices or images of Patient to whom they provide services. If the Patient is a minor or incompetent then the consent should be obtained from the parents or their legal representatives as per DHA Guidelines for Patient Consent.

13.2. This rule applies to work outside the service caring for Patients, to trainees working on case studies as part of their training, to audio and visual recording, to teaching examples, to audit, evaluation and research and publications.

14. STANDARD ELEVEN: PSYCHOTHERAPY NOTES OF TRAINING/TEACHING SUPERVISION SESSIONS

14.1. Information discussed in supervision sessions should be documented by supervisees and supervisors.

14.2. There may be occasions when it is clear that an entry about the discussion and decisions in supervision should also be entered into the PN. In this case, the PN should be signed and dated accordingly.

14.3. The minimum standard for the recording of supervision sessions is as follows:

14.3.1. Copies of all supervisory contracts and updates should be kept.

14.3.2. The date and duration of each session should be recorded.

14.3.3. A supervision logbook should be kept, and include at least minimal notes on the content of supervision, decisions reached, agreed actions.

14.3.4. A written record should be made of all regular reviews, including outcomes, of supervision. e. In some situations (e.g. risk issues) it would be good practice to also record a discussion and/or agreement in the relevant case file.

15. STANDARD TWELVE: PSYCHOTHERAPY NOTES ACCESS REQUEST

15.1. An important distinction between PN and regular medical records is the right to access them. An individual can access PHI as long as the information isn't PN.

15.2. A stricter protection of PN is applied because they are the therapist's personal notes and can contain incredibly sensitive information. They are also unlikely to be shared with anyone including Patients and their parents.

16. STANDARD THIRTEEN: TRAINING ON PSYCHOTHERAPY NOTE RECORD MANAGEMENT

16.1. Entities must ensure that all staff know the difference between the Patient's medical record and PN.

16.2. Entities must keep PN separate from the Patient's medical record.

16.3. Entities should reach out to electronic medical record (EMR) provider to determine how to differentiate PN from the clinical medical record.

16.4. Appropriate training for all MHPs is a crucial step for any implementation to meet short and long-term needs.

16.5. Mental Health Professionals should be familiar with legal and ethical requirements for record keeping in their specific professional contexts and jurisdictions.

16.6. Dedicated training should be conducted on PN record management to ensure adequate health information assets management.

16.7. During each iteration of training (online/class room), proficiency of trainee should be assessed and recommended for further sessions if required.

16.8. Mental Health Professionals are accountable for any entry they make to PN and must ensure that any entry made is clearly identifiable in accordance with DHA policies DHA Information Governance Regulations.

16.9. Mental Health Professionals have a duty to keep up to date with, and adhere to, relevant legislation, UAE law, and DHA policies relating to information and record keeping.

16.10. Mental Health Professionals must comply with the recording system of their employing Facility.

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