Digital Record Retention and Notekeeping Policy

Version 2.1 | Effective 12 August 2026

1. Policy Statement and Purpose

Behavioural Edge Psychology Pty Ltd is committed to maintaining accurate, secure and accessible client records in accordance with legal, professional and ethical obligations. This policy establishes standards for the creation, retention, storage and destruction of all clinical and administrative records.

The objectives of this policy are to ensure compliance with the record-keeping requirements of the Psychology Board of Australia Code of conduct for psychologists and the Health Records Act 2001 (Vic), to adhere to the single-record principle, to protect client privacy and confidentiality throughout the record lifecycle, to ensure records are available when needed for continuity of care or legal purposes, to establish clear procedures for record destruction and legal holds, and to support quality clinical care through comprehensive, contemporaneous documentation.

2. Scope and Application

This policy applies to the Principal Psychologist and any contractor, locum or staff member engaged by the practice in future, and covers all client clinical records (current and archived), all business and administrative records, electronic and paper-based records, and email communications, digital documents and multimedia files. Behavioural Edge Psychology is currently a sole-practitioner practice; all responsibilities under this policy sit with Dr Sarah Fischer as Principal Psychologist and sole director unless otherwise delegated in writing.

3. Regulatory and Legal Framework

Professional standards

- Psychology Board of Australia Code of conduct for psychologists (effective 1 December 2025), including standard 8.5 on client records
- AHPRA and National Board guidance on records and record keeping
- APS professional guidance on record keeping, which continues to inform good practice for APS members

Legislative requirements

- Privacy Act 1988 (Cth) and the Australian Privacy Principles
- Health Records Act 2001 (Vic) and the Health Privacy Principles
- Evidence Act 2008 (Vic) and Evidence Act 1995 (Cth), as applicable to the forum
- Corporations Act 2001 (Cth), for company and financial records
- Electronic Transactions (Victoria) Act 2000 (Vic) and Electronic Transactions Act 1999 (Cth)

4. Definitions

Client record. All information relating to a client's psychological assessment, treatment and care, including clinical notes, correspondence, assessment results, treatment plans and administrative

documents. The single-record principle requires that all information about a client be maintained in one comprehensive file.

Digital record. Any record created, stored or transmitted in electronic format, including practice management system entries, documents, emails, PDFs, audio or video recordings and scanned images.

Clinical notes. Contemporaneous records of client interactions, including session notes, progress notes, telephone contacts and clinical observations.

Active record. A record relating to a client who has had contact with the practice within the past 12 months.

Inactive record. A record relating to a former client with no contact for more than 12 months that is still within the required retention period.

Legal hold. A suspension of normal record destruction processes due to pending or threatened litigation, investigation, audit or regulatory inquiry.

Retention period. The minimum length of time a record must be kept before it may be destroyed.

Destruction. The permanent, irreversible deletion or disposal of records in a manner that ensures they cannot be recovered or reconstructed.

5. The Single-Record Principle

5.1 Principle Statement

> There is one comprehensive client file containing all information relevant to the client's psychological care.

This principle ensures completeness, prevents fragmentation, reduces the risk of information being overlooked, and facilitates continuity of care. It is consistent with the Code of conduct requirement that records be accurate, up to date, factual, objective, legible and accessible.

5.2 What Must Be Included in the Client Record

The single client record must contain:

- Identifying information: name, date of birth, contact details, Medicare or scheme identifiers where applicable, and emergency contact information
- Clinical information: intake and assessment material, presenting problems and referral information, relevant history, assessment results and interpretations, diagnoses where made, treatment plans and goals, session notes for every client contact, progress notes and outcome measures, risk assessments and safety plans, and termination or discharge summaries
- Consent and legal documents: informed consent forms, consents for communication with third parties, privacy acknowledgments, and financial agreements where held in the clinical file
- Correspondence: letters to and from referrers, GPs and other providers, reports prepared for clients or third parties, relevant email communications (see section 7), and documentation of telephone contacts

- Other relevant information: records received from other providers with consent, supervision or consultation documentation where relevant to client care, incident reports, and any other information that informs the client's psychological care

5.3 Prohibited Separate Records

To maintain the single-record principle, the psychologist must not maintain separate 'personal notes' or 'memory aids' containing client information, private diaries or journals documenting client sessions, informal notes not integrated into the official client record, or multiple files for the same client other than approved backups.

Exception for supervision notes. Notes created in clinical supervision may be maintained separately where they contain reflective commentary about the psychologist's professional development rather than client care. Any information directly relevant to client care must be incorporated into the client record.

Exception for independently commissioned assessments. Records of medicolegal and other independently commissioned assessments are maintained as a separate matter file for each referral rather than within a treatment file, reflecting that no treating relationship exists. See section 12.4.

6. Retention Periods

6.1 Client Clinical Records

Minimum retention periods, consistent with standard 8.5 of the Code of conduct for psychologists and the Health Records Act 2001 (Vic), are set out below.

Client category	Retention period	Calculation
Adult clients (18 or over)	Minimum 7 years	From the date of the last entry in the record
Clients under 18 at the date of the last entry	Until the client turns 25	Stated for completeness; the practice provides services to adults only
Deceased clients	Minimum 7 years	From the date of the last entry
Records subject to legal proceedings	Until the matter is resolved, plus 7 years	From final resolution, including any appeals
Records related to complaints or investigations	Until the matter is resolved, plus 7 years	From final resolution

These are minimum periods. Records may be retained longer where there is good reason, such as complex matters, ongoing legal proceedings or client request, balanced against the privacy obligation not to retain information beyond need.

6.2 Business and Administrative Records

Record type	Retention period
Financial records (invoices, receipts, tax documents)	7 years (Australian Taxation Office requirement)
Contractor and any future employee records	7 years after the engagement ends
Insurance policies and claims	7 years after policy expiry or claim settlement
Contracts and agreements	7 years after expiry or termination

Record type	Retention period
Complaints and incident reports	7 years after resolution
Policy documents and procedures	7 years after being superseded
Lease agreements and property records	7 years after expiry

7. Email and Electronic Communication Retention

7.1 Classification of Emails

Category 1: client-related emails (must be retained). All emails to or from clients regarding their care; emails to or from referrers, GPs or other providers about a specific client; emails containing client information, assessment results or treatment recommendations; appointment communications with clinical relevance; and any email that would inform continuity of care or clinical decision making. These must be saved to the client record within 2 business days, with client record retention periods applied.

Category 2: business and administrative emails (selective retention). Contracts, agreements or legal correspondence; financial transactions and billing matters; policy decisions or procedural changes; and complaints or incident reports. Retain for 7 years from the date or completion of the matter, saved to the appropriate business records folder.

Category 3: transient and routine emails (limited or no retention). General enquiries that did not result in services, routine confirmations with no clinical content, internal scheduling, marketing material and junk mail. These may be deleted after 30 days or when no longer needed, unless subject to a legal hold.

7.2 Email Management Procedures

The practice email account is hosted on Gmail on the practice domain. Emails are reviewed and classified regularly; Category 1 emails are saved to the client record in Cliniko within 2 business days; Category 2 emails are archived to business folders; Category 3 emails are deleted when no longer needed. A personal email account is never used for client communications. Email platform backups are for disaster recovery only and do not satisfy retention obligations; relevant emails must be actively saved to the client record.

8. Digital Record Creation and Management

8.1 Documentation Standards

All digital clinical records must be:

- **Contemporaneous:** session notes completed within 24 hours of the session, and within 48 hours at most
- **Accurate and objective:** factual observations and clinical impressions recorded separately, without judgmental or pejorative language, consistent with the Code of conduct requirement that records show respect for clients
- **Complete:** date, time, duration and type of contact; presenting issues, interventions used, client response and plan; and any risk issues, safety concerns or changes to the treatment plan

- **Professional:** written on the assumption that the record may be read by the client, other professionals or legal parties
- **Legible and accessible:** in searchable, readable formats, avoiding proprietary formats that may become obsolete

8.2 Amendments and Corrections

When correcting or amending digital records, never delete or overwrite original entries. Add a dated addendum clearly identified as such, include the reason for the amendment, and ensure the original entry remains visible. The practice management system audit trail records all changes.

8.3 Audio and Video Recordings

Where sessions are recorded with consent in accordance with section 6 of the Privacy Policy, recordings are stored on encrypted systems with restricted access, linked to the client record with metadata recording the date, purpose and consent status, subject to the same retention rules as written records, and deleted within 12 months unless a specific clinical, supervisory or legal justification is documented. Destruction must be secure and complete.

9. Storage and Security Requirements

9.1 Active Records Storage

Active client records are held in Cliniko practice management software, with psychometric data in NovoPsych, PARiConnect and Pearson Q-interactive and Q-global, intake and screening questionnaires in Jotform, and practice documents in a secure OneDrive account. Telehealth sessions are delivered through Cliniko telehealth and Doxy and are not recorded (see sections 6 and 7 of the Privacy Policy); the clinical record of a telehealth session is the written session note held in Cliniko. Records systems must provide encryption in transit and at rest, access limited to authorised users with unique credentials, multi-factor authentication where available, automated backups, and data hosted in Australia or with equivalent privacy protections.

9.2 Archived Records Storage

Inactive records are maintained in a searchable, accessible format, retrievable within 5 business days upon request, protected with the same security standards as active records, and reviewed annually for retention compliance.

9.3 Backup and Disaster Recovery

Backup arrangements comprise daily automated backups of clinical and business records, encrypted backups stored separately from primary data, periodic testing of restoration, and retention of backup versions for a minimum of 30 days. The disaster recovery objective is restoration of access to active client records within 24 hours, with a maximum of 24 hours of data loss. See the Business Continuity and Emergency Preparedness Procedure.

9.4 Access Controls and Audit Trails

Digital record systems log access to client records, implement role-based access, lock inactive sessions, and maintain audit trails. Audit trails are retained for a minimum of 7 years.

10. Legal Holds and Suspension of Destruction

10.1 When to Implement a Legal Hold

A legal hold must be implemented immediately upon receipt of a subpoena, court order or discovery request; notice of litigation or a credible threat of litigation; an AHPRA notification or investigation; a Health Complaints Commissioner inquiry; an APS ethics complaint; a police investigation or child protection inquiry; a coronial inquest or serious incident review; a workers compensation matter involving the practice; or any other circumstance where records may be subject to legal or regulatory process.

10.2 Legal Hold Implementation

Step 1: notification (within 24 hours). A written legal hold notice is prepared specifying the nature of the matter, the scope of records subject to hold, the types of records covered, and the effective date and anticipated duration. Any person with access to affected records is briefed.

Step 2: identification and preservation (within 48 hours). All records within scope are identified and flagged 'LEGAL HOLD, DO NOT DELETE', a separate backup of affected records is created, automatic deletion and archiving processes are suspended for those records, and the hold is documented in the Legal Holds Register.

Step 3: ongoing management. Compliance is monitored, new records created during the hold are captured, and a log of all actions related to the hold is maintained.

10.3 Releasing a Legal Hold

A legal hold may only be released when written confirmation is received that the matter is fully resolved with no appeals pending, legal advice confirms the hold may be lifted, or the regulatory investigation or complaint is formally closed. On release, the hold flags are removed, normal retention schedules resume, and the release is documented in the Legal Holds Register. Records remain subject to standard retention periods after release.

10.4 Consequences of Legal Hold Violations

Failure to preserve records subject to a legal hold can result in adverse inferences in litigation, sanctions or contempt findings, regulatory action by AHPRA, and serious reputational damage.

11. Record Destruction Procedures

11.1 Annual Retention Review

Each year the Principal Psychologist will generate a report of inactive records approaching the end of their retention period, verify the retention calculation, check for legal holds or other reasons for extended retention, and prepare and approve a destruction schedule.

11.2 Secure Destruction Methods

Digital records are destroyed using secure deletion that overwrites data (minimum 3-pass overwrite), deleted from backup systems and archives, with deletion verified. Decommissioned hardware is physically destroyed or wiped by a certified service. Paper records are destroyed by cross-cut shredding (minimum security level P-4) or a certified secure destruction service.

11.3 Destruction Documentation

All destruction is documented in the Destruction Register, recording the date, a description of the records destroyed, the method, the person responsible, and approval. The Destruction Register itself is retained permanently.

12. Special Circumstances

12.1 Practice Closure or Sale

In the event of practice closure or sale, active clients will be notified of transition plans and their right to transfer records, compliant transfer or storage of all records will be arranged for the required retention periods (transfer to another practice with consent, secure archival storage, or a records custodian service), and public notice of closure and contact information for record access will be provided consistent with the Health Records Act 2001 (Vic). Records may not be destroyed early because of closure.

12.2 Psychologist Death or Incapacity

The practice maintains a professional will and succession plan identifying a records custodian. In the event of death or incapacity, the custodian assumes responsibility for records, notifies clients and facilitates continuity of care, maintains records for the required retention periods, and advises estate executors of professional record retention obligations. See the Business Continuity and Emergency Preparedness Procedure.

12.3 Client Access Requests

Client requests for access to records are handled under the Privacy Policy: respond within 30 days, verify the identity of the requester, provide copies rather than originals in an accessible format, apply any lawful exceptions with written reasons, and document the request and response in the client record.

12.4 Independently Commissioned Assessment Records

Records of medicolegal and other independently commissioned assessments (see section 10 of the Privacy Policy) are practice records and are subject to this policy in full. Each referral is maintained as a separate matter file containing the referral instructions, consent documentation, interview and assessment material, raw test data, correspondence and the final report.

These records are retained for the same minimum periods as client clinical records under section 6.1. The legal proceedings category will frequently apply, in which case the record is retained until the matter is fully resolved, including any appeals, plus 7 years. Access requests are handled in accordance with section 10 of the Privacy Policy; the report is provided to the commissioning party, and access by the examinee may be declined or directed to the commissioning party where a lawful exception applies. Raw psychometric test data is stored with the same security controls as other clinical records and is released only in accordance with test publisher conditions and applicable law.

13. Roles and Responsibilities

As sole director and Principal Psychologist, Dr Sarah Fischer holds overall accountability for record-keeping compliance, including documentation standards, email classification, the annual retention review, destruction approvals, legal hold management, and system security oversight. If contractors, locums or staff are engaged in future, their record-keeping responsibilities will be set out in their agreements and induction, and this policy will apply to them in full.

14. Training and Compliance

The Principal Psychologist maintains currency with record-keeping obligations through CPD and supervision. Any future contractor or staff member will receive training on this policy at induction, annual refreshers, and training following policy updates, with completion documented.

15. Policy Review and Updates

This policy is reviewed at least annually, and following changes to Board or AHPRA requirements, changes to relevant legislation, any significant record-related incident or breach, or changes to practice systems or technology.

16. Questions and Support

> **Behavioural Edge Psychology Pty Ltd**
>
> Dr Sarah Fischer, Principal Psychologist
>
> Phone: 03 8771 4315
>
> Email: sarah.fischer@behaviouraledgepsychology.com

Document Control

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