



JOANNA HENDERSON
Clinical Psychologist

RECORDS MANAGEMENT, RETENTION & DESTRUCTION

PRACTICE (“the Practice”, “we”, “our”):

Name: Joanna Henderson Clinical Psychologist

Practice entity: Joanna Henderson as trustee for the Henderson Trust

ABN: 87 285 092 848

Practice address: 131 Wickham Terrace, Spring Hill, Brisbane, Qld, 4000

For the purposes of this policy, references to “we”, “us”, “our” or “the Practice” include the trustee of the Trust and any of its employees, contractors or agents acting within the scope of their role.

PRACTITIONER (“the Practitioner”):

Name: Joanna Henderson

Title: Clinical Psychologist

Registration: AHPRA Registration Number PSY0002012556

For the purposes of this policy, references to the “Practitioner” indicate Joanna Henderson.

CLIENT (“You” or “the client”):

For the purposes of this policy, references to “You” or “the client” refer to the client of the practice.

PURPOSE

This policy explains how client and practice records are created, stored, retained, archived and destroyed by the Practice. It supports legal and professional requirements for record-keeping and works alongside the Privacy Policy, AI Policy and Data Breach Response Plan.

SCOPE

This policy applies to all records created or received by the Practice in the course of providing services, including:

- clinical records for all clients (adults, young people and families)
- assessment and test data
- correspondence and referrals
- billing and financial records related to client care
- administrative and governance documents.

It covers records held in:

- Zanda Health (clinical records, appointments, billing, communications)
- Novopsych and MHS Assessment Centre (psychological test data)

- NovoNote (AI-supported session notes – output stored in Zanda/client file)
- Notifyre (faxed referrals and correspondence)
- Medical Objects (electronic referrals and reports received)
- Email and Microsoft 365/OneDrive
- Any paper files or notes kept at the clinic or home office.

GUIDING PRINCIPLES

The Practice manages records in line with:

- **Privacy Act 1988 (Cth)** and Australian Privacy Principles
- **Psychology Board of Australia** and Ahpra record-keeping expectations
- NDIS Practice Standards (for NDIS participants)
- Good clinical, ethical and risk-management practice.

Key principles:

- Records are accurate, complete, timely and legible.
- Records are kept secure and confidential, with access on a strict need-to-know basis.
- Records are kept for at least the minimum legal/professional retention period, and usually longer where clinically appropriate.
- Records are securely destroyed or de-identified when no longer required.

TYPES OF RECORDS

The Practice maintains the following categories of records:

Clinical records

- Intake information, referral details, consent forms
- Session notes and summaries
- Treatment plans and goals
- Risk assessments and safety plans
- Outcome measures and progress reviews
- Copies of reports or letters written for GPs, psychiatrists, schools, NDIS, insurers or others.

Assessment and test data

- Novopsych and MHS Assessment Centre test protocols and results
- Scoring sheets, interpretations and reports.

Correspondence

- Referrals and letters from GPs and specialists (Notifyre, Medical Objects, email)
- Letters, reports or emails sent to third parties about a client
- Text messages and emails to or from clients, where clinically relevant.

Billing and financial records related to clients

- Invoices, payment records, Medicare and NDIS claiming records
- Records in Xero that relate to client billing.

Practice governance and administrative records

- Policies and procedures

- Complaint and incident records
- NDIS-related service records
- Contracts and room rental/licence agreements.

CREATION AND CONTENT OF CLINICAL RECORDS

- A separate clinical record is maintained for each client.
- Each entry includes at least the date, type of contact (in-person/telehealth/phone), and the clinician's name/initials.
- Session notes include sufficient detail to support:
 - understanding of the client's presentation and context
 - formulation, treatment planning and risk management
 - continuity of care for the client and other treating practitioners
 - professional, legal and ethical accountability.
- Notes may be drafted using NovoNote or other AI tools, but the final content stored in the record is always:
 - reviewed and edited by the clinician, and
 - stored securely in Zanda (or another designated clinical system).

STORAGE AND SECURITY

Electronic records

- Zanda Health is the primary clinical system and source of truth for client files, appointments, invoices and key correspondence.
- Novopsych and MHS Assessment Centre store assessment data; key results and interpretations are documented in the client's clinical record.
- Referrals and correspondence received via Microsoft Email, Notifyre and Medical Objects are saved or uploaded to the relevant client file where clinically relevant.
- Emails containing client information are:
 - minimised where possible, and
 - stored in, or copied to, the client file if they are clinically or administratively important.
- Devices used to access client records (MacBooks, phones, tablets) are:
 - password-protected
 - set to auto-lock
 - have full-disk encryption and security updates enabled.
- Cloud services (e.g. Microsoft 365/OneDrive) are used only where they are:
 - password-protected
 - secured with multi-factor authentication
 - configured to restrict access to authorised users.

Paper records

- Paper records (if any) are stored in a locked cabinet in the clinic or home office, not accessible to the public.

- Paper documents received (e.g. mailed referrals or forms) are, wherever possible, scanned and uploaded to the client file and the paper destroyed once no longer required.

ACCESS AND CORRECTION

Clients may request access to, or correction of, their records in line with the Practice's Privacy Policy. Requests are documented in the file and responded to within a reasonable timeframe. Where a request is refused or limited by law (e.g. likely harm to the client or another person, legal privilege), reasons are documented and explained to the client as far as appropriate.

RETENTION PERIODS

The Practice keeps records for at least the minimum recommended periods and may keep them for longer where clinically, legally or administratively appropriate.

Clinical records

- **Adults:**
 - At least 7 years from the date of the last entry in the record.
- **Children and young people (under 18 at time of last contact):**
 - Until at least the client's 25th birthday,
 - or 7 years from the date of the last entry,
 - whichever is longer.
- **Assessment/test data**
 - Kept for the **same period** as the clinical record for that client.
- **Billing and financial records**
 - Medicare, NDIS and other billing records are retained for at least 7 years from the date of the transaction (or longer if required by taxation or Medicare/NDIS rules).
- **Complaints and incident records**
 - Retained for at least 7 years after resolution of the matter and linked to any relevant client file.
- **Practice governance and policy documents**
 - Kept for as long as they remain current, plus at least 7 years after they are superseded.

Where laws or professional guidelines change, the longer or more protective retention period will be applied.

ARCHIVING CLOSED FILES

A client file is considered closed when:

- the therapeutic relationship has ended, and
- no further appointments are planned or expected.

Closed files:

- remain stored in Zanda and/or other systems, clearly marked as inactive/closed, and

- are restricted to access only when reasonably necessary (e.g. new referral, legal request, complaint, audit, or client request).
- Closed files are retained in line with the retention periods above.

DESTRUCTION AND DE-IDENTIFICATION

When records have reached the end of their retention period, and are not reasonably required for ongoing care, legal, administrative or audit purposes, they will be securely destroyed or de-identified.

Electronic records

The Practice will take reasonable steps to:

- delete or de-identify records from Zanda, Novopsych, MHS, email and other systems, or
- request and rely on the system provider's secure deletion processes.
- De-identified information (where individual clients cannot be reasonably re-identified) may be retained for statistical, audit or service planning purposes.

Paper records

Paper records are destroyed using:

- a cross-cut shredder, or
- a reputable secure document destruction service.
- Destruction must occur in a way that prevents reconstruction or unauthorised access.

SUSPENSION OF DESTRUCTION

Records must not be destroyed, even if their retention period has expired, where:

- there is an active complaint, legal dispute, audit or investigation involving the records, or
- the Practice has reason to believe that the records may be required as evidence.

In these situations, destruction is suspended until the matter is fully resolved and any additional retention obligations are met.

RESPONSIBILITIES

The Principal Psychologist / Practice Owner (Joanna Henderson) is responsible for:

- implementing and reviewing this policy
- ensuring systems used (Zanda, Novopsych, MHS, Notifyre, Medical Objects, Microsoft 365) have appropriate security and retention settings
- overseeing any bulk archiving or destruction.

All contractors or others who may handle records (e.g. room renters given limited access to shared equipment) must comply with this policy and the Practice's Privacy Policy.



QUESTIONS ABOUT THIS POLICY

If you are unsure about how this policy applies to you, or if you would like to discuss your situation, please contact:

- **Email:** admin@jhpsych.com.au
- **Business mobile (SMS):** 0435 013 760

We appreciate your understanding and cooperation. This policy helps us provide a reliable and sustainable service for you and for all clients of the practice.