WAC 246-836A-080 Recordkeeping and retention. (1) Documentation. A colon hydrotherapist providing colon hydrotherapy services to a patient must document services provided. Documentation should be in sufficient detail to support and enable anticipated continuity of care. The documentation must include:

(a) Patient name and contact information or name and contact information of a parent or guardian if a patient is under 18 years of age;

(b) Age of patient;

(c) Date the colon hydrotherapy service is provided;

(d) Written informed consent to treat, which is considered valid for the duration of the treatment referral or one year unless revoked; and

(e) For colon hydrotherapy where the focus is on treating a health condition, the documentation must also include symptoms and expected outcome measures as reported by the referring naturopathic physician and the treatment plan for future sessions, if applicable.

(2) Patient records.

(a) Colon hydrotherapist records for patients shall comply with record retention requirements and be secured with properly limited access consistent with chapter 70.02 RCW and the Health Insurance Portability and Accountability Act (HIPAA).

(b) A colon hydrotherapist shall ensure the patient record is legible, permanent, and recorded within 24 hours of treatment. Documentation that is not recorded on the date of service must designate both the date of service and the date of the chart note entry.

(c) The colon hydrotherapist shall retain in the patient record correspondence relating to any referrals by a naturopathic physician concerning the diagnosis, evaluation, or treatment of the patient.

(d) Patient records should clearly identify the referring naturopathic physician and the colon hydrotherapist providing the colon hydrotherapy service.

(e) Records for clients or patients 18 years of age and older must be retained by or be otherwise accessible to the colon hydrotherapist for at least three years from the date of last treatment, or for patients under the age of 18 years old, at least three years after the patient reaches 18 years old.

(f) After the retention period, records may be disposed of pursuant to this subsection. Disposal must be done in a secure and confidential manner in compliance with chapter 70.02 RCW and HIPAA and must include, as appropriate:

(i) Shredding;

(ii) Deleting, erasing, or reformatting electronic media; or

(iii) Rendering other readable forms of media unusable or unreadable.

[Statutory Authority: RCW 18.36A.160, 18.36A.095, and 2021 c 179. WSR 22-11-017, § 246-836A-080, filed 5/9/22, effective 7/1/22.]