HIPAA-Compliant AI Prompt Guide for Social Workers

Rapid Implementation Brief: Pull this guide immediately after client sessions when converting rough, unbilled field jottings into structured clinical progress notes using consumer generative AI tools. Follow the three-step sequence below to strip all 18 HIPAA Safe Harbor identifiers, execute audit-ready prompt templates, and verify clinical accuracy before signing the note inside your secure Electronic Health Record (EHR).

> ⚠️ **Legal & HIPAA Compliance Caveat:** Standard consumer versions of ChatGPT (Free, Plus, Pro, and standard Business plans) do not execute a HIPAA Business Associate Agreement (BAA). Entering any identifiable Protected Health Information (ePHI) into a non-BAA interface constitutes an unauthorized disclosure under federal law and violates NASW confidentiality standards. Never paste client names, exact dates, addresses, or legal docket numbers into an external AI prompt.

STEP 1: PRE-PROMPT HIPAA SAFE HARBOR REDACTION MATRIX

Before typing a single word into ChatGPT, scrub your session scratchpad against the 18 HIPAA Privacy Rule Safe Harbor identifiers below. Remove identifiers pertaining to the client, relatives, employers, and household members.

Identifier Category	Specific Data Elements to Remove	Safe Field Replacement Syntax
1. Names & Household Links	Full names, initials, nicknames, caregiver names, emergency contacts, foster parents, and collateral providers.	Replace with functional roles: **Client**, **Caregiver**, **Minor Child**, **Collateral Provider**.
2. Geographic Subdivisions	Street addresses, shelter names, cities, counties, precincts, and five-digit ZIP codes.	Use broad context only when clinically relevant: **local emergency shelter** or **rural residence**.

Identifier Category	Specific Data Elements to Remove	Safe Field Replacement Syntax
3. Exact Dates & Ages 90+	Birthdates, admission dates, hospital discharge dates, court dates, and exact ages over 89.	Use relative intervals: **two weeks post-discharge**, **next week**, or **age 90 or older**.
4. Contact Information	Telephone numbers, fax numbers, and personal or work email addresses.	Omit completely. Retain contact records solely inside your encrypted EHR profile.
5. Government & Health IDs	Social Security numbers, medical record numbers, Medicaid or Medicare IDs, and health plan numbers.	Omit completely. Insert official billing and chart IDs only after pasting text into your EHR.
6. Legal & Financial Numbers	Account numbers, certificate or license numbers, court docket numbers, and child welfare case IDs.	Replace with general status: **active child welfare matter** or **pending housing court hearing**.
7. Digital & Device Markers	Vehicle license plates, serial numbers, medical device IDs, web URLs, IP addresses, and biometric data.	Omit all device, vehicle, and network identifiers from clinical session summaries.
8. Biographic & Unique Links	Specific school names, employers, rare diagnoses, or high-profile local events that identify the person.	Generalize institutions: **local elementary school**, **part-time food-service employer**, or **community clinic**.

STEP 2: COPY-AND-PASTE SAFE CHATGPT PROMPT TEMPLATES

Copy the exact prompt syntax below for your required clinical note format, paste your de-identified bullet points at the end, and run the prompt. Each template includes negative constraints to prevent the model from fabricating diagnoses or risk levels.

A. Audit-Ready SOAP Note Prompt (Behavioral Health & Outpatient Therapy)

- **Prompt:** Act as a licensed clinical social worker. Convert the following de-identified session bullet points into a concise, objective SOAP note (Subjective, Objective, Assessment, Plan) that demonstrates medical necessity for insurance auditing. Use neutral, non-judgmental clinical language. Group client self-reports under Subjective, observable presentation and screening scores under Objective, clinical synthesis and progress toward treatment goals under Assessment, and measurable action steps with timeframes under Plan. Do not invent facts, diagnoses, or risk assessments not explicitly stated below. Input observations: [Insert scrubbed session bullets]

B. Case Management DAP Note Prompt (Care Coordination & Social Services)

- **Prompt:** You are a social work case manager documenting a routine support session. Organize these anonymized observations into a structured DAP note (Data, Assessment, Plan). Under Data, summarize objective behavioral observations, service barriers, and collateral contacts. Under Assessment, evaluate client strengths, functional progress, and ongoing resource gaps. Under Plan, list concrete action items assigned to the client and case manager with target completion timeframes before the next check-in. Keep sentences brief and measurable. Input observations: [Insert scrubbed session bullets]

C. Behavioral Intervention BIRP Note Prompt (Skill-Building & Crisis Stabilization)

- **Prompt:** Act as a behavioral health clinician. Format the following de-identified session notes into a professional BIRP note (Behavior, Intervention, Response, Plan). Clearly connect the specific evidence-based clinical interventions used during the session (such as safety planning, motivational interviewing, or cognitive reframing) to the client's observable verbal and behavioral response. Maintain objective, third-person clinical phrasing and do not add assumptions beyond the provided text. Input observations: [Insert scrubbed session bullets]

💡 **Clinical Efficiency Pro-Tip:** Save these three prompt shells in a blank local text file on your desktop labeled "Safe AI Prompt Shells." Never save client session drafts

in that file; paste your scrubbed bullets into ChatGPT, transfer the output into your EHR, and clear your clipboard immediately.

STEP 3: MEDICAL NECESSITY & OBJECTIVE PHRASE BANK

AI models occasionally generate vague or stigmatizing language. Use the defensible phrasing bank below to tighten your final note inside your EHR before signing.

Documentation Domain	Weak or Non-Compliant AI Output	Audit-Ready Clinical Replacement Phrase
Affect & Presentation	Client seemed very upset, erratic, and uncooperative during the meeting.	Client presented with tearful affect, rapid speech, and initial reluctance to discuss housing barriers; responded positively to validation.
Medical Necessity	Talked about stress and coping skills for 45 minutes.	Clinician provided 45 minutes of individual cognitive-behavioral intervention targeting acute panic symptoms that impair occupational functioning.
Risk & Safety Status	Client is fine and not a danger to self or others today.	Client denied current suicidal or homicidal ideation, intent, or plan; protective factors and crisis hotline contacts were reviewed and verified.
Client Engagement	Client failed to follow through on housing paperwork again.	Client reported transportation and literacy barriers to completing housing application; clinician and client completed intake packet jointly during session.
Measurable Plan	Client will work on anxiety and call resources this week.	Client will practice paced breathing exercises twice

Documentation Domain	Weak or Non-Compliant AI Output	Audit-Ready Clinical Replacement Phrase
		daily and contact local rental assistance intake line by Friday at 3:00 PM; follow-up scheduled in 7 days.

STEP 4: PRE-SIGN-OFF CLINICAL VERIFICATION CHECKLIST

Before locking and signing any AI-assisted note inside your official client record, verify all five quality and compliance controls:

- **Zero Residual Identifiers:** Confirm no real names, dates, or locations slipped into the AI window and that official client identifiers are added only inside your HIPAA-compliant EHR.
- **Factual Fidelity Check:** Verify the AI did not insert unstated symptoms, diagnostic labels, or clinical recommendations you did not observe or deliver.
- **Intervention-to-Goal Alignment:** Confirm the documented intervention directly links to an active goal on the client's individualized service or treatment plan.
- **Time & Billing Accuracy:** Verify exact session start and end times, service codes, and modality (in-person vs. telehealth) match your agency's billing requirements.
- **Independent Clinical Judgment:** Confirm the final narrative reflects your direct professional assessment and signature accountability per NASW ethical standards.