

<b>SUBJECT</b> HIPAA Privacy Measures – Protected Health Information		<b>CHAPTER</b> 03	<b>SECTION</b> 03	<b>SUBJECT</b> 02
<b>CHAPTER</b> Information Management		<b>SECTION</b> Health Records		
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I. APPLICATION:

- ☒ PIHP Board      ☒ CMH Providers      ☒ SUD Providers  
☒ PIHP Staff      ☒ CMH Subcontractors

II. POLICY STATEMENT:

It shall be the policy of the Region 10 PIHP that the PIHP and its providers employ safeguards to ensure the privacy of individuals' protected health information to meet the Health Insurance Portability and Accountability Act (HIPAA) privacy standards, with revisions from the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), and handle SUD information as required of 42 CFR Part 2.

III. DEFINITIONS:

Protected Health Information (PHI): PHI, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), with revisions from the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), includes 18 identifiers that can be used to uniquely identify a person by their demographic information, health conditions, medical histories, assessment/laboratory/test results, services or insurance beneficiary information as i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium. For PHI exclusions see 45 CFR §160.103. (See HIPAA Privacy Rules for more information).

Provider: CMHSP and SUD providers, individual or corporation; any CMHSP subcontracted provider/practitioner, individual or corporation.

IV. STANDARDS:

All plans and policies must address the following items:

- A. The PIHP Board and its officers, employees, agents and providers will not use or supply protected health care information of persons served for non-health care uses, such as direct marketing, employment, or credit evaluation purposes without his/her written authorization.
- B. Protected health information of persons served will be used to provide proper diagnosis and treatment; with the individual's knowledge and consent; to receive reimbursement for services provided; for research and similar purposes designed to improve the quality and to reduce the cost of health care; and as a basis for required reporting of health information.

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- C. Implementation of technical safeguards to ensure which personnel positions can access which types of protected health information. When technical safeguards are impossible or impractical to establish, staff will be responsible to access only the minimum necessary protected health information required to do their job.
- D. Staff will be trained on agency policies and procedures relevant to their job duties and protected health information.
- E. A privacy notice is required to be given annually to the individuals served.

V. PROCEDURES:

**PIHP Staff**

- A. All staff will store protected health information in a secure fashion which includes:
  - Logging off/locking of workstations when not in use/away from desk
  - Locking materials away when not being worked on
  - Secure interoffice mail in confidential envelopes
  - Not leaving individuals' information unattended
  - Not faxing any identifiable personal information, unless it is an emergency
  - Not emailing identifiable protected health care information

VI. EXHIBITS: N/A