

UNIVERSITY of CALIFORNIA • IRVINE HEALTHCARE

GENERAL ADMINISTRATIVE POLICY: *CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION (PHI)*

Effective Date: 07/12

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I. POLICY

It is the legal and ethical responsibility of all Medical Center staff, faculty, house staff, volunteers, students and researchers to protect the privacy and confidentiality of patients' protected health information (PHI). Only those individuals with a need to access and use an individual patient's protected health information in order to perform their work are permitted to do so.

Accessing (written or electronic medium) or communicating protected health information not associated with your job responsibility is considered a violation of this policy and will result in corrective action which may include termination of employment and personal legal consequences. Protected health information is to be maintained with appropriate physical and electronic security to prevent unauthorized access.

The medical record or any document containing PHI must be maintained on the premises of the medical center, hospital, clinic or laboratory at all times. Neither the original medical record nor any confidential or protected health information pertaining to any patient, or any photocopy or electronic copy of the medical record or patient information, or any portion or page of it, may be removed from the medical center, hospital, laboratory or clinic premises at any time, regardless of format or device, without either the written permission of the Dean of the School of Medicine or the Chief Executive Officer of the University of California Irvine Medical Center, or in response to a search warrant, court order, administrative demand by a regulatory agency, valid subpoena or other legal process confirmed by University of California, Irvine Counsel.

Failure to follow this policy will result in corrective action which may include termination of employment and personal legal consequences including reporting to appropriate licensing agencies.

II. REQUIRED STEPS

A. Staff with Access to the Medical Record

1. Treating physicians or clinical staff and administrative staff as needed to carry out a patient encounter.
2. Persons authorized under state and federal statute
3. UC Irvine Healthcare staff as needed to execute daily healthcare operations (such as billing, coding, charge capture, risk management, quality and safety oversight, compliance, case management and utilization review).
4. Faculty, house staff, students in the School of Medicine, nursing staff, other ancillary medical staff, others designated by the Institutional Review Board (IRB) will be eligible to utilize medical records for research studies. Use of Protected Health Information for research must have the written approval of the IRB.
5. Use for teaching purposes requires a UC teaching affiliation agreement or other legal agreement that describes the teaching relationship. The minimum necessary standard applies in this case.
6. The patient and those authorized by the patient or their personal representative, as defined in the policy: *“Access, Use and Disclosure of PHI”*.

B. Limitations on Access

1. Patient Care Purposes
 - a. Access only to the amount of information needed to treat the patient
 - b. All staff will be permitted to access patient information according to their role and responsibility, but only to the extent needed to complete those job responsibilities.
 - c. Access to psychiatric records is further limited to those involved in the care of patients in the psychiatric units and clinics.
2. Non-Patient Care Purposes is limited to the amount of information necessary to perform the non-patient care purpose.
3. Research
 - a. Access only to the amount of information needed to satisfy the project and as authorized by the IRB.
 - b. At no time will patient identifiable information be released in any format in the results of the reported/published research project.

C. Possible Consequences of Unauthorized Disclosures

1. Unauthorized disclosure of PHI could subject the individual to fines and penalties under HIPAA, of up to \$250,000 and 10 year imprisonment for willful disclosure of PHI for personal gain. Unauthorized release of

confidential information may also result in civil action under provisions of the California Administrative code. In addition to civil action, a patient whose medical information has been unlawfully used or disclosed, may recover up to \$4,000.00 and the cost of litigation. Unauthorized disclosure may be criminally punishable as a misdemeanor.

2. The HIPAA Privacy Rule 45 C.F.R. 164.530 and the Confidentiality of Medical Information Act (Civil Code Section 56 et seq) governs the release of patient identifiable information by hospitals and other providers. The Lanterman Petris Short Act protects the information of patients admitted to the psychiatric unit and psychiatric outpatient practices. These laws establish protections to preserve the confidentiality of medical information and specified that a healthcare provider may not disclose medical information or records unless the disclosures are authorized by laws or by the patient. This includes any information which identifies a patient by any one of 18 identifiers.
3. The medical record is a confidential and privileged document and can only be released in accordance with the Confidentiality of Medical Information Act and the HIPAA Privacy Rule. It is therefore the responsibility of UCI Healthcare to safeguard the information in the medical record against loss, defacement, tampering or use by unauthorized persons.
 - a. Records are to be treated as confidential material and protected for the sake of the patient and the institution.
 - b. No one is permitted to access or use them beyond the extent that their job requires.
 - c. PHI is not to be discussed among co-workers or shared with individuals or other third parties who are not permitted or authorized under law to receive the information.
 - d. Confidentiality of information also applies to information that is retained or printed from any computerized system.

D. Procedure for Staff Requests for Medical Record

1. Requests for medical records will be accepted via the following:
 - a. Automated clinic pre-pull request card
 - b. Automated chart request electronic pathway
 - c. Handwritten chart request forms
 - d. Faxed requests
 - e. Counter walk-in requests (no more than three records may be requested in this manner at a time)
2. Medical Record Sign-out

As chart requests are processed, and at the time the chart is pulled, information from the request form will be entered into the tracking system as follows:

- a. Medical Record number (PF#) and patient name if applicable
 - b. Requestor name, location and phone number
 - c. Chart type/volume(s) reserved
 - d. Date pulled
3. Duration of Medical Record Release
- a. AMBULATORY CARE VISITS:
Records, including current visit record, returned by end of visit date. (Clinics, emergency department, day surgery, infusion center, ancillary service areas, physician practice).
 - b. INPATIENT ADMISSIONS
Records including current admission record available for pick-up by 8:00 p.m. the evening of discharge.
4. Review of Patient Records
- a. Charts requested for non-patient care purposes will be reviewed in Building 25
 - b. Space is provided in the Health Information Management Department (HIMS) (Building 25) where chart reviews, completion, abstracting, photocopying can be conducted. Computer terminals are also available for viewing reviews in electronic queue.
 - c. Requests for more than three records at a time must be submitted three days in advance of the requested review date.
 - d. Only the last volume/admission of multiple volume records will be retrieved unless otherwise specifically requested on the chart request form.
 - e. Records will be available for review for two days. Records will be re-filed on the third day after appointment unless specific arrangements are made to extend the review period.
5. Conference/Committee Presentations
- a. Preparatory record review will be conducted in the review room.
 - b. Records will be released from the department to the designated site of the presentation one hour before the presentation.
 - c. Records will be returned to HIMS Department upon conclusion of the presentation.

E. Follow-Up

1. Medical records are tracked through the automated tracking system. Daily reports will be generated and reviewed to determine departments or individuals with overdue records based on the time frames outlined in the policy.

2. Departments or individuals overdue in returning records in a timely manner will be contacted and requested to return the overdue records.

III. REFERENCES

A. Regulatory and Standards Analysis

Purpose of the policy is to maintain optimal safeguards for the protection of confidentiality and appropriate access and use of protected health information (PHI) in both paper and electronic format.

B. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates significant changes in the legal and regulatory environment governing the provision of health benefits, the delivery of payment for healthcare services, and the security and confidentiality of individually identifiable, protected health information (PHI) in written, electronic or oral formats. The HIPAA Privacy Rule provides for the privacy of an individual's health information. The HIPAA Security Rule provides for the security of an individual's health information when the information is transmitted electronically. Title 22 and JCAHO Information Management Standards IM.2.2.1 through IM.2.3 requires that a written organizational policy exists that requires that medical records may be removed from the organization's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute.

California Medical Information Act California Civil Code §56 et seq outlines the California Requirements for protection of medical information in the state.

The Lanterman Petris Short Act provides additional protections for psychiatric information and applies to University of California (UC) Psychiatric Hospitals and UC Hospitals with psychiatric units.

Original Implementation Date: 08/07

Policy Owner: Jennifer Hughes
Director, Health Information Management

Approvals:

Privacy & Security Policy Committee	July 13, 2012
Med Exec Committee	July 17, 2012
Governing Body	July 23, 2012

Attachment "A"

GUIDELINES (if appropriate)

I. DEFINITIONS (only if applicable)

Protected Health Information (PHI): An individual's health information, maintained in any form or medium, that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to the individual, or the past, present or future payment for the provision of health care to the individual; identifies the individual or is reasonably believed could identify the individual.

II POLICY IMPLEMENTATION GUIDELINES

HIPAA: CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION (PHI)

In an effort to facilitate the implementation of the revised policy regarding confidential information, the Vice Chancellor for Health Affairs hereby provided the following implementation guidelines. They are intended to comply with 45 C.F.R. sections 164.306 and 164/308 et seq.

1. Original medical records or any copies thereof may not be removed from medical center sites for any reason whatsoever. Licensed and credentialed UC Irvine Medical Center practitioners and students or trainees under their direct supervision may remove abstracts of material containing protected health information ("PHI") upon an affirmative showing of good cause, and then only for purposes of direct patient care (e.g. preparation of progress notes, operative notes, discharge summaries, etc) if, and only if, those functions cannot be performed in a timely fashion onsite and if denial of such removal would clearly adversely impact patient care.

An individual removing PHI from the premises pursuant to this section must continue to take all reasonable precautions to safeguard the PHI at all times. This includes keeping the PHI in the direct custody or control of the individual at all times, or in a secured container until such time as it is returned to the medical center, as medical center is defined in paragraph (5) below. If a personal electronic device is used for anything other than access to electronic medical records through University approved firewalls and security measures, such device must meet the requirements of paragraph (4) below. Under no circumstances may PHI be kept in a car or other vehicle overnight.

If questions arise regarding who or what circumstances are covered, the Dean of the School of Medicine, in consultation with the Chair of the department of the involved practitioner, will make the final determination regarding removal of such material.

2. The policy regarding confidential information is not intended to apply to the act of

- transporting PHI from one practice site to another, even if such transportation involves automobile travel.
3. PHI may be retained by authorized personnel in the context of an IRB-approved clinical research study according to and abiding by safeguards as outlined by the IRB and UC policies.
 4. The policy regarding confidential information is intended to prohibit all practitioners, students and/or trainees from maintaining ANY PHI on personal devices or media including blackberries or similar devices, cell phones and/or personal computers, etc. unless such device is certified by the University of California, Irvine Medical Center Office of Information Services as being password protected with any information related to PHI being stored on that device sufficiently encrypted as to prevent disclosure of the PHI in the event the device is lost, stolen or the information stored within is otherwise compromised.
 5. The term “medical center” as used in the policy regarding confidential information is intended to encompass and apply to any and all clinical or office sites operated by or under the auspices of The Regents of the University of California, related in any way to the provision of clinical health care to individuals. Such sites include, but are not limited to: hospital-based clinics and laboratories; physician-based clinics and laboratories; outpatient surgery centers that exist or may in the future exist, physician offices, whether or not located in space owned by The Regents of The University of California; research laboratories that may be repositories for PHI in any way; student health center; and counseling centers.
 6. It is important to emphasize that it is the intent of the new policy and implementation guidelines to hold individuals accountable if any PHI is removed from the premises of UC Irvine Medical Center in any form by any employee, student or trainee, and such PHI is lost, stolen or otherwise misplaced without adhering to the clarification and implementation guidelines set forth above.