

Tai Sophia Institute

Standards and Practices

Privacy of Patient Records

MONITOR: Special Projects Administrator

LAST REVIEW DATE: March 17, 2003

STANDARD

Tai Sophia Institute is committed to treating patients with respect. Information of a personal nature with which the Institute has been entrusted in the course of treatment, referred to here as protected health information (**PHI**), will be kept confidential, consistent with the rule of law and the standards of professional practice. In particular, these Standards and Practices are intended to assure that the treatment services of Tai Sophia Institute are in all cases performed in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**).

PRACTICE

1. Written files containing **PHI** must be secured in locked cabinets when not in use. The primary storage cabinets for these files should be housed in a locked room or in an area away from public access. Computerized **PHI** must be maintained in a secure database with access limited by passwords and/or log-on codes as appropriate. Computer screens should be positioned to assure that unauthorized persons are unable to view **PHI**. All staff having access to **PHI** must exercise discretion when using **PHI** in conversations.
2. A **Notice of Privacy Practices**, accompanied by the **Practices Regarding Disclosure of Patient Health Information** notice, will be provided to patients at registration with specific information regarding the handling of **PHI**. The patient will be asked to acknowledge receipt of the information in writing, and such acknowledgement will be kept on file for six years.
3. Patients will be asked to indicate on the **New Patient Information Form** if any discretion is necessary when being contacted to remind them of their scheduled appointment via their home telephone. Contact and address information will be routinely verified as part of scheduling office visits to assure current patient information.
4. **PHI** may be used routinely for treatment, payment, and quality monitoring activities. In addition, **PHI** may be used or disclosed without an individual's written authorization in the following circumstances:
 - a. Uses and disclosures required by law
 - b. Uses and disclosures for public health activities
 - c. Disclosures about victims of abuse, neglect or domestic violence
 - d. Disclosures for judicial and administrative proceedings
 - e. Disclosures for law enforcement purposes

- f. Uses and disclosures about decedents
 - g. Uses and disclosures for cadaver organ, eye or tissue donation purposes
 - h. Uses and disclosures to avert a serious threat to health or safety
 - i. Disclosures for workers' compensation
5. Patients have a right to request restrictions on the use and disclosure of their **PHI**, although The Treatment Centre is not required to agree with the requested restrictions. Requests should be submitted by the patient on a **Restriction Request Form**. The patient's practitioner and the Clinic Administrator will confer about such requests. Their decision to comply with or deny the requested restriction should be documented on the form, with one copy kept on file and another returned to the patient. The agreement will be binding except in emergency situations, and may be terminated upon notifying the individual, or if the individual consents to or requests termination. Requests that are denied may be appealed to the Special Projects Administrator.
 6. State law pertaining to parent/guardian authorization takes precedence over the **HIPAA** requirements in #5 above governing requests for restrictions on disclosure. Where state law is silent, practitioners may use common sense to make decisions to release **PHI** to parents or guardians of minors.
 7. Non-routine requests for **PHI** must be approved by the Clinic Administrator, and may require specific authorization by the patient. An individual's authorization to disclose **PHI** should be submitted on the **Disclosure Request Form**, specifying the information being requested for disclosure, the recipient of the information, expiration date, a statement of the patient's right to revoke, and dated signature. Professional judgment should be used to limit disclosure to the minimum necessary information needed to accomplish the purpose specified in the authorization. Minimum necessary does not apply to health care providers providing treatment to a mutual patient. A Request for Disclosure of **PHI** may be denied by the Clinic Administrator for extreme reasons, such as information that may endanger life or well-being.
 8. Individuals can request an account of **PHI** disclosures made by the Treatment Centre in the six years prior to the request. Accounting does not need to include disclosures of **PHI** in the following instances:
 - a. For treatment, payment, and health care operations;
 - b. To the individual;
 - c. To persons involved in the individual's care;
 - d. For national security or intelligence purposes;
 - e. To correctional institutions or law enforcement officials;
 - f. Information accrued prior to the **HIPAA** compliance date.
 9. In some circumstances, **PHI** may be used once it has been stripped of all elements that could potentially identify the individual who is the subject of the protected information. Identifiers that must be stripped include:
 - a. Name
 - b. All address information
 - c. E-mail addresses

- d. Dates (except year)
 - e. Social Security Number
 - f. Medical record numbers
 - g. Health plan beneficiary numbers
 - h. Account numbers
 - i. Certificate numbers
 - j. License numbers
 - k. Vehicle identifiers
 - l. Facial photographs
 - m. Telephone numbers
 - n. Device identifiers
 - o. URLs
 - p. IP addresses
 - q. Biometric identifiers
 - r. A zip code, if the geographic unit includes fewer than 20,000 people
 - s. Any other unique identifying number, characteristic, or code that in the judgment of the health care provider could be used alone or in combination with other information to identify an individual who is a subject of the information.
10. The Treatment Centre must act on requests for onsite review of **PHI** within 30 days of receipt, and 60 days otherwise. Upon prior approval from the individual, fees may be applied to the cost of copying, mailing, and summary preparation where the cost is significant. By law, individuals do not have the right to access the following **PHI**:
- a. psychotherapy notes;
 - b. information pertaining to criminal, civil, or administrative actions;
 - c. **PHI** lawfully prohibited from release because it is subject to or exempted from Clinical Laboratory Improvements Amendments (CLIA);
 - d. Information created by someone other than the provider or given to the provider under a promise not to release.
11. Patients have a right to be involved in amending their **PHI**, and should be informed of that right in the **Notice of Privacy Practices**. Requests to amend information must be submitted in writing to the Clinic Administrator, along with the reason for the amendment, and responded to within 60 days of receipt. On receipt of a request, the Clinic Administrator will consult with the patient's practitioner. If the amendment is granted, The Centre will notify the individual and, to the extent possible, all parties who received the un-amended information. For denied requests, the Clinic Administrator will provide the individual with timely written notice explaining the reason for denial and his or her right to appeal to the Special Projects Administrator. Amendment documentation must be retained for six-years.
12. Circumstances where individuals do not have amendment rights include:
- a. Information not created by the health care provider (unless the patient claims the originator of the **PHI** is no longer available to amend);
 - b. The **PHI** is not part of the designated record set;
 - c. The **PHI** was unavailable for inspection;
 - d. The **PHI** is accurate and complete.

13. The Special Projects Administrator shall be the designated Privacy Official, with responsibility for developing and implementing **HIPAA** privacy policies and procedures, monitoring changes in the law in order to update any relevant policies. The Clinic Administrator shall be responsible for maintaining current copies of policies and procedures, keeping accurate records of **HIPAA** compliance, and shall be the primary contact person to respond to inquiries relating to internal privacy practices.
14. The Clinic Administrator has the responsibility to train staff in these policies and procedures and to document this training in the employee's personnel files. New staff should be trained in these policies and procedures within 30 days of hire, and will be required to sign the **Employee Agreement Form**. Minor infractions of these policies and procedures should be addressed with a verbal warning and viewed as an opportunity to educate. Gross infractions of policies and procedures are subject to disciplinary action, up to and including termination of employment.
15. Organization(s) not directly involved with patient care but having access to **PHI** must sign a **Business Associate Contract** upon initial contracting or at contract renewal. The Special Projects Administrator will assure that these contracts are implemented. Examples of such organizations may include building maintenance and janitorial services, data managers, and financial auditors, to the extent they have access to **PHI**.
16. Complaints from patients regarding the handling of their **PHI** should be submitted in writing to the Clinic Administrator, who should attempt to resolve the complaint in a timely fashion. The Clinic Administrator will document all complaints received in a separate **Complaint File** and track the disposition of these complaints. Should the patient not be satisfied with how his or her complaint was resolved, an appeal can be submitted in writing to the Special Projects Administrator who should provide an unbiased opinion within 30 days of the appeal. Outcomes of any complaints or appeals should be documented in writing, a copy furnished to the individual, and the documentation of the review must be retained for six years.
17. Personnel of the Treatment Centre are expected to act objectively when interacting with patients about the administration of **HIPAA** requirements. Staff are not permitted to intimidate, threaten, coerce, discriminate, or retaliate against any patient who chooses to exercise his or her rights under these privacy regulations. The Treatment Centre may not condition treatment, payment, or eligibility for any benefits by pressing an individual to waive his or her right to file a complaint with the Department of Health and Human Services.
18. Minor changes in these standards and practices that do not materially affect the content of the **Notice of Privacy Practices** may be made at any time, and will be noted by the version number following the dot (Version 1.X). Substantive changes will be noted by a new version number preceding the dot (Version 2.0). These changes will be documented by the Special Projects Administrator, implemented with a new effective date, and updates communicated to all individuals who are currently in treatment. Each revision will be chronicled in a volume for referencing changes, and shall be accessible to the Treatment Centre for a period of 6 years from its effective date.

19. Maryland law that is more stringent (i.e. provides more protection for the individual) than **HIPAA**, takes precedence over the federal legislation. In situations where the **HIPAA** regulations are more stringent, or state law is unclear, **HIPAA** governs state law.

20. A patient wishing to file a complaint or appeal with the Secretary of DHHS will be provided contact information and advised of the 180-day time frame for filing complaints. All workforce personnel shall fully cooperate with the investigation of any complaint or appeal. Currently the Office of Civil Rights is the division of DHHS that is handling complaints:

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.

Room 509F, HHH Building

Washington, D.C. 20201

OCR Hotlines-Voice: 1-800-368-1019

