UC Riverside, School of Medicine Policies and Procedures
Policy Title: Confidentiality of PHI
Policy Number: COM 14.0

Responsible Officer:	Compliance Officer
Responsible Office:	Compliance
Origination Date:	06/2013
Date of Revision:	N/A
Scope:	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.

I. Policy Text :

It is the legal and ethical responsibility of all Medical School staff, faculty, residents, 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 clinical practice site 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 clinical practice site premises at any time, regardless of format or device, without either the written permission of the Vice Chancellor and Dean of the School of Medicine 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, Riverside Campus 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.

IV. Definitions:

***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 of future payment for the provision of health care to the individual; identifies the individual

or is reasonably believed could identify the individual.

V. Procedures:

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. UCR Health 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, residents, students in the School of Medicine, nursing staff, other ancillary medical staff, and 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 UCR Health 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. Handwritten chart request forms
   b. Faxed requests

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 a 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. Review of Patient Records:
   a. Charts requested for non-patient care purposes will be reviewed by Compliance and Privacy Officer for review by the requestor and requests must be received by Health Information Management Department 7 days in advance.
   b. Space is provided in the Health Information Management Department (SOM Research Building) or(Clinical Practice Site) where chart reviews, abstracting, and photocopying can be conducted. Computer terminals are also available for viewing reviews in electronic queue.
   c. Only the last volume/admission of multiple volume records will be retrieved unless otherwise specifically requested on the chart request form.
   d. 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.

4. **Conference/Committee Presentations-Quality Management** :
   a. Preparatory record review will be conducted in the review room at Clinical Practice Site prior to presentation/review by Quality Management Committee.

VI. Forms/Instructions:

A. Attachment "A"

VIII. Related Information:

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.

IX. Revision History: N/A

Approval(s)

James R. Herron
Compliance and Privacy Officer
School of Medicine

Attachment A

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 Compliance and Privacy Officer in conjunction with the Vice Chancellor and Dean of the School of Medicine hereby provided the following implementation guidelines. They are intended to comply with 45 C.F.R. sections 164.306 and 164/308 et seq.

Original medical records or any copies thereof may not be removed from clinical practice sites for any reason whatsoever. Licensed and credentialed UCR Health 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 until such time as it is returned to the clinical practice site. If a personal electronic device is used for anything other than access to electronic medical records through UCR Health 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 Compliance and Privacy Officer, in consultation with the Chair of the department of the involved practitioner, will make the final determination regarding removal of such material.

POLICY IMPLEMENTATION GUIDELINES

1 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.

2 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.

3 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, Riverside School of Medicine 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 in otherwise compromised.

4 The term "clinical practice site" 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.

5 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 UCR Health clinical practice sites 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.